Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 3 December 2025, 10.00am – 1pm
Trust Conference Room, Warrington Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/12/121	**10:00**	Engagement Story - Angela's story - Amara and her journey	***To note***	**Presentation**	Sarah Nuttie, Consultant Midwife
BM/25/12/122	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/25/12/123	**10:17**	Minutes and Action Log of the previous meeting held on • 1 October 2025	***For approval***	***Minutes***	Chair
BM/25/12/124	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/25/12/125	**10:25**	Chief Executive's Report	***For assurance***	***Report & Verbal***	Deputy Chief Executive
BM/25/12/126	**10:35**	Chair's Report – • Governor Elections Results	***For info/update***	***Report***	Chair
BM/25/12/127	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/25/12/128	**10:50**	**Integration Update** i. Full Business Case ii. Board certification iii. Post Transaction Implementation Plan (PTIP) iv. Secretary of State for Health documents	***For approval***	***Report***	Chief Strategy & Partnerships Officer
BM/25/12/129 **(a)**	**11:05**	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Quality Assurance Committee 14.10.25, 11.11.25	***For assurance***	***Report***	Chief Nurse Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee in Common 15.10.25, 19.11.25	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair

(c) **d)**		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Productivity Committee in Common 27.10.25, 24.11.25	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
		Audit Committee Assurance Report 20.11.25	***For assurance***	***Report***	Committee Chair. Mike O'Connor
Strategic aim:	**Quality**				
BM/25/12/130	**11:30**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/25/12/131	**11.40**	**Maternity Update – Overview Paper** i PMRT ii. Maternity Incentive Scheme Year 7 Update iii Maternity & Neonatal Quality Review iv Maternity Self-Assessment Tool	***To note for assurance***	**Report**	Interim Director of Midwifery
BM/25/12/132	**11:50**	Compliance Update Q2	***To note for assurance***	**Report**	Chief Nurse
Strategic aim	**People**				
BM/25/12/133	**12.00**	Bimonthly Communications and Engagement Report	***To note for assurance***	**Report**	Director of Communications and Engagement
BM/25/12/134	**12.10**	Freedom To Speak Up Guardian Report	***To note for assurance***	**Report**	Freedom to Speak up Guardian
Strategic Aim	**Sustainability**				
BM/25/12/135	**12:20**	Bimonthly Strategy Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer
BM/25/12/136	**12:30**	Emergency preparedness, resilience and response (EPRR) annual Core Assurance outcomes	***To note for assurance***	**Report**	Chief Operating Officer & Deputy Chief Executive

Governance					
BM/25/12/137	**12:40**	Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	***To approve***	**Report**	Chief Finance Officer

BM/25/12/138	**12:45**	Proposal to extend the Membership Strategy to 2026	***To approve***	**Report**	Company Secretary
BM/25/12/139	**12:50**	Updates to the Constitution – Partner Governor Composition	***To approve***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/12/140	Patient Experience 6 Monthly Report – Patient Experience Sub-committee (PESC) - **Includes In-Patient Survey**	Quality Assurance Committee Date: 14.10.2025 Ref: QAC/25/10/164 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/12/141	Learning From Experience Summary Report Q2	Quality Assurance Committee Date: 11.11.2025 Ref: QAC/25/11/190 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/12/142	DIPC Q2 Report	Quality Assurance Committee Date: 11.11.2025 Ref: QAC/25/11/187 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/12/143	Guardian of Safe Working Report Q2	Strategic People Committee in Common Date: 19.11.2025 Ref: SPCiC/25/11/161 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
Closing					
BM/25/12/144	**12:55**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/25/12/145		Any Other Business	To discuss	**Verbal**	Chair
Date and time of next meeting 4 February 2026, Trust Conference Room, Warrington Hospital					

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity Patient Story

Angela’s story - Amara and Her Journey

Presented by Sarah Nuttie, Consultant Midwife





Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Angela's Story

"My name is Angela, and I'd like to share my story — the story of my daughter Amara, my son Theo, and the incredible care I received from the ***Butterfly Team*** *and later the* ***Rainbow Pathway****"*



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Experience of Maternity Care
Baby Amara

12 week scan diagnosis

Midwifery support

Amara born at 38 weeks by caesarean section

Newborn screening checks

Butterfly Suite



Warrington and Halton Teaching Hospitals
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Experience of Maternity Care Baby Theo

Pregnancy confirmed

Continuity of Care

Rainbow pathway

Anxiety

Emotional support

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Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 1 October 2025 Lecture Theatre, Halton 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
Julie Jarman (JJ)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Ali Kennah (AK)	Chief Nurse
Apologies	
John Somers (JS)	Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Michelle Cloney (MC)	Chief People Officer
Lynne Carter (LC)	Director of Delivery Unit
Tina Moores (TM)	Deputy Director of Midwifery
Kate Preston (KP)	Supported Living Homes Representative **BM/25/10/93**
Sally Lee (SL)	service manager for Macintyre **BM/25/10/93**
Zetta Edwards (ZE)	Matron Learning Disabilities **BM/25/10/93**
John Culshaw (JC)	Company Secretary
Emily Kelso	Corporate Governance and Membership Manager **(minutes)**
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Margaret Bamforth	Public Governor, Warrington and Halton
Vicky Woodjets	Organisation Development Business Partner
Andy Carter	Member of the Public

Agenda Ref	Agenda Item
BM/25/10/93	**Engagement Story – Luke's Story - Diabetic Management Admission** KP introduced the story of Luke, a resident of the supported living facility with a learning disability and complex sensory needs, living alone but supported 24/7. KP explained that Luke communicated mainly non-verbally, expressing

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	discomfort or refusal through gestures and, at times, self-injurious behaviour. She noted that Luke thrives in familiar environments with trusted staff but struggles with change and unfamiliar faces. SP described the challenges in managing Luke's diabetes, highlighting his refusal to tolerate skin contact for monitoring devices and the difficulty in obtaining blood tests. Staff had used creative methods to collect samples, but uncertainty remains about his glucose levels. SP added that some of Luke's behaviours may be linked to undetected highs or lows in blood sugar. KP detailed the careful planning required for medical appointments, including adjusting Luke's routine and providing extra staff. On the day of his recent admission, Luke was brought directly to the back door and engaged with puzzles to help him settle. Staff observed recurring health issues, such as earaches and a lost tooth, which led to a dentist visit and a best interest meeting to consider general anaesthetic for multiple procedures. CR queried the multidisciplinary approach, asking whether the GP or several consultants initiated it. KP clarified that staff coordinated with the GP, dentist, diabetic, social worker, and learning disability team (notable ZE) to ensure all aspects of Luke's care were addressed. SP emphasised the importance of pre-admission planning, which prevented distress and allowed staff to focus on Luke's comfort. She noted that ongoing desensitisation for blood tests is slow and may take up to 12 months. The agreed plan is for Luke to return for bloods within six months, following the same supportive process. LG thanked the team and asked about the duration of Luke's stay. KP confirmed it was a day case. AK questioned whether the organisation had improved in supporting complex patients over the past five years. SP affirmed significant progress in engagement and support. KP discussed family involvement, noting that Luke's family visits every few weeks and expressed satisfaction with the support provided. **The following key ongoing actions were noted** • Continued desensitisation work for Luke's blood tests, with a repeat admission planned in six months • Review and update hospital passports, especially for theatre admissions • Integrate lessons from Luke's case into staff training and structured plans for complex patients • Monitor and improve diabetic eye screening processes, referencing national studies Board members acknowledged the flexibility and collaboration shown by staff, consultants, and providers, which led to a better outcome for Luke. The importance of communication and listening to staff was highlighted, with all agreeing that procedures must remain patient centred. **The Trust Board discussed and noted the Engagement story and thanked guests for attending to present Luke's story**
BM/25/10/94	**Welcome, Apologies and Declarations of Interest**

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	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 the Board of the passing of Dr Akash Ganguly, a respected consultant, and acknowledged his contributions to the Trust particularly in his role as Staff Governor. All Board members stood for a minute's silence to honour Dr Ganguly. SMcG informed all present that the meeting would be recorded for the purposes of producing the minutes using AI, in line with the Digital Acceptable Use Policy, and no objections were raised. **The Trust Board noted the apologies and declarations of interest.**
BM/25/10/95	**Minutes and Action Log of the previous meeting held on 6 August 2025** The minutes of the meeting held on 6 August 2025 were agreed as an accurate record subject to some minor amendments. The action log was reviewed, with ongoing items relating to accountable care organisations and neighbourhood health deferred to January for a Board development action part of business as usual. **The Trust Board approved the minutes of the meeting held on 6 August 2025 and noted the Action Log**
BM/25/10/96	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/25/10/97	**Chief Executive's Report** NK presented the paper, which was taken as read, and the following key points were highlighted: • NHSE had published new segmentation and peer group ratings, assessing trusts on quality, performance, money, and workforce. WHH was placed in segment 4, indicating higher risk and eligibility for additional support. Rankings were reviewed quarterly; WHH was ranked 118 out of 134 District General Hospitals. • The staff survey was launched on 9th September. The Trust continued to encourage staff participation, as the survey was independently assessed and informed future action plans. • The latest CQC inpatient survey showed improved response rates (41%), with positive feedback on staff kindness and respect, and some improvements in communication and cultural sensitivity. Waiting times and discharge support remained areas for improvement. • In the second half of the year, the Trust received a letter from Jim Mackey, thanking staff and urging continued focus on financial management, winter preparedness, and leadership visibility. The Trust anticipated further guidance from NHS England on financial and winter planning. • Leadership changes in Cheshire and Merseyside were noted: Janelle Holmes had become interim provider representative,

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	Andrea McGee started as CFO on 15th September, Carl March had joined the Corporate Directors leadership team as Interim Transformation Director - and Amanda Ridge was now Interim Place Director (Warrington) • The collaborative provider continued to support delivery across the region, with leadership reviewing the NHS provider blueprint and aiming to reset collective goals. • Appendix 1 provided a snapshot of Trust performance NK clarified that the report listed only formal meetings attendance, though many informal meetings had also taken place. **The Trust Board noted the Chief Executive's Report**
BM/25/10/98	**Chair's Report** SMcG provided a verbal update since the last Board meeting, highlighting the following key points: • Upon reviewing the recent NHS league table publication, District General Hospitals (DGHs) across the country were found to be in a challenging and often *grim* situation. • The Cheshire and Merseyside Integrated Care Board (ICB) had been facing particularly difficult circumstances, both financially and strategically and he had been immersed in multiple meetings associated with this turbulence • From a Non-Executive Director (NED) perspective, SMcG encouraged the Board to question itself to ensure it could be satisfied that all necessary actions were being taken. He expressed a view that open and honest conversations between Executives and NEDs to ensure robust assurance had always been a feature at WHH and even though there was huge pressure it was vital that openness and honesty prevailed. LG emphasised that it had been important to ensure any outcomes or recommendations from Board discussions were appropriately fed into the Trust's five-year plan, and that longer-term solutions were considered. The Board discussed the difficulties in producing a credible ICB plan, noting that the system had been approximately £600 million adrift. The Board agreed it was vital to have clarity on ICB leadership before committing to a new five-year plan, as many key, local decisions were contingent upon a full understanding of commissioning intentions and strategy. This was what had been lacking virtually since the inception of the ICB. CR added that the challenge extended beyond the ICB, questioning what the overall NHS landscape would look like in the coming years. CR stressed that the five-year plan needed to focus on the Trust's own aspirations and priorities, rather than being solely dictated by external uncertainties. SMcG also noted that the Trust's AMM was to be held later that day and also that the 2025 governor elections had been initiated. He hoped for a similarly enthusiastic response in terms of candidates as 2024 when important governance changes and a renewed approach to communications had transformed the number of people putting

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	themselves forward for election. The hope was again to get over 20 people seeking election to be public governors and a brief would be provided to the next Board in December. Finally, SMcG noted that the advert for his replacement had been placed, and a recruitment process led by CR was in train. SF (lead governor) and other governors would play a key role in the selection process alongside the other relevant stakeholders including a contribution from BW. **The Trust Board noted the verbal update from the Chair.** **Action: SMcG to provide a brief to the December Board in relation to governor elections 2025.**
BM/25/10/99	**Board Assurance Framework (BAF)** JC introduced the report which provided the board with an update on each of the Trust's strategic risks. Particular updates were provided on the following: • **Risk 115:** Nurse turnover and attendance initiatives had shown improvement, with new programmes helping to address persistent sickness rates among staff. • **Risk 2001:** The fragile services risk description had been clarified, with the Board noting that while some services had seen progress and improvements, fragility remained in certain areas due to ongoing challenges. It was acknowledged that, despite best efforts and mitigation strategies, some degree of service fragility may persist. • The alignment of risks with CQC domains had been reviewed, ensuring that all risks were mapped appropriately to regulatory standards. Board discussion confirmed that weekly meetings would continue to monitor fragile services, allowing for timely escalation of any emerging issues. The Board also agreed to update risk descriptions regularly to ensure they accurately reflected both current challenges and areas of improvement. Board also discussed the multiplying effect of the many challenges being faced both operationally and financially and challenged themselves in relation to whether the risk-by-risk approach of the register fully did justice to the combined risks before the Trust. Against this backdrop SMcG suggested that it would be useful for the NEDs and the CEO to take some quality time out to have a searching and testing conversation on this basis…some kind of quality/ risk summit. **The Trust Board approved the changes and updates to the Strategic Risk Register and Board Assurance Framework and noted the intention to hold a Quality/ Risk Summit in the near future.**
BM/25/10/100	**Integrated Performance Report** NK introduced the agenda item which provided a summary of Trust performance. The executives presented a set of summary slides which highlighted the indicators within the IPR that were both failing and had special cause variation of a concerning nature. **Performance:**

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- The Trust continued to manage a small number of 65-week wait patients, with procedures scheduled for completion by the end of October.
- UEC (Urgent and Emergency Care) performance remained a concern.
- Full theatre capacity was expected by the end of October.

Quality:

- There had been no recent sepsis-related harm, but a “never event” had occurred.
- a clinician was now leading on sepsis, and although there were issues with lactate measurement and proforma completion, a good percentage of patients were receiving antibiotics within six hours. Quality summits with wards were ongoing, and no harm had been observed from current practice.
- quality improvement in A&E was challenging due to departmental busyness and footprint complexity, with differential performance between inpatients and A&E.

CR explained that the clock for sepsis management started when clinical suspicion was raised, and recent changes had been made based on NICE guidance. Training for blood cultures was ongoing, but data did not always reflect clinical reality. Patients were receiving appropriate treatment, but not always within the target timeframes, especially those who did not present as acutely unwell.

SMcG asked whether the Trust could learn from others, noting that some had dedicated sepsis teams. AK responded that siloed teams were not preferred, and JD agreed, emphasising the importance of integrated practice.

SMcG queried confidence in progress and movement up the league tables. NK responded that 25% of organisations would always be in the lower categories due to segmentation, and the key was to focus on self-improvement and sustainability. Cancer performance was strong, and small percentage improvements made a significant difference.

CR and JD discussed sustainability, noting that improvements in falls and sepsis could be impacted by external factors. While no harm was currently being caused in sepsis, there had been harm in fractured neck of femur (NOF) cases. Sustainability of good practice remained a challenge.

JD raised the importance of clarity in maternity quality aims, particularly around post-partum haemorrhage (PPH), and CR highlighted the role of instrumentation in delivery as a possible cause for higher PPH rates. Assurance was provided that care quality was not an issue, and Tina (Deputy Director of Midwifery) confirmed that plans were in place.

CR raised concerns about the typing backlog, noting that dictations were not always being typed up promptly, which could delay transmission of significant clinical information. DM reported good compliance with urgent letters and outlined triaging processes to prioritise urgent cases. The backlog in routine letters was being addressed, with audit and QAC oversight.

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People and Culture:

JJ and MC highlighted the following key items from the **Strategic People Committee in Common** assurance reports from a people perspective:

- the impact of integration with Bridgewater on staff metrics, noting increased sickness rates and the need for targeted communications.
- The Trust was proactively addressing bullying and harassment, with joint strategies and triangulation of data across committees. Theatre culture improvements were highlighted, and due diligence was ongoing to understand sickness trends.

The Board emphasised the need for compassion to extend to patients and the importance of supporting managers in addressing staff issues. National alignment of nursing and midwifery profiles is underway, with significant work required to mitigate risks.

SMcG noted that industrial action had largely passed unnoticed by the public, but significant work had been done behind the scenes to ensure minimal disruption to quality of care, and thanked the team for their effort and endeavour in this respect

MC reported that long-term sickness had reduced, with efforts to keep staff in work. Due diligence was being undertaken to understand sickness rationale, and best practice was being reviewed across Cheshire and Merseyside.

JH reported on the **Finance, Sustainability and Productivity Committee in Common**, providing an update on the Committee's recent discussions and the current financial position. JH confirmed that the Committee had reviewed the Integrated Performance Report (IPR) and noted that, while the Trust remained on plan financially, there continued to be risks going forward, particularly in relation to the delivery of cost improvement programmes and the impact of external pressures such as winter demand and potential industrial action.

JH highlighted that the Committee had considered the Trust's cash position in detail and, as part of the IPR paper, requested the Board's support to submit a formal cash support request to NHS England. This request was necessary to ensure the Trust could maintain financial stability and meet its obligations in the coming months. The Board was assured that the request had been fully scrutinised by the Committee and was in line with the Trust's financial planning and controls.

The Board discussed the recommendation and gave its support for the submission of the cash support request to NHS England.

Audit Committee
MO'C reported no additional items. The typing backlog was discussed as a critical issue, with PF outlining the move towards paper-free processes and the challenges of switching between digital and paper communications. DM noted the impact on RTT and decision-making.

Charitable Funds Committee

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	SMcG reported no additional items. The charity impact story was noted, highlighting the small team's achievements with limited resources. The final version of the annual report would be presented to the December Board meeting. **The Trust Board noted the contents of the report and approved the cash support request.**
	QUALITY
BM/25/10/101	**Fragile Clinical Services Update** PF introduced the report and provided a status update on the Trust's oversight of services currently designated as fragile: Chronic Pain Service, Urology, Cancer Services, Orthopaedics – Fractured Neck of Femur (FNOF), and Cardiorespiratory/Cardiology Services. PF confirmed that no services had moved in or out of the fragile category since the last report, and the paper was taken as read. • **Orthopaedics (FNOF):** The Board noted an improvement in performance and a reduction in mortality rates. PF explained that data submitted to the national hip fracture database had flagged a true increase in mortality, which triggered further action. The team had reviewed case mix and approved mortality and held conversations to ensure all staff understood the data being submitted. More prompt surgery and weekly team discussions had contributed to the recent improvements, and the service was now back within control limits. • **Urology**: The service had moved to an improved position, with a plan in place to manage upcoming consultant retirements. • **Chronic Pain Service:** No significant improvements had been observed. There had been a change in clinical lead, and the intention was to transition the service into a community-based model. • **Cancer Services:** No incidents of harm had been reported. The service was scheduled to return to the Quality Assurance Committee (QAC) for a deep dive review. • **Cardiorespiratory/Cardiology Services:** Progress for patients awaiting results had not advanced as expected. The Deputy Medical Director was focusing on cardiology, and it was anticipated that the service would come out of the fragile category in the next month. PF emphasised the importance of ongoing data submission and review, particularly for FNOF, and highlighted the need for continued prompt surgery and regular team engagement to sustain improvements. **The Trust Board: noted the current list of Fragile Services, associated clinical risk and high-level progress updates**
BM/25/10/102	**Compliance Update** AK provided a detailed update on the Trust's preparations for an anticipated CQC inspection, which was expected to focus on the Well Led domain and potentially other services. The Trust had established regular quality compliance summits with care groups, resulting in strong engagement and collaboration. Each care group was required to complete comprehensive data packs to support self-assessment and

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	evidence gathering. These data packs were currently being validated through scheduled panel meetings. AK confirmed that a gap analysis had already been completed to identify areas requiring further improvement and support, ensuring care groups and teams were well prepared for inspection. Outstanding queries from CQC were being actively addressed, including three relating to ligature risks and two concerning complaints. Preparations for Well Led board observations were underway, with the next engagement expected at the December Board meeting. AK noted that the Quality Compliance Oversight Group (QCOG) was reviewing the reporting structure and suggested that a flow chart would be helpful to clarify assurance and escalation processes. LG commented that the QCOG was not currently reflected in the Terms of Reference and recommended this be updated. **The Trust Board noted the contents of the report.**
BM/25/10/103	**Quality Strategy Update** AK introduced the report and discussed whether to bring progress against quality priorities and the quality strategy more directly into Board reporting. It was noted that while quality priorities were referenced in the current paper, the focus should be on the progress and impact that sits beneath these priorities, with updates first going to the Quality Assurance Committee (QAC) and then to the Board. Several members commented that the current paper needed to be more robust and clearer and that bringing together progress against the priorities and the overall quality strategy would be more useful for the Trust Board. It was agreed this would be actioned prior to the next presentation of the Quality Strategy update to Trust Board in 6 months' time. LG highlighted that performance against KPIs and quality priorities were already seen by the Board but suggested that these updates should routinely come through QAC to ensure robust oversight and clearer reporting. **The Trust Board noted the report and agreed the amendments for AK to take forward prior to the next presentation of the update to Trust Board in 6 months' time.**
BM/25/08/64	**Maternity Review of Year Progress Report** TM introduced the presentation which provided the Trust board with an overview of assurance around Maternity Services. The following key highlights were taken from the reports: **I. ATAIN Q1 2025/26** The action plan from the ATAIN group had become more robust, with ongoing work to address respiratory admissions and transitional care. **II. Maternity Incentive Scheme Year 7 position** The Trust was compliant with most actions, with only a couple

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	requiring further work, particularly around safety actions 3 and 5. Staffing shortfalls had been escalated as a possible risk, but 1:1 care continued to be provided. Safety action 7 was discussed, with assurance that staff had the necessary background knowledge. **III. September Maternity Quality & Safety update** An increase in post-partum haemorrhage (PPH) rates was observed in June. Quality improvement initiatives were being reintroduced in line with new national guidelines, with the expectation that these would make a positive difference. A deep dive into caesarean section rates and mode of delivery was planned, and additional section dates had been introduced. There were no issues to raise regarding workforce, mandatory training, or triage. The induction rate in July was 40%, and a bleep holder role had been introduced to support the process. The Trust was exploring referral to consultant midwives and dedicated induction slots to reduce delays, and benchmarking induction agents used by neighbouring trusts. **IV. Transitional Care Q1 2025/26** Transitional care formed part of the Saving Babies' Lives initiative. While bedside care was not always possible, transitional care was provided, though not always to the gold standard due to staffing constraints. Staff knowledge had increased, but the staffing model sometimes did not support bedside care, resulting in babies being transferred to the neonatal unit. The Board discussed the need to explore further advances in transitional care provision. JD thanked the team for the comprehensive updates and expressed concern about transitional care, noting that CQC was likely to revisit this area. JD highlighted that nationally, some units had been asked to return monies due to assurance issues with MIS submissions. The Board agreed that assurance needed to be robust to avoid future risk and noted Tina's involvement in MIS submissions. TM clarified that transitional care, including feeding and temperature control, could be provided with mothers if staffing allowed. Specialist oversight for babies came from the neonatal establishment rather than midwifery, and current practice was driven by staffing limitations. **The Trust Board noted the content of the report.**
PEOPLE	
BM/25/10/105	**Bimonthly Communications and Engagement Report** KH introduced the report. The key highlights from the report discussed were as follows: • The Trust held its first internal session for staff focused on service change, supporting staff engagement and understanding of upcoming initiatives. • Summer was typically busy for community engagement events, with services and governors actively engaging with members of the public and recruiting members for the Experts by Experience programme. • The launch of a new charity website and a new Trust website had improved accessibility and information for both staff and the public. • Significant communications and engagement work had taken

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	place around the development of future organisational values. JJ raised interest in the "job of the week" feature highlighted on social media, querying whether it had increased interest in vacancies and whether the Trust was reaching out to socially deprived areas. It was noted that the Trust was not currently undertaking paid advertising for recruitment and did not specifically target deprived communities but acknowledged the need to improve in this area. With integration, there could be further opportunities to expand and enhance recruitment communications, and there was considerable scope for further development. **The Trust Board noted the report**
BM/25/10/106	**GMC Re-validation Annual Report inc Statement of Compliance** PF presented the annual GMC Re-validation Report and Statement of Compliance, which is submitted to NHSE and the GMC. The report provided strong assurance that the Trust's medical governance and appraisal systems were robust and compliant. Attention was drawn to the figures on page 22 of the report: - Only 1.6% of doctors were non-compliant with appraisal requirements. - Of the 76 doctors due for revalidation this year, 73 had gone straight through to revalidation. - One doctor had a deferred appraisal, and 34 had an approved missed appraisal due to legitimate reasons such as secondment or maternity leave; these were not considered compliance issues. **The Board noted the contents of the report and confirmed the Trust's statement of compliance for submission**.
BM/25/10/107	**i. Workforce Race Equality Standard (WRES) Annual Report 2024/25** The report was taken as read. MC highlighted that during the year, the Trust ran a targeted campaign on bullying and harassment, including bystander training, which empowered staff to address inappropriate behaviour in the workplace. It was noted that this campaign would continue, with a focus on ensuring all staff felt safe and supported, and that clear reporting mechanisms were in place. **ii. Workforce Disability Equality Standard (WDES) Annual Report 2024/25** The WDES Annual Report was also taken as read and scheduled for submission and publication by 31st October. The Trust worked to increase the number of staff declaring a disability, promoted accurate reporting of disability status, and saw positive trends in staff survey metrics, with further results expected in Quarter 4. The Trust continued to focus on reasonable adjustments and established staff networks across both organisations to support disabled staff. SMcG noted a deterioration in the number of people reporting harassment and questioned whether this reflected a loss of confidence in the process. MC confirmed that training for managers on responding effectively to concerns was underway. NK highlighted the need to engage and support middle managers and the leadership team to ensure they understood their responsibilities and could support staff effectively. The

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	Board agreed to prioritise ongoing training and engagement with managers to rebuild staff confidence. **The Board approved the reports for submission and publication by 31 October 2025.**
	SUSTAINABILITY
BM/25/10/108	**Strategy Programme Highlight Report** LG introduced the Strategy Programme Highlight Report, updating the Board on progress across key strategic projects supporting WHH's strategic (QPS) priorities. LG reported significant progress on the Runcorn Health and Education Hub, noting that construction was on track to finish in December or January, with plans to open early next year. The Board heard that both construction and lease arrangements were progressing well, and it was suggested that the Board development session in November could include a site visit. LG also highlighted the reinstatement of regular meetings with local partners, including MPs and place directors, as part of the New Hospitals Programme and strategic estates integration. These meetings were being used to re-engage partners and ensure alignment on future plans. On the Theatres Improvement Fund (TIF), DM reported that October was a key month for theatre capacity. Recovery areas at Halton theatres were being brought back into use, enabling a greater number of patients to be scheduled. Theatre 6 was expected to be operational from 22nd October as part of the TIF work. SMcG noted that, while progress was on track, an urgent briefing would be required if any delays arose. **The Trust Board noted the report.**
BM/25/10/109	**Organisational Strategy and Values** The Board received an update on the Organisational Strategy and Values. It was noted that this work had recently been presented to the Governors and represented a first step towards developing a unified strategy for the new organisation. The Board emphasised the importance of ensuring the strategy and values were shaped with broad organisational engagement but ultimately owned by senior leadership, including the incoming Chair. LG summarised that detailed conversations had taken place during Board development sessions, with engagement from Governors and other stakeholders. Slide 7 of the presentation set out the revised mission, vision, and aims, including updated wording for the "people" aim based on feedback. The strategic objectives had also been updated to reflect the new organisational structure. The proposed new organisational values were detailed on slide 12. Slides 10 and 11 summarised the extensive qualitative feedback received, including insights from staff surveys and broader engagement activities

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	such as culture champion discussions. The feedback informed both the new values and the ongoing work to refresh the behavioural framework. The Board noted that the new values aimed to be simple and meaningful, with a reduced number for clarity and impact. The next step would be to further develop the behavioural framework to embed these values in daily practice. JJ raised concern that only 183 people had completed the staff survey, suggesting some staff may be disengaged with such exercises. KH responded that, while the survey response rate was not high, additional engagement had taken place through other channels, noting that 44% of responses were from Bridgewater colleagues. NK and SMcG suggested that the Board should revisit the values in a couple of years to ensure they remained relevant and meaningful. KH noted that the Trust's values were aligned with the NHS Constitution, and that most NHS organisations shared similar core values. CR asked whether there was any data on how often staff demonstrated kindness or otherwise. PF explained that work was ongoing to better understand and evidence what "kindness" means in practice and cited positive examples of kindness being observed in theatre environments. The Board noted the content of the report and agreed to approve the revised mission, vision, aims, strategic objectives, and proposed values, with a commitment to ongoing review and further engagement as the new organisation develops. **The Board approved the revised mission, vision, aims, and strategic objectives, which would be in place from 1 April 2026 until December 2026. The Trust Board noted that same paper was due to be presented to Bridgewater's Board the following week**
GOVERNANCE	
BM/25/10/110	**Committee Chairs Annual Report – Audit Committee** JC introduced the report which, provided an overview of the Audit Committee's activities and key areas of focus over the past year. The report aimed to assure the Board that the Audit Committee had fulfilled its responsibilities regarding governance, risk management, and internal controls. There were no additional comments or updates from M'OC as Audit Committee Chair. **The Trust Board noted the contents of the report**
BM/25/10/111	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common** JC introduced the item, explaining that Cheshire and Merseyside providers had formalised their collaborative working arrangements through the CMPC (Cheshire and Merseyside Collaborative), building on the previous CMAST (Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative) and MHLDC (Mental Health, Learning Disabilities and Community Services) structures. The accompanying report included updated governance documents, which had been

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	endorsed by the CMPC Leadership Board and developed with legal input for adoption by the Trust Board. These documents reflected the expanded scope of the collaborative and provided clearer decision-making arrangements across acute, specialist, and community services. JC highlighted that Appendix 1 was particularly helpful in clarifying delegations of power, with any matters outside those delegations to be brought back to the Board for decision. **The Trust Board approved the updated Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common**
Supplementary Papers – To note for Assurance	
BM/25/10/112	Learning From Experience Summary Report Q1
BM/25/10/113	DIPC Q1 Report
BM/25/10/114	Learning From Deaths Q1
BM/25/10/115	Guardian of Safe Working Report Q1
BM/25/10/116	Digital Services High Level Briefing
BM/25/10/117	Senior Information Risk Officer Report
BM/25/10/118	Charitable Funds Committee Chair's Annual Report / Impact Report
Closing	
BM/25/10/119	**Review of the Meeting** The Trust Board discussed and agreed that the meeting had been effective, with robust discussion and appropriate challenge on agenda items. Members noted that the meeting maintained clear links to the organisation's strategic risks, as set out in the Board Assurance Framework (BAF). Despite the size of the agenda, the Board concluded that all key issues were given due attention, and the meeting concluded only a few minutes later than scheduled.
BM/25/10/120	**Any Other Business** No further business was raised. **Meeting ended at 12:36pm**
Date and time of next meeting – 10am, Wednesday 3 December 2025 – Trust Conference Room, Warrington Hospital	

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/25/12/123	SUBJECT:	ACTION LOG	DATE OF MEETING	3 December 2025

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/25/10/98	**01.10.25**	**Chair's Report**	To provide a brief to the December Board in relation to governor elections 2025	Execs	03.12.25	03.12.25	On Agenda - **BM/25/12/126**	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/25/10/99	**01.10.25**	**Board Assurance Framework (BAF)**	Hold a Quality/Risk Summit for NEDs to discuss combined risks	AK/JC	Feb 2026			
BM/25/10/103	**01.10.25**	**Quality Strategy Update**	Amendments to Quality Strategy update to be actioned prior to next presentation to Trust Board	AK	Feb 2026			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/25/08/70	**06.08.25**	**Strategy Biannual Delivery Report**	The executive summary to clearly list the six red-rated areas for future reporting.	LG	Feb 2026		LG confirmed this had been actioned and would be included in the February 2026 report to Trust Board	
BM/25/06/34	**04.06.25**	**Chief Executive's**	Neighbourhoods and accountable care organisations.	Execs	ongoing	01.10.2025	Updates to be built into Trust Board development agendas and discussion	

		Report	Topic should be scheduled for a future board development session to clarify the local interpretation and implementation of neighbourhood care models.				topics	

RAG Key

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

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REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/125**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	3 December 2025			
AUTHOR(S):	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A** ✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A*** ✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/25/12/125

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

2. KEY ELEMENTS

2.1 Trust News

Appointment of a new Chair for WHH

I was delighted to announce that Andy Carter was been appointed as the next Chair of Warrington and Halton Teaching Hospitals, following a robust recruitment process. Andy will join as an Associate Non-Executive Director and Chair Designate in January 2026 and formally take up the role of Chair in April, as we transition to North Cheshire and Mersey NHS Foundation Trust.

Andy brings significant experience from both public service and the private sector, including his time as MP for Warrington South and a career in media management. He is committed to supporting our staff, patients, and communities as we move forward.

I would like to thank Professor Steve McGuirk for over a decade of outstanding leadership, and it goes without saying that Steve will be greatly missed, not least for having led the board through periods of significant challenge. Under his leadership, the Trust obtained a CQC 'Good' rating in 2019 and responded to the Covid pandemic with great fortitude and resilience.

Winter Planning

The Trust's Winter Plan sets out our approach to managing increased demand and operational pressures during winter 2025/26. Developed in line with NHS England guidance, the plan focuses on ensuring safe, patient-centred care and maintaining resilience across urgent and elective services. Key priorities include escalation ward and capacity planning, robust governance and escalation processes, optimising Same Day Emergency Care (SDEC), supporting frailty and virtual wards, and sustaining elective and cancer care. The plan also details measures for infection prevention, discharge processes, and collaboration with system partners. Staffing, diagnostics, pharmacy, and support services are addressed to ensure continuity of care. Performance will be closely monitored, with regular updates and learning captured post-winter.

Finance

WHH fully owns the financial plan to deliver a £28.7m deficit and approaches this with the utmost seriousness, recognising the difficult decisions required to achieve it. While the Trust is committed to delivering the full 8.4% savings target, we acknowledge that approximately 3.4% of this will require system-level levers to unlock cost reductions within the Trust, as these savings are predominantly tied up in exceptional UEC expenditure. This risk to delivery has been consistently shared and articulated with regulators and management consultants. In response, the Trust convened an Extraordinary Board meeting to approve further measures aimed at improving financial performance. These actions involve some compromise to staff and patient experience, though patient safety remains non-negotiable.

Launch of Mutually Agreed Resignation Scheme (MARS)

To support our ongoing organisational sustainability and flexibility, we have launched a Mutually Agreed Resignation Scheme (MARS), now open for applications until 4 January 2026. MARS is a voluntary scheme enabling eligible staff, by mutual agreement, to leave employment with a financial package. This is not a redundancy scheme, but an option for those considering a change, supporting both individual choice and organisational needs.

Key points:

- Open to staff with at least 12 months' continuous NHS service.
- Applications must demonstrate a clear business case and are subject to executive approval.
- The process is entirely voluntary for both staff and the Trust.

Full details, eligibility criteria, and application guidance are available on our staff intranet and extranet. Drop-in sessions and further support are being provided to answer any questions.

WHH Strategy and Partnerships Team receives 'Highly Commended' award at annual HSJ Awards 2025

On Thursday 20th November members of the Trust's Strategy and Partnerships team were in London to attend the annual HSJ awards, the largest and most prestigious awards in the NHS. The team have been a key part of the Living Well in Warrington programme of work, which was shortlisted for this year's Integrated Care Initiative of the Year award.

They have worked in close collaboration with colleagues from Warrington Borough Council, Merseycare, Bridgewater and a wide range of local community and voluntary sector organisations over recent years to grow the Living Well programme in Warrington. Living Well focusses on simplifying the often complex system of health, care and wellbeing services to give people earlier access to the support they need, as soon as they might need it. The programme includes the Living Well Hub in Warrington town centre, the Living Well in Warrington digital platform (www.livingwellwarrington.org) and the network of local Talking Points. Living Well is designed to help improve healthy life expectancy for residents, which will help address health inequalities and reduce longer-term demand for statutory health and care services.

The team were delighted to be highly commended in the category, and it is excellent recognition for their work to date, which is leading the way nationally in the shift towards more preventative and neighbourhood-led services.

WHH HR Team receives 'Highly Commended' award at HPMA 2025

The HR Business Partnering Team received a 'Highly Commended' award at the Healthcare People Management Awards (HPMA) 2025 ceremony held in Birmingham on 20 November 2025. The team was recognised in the *Health Education and Improvement Wales Award for Developing the Profession and People Professionals* category for its work in creating a structured career development pathway within the human resources department.

The initiative introduced a clear framework to support continuous learning and professional development. Competency frameworks were integrated into everyday practice, helping colleagues identify their career goals, plan development activities aligned to professional standards and address specific skills gaps. The work has contributed to increased motivation, improved retention and strengthened skills within the HR team.

Winter Flu Vaccination Campaign

Protecting our patients, staff, and communities from flu remains a key priority this winter. Vaccination is proven to save lives and reduce hospitalisations. We have made flu vaccines easily accessible for all staff through drop-in sessions and roaming clinics across the trust.

With flu cases already three times higher than this time last year and new strains circulating, it is more important than ever that we maximise uptake. As of 25th November 2025, 47.8% of frontline staff at WHH had received their vaccine. While this is encouraging, we are aiming for even greater coverage to protect our most vulnerable patients and maintain a resilient workforce during the busy winter months.

We continue to encourage all staff to get vaccinated, emphasising both professional responsibility and personal protection. Full details of vaccination sessions are available on the intranet and extranet, and our teams are ready to support staff in accessing the vaccine at convenient times.

Freedom to Speak Up – Turning Voices into Action

Freedom to Speak Up (FTSU) remains a cornerstone of our commitment to a transparent, just, and inclusive culture across the trust. The FTSU Guardian, supported by a growing network of confidential champions, provide safe and straightforward routes for staff to raise concerns, share ideas, and drive improvements without fear of detriment.

Recent actions include:

- Strengthening confidential reporting channels to ensure all staff feel supported.
- Supporting teams to improve communication and retention.
- Launching new resources to promote sexual safety, civility, and respect in the workplace.
- Increasing awareness of incident reporting and the use of the Safe Care system.
- Providing education and support around cultural needs and disabilities.

We continue to encourage all staff to speak up, recognising that every voice contributes to progress and improvement. Staff can access FTSU resources and contact details via the intranet and extranet, and are also supported through staff forums and the annual Staff Survey.

Our ongoing focus is to embed a culture where speaking up is normalised, accountability is clear, and positive change is achieved for the benefit of our staff and patients.

Staff Survey – Your Voice Matters

Our annual Staff Survey is now in its final stages, and I want to emphasise how important your feedback is at this time of significant change and system pressures. The survey is not a tick-box exercise; it is a vital tool for understanding what we are doing well and where we need to improve to make our organisation the best place to work and receive care.

Current response rates stand at 36.4% for WHH. While this is encouraging, there are still nearly 4,000 colleagues whose voices have not yet been heard**.** Every response matters and will help shape meaningful improvements for staff experience and patient care.

The survey is confidential, quick to complete, and provides an opportunity for every member of staff to influence positive change. Please take a few minutes to complete it if you haven't already. Your feedback will help us build a thriving, inclusive environment as we move towards becoming one integrated organisation.

Thank you for your continued engagement and commitment to shaping our future together.

Thank You Awards – Nominations Now Open

I am pleased to confirm that nominations are now open for our 2025–26 Thank You Awards, the first joint celebration for Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare. This event will recognise the outstanding achievements and contributions of individuals and teams across both organisations.

The awards ceremony will take place on Friday 15 May 2026 at the Titanic Hotel, Liverpool. With over 6,500 staff working across our hospitals and community services, we want every colleague to have the opportunity to participate—whether by nominating others or being nominated themselves.

Award Categories include:

- Clinical and Non-Clinical Team of the Year
- Clinical and Non-Clinical Colleague of the Year
- Rising Star Award
- Inspiring Leader Award
- Innovation, Improvement and Research Award
- Healthcare Hero
- Diversity and Inclusion Award
- Charity Champion

Additional awards will include the People's Choice Award (public nominations) and the Outstanding Contribution Award, presented by the Chief Executive. Winners of WHH's monthly *You Made a Difference* Awards will automatically be entered into relevant categories.

Key Details:

- Nominations close on Friday 19 December 2025.
- Full criteria and entry forms are available on the WHH intranet and BCH extranet.
- Queries can be directed to whh.thankyouawards@nhs.net.

Due to financial constraints, the event will rely on sponsorship and advertising support. If you have suggestions for potential sponsors, please share them with the planning team.

This is an opportunity to celebrate compassion, innovation, and excellence across our Trusts. Please take time to recognise colleagues and teams who inspire you, every nomination matters

2.2 National News

Industrial Action

The Trust received formal notification from the British Medical Association (BMA) regarding planned industrial action by resident doctors. This strike action took place from 07:00 on Friday 14 November 2025 until 06:59 on Wednesday 19 November 2025, affecting a range of clinical areas across Warrington and Halton Teaching Hospitals.

The Trust's priority throughout was to maintain patient safety and ensure the continuity of essential services. We worked closely with clinical teams, operational leads, and system partners to implement robust contingency plans, including the redeployment of staff, rescheduling of activity as required, and enhanced communication with patients and families.

Thanks to the dedication and flexibility of our staff, we were able to minimise disruption and continue to provide safe care to our patients. We recognise the challenges that industrial action brings for both staff and patients, and we are grateful for everyone's professionalism and commitment during this time.

2.3 Regional Update

ICB Leadership

Cheshire and Mersey ICB have recently announced changes to their board leadership. Sir David Henshaw has been appointed as interim Chair for 18 months, while Liz Bishop will serve as interim Chief Executive. These appointments signal a strong commitment to enhancing operational and financial collaboration across the system, and we look forward to working closely with them to advance this agenda.

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

October 2025:

The Board discussed the need and opportunities that derive from developing an evidenced-based approach to provider action that is framed by what patients need and want and not dictated or shaped by NHS structures or institutions. Discussions included the potential to partner with suppliers in this space. Consideration would be given to system resource that could support development of this approach which was considered essential but equally the need for an aligned implementation plan on how services could or should be delivered in the most efficient, productive and safe way going forward.

The second half of the meeting focussed on discussion and agreement of the priorities for CMPC:

- Planned care
- Community and Patient Flow
- Blueprint

- Clinical Pathways / Fragile Services
- Efficiency at Scale including Corporate Services
- In year delivery

With subject matter leads also being identified for cancer, mental health and CYP

The way the Leadership Board works with, connects and uses Trust leadership capacity was also discussed with the need for CEO link officers with the following groupings agreed:
- Chief Operating Officers
- Strategy Directors and Co Secs, Comms & Engagement
- Clinical forum – MDs / DONs
- Directors of Finance
- Chief Digital Officers
- Chief People Officers

The Board also explored the current ask of providers and coordination of actions in respect of system recovery.

November 2025:

The Board met on 7th November and discussed a number of important system wide issues as follows:

Digital Programme – An update and emerging proposition was shared by John Llewellyn. A vision for a single CMPC approach was described that needed to be underpinned by clear governance and a shared enterprise architecture that should support multi-year investment and delivery. Details explored included short term workforce issues and risks and CDIO leadership of various envisaged workstreams. The Board noted that a single approach to digital and data will yield savings. A £3m RTF bid for ambient voice technology (AVT) was noted as having been successful. Alder Hey is leading this work, and the majority of providers will pilot technology. A further update on AVT roll-out will come to a future meeting.

Next the Board considered in year delivery and governance. I act as the CEO lead for this portfolio of work, and I outlined key H2 priorities:
- Improve run-rate – challenge can be expected on action taken
- Under/over performance queries – ICB reviewing to mitigate income risks
- CIP requires full implementation, and slippage needs to be offset via non-recurrent controls – there are still risks associated with CIP
- Demonstrating appropriate measures to provide assurance on grip and control
- Balance sheet reviews
- The expectations for Trusts to be categorised as low, medium and high-risk was outlined

The Board also discussed the system approach to 2026/27 planning. It was noted that at present, it might be predicted that the M12 run rate requirement will not be met which would, manifest, as actions in readiness to improve productivity and reduce workforce being required by April 2026 as part of foreseen regulatory stretching ambition and mitigation plans. The role of collaboration and CMPC has been raised by PWC who have suggested CMPC lead on a number of items including service consolidation, corporate integration, and pathway design.

Finally the Board discussed a number of wider system issues:
- The need for action and grip on UEC. Both in order to improve patient experience and outcomes but also to alleviate pressures on patient flow. It was noted that leverage with Primary Care and Local Authorities is needed to make an impact and that effort needs to

be aligned with and to the resource for UEC improvement/performance management sitting with the ICB and NHSE oversight of this area.
- Industrial action rate card for consultants – The Board endorsed use the rate card that was in place for the last round of industrial action.
- Children and Young People – the Board received an update ion an AH facilitated discussion on CYP which included a number of CEOs and service leads. The discussion considered all aspects of CYP including acute services, community, neighbourhood and mental health. The AH SD is leading on developing the scope of the work which is being taken forward as part of the CMPC Blue Print work.

2.5 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 7 – October 2025. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.6 Special Days/Weeks for professional groups

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

October 2025

- Freedom to Speak up Month
- Stoptober
- Sober October
- World Menopause Awareness
- Black History Month
- Breast Cancer Awareness Month
- National Cholesterol Month
- Cyber Security Awareness Month
- Yom Kippur
- World Sight Day
- Baby Loss Awareness Week
- World Mental Health Day
- Specialty, Associate Specialist, and Specialist (SAS) Doctor Week
- Allied Healthcare Professional Day
- International Pronouns Day
- National Pharmacy Week
- Infection Prevention Control Week
- Diwali
- World Stroke Day

November 2025

- National Pathology Week
- Mouth Cancer Action Month
- Armistice Day
- Medicine Safety Week

- Transgender Awareness Week
- World Diabetes Day
- UK Disability History Month
- World Antimicrobial Resistance Awareness Week (World AMR Week)
- International Men's Day
- White Ribbon Day

2.7 Signed under Seal

Since the last Trust Board meeting, the following items have been signed under seal:

- Counterpart Lease for carparking at Guardian Street
- Licence to underlet between WHH, Gentian Holdings Limited & Greggs PLC
- Licence for alterations between WHH, Gentian Holdings Limited & Greggs PLC

2 MEETINGS ATTENDED

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

- ICB & Provider Chief Executive Group
- Cheshire & Merseyside Provider Collaborative (CMPC) Leadership meeting
- Cheshire & Merseyside Provider Collaborative (CMPC Delivery Board
- CQC Engagement Meeting
- PricewaterhouseCoopers (PwC)
- Lydia Hughes, Healthwatch
- Health & Wellbeing Board, Halton
- Chris Adcock, NHSE Regional Director of Finance
- Linda Buckley, Managing Director CMPC
- Nicola Eardley, Clinical Dean, University of Chester
- Joint Cheshire & Merseyside CEO/ Chair/ Chief Finance Officer meeting
- Sarah Pochin, MP
- CEOs and Strategy Directors Meeting
- Cheshire & Merseyside Finance Investment & Revenues Committee

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 7 (October 2025)

Appendix 1 - CEO Dashboard Month 7 – October 2025

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	96.36%	P
RTT 18 Weeks	above 92%	60.08%	F
RTT - patients waiting 52+ Weeks	0	1279	F
RTT - patients waiting 65+ Weeks	0	33	F
Elective Outpatient activity	104%	87%	?
A&E % patients seen within 4 hours	Below 78.00%	62.95%	F
A&E % waiting longer than 12 hours	Below 2.00%	23.63%	F
Cancer 28 Day Faster Diagnostic Standard	above 75%	74.30%	F
Cancer 62 Day Wait	above 85%	77.30%	F
Ambulance Vehicle Handovers within 45 mins	100%	83.78%	F
Cancelled Operations – not rearranged within 28 days	0	2	?
Capped Theatre Utilisation	above 85%	79.30%	F

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	29	F
Sepsis Screening Emergency	above 90%	70.00%	F
Sepsis Screening Inpatients	above 90%	75.00%	F
Sepsis Antibiotics Emergency	above 90%	52.00%	F
Sepsis Antibiotics Inpatient	above 90%	75.00%	F
Inpatient Falls	31 (10% reduction from 2024/25)	34	?
VTE	above 95%	93.03%	F
Pressure Ulcers (Category 2 and above)	11 (20% reduction from 2024/25)	11	?
Medication Reconciliation (within 24 hrs)	above 80%	37.70%	F
Complaints over 6 months	0	1	F
Healthcare Infections - MRSA	0	1YTD	?
Healthcare Infections - MSSA	below 8 YTD	29 YTD	No SPC
Healthcare Infections – CDI (cumulative)	below 15 YTD	48 YTD	?
Healthcare Infections - E. coli (cumulative)	below 20 YTD	49 YTD	?
Healthcare Infections – Klebsiella (cumulative)	below 7 YTD	18 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	below 2 YTD	9 YTD	?
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	6.60%	?
MUST nutritional assessment completion	above 85%	73.52%	F

Sustainability

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£2.54	-£2.54	No SPC
Capital Spend (£m)	£13.74	£3.66	F
Cash Balance (£m)	£3.38	£11.93	No SPC
Better Practice Payment Code (£m)	above 95%	63%	F
Agency Reduction (£m)	£1.69 (30% reduction from 2024/25 plan)	£1.56	?
Bank Reduction (£m)	£15.85 (10% reduction from 2024/25 plan)	£18.11	F
CIP In Year Delivered in relation to plan	90% of plan	100%	P
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	48%	F

People

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	6.44%	F
Turnover	Below 13%	11.48%	P
Core/Mandatory Training	above 85%	90.80%	P
PDR Compliance	above 85%	82.16%	F

Strategy

- **WHH and BCH continue to work towards becoming a single organisation**. NHSE have been completing their review of our strategic case throughout October, with recommendations expected early November. We have been developing the draft full business case (FBC) and working with external consultants and legal advisors to complete due diligence.
- **The Runcorn Health and Education Hub** is due to start to open services from February 2026.
- **A new Council led strategic Board has been established to lead the development of Widnes town.**
- **The Living Well Warrington online platform went live to the public on 26th March**. The site has received over 126,000 views with the membership growing daily. The platform showcases over 700 activities that support living well across Warrington.
- **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

  A first submission is due in December 2025, with a revision and expanded submission due in January/February 2026.

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

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

? Inconsistently passing/failing target

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/126**			
SUBJECT:	**Chairs Report – 2025 Governor Elections Results**			
DATE OF MEETING:	3 December 2025			
AUTHOR(S):	Emily Kelso, Corporate Governance and Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGurik, Chair			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No** ✓	***N/A*** ✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust holds Governor Elections each year to fill any vacant seats on our Council of Governors and/or to open up seats in relation to those Governors whose term of office is ending. The elections have been facilitated by an independent, external election company namely Civica Election Services. For the 2025 Governor Elections there were 8 vacancies, these were:			

	Public Governors • 4 in Warrington and Halton • 1 in Rest of England **Staff Governors** • 1 in Medical and Dental • 1 in Nursing and midwifery • 1 in Estates, Administration, Managerial At the close of the nominations Thursday, 9 October 2025, 5pm, all seats were contested except the staff seat for the **Medical and Dental** constituency which remains vacant as no nominations were received Elections closed at 5pm, Tuesday 25th November, the results are as follows: **Public Governors** **Warrington and Halton – 4 seats** • Diane Nield • Helen Bennett • Matt Machin • Stephen Bryan Walton **Rest of England – 1 seat** • Dorcas Akeju **Staff Governors – 1 seat** **Medical and Dental – remains vacant** **Nursing and Midwifery – 1 seat** • Mary Kho **Estates, Administration, Managerial** • Suresh Arni-Sukumaran Governors are appointed for a term of 3 years and are eligible for re-election or re-appointment at the end of their initial term, for two further terms (9 years in total). Newley elected Governors will start their term on 1 December. A Governor Induction Day will take place in January 2026 led by Steve McGuirk, Chair and the Company Secretary, the date is to be confirmed.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board are asked to note the Governro Elections results, and the progress made with Governor Elections during 2025.		
PREVIOUSLY CONSIDERED BY:	**Committee**	n/a	
	Agenda Ref.		
	Date of meeting		
	Summary of		

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

REPORT TO TRUST BOARD

SUBJECT	Chairs Report – 2025 Governor Elections Results	AGENDA REF:	BM/25/12/126

1. Background/context

The Trust holds Governor Elections each year to fill any vacant seats on the Council of Governors and/or to open up seats in relation to those Governors whose term of office is ending.

As in 2024 the Council of Governor Elections 2025 were facilitated by the independent, external electoral provider namely Civica Election Services.

2. Key elements

The Warrington and Halton Teaching Hospital NHS Foundation Trust Constitution sets out the Model Rules for Election, which are being followed throughout the election process.

2.1 The Nomination Stage

For the 2025 Governor Elections there were 8 vacancies to be filled, these were:

Public Governors

- 4 in Warrington and Halton
- 1 in Rest of England

Staff Governors

- 1 in Medical and Dental
- 1 in Nursing and midwifery
- 1 in Estates, Administration, Managerial

Elections Timetable

The timetable for 2025 elections is provided below:

Notice of Election / Nomination open	Thursday, 11 September 2025
Nominations Deadline	Thursday, 9 October 2025, 5pm
Summary of valid nominated candidates published	Friday, 10 October 2025
Notice of Poll published	Thursday, 30 October 2025
Voting Packs Dispatched, Voting Open	Friday 31, October 2025
Close of Election	Tuesday, 25 November 2025
Declaration of Results	Wednesday, 26 November 2025

Promotion of Elections

This year a robust communications plan was developed to promote elections from the nomination stage through to the ballot stage and finally the declaration of results. Examples can be found on the Trusts social media accounts (given below).

A desktop background was published on the week of 29th September November providing the QR code to the elections website and details of the Staff Governor vacancies and how to submit a nomination.

In addition, a prospective Governor information stand was facilitated prior to the Annual Members Meeting (1 October), this was supported by current Governors who shared their knowledge and experience with those members considering submitting a nomination form to become a Governor.

Instagram: @WHHNHS
X: WHH (@WHHNHS) / X

An information site was developed to provide members with information about elections and the role of and NHS FT Governors, the website also provided details on how to submit a nomination form **www.cesvotes.com/WHH2025**.

Targeted Communications with Bridgwater Community Healthcare NHS FT Members

Bridgewater members were proactively informed about the upcoming WHH governor elections through their Members' Newsletter. As part of this communication, they were encouraged to join WHH as members to strengthen engagement and collaboration across organisations.

The response was positive. Notably, five current Bridgewater Public Governors submitted nominations to stand in this year's WHH elections across both public constituencies (two BCH Governors for Rest of England and three BCH Governors for Warrington and Halton). This outcome demonstrated strong interest and commitment from Bridgewater representatives and reflects the success of WHH outreach efforts.

This engagement directly supports our organisational commitment to integration and aligns with the **Better Care Together** programme of work. By fostering closer relationships between WHH and BCH members and Governors, we are advancing our shared goal of delivering more coordinated and patient-centred care across the region.

Contested Elections
The nomination stage closed on Thursday, 9 October 2025, 5pm. All validated nominees were contacted on Friday the 10th of November confirming receipt of their valid nomination and also informing them of the deadline of 14 October 2025 to withdraw their nomination, prior to moving to the ballot stage.

2.2 Ballot Stage

The ballot stage takes place when there are contested seats for one or more constituencies. This year we had contested seats for:

Public Seats:

- The seats **Warrington and Halton public** constituency are contested, following receipt of 11 valid nominations for 4 seats.
- The **Rest of England** public seat is also contested, following receipt of four valid nominations for one seat.

Staff Seats:

- The **Nursing and Midwifery** seat is contested, following receipt of five valid nominations for the one seat available.
- The **Estates, Admin and Managerial** seat is contested, following receipt of four valid nominations for one seat. However, one of the nominees has since withdrawn their

candidacy. As a result, the seat was contested, with three candidates actively standing for election.

The **Medical and Dental** seat will remain vacant as no nominations were received for the one seat available.

The **Statement of Nominated Candidates** is included as **Appendix 1.**

2.3 Voting Stage

The notice of poll was published on the 30 October 2025 and voting packs distributed on Friday 31 October 2025.

Eligibility to Vote

As per the WHH Constitution:

> *Any individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.*

This window closed on Thursday 9 October, 5pm. All individuals who had signed up to become a member by this deadline received a voting pack. Members are only able to vote for Governors in the constituency under which they fall.

2.4 Results

Voting closed on Tuesday 25 November 2025;5pm. The results are as follows:

Public Governors

Warrington and Halton – 4 seats

- Diane Nield
- Helen Bennett
- Matt Machin
- Stephen Bryan Walton

Rest of England – 1 seat

- Dorcas Akeju

Staff Governors – 1 seat

Medical and Dental – remains vacant

Nursing and Midwifery – 1 seat

- Mary Kho

Estates, Administration, Managerial

- Suresh Arni Sukumaran

The **Report on Voting** (results) is attached as **Appendix 2.**

Governors are appointed for a term of 3 years and are eligible for re-election or re-appointment at the end of their initial term, for two further terms (9 years in total).

Newley elected Governors will start their term on 1 December 2025.

A Governor induction day will be scheduled January 2026, this will be led by the Chair and Company Secretary (date TBC), all current and new Governors will be encouraged to attend.

3. Recommendations

The Trust Board are asked to note the Governro Elections results, and the progress made with Governor Elections during 2025.

Warrington and Halton Hospitals NHS Foundation Trust

Statements of Nominated Candidates

Election to the Council of Governors

CLOSE OF NOMINATIONS: 5:00:00 PM ON 09/10/2025

Further to the deadline for the nominations for the above election, the following valid nominations were received:

Constituency name	Candidate forename	Candidate surname	Political interests	Financial or other interest in the Trust
Public: Rest of England	Dorcas	Akeju	None	None
Public: Rest of England	Jonathan	Berry	None	None
Public: Rest of England	Marc	Byram	None	None
Public: Rest of England	Christine	Stankus	None	None
Public: Warrington and Halton	Michael Mathew	Ashley	None	None
Public: Warrington and Halton	Helen	Bennett	None	None
Public: Warrington and Halton	John	Fagan	None	None
Public: Warrington and Halton	Kevin	Goucher	None	None
Public: Warrington and Halton	Norman	Holding	None	Public Governor at Bridgewater NHS Foundation Trust
Public: Warrington and Halton	Joseph	Leigh	None	None
Public: Warrington and Halton	Farah	M Jones	None	None
Public: Warrington and Halton	Matt	Machin	None	None
Public: Warrington and Halton	Oluchi	Mellor	I am a Parish Councillor for Poulton with Fearhead, Warrington, representing the Labour Party.	None
Public: Warrington and Halton	Diane	Nield	None	None
Public: Warrington and Halton	Stephen Bryan	Walton	None	None
Staff: Estates, Admin & Managerial	Suresh Krisshna	Arni Sukumaran	None	None
Staff: Estates, Admin & Managerial	Ki Cheong	Ho	None	None

Staff: Estates, Admin & Managerial	Brian	Rigby	None	None
Staff: Nursing and Midwifery	Jonathan	Cliffe	None	None
Staff: Nursing and Midwifery	Rachel	Crone	None	None
Staff: Nursing and Midwifery	Alistair	Greenough	None	None
Staff: Nursing and Midwifery	Mary Michelle Teodora	Kho	None	None
Staff: Nursing and Midwifery	Danielle	Whittaker	None	None

The contact address for each of these candidates is C/O The Returning Officer, Warrington and Halton Hospitals NHS Foundation Trust, Civica Election Services, The Election Centre, 33 Clarendon Road, London, N8 0NW, or email at ftnominations@cesvotes.com.

Ciara Hutchinson
Returning Officer
On behalf of Warrington and Halton Hospitals NHS Foundation Trust

Report generated on: 10/10/2025

Report of Voting

WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

ELECTION TO THE COUNCIL OF GOVERNORS

CLOSE OF VOTING: 5PM ON 25 NOVEMBER 2025

CONTEST: Public: Rest of England

RESULT		1 to elect
AKEJU, Dorcas	10*	**ELECTED**
BERRY, Jonathan	9	
STANKUS, Christine	8	
BYRAM, Marc	2	

*result confirmed be recount

Number of eligible voters		967
Votes cast by post:	13	
Votes cast online:	16	
Total number of votes cast:		29
Turnout:		3.0%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		29

CONTEST: Public: Warrington and Halton

RESULT		4 to elect
NIELD, Diane	108	**ELECTED**
BENNETT, Helen	107	**ELECTED**
MACHIN, Matt	76	**ELECTED**
WALTON, Stephen Bryan	66*	**ELECTED**
HOLDING, Norman	60	
GOUCHER, Kevin	50	
MELLOR, Oluchi	45	
ASHLEY, Michael Mathew	37	
FAGAN, John	29	
M JONES, Farah	27	
LEIGH, Joseph	13	

*result confirmed be recount

Number of eligible voters		2,100
Votes cast by post:	16	
Votes cast online:	181	
Total number of votes cast:		197
Turnout:		9.4%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		197

CONTEST: Staff: Estate, Admin & Managerial

RESULT		1 to elect
ARNI SUKUMARAN, Suresh Krisshna	159	**ELECTED**
RIGBY, Brian	66	
HO, Ki Cheong	42	

Number of eligible voters		1,409
Votes cast online:	267	
Total number of votes cast:		267
Turnout:		18.9%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		267

CONTEST: Staff: Nursing and Midwifery

RESULT		1 to elect
KHO, Mary Michelle Teodora	55	**ELECTED**
GREENOUGH, Alistair	39	
CLIFFE, Jonathan	28	
CRONE, Rachel	17	
WHITTAKER, Danielle	12	

Number of eligible voters		1,327
Votes cast online:	151	
Total number of votes cast:		151
Turnout:		11.4%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		151

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the election:-

a) was sent the details of the election and

b) if they chose to participate in the election, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and CES is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for 12 months.

Ciara Hutchinson
Returning Officer
On behalf of Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/127**
SUBJECT:	**Board Assurance Framework**
DATE OF MEETING:	3 December 2025
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager
EXECUTIVE DIRECTOR SPONSOR:	All Executives
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. ✓ SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future ✓ SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

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

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	**Board Assurance Framework** This report provides an update on the Trust's 11 strategic risks as per the Board Assurance Framework, following review by the assigned monitoring Committee. Each strategic risk is linked to one or more of the Trust's strategic objectives. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. **Since the last Trust Board meeting:** • There have been no new strategic risks added to the BAF. • It is proposed that the wording of **Risk 2253** is

	amended to reflect additional insights gained from the completion of due diligence work. • There have been no updates to current risk ratings • No target risk ratings or risk appetites to current risk have changed Key updates to existing risk; controls, assurances and gaps are detailed within section 2.7 of the report. Detailed individual strategic risk reports are included as **Appendix 1.** The Trust has an overall Risk Appetite Statement **(Appendix 2)** which is reviewed and approved annually by the Trust Board. In addition, each strategic risk on the BAF has been assigned a unique risk appetite as approved by its monitoring committee.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: • Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework • Approve the updated risk description to **Risk 2253** to reflect additional insights gained from the completion of due diligence work.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee, Audit Committee	
	Agenda Ref.	Multiple	
	Date of meeting	Multiple	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/25/12/127

1. BACKGROUND/CONTEXT

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

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

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

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

		for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	⟷		
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	12 (L3xC4) ⟷	Minimal	QAC
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	12 (L3xC5) ⟷	Open	SPC
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	12 (L3xC4) ⟷	Cautious	QAC
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	9 (L3xC3) ⟷	Open	EMT

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

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

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

2.3 Amendment to risk ratings

There have been no amendments to current risk ratings.

2.4 Amendments to descriptions

It is proposed that the wording of **Risk 2253** is amended to reflect additional insights gained from the completion of due diligence work. While the original description focused on the strategic and governance implications of not proceeding with integration, the revised wording

incorporates the heightened risk that previously unidentified financial, operational, or regulatory issues may remain unresolved. This change ensures the risk statement fully captures the potential impact on the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not occur.

From: 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.

To: 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*.

2.5 De-escalation of risks

No risks have been closed or deescalated.

2.6 Risk appetite

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

2.7 Existing risks - updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access	**Controls** • QI led project completed to support improving Ambulance handover times • UEC improvement group established, supported by Executives with a focus on sustained recovery • Workforce review completed to increase evening cover where demand is highest **Assurances** • Change to Triage model with the introduction of streaming to support deflection away from ED and faster triage times • Transition to type 5 SDEC from 1st November 2025	20 (L5xC4)	**None**

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	• Actions being followed up following external review by NEWTON to support decrease in LOS and support flow		
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	**Controls** • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton sit. This has given the Trust an additional endoscopy room which is operational now and an additional Theatre at Nightingale which is due completion. **Assurances** • Endoscopy Hub is operational to provide additional capacity to WHH and C&M patients **Controls & Assurance Gaps** There are a number of Fragile services that require further support	**20**	None ⟷
134	If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken	**Controls** • Counter Fraud campaign took place for national anti-fraud week 18/11/25 • Cash Support received for 2024/25 was £12.145m and £11m YTD 2025/26 **Assurances** • 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. At month 7 2025/26 CIP is on plan achieving £10.8m YTD **Control & Assurance Gaps** • Risk funding for integration will not be given • Risk of not receiving deficit support funding. The Trust received Q1 but Q2 and Q3 has been withheld until C&M ICS has more robust delivery plans in place	20	No impact on risk rating
2001	If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	**Services added to fragile services oversight** • Rheumatology **Services removed from fragile services oversight:** • Cardiology/Cardiorespiratory	**20 (L4xC5)**	**none** ⟷
1372	If the Trust is unable to procure a new	**Assurances** • Regular, documented conference calls	**16**	No impact

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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	with the ICS and NHSE – external partners supportive of single instance relaunch with partner Trust. • Legal advice confirms that a single host contract is necessary to support and govern the single-instance model. • EPR project group and joint Programme Executive Board (PEB) have oversight on state of readiness for deployment and associated risks • PME to be launched January 2026 **Controls** • Working with incumbant EPR vendor to extend contract for 2.5 years in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 2.5 - year extension Lorenzo costs • ICB Executive Leads and FD program supportive of single instance in partnership with Merseyside and West Lancs NHS Trust – with output based specification (OBS) and pre procurement evaluation criteria complying with single instance guidance. • Approach to standard clinical pathways and single instance architecture agreed wih FD team **Gaps in Assurance** • Frontline Digitisation will conclude on 31 March 2026. Following this, the Trust will be able to apply to the Frontline Productivity Fund to secure the remaining funds required for the project. • Requirement for single contract pushing PME to January 2026 **Gaps in Controls** • Delay to procurement has push implementation date past Lorenzo contract and Lorenzo sunsetting date requiring 2.5-year extension increasing the costs these costs will be formulised Q4 2025/26 • Phasing of frontline Digitisation Funding and funding availability the Trust will have to rebid for remaining funding from new funding programme Frontline Productivity to complete the project		on risk rating
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure	**Assurance** • All servers and desktops are currently under Microsoft support, including extended support for Windows 10. **Controls** • Comply with NHS England high cyber alerts	**16**	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.	Version 7 of Clinisys Ice has been upgraded to version 7.1.9 which is cyber secure		
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	**Controls** • Daily audit of gold command and safe care compliance to monitor completion of twice daily acuity scores and the adding of professional judgement, gaps highlighted weekly to the senior nursing team. • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency with authorisation only by Chief Nurse, Deputy Chief Nurse or Associate Chief Nurse for Corporate Nursing. • Local recruitment in place targeting ED and the remaining areas with outstanding vacancy. • Gant Chart mapping projections of Maternity Leave and Supernumerary Staff with the information taken from E Roster. **Assurances** • Since April 2025 ED has recruited 30 registered nurses. • Nursing: Overall Registered Nurse vacancy has decreased from 10.36% in August 2025 to 7.30% in September 2025 • Since April 2025 the average Overall CHPPD has been 7.6 • Overall Healthcare Support Worker vacancy has decreased from 12.47% in August to 10.63% in September 2025 • There is ongoing recruitment with regular shortlisting and interviews for both Registered and Unregistered staff. • In September 2025,18 wards achieved the 90% fill rate on day shifts and 21 ward achieved 90 % fill rates on nights **Assurance Gaps** • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B18 & A4; accelerated transfers and boarding out of hours – there were 262 escalated beds during August 2025 this increased to 314	**12 (L3xC4)**	**none**

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		in September 2025 • The winter of ward A10 closed in June 2025 and was utilised for one week in August 2025 for escalation. Ward A10 re-opened 2 November 2025 for escalation as part of the winter plan. Discharge Lounge is bedded overnight when required with patients being discharged the following day to support flow. • There were 596 Red Flags reported in August 2025, and this increased to 665 reported in September 2025- Red Flags were linked to escalation areas and enhanced care		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness absense** The rolling 12-month sickness absence rate is 6.18% as at October 2025 and is showing a slight increase from Sept 2025 (6.14%). Trust target from April 2025 is 5% • The Trust has benchmarked itself against the NHS Wellbeing Framework and benchmarks well, with minor areas for improvement, being picked up through the Improving Attendance Task and Finish group. • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.09 % in Octover 2025. An MDT review in collaboration with HR and OH to review all long term sickness absence cases over 100 days continues to ensure absences are being managed in accrodance with Trust policy and that a plan is in place to welcome the individual back to work or exit the organisation. • Welcome Back Conversations annual compliance was 89.69% in October 2025. **Turnover and Attraction** • Turnover in October 2025 remains below the limit of 13% at 11.48%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in October 2025 was 10.72%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's October 2025 vacancy rate is 7.24%, the Trust limit is 9%. **Assurances** • The responses to Exit Interviews are positive, only 12.60% as at October 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative	**12** (L3 x C4)	none

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		responses. **Temporary Staffing and Agency spend** Bank and Agency reliance in October 2025 is 11.51% . The Trust limit is 9%. Bank reliance is 10.48% and agency reliance is 1.44%. **Controls** Medical bank rate card was implemented in Oct-24 and alongside a rate escaltion SOP, which is currently under review to ensure it is algined to the C&M approach.		
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.	**Controls** • Use of Industrial Action Cheshire & Merseyside Rate Card to incentivise and secure adequate medical staffing during periods of medical IA. • Updated supporting materials available on the Trust intranet including FAQs and the response plan **Assurance** • Resident Doctor's industrial action took place 14th November – 19th November 2025 and all clinical areas were asked to identify mitigation plans and escalate risks. • The Industrial Action Response Group was in place with five planning meetings ahead of the planned action, this group will continue to monitor the preparation for future of action. • A robust Trust plan was shared ahead of the Resident Doctors Industrial Action. • Elective cancellations were approved by exception with sign off through the Director of Operations and Performance. • A debrief has been shared to capture any lessons identified and these will be embedded into future rounds of planning. • Services were asked to ensure any planned cover for the period of November action was sustainable and financial considerations were acknowledged. **Assurance Gaps** • Currently there is no scheduled date for the next instance of industrial action – the next phase could possibly occur during a more significant period of winter pressure and possibly during the holiday period. Planning will be initiated once the notice has been received.	**12**	**none**
2253	**Updated Description** If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction,	The integration programme- "Better Care Together" has been established. Each workstream has developed a delivery plan and is working with partners to deliver objectives. Subject to all necessary approvals, we hope to become a single organisation on 1st April 2026	9	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed.	**Assurance** • Draft FBC shared with both Boards for feedback • NHSE transaction amber rating received at strategic case stage **Assurance Gaps** • Full integrated governance will not be in place prior to establishment of enlarged organisation		

3. RECOMMENDATIONS

The Trust Board is asked to:

- Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework
- Approve the updated risk description to **Risk 2253** to reflect additional insights gained from the completion of due diligence work.

Appendix 1

Board Assurance Framework – December 2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

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

Board Assurance Framework – December 2025

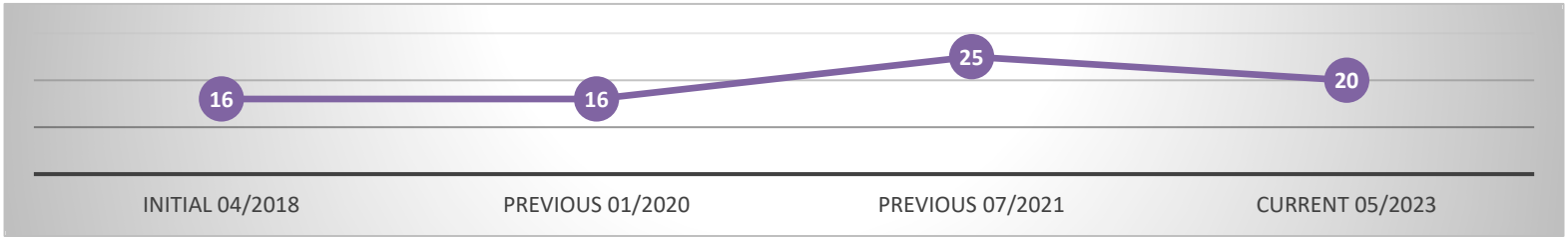
		short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances						
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	12 (L3xC4)	8 (L2xC4)	Safe Caring	Minimal	Quality Assurance Committee
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Safe Caring	Open	Strategic People Committee
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	1	12 (L4xC3)	8 (L4 xC2)	Safe Responsive	Cautious	Quality Assurance Committee
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed	1,2,3	9 (L3xC3)	2 (1LxC2)	Well-Led	Open	Executive Management Team

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

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Assurance Details

Controls

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

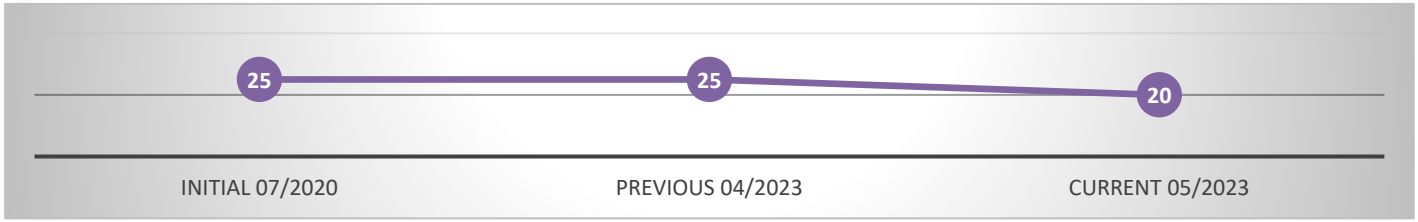
	• Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy. • Progress chaser in ED to support flow and timely • Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2025/26 to support flow and urgent care • The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee • QI led project completed to support improving Ambulance handover times • UEC improvement group established, supported by Executives with a focus on sustained recovery • Workforce review completed to increase evening cover where demand is highest **Assurances** • System actions agreed supporting the Winter Plan • Redeveloped ED 'at a glance' dashboard • Trust implemented NHS 111 allowing for directly bookable ED appointments • Integrated discharge Team in place • Respiratory Ambulatory Care Facility agreed. • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • Same Day Emergency Care Centre (SDEC) opened July 2022 • Plans to reduce length of stay for criteria to reside patients using SAFER methodology. • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opened in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. • As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust continue working with ECIST to support a service improvement programme. • Continuous flow commenced on 8th October 2023. • Change to Triage model with the introduction of streaming to support deflection away from ED and faster triage times • Transition to type 5 SDEC from 1st November 2025. • Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12-hour time in department as referenced in the Tier 1 urgent care metrics. • Actions being followed up following external review by NEWTON to support decrease in LOS and support flow • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds into the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. • Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

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

Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG and monthly Unplanned Care Performance Meetings.	Bowman, Karen	ongoing	
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	ongoing	

Board Assurance Framework

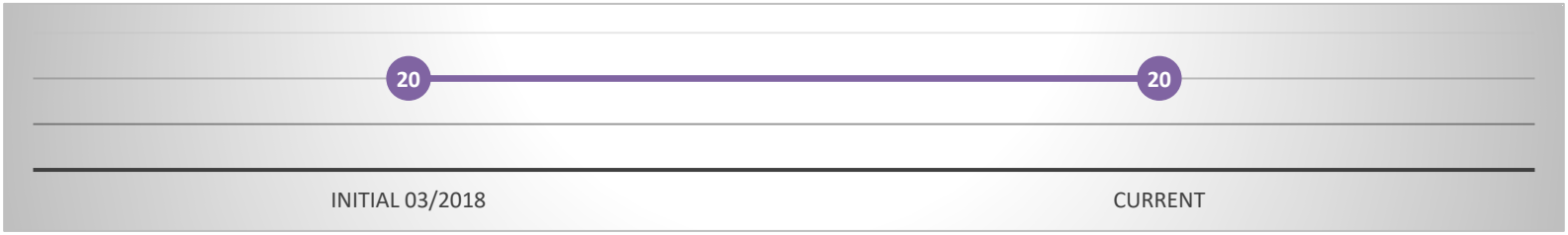
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1215	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial**	25 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
CQC Domain(s)	**Safe and Responsive**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls**. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Weekly review meetings with C&M diagnostics hub, Mutual aid opportunities utilised across C&M to reduce delays • Recruitment and development of Transfer of care hub team is gaining maturity • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers and through mutual aid and surgical hubs • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton sit. This has given the Trust an additional endoscopy room which is operational now and an additional Theatre at Nightingale which is due completion. • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2025/2026 to support recovery will be reviewed to ensure value for money • Ongoing validation of the trust waiting lists to improve data quality • All performance activity monitored through weekly performance review group (PRG) • FOP Platform launched to support effective theatre scheduling • Overnight capacity on ward B4 at Halton planned to open October 25 will take pressure from the Warrington site and support elective recovery **Assurances** • All elective patients have been clinically reviewed and categorised in line with national guidance.				

	• New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GPs to inform them with recovery progress within the organisation and to highlight/address any identified problems. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • Endoscopy Hub is operational to provide additional capacity to WHH and C&M patients • CDC phase 1 gone live in July 2023. CDC phase 2 including CT & MRI opened in June 2025 CDC phase is underway • Trust Board support for additional use of independent sector to reduce waiting times. Monthly reporting to the Finance and Sustainability Committee.
Controls & Assurance Gaps	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint on the Warrington site. • Workforce capacity challenges in the medical workforce • There are a number of Fragile services that require further support

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

Board Assurance Framework

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

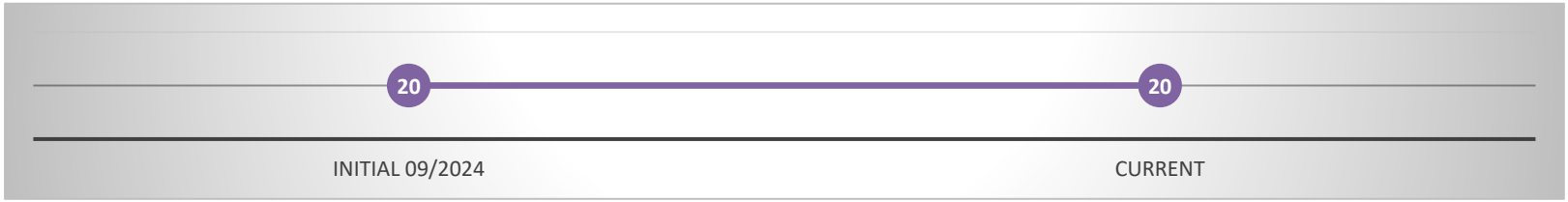
	• Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65- & 52-Week recovery. • 2024/25 Phase 2 PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID. • 2024/25 received high assurance for general ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement • Implemented reduction in bank rates 13/01/25, reducing exp circa £700k p.m and to bottom of scale 01.05.25 • Daily cash flow + 12 month forecast in place to manage cash • Delivery Unit Set Up - Delivery Unit Oversight Groups established, comprising the Delivery Unit Workforce (DUW), Delivery Unit Non-Pay (DUNP) and Delivery Unit Productivity (DUP), to provide robust oversight, challenge, and accountability for key financial and operational workstreams with focus on workforce pay, non-pay expenditure, and productivity improvements. **Assurances** • The 2024/25 position was £16.8m deficit which was in line with the forecast and £5.5m off plan. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 and 2024/25 Capital Plans • Unqualified audit opinion (2024/25) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency and bank staff. The 2025/26 challenge is to reduce agency by 30% and bank by 10%. Agency is achieving this target. Bank is slightly over due to IA costs and speciality. • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2024/25 received high assurance for accounts receivable, general ledgers and treasury management with no recommendations. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. At month 7 2025/26 CIP is on plan achieving £10.8m YTD • Operational Plan submitted in line with timetable. • Monthly reports to be submitted to the Finance & Sustainability Committee to review the cash position, plus request for cash support approved at Trust Board as required. • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high-risk schemes, presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Additional capacity remained open in quarter 1 and closed in June 2025, capacity which should have closed mid-January remained open in March 2025 • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP • There is a risk that NHSE will not approve the cash request. Mitigations to this could include, using capital cash in the short term and delay of payments to creditors •Risk of over performance of activity which may not be paid due to cap on income and affordability • Risk finding for Industrial Action will not be given • Risk funding for integration will not be given • Risk delivery of the system wide (Level 3) CIP £13M • Risk of not receiving deficit support funding. The Trust received Q1 but Q2 and Q3 has been withheld until C&M ICS has more robust delivery plans in place.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

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

Board Assurance Framework

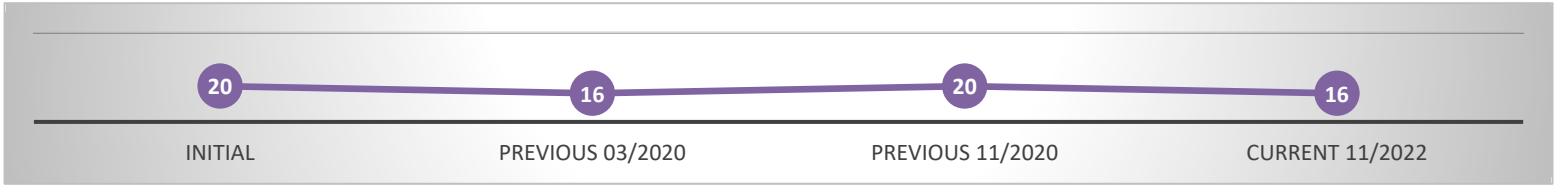
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	2001	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial**	20 (L5 xC4)
				Current	20 (L5xC4)
				Target	6 (L2 xC3)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
CQC Domain(s)	**Safe, Responsive**				
Risk Movement					
Assurance Details	The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'. Current services included in the Fragile Services Oversight program are: • Urology • Orthopaedics – Fractured Neck of Femur • Cancer Services • Chronic Pain • Rheumatology **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • Escalation to Quality Assurance Committee via PSCESC escalation reports • Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps	• Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bed base) • Increasing demand				

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1114	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial**	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
CQC Domain(s)	**Well-Led**				
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	**Assurace** • Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. • Digital Services uses several cyber threat intelligence services (C&M Cyber Group, NCSC, NHSE CSOC) • Audit on 3rd party vendor management by MIAA (waiting on audit report) • All servers and desktops are currently under Microsoft support, including extended support for Windows 10. **Controls:** • Digital Operations Governance including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Digital Change Management regime including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • Trust Data Quality Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting EPR Training regime for new starters including doctor's rotation and annual mandatory training.				

	• External NHS England approved Cyber Training for the Trust Exec Board • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • MFA active on for NHSMail • MUSE migrated to new server • Unisoft Server upgraded to Windows 2019 • Comply with NHS England high cyber alerts • Version 7 of Clinisys Ice has been upgraded to version 7.1.9 which is cyber secure
Assurance Gaps	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). 24/25 assessment is being conducted during February and April 25 • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030. **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting “remember me” • No dedicated logging tool to pull all key logs together and provide useable alerts. • Lack of process to proactively check antivirus/MDE alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life • Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network. • Unsupported software being used by BadgerNet • Despite discussions and efforts last year, progress on a regional Cheshire and Merseyside cyber initiative has stalled leaving gaps in Trusts' compliance, assurance, processes, and purchasing of cyber technologies. • A number of Windows 10 devices are not Windows 11 compliant and would need renewal, posing a significant cost impact due to their unique nature.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no	Migrate all 2003 and 2008 servers to 2016.	NICE guidance fully migrated by IT Services and the Communications Team.	Deacon, Stephen	30/06/25	31/07/25

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

		5. Configure Vendor Access (Phase 1) – Digital Compliance, IT Services Set up PAM access with MFA for 3rd party vendors. Status: IN PROGRESS 6. Configure WHH Admin Access (Phase 2) – Digital Compliance, IT Services Enforce PAM and MFA for all internal privileged users. Status: NOT STARTED Measurable Outcome: 100% of targeted WHH admins and approved vendors securely access critical systems via PAM with MFA by the target date Progress Tracking: 3rd Party Vendors added: - Autsco – CDC Nurse Call - DB Dental Equipment – Dental scanners - OBSBMS – Estates BMS systems - Solventum - Medicode WHH system and network administrators added: - To be completed after the vendors access			
Migrate Windows 10 to Windows 11	Upgrade Windows 10 to Windows 11 before October 2025, as security update support will end.	Objective: Complete the organisation-wide upgrade from Windows 10 to Windows 11 by 30 October 2025, ensuring compatibility with all critical systems and devices. Specific Tasks & Owners: 1. Internal Testing in IT Services – IT Services Validate Windows 11 functionality in a controlled environment. Status: COMPLETE	Waterfield, Tracie	31/12/2025	

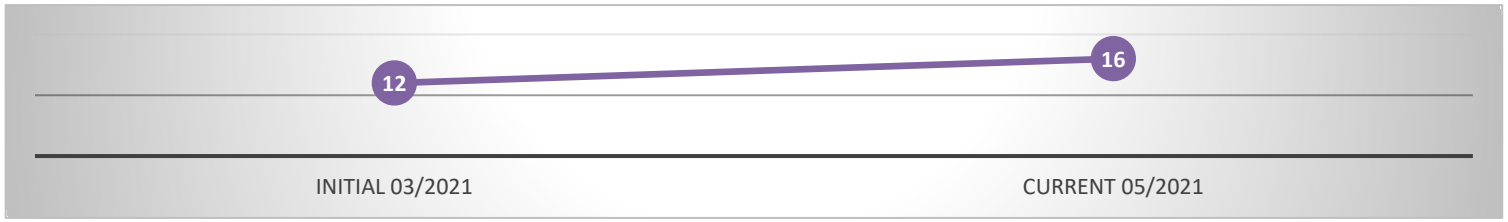
		2. Testing with Critical Systems – IT Services & Clinical/Business Application Owners Ensure compatibility with key operational systems. Status: COMPLETE 3. Rollout on New Devices – IT Services Deploy Windows 11 on newly procured hardware. Status: IN PROGRESS 4. Rollout on Rebuilt Devices – IT Services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

		Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old servers. Status: IN PROGRESS 3. Plan and schedule complex server migrations – Server Team Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old ones using vendor support when required. Status: IN PROGRESS Measurable Outcome: Upgrade completion rate reaches 100% by the 30 October 2026. Progress Tracking: Current progress is 55% complete.			
Removal of generic Window accounts	While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access.	Objective: While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access. Specific Tasks & Owners: 1. Clinical Safety Risk Assessment – CNIO, Digital Compliance, IT Services & Head of Information Review the existing and planned processes to assess potential risks, estimate user logon time with the new process, and determine the scope of the task. Status: COMPLETED 2. Plan for removal of generic accounts – IT Services Develop a plan for the removal of generic accounts. Status: STARTED	Waterfield, Tracie	31/03/26	

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

	(CMdIO) team aware and provided a mitigation plan.	the Change Approval Group to seek approval of the software upgrade.			
Extend Microsoft Windows 10 support for a limited number of devices	Some Windows 10 devices are not compatible with Windows 11 and need renewal, which would require Trust capital bids for 2026/27 due to the high cost. From October 2025, these devices will pose a cybersecurity risk as any vulnerabilities identified will remain unaddressed. Although Microsoft provides extended support for Windows 10, it entails additional costs.	No longer required as we have purchased the extended cover from a different fund.	Whitfield, Simon	31/10/25	31/10/25

Board Assurance Framework

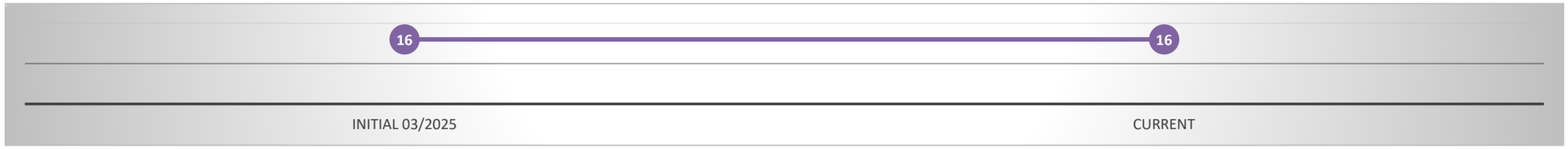
Risk ID	1372	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to procure a new Electronic Patient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

Board Assurance Framework

	Gaps In Controls • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay to procurement has push implementation date past Lorenzo contract and Lorenzo sunsetting date requiring 2.5 year extension increasing the costs these costs will be formulised Q4 2025/26 • Phasing of frontline Digitisation Funding and funding availability the Trust will have to rebid for remaining funding from new funding programme Frontline Productivity to complete the project • Deficit in programme year 3 • Further assurance required regarding state of readiness for implementation

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Co-develop a single OBC and FBC for the joint procurement as mandated by FD	FD require a single OBC and subsequent FBC	MWL and WHH teams supported by NHSE developing single OBC Planning to launch the PME in January 2026, with OBC development running in parallel. The Investment Agreement (IA) has been submitted to NHSE and we are currently awaiting feedback. Current Frontline Digitisation funding is due to expire in March 2026 . A new funding scheme Frontline Productivity will be available for the Trust to further bid for EPR and other digital initiative aligning with the 10 Yr plan	Poulter, Tom	30/11/25 March 2026	

Board Assurance Framework

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

Control & Assurance Details

Controls

- Annual capital funding is allocated for mandated and statutory estates projects.
- Estates team manages Planned Maintenance (PPM) and reactive maintenance through CAFMS.
- Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities.
- The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works.
- Effective clinical networking and partnerships are in place.
- Full delivery of the TIF (elective) programme due to complete in 2024/25, which includes £9m investment to provide 2 new operating theatres, an Endoscopy Room and Elective ward capacity.
- Full Business Case (FBC) for Pathology Hub to be created with MWL to be presented to the Trust Board in Quarter 1 2025/26
- CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds.
- Living Well Hub funded via Warrington Town Deal fund led by WHH opened in March 2024
- Runcorn Health & Education Hub funded by the Runcorn Town Deal led by WHH due to open in Quarter 4 2025/26
- Strategy refresh for 2025/26 approved by the Trust Board.
- WHH leads on addressing health inequalities and sustainability, with initial recognition in Cheshire & Merseyside.
- Consistent Trust representation in Cheshire & Merseyside ICS and Place-based boards.
- One Public Estate funding supports Halton redevelopment and Warrington public sector estate review.
- Partnerships with educational institutions have enable tailored education and research.
- CSPO co-led CMAST priorities for ICB 5-Year Joint Forward Plan.
- Trust estates priorities reflected in the ICB infrastructure plan.
- Agreement from the Boards of Warrington & Halton and Bridgewater to progress transaction to become a single organisation in 2027
- Joint Executive Team meetings with Bridgewater Community Healthcare NHS FT.
- Estates strategy for new hospital plans completed.
- External funding sought for estates developments supporting new hospitals.
- All partners support new hospitals plans, including MPs, Councils, Education Providers, Place Partners, and ICB.
- Financial and economic cases for new hospitals to be updated, with funding options explored.
- Capital Planning Group oversees capital funding allocation, prioritised schemes reported monthly
- Health and Safety Sub-Committee escalates estates issues, managed through relevant safety groups.
- The Government's White Paper, “Integration and Innovation: working together to improve health and social care for all,” published in February 2021, continues to inform and guide Trust activities.

Assurances

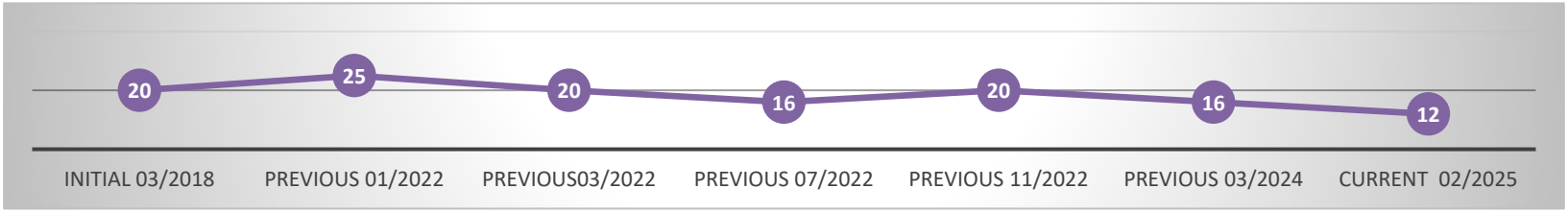
- 3 Phase CDC funded nationally due to complete in June 2025. CDC Phase 2 opened in December 2023, including ultrasound, spirometry, sleep studies, audiology, and phlebotomy services at Halton Health Hub. CDC Phase 3 (including CT and MRI) opened in June 2025.
- Regular meetings through Capital Planning Group and Tactical Estates Group (TEG) support decision-making on estate allocations and capital expenditure.
- Estates priorities identified through PLACE assessments, health and safety audits, and risk registers.
- Safety and Compliance - Ongoing monitoring for compliance with Health Technical Memorandum (HTM) standards, with actions taken to reduce identified risks.
- Remedial Works - RAAC survey completed, identifying small extension building with RAAC, with NHSE funding secured for necessary remedial actions, including roof replacement. Environmental health inspection upgrades completed for Warrington kitchen facilities in October 2024
- Halton Health Hub opened in November 2022 in Shopping City, Runcorn, supported by Halton Borough Council and Liverpool City Region Town Centre Fund for a phased reconfiguration of the Halton site.
- The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside, with the hub opening in 2024.
- Strategic and Collaborative Efforts - Regular strategy updates are provided to the Council of Governors and Trust Board. The Trust is engaged in national initiatives, including securing funding for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside, with the draft business case approved by the Trust Board in June 2024

Board Assurance Framework

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work Project manager post to support phased redevelopment plan approved at executive EC panel and will be advertised in September 25	Lucy Gardner	30.03.2026	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2026	
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Lucy Gardner	30/04/2025	Completed 30.4.25
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

Board Assurance Framework

Risk ID	115	**Executive Lead**	Chief Nurse	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial**	20 (L5xC4)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
CQC Domain(s)	**Safe and Caring**				
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details:	**Controls** • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • Weekly ERostering KPI sign off meetings in place. • NHSP Request Review /10% reduction review Meetings chaired by Chief Nurse or Deputy Chief Nurse every week • Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity. • Twice daily review of Red Flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels. • Daily audit of gold command and safecare compliance to monitor completion of twice daily acuity scores and the adding of professional judgement, gaps highlighted weekly to the senior nursing team. • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency with authorisation only by Chief Nurse, Deputy Chief Nurse or Associate Chief Nurse for Corporate Nursing. • Staff numbers and skill mix and professional judgement recorded daily on Gold Command report for transparency of clinical decision making. • Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust. • Agency reduction plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team • Local recruitment in place targeting ED and the remaining areas with outstanding vacancy. • Open advert for RN/HCSW recruitment • Sickness absence being manged in line with Trust policy. • Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of Governance • Gant Chart mapping projections of Maternity Leave and Supernumery Staff with the information taken from E Roster. • Twice daily Acuity Recording on Safe Care **Assurances** • Increase in registered nursing establishment in the Emergency Department, November 2024. Ongoing recruitment, with regular shortlisting and interviews which has reduced band 5 vacancy rate to 30.0 WTE. • Since April 2025 ED has recruited 30 registered nurses. • Nursing: Overall Registered Nurse vacancy has decreased from 10.36% in August 2025 to 7.30% in September 2025				

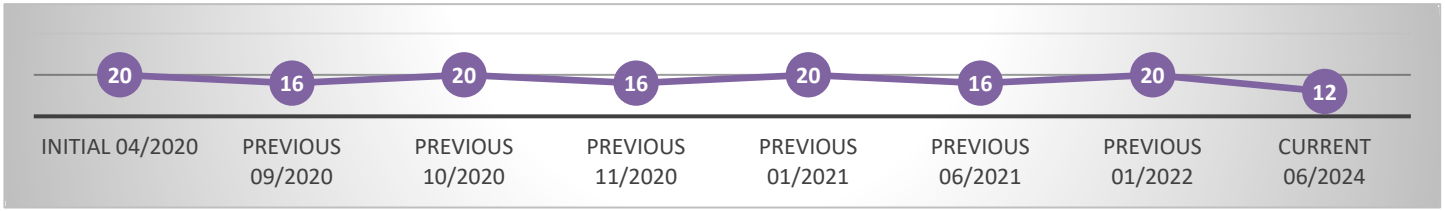
	• Since April 2025 the average Overall CHPPD has been 7.6 • Overall Healthcare Support Worker vacancy has decreased from 12.47% in August to 10.63% in September 2025 • There is ongoing recruitment with regular shortlisting and interviews for both Registered and Unregistered staff. • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. • CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025., • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly. • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends • Leaver data is closely monitored, and the Board of Directors have supported a position of over recruitment to enable replacement of leavers in a timely manner. • Internal Transfer process in place for staff to support retention. • Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. • In September 2025,18 wards achieved the 90% fill rate on day shifts and 21 ward achieved 90 % fill rates on nights
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B18 & A4; accelerated transfers and boarding out of hours – there were 262 escalated beds during August 2025 this increased to 314 in September 2025 • Increased requests to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – with a decision to increase to 2 extra patients. • The winter of ward A10 closed in June 2025 and was utilised for one week in August 2025 for escalation. Ward A10 re-opened 2 November 2025 for escalation as part of the winter plan. Discharge Lounge is bedded overnight when required with patients being discharged the following day to support flow. • Partially funded revenue requests • Time to post when recruiting new staff. • There were 596 Red Flags reported in August 2025, and this increased to 665 reported in September 2025- Red Flags were linked to escalation areas and enhanced care • In Quarter 2 over 1200 patients were admitted to WHH with a mental health condition • Admissions of patients over 65 continues to range between 900 to 1000 per month.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recruitment	Continued recruitment into registered and unregistered vacancy	• Completion of the local vacancy tracker • Rolling adverts for both registered & unregistered staff with regular shortlisting & interviews • Monthly meetings with ward managers to support their recruitment & ward managers part of the interview panels • Attendance to all student nurse engagement sessions to support to qualifying & employment • Support flexible working, job share & substantive posts for maternity cover	• Deborah Hatton – Lead Nurse for Nurse Staffing • Lisa Miles – Workforce Improvement Lead	March 2026	
Student Nurse Associate (SNA) Programme	Continued support to the SNA programme and 4 places per cohort	Support recruitment to each cohort and placement of SNA's and RNA's	• Jennie Shearn - Practice	March 2026	

			Education Facilitator (PEF) • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead		
NHSP Care Support Worker Development Programme (CSWD)	Continued support of the NHSP CSWD Programme	• Allocation of each cohort into unregistered vacancy • Support to CSWD's at the end of programme into Trust vacancy	• Charlotte Plant - NHSP • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	January 2026	
Transfer process	Promote Trust transfer process to aid turnover/leavers	• Continue to share and support the Trust's internal transfer process	• Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	March 2026	
Over recruitment	Support the over recruitment process	• Review leaver & turnover data & set over recruitment targets for each CBU • Support flexible working, job share & substantive posts for maternity cover	• Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	December 2026	
Preference rostering	Roll out of preference rostering	• Continue to roll out preference rostering to all areas • Submit Charitable Funding Bid for additional staff to support timely roll out of the project	• Adam Harrison-Moran • Associate Chief People Officer: Strategic	March 2026	

			Workforce Development & Culture • Nikki Chesters - E Rostering Team • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead		

Board Assurance Framework

Risk ID	1134	**Executive Lead**	Chief People Officer	**Rating**	
Strategic Objective	**Strategic Objective 2:** We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial**	20 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
CQC Domain(s)	Caring and Safe				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	**Sickness Absence** The rolling 12-month sickness absence rate is 6.18% as at October 2025 and is showing a slight increase from Sept 2025 (6.14%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. Review of Supporting Attendance Policy and processes in progress August 2025 taking into account benchmarking the policy and best practice. • Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. • Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. • Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. • Focused welcome back conversation recording and internal audit • Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. • Sickness absence, turnover and attraction workstreams have been reviewed in line with the ICB letter and action plans updated to ensure all actions from the letter have been considered. • New stage 3 absence process has been successfully piloted to provide a compassionate and dignified exit out of the organisation on the grounds of ill health capability. Review of absence data by OH to ensure all relevant cases have been referred to OH. • There is a regional and executive-level call to action initiated in May. The 'Improving Attendance Together' initiative is a strategic response to reduce sickness absence by 1%. Led by the People Directorate, it addresses persistent high absence impacting teams, care, and budgets. It is a strategic priority for the Board and part of the People Plan. Due to high and persistent sickness absence across the Trust and the pressure absence places on teams, patient care, and financial resources. • The WHH Improving Attendance Plan aims to foster a supportive and healthy work environment that encourages staff to maintain their well-being and attendance. This initiative is designed to address the challenges of absenteeism and promote a culture where employees feel valued and motivated to be present at work. Objectives of the programme are as follows:				

Board Assurance Framework

	• **Enhance Employee Well-being:** To embed a systematic and compassionate approach to health and wellbeing. • **Reduce Absenteeism:** To demonstrate clear grip and control over staff absence trends and interventions and ensure compliance with regulatory, financial and operational obligations • **Promote a Positive Work Culture:** To enable Board-level scrutiny and accountability on staff experience and productivity where employees feel appreciated and motivated to attend work regularly. • Improving attendance action plan summary: • Promoting Health and Wellbeing: Mental health responders, wellbeing champions, physiotherapy, OH services. • Absence Management: Data deep dives, reduction targets, review of dashboards, intervention packages. • Training: Stress risk assessments, OH referrals, leadership modules. • Support Mechanisms: Culture of belonging phased return, redeployment. • Policy Review: Compassionate language, updated triggers, alternative leave options. • WHH Chief People Officer has agreed to be SRO for a regional C&M led reducing sickness absence policy and WHH Chief Finance Officer has agreed to provide the financial overview and scrutiny of the regional project. Actions to date: • A project plan with key milestones is under development • A data gathering exercise is underway focusing on absence data, reasons, policy and interventions **Assurance** • The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. • The Trust has benchmarked itself against the NHS Wellbeing Framework and benchmarks well, with minor areas for improvement, being picked up through the Improving Attendance Task and Finish group. • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.09 % in Octover 2025. An MDT review in collaboration with HR and OH to review all long term sickness absence cases over 100 days continues to ensure absences are being managed in accrodance with Trust policy and that a plan is in place to welcome the individual back to work or exit the organisation. • Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff. • Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data. • HR and OH identifying areas with high sickness absence, and target interventions, such as specialist OH support for leaders. • Welcome Back Conversations annual compliance was 89.69% in October 2025. **Turnover and Attraction** • Turnover in October 2025 remains below the limit of 13% at 11.48%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in October 2025 was 10.72%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's October 2025 vacancy rate is 7.24%, the Trust limit is 9%. **Controls** • Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review. • Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process. • Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in workwith funding secured to continue with this programme. • Grief and Menopause cafes implemented to support individuals • Social media accounts have been created to support recruitment attraction across a number of social media platforms

Board Assurance Framework

	• Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
	• A dedicated area to supporting Agile/Flexible working is available on the extranet, and as part of the culture plan, an improved approach to agile and flexible working has been lauched through the #MYFlex campagin which incldues two wards going live with preference rostering from Jan 2025.
	• Implementation of VCP panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa.
	• To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included:
	  • Enhanced HCA recruitment events
	  • Investment in TRAC (Recruitment system)
	  • Enhanced Student Nurse recruitment
	  • Enhanced wellbeing benefits package (financial and mental)
	  • Improvements in agile/flexible working
	  • Enhanced retirement support/offers
	Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention.
	
	Assurances
	• The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
	• As a result of analysis of exit interviews, a theme identified was working hours and flexible working. #MYFlex campaign has been launched with a central recording of flexible working requests enabling greater understanding/scrunity.
	• The responses to Exit Interviews are positive, only 12.60% as at October 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses.
	• Staff completing apprenticeships is above the 2.3% target.
	
	Temporary Staffing and Agency spend
	Bank and Agency reliance in October 2025 is 11.51% . The Trust limit is 9%. Bank reliance is 10.48% and agency reliance is 1.44%.
	
	Controls
	• Bank reliance is driven by the Trusts plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care.
	• The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are:
	  ○ VCP process for non-clinical vacancies, overtime and medical agency.
	• NHSP bank rates have reduced to the bottom of the banding pay scale and all other AFC bank rates will be mirroring this apporach from Oct-25.
	• Medical bank rate card was implemented in Oct-24 and alongside a rate escaltion SOP, which is currently under review to ensure it is algined to the C&M approach.
	• Top earning workers, are reported to the care groups monthly, so enable mitigation plans to be developed.
	
	Assurances
	• Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee
	• To support agency controls, a refined VCP process has been introduced.
	• Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives.

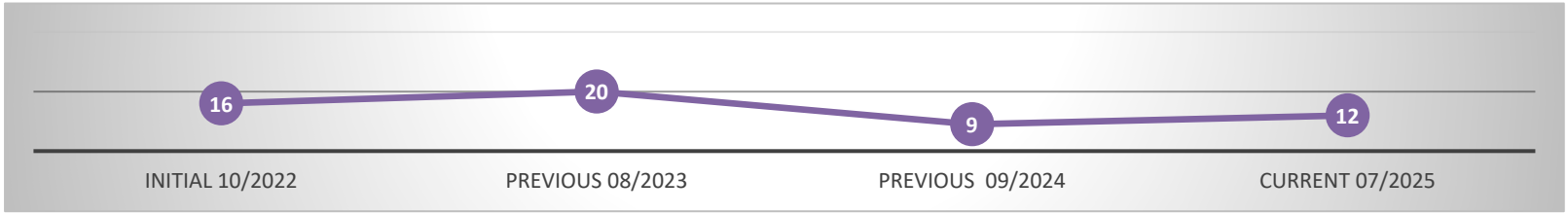
Assurance Gaps	• Sickness absence continues to be above target. It is demonstrating no significant change. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating no significant change. • Lack of assurance regarding reduction of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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including	• Analysis of areas with high sickness absence to develop targeted interventions	Laura Hilton & Carl Roberts	31.08.25	31.08.25

	wellbeing days, cardiac clinics, smoking cessation.	• Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff			
Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	30.09.25	30.09.2025
Establishment of an Improving Attendance Task and Finish Group	Establish an MDT group to review the Trusts approach to managing absence and improving attendance.	• Establishment of an Improving Attendance Task and Finish Group with representation from HR, OH, OD, Medical Education and Workforce Systems	Laura Hilton	30.09.2025	30.09.2025
Delivery of an Improving Attendance action plan	Establish a range of actions to address gaps in the Trusts approach to managing absence and improving attendance. Actions will range from quick wins to long term actions; the full action plan can be made available as evidence.	• Development of an evidence-based actin plan to inform system and process improvements. • Development of actions to support the improvement of the Trusts wellbeing offer. • Develop actions to attempt to address the limitations of the current systems in use to manage absence (ESR and E-Rostering).	Laura Hilton	31/03/2026	
Benchmark WHH against the NHS Wellbeing Framework and refine the Trusts Wellbeing offer.	Completion of the NHS Wellbeing Framework to inform refining the WHH Wellbeing offer.	• Complete the NHS Wellbeing Framework • Report findings to the Improving Attendance Task and Finish Group • Refine the Trusts Wellbeing offer following the benchmarking results. • Launch the refined Wellbeing Offer	Carl Roberts and Caroline Eardley	31/12/2025	
Launch a targeted attendance improvement approach.	Develop and launch a targeted approach to improving attendance in areas of high temporary staffing spend linked to sickness absence.	• Define the targeted areas, by reviewing temp staffing spend due to absence.	Laura Hilton	31/12/2025	

		• Engage an MDT to offer targeted support to the areas identified. The MDT will include, HR, OH, OD, Workforce Analysts and the Trust CPO. • The targeted approach will include a check and challenge with the CPO, deep dive into all absences within the areas to ensure the policy is being adhered too, piloting the e-WBC form and further analysis of all workforce KPIs to understand the wider culture.			

Board Assurance Framework

<table>
<tr><td>Risk ID</td><td>1757</td><td>Executive Lead</td><td>Executive Medical Director</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td>Risk Description</td><td colspan="3">If 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.</td><td>Initial
Current
Target</td><td>16 (L4 xC4)
12 (L3 xC4)↑
8 (L4 xC2)</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Cautious – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Control & Assurance Details:</td><td colspan="5">Controls
• Trust policies updated in relation to industrial action
• Trust approach to industrial action established following learning from experiences in 2022-2025
• Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.
• Planning templates shared with all clinical services with risks flagged through the Industrial Action Planning Group in advance of the periods of action
• Escalation processes and support materials incorporated into industrial action communications
• IA tactical meeting schedule established for the days of strike action, including where system IA being taken and not specific to WHH.
• Participation in ICB IA Clinical Cell calls where applicable.
• Use of Industrial Action Cheshire & Merseyside Rate Card to incentivise and secure adequate medical staffing during periods of medical IA.
• IA Task and Finish group completed organisational preparedness for industrial action policies and procedures ratified and FAQ documents created and published and updated regularly.
• Executive Medical Director led check and challenge meetings for periods of industrial action to prepare and mitigate risk. Final sign off of rotas and plans by the Executive Medical Director / Deputy
• Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
• Following national guidance available for instances of IA
• Regular briefing sessions held virtually for senior leaders and staff
• Updated supporting materials available on the Trust intranet including FAQs and the response plan
Assurance
• Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
• No derogations been required thus far - awaiting further instruction from ICS / NHS England
• Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of industrial action
• Long term NHS Workforce plan published 30/06/23 to address gaps in workforce.
• Ballot open for Resident Doctors with 55% in favour of Industrial Action, 6-month period for action to be carried out (until January 2026)
• First phase of industrial action did take place place 25th - 30th July 2025, with a planning and oversight structure in place led by the Executive Medical Director / Deputy Medical Director
• Learning identified from 2022-2025 industrial action has been embedded into Trust policy and planning for industrial action
• Learning identified from the July 2025 experience will be embedded into any future instances of action, a debrief was carried out to capture the learning
• Resident Doctor’s industrial action took place 14th November – 19th November 2025 and all clinical areas were asked to identify mitigation plans and escalate risks.</td></tr>
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Board Assurance Framework

	• The Industrial Action Response Group was in place with five planning meetings ahead of the planned action, this group will continue to monitor the preparation for future of action. • A robust Trust plan was shared ahead of the Resident Doctors Industrial Action. • Elective cancellations were approved by exception with sign off through the Director of Operations and Performance. • A debrief has been shared to capture any lessons identified and these will be embedded into future rounds of planning. • Services were asked to ensure any planned cover for the period of November action was sustainable and financial considerations were acknowledged.
Assurance Gaps:	• Trust EPRR Lead linking in with ICB to provide any information requests • Potential financial and recovery implications associated with periods of industrial action. • Cancellation of elective and outpatient appointments to support medical cover over the period of Resident Doctor industrial action. This will impact on performance. • Ballot for Consultant and SAS Doctors opened on 21st July 2025 and closed on 1st September 2025. The groups voted in favour of industrial action and have called for negotiations with the government. There has been no further information released regarding intentions to strike. • Ballot for FY1 closed on 6th October. 97% of respondents voted in favour of industrial action, with a 65% turnout indicating a mandate for action. • Other Trade Union groups have opened consultation with members regarding the 2025/2026 pay award • 67% of GMB Union workers have voted to reject the pay award in an initial consultative vote, this mainly impacted upon the Ambulance service in 2022-2023. Future industrial action is anticipated from this group, a formal ballot is expected • The ballot for Unite the Union closed 21st July 2025, the results are not yet published • The Royal College of Nursing carried out consultation and is likely to reject the pay deal for 2025/26. A formal ballot is likely in the Autumn • Financial implications of cancelled activity, mitigation plans and safe staffing plans • Impact on restoration and recovery • Reputational damage • Currently there is no scheduled date for the next instance of industrial action – the next phase could possibly occur during a more significant period of winter pressure and possibly during the holiday period. Planning will be initiated once the notice has been received.

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

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

Board Assurance Framework

Risk ID	2253	**Executive Lead**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed.			**Initial**	9 (L3 x C3)
				Current	9 (L3 x C3)
				Target	2 (L1 x C2)
CQC Domain(s)	**Well-Led**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	The integration programme- "Better Care Together" has been established. Each workstream has developed a delivery plan and is working with partners to deliver objectives. Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and make progress in delivering improved pathways for our patients. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation on 1st April 2026. **Controls** • Nikhil Khashu commenced as Chief Executive Officer for both Trusts on the 1st November • Paul Fitzsimmons appointed as joint Executive Medical Director • Dan Moore appointed a joint Chief Operating Officer • Summary case for change – approved – Novembver 2024 • Signed data sharing agreement • Ali Kennah appointed as joint Chief Nurse • Strategic People Committee in common established April 2025 • Finance, Sustainability and Performance Committee in Common established July 2025 • ToR for Joint Committee of the Board approved July 2025 **Assurance** • Workstreams identified 6, 12 and 24 month priorities • Programme governance arrangements in place, including joint executive team meetings, delivery group and steering group • Held joint board sessions • Developed and approved initial milestone plan • Held first clinical and operational services workshop to identify where services can align to deliver patient benefit • Communication and Engagement Plan approved • Strategic case for integration of WHH and Bridgewater approved by both boards and supported by ICB • Proposal to accelerate our transaction approved by both boards and supported by ICB • Draft timeline for an accelerated transaction approved by both boards and supported by ICB • Draft FBC shared with both Boards for feedback • NHSE transaction amber rating received at strategic case stage				
Assurance Gaps	• Full integrated governance will not be in place prior to establishment of enlarged organisation				

Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Boards at both Warrington and Halton Teaching Hospitals (WHH) and Bridgewater Community Healthcare FT (BCH) to approve the recommendation for WHH to acquire BCH	Boards at both WHH and BCH to discuss the recommendation for WHH to acquire BCH to be presented to retrospective Boards on 5th and 6th of February 2025	Proposal for WHH to acquire BCH to be presented to respective Boards on 5th and 6th February 2025.	Lucy Gardner	06.02.2025	Complete 6.2.25
Implement a more integrated governance structure to support timely and effective decision making	Develop, agree and implement a joint integrated governance structure	Develop, agree and implement a joint integrated governance structure.	John Culshaw	01.08.2025	Joint committees FSPCiC and SPCiC established, along with Joint Committee of the Board
Transaction to become a single organisation accelerated to 1st April 2026	Both Boards approved strategic case and accelerated transaction timeline July 25 FBC in development	FBC due diligence and NHSE review	Lucy Gardner	31.07.2025 FBC – 5.12.2025	Complete

Appendix 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk Appetite Statement

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

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

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

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

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

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

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

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

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

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

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/128**	
SUBJECT:	**Integration: Transaction documents for Board approval and next steps**	
DATE OF MEETING:	Wednesday 3 December 2025	
AUTHOR(S):	Lucy Gardner, Chief Strategy & Partnerships Officer Stephen Bennett, Head of Strategy & Partnerships Lefteris Zabatis, Senior Strategic Project Manager	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department. **1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **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. **1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **1372** If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **1898** If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions. **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 **145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff

	2253 If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

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

EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper and accompanying presentation provide an update on the planned integration of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH), which remains on track for completion by 1 April 2026. The paper and presentation accompany the key documents required for the next step in the NHS England (NHSE) transaction process, including the Full Business Case (FBC), Board Certification, Post-Transaction Integration Plan (PTIP), and Secretary of State (SoS) documents. These documents collectively demonstrate that the transaction is being delivered in line with national requirements, guidance and assurance standards. The documents are being presented to Board for approval ahead of planned submission to NHSE on 5th December 2025.

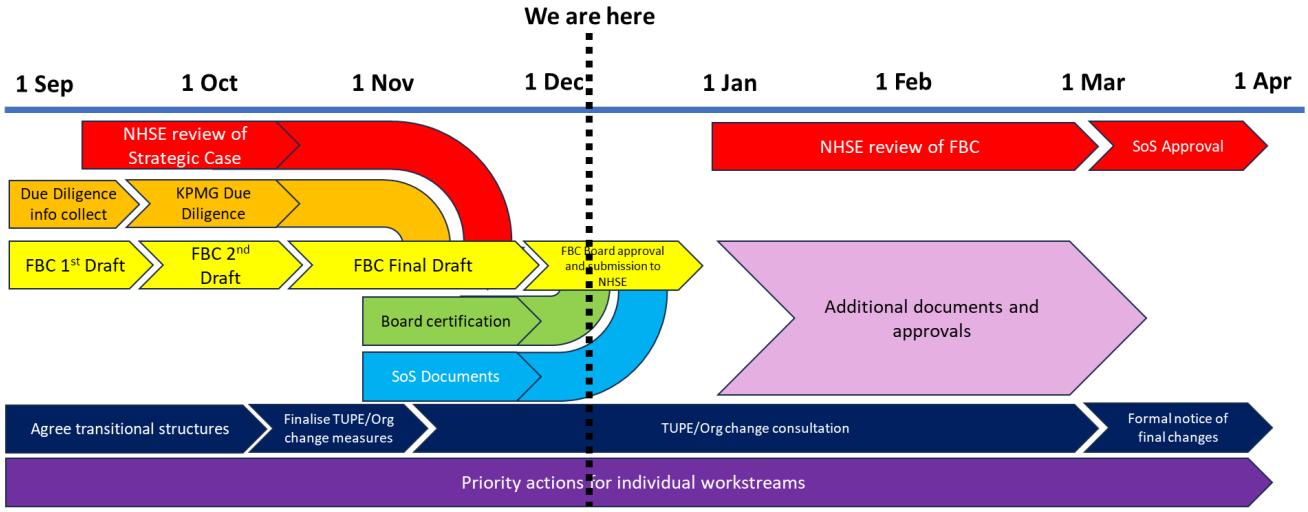
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note**	**Decision**
	✓		

RECOMMENDATION:	It is recommended that Trust Boards approve the following documents for submission to NHSE to continue to progress the transaction for WHH to acquire BCH as part of our integration programme: • Full Business Case (FBC) • Board Certification (Requires approval from WHH Board and support from BCH Board) • Post Transaction Implementation Plan (PTIP) • SoS Duties (NHS Act 2006) – Promoting a comprehensive health service, improving quality, reducing inequalities, and ensuring strong governance. • Environmental Principles – Assessing potential environmental effects of the transaction. • Public Sector Equality Duty (PSED) – Ensuring equality, inclusion, and fairness in line with the Equality Act 2010. • Family Test – Considering the impact of the transaction on families, patients, and staff wellbeing.	
PREVIOUSLY CONSIDERED BY:	**Committee**	The Full Business Case and Board Certification have been considered previously (in November) by Trust Boards and Committees of the Boards in draft form.
	Agenda Ref.	
	Date of meetings	November
	Summary of Outcome	Reviewed for comment, no comments received
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Integration: Transaction documents for Board approval and next steps	AGENDA REF:	BM/25/12/128

1. BACKGROUND/CONTEXT

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) continue to progress the planned integration of the two organisations. The key milestones for completing the transaction by **1st April 2026** are described in the diagram below.



2. TRANSACTION APPROVAL DOCUMENTATION

As part of the NHS England (NHSE) transaction approval process, a suite of key documents is required to support the formal submission for approval. These documents form an essential component of the overall assurance and governance framework for the transaction.

The Programme Delivery Team has worked collaboratively with all programme workstreams, the executive team, NHSE and KPMG to develop the documents, ensuring alignment with the key requirements of the transaction process. Early draft versions of the FBC and Board Certification were shared to seek Board members' feedback and input prior to finalisation.

Final versions are now presented to Trust Boards for approval, prior to submission to NHSE.

Table 1 below provides a summary of each key document required as part of the next phases of the transaction in accordance with the NHSE transactions guidance. For each document, included is whether it is presented to Trust Board today for approval, along with a summary of its purpose.

Document	Presented for	Purpose

	approval today	
FBC, including due diligence.	✓	A formal document setting out the detailed case for integration which: -demonstrates how the transaction will be executed -outlines the benefits and how they will be delivered -identifies key risks -details the resources and processes in place to ensure both a safe landing of the transaction and the achievement of the intended benefits. Due diligence identifies areas of risk so that we can decide if we should proceed with the transaction and if so, what action to take to mitigate the risks as part of our integration planning.
FBC Supporting documents		We have developed over 50 supporting documents to support delivery of our integration and transaction and to provide assurance to Trust Boards and/or NHSE. These will be submitted to NHSE along with our FBC, Board Certification, PTIP and SoS documents. Many of the supporting documents have been previously shared with and/or approved by Trust Boards as part of our integration programme. Where necessary they will be reviewed by EMT prior to submission and shared at future Trust Boards as appropriate.
Board certification	✓	All Trusts undertaking material and significant transactions must complete a Board Certification as part of the transaction review process. It is submitted to NHSE alongside the FBC, to demonstrate the Board's confidence that the requirements of the transaction guidance have been met.
Post Transaction Integration Plan	✓	The PTIP is a roadmap that describes the process of integrating the 2 Trusts, from their current state to the integrated single Trust post-transaction. A "live" document that shows how the Trusts will achieve a safe transition but also continue to integrate and deliver the intended benefits. It focuses on aligning culture, integrating systems, and combining operations.
Secretary of State for Health and Social Care (SoS) documents	✓ **(bar qualitative submission)**	These are documents that demonstrate how the new organisation meets the statutory duties of the Secretary of State for Health and Social Care under the NHS Act 2006.
Management letter of representation		A key document that provides NHSE with assurance that: • All information supplied for the transaction is accurate and complete • The Trusts have disclosed all material risks, issues and liabilities • The Trusts have complied with all legal, regulatory and

		policy requirements
New constitution		A formal, legally binding document that defines the governance framework of the NHS Foundation Trust after the transaction. It sets out the organisation's structure, powers, membership rules, Board arrangements, accountability mechanisms, and decision-making processes. Once approved, it becomes part of the Trust's legal standing and must be adhered to by the Board, governors and members.
Application letter		An Application Letter is a Board-approved, formally signed request submitted by the Trust(s) to NHS England, confirming that they are applying for NHSE approval of the proposed transaction. It acts as the official notification that the Trust(s) have completed the required planning, due diligence and assurance steps, and now seek NHSE's authorisation to implement the transaction.
Transaction agreement		A legally binding contract between the Trusts involved in a merger or acquisition. It defines the terms, responsibilities, liabilities and arrangements under which one Trust acquires another. It ensures that both parties and NHS have absolute clarity about what is being transferred, how risks are managed, and what obligations remain before and after the transaction date.

A more detailed summary of each document provided today for Board approval is provided in the accompanying presentation.

3. RECOMMENDATIONS

It is recommended that Trust Boards approve the following documents for submission to NHSE to continue to progress the transaction for WHH to acquire BCH as part of our integration programme:

- Full Business Case (FBC)
- Board Certification (Requires approval from WHH Board and support from BCH Board)
- Post Transaction Implementation Plan (PTIP)
- SoS Duties (NHS Act 2006) – Promoting a comprehensive health service, improving quality, reducing inequalities, and ensuring strong governance.
- Environmental Principles – Assessing potential environmental effects of the transaction.
- Public Sector Equality Duty (PSED) – Ensuring equality, inclusion, and fairness in line with the Equality Act 2010.
- Family Test – Considering the impact of the transaction on families, patients, and staff wellbeing.

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1.0 Foreword

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) have long shared a commitment to delivering outstanding care for the communities of Warrington, Halton, and beyond.

As two organisations providing services across different parts of local patient pathways, we recognise that by coming together we can deliver even greater benefits for our patients, our people, and our system partners.

Since 1 November 2024 we have taken significant steps towards closer collaboration, including the appointment of a joint chief executive and the establishment of joint governance arrangements. These include combined executive team and Board development meetings, alongside a dedicated integration steering group with representation from both Trusts and our system partners. These foundations have already enabled us to explore new opportunities to improve the quality, experience, and sustainability of care.

This programme of integration is not simply about reducing duplication or addressing financial challenge, it is about transforming how we deliver healthcare for the future. By uniting acute, secondary, and community care into a single organisation, we can better respond to the evolving needs of our population and provide care that is truly centred on patients rather than organisational boundaries.

Our shared vision aligns closely with national priorities, including the government's NHS 10-year plan to reshape the health service through integrated and patient-focused care. Together we are committed to tackling health inequalities, supporting older and frail people in the community, preventing avoidable hospital admissions, and accelerating safe and effective discharge. Above all, we aim to make the best use of our shared resources to deliver the highest standards of care.

A formal integration of WHH and BCH represents the next pivotal step in our journey. By bringing our organisations together as a single unified Trust, we will be able to harness our combined expertise, strengthen our resilience, and enhance our ability to provide safe, effective, and compassionate care. This will create a stronger platform for innovation, integration, and improvement, benefiting both our patients and our staff.

As we move forward our focus will remain on our communities, maintaining trust, communicating openly, and working collaboratively to shape the next chapter in local healthcare. With strong foundations already in place through shared leadership and a united purpose, we are confident that we can move quickly to realise our vision: to create a new organisation that is greater than the sum of its parts.

Steve McGuirk

Chair of WHH

Martyn Taylor

Chair of BCH

Nikhil Khashu

Joint CEO of BCH and WHH

2.0 Executive Summary

2.1 Our organisations

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) provide healthcare services to broadly the same population of 340,000 people in Warrington and Halton, and to a lesser extent, the surrounding areas.

Each organisation specialises in different parts of the clinical pathway with WHH predominantly delivering acute and elective hospital-based services and BCH predominantly delivering community and domiciliary services.

Both Trusts have underlying financial deficits and face increasing challenges relating to their ability to meet ever-growing demand and remain financially sustainable. The underlying deficit for financial year 2025/26 of both WHH and BCH combined stands at an estimated £48.3m.

From the recent NHS oversight framework data, WHH has been placed in segment 4 of 5 in terms of overall performance and support needs, with BCH in segment 3. Both Trusts currently perform well against numerous patient safety metrics. However, both Trusts have key challenges relating to access to services, performing poorly in terms of the number of people waiting more than 52 weeks for some services. WHH's performance relating to waiting times in the Emergency Department (ED) is currently amongst the worst in the country.

2.2 Background and history to the planned integration

The work to explore the integration of WHH and BCH dates back to 2018 and in February 2020, both Trusts formally communicated their intent to integrate to NHS England. Within weeks of that decision, the COVID-19 outbreak impacted and discussions around integration ceased while both providers focused on the requirements of maintaining their own services through the pandemic.

Five years on, and all of the reasons why integrating the two partner organisations made sense in 2020, still apply. Therefore, the plans to bring together the two organisations have been reinvigorated and accelerated, supported by the NHS Cheshire and Merseyside Integrated Care Board.

2.3 Strategic rationale

The strategic case for integration is clear. The combined organisation will help address health inequalities, strengthen clinical sustainability, enhance patient experience and improve financial performance.

Both Warrington and Halton record ever-growing demand for services, static healthy life expectancy figures, an ageing population – often with multiple, complex and non-health related challenges, and system-wide inefficiencies. In order to tackle these challenges, the future will require unified leadership, a single, transformational vision for the future and an ability to deliver large-scale change at pace. Integration will deliver a single, resilient healthcare organisation capable of meeting both current and future population health needs.

Strategic direction locally, regionally and nationally (NHS 10-year plan) focusses on a ‘left shift’ of care out of hospital into community and from ill-health to prevention as a way to manage future demand. The integration of WHH and BCH creates the perfect platform to make the required transformation of services happen.

2.4 Options appraisal

Following a robust appraisal process, the acquisition of BCH by WHH was approved as the most suitable and appropriate legal mechanism for integration. The acquisition of BCH was selected due to its lower risk, value for money, and ability to deliver greater patient and staff benefits sooner.

2.5 Programme delivery and programme management

The Trusts have established a detailed and wide-reaching programme of work to drive delivery and governance of the integration. The programme is entitled ‘Better Care Together’ and consists of ten core workstreams, each with exec-level leadership and programme support.

The programme has been split into three phases:

- Phase one focusses on completing the legal transaction and setting up the critical infrastructure to ensure day one (1 April 2026) delivery and commence the integration of leadership, corporate services and some clinical support functions.
- Phase two (April 26 to Mar 27) focusses on embedding initial infrastructure changes and driving early benefits whilst commencing work on the longer-term clinical integration and priority services.
- Phase three (Apr 27 onwards) will see the transformation of remaining clinical services and the shift towards a new model of care.

The three phased approach will help us to move at pace whilst keeping additional costs and disruption to clinical services to a minimum. The Trusts have redirected significant internal resources to support delivery of the integration programme across its duration. Those resources will be deployed flexibly to ensure that priority workstreams are supported appropriately, and at the right times.

2.6 Vision and strategies for integrated trust

Our vision for integration is to create a new single organisation which is greater than the sum of its parts, anchored with a core principle of **‘Home first, community next and only then hospital’.**

Throughout the initial phases of the programme, we will develop a series of formal and connected strategy documents to help define our future clinical and operational model. Those documents will describe how the future model will meet the needs of our local populations and help address the strategic challenges we face now and in the future.

2.7 Organisation design

Plans are in place for a single Board to lead the integrated organisation, supported by elected governors and underpinned by a renewed Trust constitution. Board committee structures and quality, financial, and people

governance structures are detailed within the FBC to ensure robust governance from day one and beyond.

Draft transitional structures - effective from 1 April 2026 - have been developed for all teams, including clinical and corporate. These support the formal consultation around TUPE and organisational change, which commenced in November 2025.

2.8 Clinical model

The future clinical model of the integrated organisation will be shaped in line with national and local strategic direction and developed in full collaboration with local and regional partners. It will be clearly defined in a new clinical strategy to be published by the end of 2026. The clinical model will build on strong existing foundations of collaboration between the two organisations and a commitment to transforming clinical pathways and promoting localised, data-led health and wellbeing care.

Seven clinical priorities have been identified from initial engagement. These will form the basis of the initial integration work focussed on clinical service redesign and improvement for patients. The service level clinical strategy and transformation will align to the core principle of ‘Home first, community next and only then hospital’.

2.9 Corporate support functions

The most significant financial improvement opportunity that can unlocked through integration is linked to corporate services. National benchmarking clearly demonstrates short-term benefits can be delivered through integration unlocking improved economies of scale.

Our corporate services will come together from day one and draft transitional structures have been developed for consultation. Corporate teams have been working closely together, starting to align internal processes and streamline activities to make the transition as smooth as possible from day one.

2.10 Expected benefits and quality impact

There are a number of key areas that together, summarise the benefits of the integration to our patients and communities; a fundamental shift in care - Home first, community next and hospital only when needed, data-led local approaches to service design and delivery, streamlined clinical pathways, removal of organisational barriers, better use of resources, strengthening fragile services, and enhanced public and patient involvement.

2.11 Financial case

The combined planned deficit for the two organisations at the start of 25/26 prior to in year savings and deficit support funding stood at £72m. The combined underlying deficit of the Trusts is estimated to be £48.3m.

Recent historic financial performance illustrates a worsening financial position, largely in response to growing demand for services and a need to increase capacity to meet it. The integration programme presents financial improvement opportunities totalling up to £33m (both direct and indirect opportunities) and is therefore a fundamental part of the journey towards longer-term financial

sustainability. The estimated additional costs of the integration stand at around £1.1m, demonstrating the value in bringing the organisations together and the urgency to make this happen as quickly as possible.

2.12 Inequalities

Warrington and Halton have high levels of inequality across the populations, including significant variation in life expectancy and healthy life expectancy within each borough.

By aligning community and acute services, the new organisation will target the root causes of inequality, deliver prevention-focused care, and strengthen partnerships with local authorities, primary care and the voluntary sector to close health gaps across populations.

The integration between WHH and BCH creates opportunities for the development of seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home, contributing to the development of neighbourhood health.

Increased collaboration with other local partners from across the sectors also creates opportunities to tackle the wider determinants of health that can help make a long-term and sustainable improvement in health outcomes and demand for statutory services.

2.13 Communications and engagement

Our new organisation will be known as North Cheshire and Mersey NHS Foundation Trust. We have commenced a large-scale programme of engagement with staff, patients, local stakeholders and the wider public around a number of elements of our approach to the integration. This will set the tone for how we aim to continue over the coming years as we bring the two organisations together.

We have support for the integration from our local MPs, NHS Cheshire and Merseyside ICB, both local authorities, GPs, voluntary sector partners and NHS England.

2.14 People strategy

Between us, the two organisations employ over 6,700 staff from over 80 different nationalities. The vast majority of our staff are also Warrington and Halton residents. The success of our integrated Trust is important to them on many levels.

Our teams tell us that working closely together has already provided advancements in service delivery, and the energy and commitment to take the opportunity to make things better is tangible and a source of optimism.

We have already developed a joint culture plan and consulted with staff around our core Trust values that we commit to keeping at the heart of our work as we progress.

2.15 Digital strategy

Nationally, the NHS 10-year plan sets out an ambition to shift care away from traditional analogue systems and processes and towards digitally enabled care.

In order to maximise the benefits available to us through the integration, and truly seize the opportunity to transform services, digital services must be central to our ambitions.

We have set out a roadmap for the integration of our digital systems, including short-term interoperability of our EPR systems and a longer-term plan to move to a single EPR to support our clinical and operational vision.

2.16 Estates strategy

Across both organisations, our staff currently operate from approximately 98 sites within Warrington, Halton, Knowsley, St Helens and Greater Manchester. The quality of the estate varies greatly, creating variation in terms of staff and patient experience and financial efficiency.

The development of a new clinical strategy and the future vision for more services in community creates a platform for a transformational approach to the use of estate.

A new estates strategy will be developed to support the organisation's strategic long-term ambition to deliver more care locally and redevelop/modernise the acute hospital sites to enable the delivery of 21st century healthcare that meets the growing demands of our local population. The estates strategy will be developed in collaboration with local partners and align to national and regional estates priorities.

2.17 Risks

The individual workstreams within the Better Care Together programme capture and record all operational and strategic programme-related risks. Robust governance is in place to ensure that programme risks feed into the existing organisational risk management processes within BCH and WHH.

Alongside this, appropriate and detailed due diligence has helped us to improve visibility of some of the key risks, issues and challenges associated with the acquisition. We have clarity around the most significant risks, and we have plans in place to mitigate and manage these as we progress through each phase of the integration programme, including those risks that are critical to manage as part of ensuring a successful day one.

2.18 Conclusion

The integration of BCH and WHH is essential to enable us to provide the seamless care our growing populations need and deserve. Joining together to form a single organisation allows us to deliver the left shift of care described in the NHS 10-year plan, as well as ensuring our services are clinically and financially sustainable for the future.

Put simply we will provide Better Care Together, for our patients, our staff and our partners and communities.

3.0 Our organisations

This section provides an overview of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH), highlighting their shared purpose, complementary service portfolios and collective commitment to improving health outcomes across Warrington, Halton and neighbouring communities.

It describes how both organisations serve broadly the same population footprint through acute, community and specialist care, with WHH delivering mainly hospital-based services and BCH providing mainly community and dental care closer to home.

The section also sets out some of each organisation's key performance, workforce, estate, and service data to establish a clear baseline for integration. These details demonstrate the foundations, upon which a single, integrated provider can build to deliver seamless, person-centred care, improve efficiency and equity of access, and create a sustainable model of care for the future.

Key message: Together, WHH and BCH represent a complementary partnership built on shared purpose and proven collaboration. Each organisation brings distinct expertise, WHH in acute and elective care, BCH in community and out-of-hospital services, creating a fully integrated care offer aligned with the NHS 10-year plan's vision of prevention, digital transformation, and care closer to home.

This integration is a natural progression of our joint commitment to quality, efficiency, and equity of care across our shared populations.

3.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH)

WHH comprises three hospital facilities delivering secondary care and acute services across two main sites in the boroughs of Warrington and Halton. It also provides a range of services across more than 30 community locations.

The Warrington Hospital site provides emergency care, general medicine, intensive and high dependency care, surgery, cardiac care, stroke care, cancer care, maternity, paediatrics, and support services like physiotherapy, pathology and pharmacy.

The Halton Hospital site in Runcorn specialises in elective and diagnostic care. It includes the Captain Sir Tom Moore Building and Nightingale Building, offering services including general surgery, urology, orthopaedics, endoscopy, cancer care and a broad range of outpatient clinics. The site is also home to the Delamere Macmillan Unit, Halton Clinical Research Unit, two phases of the Community Diagnostic Centre and Runcorn Urgent Treatment Centre.

All three facilities across the two main sites offer outpatient clinics and diagnostic services in a range of settings to ensure patients can access care close to home. In addition to hospitals, community hubs and mobile facilities, the Trust also offers virtual options to improve access to quality care and reduce health inequalities.

The Trust is rated 'Good' by the Care Quality Commission, and its workforce of nearly 5,000 staff comprises 80 different nationalities. The organisation's turnover in 2024-25 was £392 million. Across 2024-25 the Trust[1]:

- Delivered 2,473 babies in hospital and in the community.
- Delivered 59,474 procedures and inpatient stays.
- Delivered 109,928 individual new outpatient appointments each year (face-to-face and telephone).
- Operated 744 beds – assessment beds and trolleys – across both sites.
- Provided 144,951 episodes of emergency care – 84,816 episodes at the Emergency Department (ED), 22,842 at Warrington Same Day Emergency Care (SDEC) facility, and 37,293 at the Runcorn Urgent Treatment Centre (UTC).

3.2 Bridgewater Community Healthcare NHS Foundation Trust (BCH)

BCH provides community adult and children's nursing and therapy services in Halton and Warrington. The Trust also provides specialised community dental services reaching more than 18,500 people across Cheshire, Merseyside and Greater Manchester. These services fall outside the two main boroughs but remain an important part of the partnership landscape, requiring close collaboration with local authorities, primary care networks, NHS providers and voluntary and community sector organisations. This wider footprint provides opportunities for shared learning and consistency in service delivery across localities, while ensuring that care is aligned with the priorities of each local Place.

As a dedicated provider of community services, the current Trust strategy is to bring more care closer to home. Most services are delivered in patients' homes or from over 60 community locations including health centres, GP practices, community centres and schools.

[1] Warrington and Halton Hospitals NHS Foundation Trust (2025) *Annual Report and Accounts 2024–25.* Available at: https://www.whh.nhs.uk/media/b12hznuj/whh-anual-report-and-accounts-2024-25.pdf

The Trust employs approximately 1,700 people and has more than 100 apprentices working within its clinical and corporate teams.

The Trust is rated 'requires improvement' by the Care Quality Commission and its turnover in 2024-25 was £108 million. Across 2024-25 the Trust[2]:

- Administered 37,171 vaccinations to 32,045 children in schools and communities across Warrington and Halton.
- Delivered 201,410 District nursing care contacts in community across Warrington and Halton.
- Delivered 12,166 Community Matron care contacts in community across Warrington and Halton.
- Delivered 30,030 District Nursing treatment room care contacts across Warrington and Halton.
- Provided 39,074 same day urgent care contacts at Widnes Urgent Treatment centre (unplanned activity only).
- Delivered 40,917 dental appointments across Greater Manchester, and Cheshire and Merseyside.

3.3 NHS oversight framework and current performance

The recent publication of Trust league tables (September 2025)[3] following the launch of the new NHS oversight framework shows that WHH lies 118th out of 134 acute and specialist Trusts in England. BCH is listed as 39th out of 61 non-specialist Trusts.

WHH is in segment 4 of 5 in terms of overall performance and support needs with BCH in segment 3.

Both Trusts currently perform well against numerous patient safety metrics, as well as the metric assessing financial variance to agreed plans. However, both Trusts have key challenges relating to access to services, performing poorly in terms of the number of people waiting more than 52 weeks for some services. WHH's performance relating to waiting times in the Emergency Department (ED) is currently amongst the worst in the country.

Both Trusts also have challenges relating to longer term financial sustainability. The underlying deficit for financial year 2025/26 of both WHH and BCH combined stands at £48.3m.

[2] Info sourced from BCH data warehouse
[3] NHS England (2025) *Acute Trust league table*. Available at: https://www.england.nhs.uk/long-read/acute-trust-league-table/

4.0 Background and history to the planned integration

This section outlines the journey that has led to the proposed acquisition of BCH by WHH, tracing the evolution of partnership working through the Better Care Together programme.

It highlights the shared challenges of fragmented care, workforce pressures and financial constraints that prompted greater collaboration between the two Trusts, alongside system drivers from the Cheshire and Merseyside Integrated Care System (ICS).

The section summarises how both Boards, supported by NHS England, have worked together to develop a structured, transparent and evidence-based case for integration. It demonstrates how early joint governance, shared leadership, and collaborative service redesign have already improved outcomes and operational efficiency, providing proof of concept for a fully integrated model of care.

Key message: The proposed integration is the product of deliberate, incremental collaboration, not a reactive acquisition. Since 2023, both organisations have demonstrated a sustained commitment to collective problem-solving.

The integration represents the next logical step to achieve sustainable, system-wide benefits, aligned with national policy and the Cheshire and Merseyside ICS strategy.

4.1 Options for integration with other local partners

In November 2018, WHH and BCH entered into a Memorandum of Understanding (MoU). The MoU established a shared commitment to explore and implement opportunities for collaboration with the aim of enhancing service delivery, achieving mutual efficiency and effectiveness, and supporting the long-term

sustainability of services. The MoU formalised the joint working that had already commenced between the two organisations.

At that time, both Trusts also considered the potential for merger or integration with other local acute and community providers.

4.1.1 BCH options

BCH had previously explored partnering with North West Boroughs Healthcare NHS FT (NWBH). The option was ultimately deemed not to deliver the same level of benefits to patients, staff and system financial recovery as the option to integrate with WHH. It was also felt that the option would be harder to deliver for a number of reasons, including the following:

- NWBH and BCH would have a prohibitively large, shared footprint.
- NWBH had recently indicated its intention to be acquired by Mersey Care NHSFT.
- A transaction between NWBH and BCH would not create opportunities to shift more acute care into the community and improve transition between hospital and community care, enabling more people to stay in the community and their homes for longer.
- A transaction between NWBH and BCH would not help to address clinical and financial sustainability challenges faced by WHH.

BCH did not consider partnering with other community service providers at that time, given the geographical constraints it would bring. BCH Board's view was that a formal transaction with NWBH, and therefore given the timing of the discussion, also with Mersey Care, would create an organisation with too large a geographical span. This would make it difficult and costly to ensure both strong quality governance and effective leadership to multiple place-based services and would not realise the benefits required to offset the costs and disruption caused by an integration programme.

Furthermore, the Warrington population at the time was the fastest growing in Cheshire and Merseyside. A transaction with an organisation outside of Warrington would have potentially posed a risk to ensuring that the needs of the growing Warrington population were appropriately prioritised. The Chairs and CEOs of BCH and NWBH met in December 2018 to discuss the option of the two Trusts formally collaborating, following which the BCH Board agreed it was not the Trust's preferred option. This was also reflected in NWBH's options appraisal completed as part of the process of them approaching NHSE/I to describe their intention to be acquired by Mersey Care.

4.1.2 WHH options

Prior to November 2018, WHH had worked closely with St Helens and Knowsley Teaching Hospitals NHS Trust (STHK)[4] and had successfully implemented a number of changes to enable sustainability of acute services. These included a new stroke pathway and joint on-call rotas for some smaller surgical specialties. However, a formal transaction between the two organisations was not considered a preferred option at that time for a number of reasons, including:

[4] The organisation is now known as Mersey and West Lancashire Teaching Hospitals NHS Trust following a recent merger between STHK and Southport and Ormskirk NHS Trust.

- Learning and experience from previous transactions and national benchmarking, at that time, suggested that horizontal integration between large acute hospital Trusts were likely to create further complexity rather than remedying it. However, there was evidence to suggest that there may be a role for vertical integration developing more coherent organisations[5].
- A formal transaction between STHK and WHH would not help to address the opportunities to shift care into the community and improve transition between hospital and community care.
- The Warrington population was the fastest growing in Cheshire and Merseyside and again, integration with an organisation operating outside that area created a risk around WHH's ability to deliver on the specific needs of the local Warrington population.
- A transaction between STHK and WHH would not help to address the clinical and financial sustainability challenges faced by BCH at that time.

4.2 Initial proposal for integration of WHH and BCH in 2019

Following careful assessment, it was concluded that all other alternative integration options for both WHH and BCH would not deliver the same level of benefits for the organisations themselves or for the local populations they served.

Subsequently, a structured programme of work to start to bring the organisations together was developed and progressed through a series of joint executive team meetings. In parallel, both organisations held a number of Board-to-Board meetings and established a committee in common to consider the range of collaboration and transaction options available.

In November 2019, a comprehensive options appraisal was presented and scrutinised at a Board-to-Board meeting. Following this appraisal, both Boards resolved in January 2020 that the preferred course of action was for WHH to acquire BCH. This decision was formally communicated to NHS England/NHS Improvement in February 2020 through a joint letter of intent.

The two Trusts commenced on a programme to recruit joint executive positions with the appointment of WHH's Chief People Officer into a joint role covering BCH between January 2019 and March 2020.

The full transaction was originally scheduled for completion in June 2021. However, the process was subsequently stopped as a direct result of the global COVID-19 pandemic and both organisations returned to focus on delivery of services as individual providers.

4.3 Revisiting previous plans

Five years later and a number of the sustainability challenges faced by WHH and BCH remain unresolved, demand for services across both providers has increased significantly, and the financial climate has grown ever more challenging. These circumstances have re-invigorated discussions between the WHH and BCH Boards about the possibility of integrating the two organisations.

[5] The King's Fund (2015) *Foundation trust and NHS trust mergers: 2010 – 2015*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/foundation-trust-nhs-trust-mergers

The planned financial deficit for 2025/26 for the whole of Cheshire and Merseyside is £178.3m (before deficit support funding). This challenging financial situation has led to a number of detailed financial reviews across the ICS to explore financial improvement opportunities. Alongside this, the publication of Trust league tables driven by the new NHS England oversight framework highlights the urgent need for performance improvement across both WHH and BCH. Subsequently these factors have led to a direct request from the ICS for the two organisations to revisit the proposed integration plan, and if still feasible, explore how to make it happen as quickly as possible to drive required improvement.

5.0 Strategic rationale

The strategic rationale sets out the case for why integration is the only sustainable and logical next step for both organisations. It positions the proposal within the context of the NHS 10-year plan and the priorities of the Cheshire and Merseyside ICS.

The section articulates the strategic need for integration, grounded in local population health need, financial and workforce sustainability, and alignment with regional and national NHS priorities; prevention, digital innovation, and out-of-hospital care. It identifies the challenges faced by both organisations independently, including fragmented pathways, duplicated support services, and rising demand, and sets out how integration offers a viable, forward-looking solution

Key message: The strategic case for integration is clear. This section explains how the combined organisation will address health inequalities, strengthen clinical sustainability, enhance patient experience and improve financial performance.

It highlights the growing demand for services, an ageing population, and system-wide inefficiencies that require unified leadership and delivery and ensuring both Trusts remain sustainable contributors to the Cheshire and Merseyside system.

Ultimately, it establishes how integration will deliver a single, resilient healthcare organisation capable of meeting both current and future population health needs.

5.1 Our places

5.1.1 Warrington

Warrington is a large town and unitary authority area in Cheshire, England, situated on the banks of the River Mersey. Historically part of Lancashire, it became a significant industrial centre during the industrial revolution, known for its traditional industries including wire, textiles, and brewing.

Today, Warrington is one of the fastest growing towns in the UK and has a diverse economy with strengths in logistics, advanced manufacturing, and retail, all benefiting from its strategic location at the intersection of major motorways and railways. It serves as a key regional hub with a vibrant town centre, numerous business parks, and a growing population, making it an important economic and residential area in the northwest.

The population of Warrington is currently around 210,900[6].

5.1.2 Halton

Halton is a unitary authority and borough in Cheshire, England, comprising the towns of Runcorn and Widnes, along with several smaller parishes. Situated on either side of the River Mersey, it is perhaps best known for its industrial heritage – particularly in chemicals and engineering – and its iconic bridges including the Silver Jubilee Bridge and the more recent Mersey Gateway, which significantly improved regional connectivity.

Historically rooted in the ancient Barony of Halton, the area has transformed from industrial centres to a diversified economy with a focus on logistics, science, and manufacturing, while also offering cultural attractions and green spaces. Since 2014 Halton has been part of the Liverpool City Region Combined Authority, playing a role in the wider regional development.

The population of Halton is currently around 128,200[7].

5.1.3 Regional differences and potential impact of devolution

Halton lies within the Liverpool City Region (LCR). Warrington sits outside of LCR and preparing to join the Cheshire and Warrington Mayoral Combined Authority.

[6] Office for National Statistics (ONS) (2022) *Population and household estimates, England and Wales: Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021

[7] ONS (2022) *Population and household estimates, England and Wales: Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021

Funding flows are different across each Place. Areas within LCR have access to devolved funding and regional initiatives that support health equity, digital inclusion, transport and access, and economic growth.

Both WHH and BCH are often required to navigate multiple commissioning geographies to secure funding to ensure consistent, equitable service delivery across both Places. This can occasionally lead to differences in service provision.

5.2 Local life expectancy and health inequalities

5.2.1 Life expectancy

Average life expectancy at birth for a female born in Warrington is 82 years, and for a male is 79 years. These figures are comparable to national averages.

Average life expectancy at birth for a female born in Halton is 81 years, and for a male is 78 years. These figures are below the national averages.

5.2.2 Health inequalities

Whilst overall life expectancy in Warrington may be close to national averages, there is significant variation in life expectancy within the borough itself. For example, a male born in the Latchford East ward would be expected to live up to ten years less than a male born in the Grappenhall ward. Latchford East and Grappenhall are separated only by the width of the Manchester Ship Canal.

There is a similar picture in Halton, where a male born in the Halton Lea ward would be expected to live 10 years less than a male born in Daresbury, Moore, or Sandymoor wards.

The wide variation in life expectancy across the two boroughs links strongly to levels of deprivation.

As of 2019, Warrington was considered the 148th most deprived of 317 local authorities in England[8]. In general, the more deprived areas lie in the central parts of Warrington, and the less deprived areas lie in the outer parts, particularly in the wards south of the canal.

[8] Warrington Borough Council (2021) *Borough profile 2021 Warrington*. Available at: https://www.warrington.gov.uk/sites/default/files/2021-04/warrington_borough_profile_2021.pdf

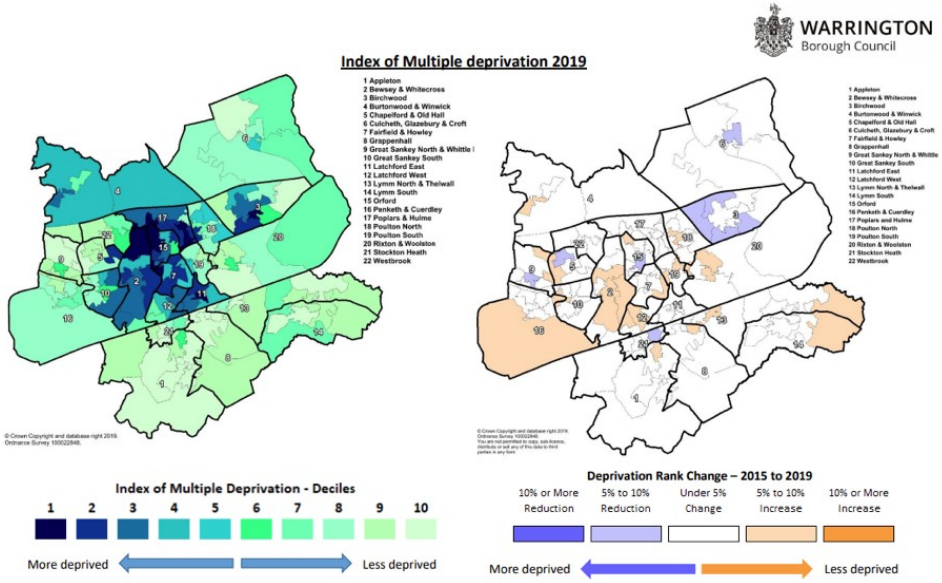


Figure 1: Map of deprivation within Warrington, WBC, 2019

Five wards within Warrington were amongst the 20% most deprived in England, equating to more than 35,000 residents or 17% of Warrington's population. It is these wards that also record many of the poorest health outcomes and therefore the lowest levels of life expectancy.

Warrington is less ethnically diverse than England as a whole, with a larger proportion of residents identifying as 'white' than England or the northwest[9]. Levels of ethnic diversity in the town are also greater in the central, most deprived wards. Therefore, recorded inequalities linked to geography also correlate with inequalities in ethnic backgrounds.

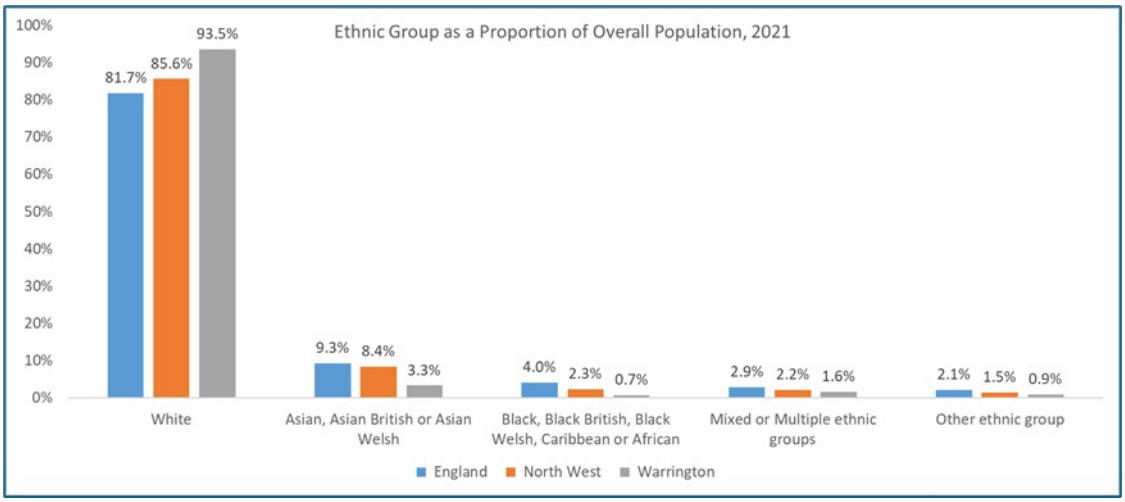


Figure 2: Ethnic group identification for Warrington as per 2021 census

Again, the picture is similar in Halton where the more deprived areas lie in the central parts of both towns of Widnes and Runcorn, and the less deprived areas lie in the outer parts.

[9] Warrington Borough Council (2025) *Warrington population - facts and figures 2025*. Available at: https://www.warrington.gov.uk/sites/default/files/2025-03/Warrington%20population%202025.pdf

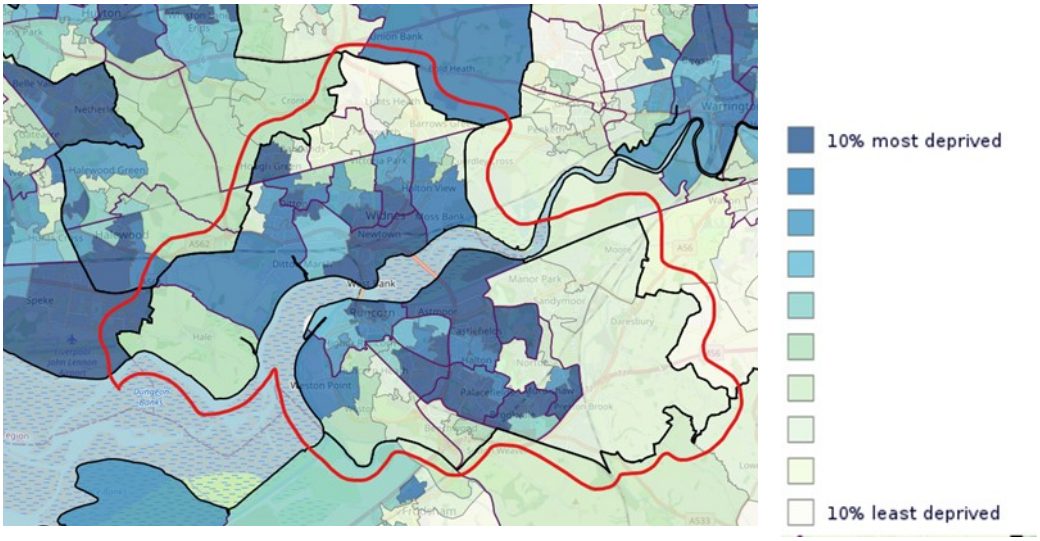


Figure 3: Deprivation within Halton

Statistics from 2019 show that seven wards within Halton were amongst the 20% most deprived wards in England, equating to more than 53,000 residents or 42% of Halton's population[10].

5.3 Healthy life expectancy

Healthy life expectancy is defined as 'a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health'.

The healthy life expectancy at birth for people in Warrington is, on average, around 64 years[11]. In Halton, the figure is around 57 years[12].

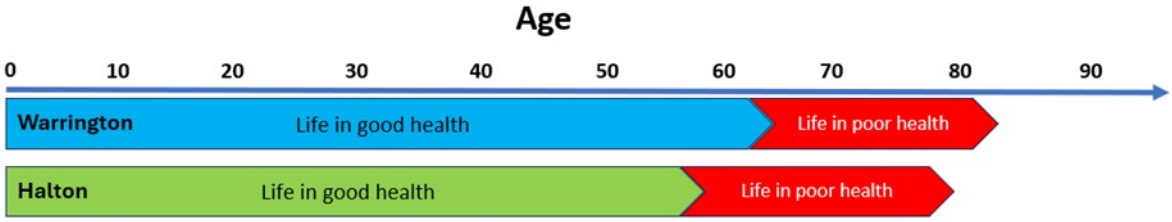


Figure 4: Average healthy life expectancy and overall life expectancy Warrington and Halton

On average, people in Warrington and Halton live approximately 17-23 years in poor health in the later years of their lives. It is these years lived in poor health that drive a significant amount of the demand for health and social care services across the boroughs. Estimates suggest that at least 50% of all healthcare

[10] English indices of deprivation (2019). Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

[11] Office for Health & Improvement Disparities (2025) *Public Health Outcomes Framework - at a glance summary: Warrington*. Available at: https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000007.html?area-name=Warrington

[12] Office for Health & Improvement Disparities (2025) *Public Health Outcomes Framework - at a glance summary: Halton.* Available at: https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000006.html?area-name=Halton

demand and 65% of social care demand is driven by people aged 65 and above living with at least one long-term condition.

5.4 Local health inequalities and wider determinants of health

Chapter 14 of this document describes the challenges within Warrington and Halton in relation to local health inequalities and stark differences between life expectancy within some of the more deprived areas of the boroughs compared to other more affluent areas. Data shows that residents in more deprived areas are more likely to access care through emergency departments and less likely to engage with preventative or planned services. These are some of the reasons why the more deprived parts of the towns record overall poorer health outcomes.

Research[13] also shows that health outcomes for an individual are determined by a wide variety of factors outside of direct healthcare. In fact, as little as 20% of what contributes to a person's health stems from access to, and quality of care. 30% links to lifestyle factors such as smoking, alcohol use, and diet and exercise. 10% links to physical and environmental factors such as air quality and housing. The remaining 40% links to socio-economic factors including education, employment, income, community safety, and social connections.

It is within these 'wider determinants of health' that the real opportunity to transform future healthcare possibly lies. By bringing acute and community services closer together, but also by bringing statutory health care services closer together with social care and wider community support, there is a huge opportunity to address some of the historically more difficult health challenges. That is the real prize for all organisations providing health and wellbeing support at Place.

For example, by supporting the population to live healthier lives for longer, empowering them to take greater responsibility for their own health and wellbeing, and helping them to access low-level support as soon as a need arises, it could be possible to see local healthy life expectancy figures increase. If local residents lived in good health until 70 rather than 65, this would help materially reduce – or at least contain – future demand for health and care services. This could significantly improve access to essential services for patients, improve their experience of accessing health and care, and possibly even help break the constant cycle of increasing investment in acute and reactionary care.

5.5 Future population projections and demand for health and care services

The overall populations of both Warrington and Halton are expected to grow by around 1.3% and 3.9% respectively over the next decade[14]. These projections do not take into account the impact of any planned large-scale housing developments in either borough.

[13] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, 2015

[14] ONS (2025) *Subnational population projections for England: 2022-based*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2022based?utm_source=chatgpt.com

As a result of both a growing but also an ageing population, the expected changes to the demographic profile of the local population is more significant.

Table 1 below shows how the age profile of residents in both boroughs is projected to change over the coming years. By 2033, both Warrington and Halton are likely to have at least 20% more people aged over 65 than they do currently.

Age group	England	NW	Warrington	Halton
0-19	-2.56%	-1.73%	-6.49%	-5.50%
20-64	+0.65%	-0.16%	-3.14%	-0.09%
65+	+21.44%	+19.11%	+22.72%	+20.20%

Table 1 : Estimated change in population by age, 2023 to 2033

Given that such a high proportion of demand for statutory health and care services stems from the older age groups, and without any change to average healthy life expectancy, it is clear that the future projections around age profiles of the local population is likely to significantly increase demand for services further.

5.6 Recent population changes and impact on demand for health and care services

By looking back at facts and figures from the year pre-covid (2018/19), the impact of demand growth can be seen clearly.

Between 2018/19 and 2024/25, the following changed:

- Overall population in Warrington and Halton increased by around 2%.
- Population of residents aged over 65 increased by around 10%.
- Attendances at either the ED in WHH or the Urgent Treatment Centre (UTC) in Runcorn increased by around 8%.
- Non-elective activity at WHH increased by almost 29%.
- Total patients on the WHH elective waiting list increased by 62%.
- Total patients waiting more than 52 weeks for surgery at WHH increased from 47 to almost 600.
- Total patients waiting more than 52 weeks for community services at BCH increased from zero to 1,429.
- Performance against the 4-hour ED target deteriorated from 85% to 69%.
- Funded posts within the unplanned care clinical and operational workforce increased by 28% (+320 whole time equivalents WTE).
- Unplanned care pay budgets (adjusted for pay inflation) increased by 32% (+£16.8m).

Whilst overall performance and financial sustainability of NHS providers is a multi-layered challenge, it is clear that growing demand from the local population is a key factor in this.

5.7 Patient impact of current situation

The performance metrics and financial impact of continually increasing demand for healthcare services outlined in the section above makes for stark reading, but it is the impact of these figures on the experience of patients that creates the real reason that change is required.

62% more patients are waiting for elective surgery now, than they were six years ago. Within that figure, a significant number are now waiting more than a year for that surgery. Almost 1,500 more patients are waiting over a year for a service in community than were six years ago. 16% more patients are waiting more than four hours to be seen in ED. A significant number of them are waiting over 12 hours to be admitted to a hospital bed and an increasing number are being cared for on hospital corridors due to bed capacity constraints.

Additionally, local residents often experience significant challenges in getting an ambulance following a 999 call, accessing a routine appointment with their GP, or the length of time they may need to wait for some mental health services. It is no surprise to read that just 1 in 5 people (21%) in 2024 said they were satisfied with the way the NHS runs[15].

5.8 Managing demand and addressing performance and sustainability challenges

Both WHH and BCH acknowledge that the ability to manage future demand for statutory services, maintain access and quality of services, address local health inequalities, and deliver financial sustainability of the organisations is severely limited if they continue to operate independently. The integration of the two local providers will create new opportunities for improvement on numerous fronts.

In the context of current organisational performance, the regional and national financial climate and ever-increasing demand, the proposal to bring the two organisations together as soon as possible is of growing importance.

5.9 National strategic direction

5.9.1 Independent investigation of the NHS in England (2024)

Lord Darzi's 2024 independent review of the NHS[16] painted a clear picture: the NHS is in critical condition, particularly due to fragmentation of clinical services, lack of workforce planning, and inefficiencies in hospital-based care.

One of the core recommendations of the review was to encourage 'group hospital networks and shared services' across multi-site collaborations that retain local accountability, while operating with a single strategic vision, unified leadership, and standardised care models.

Lord Darzi identified that many single-site or smaller acute hospitals were no longer clinically or financially sustainable in isolation, particularly in the face of growing demand, ageing populations, and increasingly specialist clinical workforce requirements.

5.9.2 NHS 10-year plan

NHS England acknowledged the findings from Lord Darzi's review and subsequently launched a large-scale consultation around the future of the NHS. Members of the public and NHS staff were asked to help inform the new 10-year plan, which seeks to reshape healthcare in the UK.

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[15] British Social Attitudes Survey 2024, Nuffield Trust and The King's Fund.
[16] Department of Health and Social Care (2024) *Independent investigation of the NHS in England.* Available at: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

The plan recognises that many of the challenges seen locally in Warrington and Halton are also reflected on a national level. Advancement in medicine and technology is opening up increasing numbers of treatment options for people and is ultimately leading to people living longer. The challenge for the NHS over the coming decade is to ensure that the model of care adapts to support this positive change.

The plan is built around three key strategic shifts in approach for the NHS:

- From ill health to prevention.
- From analogue to digital.
- From hospital to community.

The plan also makes explicit the need for the NHS nationally to manage within its annual financial allocations, through both improved fiscal planning and day-to-day management.

The financial outlook for the NHS is under unprecedented pressure with NHS England's total revenue allocation only rising by 0.2% in real terms in 2024-25, placing demands on Trusts to identify exceptional levels of efficiency savings.

In this context, incremental improvement is unlikely to deliver the size and scale of transformational change required to ensure the long-term sustainability and viability of high-quality health and care services. Instead, it is incumbent on health and care commissioners, regulators, and providers to deliver a 'quantum shift' in healthcare delivery if collectively we are to succeed at meeting tomorrow's needs and expectations.

The Ten-Year Plan sets out key priorities to transform healthcare over the next five to ten years.

Table 2 below shows how the planned integration of WHH and BCH helps meet the strategic objectives set out in the NHS 10-year plan.

NHS 10-year plan chapter	NHS 10-year plan objectives	How WHH-BCH integration delivers
Chapter 1 – A new service model for the 21st century	• Boost 'out of hospital care' • Further integrate primary and community services • Reduce pressure on acute emergency services • Focus on population health • Maximise opportunities of working within Integrated Care Systems	The integrated Trust will create a seamless acute–community organisation across Warrington and Halton. This will enable new neighbourhood models of care, providing more services closer to home and reducing unnecessary ED attendances (already down 4% in 2024/25) and long lengths of stay. Closer alignment between secondary care services, primary care, and wider public and voluntary sector services will mean patients experience smoother transitions between hospital and community care. This will reduce overcrowding, improving discharge flow, and enhance population health outcomes.

Chapter 2 – More NHS action on prevention and health inequalities	• Strengthened focus on prevention • Reduce health inequalities	The integrated Trust will be able to take greater responsibility for larger parts of patient pathways, improving the emphasis on preventative care and managing more long-term conditions without the need for secondary care. With a 17–23 year gap between life expectancy and healthy life expectancy across Warrington and Halton, the integration allows for targeted intervention in the areas with greatest need, improved outreach via community services, and closer partnership with local authorities, schools and voluntary groups.
Chapter 3 – Further progress on care quality and outcomes	• Address biggest causes of morbidity and mortality	Integration will allow the Trust to review and optimise its clinical pathways across a wide range of services. A move towards more anticipatory care models will support more patients with long-term conditions to manage at home, preventing crisis admissions. Integration also enables fragile services across both providers to become more resilient and sustainable.
Chapter 4 – NHS staff will get the backing they need	• Increase training opportunities for staff • Make the NHS a better place to work (recruitment and retention)	Integration will create a combined single workforce of 6,700 staff and opportunities to create improved career pathways, rotational posts across community and acute, and shared training/education. Joint staff networks and a new joint strategic people committee will embed the NHS People Promise. Staff will benefit from stronger team resilience, shared wellbeing offers, harmonised pay structures (including bank rates), and reduced reliance on agency staff. This will improve retention and make the Trust a more attractive employer both locally and regionally.
Chapter 5 – Digitally enabled	• Use digital technology to	Integration creates the opportunity to align digital strategies across hospital

care will go mainstream	make access easier • Improve planning/delivery through better use of data • Provide improved digital tools for clinicians	and community care. A joint digital infrastructure will reduce duplication, streamline electronic patient records (EPR), and extend digital access for patients. Combined data sets will enable stronger use of population health analytics to plan services, reduce health inequalities, and improve safety. Clinicians will benefit from access to shared digital tools, diagnostics, and estate infrastructure, enabling smoother care delivery across settings.
Chapter 6 – Financial sustainability and productivity	• Improve efficiency and value for money • Ensure long-term financial sustainability of NHS providers	The WHH–BCH integration unlocks significant financial improvement opportunities for the organisations. By consolidating estates, corporate functions, leadership and senior management and clinical support services in the short term, the integrated Trust can achieve greater economies of scale. A single financial strategy will help tackle the current combined underlying £48.3m deficit, supported by joint cost improvement programmes, shared procurement, and harmonised bank rates. This will strengthen the Trust's ability to invest in patient care, workforce development, and innovation.

Table 2: how the planned integration of WHH and BCH helps meet the strategic objectives set out in the NHS 10-year plan

5.10 Regional strategic direction – NHS Cheshire and Merseyside Integrated Care System (ICS)

5.10.1 NHS Cheshire and Merseyside ICS strategy

The Cheshire and Merseyside ICS is made up of nine individual 'Places' – Cheshire East, Cheshire West and Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral. Cheshire and Merseyside has a population of approximately 2.7 million people, living across a mixture of urban centres, market towns, and rural communities. The area is home to a diverse population with significant variation in levels of deprivation, health inequalities and ethnicity across its different Places.



Figure 5: Cheshire and Merseyside ICB Places and Boundaries

NHS Cheshire and Merseyside ICS have four key strategic objectives, which are:

- Tackle inequalities in outcomes, experience and access.
- Improve outcomes in population health and healthcare.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

The proposed integration of WHH and BCH will create the conditions to support delivery of these objectives over the coming years.

NHS Cheshire and Merseyside ICS has invested heavily in data and analysis tools to help improve knowledge and insight around health and social care challenges in local areas and communities.

The immediate challenge for organisations within the region is how to unlock the potential within the data by using it to drive meaningful change and improvement. The rich data available can support service redesign and shift towards a more proactive model of care. This will facilitate increasing volumes of activity being shifted away from hospital settings and into communities.

The financial challenges facing NHS Cheshire and Merseyside ICS at present are also significant. There are opportunities for improved productivity and efficiency across clinical pathways and estates and significant financial improvement opportunities available through integrating the corporate support functions between organisations. The integration programme will create the conditions to drive financial improvement as part of a medium to long-term financial sustainability plan.

The Cheshire and Merseyside ICS strategy sets out a clear ambition for providers of health and care to work more collaboratively, breaking down traditional organisational boundaries. Many of the objectives within the strategy will only be achieved at a local level through seamless service delivery, which the proposed integration will enable. Table 3 summarises how the proposed strategic direction

of the integrated organisation is aligned with the strategic objectives of NHS Cheshire and Merseyside ICS.

NHS Cheshire and Merseyside ICS strategic objective	Examples of how our integration will support delivery
Tackling health inequalities in outcomes, experiences and access	We will develop an integrated clinical model based on the principle of 'home first, then community and hospital only when needed', taking services closer to people's homes wherever possible. This will make it easier for people to access the support they need, as soon as they need it.
Improve outcomes in population health and healthcare	Our integration will enhance opportunities to work with local partners using a data-led approach to increase the focus on prevention, targeted early intervention and empowering people to take greater responsibility for their own health and wellbeing. Through increased collaboration across our Places we can work to address the wider determinants of health that drive longer-term, sustainable improvements in health outcomes.
Enhance productivity and value for money	We recognise that continuing to function as two individual providers severely restricts our abilities to deliver the care our populations require in a financially sustainable way. National benchmarking data and local insight identifies areas where we can improve our collective financial performance and protect investment in front-line clinical services by coming together as one single organisation.
Help the NHS support broader social and economic development	We know that we can work to address the wider determinants of health that drive longer-term, sustainable improvements in health outcomes through increased collaboration

	across our Places. Closer collaboration, planning, and service delivery alongside partners from across the sectors in Warrington, Halton, and further afield can help us tackle broader challenges that can often lead to health issues later in life.

Table 3: The proposed strategic direction of the integrated organisation and how it is aligned with the strategic objectives of NHS Cheshire and Merseyside ICS.

5.10.2 Cheshire and Merseyside provider blueprint

The majority of the provider Trusts within Cheshire and Merseyside have identified long term financial sustainability concerns, with many forecasting rolling deficits in future years, without significant organisational redesign or reduction of clinical services.

In addition, the ICS receives one of the highest per head of population NHS funding allocations in England, in comparison to other ICSs. Nationally, there is a move to review the funding allocation formulae and weighted capitation model, which could impact on the allocation of funding to NHS Cheshire and Merseyside ICS in future years.

Across the ICS, there is also significant use of independent sector provision, primarily for surgical services, with a need to repatriate a large proportion of this activity to local NHS providers.

There is a clear need to deliver medium- and long-term financial stability across C&M ICS and C&M provider Trusts, enabling improved delivery of care to the C&M population.

Similarly, across the C&M ICS footprint, a number of NHS provider Trusts have identified ‘fragile’ clinical services, due to workforce constraints, scale, clinical expertise, infrastructure or location. This has become more apparent in the Trusts providing clinical services outside of the Liverpool City footprint and include services such as ENT, stroke, dermatology, cardiology, neonatology and maxillofacial surgery.

Cheshire and Merseyside Provider Collaborative (CMPC) has commenced work with NHS provider Trusts to examine a number of these services. To date, there have been limited clinical service reconfigurations or moves across the C&M footprint. The move to reconfigure regional pathology services being one of the few, with WHH currently planning to TUPE affected pathology staff across to Mersey and West Lancashire Teaching Hospitals NHS Trust in 2026, subject to formal consultation.

There is a requirement to sure up fragile clinical services, networking and hosting service across providers to enhance service delivery and staff recruitment and retention and clinical expertise as well as improve patient outcomes.

In order to address the known challenges, the CEOs across Cheshire and Merseyside have supported the principles behind a new ‘C&M blueprint’ setting

out a high-level strategic direction for NHS providers over the coming years. This is based around five key areas of focus, as shown in figure 6.



Figure 6: Key areas of focus for the C&M NHS provider blueprint

The integration of WHH and BCH is explicitly reflected in the C&M blueprint and is a key early part of a potentially much wider and longer-term reconfiguration of provider services across the region.

5.11 Local place strategic direction – Warrington and Halton

Both Warrington and Halton operate as distinct 'Place' partnerships within the Cheshire and Merseyside ICS. These place-based partnerships, known locally as Warrington Together and One Halton, bring together health, care, local authority services, and voluntary sector organisations to co-design services and deliver more joined-up, sustainable and collaborative care.

The current health and wellbeing strategies for both Warrington[17] and Halton[18] identify the importance of partnership working and addressing the wider determinants of health and wellbeing to improve health outcomes for local populations.

[17] Warrington Borough Council (2024) *Living Well in Warrington Health and Wellbeing Strategy 2024-2028*. Available at https://www.warrington.gov.uk/sites/default/files/2024-02/Health%20and%20Wellbeing%20Strategy%202024-28.pdf
[18] One Halton (2022) *One Halton Health and Wellbeing Strategy 2022-2027*. Available at: https://onehalton.uk/wp-content/uploads/2022/12/One-Halton-strategy.pdf

The integration of WHH and BCH creates a unique opportunity to redesign how and where services are delivered and allow us to focus on the delivery of intervention and support into areas with the most significant challenges.

As both Warrington and Halton Places start to develop plans to deliver health and care on a neighbourhood basis, the integration of WHH and BCH brings the chance to develop a complimentary model of secondary and community care. Both organisations have been working in close collaboration with partners within both Places over recent years to co-create and embed a number of transformational health and care projects:

- The Living Well Hub in Warrington town centre.
- The Living Well digital platform for health and wellbeing services in Warrington.
- The Well Runcorn multi-agency health and education hub, which is currently under construction.
- Community Diagnostic Centres in Halton and the development of new AI-led dermatology pathways.
- Development of integrated urgent community response and hospital discharge teams along with the local authority social care teams.

More detail on some of these projects can be found later in this document.

As we continue to integrate our services our local system partners will play an even greater role in shaping delivery, ensuring community services are aligned to primary care footprints, have seamless interfaces with acute services, and are delivered smoothly, coherently and collaboratively.

Details of the key system partners we work with at a local level can be found in the supporting documents accompanying this document.

5.12 Strategic commissioning context

Commissioning is how local integrated care Boards (ICBs) and their partners ensure allocated public money is best used to improve health. Although commissioning is further away from patients' eyes than provision of care, it determines what services are delivered, by whom, for whom, where and why.

The Secretary of State has tasked ICBs to be 'pioneers of reform' through 'strategic commissioning', driving the three shifts for health services (see section 5.9.2) outlined in the 10-year plan. The intention is to help the NHS better manage rising demand for services without consuming an ever-growing share of national wealth.

In 2024/25, 88% of the combined turnover of WHH and BCH came from NHS England and local NHS commissioners. Less than 1% came from other NHS providers and 3.5% came from local authorities.

With such a significant proportion of the combined organisation's revenue flowing via the NHS commissioning route, it is imperative that our plans for integration reflect the changes happening outside our organisations. This will ensure that we are aligned and responsive to changing needs and priorities and able to sustain (and potentially grow) our revenue to support delivery of new models of care.

5.13 Summary of national, regional, and local system challenges

The challenges facing WHH, BCH, Cheshire and Merseyside ICS and the wider NHS at present are significant and complex.

Operational performance is deteriorating in terms of access to services and waiting times, demand is continually increasing from a growing and ageing population, and there is limited workforce availability and restricted revenue and capital resources. These all combine to create an environment where a more radical and transformational approach is now required. The scale of the challenge is so large that it is unlikely it can be solved by individual organisations alone.

The NHS 10-year plan sets out a vision for the development of more collaborative, locally focused approach to the delivery of health and wellbeing services, that makes use of the wealth of data available and one that has digital services at its core.

This vision creates the opportunity to develop services alongside the local population and re-invigorate and engage a workforce that are desperate to see a brighter, more sustainable future emerge.

5.14 Conclusion: The next step is integration

The strategic rationale for the integration of BCH and WHH is clear: only by integrating acute and community services into a single provider can we sustainably meet the needs of our population, deliver on national and local priorities, tackle inequalities, and secure long-term clinical and financial sustainability.

Our aim is to formally bring together the two organisations as quickly and as simply as possible. This will unlock potential short-term financial improvement opportunities to help address urgent sustainability challenges.

Integration will remove existing organisational boundaries and simplify the processes needed to enable longer-term strategic transformation.

In the medium-term, we will develop a new and exciting vision for the future of our clinical services as part of the shift towards neighbourhood health at Place. This new integrated clinical strategy will bring together connected teams, join up clinical pathways between hospital and community, and facilitate the shift of care into community and domiciliary settings.

It is a time of significant change across the NHS and wider public services, but we believe the integration of the two organisations enables that change to happen at the level of speed required.

The integration of the two organisations aligns with the strategic direction of travel on a national, regional, and local level and creates increased opportunities for the organisations to address significant performance and sustainability challenges.

6.0 Options appraisal

This section describes the rigorous process undertaken by both executive teams and Boards to evaluate potential models for integration. It outlines the long list of options considered, from maintaining the status quo through to merger and acquisition. It summarises how the long list was evaluated to produce a shortlist of options and how each shortlisted option was assessed against agreed evaluation criteria covering patient impact, workforce, financial sustainability, and deliverability.

The section explains the transparent scoring methodology and stakeholder involvement, including clinical and system partners, and presents the rationale behind the recommended option.

Key message: Following an open, evidence-based appraisal involving both Boards, NHSE, and local system partners, acquisition of BCH by WHH was identified as the most suitable option. This route offers the greatest patient benefit, best value for money, and lowest delivery risk.

It enables continuity of leadership, legal simplicity, and the realisation of integration benefits at pace, providing the clearest route to long-term sustainability for both organisations.

It evidences how this route offers the greatest patient, staff and financial benefits, with manageable delivery risk, aligning fully with national and system priorities

6.1 Long list of options for integrating BCH and WHH

In October 2024 a detailed 'long list' of the different legal options for the integration between WHH and BCH was developed. The long list was compiled with input from colleagues from NHS England's transactions team, local partners and external NHS organisations from across the country with recent experience of organisational integration. The long list was shared with both Trust's executive teams on the 15th October 2024 and subsequently approved on the 17th October 2024.

Table 4 details the long list of options in more detail.

Option number	Option title	Option description
1	Do nothing	Organisations remain as two separate legal entities and continue to operate independently.
2	Shared leadership with separate formal governance	Trusts could have a joint CEO, joint Chair or both, as well as potentially a shared executive team and/or Trust Board. However, no shared governance would be in place for formal decision making.
3	Shared leadership with joint strategic and/or limited remit formal governance	Trusts could have a joint CEO, joint Chair or both, as well as potentially a shared executive team and/or Trust Board. The Trusts could make joint decisions via a joint committee.
4	Shared leadership with joint operational governance	Trusts could have a joint CEO, joint Chair or both, as well as potentially a shared executive team and/or Trust Board. The Trusts could make joint decisions via a joint committee and implement shared governance via committees in common.
5	Merger between WHH and BCH	A legal transaction that sees the dissolution of two existing separate organisations and the creation of a new single organisation.
6	Acquisition of BCH by WHH	An acquisition involves the dissolution of the acquired Trust and the wholesale transfer of its

		assets and liabilities to the acquiring Trust. Under this option WHH would be the acquiring Trust and BCH the acquiree.
7	Acquisition of WHH by BCH	As per option 6 but with BCH as the acquiring Trust and WHH as the acquiree.

Table 4: Long list of integration options

6.1.1 Eliminated options

The long list of options was appraised by the joint executive teams to enable a short list of viable options to be recommended for more detailed appraisal and evaluation.

Following discussion and review of the long list, the following options were ruled out:

Option 1 – Do nothing

Rationale for exclusion: This option would see both organisations continue to operate as individual stand-alone providers. Given the scale of the current and future challenges facing both Trusts, doing nothing was deemed not to be a feasible option. This option is also not aligned to the strategic direction across Cheshire and Merseyside.

Furthermore, the two organisations had already commenced a degree of integrated working meaning that this option would require both Trusts to revert back to previous (separate) ways of working.

Option 2 – Shared leadership with separate formal governance

Rationale for exclusion: While this option would enable closer working between the two Trusts, it was deemed unlikely to deliver the larger-scale transformational benefits that a formal integration via other options would achieve.

Option 3 – Shared leadership with joint strategic and/or limited remit formal governance

Rationale for exclusion: As per option 2 above.

The remaining four options were then taken forward as a shortlist for formal, detailed consideration. The retained options were deemed to deliver the most benefits from integration for our patients, staff, and stakeholders in the least complex way. On 5 November 2024 the executive teams from both organisations approved the shortlist, which was subsequently shared with and supported by both the Trust Boards on 6 November 2024.

6.2 Appraising the short list of options

In order to undertake a detailed and thorough appraisal of the remaining four shortlisted options, a number of steps were followed.

6.2.1 Creation of scoring panel

To ensure fairness and balance throughout the options appraisal process, a scoring panel was recruited from across both BCH and WHH executive and non-executive Board members. The panel consisted of the joint chief executive and joint executive medical director, chief people officer (WHH), executive director of

finance (BCH) and the Chairs, senior independent directors, and chief nurses from both WHH and BCH. Both Trust Boards were given the opportunity to suggest members of the scoring panel, and these suggestions were taken into account when selecting the panel. The final panel was approved by both Chairs and the joint CEO.

6.2.2 Agreement around assessment criteria

A framework for assessing each option was then developed by agreement with both Trust Boards. Each of the four shortlisted options would be assessed against a total of nineteen individual criteria grouped into the following six domains:

- Patient impact and benefits
- Patient care sustainability
- Financial sustainability and value for money
- Workforce and culture impact
- Strategic alignment
- Deliverability

The domains and the detailed criteria were compiled with significant input from colleagues within the NHS England transactions team and representatives from external Trusts with recent integration experience.

The individual criteria were also allocated a weighting to ensure that scores for those areas that the Boards felt were more critical influenced the final outcome the most significantly.

6.2.3 Development of evidence and information pack to support evaluation and scoring process

A detailed evidence and information pack was then constructed to support the scoring process and circulated to the scoring panel on 10 December 2024. All Executives, key partners including local authorities, the ICB, voluntary sector and primary care colleagues, and NHS England contributed to the detailed evidence and information pack used to support the evaluation of options.

The guidance and template including the criteria and weighting are included within the supporting documents to the FBC.

6.2.4 Option evaluation

The options appraisal shortlist was then scored independently by each member of the scoring panel against the agreed detailed assessment criteria. The panel then met on 17 December 2024 to review individual and combined scores and make an agreed recommendation on the most suitable option. As per guidance, assessment demonstrated impact on patients, finances, workforce and other stakeholders.

The final total scores and total weighted scores for each of the four shortlisted options are provided in table 5 below.

Score	Option 4 Shared leadership	Option 5 Merger	Option 6 Acquisition of BCH by WHH	Option 7 Acquisition of WHH by BCH
Total	326	470	611	513

(unweighted)				
Total (weighted)	1244	1785	2337	1937

Table 5: Total scores and total weighted scores for appraisal of short-listed options

The key outcomes of the options appraisal process, as agreed by the panel on 17 December, were as follows:

- All ten panel members scored option 6, acquisition of BCH by WHH, the highest.
- Option 6 had a total weighted score of 2,337 vs the next highest score of 1,937 for option 7.
- The process was agreed by both Boards, supported by NHS England, and was detailed, transparent and robust.

The result of the appraisal process was that **Option 6 – Acquisition of BCH by WHH** was judged to be the recommended option.

6.3 Approved option

Option 6 was unanimously selected as the first choice by all ten panel members. The chosen option scored higher than or equal to option 7 against every one of the 19 criteria. The option was also deemed to enable delivery of broadly the same high levels of patient, staff, and financial benefits as options 5 and 7, but provided the best value for money and did not present significant delivery risks against the Department of Health and Social Care's (DHSC) risk assessment process.

The Boards of both Trusts subsequently reviewed the outputs from the options appraisal exercise in February 2025 and formally approved the recommendation of progressing an acquisition of BCH by WHH.

7.0 Programme delivery and programme management

7.1 Chapter summary

This section sets out the governance, assurance and delivery framework for managing the integration process. It outlines the programme structure, including the role of the Better Care Together (BCT) delivery group, Trust Boards, Senior Responsible Officers (SROs), programme workstreams and underpinning reporting mechanisms.

The section highlights the clear governance arrangements already in place between the two Trusts, such as joint executive leadership, and alignment with NHSE transaction oversight. Integration will progress in three phases: completing the acquisition and aligning systems by March 2026; operating as a single organisation with integrated leadership and integrated corporate infrastructure by March 2027; and fully embedding a long-term clinical model focused on 'home first, then community and hospital only when needed' from April 2027 onwards.

It explains the mechanisms for monitoring progress, managing interdependencies and mitigating risks. The section concludes by emphasising the disciplined, transparent and well-coordinated approach that underpins delivery of a safe and successful transaction.

Key message: A robust programme management framework underpins the integration, combining joint governance, system assurance, and transparent reporting. The use of a shared PMO, aligned milestones, and a structured Post-Transaction Integration Plan (PTIP) ensures the programme remains on track, accountable, and outcomes-driven, reinforcing confidence among partners and regulators.

7.2 Governing our integration programme

Bringing the two organisations together is a complex and challenging programme of work involving multiple critical actions requiring input from every team across both Trusts.

We have set up a robust programme governance structure around this to help ensure accountability, clarity around requirements, and prioritise key actions and pieces of work. Our integration programme has been titled '**Better Care Together'** (BCT).

A BCT programme delivery group has been established to oversee the programme. The group is Chaired by the joint CEO and consists of executive directors from both Trusts alongside members of the BCT programme management team. Key responsibilities of the group include:

- Overseeing delivery of integration workstreams and benefits.
- Managing programme risks and issues.
- Ensuring open communication between organisations.
- Delivery of strategic and full business cases.
- Maintaining commitment to the programme plan.
- Ensuring delivery of the programme within scope, time, cost, and quality.

- Reporting progress to Trust Boards and key stakeholders.

Key decisions relating to the integration are taken by both Trust Boards, and the Boards have been provided with progress updates since October 2024. We have also kept both councils of governors (COG) informed of progress and engaged in programme development and delivery through the usual COG meetings.

We have used a workstream approach to develop the business case and support our planning for the date of acquisition and beyond. Each workstream has a senior responsible officer (SRO) and has identified specific projects determined by its key deliverables. We have also developed a robust risk management process for managing all risks associated with the integration programme (see chapter 19).

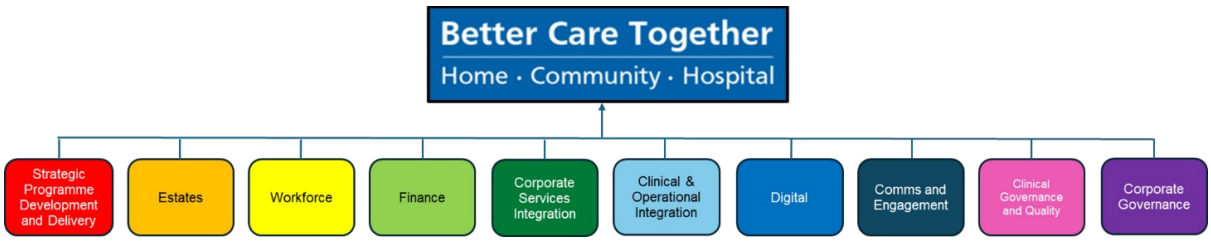


Figure 7 : The BCT integration programme and ten core workstreams within the programme

A more detailed programme structure including the key sub-workstreams within each of the ten core workstreams is included within the supporting documents to the FBC.

The table below details the SROs for each workstream alongside the designated support and operational leads.

Workstream	SRO	Operational Leads	Programme Support
Strategic programme development and delivery	Lucy Gardner	Steve Bennett	Lefteris Zabatis, Carolyne Ward
Estates	Dan Moore, Nick Gallagher	Val Doyle, John Morris	Carl Mackie
Workforce	Paula Woods, Michelle Cloney	Adam Harrison-Moran	Adam Harrison-Moran
Finance	Jane Hurst, Nick Gallagher	Jan Parker, Rachel Hurst	Jess Phillips, Paula Brereton
Corporate services integration	Jane Hurst, Nick Gallagher, Paula Woods, Michelle Cloney	Steve Bennett	Adam Harrison-Moran
Clinical and operational services	Dan Moore, Paul Fitzsimmons, Ali Kennah	Various	Hayley Heard, Rachel Moran, Mark Charman
Digital	Paul Fitzsimmons, Nick Gallagher	Tom Poulter, Dave Smith	Meg Wainwright, Bethan Savage

Communications and engagement	Kate Henry, Paula Woods	Hayley Smith, Mike Baker	Meg Wainwright
Clinical governance and quality	Ali Kennah, Jeanette Hogan	Susan Burton	Hayley Heard, Philip Mumberson, Carolyne Ward
Corporate governance	John Culshaw, Jan McCartney	John Culshaw, Jan McCartney	Kat Cornthwaite

Table 6: BCT workstream SROs and support

Figure 8 below illustrates how the overall integration programme is governed and the groups that report into/from the main programme governance structure.

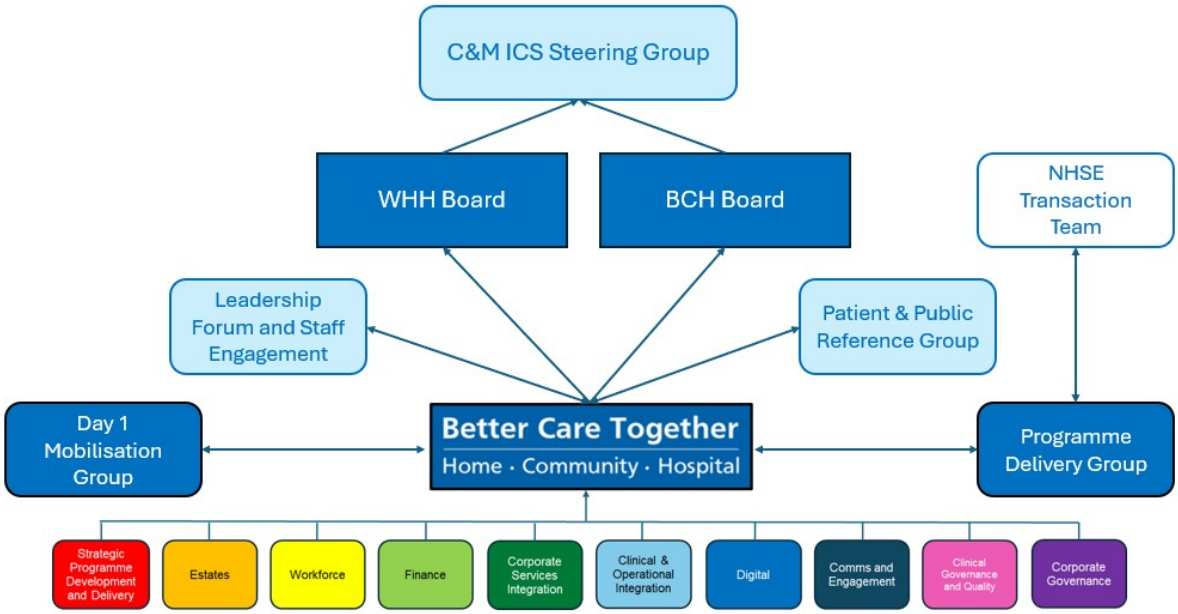


Figure 8: BCT programme governance

7.3 Ten core workstreams

The ten core workstreams, their main purpose and key milestones are detailed in table 7 below.

Workstream	Purpose/Output	High-level key milestones
Strategic programme development and delivery	To co-ordinate and progress the core aspects of the overall integration programme in line with the required timeframes. This includes the production of required business cases and supporting information, progression of the legal transaction, development and co-ordination of programme/project support, engagement with external	Develop overall programme plan, governance, and resources to deliver. Creation and approval of strategic case. Creation and formal approval of Full Business Case (with accelerated

	professional support and overall programme governance and reporting.	timeline). Oversee transaction. Record, report and, where appropriate, manage all risks arising from the programme.
Workforce	The workforce workstream has the following responsibilities: • Enable staff from both organisations to work and behave as a single workforce. • Establish the leadership and organisational structure. • Align the vision and cultural behaviours. • Support workforce transformation arising from integration workstreams. • Develop effective change management and staff transition plans.	Develop organisational change framework. Agree required TUPE/organisational change measures and manage associated processes. Develop joint culture plan. Develop joint people strategy. Integrate workforce teams from WHH and BCH. Align all key systems and processes across the two organisations.
Communications and engagement	The communications and engagement workstream has the following responsibilities: • Maintain effective and appropriate comms around the programme with all key stakeholders. • Capture and respond to feedback from all stakeholders, but especially staff from both organisations. • Lead on public engagement and any required public consultation. • Develop new organisational name and associated branding.	Oversee all internal and external communications linked to the BCT programme. Support monthly staff engagement sessions. Ensure all stakeholders are appropriately engaged. Develop and monitor communications and engagement plan for BCT programme. Integrate communications teams from WHH and BCH.
Digital	This workstream will develop and deliver a strategy for digital integration of WHH and BCH, ensuring	Develop joint digital strategy. Align all key systems

	the managed consolidation of systems and digital services to achieve quality improvements and efficiencies for both Trusts.	and critical digital infrastructure. Integrate digital teams from WHH and BCH.
Finance	Aim to make both Trusts more financially sustainable, create opportunities for efficiencies and productivity gains, and make the best use of our shared resources.	Develop joint financial strategy. Integrate finance teams from WHH and BCH. Align all key systems, processes and financial governance policies.
Clinical and operational services	The clinical and operational workstream has been established to support the overall delivery of the integration programme, with particular focus on: • Managing emerging clinical and operational risks. • Integrating teams to create clinically improved models of care and better outcomes for patients. • Improving urgent and emergency care pathways and delivery of flow. • Developing sustainable services which are delivered in settings which are accessible, and which facilitate the delivery of optimum care and ensuring financial and clinical sustainability of services.	Develop joint clinical strategy. Identify priority pathways and begin to integrate clinical and operational teams. Integrate all clinical and operational teams in line with phased plans. Develop future organisational form. Work with place partners to agree future clinical vision. Work to improve key organisational performance metrics through integration opportunities.
Corporate services	Develop and then implement plans to create single services for each corporate function serving a new integrated organisation between WHH and BCH. Ensure the corporate functions of the integrated organisation will be cost effective, efficient, and fit for the future.	Oversee integration of all corporate services and delivery of financial improvement through corporate service integration.
Corporate governance	The programme is threefold; 1. To ensure both Trusts continue to remain Well Led during the integration programme,	Agree structure of new Trust Board for integrated organisation. Develop and implement

	2. To develop a strategy for greater collaboration between the Trusts, focusing on joint / shared governance where appropriate, and, 3. To safely guide the Trusts towards the formal legal mechanism and ensure the governance is in place post transaction.	committees in common for all key sub-committees of the Board. Oversee new legal organisational form, membership of new organisation, and governance arrangements.
Clinical governance and quality	The clinical governance and quality workstream has been established to support the overall delivery of the integration programme, with particular focus on: • Risk management, inclusive of complaints, incident management, litigation and associated documentation, guidance and assurances. • identifying opportunities and efficiencies for improvement in clinical governance services pathways and functions. • Managing emerging risks of integration from a functional and operational standpoint. • Integrating teams to create improved working models of care and safer outcomes for patients • Developing aligned and sustainable services supporting patient experience such as bereavement, chaplaincy, and medical examiners. • Ensuring financial and clinical sustainability of services.	Integrate clinical governance teams from WHH and BCH. Align all key systems, processes and clinical policies across the two organisations. Implement a single risk management system and supporting processes. Oversee quality impact assessment (QIA) for the programme and quality assurance processes for the new organisation.
Estates	Integration of the estates department functions, contracts, and sites of WHH and BCH to appropriately serve the population of Warrington and Halton and further afield.	Integrate estates teams from WHH and BCH. Ensure all ‘business as usual’ compliance, maintenance and

		estates safety issues are identified and addressed alongside the integration programme. Review and make recommendations on the rationalised use of estate.

Table 7: The ten BCT workstreams and key milestones.

7.3.1 Monitoring progress and assuring delivery

Each of the ten core workstreams detailed above has an individual ‘delivery tracker’ that they use to capture all key milestones across the various phases of the integration programme. Delivery of each milestone is supported by a number of more detailed actions, which are also recorded in the trackers. The list of actions and milestones have been compiled by the SROs and workstream leads, with support and advice from NHS England and other Trusts nationally that have recent experience of integration.

Within the detailed actions, all workstreams have identified and flagged all tasks that are classed as ‘critical day one’ requirements. These include all relevant items of risk or potential risk to the organisation based upon the due diligence exercise undertaken in October 2025 (see chapter 19 for further details).

Delivery of all critical day one actions is monitored through a separate fortnightly ‘day one mobilisation’ meeting. This meeting has representation from all core workstreams and reports directly into the BCT delivery group (see figure 8).

An overview of all key programme actions and milestones is included in the supplementary information accompanying this document.

7.3.2 Monitoring workstream risks

Within the individual workstream delivery trackers, teams capture and record any risks associated with the workstream or the wider programme.

All risks relating to individual workstreams are recorded on the WHH Datix system and owned by the workstream teams, along with any required mitigating actions. They are also recorded on the BCH Ulysses system for completeness and to support dual reporting through the existing governance processes in the respective organisations.

All risks relating to the overall programme are recorded on the WHH Datix system and owned by the BCT programme team. They are also recorded on the BCH Ulysses system.

All risks are then monitored via the usual organisation risk monitoring processes, and they are also reported to the BCT delivery group on a monthly basis.

An overview of the programme risks is included in chapter 19 of this document.

7.3.3 Monitoring workstream benefits – people, patients and productivity

Within the individual workstream delivery trackers, teams also capture and record any benefits relating to patients, people or productivity (non-financial benefits) that are expected to be delivered via the programme.

Progress against delivery of these benefits is tracked via the BCT delivery group each month.

A number of the more detailed people, patients and productivity benefits anticipated from the integration are described in later sections of this document.

7.3.4 Monitoring workstream benefits – financial

All workstreams also record and monitor delivery of any anticipated financial benefits from the programme. These are detailed on the existing organisational central CIP trackers to ensure a single data source for all financial improvement across each Trust.

Delivery of the respective Trusts' financial improvement plans is reported each month via a range of meetings culminating in the joint finance and sustainability committee in common.

Progress against all anticipated financial benefits arising specifically from the BCT programme are reported to the BCT delivery group each month for information.

7.4 Senior programme leadership

The SRO for leading the integration programme is Lucy Gardner, chief strategy and partnerships officer at WHH. Lucy holds the executive portfolio for strategy at WHH, which includes the direct line management of the strategy team.

The WHH strategy team form the core of the BCT programme team, including the programme director role. The WHH strategy team are primarily responsible for the development and delivery of externally focussed strategic change and improvement. Over recent years the team have delivered a range of collaborative programmes of work across both Warrington and Halton Places, including:

- The Halton Health Hub, a multi-million pound project to convert an unused retail unit in a local shopping centre in Runcorn into a multi-use health facility.
- A £16m programme to create Community Diagnostic Centre facilities in three different locations in and around the Trust's Halton site, including the Halton Health Hub.
- The Living Well Hub in Warrington, a £3m multi-agency health and wellbeing facility bringing together connected services from over 30 different providers (including both WHH and BCH) from a range of sectors (referenced in section 10.3.1).

Lucy Gardner has prior experience of integrating organisations from her time at EY. Her consultancy experience includes leading the advice and consultancy support to the Royal Free Hospital when they acquired Barnet and Chase Farm.

There is also substantial experience in mergers and acquisitions across the wider senior leadership teams:

- The joint CEO, Nikhil Khashu, was the executive lead for the transaction of Calderstones to Mersey Care and worked on the early stages of the acquisition of Southport and Ormskirk Hospitals by St Helens and Knowsley. Nikhil also worked closely with the national transactions team as part of his previous role at NHS England.
- The joint medical director, Dr Paul Fitzsimmons, was previously deputy medical director at Liverpool University Hospitals NHS Foundation Trust (LUHFT) and was accountable for the reconfiguration of clinical services when Aintree University Hospitals acquired the Royal Liverpool to create LUHFT.
- The chief people officers from both WHH and BCH have extensive experience of leading TUPE transfers of staff into and out of organisations and creating an integrated workforce.
- The WHH chief finance officer supported the integration of Lancashire ambulance trust into North West Ambulance Service in her role as assistant director of finance at that time.
- The WHH director of communications and engagement was executive director of communications at South West Yorkshire partnership NHS Foundation Trust and oversaw communications and engagement activities around TUPE of various community services in and out of the organisation.
- A number of the non-executive directors across both Trusts have significant experience of transactions, including as NHS executives and commercial directors and lawyers.

7.5 Public Sector Equality Duty: Development and ongoing implementation

The integration programme is underpinned by a strong commitment to the Public Sector Equality Duty (PSED), ensuring that equality, diversity and inclusion are at the heart of organisational change. In 2024, both Trust Boards formally agreed the Equality and Health Inequalities Impact Assessment (EHIA) process and governance arrangements, which have since been used to develop a combined EHIA for the integration. This comprehensive assessment is available as a supplementary document to the business case and provides assurance that potential impacts on protected groups and health inequalities have been thoroughly considered. This work continues and the EHIA will be a live document which continues to be reviewed post transaction as part of our implementation plans.

A standard operating procedure (SOP) has been established to ensure consistency and rigour in the EHIA process, and a bespoke combined EHIA training programme has been developed for staff. This training aligns with statutory requirements for public consultation and engagement, equipping colleagues to identify, assess and mitigate equality impacts throughout the programme. In addition, assurance reviews are being developed in partnership with equality, diversity and inclusion leads from both Trusts, providing ongoing oversight and challenge. This structured approach ensures that the PSED is not only met at the outset but will continue to be actively monitored and embedded as the new organisation moves forward.

7.6 A three-phase approach to integration

The scale and pace of change happening across the NHS, and public services nationally, is significant and unprecedented. As a result, it presents a challenge for our integration programme to be able to precisely define our long-term future operating model at this point in time. The main reason for this is because we know that the future success of our combined organisation will be based upon our ability to work collaboratively with our partners across the system. Therefore, our future operating model needs to be developed as part of much broader operating model across our local Places and region.

Whilst development and agreement around future operating models and the various Place vs regional aspects may require time, there are certainly elements that we can progress in the short-term to deliver improvement and create the foundations for future success. This is why we are following a three-phased approach to the integration programme as described in more detail in the following sections. This phased approach will allow us to fully engage with the right partners at the right time to create the correct, sustainable, longer-term solutions, whilst simultaneously allowing us to progress critical improvement work that makes the most of the immediate opportunities created via the integration.

Figure 9 below, illustrates the three planned phases of our programme, summarising the key work that will happen during each phase to bring together the respective elements of the two integrating partner organisations.

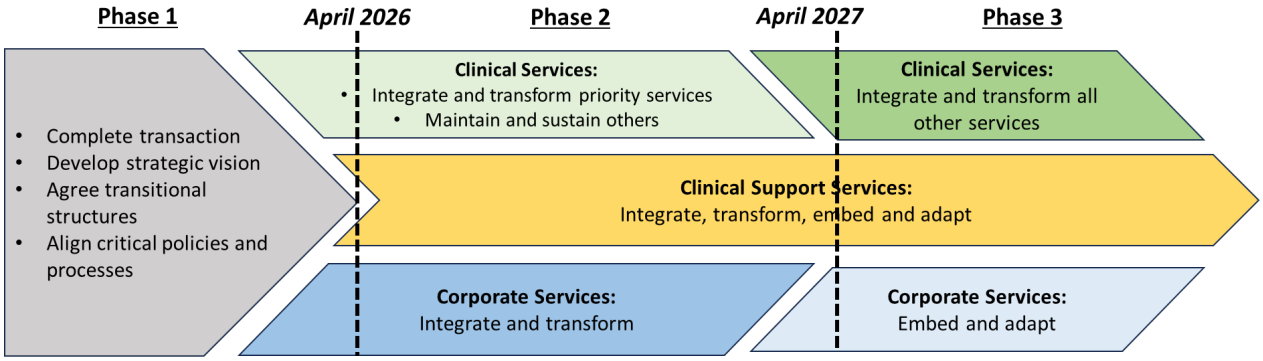


Figure 9: Three-phased approach to integration of services

7.7 Phase one: Period to 31st March 2026

In the short-term, our aim is to bring BCH and WHH together through a formal acquisition as quickly as possible. We are aiming to complete the transaction in time to commence the new integrated organisation from 1st April 2026.

Completing the transaction quickly is more cost-effective, minimises disruption for patients and staff, creates the opportunities for improvement sooner and also makes them much easier to realise.

In the period leading up to the end of March 2026, we will focus on developing and agreeing initial integrated 'transitional' staffing structures for a number of services. These structures will create single teams and services across key parts of the organisation. The structures will come into effect from the first day of our newly integrated organisation on 1st April 2026.

In addition, we will work to align all critical policies, processes and operating systems between the two partners to ensure safe and seamless running of services from day one.

We will also continue to develop the strategic vision (along with supporting documents) and operating models for future services in collaboration with multiple local and regional partners, ensuring this is aligned to wider national strategic direction and the needs of our local communities.

7.7.1 Accelerating the transaction

Accelerating the process to complete the transaction and integrate the two organisations makes financial sense. It will reduce the costs associated with the transaction itself and also bring forward the date from which a number of key benefits can be delivered. The benefits of the integration are detailed in later sections of this document but include financial benefits as well as benefits to patients and staff.

In terms of financial benefits, we estimate that accelerating our transaction will reduce the overall transaction costs by around £0.55m (see section 7.12). We also believe it will bring forward up to £4m in corporate savings by a year.

In terms of wider patient and staff benefits, formally bringing together the organisations sooner will help to simplify the process of service improvement, pathway redesign and makes it easier to divert resources between acute and community services to be more responsive to need.

We acknowledge that accelerating the transaction will also create new risks in terms of the time available to complete key tasks to support the integration. However, we believe that our phased approach to delivery will help us to mitigate that risk and allow us to divert the resources we have available to support the programme to the right projects at the right time.

7.8 Phase two: Period from 1st April 2026 to 31st March 2027

Figure 10 below illustrates the planned form of the integrated organisation, effective from 1st April 2026.

From this date, the organisation's senior leadership and senior operational management will operate as single integrated teams.

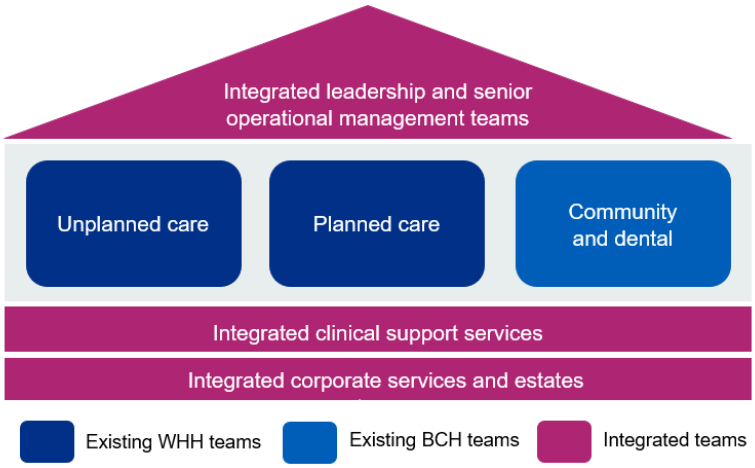


Figure 10: Proposed organisational form for integrated organisation, effective from 1st April 2026

The vast majority of clinical services from BCH will simply ‘slot in’ to the new integrated organisation, in the form of a new ‘community and dental services’ care group. This will operate alongside the existing WHH unplanned care and planned care groups.

The only exceptions will be where specific clinical services and pathways have been identified as priorities for integration and therefore the aim would be to deliver required service redesign/transformation work in these areas during this phase of the programme. These clinical priorities are discussed in more detail in section 10.5.2 of this document.

The three main clinical care groups within the organisation will be supported by integrated corporate service and clinical support teams. More details on the plans to bring these teams together from 1 April 2026 is also included in later sections of this document (corporate teams in section 11.9 and clinical support teams in section 10.7).

Further detail on integration governance, risk management and delivery of the programme beyond the date of the formal transaction is set out in the post-transaction integration plan (PTIP). The PTIP is discussed further in section 7.10 below.

7.9 Phase three: Period from 1st April 2027 onwards

The third phase of our planned integration programme will see the remaining (non-priority) clinical services brought together and the delivery of our long-term vision for a new clinical model.

The rest of the organisational infrastructure, key systems and processes should be in place and embedded at this stage and therefore allows for the redirection of service change/transformation/organisational development resources to support the necessary clinical change work.

The future clinical model will be firmly based on the principle of ‘home first, then community and hospital only when needed’ and will be grounded in the national strategic direction around developing neighbourhood health and data-led intervention. More detail on the vision for the future clinical model is included in chapter 10 of this document.

7.10 Post-transaction integration plan (PTIP)

The post-transaction integration plan (PTIP) is developed alongside this FBC, and operates as a standalone, complementary document, setting out distinct milestones, objectives, and governance arrangements that will guide the integration.

The PTIP outlines the approach and actions required to deliver the full integration of the two organisations following the formal transaction date of 1 April 2026. Therefore, it essentially sets out the plans for bringing together the services and teams across phase two and three of the BCT programme, ensuring all risks are managed and all benefits are realised along the way.

7.11 Accelerating the transaction

Figure 11 below illustrates the key steps and timeframes associated with the accelerated timeline for phase one of the integration programme.

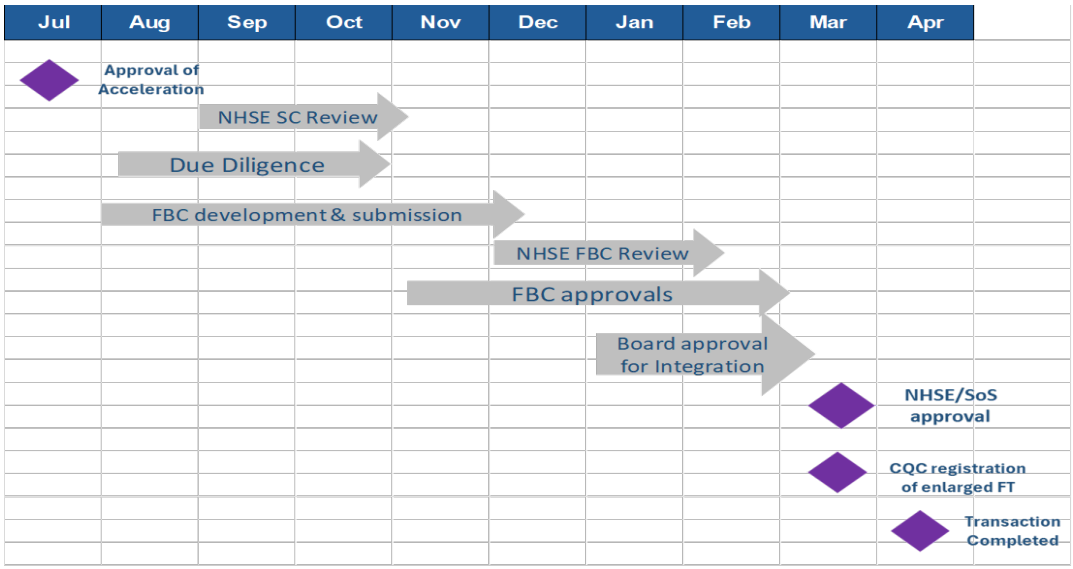


Figure 11: Timelines for key milestones as part of accelerated transaction (phase one) of programme plan

The key milestones achieved to date in relation to progressing the formal transaction for the integration is included in the supporting documents.

7.12 Resourcing the programme

Our ask of the ICS in terms of funding support to progress and complete the transaction was originally £1.65m spread across 2 years.

The current financial challenges across both WHH and BCH, but also across the wider ICS, present an urgent need for us to progress the accelerated timeline for the transaction. This should help to realise improvement opportunities sooner, reduce uncertainty and disruption for staff, and reduce the costs of the transaction itself.

The revised ask of the ICS to support the accelerated transaction has subsequently been reduced by £550,000. The partner organisations have agreed to realign internal resources wherever possible to deliver as much of the work required to support the integration as possible 'in house' and therefore reduce the costs. The overall revised ask is therefore just over £1.1m broken down as follows:

Funding support requested based on original transaction timeline	Programme requirement	Funding support requested based on accelerated transaction timeline
£32,000	Programme leadership and programme management support	£32,000
£120,000	Finance costs to support to the programme	£120,000
£90,000	Communications and engagement costs to support to the programme	£90,000

£112,000	Dedicated clinical leadership to the programme	£112,000
£1,100,000	External consultancy support to the programme	£550,000
£200,000	Legal advice and support	£200,000
£1,654,000	Total funding support requested	£1,104,000

Table 8: Anticipated initial, and revised programme costs

7.13 Programme costs and additional funding to date

Table 9 below details the known/estimated programme costs to date (as at the end of November 2025). Note that costs associated with operating a mutually agreed resignation scheme (MARS) are factored into profiled annual savings included in the finance section of this document (see section 13.3) and are therefore not included as additional costs below.

Table 51 in section 13.5 of this document details the anticipated annual additional programme costs profiled by year.

Programme requirement	Costs identified to date
Programme leadership and programme management support	£0
Finance costs to support to the programme	£140,000
Communications and engagement costs to support to the programme (including signage)	£110,600
Dedicated clinical leadership to the programme	£0
External consultancy support to the programme	£415,000
Legal advice and support	£140,000
IT and system realignment costs	£97,500
Contingency	*£200,900*
Total funding support requested	£1,104,000

Table 9: BCT programme costs as at the end of November 2025

NHS Cheshire and Merseyside formally supported our strategic case, timeline and acceleration of the transaction in July, which included the £1.1m estimate of additional costs. A request for funding had also been submitted to the ICB prior to July's Board meeting. At the time the ICB agreed to make a 'modest sum' of funding available to support the integration programme and have so far confirmed £200k of this. WHH have subsequently formally written to the ICB to confirm that unless the remaining £900k funding is allocated, the Trust will potentially go off plan by up to £900k due to the additional costs of the integration programme in 2025/26. This is included as a key programme risk on the risk log (see table 58, section 19.2).

The funding requested of £1.1m is significantly less than that provided to other integrations completed locally in recent years. Our integration is forecast to deliver £2.4m of cashable financial benefits in 2025/26 (part of WHH/BCH internal CIP challenge), and cost up to £0.9m in 2025/26 (£1.1m in total), both costs and savings are reflected in our financial forecast.

7.13.1 Use of internal resourcing as programme support

In order to keep additional programme costs to a minimum, given the current financial challenges, both WHH and BCH have identified and diverted internal

resources to support the core workstreams with managing the programme of work.

Table 10 below shows the total whole time equivalent (WTE) staffing released from a number of internal teams across the two organisations to date, and up to the end of 26/27. Resource requirements beyond 26/27 will be reviewed and agreed prior to the end of 26/27.

Resource diverted from	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27
BCH - Digital team				0.20	0.20	0.20	0.20	0.20
BCH - Transformation team	0.20	0.20	0.20	0.20	0.20	0.05	0.05	0.20
WHH - Finance team		0.20	0.40	0.40	0.40	0.40	0.40	0.40
WHH - QI team	1.00	1.30	1.50	0.50	1.50	1.50	1.00	1.00
WHH - Strategy team	3.40	3.60	4.05	5.95	6.80	6.80	6.30	6.30
WHH - Transformation team				0.20	0.20	0.20	0.20	0.20
WHH - Workforce team	0.80	0.80	0.80	0.85	0.60	0.60	0.60	0.60
Grand Total	**5.40**	**6.10**	**6.95**	**8.30**	**9.90**	**9.75**	**8.75**	**8.90**

Table 10: Internal resource diverted from BCH and WHH to support the ten core workstreams

Figure 12 below illustrates how the internal resources quantified in table 10 are aligned to individual workstreams across each of the three phases of the BCT programme. We are planning to continue to resource the programme as required into 2027/28 and will review the resource requirements and ensure they are met prior to the end of 2026/27.

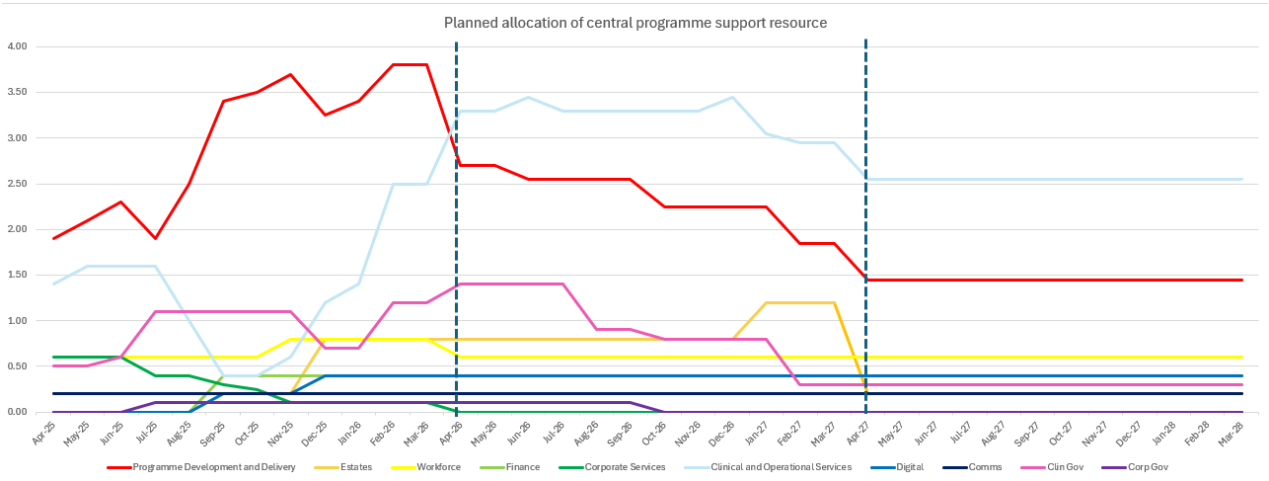


Figure 12: Alignment of central programme resource to support individual workstreams

7.13.2 Use of internal resourcing to support workstream delivery

In addition to the central programme support identified above, both BCH and WHH have diverted internal resources from teams within each of the core workstreams to support the delivery of all programme actions and milestones, including those classed as critical day one actions.

Table 11 below shows the total whole time equivalent (WTE) staffing released from a number of internal teams across the two organisations to date, and up to the end of September 2026 (mid-way through phase two of the programme). Resource requirements beyond September 2026 will be reviewed and agreed depending upon the outstanding actions within each workstream at that point.

Resource diverted from	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27
BCH - Clin Gov team		1.10	4.65	4.65	4.65	4.65
BCH - Comms team	0.60	1.00	1.40	2.10	2.10	2.10
BCH - Corp Gov team	0.10	0.20	0.45	0.45	0.10	0.10
BCH - Digital team	0.10	0.20	0.51	0.51	0.51	0.51
BCH - Estates team	0.20	0.20	0.60	0.90	0.90	0.90
BCH - Finance team			0.10	0.10	0.10	0.10
BCH - Health visitors	0.30	0.30	0.30	0.30	0.30	0.30
BCH - IPC team			0.20	0.20	0.20	0.20
BCH - Management team			0.10	0.10	0.10	0.10
BCH - Med Mgmt team			0.10	0.10	0.10	0.10
WHH - Clin Gov team		0.50	1.40	3.02	3.02	3.02
WHH - Comms team	0.40	0.80	1.20	2.00	2.00	2.00
WHH - Corp Gov team	0.10	0.20	0.45	0.45	0.10	0.10
WHH - Digital team	0.20	0.20	0.91	0.91	0.91	0.91
WHH - Estates team	0.20	0.20	1.40	1.80	1.80	1.80
WHH - Finance team	0.05	0.10	0.50	0.50	0.50	0.50
WHH - IPC team			0.10	0.10	0.10	0.10
WHH - Management team			0.05	0.05	0.05	0.05
WHH - Pathology team			0.10	0.10	0.10	0.10
WHH - Pharmacy team			0.10	0.10	0.10	0.10
WHH - QI team			0.20	0.20	0.20	0.20
WHH - Radiology team			0.20	0.20	0.20	0.20
WHH - Workforce team			1.40	7.00	7.00	7.00
Grand Total	**2.25**	**5.00**	**16.41**	**25.83**	**25.13**	**25.13**

Table 11: Internal resource diverted from BCH and WHH to support delivery of actions within the ten core workstreams

8.0 Vision and strategies for the integrated Trust

8.1 Chapter summary

The integration of WHH and BCH seeks to establish a sustainable, high-performing organisation that delivers seamless acute and community care, meeting the evolving health needs of local people. This section articulates this shared vision, the mission and strategic priorities for the new integrated organisation.

It sets out how WHH and BCH will build on existing partnership work to deliver seamless care across the acute–community pathway, supporting the 'Start Well, Live Well, Age Well' principles of the Cheshire and Merseyside ICS, focusing on health equity, digital transformation, and population wellbeing.

Key message: The section details the Trusts new vision, to deliver seamless, sustainable, person-centred care across hospital and community settings It explains how the integrated Trust will drive clinical excellence, workforce wellbeing, digital innovation, and environmental sustainability, shaping a single, forward-thinking organisation built for the future.

It highlights how strategic alignment with the NHS 10-year plan will enable transformation at scale, improving access, prevention and continuity of care, and outlines the overarching outcomes framework through which success will be measured.

8.2 Our vision for the future

As described in chapter 5 of the case, the challenges we are aiming to address via integration are as follows:

- Meet the current and future health and wellbeing needs of our local population.
- Manage future demand for statutory services within available resources.
- Deliver on national priorities and performance standards.
- Tackle known health inequalities.
- Secure long-term clinical and financial sustainability.

In order to rise to these challenges, transformational change of our respective organisations is required.

Our vision for the organisation is to evolve into a thriving and responsive integrated acute and community provider delivering high-quality, effective services that meet the needs of residents. We will build sustainability and cost-efficiency into our pursuit of this vision.

Our clinical ambition, aligned closely to the principle requirements of the NHS 10-year plan, is to achieve a fundamental shift in the delivery of care from an illness focussed, hospital-based model to a more sustainable, community-based, collaborative model focusing on health promotion and prevention. As we develop the detail of what the future clinical model will look like alongside our local partners, there are a number of guiding principles we will follow that have been agreed by the senior clinical and operational leadership of both Trusts. These are:

- **Home first, then community and hospital only when needed – this is our core principle.**
- Any changes to clinical service delivery should aim to improve access and reduce health inequalities.
- Service changes should aim to deliver the most cost-effective care possible.
- Clinical service delivery should align to ‘getting it right first time’ opportunities (GIRFT) and seek to achieve compliance with national, college and national institute for clinical excellence (NICE) guidance where applicable.
- Services should be delivered as close to home as feasibly possible and centralised when necessary.
- Services that are complex, specialised or small volume should be consolidated to enable future sustainability.
- Co-production should be considered wherever feasibly possible.

8.3 Long-term planning and key organisational strategies

A number of documents are currently in development that together will set out how we aim to achieve our vision for the integrated organisation. Figure 13 below shows how the various documents align and connect with one another.

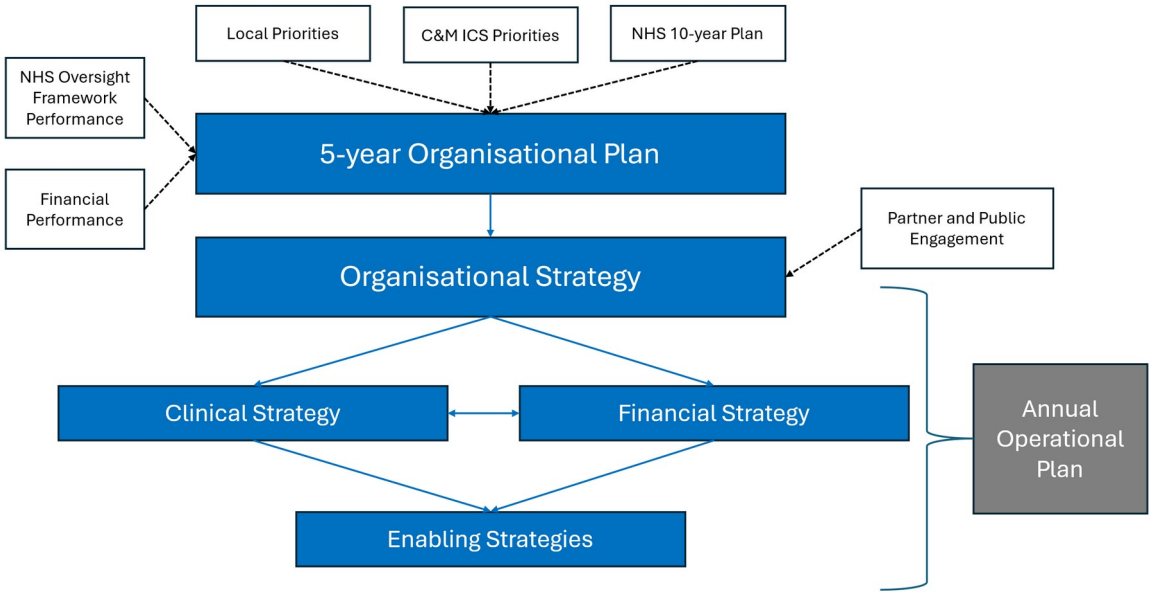


Figure 13: Alignment of Trust strategies

8.4 Five-year organisational plan

The first draft of the five-year plan for the integrated organisation is due to be submitted to NHS England in December 2025. This plan will detail the organisation's baseline position with regards its current performance and its capacity and capability to deliver on the challenges it faces. It will then describe the detailed plan for improvement over a five-year timeframe.

The integration of WHH and BCH will feature heavily in the plan as a critical enabler to improvement in terms of finance, performance, addressing health inequalities and managing future demand.

The five-year plan will incorporate the plan for financial and performance improvement.

8.5 Organisational strategy

8.5.1 Our strategy for an integrated organisation – 2026-2029

A joint strategy for the integrated organisation is currently in development with adoption expected at the end of 2026. It will describe in more detail our strategic vision to provide more joined-up care for people living in Warrington and Halton, with greater focus on providing more of their care at home and in the community as set out in chapter 10. It will also align with national guidance to develop local neighbourhood health models which aim to strengthen collaboration between health and social care and wider public services.

The strategy will link closely with the organisation's five-year plan to help define a number of key strategic objectives and it will be underpinned by enabling strategies. These enabling strategies will provide greater depth around specific strategic objectives and start to demonstrate not just where we are going, but how we intend to get there.

A comprehensive engagement programme to ensure wide input into the new strategy for the integrated organisation has been developed. Implementation commenced in August 2025 with initial engagement on the values that our new integrated Trust needs to demonstrate and uphold (section 8.6). The engagement programme will be ongoing throughout 2025 and 2026 until the new strategy for the integrated organisation is approved as illustrated in figure 14.

We are following a five-stage process to develop our new strategy:

1. Aug-Nov 25 - Assess the relevance of existing strategies and engage on new values.
2. Dec 25 - Define the scale and nature of change needed.
3. Jan – Apr 26 - Develop the building blocks for our organizational identity, vision and mission.
4. May-Aug 26 - Determine the final strategy and engagement.
5. Sept - Dec 26 - Approval and launch new strategy and agree ongoing governance and monitoring.

Ongoing regular communication and engagement via digital channels, bulletins, and forums will bring together people's experience, expertise and ideas to help shape our future plans.

We will engage internally through staff forums, equality, diversity and inclusion champions, staff network meetings, staff-side meetings, and with our Freedom to Speak Up (FTSU) guardians.

We will also seek external views from the Place committees, voluntary sector partners, Healthwatch, local authority groups, council of governors and members and local councillors and MPs.

We will hold dedicated meetings with the GP leads from our Places – Warrington and Halton – and hold patient and public reference groups to help capture the views of our local population around what we are planning to do and what is particularly important to them.

The feedback received during this extensive programme of engagement will be vital in the development of our strategy and in shaping our plan for integration of clinical and operational services.

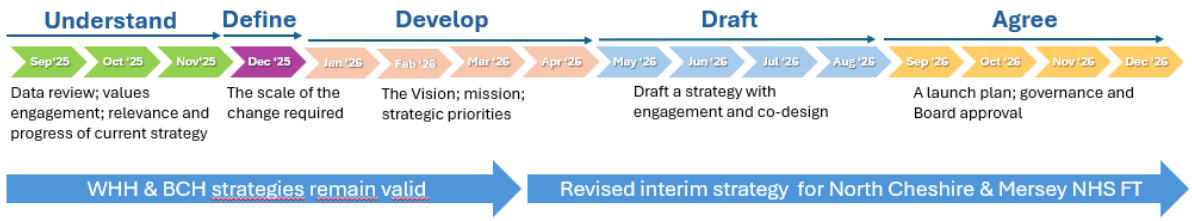


Figure 14: Timeline for development, approval and publication of new organisational strategy

8.5.2 Interim organisational strategy to 2026

Whilst the new strategy is in development, an interim strategy will be adopted by the new organisation from the date of the acquisition for the remainder of 2026. The interim strategy is based on the existing WHH strategy, which has been

formally extended and approved by both the WHH and BCH Trust Boards with some amendments to reflect the priorities of BCH and opportunities realised through the integration.

Amendments to the WHH strategy include a change to the mission statement, which now states the ambition to be exceptional, our vision statement which previously referred to a great 'place' to receive healthcare and now refers to a great 'organisation providing healthcare'. Similarly, all three aims have had amendments to wording to incorporate phrases currently familiar within the BCH strategy as illustrated in figure 15.



Figure 15: Amended WHH organisational strategy

8.5.3 Interim strategic objectives

As part of the interim strategy for the integrated organisation, the current WHH strategic objectives will be adopted in the short-term with one minor amendment to include belonging in *our organisation* rather than belonging in WHH. Figure 16 below details the existing strategic objectives that are framed around the three strategic domains: quality, people and sustainability. These strategic objectives align to both WHH and BCH's existing strategies.



Figure 16: Amended interim strategic objectives

8.6 Trust values

Feedback received in staff engagement events suggested that the values of the integrated Trust would be an important area for prioritisation and were something that staff were keen to input into. Refreshed organisational values will serve to guide the development of the wider strategy, and support work on culture and business planning such as a new behavioural framework and branding.

A three-week engagement exercise was undertaken across August and September 2025 via a short survey to staff which was shared widely within both Trusts and with external partners. A total of 183 people completed the survey – 44% BCH, 55% WHH, 1% external.

8.6.1 Quantitative data

- 'Kindness' and related values (such as 'kind', 'caring' and 'compassion') are the most frequently mentioned and resonate strongly with staff across both Trusts, indicating a shared priority for a caring and supportive culture.

- Many respondents express a desire for simplicity and clarity in organisational values, with comments suggesting that values should be memorable, collective and not overly numerous or complex.
- There is a notable emphasis on inclusivity, teamwork, and openness, with staff highlighting the importance of working together, celebrating differences, and maintaining honesty and transparency as the organisation moves forward.

8.6.2 Qualitative data

Qualitative information was gathered through discussions at various internal and external forums including Place partnership Boards and the joint Trust leadership forum.

- Values should be concise, meaningful and reduced to around three to four in total.
- There is an important link between the values and associated behavioural framework.
- Behaviours should additionally be engaged on, with communications clearly outlining the differences and similarities between old and new, to ensure they are embedded.

Survey results and qualitative information were triangulated to develop the set of refreshed values, which will come into effect from 1 April 2026, described below.

Kind	Open	Fair	One Team

Table 12: Refreshed Trust values for the integrated organisation

8.7 Supporting strategies and enabling strategies

Alongside the development of a new organisational strategy, there will be a need to develop a number of key supporting strategies and enabling strategies. These complimentary documents will provide further clarity and focus on specific areas of the integrated organisation's operations.

The clinical strategy will describe the future clinical model at service level and how it will enable the Trust to realise the majority of the patient benefits of the integration. The content and principles within the clinical strategy are discussed further in chapter 10.

The financial strategy will form part of the five-year organisational plan and demonstrate the plan to move the integrated organisation to a position of financial sustainability in the medium-term. The content and principles within the financial strategy are discussed further in chapter 13.

Other enabling strategies that will be produced include the estates strategy, the people strategy and the digital strategy. The content and key principles within these other enabling strategies are discussed in chapters 16 to 18.

Strategy	High-level description	Timeframe
Five-year organisational	Internal and regional use. Aligned to NHS 10-year plan, to set out the long-term objectives	December 2025

plan	for the organisation including financial sustainability plans. Feeds into detailed operational plans on annual basis, including impact measures.	
Financial strategy	Internal and regional use. Plan to break even from current deficit position and maintain financial sustainability.	December 2025
Organisational strategy	Public facing. Vision, values and objectives and priorities to deliver strategic goals.	December 2026
Clinical strategy	Public and internal facing. Sets out vision for neighbourhood health. Includes responsibilities to address health inequalities and wider determinants of health. Supported by service level clinical priorities and plans.	December 2026
Estates strategy	Internal use. To describe estate requirements to deliver clinical strategy in fit for purpose facilities. Supported by detail to inform investment cases and deliver cost improvement.	October 2026
Enabling strategies incl. People strategy Digital strategy	Internal use. Approaches to provide support, resources and conditions to enable delivery of the overarching strategy and five-year organisational plan priorities.	December 2026

Table 13: Key organisational strategies and timeline for production

8.8 Strategy development timetable

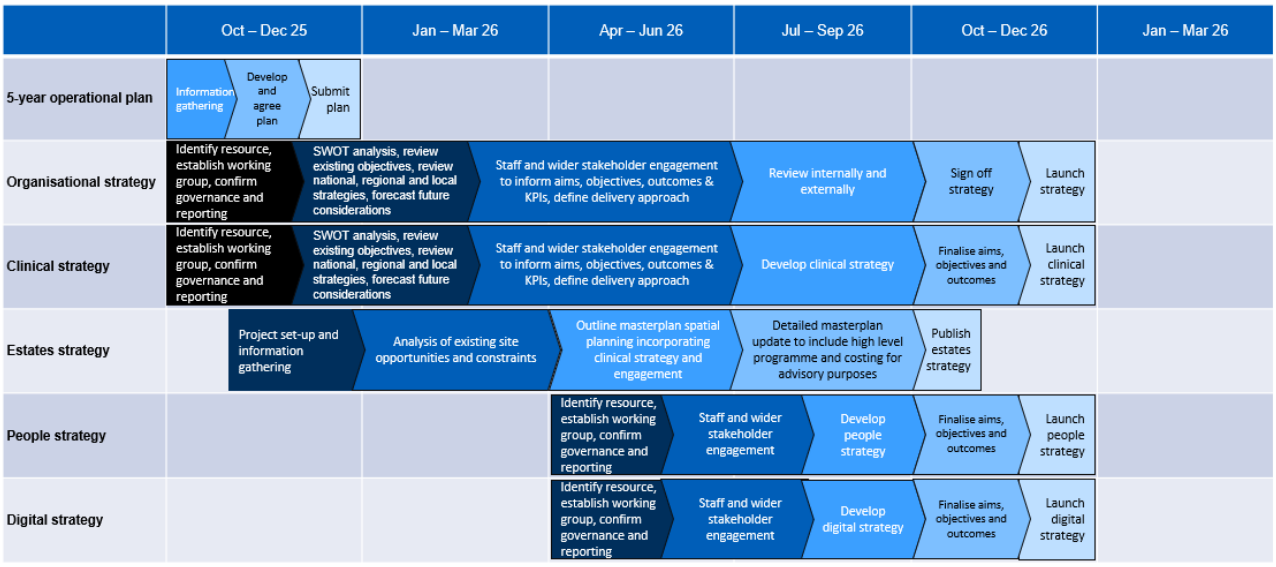


Figure 17: Timeline for development of various strategies for integrated organisation.

8.9 Annual operating plans

Once the medium to long-term strategic direction of the new integrated organisation is set, the Trust will need to translate this into clear, manageable

objectives that can be monitored to ensure delivery. This will be achieved via annual operating plans that are agreed for each care group prior to the commencement of each new business year.

Through this process, all care groups are required to commit to a range of operational targets and goals aligned to the longer-term strategic objectives of the wider organisation.

Progress against the targets and goals set in the annual operating plans is monitored throughout the year by the Trust senior leadership team to provide appropriate challenge and assurance, but also to identify risks to delivery and support required.

9.0 Organisation Design

9.1 Chapter summary

This section outlines the proposed structure and governance of the new integrated organisation. It describes how leadership, clinical and corporate functions, the legal mechanism for the acquisition, Board committee structures, the quality and financial governance structures, and the operating model will be configured to support delivery of the Trust's strategic vision and operational priorities.

The section emphasises principles of simplicity, accountability, and inclusivity, ensuring the new organisation's design supports integrated working and informed and timely decision-making.

It references early work undertaken through joint committees and collaborative working to ensure readiness for day one.

The section concludes by setting out the next steps for consultation, engagement and implementation of the future operating model.

Key message: The proposed design ensures a balanced, transparent, and responsive structure, maintaining continuity while enabling innovation.

It integrates acute and community leadership, reflects the values of both organisations, and ensures accountability from Board to frontline services. This design positions the new organisation to deliver both local responsiveness and system-level impact.

9.2 Legal mechanism

The integration process between BCH and WHH has been driven by the need to improve services and achieve clinical and financial sustainability. As described in chapter 6, the chosen legal mechanism for achieving this will be through the acquisition of BCH by WHH.

Governance arrangements put in place to date include joint executive team meetings, joint Board development meetings, and the creation of an ICS steering group made up of senior representatives from both Trusts, NHS Cheshire and Merseyside ICS and local system partner organisations.

As part of our BCT programme, BCH and WHH undertook a Board-to-Board session on 4 September 2024 to consider how BCH and WHH could effectively

work together as a single organisation. This resulted in the options appraisal being undertaken as described in chapter 6.

Since November 2024, the Trusts have been working together to introduce a joint executive team with a number of shared posts including chief executive, executive medical director, chief nurse, chief operating officer, and director of delivery to date.

At respective public Trust Board meetings, on 5 and 6 February 2025, the recommendation of the options appraisal for BCH to be acquired by WHH was approved.

On 4 and 5 June 2025 respectively, it was agreed by both Boards to propose acceleration of the acquisition to 1 April 2026 to the C&M ICS Board. This happened on 24 July 2025, and the proposal was subsequently supported. Both Boards also approved the strategic case for our integration and acquisition at the same meetings on 4 and 5 June. The strategic case was also supported by the C&M ICS Board on 24 July 2025. The strategic case was then submitted to NHS England for review and feedback to be incorporated into this FBC.

9.3 Overall Board committee structure for WHH and BCH

Figure 18 below shows the current combined Board and sub-committee governance structure for WHH and BCH. Figure 19 and figure 20 show the current Board sub-committee structures for both BCH and WHH respectively. Finally, figure 21 shows the proposed Board sub-committee structure for the new integrated organisation.

The introduction of committees in common ensures that both Boards and the joint committee of the Boards have oversight of all domains of the two Trusts and are able to balance information and appropriate challenge across shared agendas. This is complemented by integrated performance quality review reports for each Trust with a single version across the two Trusts scheduled to be produced ahead of day one. As outlined in figure 18 below, we have already established committees in common for both people and finance and performance. We also have approved terms of reference for a joint committee of the Boards, should we need to stand it up ahead of the acquisition date.

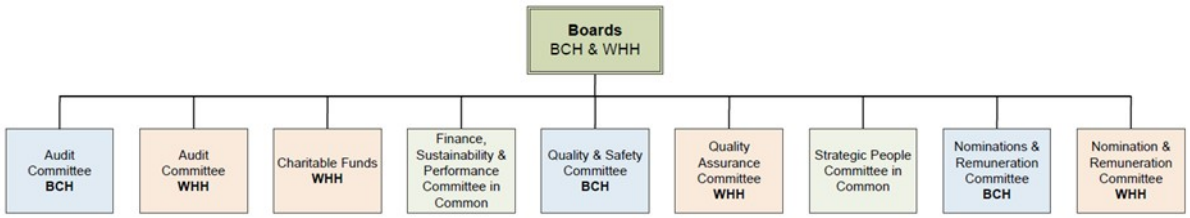


Figure 18: Current combined Board sub-committee governance structure

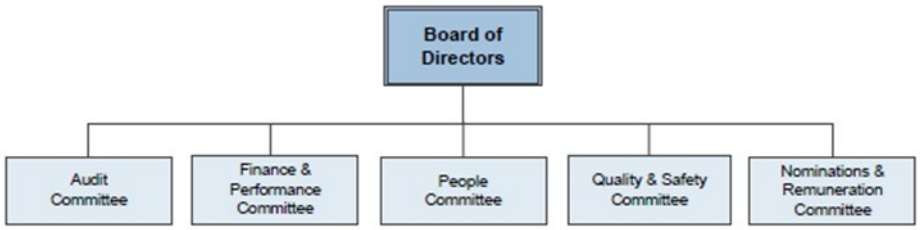


Figure 19: Previous BCH Board sub-committee structure

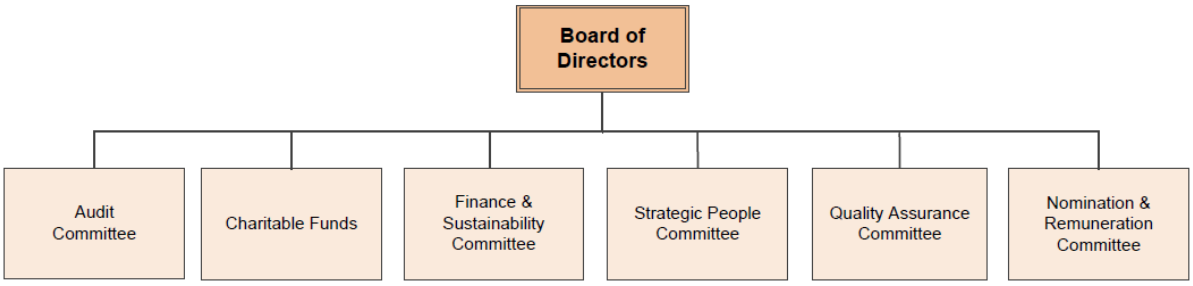


Figure 20: Previous WHH Board sub-committee structure

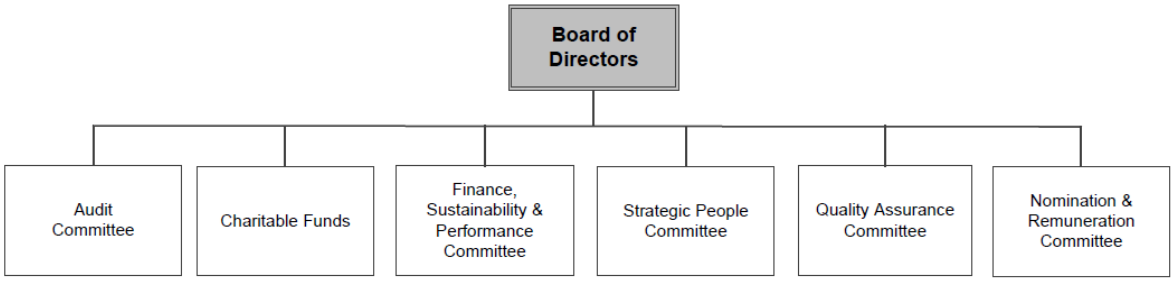


Figure 21: New Board sub-committee structure for integrated organisation

9.4 Board of integrated Trust – Day one proposed position

With the introduction of joint executive roles across both Trusts since November 2024 and establishment of committees in common, a significant amount of joint governance has been put in place ahead of the formal transaction.

Assurance on the progress of the acquisition has been reported through the BCT programme delivery group, which reports into both Trust Boards directly. The delivery group will continue following the acquisition to provide assurance on the progress of delivery of the subsequent phases of the programme and further development and delivery of the PTIP.

Post-acquisition, the Board committee structure will be further reviewed as part of the review of the constitution and self-evaluation against the well-led framework, to ensure the optimal balance of strategic development and assurance, and appropriate number of Board committees. This may lead to refinement of the committee structure for the integrated Trust.

The terms of reference for the strategic people committee in common were approved separately by both Boards in April 2025. Similarly, the terms of reference for the finance, sustainability and productivity committee in common were approved in August 2025.

The remaining Board committees are currently reviewing their terms of reference, which will be submitted to both Trust Boards for approval during the 2025/26 financial year.

From day one of the integrated organisation the following committees will also be in place:

- A single audit committee
- A single nomination and remuneration committee, comprised of all non-executive directors of the new Trust
- A single quality assurance committee

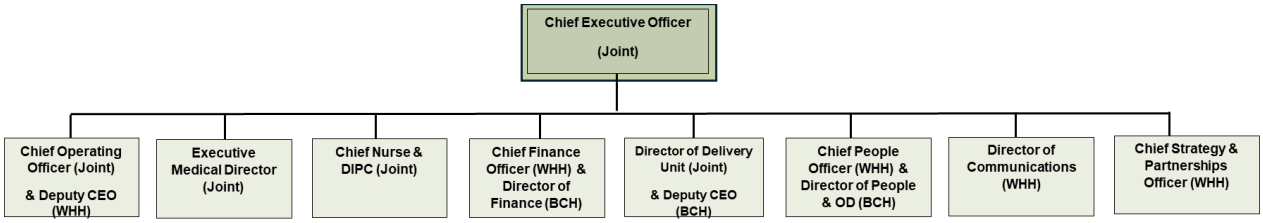


Figure 22: Current executive structure of both BCH and WHH

The integrated organisation will have a Board structure comprised of a single executive team and non-executive directors.

The Trust will be led by an effective and diverse Board which is innovative and flexible and will support the delivery of the new organisation's strategy. The role of the Board of directors will be to:

- Provide effective and active leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed.
- Ensure compliance with the provider licence, the constitution, mandatory guidance issued by NHSE, and all relevant statutory requirements and contractual obligations.
- Set our strategic framework, taking into account the views of the council of governors, reviewing progress, and managing performance.
- Assure the quality and safety of care, the reduction of health inequalities, education, training and research.
- Ensure that all functions are exercised effectively, efficiently and economically.
- Promote the long-term sustainability of the Trust as part of the ICS, the local ICB and wider healthcare system in England, generating value for members of the foundation Trust, patients, service users and the public.
- Help set the vision, values and standards of conduct and ensure obligations to members, service users and other stakeholders are understood, clearly communicated, and met.

The integrated organisation will have a newly appointed Chair with a three-year term from April 2026/7 who will lead the organisation with the incumbent non-executive directors from WHH. The non-executive directors (NEDs) of WHH will continue their terms with the integrated organisation. The existing BCH NEDs will not automatically transfer to the new Board. However, as the terms of the current WHH NEDs come to an end, BCH NEDs will have the opportunity to apply for any forthcoming NED vacancies on the new Board, ensuring fair access to future roles within the integrated organisation.

The existing members of the WHH and joint executive team will transfer to the executive posts in the integrated organisation. The executive team structure was reviewed in 2024 as part of the appointments within the joint executive team. The required legal processes will be undertaken in line with the Transfer of Undertakings (Protection of Employment) regulations to establish the integrated Board.

Figure 23 below of the proposed executive team will support the integrated organisation with the capacity oversight and capability to deliver our integration programme and capital projects alongside business as usual.

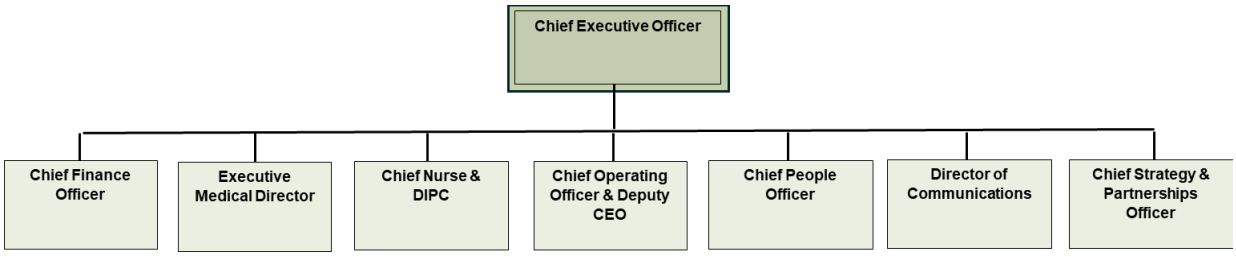


Figure 23: Executive team of the integrated organisation

In developing our Board structure, we have been mindful that the Board of the integrated organisation needs the necessary skills and experience to enable it to provide effective leadership and oversight of the new, integrated Trust. This will help assure the delivery of the strategic objectives for the new organisation. The proposed Board will have the necessary skills to ensure that the integrated organisation delivers high quality, safe care to the populations we serve.

9.5 Constitution

An exercise will take place to review the constitutions of both WHH and BCH and align these where necessary for the integrated trust. Trust Boards and Governors will be engaged during the exercise. The updated constitution will be presented to the WHH Council of Governors and Trust Board for approval in February 2026.

Additionally, the Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs) will be presented to the WHH Board for approval in February 2026.

9.6 Governors

WHH currently has 27 governors, while BCH has 24. As WHH is the acquiring Trust, its council of governors will become the council of governors of the new organisation upon acquisition. The BCH council of governors will be dissolved.

Given that both Trusts serve broadly the same population, work was undertaken during 2023/24 to align WHH's public constituencies with those of BCH. This resulted in the agreement of two public membership constituencies: Warrington and Halton, and rest of England, with governor representation from both. In 2023/24, the WHH constitution was updated to allow individuals to serve as governors at more than one Trust encouraging cross-FT collaboration.

Staff constituencies across BCH and WHH are identical; therefore, no changes are proposed. partner governor positions are similar across both Trusts. WHH currently has partner governors for all partner organisations specified by BCH,

including; statutory borough-based partner organisations, voluntary services and higher education.

Between September and November 2025, WHH will conduct routine elections to fill vacant seats or those with governors nearing the end of their term. Election results will be announced on 26 November 2025.

The newly formed governor engagement group in common (GEGiC) merges the WHH governor engagement group and the BCH communities matter public & community engagement group. Approved by both councils of governors in August 2025, GEGiC aims to strengthen collaboration between the two Trusts and align membership and engagement strategies to support the integration journey.

The statutory role of the council of governors is defined in the constitution. Governors work closely with non-executive directors through council meetings attended by all non-executive directors, with executive directors participating in specific agenda items as subject matter experts.

9.7 Membership

As of 31 March 2025, WHH had 3,062 public members, and 4,790 staff members and BCH had 1,655 staff members and 6,219 public members.

In the time leading up to the integration, efforts will be made to encourage BCH public members to become members of WHH, which will become the membership base of the new organisation. This message will be communicated through BCH and WHH member newsletters and media releases related to the 2025 WHH elections.

BCH members may submit nominations to become governors of WHH (and therefore the new Trust), provided they submit a valid membership form. BCH membership will be dissolved upon acquisition. During the transaction period and beyond, the public will be encouraged to join WHH and the new organisation to ensure they can contribute to the strategic direction of the Trust, stand in governor elections, and vote for their representative governors.

BCH staff members will automatically become members of the new organisation following the transaction.

9.8 Quality governance structure for the integrated Trust

The integrated organisation will adopt a unified quality governance framework that ensures safe, effective, and person-centred care across acute and community settings. This framework will align with NHS England’s quality governance principles and the requirements of the care quality commission (CQC), while supporting the Trust’s strategic objectives and ICS priorities.

A unified quality focussed Board-level committee responsible for oversight of clinical quality, patient safety, and experience will be established building on the existing quality governance framework form each Trust. The committee will report directly to the Board of directors having received briefing papers from a range of subcommittees covering areas such as patient safety, experience, safeguarding, infection prevention, medicines governance, and risk review. The committee will also oversee the development and implementation of quality strategies, monitor compliance with regulatory requirements, and ensure effective communication and learning frameworks are in place across the Trust.

The supporting documents show the proposed internal governance structure for the integrated organisation covering the three core strategic domains of quality, people and sustainability.

9.8.1 Integration of quality support functions

The integration of BCH and WHH will encompass all governance functions, including risk and incident management, central alerting system (CAS) alert management, policy, standard operating procedure (SOP) and guideline oversight, legal and claims management, and complaints and patient advice and liaison services (PALS).

More detail around the integration of clinical governance and quality teams can be found in section 11.15 of this document.

9.8.2 Clinical policies and procedures

To ensure safe and effective service delivery from day one, it is essential that all high-risk clinical policies and procedures are aligned and fully understood by all staff. Policies are categorised as high-risk if they will potentially require a material change in practice or process for either WHH or BCH staff following the date of integration, and the change in practice or process, if not fully communicated and/or understood, could create a risk of harm.

Successful alignment of clinical policies will promote consistency in clinical practice, improve quality and safety standards, and enhance staff confidence in the new organisation’s governance arrangements. It will also reduce duplication, streamline clinical decision-making, and lay the foundation for a more efficient, integrated, and sustainable approach to patient care across the integrated Trust.

The process of reviewing, prioritising, and aligning all clinical policies ahead of the transaction date has already commenced. Relevant documents, SOPs, and policies are being updated and consolidated to ensure clarity, accountability, and robust governance structures. All processes will be concluded and fully communicated by 31 March 2026, with joint governance meetings commencing from 1 April 2026. Many activities will begin ahead of full integration to maintain continuity and safety. Where full alignment cannot be achieved by day one, clear interim arrangements and governance controls will be established and communicated to provide staff with definitive guidance on which policies to follow. This approach will safeguard patient care, maintain regulatory compliance, and support a smooth transition to a unified clinical governance framework.

9.8.3 Incident management

Incidents will be managed collaboratively across both organisations on a daily basis. Clinical governance managers, aligned to each care group within the organisation, will provide daily escalations to the triage meeting chaired by the Deputy Director of Governance. For any incidents of concern or interest, an SBAR report will be prepared and reviewed at the weekly executive-led safety oversight meeting (SOM), which is attended by ICB colleagues. During SOM, proportionate learning responses will be agreed and subsequently presented back for review. SOM currently reports into the WHH quality assurance committee (QAC) through relevant governance reports and escalates to the executive-led PSIRF Group. It will report into the joint quality committee once this

is established. Learning from incidents will be monitored through the sustained learning group, which will commence in quarter 4 of 2025/26.

9.8.4 Risk management

The Trust is currently undertaking a procurement exercise to purchase a single governance system across both organisations. It is proposed that training and rollout of the new system will commence from the first quarter of 2026/27. This will further strengthen integration, streamline reporting, and enhance assurance across both organisations.

In the meantime, we will ensure that risk management processes remain robust throughout the duration of the integration programme and beyond. WHH will continue to manage risk registers and incidents on the Datix system, while BCH will continue to utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single data analyst governance team, which will produce joint reports for governance committees and care groups to ensure safe business continuity.

All risk registers will be overseen by a single risk review group, attended by the executive team, all care groups, and the corporate secretary. This group will ensure that all risks are managed, reviewed, and aligned with the corporate risk register and the Board assurance framework. The risk review group will report into quality committee and Trust Board by exception. The clinical governance managers/governance teams will be fully trained in both systems.

9.8.5 Health and safety management

Presently, the oversight of organisational health and safety resides within different portfolios across the two organisations. In the future integrated structure, health and safety will be managed and governed within the clinical governance portfolio to ensure clarity and consistency. BCH currently uses external contracted support to manage health and safety; this was identified as a potential risk as part of the health and safety due diligence exercise (see section 19.3.2). It is envisaged this arrangement will continue temporarily while the capacity of the governance team is scoped and adequate resources are allocated to maintain all health and safety activity internally.

9.8.6 Legal and claims management

Legal and claims management currently sits within the corporate governance team at BCH, but with limited activity. This function will transfer to the WHH legal team at the point of integration, utilising existing WHH policies, procedures, and governance reporting frameworks.

9.9 Financial governance for the integrated Trust

The new Trust will operate under a robust financial governance framework, drawing on the existing structures of both organisations and aligning them through aligned policies and procedures.

While WHH and BCH remain separate legal entities until completion, both Boards have approved a ‘committees in common’ approach to provide unified oversight ahead of the legal transaction. For finance, this is the finance, sustainability and

productivity committee in common (FSPCiC), replacing WHH's finance and sustainability committee (FSC) and BCH's finance & performance committee for joint scrutiny of plans, in year performance and strategic investments. FSPCiC reports via assurance reports to each sovereign Board and escalates as required to each Trust's audit committee, operating within each Trust's scheme of reservation and delegation (SORD). The CiC oversees financial and operational planning, operational performance, strategic and business development, EPRR, estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

Following integration, the CiC will revert to a single committee reporting within the internal governance structure illustrated in the supporting documents.

9.9.1 Individual elements of financial governance

The Board of directors are the unitary Board responsible for stewardship of public funds, strategy, risk and assurance.

Audit committee – independent committee that reviews and assures integrated governance, risk management, internal control, and the work of internal audit, external audit and counter fraud; meets at least five times a year, with provision for private meetings with auditors. Reports to the Board after each meeting and supports the annual governance statement.

Finance, sustainability & performance committee – provides strategic oversight and scrutiny of financial planning, in year performance to plan/budget, efficiency and productivity, cost improvement programme (CIP), capital programme, cash and triangulation across performance and workforce; makes recommendations to the Board on plans, budgets and investments; operates to an agreed cycle of business.

The governance model will be underpinned by a corporate governance manual and the annual governance statement which outline the control environment and responsibilities of key committees.

Furthermore, a single **delivery unit** has been established across both organisations to review and scrutinise productivity, non-pay, workforce and recruitment and overall financial grip and control.

9.9.2 Reporting lines and responsibilities

- The chief finance officer will be accountable for financial stewardship and reporting across the integrated entity.
- The audit committee reports to the Board and provides independent assurance on the adequacy of internal controls, risk management, and governance processes.
- The finance, sustainability and productivity committee will report to the Board and is responsible for scrutinising financial plans, investment proposals, and budget performance.
- The company secretary ensures governance compliance and supports committee operations, including documentation and escalation protocols

9.9.3 Internal control system and lines of financial accountability

a) Core instruments

- Standing financial instructions (SFIs) set out duties of all staff and the CFO to design and maintain internal financial controls, including segregation of duties, internal checks, record keeping and reporting—ensuring probity, accuracy, economy, efficiency and effectiveness.
- The scheme of reservation and delegation (SORD) defines decision rights and delegated financial limits (revenue, capital, tendering/quotations, waivers), and clarifies who may commit, approve, or vary budgets; waivers of procurement processes are reported to the audit committee.
- Standing orders codify Board/committee composition and delegation, and requirements for conduct, declarations and meetings.

These documents will be reviewed and updated prior to the transaction to ensure they are fit for purpose for the new organisation.

b) Budget accountability and reporting

- The CFO chaired finance resource group (FRG) reviews clinical business unit (CBU) and corporate financial performance monthly and reports to the non-executive led finance committee; the financial control group provides further grip and oversight of efficiency and controls. Quality impact assessments for CIPs are reviewed to ensure financial actions do not compromise quality.

c) Assurance on segregation of duties

- The integration will maintain strict segregation of duties across financial processes, supported by standing financial instructions and scheme of delegation. These clearly define roles for budget holders, approvers, and reviewers to prevent conflicts of interest and use financial systems with embedded controls to enforce separation of duties and prevent unauthorised transactions.

d) Budget accountability

Budget accountability will be embedded through:

- Delegated budget responsibilities to operational leads and service managers.
- Regular financial reporting to the finance, sustainability and productivity committee and executive team.
- Integration of financial performance into the Board assurance framework (BAF) and risk registers

9.9.4 Internal audit, external audit and assurance alignment

Internal audit: The Trust’s internal audit provider (Mersey Internal Audit Agency – MIAA) delivers a risk based annual plan approved by the audit committee. The 2024/25 cycle included mapping and follow up of actions with regular reporting to the committee, and the Head of Internal Audit (HOIA) opinion for 2024/25 concluded substantial assurance. As part of integration, MIAA is aligning annual plans and projects across WHH and BCH to ensure continuity of controls before and after transaction.

Internal audit services will be aligned across the integrated Trust to ensure consistency and coverage:

- A unified audit plan will be developed in consultation with both legacy organisations' audit teams.
- Counter fraud activities will be aligned, with green ratings already achieved on fraud standards.

External audit: External audit (statutory) provides independent assurance on the annual report and accounts, AGS and quality report.

Following the planned acquisition on 1 April 2026, there will be a move to a single provider of external and the same for internal audit services to the integrated Trust.

Audit committee oversight: Audit committee meets on a five times yearly cycle, receives internal/external audit and counter fraud reports, and tracks overdue actions; cycles of business are published and monitored.

9.10 People governance for the integrated Trust

The new Trust will operate under a robust people governance framework, drawing on the existing structures of both organisations and aligning them through harmonised policies and procedures. While Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT) remain separate legal entities until completion, both Boards have approved a committees in common approach to provide unified oversight of people and organisational development ahead of the legal transaction.

For people governance, this is the Strategic People Committee in Common (SPCiC), replacing WHH's Strategic People Committee and BCHT's People Committee, to enable joint scrutiny of workforce strategy, organisational development, equality, diversity and inclusion, and staff wellbeing. The SPCiC provides assurance to each sovereign Board via formal assurance reports and escalates as required to each Trust's audit committee, operating within each Trust's Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs). The Committee oversees the development and implementation of joint people strategies, workforce planning, staff engagement, and culture transformation across both Trusts, ensuring compliance with NHS regulations and local priorities.

Following integration, the SPCiC will revert to a single committee reporting within the new internal governance structure, supporting the Trust's ambition to be the best place to work, with a diverse and engaged workforce that is fit for now and the future. The Committee will continue to monitor performance against national standards, oversee statutory and regulatory obligations in relation to equality, diversity and inclusion, and ensure that the Trust attracts, develops, and retains its workforce in line with the principles of the NHS People Promise.

10.0 Clinical Model

10.1 Chapter summary

This section describes the emerging joint clinical model that will underpin delivery of care across the new organisation. It demonstrates how acute, community and specialist services will be connected through integrated clinical pathways designed around patient need, not organisational boundaries.

The section explains how this model supports prevention, early intervention, and reduced hospital admissions through multidisciplinary working, shared digital systems and community-based care. The integrated clinical model transforms patient journeys by removing boundaries between hospital and community care.

It strengthens clinical sustainability, reduces variation, and enables proactive, preventative care closer to home.

Key message: This section outlines the four priority areas for early integration — starting well, ageing well, urgent and emergency care, and long-term conditions, and the subsequent seven priority pathways of focus: frailty response; infant feeding; heart failure; chronic pain services; movement disorders, female urinary incontinence and end of life care. It illustrates how these will improve outcomes and experience while ensuring long-term clinical and financial sustainability.

10.2 Clinical vision and strategy

Our vision for the future model of the integrated organisation has been set out clearly since the production of the original strategic case for change document that we produced in October 2024.

We will deliver new models of care, with the continued involvement of a wide range of partners and voices, including primary care, local authorities and people with lived experience. We want to provide care as close to home as feasibly possible and focus significantly on improving population health and reducing health inequalities.

The NHS 10-year plan provides a mandate to bring this vision to life and the integration programme between WHH and BCH becomes a key enabler to achieving that transformational change. Our aim is to play a lead role in the development and then the delivery of pro-active neighbourhood health across our local places.

It also aligns with national guidance to develop local neighbourhood health models which aim to strengthen collaboration between health and social care and wider public services including the third sector

As demonstrated in chapter 5, our current model of care results in too many people coming into hospital for inpatient and outpatient care. With a rapidly growing and ageing population, this model will contribute to unsustainable levels of demand for services in future. The NHS 10-year plan sets out three strategic shifts and our medium to long-term vision for clinical services aligns perfectly with each of these:

1) **From ill-health to prevention**
   We want to work more collaboratively with local system partners to address the wider determinants of health and drive forward an agenda of ill health prevention and earlier intervention. Increasing healthy life expectancy for current and future generations and reducing demand for statutory health and care services.

2) **From analogue to digital**
   We want to be innovative and creative in our approach and make use of current and emerging technology to promote remote/virtual management of health conditions. We also want to promote self-care and empower the local population to take greater responsibility for their own health and wellbeing. Digital technology can be a key enabler in that aim.

3) **From hospital to community**
   For those people who do require support from secondary care services, we want to rebalance the pathways so that increasing numbers are able to access those services in community settings, supported by secondary care clinicians, advice and expertise where required. The neighbourhood health agenda can be the vehicle to really make that happen.

10.3 Foundations for the clinical vision

WHH and BCH have been working closely for a number of years on a number of initiatives that demonstrate the three strategic shifts are realistic and achievable:

10.3.1 From ill-health to prevention

10.3.1.1 Case Study: Living Well programme in Warrington

WHH and BCH are two of the core partners leading the Living Well programme of work across Warrington over recent years. There are a number of projects within the programme that are focussed on supporting prevention, early intervention and self-care.

The first of the Living Well projects was the Living Well Hub, which opened in March 2024 in Warrington town centre. The Hub has rapidly established itself as a trusted, non-clinical access point for early help and wellbeing support. In its first 18 months of operation it recorded over 30,000 attendances, with 50% of people walking in on a drop-in basis rather than via referral – clear evidence of unmet demand for accessible, face-to-face support. Importantly, 88% of visitors come from the town's most deprived central areas, and 9% report they would not have accessed any help without the Hub. Activity data shows that 15% of visitors use more than one service per visit, and over 5% are actively signposted onwards, demonstrating the hub's role in diverting people away from crisis and into early, preventative support.

The co-location of WHH midwives, BCH community services, carers' support teams, dementia navigators, Home Start, job centre advisors, wellbeing teams and other statutory and voluntary providers enables seamless, multi-agency responses to complex social and health needs. Case studies from the project show tangible impact: vulnerable expectant parents receiving immediate financial and emotional support; unregistered carers identified early and connected into structured help; individuals with unmanaged long-term conditions brought into clinical pathways via informal engagement; and people in distress supported before reaching emergency services. Staff and people accessing services consistently report that these outcomes "would not have been possible" without the shared Hub model.

Alongside the Hub, a wider network of 10 neighbourhood Talking Points delivered over 900 visits in the first year and generated more than 2,000 requests for support, ensuring that early help is available close to where people live.

Building on this physical presence, the launch of the Living Well Warrington digital platform in March 2025 has created a 24/7 preventative "front door" for residents and professionals. Co-designed and governed by WHH, BCH, Warrington Borough Council and VCFSE partners, the platform consolidates

previously fragmented information sources into a single, quality-assured resource. Early usage trends demonstrate that both clinicians and social prescribers are now routinely using it to connect patients to non-clinical support – further reducing unnecessary clinical contacts and strengthening community capacity.

The financial and system impact of the programme is significant: Living Well's face-to-face connections are estimated to have delivered £40m in system savings, while the digital platform has created £1m in social value within its first 6 months. The three projects to date operate at an annual cost of £490k – a fraction of the cost of a hospital ward. This demonstrates that the push towards community services and prevention creates opportunities to manage greater demand in a different way and support financial sustainability of the whole system.

Together, the Living Well Hub, Talking Points and digital platform represent a mature model of joint WHH–BCH population health working. They deliver measurable benefits in demand reduction, improved access, health equity and community resilience. Most importantly, they demonstrate that both Trusts are already operating beyond organisational boundaries, jointly leading the cultural and operational shift from illness to wellness which this acquisition seeks to scale.

The Living Well Warrington programme was recently 'highly commended' in the 'integrated care initiative of the year' award at the 2025 HSJ awards.

There are opportunities to go further with the collaborative work in Halton too, through the 'WELL Runcorn' project, which will see a similar multi-agency health and education facility open in the town centre of Runcorn in early 2026.

10.3.2 From analogue to digital

10.3.2.1 Case Study: Skin Analytics – AI-led Dermatology service

April 2025 saw the launch of a brand new AI-led Dermatology service, the result of three months of fast-paced collaboration between BCH, WHH and the software providers.

The new service uses revolutionary medical-grade artificial intelligence called DERM, which recognises skin cancer and common harmless skin conditions using photographic images instead of assessment by clinical staff. The results of the AI system are proven to be more accurate than those from the human assessment and the software also results in a faster diagnosis.

Using AI will reduce the number of hospital appointments for patients with benign lesions and allow faster care for more urgent cases, with treatment often performed on the same day, at the same location. In line with wider NHS aims, waiting times will be reduced and a rising demand better met.

The pioneering new service is delivered from the Warrington and Halton Diagnostics Centre, located at Halton Health Hub, within Runcorn Shopping City. This is one of only a small number of Community Diagnostic Centres to be launched in a shopping centre in the country – and the first in Cheshire and Merseyside, making it easy for patients to access modern diagnostic services outside of a hospital environment.

There are exciting and rapidly expanding opportunities for service improvement and financial efficiency linked to the use of AI. This is an area that the integrated organisation will be focusing on over the coming years as the programme of clinical and operational transformation continues to develop and deliver.

10.3.3 From hospital to community

10.3.3.1 Case Study: Urgent Community Response (UCR) Team

BCH's UCR teams across both Warrington and Halton work in close collaboration with the acute Trust as well as Warrington and Halton Borough Councils. The UCR teams support people to get the care they need at home. The service receives a high volume of referrals and supports patients with high acuity to prevent unnecessary hospital admissions.

The urgent care improvement programme continues to work collaboratively with WHH, BCH and local authority colleagues, and benefits of integration are demonstrated with significant increased referrals to the UCR team as an alternative to ED. More than 120 more patients each month were referred to UCR in 2024 compared to 2023. Other improvements include a 4% reduction in attendance at ED and a 17% reduction in the length of time spent on the ED corridor from 2022-23 to 2024-25.

10.3.3.2 Case Study: Frailty virtual ward

The Warrington Frailty Virtual Ward is a partnership between WHH and BCH. The aim of the Frailty Virtual Ward is to provide 'hospital at home', patient-centred care to patients over 65 years with a frailty condition. The virtual ward currently onboards patients who reside within both nursing and residential care homes, with an additional step-down pathway that was introduced early in the Spring of 2024 to allow patients from the Frailty Assessment Unit to be stepped down to their own home. Moving forwards, plans are in place to introduce a step-up pathway to onboard patients from their own homes into the virtual ward.

New opportunities to shift work away from acute settings will arise from the proposed neighbourhood health agenda. The NHS 10-year plan sets out a vision for more multi-disciplinary, neighbourhood health centres and these could potentially be facilities offering enhanced community services delivered by integrated community and acute specialty teams alongside primary care teams.

10.4 Clinical strategy

The impact of delivering and sustaining these three shifts will ultimately see care provided closer to the patient's home and help prevent more people reaching poor health and crisis point. Over time, this shift of care will free-up clinical time within the acute Trust, allowing secondary care clinicians to focus on complex care and potentially releasing resources that can be shifted back into the community.

By following the core principle of 'Home first, community next and only then hospital', patients will only need to attend acute services as a last resort. This should free-up professional time, reduce secondary care resource requirements, reduce waiting lists and ultimately increase the sustainability of the overall care model.

This principle will form the basis of a new clinical strategy for the integrated organisation, which is planned to be completed by December 2026. The new clinical strategy will provide further details about what the clinical model will look like across our local Places as the thinking and planning around neighbourhood health develops and matures with our partners.

The overall approach to clinical integration that will be captured by the strategy is based on principles of co-production, quality improvement and systems thinking. By creating the conditions for a culture of shared learning, collaboration, and innovation, we will facilitate the development of integrated pathways and services that lead to sustainable improvements.

Further detail around how our future integrated clinical model can support improvements in health outcomes and health inequalities can be found in chapter 14 of this document.

10.5 Clinical integration in phase two of the programme

We acknowledge that the development of a new clinical strategy and clinical model will take time (for context, the neighbourhood health plans on a national scale form part of the 10-year plan). But we also acknowledge that there are opportunities for clinical improvement that exist without the longer-term, large-scale transformation that is described in the sections above.

Having established our principles for clinical and operational integration (see section 8.2), an initial workshop for senior clinical and operational leads was held in October 2024. Chaired by the chief strategy and partnerships officer (WHH) and joint medical director, the aim of the workshop was to understand services across both Trusts, to understand where we care for the same people, to identify clinical alignment and to make recommendations on priority themes for integration.

50 senior leaders from across both organisations and external partners including third sector organisations and primary care participated in the workshop and following two facilitated interactive sessions, the following themes emerged as priorities for integration:



Figure 24: Thematic priorities for clinical integration

- Starting well- women, children’s and family services

- Ageing well
- Urgent and emergency care and discharge
- Long term conditions

Subsequently, it was decided that urgent and emergency care already had a programme of work (ED improvement programme) being undertaken collaboratively between WHH, BCH and local authority colleagues and a separate summit for this area was therefore not considered necessary.

Also, it was decided that long term conditions should be divided into two sub-groups to consider physical conditions and neurological conditions separately and similarly, women's health and children's services were separated too.

In total, five themes were agreed to be taken forward for further initial work. These themes then formed the basis for the next stage of the planning, which was to identify the priority services for integration in phase two of the programme as part of a series of 'clinical summits'.

10.5.1 Clinical summits

Services falling within each of the five identified themes were grouped together and appropriate representatives from clinical and operational teams for each service from each Trust invited to the relevant summit. Director level partners including local authority, primary care and voluntary sector representatives were also invited.

The clinical vision and ambition to move more care into the community were integral to the clinical summits. Discussion focused on high level pathways and opportunities to strengthen services rather than detailed plans or organisational structure.

Focused discussion was facilitated to:

- Understand the pathways within each service and the challenges within them.
- Understand where patients would benefit most from integration and a shift of services into the community.
- Consider how integration could support improvement in pathways and the priority order for this integration.

10.5.1.1 Clinical summit – Long term conditions (physical)

The specific services discussed at this summit were:

- Podiatry and orthotics
- Diabetes
- Heart failure
- Respiratory disease
- End of life care

The integration priorities agreed by the group were **heart failure & end of life care**

10.5.1.2 Clinical summit – Long term conditions (neurological)

The specific services discussed at this summit were:

- Neurological rehabilitation
- Stroke
- Movement disorders/Parkinson’s disease
- Chronic pain services

The integration priorities agreed by the group were **movement disorders/Parkinson’s disease & chronic pain services**

10.5.1.3 Clinical summit – Women’s health

The specific services discussed at this summit were:

- Women and family services
- Gynaecology, bladder and bowel
- Breast screening and surgery

The integration priority agreed by the group was **female urinary incontinence.**

10.5.1.4 Clinical summit – Children’s services

The specific services discussed at this summit were:

- Community paediatric and nursing care
- Paediatric therapies
- Antenatal and intrapartum care
- Postnatal and neonatal care

The integration priority agreed by the group was **infant feeding.**

10.5.1.5 Ageing well

A seventh and final clinical priority was added following the completion of the clinical summit meetings in the summer of 2025. Given the significance and the impact of the ageing and growing population locally, it was agreed that the clinical integration work also needed to include a focus on older adults. More specifically, the system-wide management of people living with frailty syndromes and **frailty response services**.

10.5.2 Clinical priorities

Category	Priority Area
Acute & Community Care	Acute care closer to home – Frailty response
Cardiovascular Health	Heart failure
Pain Management	Chronic Pain Services
Maternal & Child Health	Infant feeding
Neurological Care	Movement Disorders / Parkinson’s Disease
Women’s Health	Female urinary incontinence
Palliative & Supportive Care	End of life care

Table 14: Seven services identified as priorities for integration as part of phase 2 of the programme

The following tables summarise the main outcomes from the initial meetings to discuss the identified clinical priorities.

Clinical priority 1: Frailty response	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ No single community frailty service ▪ Lack of senior frailty clinical support to BCH services meaning patients often sent into ED for further assessment rather than positive risk-taking occurring ▪ Services disjointed with no direct care pathways enabling flow to step in to secondary care or step down back to community – means patients often conveyed to ED for senior medical review when SDEC services may be more appropriate. Similarly, patients remain on wards for bloods to be repeated when this could occur in patients own home with medical input virtually if required. ▪ Staffing constraints in both organisations with incorrect skill mixes ▪ Limited therapy, nursing, and specialist geriatric support in community ▪ No provision of own home falls assessments for patients who are not housebound (despite gold stand falls assessment including a own home mobility/environmental review) ▪ Digital fragmentation – usage of different clinical systems in WHH compared to BCH mean not all documentation is visible to both organisations - ACPs, CFS, 4AT delirium assessments, and care plans not consistently visible across hospital, community, and GP systems. ▪ No single governance structure for community and hospital-based frailty services, delaying service change/improvement and preventing optimal pathway design for patients ▪ Care Home Integration- variable support for falls, infection management, and end-of-life care; inconsistent pathways to avoid unnecessary hospital admission.	▪ Early Frailty Identification & Comprehensive Geriatric Assessment (CGA) ▪ Mandatory CFS assessment for all ≥65 in ED, FAU, and community referrals. ▪ CGA delivered within 24h for moderate/severe frailty (CFS ≥6), including ANP/ACP support. ▪ CGA-lite offered in virtual ward or home for community-managed patients by community team. ▪ Admission Avoidance & Community Integration ▪ Expand virtual ward “step-up” to prevent hospital admissions from ED, GP, ambulance, UCRS, community matrons and care homes. ▪ Strengthen links (both in and out of secondary care building) with community UCRS, ECHST and community matron teams to enable same-day or home-based care. ▪ Deconditioning & Functional Recovery ▪ Mobilisation-first ethos organisation wide and in community (dress, sit up, move daily). ▪ Therapy input coordinated across hospital and community to maintain function and independence. ▪ Delirium, Falls, & Bone Health ▪ Universal 4AT delirium screening in all hospital and community assessments. ▪ Standardised falls protocols across hospital, virtual ward, community and care homes. ▪ Osteoporosis risk assessment and post-falls rehabilitation offered in hospital and community settings. Therapy assessment for falls clinic patients to be completed in their own home. ▪ End-of-Life Care & Advanced Care Plan ▪ Routine ACP conversations across all hospital and community services with one standardised document to be shared between all. ReSPECT document is used

	nationally but not in Warrington/Halton. ▪ Shared digital records accessible to ED, FAU, virtual ward, community teams, and GPs. ▪ Care Home Integration ▪ Direct care pathways for hospital avoidance and early intervention with increased utilisation of virtual ward step up pathways. ▪ Standardised falls, infection and end-of-life protocols aligned with hospital services. Apply same formulary to community care as hospital-based care. ▪ Rapid access to specialist geriatric support without unnecessary hospital conveyance. ▪ Metrics, Monitoring & Digital Integration ▪ Dashboards to track: CFS completion, 4AT screening, admissions avoided, LOS, readmissions, functional outcomes. ▪ 75+ benchmarking to assess system performance and identify gaps. ▪ Fully integrated EPR system across hospital, community, and GP networks to support shared decision-making. ▪ Clinical Governance to be led medically by DMOP clinical lead with one centralised governance meeting for entire frailty service encompassing community and hospital provision.
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ More care delivered at home or in community ▪ Reduced corridor waits in ED as increased direct conveyance to FAU ▪ Reduced delirium and deconditioning rates ▪ Reduced LOS as seen by right team at the front door and increased early supported discharge support back out into the community ▪ Better end-of-life alignment with patient wishes ▪ Improved flow of pathway for patients due to integrated service	▪ Increased support from senior frailty clinicians ▪ Upskilling of community workforce ▪ Increase awareness of community services for hospital-based staff ▪ Right patient in right place; less duplication of assessment ▪ Focused use of specialist staff for high-impact interventions

Table 15: Outcomes from initial discussions around clinical priority 1

Clinical priority 2: Heart failure	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**

▪ Variation in practice for management of referrals and wider clinical practice by area ▪ Too many patients wait too long for diagnosis and management leading to an increase in admissions ▪ Availability of diagnostic tests varies by area and service ▪ Variation in prescribing rights across WHH and BCH ▪ Waiting times for outpatient appointments ▪ Lack of clinical vetting for patients on the waiting list ▪ Visibility of medical history and test results across disparate EPR systems ▪ Waiting time for high complexity treatment e.g. intravenous diuretic medication ▪ Suboptimal management of end-of-life heart failure patients leading to unnecessary admissions	▪ Have a single service serving patients across the heart failure pathway ▪ Deliver a seamless integrated service to manage heart failure from diagnosis throughout the disease course – aiming to maximise the time patients are at home and minimise time and contact with the hospital. ▪ Developing a community IV diuretics service ▪ Establish community clinics for heart failure nurses shifting clinic workload into the community ▪ Standardise the scope of practice of heart failure nurses including prescribing and referral right ▪ Developing a one stop approach to diagnosis and treatment in the community wherever possible ▪ Reducing variation in practice between Halton and Warrington
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ More access to specialist care closer to home, less unnecessary travel for certain types of heart failure care. ▪ Shorter waits for diagnosis and treatment ▪ Care available will be less variable by patients' geographical location	▪ Staff will work in an integrated team across community and hospital with clear agreed structures ▪ Staff will see their job roles and task standardise, making the best use of their skills – for example specialist nurses in Halton can currently prescribe but those in Warrington cannot – this will change in the new model ▪ An integrated team will allow for more resilience within the staffing model ▪ Co-ordination of care for people living with heart failure will be easier, and staff will see the immediate benefits for the patients and families that they support

Table 16: Outcomes from initial discussions around clinical priority 2

Clinical priority 3: Chronic pain services	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ Dated model of pain service provision in a predominantly hospital medical intervention-based model ▪ Significant volume of pharmacological	▪ We will move to an integrated model of community based Chronic Pain Service shifting the focus from a dated hospital-based model relying on pharmacological

interventions for pain ▪ Significant volume of day case invasive interventions for chronic pain – spinal injections etc ▪ Lack of a joined-up approach to non-pharmacological interventions such as physiotherapy between acute trust and community trust ▪ A focus on pharmacological management of pain rather than community-based therapies enabled	and theatre-based interventions to manage pain symptoms, to a predominantly community and therapies-based model, with hospital intervention being limited to only the most complex cases
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ Patients will be cared for in a model that will focus on rehabilitation and re-enablement (rather than pharmacological intervention) that will more effectively support their pain management and returning to the things they want to do ▪ Reduced opioid and gabapentoid prescriptions, delivering significant patient and community benefits ▪ Fewer invasive procedures will be required ▪ Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – significantly reducing the number of procedures of limited evidence-based value taking place	▪ A reduction in opioid and gabapentoid prescribing will result in less work for primary care, both in prescribing burden and in the management of complications of these therapies ▪ Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – this will allow staff to see greater benefits to patients from inpatient theatre and procedure room work ▪ An integrated team will allow for more resilience within the staffing model ▪ Co-ordination of care for people living with Chronic Pain will be easier, and staff will see the immediate benefits for the patients and families that they support

Table 17: outcomes from initial discussions around clinical priority 3

Clinical priority 4: Infant feeding	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ Communication between services/departments (not being on the same IT systems) Not sharing an infant feeding policy. Pathways not embedded. ▪ Mixed messages and information provided across disciplines to parents ▪ Maternity and NNU UNICEF BFI accreditation challenges due to staffing levels and culture and finances ▪ Staff training not provided in settings (paediatrics, A&E, Urgent care, GPs) where infants are presented with feeding issues as they do not currently have BFI standards as do maternity, NNU and Community.	▪ Organisational wide infant feeding policy covering all departments and services to ensure pathways are embedded and staff are aware of where to refer to for the right support. ▪ Multi-disciplinary staff training to ensure standardisation and relationship building between services. ▪ Pilot tongue tie service for Halton run by maternity and infant feeding using funding from Halton Family Hubs

▪ Different service offer in each borough due to demographics and funding associated with this. Halton also has two local acute trusts where woman birth, which creates more complexities. ▪ Tongue tie services currently sit outside of women and children's services	
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ Consistent advice - trust in services/NHS ▪ Assessed level of need will result in service users being directed to the appropriate practitioner via universal referrals/pathways ▪ Improved patient outcomes and satisfaction ▪ Reduced waiting times ▪ More service users seen in the community were appropriate ▪ Those that do need care from acute services or GPs will be seen more quickly	▪ Confident in the information that they are providing for families ▪ Evidenced based ▪ Know how to escalate or refer ▪ Build relationships between services ▪ Improve culture and morale ▪ Less patient complaints ▪ Opportunities for upskilling

Table 18: outcomes from initial discussions around clinical priority 4

Clinical priority 5: Movement disorders / Parkinson's disease	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ Disjointed pathway with multiple hand offs and clunky transfers of care when patients move between the hospital and community settings ▪ 56 weeks waiting time to see consultant ▪ Deconditioning of patients whilst waiting for appointments and in hospital ▪ Staffing capacity in community and hospital ▪ Length of stay in hospital ▪ Different IT systems ▪ Variation in practice between Halton and Warrington	▪ Bring together the multidisciplinary team across the hospital and community service will allow more effective use of capacity and shift the focus of care into the community supported by in reach into the hospital setting ▪ We will develop a Parkinson's passport to support holistic care ▪ We will upskill our specialist and general workforce to manage movement disorders patients in an integrated model across the pathway ▪ We will move to consolidate the movement disorders pathway onto (wherever possible) a single IT system ▪ Forge closer links and working with community matrons and district nurses
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ More joined up and effective care with fewer disruptions to care and medications when hospital care is required ▪ Smoother discharges to community from inpatient stays ▪ Reduced waiting times for clinic appointments and initial diagnosis	▪ Staff will provide care to people with Parkinson's / Movement Disorders in an integrated team across hospital and community ▪ Job satisfaction will be increased seeing patient experience and outcomes across the pathway improve and knowing the most appropriate care is given to the

	people we serve.

Table 19: Outcomes from initial discussions around clinical priority 5

Clinical priority 6: Female urinary incontinence	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ Women, particularly older women, may under-report symptoms. Integrating UI care ensures equitable access to assessment, diagnosis, and treatment, reducing health inequalities. ▪ Lack of appropriate clinic room space at Hospital sites for pelvic health physio. ▪ Waiting list for Gynae appointments ▪ Variable and complex pathways, with complex referral processes and rules that make accessing services challenging at times and can delay care ▪ Commissioning variance driving inequality of service access and provision across Warrington and Halton ▪ Complex prescribing arrangements spanning clinical pathways across primary, community and secondary care elements of the pathway ▪ Availability of female clinicians to support pathways in all settings	▪ More collaborative working and alignment of care pathways to deliver seamless care across acute Trust and community settings ▪ A joint MDT (hospital and community) to discuss complex patients ▪ A single referral pathway and direct referral into services ▪ Improved access to IT systems to improve visibility of lab results and blood tests ▪ Development of community-based clinics shifting care out of the hospital Review of pathways / contracts. Review of capacity and demand. Streamline referral pathways to pelvic health physiotherapy so comparable for each site. ▪ Consideration of “one-stop-shop” for patients ie, consultant, physio , nurse to provide timely treatment
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ Prioritising UI management allows timely interventions that restore confidence, independence, and participation in work, social, and family life. ▪ Early identification and treatment of UI can reduce secondary complications such as urinary tract infections, skin breakdown, and falls (from urgency or rushing to the toilet). ▪ Access to conservative management (bladder training, pelvic floor exercises, weight management) and specialist interventions improves long-term continence outcomes. ▪ Managing UI proactively in the community can prevent hospitalisation related to complications, improve discharge from acute care, and reduce re-admissions. ▪ Providing UI care as part of a community-focused, integrated pathway promotes co-production, empowering patients to be involved in treatment decisions, self-management, and goal setting. ▪ Better patient experience	▪ Staff will be empowered to ensure patients get the right care in the right place ▪ By making prescribing rights equitable across the service staff will get to utilise their skills and qualifications to best effect and gain increased work satisfaction from this. Better job satisfaction - seeing patients earlier in symptom journey- increased rehab potential to improve. Less requirement on further medical / surgical support. ▪ Easier to support patients with navigating referral pathway system. ▪ Will free up consultant time for more complex patients.

▪ Reduced waiting times to receive NICE recommended treatment.	

Table 20: Outcomes from initial discussions around clinical priority 6

Clinical priority 7: End of life care	
What are the challenges currently across WHH and BCH?	**What will we do in terms of integration of our clinical model?**
▪ Too many patients are not dying in their preferred place with their preferences met ▪ Too often patients do not receive timely, responsive access to face-to-face support, whether from generalist or specialist palliative care	▪ Strengthen our integrated MDT approach with accessible electronic solutions to share clinical information. ▪ Up to date Personalised Care Planning discussions and decisions will be available, accessed and updated wherever the patient is met on their journey (EPaCCs). ▪ Build our Palliative Care at the Front Door Model, working to integrate with Rapid Response in the community. ▪ Work towards an enhanced Integrated hub model to ensure needs are met by the right people at the right time. ▪ Further integrate to work alongside primary care to improve effectiveness of the Gold Standards Framework process. ▪ Standardise multidisciplinary process for the transition of young people to adult services. ▪ Develop a smoother, integrated discharge process. ▪ Integrate education for non-specialists across sectors, ▪ Work towards a 7/7 face to face specialist service within all settings ▪ Strengthen our integrated governance processes to streamline the patient journey across the whole pathway ▪ Align our Learning From Deaths process across acute and community settings, including evaluation of whether the Five Priorities of Care for the Dying Person are met
How will this look and feel better for patients?	**How will this look and feel better for staff?**
▪ More patients will have the opportunity for timely discussions about personalised care planning at the end of life ▪ Patients will be more likely to have their needs and preferences met and their symptoms managed ▪ Fewer avoidable hospital admissions in the last year of life, whilst ensuring necessary admissions are not unnecessarily prolonged	▪ Increased team morale, with effective administration enabling more time spent with patients, ▪ Feeling a part of an integrated team and having a shared influence over the whole patient experience, throughout an integrated pathway ▪ Greater understanding of the whole system, sharing responsibility for overcoming challenges ▪ Non-specialist staff to feel valued and more

	confident in managing patients' generalist palliative needs, with improved timely access to specialist support

Table 21: outcomes from initial discussions around clinical priority 7

10.5.3 Clinical priorities – next steps

A number of 'quick wins' and smaller scale improvement projects have been identified via the initial clinical summits to be taken forward by clinical teams with minimal support from the central project management team. A standardised process has been developed to ensure consistency and transparency including information collection template, a standardised equality and health inequality impact assessment (EHIA) process and governance structure. Clinical and operational integration projects undertaken by service teams will require authorisation from the executive management team and progress and benefits realisation will be reported through the clinical and operational services integration workstream to the BCT delivery group.

The larger scale clinical priorities will need project management support to mobilise and maintain progress, and the pace of delivery will be dependent on available resource. Delivery plans will be developed for each project and managed through the workstream, also reporting to the BCT delivery group. We will aim for the first three priority pathways to be integrated by July 2026 with further prioritisation of remaining pathways. Public, patient and partner involvement will be crucial in the next steps of the integration process. The plans around public and patient engagement are discussed further in chapter 15.

The BCT delivery group approved the recommendation for the priority order of pathways for integration in May 2025 as illustrated in figure 25 below. Next steps include:

- Integration projects already in progress, e.g. 0-19 and maternity services should continue with regular reporting to the BCT delivery group.
- Small scale integration projects should be taken forward by clinical and operational teams with approval from the executive management team, standardisation of data collection and routine reporting.
- Heart failure, infant feeding and chronic pain management pathways should be prioritised as larger scale integration projects with allocated project management support.

- Urgent and emergency care integration should continue through the ED improvement programme.

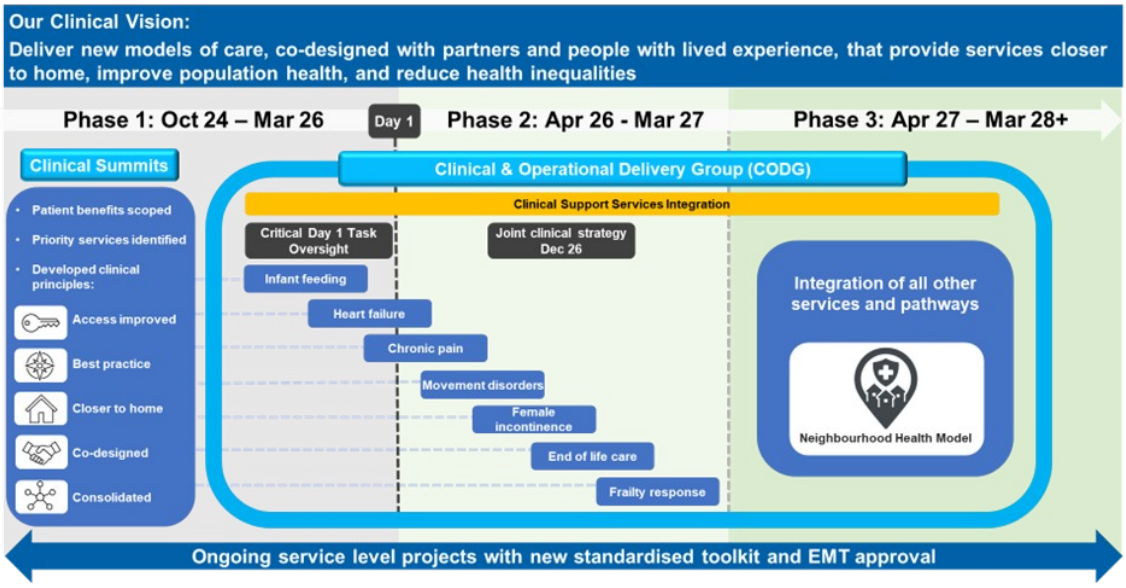


Figure 25: Next steps and timeframes around clinical priority workstreams

10.6 Urgent and emergency care

As noted in section 10.5, the work to more closely align and eventually integrate urgent and emergency care services is covered by the well-established ED improvement programme, which has involvement and engagement from both WHH and BCH teams.

Achievements of this programme of work as at early summer 2025 include a **4%** reduction in ED attendances from people aged over 65 years from **7,359** per month in 2022/23 to **7,060** in 2024/25 and a **17%** improvement to the length of time patients spend on the ED corridor (from 8.2 hours in 2022/23 to 6.8 hours in 2024/25). Referrals to the urgent community response team in Warrington have increased by 126 patients per month compared to 2023 and more people are being referred to the same day emergency care (SDEC) department (246 more each month compared to 2023). On average patients are spending 1.5 days less in hospital than they were in 2023 (12.2 days compared to 13.7 days).

A workshop held in May 2025 agreed to revise the structure of the programme to establish three distinct workstreams: pre-hospital, in-hospital and post-hospital as illustrated in figure 26 below.

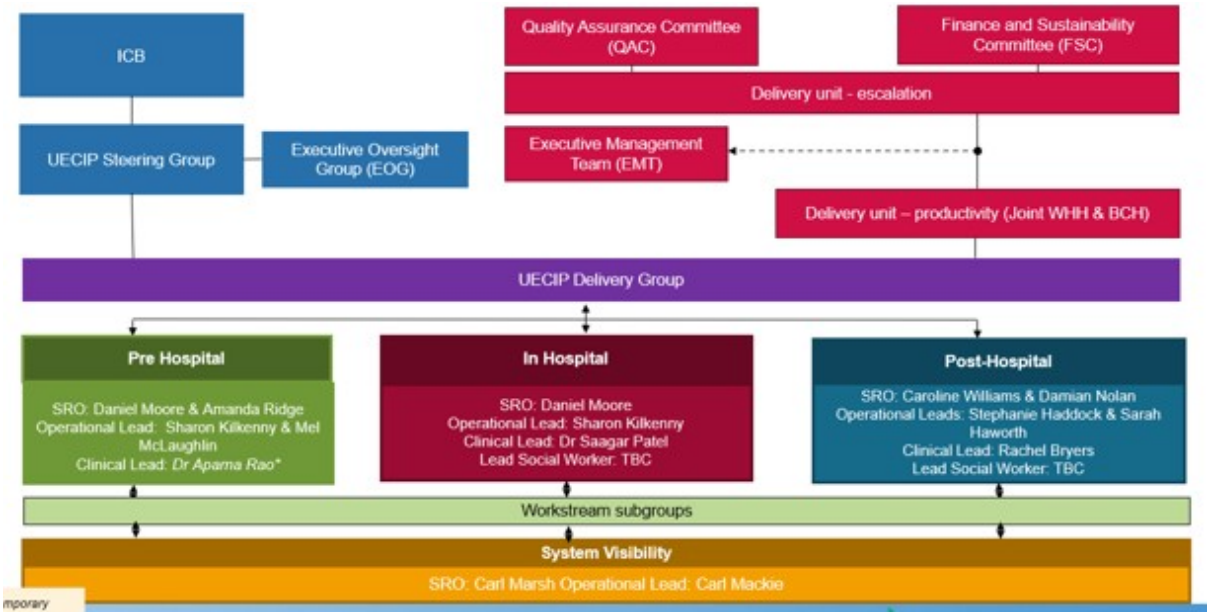


Figure 26: UEC/ED improvement programme of work

Each workstream has an SRO and clinical lead to deliver their work plan. Key areas of focus are outlined in the table below.

ED improvement programme: Key areas of focus		
Pre-hospital	**In-hospital**	**Post-hospital**

• Alternatives to ED:
  • UCR*
  • FAU
  • SDEC
• Education/training on alternatives to ED
• Decision to refer GP/111
• Conveyances- NWAS
• Single point of access
• Palliative/ end of life care
	• Frailty
	• 4- and 12-hour waiting time
	• Non-Elective Length of Stay
	• Transfer of care (discharge)
	• Decision to admit
	• Front door UTC
		• ICAHT* Single Assessment
		• In-Reach (pull model)
		• Flow through ICAHT / Bed bases
		• Standardisation and optimisation of information
		• NCTR*

Table 22: Key areas of focus of the ED improvement programme

**UCR= urgent community response*
FAU= Frailty Assessment Unit
SDEC= Same Day Emergency Care
ICAHT= Intermediate Care at Home Team
NCTR=No criteria to reside

The ED improvement programme will work closely with the clinical and operational integration workstream with shared SROs and alignment of delivery plans.

10.7 Integration of clinical support services

The integration of the clinical support services (CSS) clinical business unit (CBU), bringing WHH and BCH services together, represents a key enabler for delivering high-quality, efficient, and seamless care across acute and community settings. The approach to bringing these teams and services together has been aligned with the overarching objectives of the initial phases of the integration programme. Namely, ensuring safe transition at day one, maintaining continuity of service, and realising longer-term clinical and operational benefits through unified service models.

10.7.1 Integration approach and principles

The integration of CSS will follow a structured, risk-managed approach underpinned by clear governance and engagement. The key principles are:

- Service continuity and patient safety during transition.
- Alignment of governance and quality systems under established clinical governance frameworks.
- Operational efficiency through unified management structures and shared resources.
- Improved patient pathways through more consistent diagnostic, therapeutic, and support service delivery across community and acute settings.
- Workforce alignment and engagement to ensure staff feel supported and valued during change.

10.7.2 Service-specific CSS integration plans

10.7.2.1 Pharmacy

We intend for WHH Pharmacy services and BCH medicines management services to be fully integrated from day one, adopting a new operational structure that brings together acute and community pharmacy functions under a single governance and leadership model. This will be achieved through meaningful consultation.

10.7.2.2 Radiology/Imaging services

Radiology services will remain within the pre-existing CSS structure and form part of the new integrated CSS CBU. BCH imaging colleagues will join WHH's established radiology safety meetings from day one, ensuring alignment of clinical governance, safety standards, and reporting processes. This will support consistent diagnostic quality and more efficient cross-site reporting.

10.7.2.3 Pathology

Regional pathology service transformation is progressing through the Cheshire and Merseyside pathology network. As noted in section 5.10.2, WHH and Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) plan to deliver a single,

integrated pathology service for the local geography, including an essential service laboratory (ESL), collectively referred to as the East Hub.

Non-patient-facing pathology staff from WHH are planned to transfer via TUPE to MWL, which will deliver the service on behalf of both organisations. Oversight will be provided by the east hub pathology service committee, with TUPE transfers scheduled to complete in 2026 and full implementation of the regional model, including integration of the laboratory information management system (LIMS), by April 2027.

It is anticipated that regulatory responsibilities for laboratory quality and safety will transfer to MWL, while the new integrated CSS will operate under a shared clinical governance structure. Oversight will be provided by the joint executive medical director, ensuring effective coordination of regional and local priorities.

Within WHH, clinical haematology (consultants, nursing, and administrative teams) will remain locally managed within the integrated CSS, ensuring continuity of specialist services. Phlebotomy services are also included in the CSS integration, with BCH staff phased into the new CBU. A draft PID is being developed to confirm accountability, timelines, and delivery plans for a single, efficient and patient-centred phlebotomy service.

Despite the organisational and contractual changes, there will be no material impact on patient experience or clinical service delivery, ensuring continuity of safe, high-quality pathology services throughout the transition.

10.7.2.4 Breast screening

The breast screening service will remain within CSS in its current form. The mobile screening unit, which operates under regional branding, will continue to deliver screening services on behalf of the wider programme, maintaining current governance and operational arrangements.

10.7.2.5 Therapies

WHH Therapy services, including physiotherapy, occupational therapy, speech and language therapy, orthotics, dietetics, heart failure and stroke nursing, exercise physiology, and support staff, will continue within the CSS CBU at day one to maintain continuity of care. BCH therapy services will transfer to the new Community and Dental CBU on 1 April 2026.

As part of the phased approach, there is significant opportunity over time to review, optimise, and realign therapy structures and pathways in line with the NHS 10-year plan and emerging neighbourhood health models. From April 2026, a structured programme of full integration will focus on developing seamless acute–community therapy pathways and management structures that enhance patient flow, reduce duplication, and improve rehabilitation and reablement outcomes.

10.7.2.6 Infection prevention and control (IPC)

IPC services across WHH and BCH will be fully integrated from day one under a single operational and governance structure. This will ensure consistent infection control standards across all care settings, strengthen outbreak management and surveillance, and enhance audit, education, and assurance processes across the merged organisation.

10.7.3 Summary and overview of clinical pathway integration

Figure 27 provides a high-level overview of the proposed alignment of services within the two new Clinical Business Units (CBUs): the new Community and Dental CBU and the integrated Clinical Support Services (CSS) CBU. It sets out the proposed structure from day one and highlights the phased opportunities for service integration that will support more seamless care delivery across community and acute settings.

The new Community and Dental CBU will bring together a range of existing community-based and specialist nursing services currently delivered by BCH. These include adult community and district nursing, children's specialist and paediatric services, health visiting and school nursing, audiology, and wellbeing services. The formation of this CBU establishes a coherent framework for the delivery of integrated community care, strengthening local provision and supporting population health management.

Building on this foundation, the diagram identifies phase one priority clinical pathways where integration offers the greatest immediate impact and will be considered as part of priority pathway workstreams. These include services such as heart failure, dermatology, infant feeding, specialist palliative care, and bladder and bowel care. Each of these pathways represents a highlighted key area where improved coordination between community and acute teams can deliver tangible benefits for patients through more consistent management, reduced duplication, and enhanced continuity of care.

Further phase two opportunities for integration are also illustrated. These encompass multidisciplinary services such as falls and rehabilitation, single point of access, urgent community response (UCR), adult and children's therapies, and neurorehabilitation. These areas will be explored in subsequent phases once the foundational integration work is embedded, enabling the model to evolve in a controlled and sustainable way whilst maintaining continuity of existing services.

The integrated clinical support services (CSS) CBU will consolidate cross-cutting clinical support functions that underpin both community and acute delivery. Specific services situated within BCH will be integrated from day one, including pharmacy, infection prevention and control, pathology and radiology. The other pre-existing CSS services operating with WHH will continue into the new CSS CBU. Their integration under the CSS CBU will further strengthen consistency, efficiency, and quality across organisational boundaries.

It should be noted that the service list presented in the diagram is not exhaustive, and certain services have been grouped together to provide a high-level strategic overview. There are likely to be specific complexities relating to contracting and commissioning arrangements that will need to be addressed as the integration develops — for example, the transfer of some pathology staff to MWL. As the integration programme progresses, further detailed mapping and analysis will be undertaken to confirm the inclusion of additional services and to refine the associated operational, governance, and workforce arrangements.

This phased approach ensures that the development of the CBUs is both pragmatic and progressive, enabling early wins through targeted pathway integration, while establishing a robust framework for longer-term transformation across the wider clinical and community system.

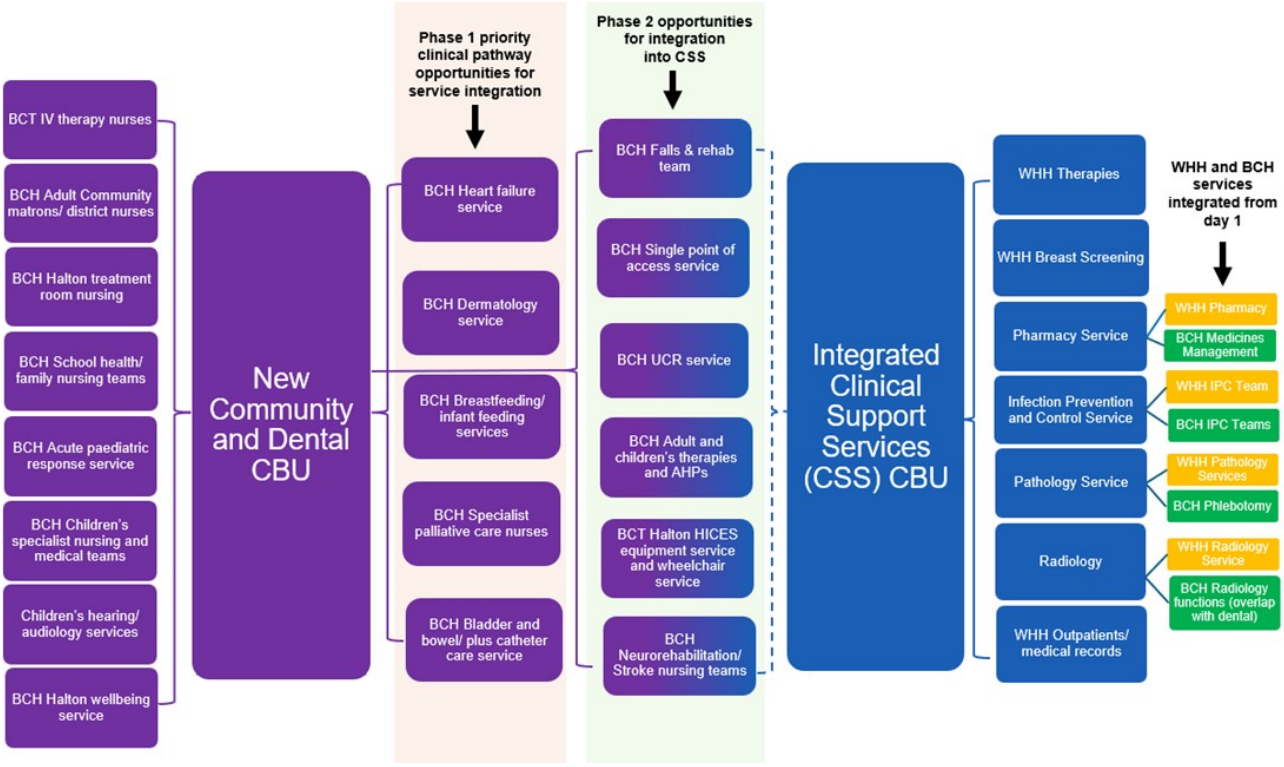


Figure 27: Visual showing planned integration of clinical support services

10.8 Research and development

As part of our integration programme, we are establishing a joint research growth strategy designed to strengthen, expand and align research capability across acute and community settings. The Integration represents a key opportunity to create a single, system-wide approach to research delivery that enhances patient outcomes, attracts investment and supports long-term sustainability.

The integration presents multiple opportunities to expand and enhance the research capabilities of the new organisation through:

- **Expanding patient access** to clinical research opportunities across both hospital and community settings, ensuring equitable participation for all populations, including underserved groups.
- **Improving the ability to apply for and deliver a greater volume of clinical trials**, supported by integrated governance, streamlined processes and shared expertise.
- **Developing multidisciplinary staff** to increase the number of qualified principal investigators and strengthen the overall research leadership pipeline.
- **Growing the academic portfolio** to support recruitment, retention and professional development of clinicians, nurses, midwives and Allied Health Professionals.
- **Expanding the research footprint** by leveraging WHH's infrastructure such as the Halton Clinical Research Unit (HCRU), alongside BCH's access to diverse community populations.
- **Increasing the number of HCRU-delivered trials** and extending capacity to host high-value, phase II/III studies.

- **Growing annual commercial research income**, enabling continued reinvestment into infrastructure, workforce and study delivery.

WHH brings a proven track record in commercial research, having generated over £4.8 million since 2021 through delivery of large-scale industry-sponsored trials across specialties including gastroenterology, respiratory medicine, rheumatology and maternity.

BCH complements this with recognised expertise in community-based and oral health research, as well as strong engagement of NMAHPs in early-career research and education. Together, these complementary strengths create a balanced and scalable platform for future growth.

The partnership also aligns strategically with the newly established **NIHR Commercial Research Delivery Centre (CRDC)** hosted by the University Hospitals of Liverpool Group. Participation in the CRDC will enable WHH and BCH to attract prestigious commercial trials, enhance visibility across the Cheshire and Merseyside region, and increase access to cutting-edge research for local patients.

Integrated governance and risk management structures will ensure regulatory compliance, operational resilience and financial stability. Shared infrastructure, joint governance frameworks and coordinated staffing models will reduce duplication, optimise use of resources and create capacity for larger, more complex studies.

Ultimately, the integration will deliver a more connected and equitable research ecosystem that drives innovation, improves patient outcomes and contributes to workforce development across the health system.

The combined strengths of both organisations will enhance the position of the new Trust in clinical and applied research, capable of delivering sustainable income growth, supporting national NIHR priorities, and embedding research as a core component of high-quality patient care.

11.0 Corporate Support Functions

11.1 Chapter summary

This section details the approach to integrating the corporate services that underpin effective delivery across the new organisation. It outlines the benefits of unified functions in areas such as finance, workforce, digital, estates, governance, communications, and demonstrates how alignment will create efficiencies, eliminate duplication and strengthen resilience.

The section also highlights the importance of maintaining continuity during transition, supported by joint governance structures and shared best practice from both Trusts.

Key message: Integration of support functions creates a unified backbone for the new organisation — improving efficiency, reducing duplication, and enhancing service quality.

By standardising systems and processes, the new organisation will deliver greater value for money and ensure a consistent, high-quality service across all operational areas.

11.2 Corporate support integration – our approach

The integration of all corporate functions across both WHH and BCH will be guided by principles of safety and efficiency. Alongside this, we will ensure that future services are fit for purpose and able to provide the appropriate corporate support to clinical teams and the wider organisation and respond quickly to changing demands and needs.

The approach to integration will follow the phased plan as set out in section 7.6, ensuring that both short-term continuity (from day one) and medium to long-term transformation are achieved.

The work to integrate all support functions is overseen by the corporate services integration workstream within the Better Care Together programme governance (see section 7.2).

11.3 Financial opportunities within corporate service

The latest 2024/25 data from the NHS Model Health System website highlights the significant opportunities that exist for financial improvement through the integration of the corporate functions across WHH and BCH. Bringing two sets of corporate teams together formally, unlocks economies of scale that are not available to the organisations in their current form.

The supporting documents provides further detail at corporate sub-function level but in total there is estimated to be around £8m of recurrent financial improvement to be achieved if the combined corporate service costs of the two Trusts were to reduce to the median levels recorded across the country (see section 13.3.1 for links to overall financial benefits).

If the integrated organisation was to be able to go beyond this and deliver costs in line with national lower quartile performance, there would be further potential savings of around £9m (in addition to the £8m) to be achieved. It should be noted that the vast majority of providers reporting lower quartile corporate costs are much larger organisations (£1bn+ turnover).

11.4 A three phased approach to integrating corporate services

Section 7.6 details the three-phased approach to the integration programme, the following sections detail how the plan for integrating corporate services will follow that approach.

11.4.1 Phase 1 – the period up to 31 March 2026

In the pre-transaction period, the focus of the work around integrating corporate services will be around planning and preparing the future service models. The key part of this will involve bringing the teams from the two partner organisations together to start to familiarise themselves with each other's services, processes and ways of working. All corporate teams will work to align business-critical systems and processes as part of phase one, to ensure a smooth transition into a single service supporting both acute and community services immediately following the transaction date.

Alongside the work to align processes, initial transitional structures for each service that will become effective immediately following the formal transaction date, will be developed and agreed following formal consultation.

11.4.2 Phase 2 – 1 April 2026 to 31 March 2027

In the 12-month period following the transaction, the challenge for all corporate services will be to embed all immediate changes and ensure smooth and effective delivery of all corporate support functions to the newly integrated organisation. In addition, each service will be expected to start to unlock the known financial opportunities and begin to bring the combined corporate costs down to median national performance (as a minimum). The launch of mutually agreed resignation scheme (MARS) across both BCH and WHH in November 2025 will help to expedite this.

11.4.3 Phase 3 – 1 April 2027 onwards

By April 2027, it is expected that the integrated corporate services will be running smoothy and cost-effectively and working towards national median cost performance based on model health benchmarking.

From this date onwards, the challenge will be to review the latest national benchmarking information each year to check progress and drive further efficiency if required. Corporate teams should also start to consider the implications of moving further towards lower quartile national benchmarking levels in future years. In order to achieve this, it is likely that shared service corporate models may need to be explored, potentially as part of the work around the Cheshire and Merseyside provider blueprint (see section 5.10.2).

11.5 Transitional arrangements and target operating models

Transitional arrangements will be put in place to ensure a smooth transition from legacy structures to the new integrated model. This will involve the establishment of a transitional structure for both governance and staffing by day one of the transaction, in line with TUPE law. Much of the transition will be a "lift and shift" process, ensuring minimal disruption to ongoing operations. Following this, a wider service redesign will be completed once the clinical structures have been finalised, ensuring that support functions are reflective of the organisation's needs and aimed at delivering high-quality patient outcomes.

11.6 Organisational change framework

An organisational change framework has been developed to ensure that the integration processes reflect our legal and statutory requirements. This framework includes comprehensive governance arrangements to ensure compliance and oversight. The ambition is to have a transitional structure in place for both governance and staffing by day one of the transaction, ensuring continuity and stability.

11.7 Governance arrangements

Governance arrangements are being incorporated into the integration process to ensure that all legal and statutory requirements are met. This includes the establishment of clear governance structures and processes to oversee the integration and ensure accountability across the length of the programme.

11.8 Staff consultation

Formal staff consultation around the initial integration of services will commence in November 2025 and run for a period of 3-4 months to ensure that it is meaningful and inclusive. During this period, transitional structures may adapt based on feedback and evolving needs. However, governance arrangements will remain in place to ensure stability and compliance throughout the transition.

11.9 Integration of Corporate Governance services

11.9.1 Vision for an integrated Corporate Governance service

The vision for the integrated corporate governance service is to create a single, resilient team that supports the integrated organisation with robust governance, compliance, and assurance. By bringing together the expertise and resources of WHH and Bridgewater, the new service will enable effective decision-making, transparency, and accountability across all levels of the Trust. The integrated team will foster a culture of continuous improvement, partnership working, and shared learning, ensuring that governance arrangements are fit for the future and aligned with the strategic objectives of the new organisation.

This approach will help the Trust to meet statutory and regulatory requirements, support the Board and its committees to facilitate high-quality services to patients and communities. The integrated governance service will also play a key role in supporting transformation, risk management, and stakeholder engagement.

The draft transitional structure is included within the supplementary information to this document.

11.9.2 Scope of corporate governance services

Service Area	Description
Board and Committee Support	Secretariat, agenda planning, minute-taking, action tracking
Statutory Compliance	Annual reporting, regulatory submissions, licence management
Risk Management (BAF)	Board assurance framework management
Corporate Governance Policy and Procedure	Development, review, alignment of policies and procedures
Corporate Records Management	Information governance, records retention, FOI coordination
Stakeholder Engagement	Governor and member support, public engagement, communications
Legal and Transactional Support	Due diligence, co-ordination of legal advice
Training and Development	Governance training for staff and Board members

Table 23: Core duties of the integrated corporate governance team

11.9.3 The key integration objectives for the integrated Corporate Governance team include:

- Ensure effective and compliant governance across the new organisation
- Support the Board and committees with timely, accurate information and assurance
- Align policies, procedures, and systems to enable seamless operations
- Align Board Assurance Framework
- Facilitate stakeholder engagement and transparent communications
- Enable continuous improvement and shared learning
- Deliver efficient, cost-effective corporate governance services

WHH and BCH already have a number of Board sub-committees working as joint committees in common and already have a number of shared Executive Director posts in place.

11.9.4 Current challenges and opportunities – Corporate Governance

Challenges:

- Aligning different governance cultures, policies, and systems
- Managing capacity and workload during transition
- Ensuring continuity of statutory compliance and assurance
- Integrating digital systems and records management
- Addressing resource gaps and vacancies in both teams

Opportunities:

- Streamlining processes and reducing duplication
- Sharing best practice and expertise across both organisations
- Enhancing resilience and flexibility of the governance function
- Improving stakeholder engagement and communications
- Supporting transformation and innovation in corporate governance

11.9.5 Success criteria – Corporate Governance

- ✓ Seamless transition to a single, integrated governance team with minimal disruption to statutory compliance and Board assurance.
- ✓ Alignment of policies, procedures, and governance systems across the new organisation within agreed timescales.
- ✓ Improved efficiency and effectiveness of Board and committee support, evidenced by timely agendas, accurate minutes, and clear action tracking.
- ✓ Enhanced risk management, with a unified risk register and robust incident reporting processes.
- ✓ Positive feedback from Board members, governors, and stakeholders regarding the quality and responsiveness of governance support.
- ✓ Achievement of regulatory and accreditation standards, with no adverse findings from external audits or inspections.
- ✓ Establishing an effective Board assurance framework (BAF).
- ✓ Increased staff engagement and participation in governance training and development.
- ✓ Delivery of cost savings or resource efficiencies through streamlined processes and reduced duplication.
- ✓ Evidence of continuous improvement, innovation, and shared learning within the governance function.

11.10 Digital services integration

11.10.1 Vision for an integrated Digital service

Our vision is to establish a fully integrated digital services that bring together acute and community capabilities under a single, collaborative digital team structure. Creating a single, seamless digital service that connects acute and community care, enabling our workforce to access the right information, in the right place, at the right time, delivering safer, more coordinated, and patient-centred care across the system.

The integrated service will deliver a unified digital infrastructure, shared data environment, and support services with a consistent user experience, allowing staff across all care settings to work as one team. By aligning technology, information, and processes, we will improve care continuity, efficiency, and population health outcomes, while reducing duplication and operational silos.

Through this approach, the digital service will function as an enabler for transformation, supporting the move towards integrated care delivery, data-driven decision-making, and a sustainable, paper-light Trust.

The transitional structure is included within the supplementary information to this document.

11.10.2 Scope of Digital services included

Service Area	Description
Digital Strategy & Governance	Development and delivery of the Trust's digital strategy, ensuring alignment with organisational priorities, national digital standards, and ICS

Service Area	Description
	integration initiatives. Oversees governance, compliance, and benefits realisation.
Clinical Systems/EPR	Management, optimisation, and support of clinical systems including Electronic Patient Record (EPR) and associated clinical applications across the Trust. Ensure interoperability and continuity of care.
Data & Analytics	Provision of data warehousing, reporting, business intelligence, and advanced analytics. Supports operational performance, population health, and decision-making through accurate and timely information
Infrastructure & Networks	Delivery and maintenance of core IT infrastructure including data centres, cloud services, network connectivity, Wi-Fi, and device management. Ensure resilience, scalability, and business continuity.
Desktop Support	Management of user devices, desktop/laptop provisioning, mobile device management, and end user support via service desk and field engineering teams. Focus on user experience and responsiveness.
Cyber Security & Information Governance	Protection of information assets through cybersecurity monitoring, risk management, and compliance with NHS DSPT and IG standards. Works in partnership with Information Governance whilst ensuring digital clinical safety.
Unified Communications & Collaboration	Delivery of communication and collaboration tools (email, telephony, MS Teams, video, messaging) to enable flexible and efficient working across acute and community settings.
Records Management & Scanning Services	Delivery of EDMS, records digitisation, retention and destruction policies, and digital archiving to support the Trust's transition to paper-light working and BS 10008 compliance.
Programme & Project Delivery	Oversight and delivery of digital projects and programmes, ensuring alignment with Trust strategy, governance compliance, and benefits realisation.
Service Management & Performance	End-to-end service management including SLAs, incident/problem management, capacity planning, and continual service improvement across all digital functions.
Training and Digital Enabled Workforce	Ensuring confident digitally literate staff, digital skills assessments, learning and development and support from Digital advocates.

Table 24: Core duties of the Digital services included

11.10.3 The key integration objectives for the integrated Digital team include:

The integrated digital team will deliver a unified, system-wide digital service that supports safe, efficient, and joined-up care for all stakeholders across acute and community settings.

The key integration objectives are to:

- Create a single, unified digital service - Establish one integrated digital operating model with shared leadership, governance, and standards.
- Enable seamless care through shared systems and data - Align clinical, corporate, and data systems to support continuity of care and improved access to information across all sites.
- Optimise resources and reduce duplication - Consolidate contracts, infrastructure, and support functions to improve efficiency, enable transformation, and maximise value for money.
- Provide a consistent user experience - Deliver standardised support, digital tools, and processes to ensure all staff receive the same high-quality service, empowering patients with access to their information.
- Strengthen data, security, and compliance - Align data governance, cyber security, and information management standards to ensure resilience and compliance.
- Drive innovation and digital maturity - Create capacity for innovation and transformation, supporting continuous improvement and readiness for AI and wider future system integration.

11.10.4 Current challenges and opportunities – Digital services

Challenges

- Fragmented digital teams and systems - Separate acute and community digital services lead to duplicated effort, inconsistent processes, and limit interoperability between systems.
- Inconsistent user experience and support - Variability in service levels, IT support, and capabilities reduces efficiency and hinders adoption across BCH and WHH teams.
- Limited data integration for patient pathways - Disconnected systems make it difficult to share patient information, track outcomes across care settings, or analyse population health effectively.
- Resource and capacity constraints **-** Recruitment and retention challenges, with limited digital staff capacity and competing priorities make it challenging to deliver the integration, manage infrastructure changes and deliver the new service.
- Financial pressures and contract inefficiencies - Multiple contracts for infrastructure, hosting and applications increase costs, duplication and limit flexibility for shared EPR’s and digital service models.
- Change fatigue and cultural differences - Differences in organisational culture, process maturity, and readiness for digital change could slow integration and adoption of shared systems.

Opportunities

- Integrated acute and community digital service - Consolidating digital teams and governance across WHH and BCH will streamline delivery, reduce duplication, and improve accountability.
- EPR convergence and shared instance - Moving toward common EPR systems allows consistent workflows, enables further interoperability, and real-time access to patient information across acute, community services and wider place partners.
- Enhanced data, analytics, and reporting - Integrated data platforms enable population health management, pathway optimisation, and system-wide insights for decision-making.
- Consistent user experience across our services - Standardised tools and processes improved digital adoption and productivity, and user satisfaction across our pathways services.
- Efficiency and financial sustainability - Rationalising infrastructure, contracts, and support services will reduce costs, free investment capacity, and supports a sustainable integrated digital model.
- Acceleration of digital innovation - A shared digital service facilitates the adoption of digital transformation initiatives, automation, and innovative technologies to improve care delivery and patient outcomes.

11.10.5 Success criteria – Digital services

- ✓ Integrated service delivery - single integrated digital team operational adherence to agreed governance framework.
- ✓ EPR and system availability - shared EPR instances offer reliable, easy access with standard workflow experience.
- ✓ Data availability and quality - >95% data quality, seamless information sharing between acute and community services, analytics driven decisions new FDP functionality.
- ✓ User adoption and satisfaction - >85% staff adoption positive user satisfaction ratings; support tickets reduced over baseline.
- ✓ Operational efficiency and cost optimisation - reduction in duplicated systems/contracts measurable cost savings achieved.

11.11 Workforce team integration

11.11.1 Vision for an integrated Workforce service

The integration of workforce services across BCH and WHH is designed to deliver a comprehensive and consistent approach to people management, supporting the NHS People Plan, statutory requirements and organisational priorities. The integrated service will continue to be responsible for providing core HR, organisational development, staff engagement, workforce planning, recruitment, education and training, EDI and wellbeing functions, ensuring a positive and inclusive working environment for staff and high-quality care for patients.

Both organisations operate within a robust governance framework, with clear reporting lines, performance monitoring and a commitment to equality and health inequalities impact assessments. The integration will align systems, key

performance indicators and leverage best practices from both organisations, ensuring efficient use of resources, improved service delivery and enhanced staff experience.

The transitional structure is included within the supplementary information to this document.

11.11.2 Scope of Workforce services

Service Area	Description
Apprenticeships and Widening Participation / Talent for Care	Supporting and implementing government and local initiatives in relation to apprenticeships, work experience and work placements.
Employment Services	End-to-end recruitment support to managers, managing return to practice process for AHPs and nursing, supporting international recruitment for nurses and clinical fellows, running the medical bank and non-nursing agency requirements. In addition, supporting the effective running of rostering services.
Human Resources (HR)	Working in partnership with the organisation on a wider range of people management, employee relations, deployment and development matters. Providing managers and employees with specialist expertise, information, guidance and advice.
Learning and Development	Supporting mandatory and role specific training as well as corporate induction across the organisation.
Medical Job Planning	Supporting and facilitating the job planning process for medical staff across the Trust. Providing specialist advisory support regarding the job planning framework and system.
Mental Wellbeing Hub	Inhouse staff counselling and wellbeing services to support the mental wellbeing of the workforce.
Occupational Health and Wellbeing	Specialist clinical service providing a targeted, proactive and accredited support system for staff.
Organisational Development (OD)	Specialists in developing interventions and programmes to support leaders and teams in creating a compassionate and inclusive culture to enable individuals to thrive in the workplace.
ESR Helpdesk	Manage ESR data quality ensuring information is accurate, managing expenses system and processing payments. In addition, project manage the transition to the new national workforce system.
Culture and Equality, Diversity and Inclusion (Workforce)	Supporting staff networks and statutory duties relating to workforce equality, diversity, inclusion and human rights related issues and developments.
Culture and Staff Engagement	Lead and support staff voice, feedback, reward and recognition and staff experience initiatives across the organisation.
Workforce Information	Manage and create Trust level reporting for the Workforce Dashboard with key people metrics, manage the infrastructure of these reporting systems and provide other daily, weekly and monthly reporting for both national returns and locally required reports.

Service Area	Description
Clinical Education and Resus Services	Leads the development of a skilled, confident and compassionate clinical workforce capable of delivering outstanding patient care. This multi-professional team provides structured education and training across the career lifecycle, from student placements to post-registration development, ensuring staff have the clinical and non-clinical competencies required to thrive in their roles.
Medical Education	Leads the development of a skilled, confident and compassionate medical workforce capable of delivering outstanding patient care. This dedicated team provides structured education and training across the career lifecycle, from undergraduate placements to postgraduate specialty training, ensuring doctors have the clinical and professional competencies required to thrive in their roles.

Table 25: Core duties of the Workforce services

11.11.3 The key integration objectives for the integrated Workforce team include:

- Inclusive recruitment and retention - become a local employer of choice, attracting and retaining talent to deliver the new organisations aims.
- Development of a robust people strategy to meet the future priorities of the organisation and NHS 10-year plan.
- Development of a robust workforce equality, diversity and inclusion strategy which achieves the NHS equality, diversity and inclusion improvement plan.
- Development of a leading career development programme, ensuring our workforce have the skills, behaviours and capability to respond positively to a changing health and social care environment.
- Create a pre- and post-integration organisational development and organisational design programme which supports managers and leaders to have the skills for their teams to thrive through change.
- Integration of the two electronic staff records systems and project manage the transition to the new national workforce system.
- Delivery of the joint culture plan to support all our workforce to have a good day at work.

11.11.4 Current challenges and opportunities – Workforce services

From a workforce and people perspective, the integration presents both challenges and valuable opportunities. One of the key challenges lies in balancing the delivery of transformational change alongside maintaining business-as-usual activity. Current workforce capacity is limited and there is a risk that progress on transformation could impact the quality and consistency of ongoing operational services. This has been carefully managed and a dedicated role has been put in place to support the workforce and HR elements of integration.

High levels of sickness absence across the workforce continue to affect productivity, service continuity and staff wellbeing. Sustained organisational change also carries risks of change fatigue, with potential impacts on morale, engagement and retention of critical roles.

Despite these challenges, the integration offers considerable opportunities to strengthen the workforce function and enhance organisational effectiveness. By bringing together people and workforce teams, the integration can enable more collaborative and efficient ways of working, improve coordination and reduce duplication. There is a significant opportunity to develop and share deeper expertise in organisation development and design, supporting a more strategic and evidence-based approach to shaping services. This includes alignment with the new organisation's values and behavioural framework.

The programme has already demonstrated the value of shared learning, collaboration and professional partnership across teams. Building on this foundation will enable the organisation to make better use of its collective expertise in HR, workforce planning, organisational development, design and leadership, enhancing both capability and capacity. Over time, the integration can also help create a more flexible and resilient workforce model, enabling the more agile deployment of staff and improved alignment of resources with organisational priorities.

Finally, through a more cohesive and connected approach to people management, learning and wellbeing, the integration provides a platform to improve the overall employee experience. This will help strengthen engagement, support retention and contribute to reducing sickness absence levels over time, while embedding a culture of collaboration, learning and continuous improvement across the organisation.

11.11.5 Success criteria – Workforce services

The success of the workforce integration will be evidenced by:

- ✓ Continued improvement in response rates and NHS staff survey results through aligned action plans which consider the quantitative and qualitative results.
- ✓ Improved employee engagement and satisfaction scores which demonstrate improvement in areas relating to communication, leadership and change management.
- ✓ Sickness rates to achieve the Trust target and maintain performance.
- ✓ Achievement of the integrated workforce plan and interdependencies in reporting.
- ✓ Ensure alignment of workforce key performance indicators which consistently achieve the Trust targets.
- ✓ Programme of organisation design developed to support the clinical and corporate transformation programme, as highlighted within this business case.
- ✓ Achievement of statutory returns and requirements for the new organisation.
- ✓ Develop and prepare our workforce to deliver care and services at a system level.

11.12 Finance integration

11.12.1 Vision for an integrated Finance team

Our vision is to become one team delivering expert financial advice and stewardship to the integrated organisation as efficiently and effectively as possible. We also want to use the integration of our two organisations to reduce or eliminate single points of service failure (for example capital management processes) across both Trusts.

Both teams currently use the same ledger (SBS) which will be merged from the 1 April 2026, along with the capital (CARS) and costing system (CIVICA). For the first three months post-integration the teams will work independently to produce the audited accounts for the individual Trusts whilst coming together to undertake a combined month 1 position. Following the production of the accounts the team will become co-located and continue to work flexibly with hybrid working. Integration and culture change takes time, and the senior team will support this with staff training & development, regular communication and away day sessions. The team will work towards becoming an award-winning level 3 accredited team.

The draft transitional structure is included within the supplementary information to this document.

11.12.2 Scope of Finance services

Service Area	Description
Financial Planning	Strategic financial planning using patient-level costing and national benchmarking to inform strategic decision-making.
Improvement and performance	Relentlessly exploring commercial development and financial improvement opportunities to support long-term sustainability.
Management Accounting	Budget setting, management and monthly reporting to keep the organisation on track financially and identify emerging financial challenges as early as possible.
Financial Services	Treasury management of organisation including cash flow, capital and all external financial reporting.
Procurement	Constantly ensuring value for money through commercial contracts and purchasing. Also, includes stores, receipts and distribution.
Clinical Coding	Ensuring the accurate and timely coding of all recorded clinical activity to support appropriate income maximisation and external reporting.

Table 26: Core duties of the Finance services

11.12.3 The key integration objectives for the integrated Finance team include:

- Annual accounts for external submission
- Monthly submissions to ICS and NHS England
- Contribution to internal Board performance and finance committee reporting
- Charity Accounts for external submission

- National Cost Collection for external submission
- Contribute to system working across Cheshire and Merseyside and the North-West
- Working collaboratively across all teams in the integrated Trust and supporting operational teams
- Contribute to sustainability plans and ensure value for money
- Develop and maintain a highly professional and competent team

11.12.4 Current challenges and opportunities – Finance services

Challenges:

- Requirement to complete two separate sets of accounts whilst coming together and simultaneously producing a joint month one position and reports.
- Two separate audit processes (with two sets of auditors) to be managed.
- Possible increased absence, retirement and leavers in teams. Potential for loss of local knowledge.

Opportunities:

- Economies of scale and reduce single point of failure.
- Learning from each other, sharing skills and best practice.

11.12.5 Success criteria – Finance services

- ✓ Unqualified accounts
- ✓ Positive internal audit reviews
- ✓ All key deadlines achieved
- ✓ Working with one single ledger from the 1 April 2026 and all information feeds working
- ✓ Accreditation for new Trust
- ✓ Feedback from away days / staff survey
- ✓ New Board agrees operational plan and budget setting
- ✓ New contracts in place for SBS, CARs, CIVICA, Auditors, insurance etc.
- ✓ Successful transition to new location(s)

11.13 Estates integration

11.13.1 Vision for an integrated Estates team

Our integrated estates and facilities team will provide operational support across the expanded organisation, ensuring that services are provided from clean, safe, and efficient spaces across our portfolio. The team will be responsive to the needs of our staff across acute and community sites and ensure that all sites are accessible and welcoming for our patients. Strategically our integrated team will work across our expanded geography, supporting the Trust's aim of home, first, community second and hospital only when necessary.

The transitional structure is included within the supplementary information to this document.

11.13.2 Scope of Estates services

Service Area	Description
Management and maintenance of new and existing Trust assets	Maintenance and repair of Trust physical assets, management of major Trust capital projects (strategic and infrastructure), management of backlog maintenance, and overall estates portfolio
Leadership and management of environmental sustainability	Management of overall environmental sustainability and development and delivery of green plan
Compliance with all statutory and mandatory requirements	Fire safety, cleaning standards, waste management and recycling, grounds and gardens maintenance
Management of the Trust's catering service	Including all patient, staff and retail catering offers across the sites
Management of site access and security	Including car parking, site security, staff ID badges and associated access control
Management of patient movement and transport services	Including portering, patient and staff transport, and equipment logistics services
Management of equipment maintenance and storage	Including medical engineering and maintenance and distribution of medical devices
Management of linen and laundry services	Including all site linen and laundry services and staff uniforms
Management of inbound telephony services	Including hospital and community site switchboard

Table 27: Core duties of the Estates services

11.13.3 The key integration objectives for the integrated Estates team include:

- Align the estate to the clinical strategies and underpin the Trust's values and objectives.
- Reduce backlog maintenance and critical infrastructure risks.
- Enable the delivery of clinical and operational services and sustainability.
- Improve functional suitability and net zero target.
- Improve utilisation of estate.
- Improve compliance with health building notes and health technical memorandums.
- Provide a solid platform to prioritise investment and prepare for future opportunities.
- Support the ambitions of Warrington and Halton as growing boroughs, focussing on regenerating built and natural environment and reducing health inequalities.

11.13.4 Current challenges and opportunities – Estates services

Challenges:

- WHH estates services are predominantly focussed on a small number of larger sites with many facilities management services delivered in-house. BCH estates services are predominantly focussed on a large number of smaller sites with many facilities management services delivered via

external contracts. The two estates teams function in different ways and therefore need to understand each other's challenges and ways of working.
- Some opportunities for financial benefits through bringing externally contracted services in-house may prove not to deliver benefits due to NHS terms and conditions.

Opportunities:
- Evolving neighbourhood health plans across both Warrington and Halton creates the opportunity to review and potentially rationalise use of estate.
- Underutilisation of space across both organisations is an opportunity to review and either improve use or rationalise.

11.13.5 Success criteria – Estates services

- ✓ All staff have access to sites as required.
- ✓ Operation of a unified estates helpdesk.
- ✓ Singular reporting as an integrated organisation from 1 April 2026.
- ✓ Integrated estates contracts and asset registers in place.
- ✓ Approved single capital programme agreed for integrated organisation.
- ✓ Consolidation of sites and reduction in spend on leases wherever appropriate.
- ✓ Reduced spend on external facilities management contracts.

11.14 Communications and Engagement team integration

11.14.1 Vision for an integrated Communications and Engagement team

Our vision is to work together and in partnership with our colleagues, patients and communities to deliver a proactive and strategic communications and engagement service that supports better care, stronger relationships and has a lasting impact.

The draft transitional structure is included within the supplementary information to this document.

11.14.2 Scope of Communications and Engagement services

Service Area	Description
Public affairs	Manage relationships with the government, policymakers and regulatory bodies to support organisational goals.
Patient and public engagement and consultation	Involve patients/public in relation to new services and service change.
Stakeholder engagement	Build and maintain positive relationships with key individuals/groups.
Brand and reputation management	Protect and enhance the Trust's identity and profile internally and externally.
Campaign development	Create targeted comms initiatives to raise awareness and promote services.
Internal communications	Ensure staff are informed, engaged and support Trust values and priorities.

Service Area	Description
Strategic communications	Plan and deliver comms that support long-term organisational objectives.
Media relations	Manage relationships with media outlets to achieve positive and accurate coverage.
Digital communications	Use online platforms to share information and engage audiences.
Patient information	Produce accessible materials to help patients understand their care, treatment and services.
Film, photography and design	Create visual content to support Trust communications.
Communications and engagement strategy	How the organisation communicates and supports future strategic plans.
Staff awards event management	Organise annual staff awards to recognise and honour achievements.
Hospital charity communications and engagement support	Comms and engagement support for the organisation's WHH Charity.

Table 28- Core duties of the Communications and Engagement services

11.14.3 The key integration objectives for the integrated Communications and Engagement team include:

The Communication and Engagement Team's primary objectives and responsibilities will be to:

- Provide communications and engagement support for the overall BCT integration programme and subsequent integrated organisation. This includes the Trust rebrand and associated communications.
- Provide support to engage patients, Trust governors, carers, and communities in Warrington, Halton and surrounding areas, to ensure their voice is used to help influence decisions on service design and strategy development. This includes public consultations, managing patient reference groups and forums, and attending events when required.
- Develop accessible and inclusive patient information, leaflets and resources.
- Keep staff updated and engaged via internal communications channels, news bulletins and digital platforms.
- Manage the reputation and brand of North Cheshire and Mersey NHS Foundation Trust / handle crisis communications.
- Promote the Trust's services and initiatives externally through the media, social media, websites, stakeholders and events.
- Develop a proactive and strategic approach to the communications and engagement service, objectives and growth.
- Develop communications and public relations campaigns for the Trust.
- Support other teams and departments with their communication needs, e.g. campaigns, digital work, essential branded materials, governance requirements. This also excludes our external services when needed.
- Provide briefings, speeches and presentations for our Trust executives and Board members as required.

- Maintain and uphold NHS and Trust identity guidelines (e.g. branding and style guide), statutory accessibility requirements and health literacy standards.
- Support system-level communications including ICS/NHS North West.
- Manage the communications for WHH Charity.

11.14.4 Current challenges and opportunities – Communications and Engagement services

Challenges:

- Due to the differences in acute and community requirements there are likely to be variations in communications support and the level of service provided to other departments by each team that need to be worked through. Prioritisation of communications requests across acute and community services that may be different to previous expectations. Any variances will be considered and an aligned comms offer agreed.
- Effective segmentation of staff groups will be required to achieve effective internal communications across a larger and more dispersed workforce.
- Team members will need to adapt to different working styles and patterns.
- Ensuring communications reach patients and service users with limited access to mainstream communication channels.
- Ensuring communications reach staff working with underserved populations, including those in outreach, safeguarding, and community-based roles, will be critical to maintaining equity in messaging and engagement.

Opportunities:

- Ability to pool resources and share skills and individual specialisms where they will be of the greatest benefit.
- Reduced duplication – both internally within the team, and externally e.g. patient engagement approaches (our organisations largely cover the same communities).
- Creation of a new joint communications and engagement strategy and service model offer that truly meets the needs of a modern, integrated acute and community health provider aligned with 10-year plan priorities.
- A stronger, more unified voice across acute and community services, improving clarity and consistency in messaging to patients, staff, stakeholders and local communities.
- Improved stakeholder engagement through coordinated campaigns.
- Enhanced internal communications that support a more connected and informed workforce.
- Ability to co-design messaging with communities experiencing health inequalities, ensuring that campaigns are culturally relevant, accessible, and emotionally safe.
- Potential to improve responsiveness in managing media relations and crisis communications, as well as capacity to be more proactive in generating positive comms for the benefit of the Trust.
- Further opportunities will be explored as the team integration progresses.

11.14.5 Success criteria – Communication and Engagement services

✓ A unified team delivering a single high quality service offer.

- ✓ Communications channels will be fully integrated to reduce duplication, and engagement with our patients and public will happen in a coordinated manner.

Key communications metrics to evidence success are highlighted in the communications section of this case (see chapter 15).

11.15 Clinical Governance team integration

11.15.1 Vision for an integrated Clinical Governance team

The vision for the integrated clinical governance team is to create a unified, transparent, and accountable infrastructure where teams collectively ensure safety, quality, and excellence in patient care. A single leadership structure bringing teams together reduces variation, promotes effective, sustainable coordinated services and excellence in delivery of clinical governance across the Trust.

The draft transitional structure is included within the supplementary information to this document.

11.15.2 Scope of Clinical Governance services

Service Area	Description
Risk and Patient Safety	Management of the incident reporting system and leads on the approach to patient safety in the Trust i.e. patient safety incident reporting framework (PSIRF). Monitoring central alert system alerts, management of risk registers.
Clinical Governance	NICE compliance and clinical policies Compliance – CQC and accreditation
Complaints/Pals	Management of complaints and compliments
Patient Experience	Coordination of systems including friends and family test (FFT) and patient-reported outcome measures (PROMS). Translation and interpretation. Management of volunteers
Legal Services/ Claims	Manage and respond to legal claims, including clinical negligence and personal injury. Liaise with NHS Resolution and external legal counsel. Support staff involved in litigation or inquests. Prepare documentation and represent the hospital at coroner's inquests. Advise clinicians and staff on giving evidence and legal implications

Table 29: Core duties of the Clinical Governance services

11.15.3 The key integration objectives for the Clinical Governance team include:

- Develop an integrated leadership hierarchy structure.
- Ensure clinical functions, systems and processes are coordinated and delivered across the organisation.
- Align and synchronise portfolios of the teams from each organisation into one cohesive team.

11.15.4 Current challenges and opportunities – Clinical Governance team

Challenges

- Establishing a single risk management system.
- Standardising clinical governance systems and processes and sub-committee meetings across the organisation.
- Capacity of clinical staff to align relevant clinical policies by end of March 2026 in line with phase one of the integration programme.

Opportunities

- Create efficiencies and reduce duplication.
- Improved resilience of clinical governance teams.
- Improved communication and responsiveness.
- Improved outcomes – sharing of knowledge and skills

11.15.5 Success criteria – Clinical Governance team

- ✓ Seamless high-quality care. Patient-centred decision making and outcomes.
- ✓ Responsive clinical governance team that supports delivery of organisational strategy
- ✓ Collaborative and engaged workforce.
- ✓ Clear data driven reporting, transparency of decision-making providing assurance to the Board and sub-committees of the Board.
- ✓ Sustainable system integration.

11.16 Data, BI and Performance team integration

11.16.1 Vision for an integrated Data, BI and Performance team

Our vision is to provide a single, trusted source of data and insight to support safe, efficient, and high-quality care, operational excellence, and strategic decision-making. The goal is to unify data, embed analytics in decision-making, and enable improvement at every level — from ward to Board.

There are five core components of our vision:

Integrated Data Platform

- Single data environment (data warehouse) that consolidates data from:
  - EPR and PAS systems
  - Workforce, finance, estates, digital systems
  - National datasets (SUS, HES, Model Hospital, etc.)
- Automated data pipelines to reduce manual collection.
- Common data model and definitions — a “single version of the truth”

Business Intelligence (BI) Layer

- Modern BI tools (Power BI, Qlik) used across the Trust.
- Self-service dashboards with governed access for different user groups:
  - Executives: Board performance, quality, financial sustainability.

    - Operational teams: patient flow, bed occupancy, RTT, theatre utilisation.
    - Clinicians: outcomes, safety metrics, clinical effectiveness.
- Dashboards aligned to national priorities (Elective Recovery, UEC,CDS Quality, Workforce).

Real-Time & Predictive Analytics

- Integrate live feeds from EPR and other operational systems.
- Deploy predictive tools for:
    - Patient flow & discharge planning
    - Demand & capacity modelling
    - Infection or readmission risk

Data Governance

- Strong information governance framework: role-based access, privacy, audit trails.
- Data quality framework: regular checks, automated monitoring, feedback loops.
- Transparency: clear ownership of data and metrics.

Culture & Capability

- Build a data-literate workforce:
    - Training for staff in data interpretation and use.
    - Clinical and operational teams empowered to use self-service dashboards.
    - Encourage data-driven conversations at all performance and quality meetings.
- Promote collaboration between business intelligence, digital, performance, clinical and improvement teams.

The draft transitional structure is included within the supplementary information to this document.

11.16.2 Scope of Data, BI and Performance team services

Service Area	Description

Business Intelligence (BI)	• Modern BI tools (Power BI, Qlik) used across the Trust.
	• Self-service dashboards with governed access for different user groups:
	  ○ Executives: Board performance, quality, financial sustainability.
	  ○ Operational teams: patient flow, bed occupancy, RTT, theatre utilisation.
	  ○ Clinicians: outcomes, safety metrics, clinical effectiveness.
	• Dashboards aligned to national priorities (Elective Recovery, UEC,CDS Quality, Workforce).

Real-Time & Predictive Analytics	• Integrate live feeds from EPR and other operational systems. To support: ○ Patient flow & discharge planning

Service Area	Description
	○ Demand & capacity modelling ○ Infection or readmission risk
Data Governance	• Strong IG Framework: Role-based access, privacy, audit trails. • Data Quality Framework: Regular checks, automated monitoring, feedback loops. • Transparency: clear ownership of data and metrics.

Table 30: Core duties of the Data, BI and Performance team services

11.16.3 The key integration objectives for the integrated Data, BI and Performance team include:

- ✓ To be able to report nationally via integrated sit reps from day one
- ✓ To move to new operating model within 12 months of integration

Level	Function	Example Deliverables
Trust Board / Execs	Strategic insights, benchmarking	Integrated Board Report; IPR national KPI tracking
Care Group / Directorate	Operational and quality management	Divisional dashboards; service line reports
Frontline / Clinical Teams	Local improvement and safety	Real-time ward metrics, SPC charts
Corporate Services	Finance, workforce, digital	Integrated resource and productivity dashboards

Table 31 - Key integration objectives for the integrated Data, BI and Performance team

11.16.4 Current challenges and opportunities – Data, BI and Performance team

Challenges:

- Ensuring that integrated data systems can support population health management and track progress on reducing health inequalities across both Places.
- Aligning data definitions and metrics across acute and community settings to enable consistent reporting on equity, access, and outcomes.

Opportunities:

- Integration will increase skills pool within the team as different products are currently being used in each organisation prior to integration.
- Enable intelligent procurement exercise to arrive at future BI platform of choice taking into account affordability, usability and scalability.
- Streamlining of dashboards to provide the right information, in the right format, at the right time for the new organisation.
- Enhanced use of CIPHA data, which includes Trust level health inequalities dashboards, will enable targeted analysis of variation in access, outcomes,

and experience - supporting Place-based planning and equity-focused decision-making.
- Opportunity to embed population health metrics into core performance reporting, ensuring that system transformation is informed by real-time insights into deprivation, long-term conditions, and service reach.

11.16.5 Success criteria – Data, BI and Performance

- ✓ Integrated sit reps to be submitted from day one.
- ✓ Ability to provide access to relevant dashboards to Executive team, Trust Board and Clinical/Operational management teams from day one.

12.0 Expected benefits and quality impact

12.1 Chapter summary

This section summarises the expected clinical, operational, workforce and financial benefits of integration. It highlights how joining acute and community care will improve patient outcomes, enhance workforce satisfaction, and deliver long-term sustainability.

The section provides an overview of the benefits realisation framework and the approach for monitoring and evaluation. It reinforces that integration will result in better continuity of care, reduced duplication, improved access and greater equity across populations, ensuring that quality and safety remain central to every element of transformation.

Key message: The benefits of integration are significant and measurable. Patients will experience more consistent, joined-up care; staff will benefit from expanded opportunities and shared learning; and the system will achieve greater efficiency and resilience. The benefits realisation framework ensures delivery is tracked, quantified, and sustained over time.

This section covers the expected patient benefits; scale of those benefits and the realisations measured as identified through the initial ideas and 7 early priorities developed through collaborative clinical workshops.

12.2 Key points supporting the patient benefits case

1. **A fundamental shift in care - Home first, then community and hospital only when needed:** The integration will enable holistic, joined-up care closer to patients' homes, with a strong emphasis on prevention and early intervention. This shift supports population health goals by addressing needs upstream and reducing avoidable hospital admissions - particularly for those in deprived or underserved communities.

2. **Enhanced clinical model implementation:** The joint clinical model prioritises seven service areas that span acute and community care. These priorities are designed to reduce unwarranted variation, improve continuity, and ensure that care is tailored to the needs of populations experiencing the greatest health inequalities.

3. **Overcoming operational barriers:** Integration will remove longstanding obstacles such as fragmented IT systems, commissioning arrangements, and governance structures that currently hinder equitable service delivery. A unified approach will enable better coordination and more efficient use of resources, ensuring that patients receive consistent care regardless of geography or provider.

4. **Cross-cutting patient benefits:** Integration will improve patient experience by simplifying pathways and reducing fragmentation. It will also enhance equity of access, directly addressing health inequalities through better use of pooled resources and more consistent service offers, helping to eliminate postcode lotteries and ensure that care reaches those who need it most.

5. **Financial and professional advantages:** The integration is expected to generate financial benefits for the integrated Trust and the wider healthcare system. Without sustainability clinical services will not thrive. Additionally, it will create expanded professional opportunities for staff, drawing on the strengths of both organisations and improving job satisfaction.

6. **Specific clinical improvements:** Building on the seven clinical priorities, integration will strengthen coordination between hospital and community settings, improving outcomes for patients with complex needs and those at risk of exclusion:

    - Frailty services will shift focus to earlier, community-based interventions—reducing crisis admissions and supporting independence, especially in areas with high deprivation and multimorbidity.
    - Infant feeding support will be consistent and specialist-led, improving outcomes for mothers and babies, particularly in communities with lower breastfeeding rates and limited access to early years support.
    - Heart failure services will offer greater access to specialist care closer to home, reducing travel barriers and improving outcomes in areas with high cardiovascular risk.
    - Chronic pain management will be enhanced through coordinated, multidisciplinary pathways—reducing delays and improving quality of life for patients often marginalised in traditional models.
    - Movement disorders and Parkinson's disease care will be more joined-up, ensuring reliable access to medication and continuity of support, especially for those with mobility or transport challenges.
    - Urinary incontinence services will offer timely assessment and treatment, reduce stigma and improve daily functioning particularly for women in communities where access to pelvic health services is limited.
    - End-of-life care will be strengthened through better coordination and personalised support, often delivered closer to home ensuring dignity and compassion regardless of socioeconomic status or setting.

7. **Patient and public involvement:** Patient and public voices are central to service design and monitoring, with engagement already underway through clinical workshops and summits. This is described in further detail in section 10.5.1.

8. **Benefits realisation:** As the programme advances, progress will be tracked through specific indicators and milestones, ensuring accountability for delivery. All workstreams within the BCT programme maintain a detailed tracker recording actions, milestones, risks and benefits. These are updated periodically and reported monthly through to BCT delivery group for assurance around progress.

In summary, the integration of BCH by WHH is predicted to deliver substantial improvements in healthcare delivery and patient outcomes. By addressing current operational barriers and clinical inefficiencies, the integration aims to create a more efficient, equitable, and patient-centred healthcare system. The comprehensive approach outlined in the document underscores the commitment to transforming health services, through vertical integration, for the benefit of the population we serve.

12.3 Summary of patient benefits

12.3.1 Introduction to patient benefits

This section summarises the patient benefits we expect to achieve from integration. Becoming a single organisation will enable us to implement our clinical model, deliver improvement in our clinical priorities, and realise substantial patient benefits.

We are ambitious on behalf of the population we serve and want to transform the way we deliver services to improve the health of Warrington and Halton. Together with our local partners we want to better meet our patients' health needs now and in the future. We will do this by providing integrated, holistic care, closer to patients' homes, with a focus on prevention and early intervention - **Home first, then community and hospital only when needed.**

Although we have seen some early benefits from partnership working to date as part of the Better Care Together programme, integration enables us to take forward more opportunities at a much greater scale and pace than is possible while we are two separate legal entities. The Boards strongly believe that integration is an essential enabler to making these planned changes a reality within the timescale required.

The planned integration will deliver substantial and lasting improvements to the health outcomes and experiences of our local populations as we move to transform our model of care locally. Integration at scale and pace will also expand the professional opportunities available to colleagues, drawing on the strengths of both organisations and improving staff satisfaction. The single organisation will achieve these benefits while also reducing costs for the combined Trust and the wider system.

Although some BCH and WHH services are already working closely together, different IT systems, commissioning arrangements, employment contracts, governance arrangements and fractured clinical pathways limit this collaboration. Integration offers the opportunity to overcome these barriers and secure significant patient benefits in terms of better care and experience. It also enables us to streamline processes and remove duplication to free up clinicians' time for front line care and to work more effectively with system partners.

12.3.2 Cross-cutting patient benefits

The integration presents the opportunity to create a new and exciting joint clinical strategy for the combined organisation.

The seven clinical priorities identified by the clinical and operational integration workstream outline clear patient and population benefits, and the approach taken with these priorities will be used as a future blueprint for all the clinical integration work. As the wider corporate and clinical services identify their integration scope, vision, key milestones and opportunities, they will also define their benefits.

The table below details the cross-cutting benefits that the Trusts have identified as critical benefits from integration:

Benefit	Measure

Patient and Population Benefits **Improved patient experience** by creating services that are less fragmented, across both clinical pathways and geographic areas.	Improved equity of access to health and care services across our places; pooling our resources to remove existing ‘post-code lotteries’, particularly where current disparities and/or health inequalities exist because of historic commissioning decisions.
	Improved patient experience by simplifying pathways and reducing hand-offs.
	Improved accessibility of our services by reducing the number of interfaces encountered by patients and their carers that can act as barriers to the provision of fast and easy access to care.
	Improved continuity of care by aligning the geographic coverage of our service teams and reducing the number of interfaces across care pathways.
	Improved communication with patients, their carers, and across clinical teams by reducing the inter-organisational boundaries along patient pathways that can act as barriers to the provision of consistent and complete information.
Patient and Population Benefits Improvements to patient safety and outcomes	Working with primary care and other partners to support multi-disciplinary team working, so that when people do require care, this is delivered at home or as close to home as possible through a model that has the benefit of ‘acute oversight’ where required, allowing a greater degree of clinical risk to be managed locally. **Home first, then community and hospital only when needed**.
	Establish a universal, Trust wide approach to Quality Improvement (QI) and transformation that utilises our combined expertise and recognises the importance of both standardisations to reduce unwarranted variation, and adaptation to meet the needs of Warrington and Halton.
	Improving the quality of patient care by improving clinical information sharing, enhancing access to specialists in community settings and reducing gaps in specialist clinical knowledge by sharing resources more widely and improving knowledge transfer within teams.

	Sharing resources more effectively to maintain sustainable staffing levels, service delivery integrity and reducing gaps in specialist clinical knowledge, particularly of smaller services.
Wider Benefits to Health and Care System	Simplifying and integrating our care pathways and making it easier for primary, social care and other partner colleagues to access and work with our services to support people in the community to avoid unnecessary deterioration and admissions to hospital.
	Reducing A&E attendances and avoidable admissions to secondary care through reducing the complexity and duplication of our care pathways to always care for patients in community settings when appropriate.
	Inform and shape future system and place strategy development, particularly neighbourhood models, from an integrated acute/community Trust perspective.
	Simplify governance and commissioning arrangements with place and ICB with a single Trust being held accountable for the delivery of equitable safe and high-quality acute and community services.

Table 32: Anticipated public and patient benefits from integration

12.4 Patient and population benefits aligned to clinical priorities

In addition to the cross-cutting benefits described above, the integration will enable delivery of specific patient and population benefits aligned to the seven clinical priorities identified as the start point for the clinical and operational integration workstream. These priorities represent the areas where integration is expected to have the greatest or most urgent impact on outcomes, experience, and sustainability of services.

The benefits identified in this section are grounded in evidence and practice. They draw on the extensive clinical engagement process described in chapter 10, a review of published literature, and insights from clinical integration leads and the clinical summits.

It is important to note that the benefits presented here are initial ideas and early priorities developed through collaborative clinical workshops. They should be regarded as the starting point for a programme of work that will continue to evolve. As the integration progresses, each priority will be supported by detailed delivery plans, refined benefit realisation measures, and evaluation frameworks that will be tested and adapted in practice.

Accordingly, the measures and outcomes set out in the following six tables should not be considered final or fixed. They will develop iteratively through co-design with patients, staff, and partners, and will be subject to ongoing scrutiny and oversight by the Better Care Together delivery group. This flexible approach ensures that the programme remains responsive to patient needs, local system

capacity, and emerging evidence, while retaining clear accountability for the delivery of benefits.

Clinical priority 1 – Frailty response services			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**
Establishment of a single, integrated frailty response model across Warrington and Halton. Brings together acute, community, and primary care teams under shared clinical governance and pathways. Enables rapid, multi-disciplinary assessment and response in the community, reducing duplication and delays.	Improved access to timely and coordinated care for people living with frailty. Reduction in avoidable hospital admissions and length of stay. Enhanced patient experience through continuity of care and care closer to home. Improved support for carers and families.	c. 27,500 people aged 65+ living in Warrington and Halton with moderate to severe frailty.[19]	• Reduction in non-elective admissions for frail older adults • Reduction in average length of stay for frailty-related admissions • Increase in same-day/within 2-hour community response rates • Improved patient and carer experience scores • Reduction in repeat attendances to ED or UCC within 30 days • Increased proportion of people dying in their preferred place of care

Table 33 - Clinical priority 1 – Frailty response services benefits

Clinical priority 2 – Heart failure			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**
Develop an	An integrated service can	Based on NW	Increase in early

[19] CIPHA ICB Frailty Dashboard

integrated heart failure model with a single team serving patients across the pathway and shifting care closer to home. Developing a community diagnostic service for heart failure including standardisation of referral criteria. Developing a community IV diuretics service. Establishing community clinics for heart failure nurses Increasing the scope of heart failure nurses and access to blood results.	create more cohesive care pathways, reduce transitions, and improve continuity of care. Being treated at home rather than in hospital helps with recovery, improves outcomes, and provides a personalised service. Better communication and data sharing between teams can ensure a more personalised and responsive care provision, reducing waiting times for appointments, tests and treatments leading to faster diagnosis and commencement on an appropriate treatment plan. Better and more equitable access to specialised services, expertise, and treatment modalities. Provides patients with more opportunities for education, support and engagement in their care improving their quality of life and self-management of their care pathway. Timely interventions and supportive care reduce mortality risk and need for	England HF prevalence rate of 1.22% estimated HF cases are Warrington 2,600 people and Halton 1,600 people[20]. In the UK approx. 385,000 people are living with undiagnosed and untreated HF and modelling suggests that there are over 1,200 people living in Warrington and Halton[21] [22]. HF accounts for 5% of all emergency hospital admissions in the UK[23]. Since April 2023 784 attendances at WHH ED with HF as primary diagnosis were admitted to a hospital bed. RTT Stats: 1940 patients wating	HF diagnosis rates. Improved recognition of terminal heart failure and initiation of appropriate management plan. Improved quality of life indicators and qualitative patient feedback scores.

[20] Department for Health and Social Care (no date) *Health trends in England: Cardiovascular disease in the North West*. Available at: https://fingertips.phe.org.uk/static-reports/health-trends-in-england/North_West/cardiovascular_disease.html

[21] British Heart Foundation (2020) *Heart Failure: A Blueprint for Change*. Available at: https://www.bhf.org.uk/-/media/files/health-intelligence/heart-failure-a-blueprint-for-change.pdf?rev=f89dedb7c933452e8086cc063ff98c26

[22] Lippi, G. and Sanchis-Gomar, F. (2020) 'Global epidemiology and future trends of heart failure', *AME Medical Journal*, 5(15), doi:10.21037/amj.2020.03.03

[23] NHS Cheshire and Merseyside (2023) *Expanding the use of virtual wards to support heart failure patients in Liverpool*. Available at: https://www.cheshireandmerseyside.nhs.uk/posts/expanding-the-use-of-virtual-wards-to-support-heart-failure-patients-in-liverpool/#:~:text=Heart%20failure%20NHS%20virtual%20wards%20in%20Liverpool&text=Allowing%20patients%20to%20recover%20in,been%20successfully%20treated%20this%20way. (Accessed: 28 November 2025)

Developing a one stop approach to diagnosis and treatment. Reducing variation in practice between Halton and Warrington.	hospital admission.	for new cardiology OP appointments and 6,534 waiting for follow up. In Warrington, on average around 39% of all cardiovascular disease mortality in people aged under 75 is considered preventable[24].	

Table 34 - Clinical priority 2 – Heart Failure benefits

Clinical priority 3 – Chronic pain services			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**

[24] Warrington Borough Council (2025). Joint Strategic Needs Assessment Warrington 2024–May 2025.

We will move away from the current hospital-based model to an integrated, community-based chronic pain service. The focus will shift from a service that relies on pharmacological and theatre-based interventions to manage pain symptoms, to a predominantly community and therapies-based model, with hospital intervention being limited to only the most complex cases.	Patients will be cared for in a model that will focus on rehabilitation and re-enablement (rather than pharmacological intervention) that will more effectively support their pain management and returning to the things they want to do. Reduced opioid and gabapentoid prescriptions, delivering significant patient and community benefits. Fewer invasive procedures will be required. Theatre capacity will be freed up to allow more procedures that deliver greater benefit to be undertaken – significantly reducing the number of procedures of limited evidence-based value taking place.	National evidence shows ~34% of adults live with chronic pain and ~12% with high-impact chronic pain; in Warrington and Halton, this equates to ~90,000 with chronic pain and ~30,000 with high-impact chronic pain[25] [26]. Around 84% of chronic pain cases are musculoskeletal in nature, meaning community-based rehabilitation models could directly target the majority of cases[27]. The published average waiting time for pain management treatment at WHH is currently 25 weeks. c. 700 people on waiting list for the specialist pain management service in Warrington and	Improved function, participation in meaningful activities, reducing pain impact, and enhancing quality of life as measured by patient-reported outcomes such as the Patient-Specific Functional Scale (PSFS). Increased physical activity levels as assessed through patient supported outcomes. Decreased rates of opioid and gabapentoid prescription. Decreased rates of pain related invasive interventions such as spinal injections.

[25] Versus Arthritis (2021) *Chronic pain in England: Unseen, unequal, unfair*. Available at: https://www.arthritis-uk.org/media/23739/chronic-pain-report-june2021.pdf
[26] Fayaz, A. *et al*. (2016) 'Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies', *BMJ Open*, 6(6), p.e010364. doi: 10.1136/bmjopen-2015-010364
[27] Versus Arthritis (2021) *Chronic pain in England: Unseen, unequal, unfair*. Available at: https://www.arthritis-uk.org/media/23739/chronic-pain-report-june2021.pdf

		Halton[28].	

Table 35 - Clinical priority 3 – Chronic Pain Services benefits

Clinical priority 4 – Infant feeding			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**
Provision of an integrated service model reducing inequality across the population served. Consistency with regional priorities as outlined in the Cheshire & Mersey Infant Feeding Strategy to include: • Consistent referral criteria • Equitable advice and support • Coherent and joined up approach. Policy Alignment. Closing service gaps between hospital and community care.	Seamless support in various formats Equality and accessibility Consistent information and education	c. 2500 in accordance with birth rates recorded for Warrington and Halton Hospital	Increase breast feeding rates at 6-8 weeks equal to or exceed the national average of 52.7%. Increase first feed of breast milk equal to or exceeding the national average of 71.3%. Increase in women's satisfaction with breastfeeding support.

Table 36 - Clinical priority 4 – Infant Feeding benefits

[28] CIPHA, Elective recovery database (in pilot).

Clinical priority 5 – Movement disorders / Parkinson's			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**
Bringing together the multidisciplinary teams caring for patients with movement disorders across the hospital and community service will allow more effective use of capacity and shift the focus of care into the community supported by in-reach into the hospital setting. We will develop a Parkinson's passport to support holistic care. We will upskill our specialist and general workforce to manage movement disorders patients in an integrated model across the pathway. We will move to	Patients will receive earlier diagnosis of Parkinson's disease and other movement disorders. Patients will receive a greater proportion of their care in the community with fewer visits to hospital clinics. Care will be better coordinated across primary, community and secondary care, with fewer missed does of medication when patients have an acute admission.	4,925 admissions to hospital for people with Parkinsons (planned or unplanned) in Cheshire and Merseyside in FY 24/25 compared to a national average of 2,625. 10% of these admissions were to WHH with an excess bed day cost to the Trust of nearly 160K[29]. Approx 114 new cases of Parkinsons diagnosed in Warrington and Halton every year (based on NICE prevalence rates)[30]*. In Warrington and Halton 831 are currently registered as having Parkinson's	Reduced waiting list times for first appointment and follow up. Reduction in hospital based follow up appointments. Fewer missed doses of medication following admission.

[29] Parkinson's UK (2021) *Hospital admissions for people with Parkinson's.* Available at: https://parkinsonsuk.hsj.co.uk/hospital-admissions-people-parkinsonss

[30] National Institute for Health and Care Excellence (NICE) (2025) *Parkinson's disease: How common is it?* Available at: https://cks.nice.org.uk/topics/parkinsons-disease/background-information/prevalence/

*Actual diagnosis rates and numbers of people living with Parkinsons and other movement disorders will be available via a local GP database review

consolidate the movement disorders pathway onto (wherever possible) a single IT system. Forge closer links and working with community matrons and district nurses to identify deterioration and changes in treatment requirements in Parkinsons patients earlier.		disease[31].	

Table 37 - Clinical priority 5 – Movement disorders/Parkinson's benefits

Clinical priority 6 – Female urinary incontinence (UI)			
Change enabled by integration	**Patient Benefit**	**Scale of benefit - how many people benefit**	**Benefit Realisation Measures**

[31] CIPHA ICB Population Explorer tool

More collaborative working and understanding of care pathways. A joint MDT (hospital and community) to discuss complex patients. A single referral pathway and direct referral into services. Seamless care. Improved access to IT systems to improve visibility of lab results and blood tests. Development of community-based clinics.	Prioritising UI management allows timely interventions that restore confidence, independence, and participation in work, social, and family life. Early identification and treatment of UI can reduce secondary complications such as urinary tract infections, skin breakdown, and falls (from urgency or rushing to the toilet). Access to conservative management (bladder training, pelvic floor exercises, weight management) and	It is estimated that 34% of UK women are living with UI[32]. Using local age/sex data and applying plausible prevalence rates, ~34,500* women aged 18+ across Warrington and Halton may currently experience urinary incontinence and could benefit from improved diagnostic and treatment pathways[33, 34, 35].	Reduction in complications such as urinary tract infections, falls, or skin breakdown related to incontinence. Reduced waiting times for assessment and treatment. Increased number and proportion of women receiving assessment and treatment within community settings. Reduction in acute hospital admissions related to complications of UI. Increased patient satisfaction and symptom control.

[32] NICE (2025) *Incontinence – urinary, in women*. Available at: https://cks.nice.org.uk/topics/incontinence-urinary-in-women/
[33] Based on ONS (2024) *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2023*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2023
[34] Warrington Borough Council. (2025) *Joint Strategic Needs Assessment (JSNA).* Available at: https://www.warrington.gov.uk/jsna
[35] Halton Borough Council. (2024) Joint Strategic Needs Assessment: Population Overview. Runcorn: Halton Borough Council. https://www3.halton.gov.uk/Pages/health/publichealthinfo.aspx
*While an estimated 34,500 women across Warrington and Halton may be affected, a clearer picture of the true unmet need (as not all women with UI will present for treatment) and target population can be built over time by triangulating GP coding data, continence service referrals, prescribing patterns, and local survey insights as the integration programme develops.

	specialist interventions improves long-term continence outcomes. Women, particularly older women, may underreport symptoms. Integrating UI care ensures equitable access to assessment, diagnosis, and treatment, reducing health inequalities. Managing UI proactively in the community can prevent hospitalisation related to complications, improve discharge from acute care, and reduce re-admissions. Providing UI care as part of a community-focused, integrated pathway promotes co-production, empowering patients to be involved in treatment decisions, self-management, and goal setting.		

Table 38 - Clinical priority 6 – Female urinary incontinence (UI)benefits

Clinical priority 7 – End of life care			
Change enabled	**Patient Benefit**	**Scale of**	**Benefit Realisation**

by integration		benefit - how many people benefit	Measures
Multi-disciplinary, electronic and governance processes will be streamlined across sectors to deliver an integrated pathway. All staff will view and use the Personalised Care Plans. Access to specialist palliative care across the whole week and including at the Front Door will be strengthened. Integration of education to specialists and non-specialists will continue.	Increased opportunity for timely Personalised Care Planning. More likely to have preferences met, including preferred place of care and preferred place of death. Timely access to appropriate generalist and specialist palliative care with improved symptom management across the patient journey, across the whole week and equitable across patient groups.	Approx. 3,370[36, 37] people each year across Warrington and Halton likely to be in last year of life (for Halton estimated based on available data), expected to rise by 25.4% by 2040 with an increase of 42.4% in those needing specialist palliative care services[38]. Using population data in England over a two-year period, it has been estimated that 69-82% of people who die need palliative care[39].	Improved experience including symptom management, reduced avoidable admissions and safely reduced lengths of stay measured by; - Integrated Palliative Care Outcomes Scale (IPOS) - Key performance indicators and clinical audits including re: front door and gold standards framework (GSF) - National audit of care at the end of life - CODE™ survey - Cheshire & Merseyside palliative end of life care population based needs analysis - Palliative care activity dashboard (including GSF data for front door attendances and admissions)

Table 39 – Clinical priority 7 – End of life care benefits

12.5 Why integration is essential

[36] Stopford (2024) *Analysis: Deaths registered in England and Wales 2022*. Available at: https://stopford.com/analysis-deaths-registered-in-england-and-wales-2022/

[37] Warrington Borough Council (2021) *Joint Strategic Needs Assessment Summary 2021*. Available at: https://www.warrington.gov.uk/sites/default/files/2022-01/Joint%20Strategic%20Needs%20Assesment%20Summary%202021.pdf

[38] Sue Ryder (2021) *Modelling demand and costs for palliative care services in England: A final report for Sue Ryder.* Available at: https://media.sueryder.org/documents/Modelling_Demand_and_Costs_for_Palliative_Care_Services_in_England_1.pdf

[39] Murtagh, F. E. *et al.* (2013) 'How many people need palliative care? A study developing and comparing methods for population-based estimates'. *Palliative Medicine*. 28(1), pp. 49-58. doi:10.1177/0269216313489367

The case studies presented in section 10.3 illustrate how colleagues and teams from BCH and WHH have already worked together pre-transaction to secure tangible benefits for patients. These examples show that integration of individual services can be achieved through collaboration, given sufficient resource, effort, and commitment. However, this approach is inherently limited. With finite resources and competing demands on clinicians and operational leaders, relying on workarounds is unsustainable and cannot deliver the scale or pace of change that patients need.

Integration provides the essential lever to unlock systemic transformation across all services. It removes dependence on self-selecting groups of clinicians driving change in isolation and instead embeds integration as a strategic, organisation-wide and system-wide priority. This enables improvement efforts to be aligned with the areas that clinicians, partners, and patient representatives have identified as offering the greatest benefits. It also ensures that resources are used most effectively, accelerating transformation while maintaining safety and quality.

The wider evidence base on integration highlights well-documented barriers to delivery of clinical improvement[40, 41] including:

- Lack of organisational commitment.
- Insufficient resources.
- Misaligned payment mechanisms.
- Poor information sharing between professionals.
- Weak coordination across services
- Limited focus on patient needs and preferences.
- Workforce pressures and role uncertainty.
- Conflicting priorities and resistance to change.

Conversely, research identifies clear enablers of success, such as well-defined and evidence-based service models, collaborative working between general practices, adequate resourcing, shared values, effective digital communication, and robust monitoring of quality and outcomes.

Integration directly addresses many of the barriers while embedding the recognised enablers. Although the national evidence integration is complex, NHS case studies demonstrate that bringing acute and community services together within a single organisation can accelerate transformation. Staff working in combined acute-community Trusts report that integration strengthens teamwork, speeds up service redesign, and improves continuity and coordination of care, all of which are critical to achieving the fundamental shift in focus required for our population[42].

[40] Ling, T. *et al.* (2012) 'Barriers and facilitators to integrating care: experiences from the English Integrated Care Pilots'. *International Journal of Integrated Care*, 12(5), pp. e129. doi: 10.5334/ijic.982

[41] Kozlowska, O. *et al.* (2018) 'Barriers and facilitators to integrating primary and specialist healthcare in the United Kingdom: a narrative literature review'. *Future Healthcare Journal*, 5(1), pp. 64-80. doi: https://doi.org/10.7861/futurehosp.5-1-64

[42] The King's Fund (2015) *Acute hospitals and integrated care: From Hospitals to health systems*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/acute-hospitals-and-integrated-care

12.6 Patient and public involvement in clinical integration

A communications and engagement plan has been developed for the overarching BCT programme to inform and engage a broad audience about the integration of the organisations and clinical pathways.

This plan sets out an approach that will cover both engagement and involvement, and public consultation where required across both BCH and WHH stakeholders and services. This is based on a 'start with people' approach and a commitment to ensuring effective engagement with staff, stakeholders and communities, including people with lived experience of services.

Chapter 10 of this business case describes early engagement with staff and wider stakeholders, including Healthwatch which informed the priority areas for clinical transformation.

The next steps to support this activity and to ensure meaningful patient and public engagement informs any changes to services will be the involvement of Healthwatch Halton and Healthwatch Warrington, to provide independent chairing and project coordination of feedback from a BCT patient and public reference group (PPRG).

The PPRG will formally report into the BCT programme delivery group and will tap into wider engagement networks, helping to ensure that the voice of our patients and local public is heard. The inaugural meeting will be held in December 2025 to agree the format and terms of reference and will be followed by three further monthly meetings, progressing to bi-monthly meetings focused on topic areas including seven areas of clinical pathway transformation.

Provisional meeting timetable:

Meeting date	Area of focus
December 2025	Overview of BCT integration plans, the case for change, understanding engagement and feedback to date, and agree PPRG terms of reference
January 2026	Infant feeding pathway
February 2026	Urgent and emergency care/ self-care
March 2026	Heart failure pathway
May 2026	Chronic pain management/ frailty services
June 2026	Movement disorders/ end of life care
September 2026	Female urinary incontinence

Table 40 – PPRG provisional meeting timetable

Members of the group will be expected to share information and engage with their respective networks / communities on behalf of the PPRG, feeding back into the group with community responses about the wider integration programme, to inform clinical integration plans.

In addition, we will incorporate engagement on clinical integration priorities through our established engagement networks and activity across both BCH and WHH. This will include those with lived experience of both community and hospital services in the priority workstream task and finish groups as required. It will also include engagement attendees at community events in Halton and Warrington and through those services delivered across a wider footprint. We will provide opportunities for local people to hear about our integration plans from senior leaders through established forums and groups so that people can ask questions, make suggestions and share thoughts and concerns.

12.7 Benefits realisation

The evidence base to support the tangible benefits resulting from integrated care is complex, but systematic reviews report that integration can enhance patient satisfaction, increase perceived quality of care, and enable access to services.

Examples of where expected benefits of integration have failed to be delivered often link to one or more of the following:

- Poor design of the integrated service model.
- Problems with implementation of the model.
- Problems with evaluation of the benefits of integration.

Mitigating design and implementation challenges has been addressed in the above section on our approach to clinical integration. As described, our approach has been designed with reference to the insight drawn from the evidence base, best practice guidance and expert advice.

Realising the benefits of integration through integration therefore relies on the successful delivery and evaluation of three key elements:

- New or changed capabilities (e.g. new or redesigned pathways, operating models, digital technologies, roles or infrastructure);
- Adoption of the changed capabilities (e.g. the behaviour change by staff, patients and the public required to make use of the new capabilities);
- Measuring the outcome of the change process (e.g. capturing the benefits that should be accrued with successful delivery).

Our plan for clinical integration will empower teams to take a systematic approach to the design and delivery of new or transformed services. Each of the clinical priority areas detailed in section 10.5.2 will have key performance indicators, visible to staff and regularly reviewed, which will provide the “leading” measures of improvement at team level. This will allow us to clearly communicate performance improvements from integration, alongside any risks to performance that may emerge. By empowering our clinical teams in this way, we provide an engine for front-line change that is focused on the things that matter most to our staff, patients and populations.

True benefit measures will typically be ‘lagging’ measures – outcomes that impact directly on people and that may accrue over a longer period after change has taken place and may be more challenging to measure. Our evaluation of the benefits of integration will be managed and monitored via the Better Care Together programme governance structure in 2025/26 and then via our post transaction integration programme governance structure from 2026/27 onwards.

13.0 Financial Case

13.1 Chapter summary

This section presents the financial evidence supporting the integration, including baseline and projected future financial positions of the partner organisations, financial improvement opportunities associated with the acquisition and the anticipated additional costs incurred as a result of the programme.

The section sets out the medium-term financial plan for the integrated Trust to support financial sustainability that will help protect resources allocated to front-line patient care.

Key message: Integration will create significant opportunities for financial improvement for both WHH and BCH. Without integrating, the ability of both providers to reach a position of financial sustainability and maintain clinical quality and effectiveness is severely restricted.

By removing duplication, optimising resources, and leveraging shared investment, the new organisation will deliver better value for money and greater system resilience.

In this section, we detail how integration will deliver economies of scale, streamline services and unlock up to £33 million in financial opportunities, helping to significantly improve the current combined underlying deficit of £48.3 million across the two organisations (projected as at the end of 25/26). The opportunities for financial improvement identified to date, far outweigh the anticipated £1.1m additional costs of the integration programme.

This aligns with NHSE's expectations for integrated, financially sustainable care systems.

13.2 Historic financial performance

13.2.1 I&E performance

WHH and BCH financial performance over the three years to 2024/25 is set out below. Both organisations have historically achieved their ICS agreed risk adjusted plans / forecasts each financial year for both revenue and capital and CIP delivery has improved year on year.

Note: the WHH 2024/25 position includes deficit support funding of £16.5m.

£m	Actual	Actual	Actual
I&E – WHH	2022/23	2023/24	2024/25
Income	347.1	356.1	392.0
Pay	(255.0)	(275.8)	(293.8)
Non pay	(95.1)	(103.8)	(117.6)

Non operating expenditure	(4.5)	(4.7)	2.3
Surplus / (deficit) as per accounts	**(7.6)**	**(28.2)**	**(17.2)**
Adjustments to Financial Performance	(0.3)	(1.7)	0.3
Adjusted Surplus / (deficit)	**(7.9)**	**(30.0)**	**(16.8)**
Exclude Deficit Support Funding (DSF)	0.0	0.0	(16.5)
Adjusted Surplus / (deficit) Excluding DSF	**(7.9)**	**(30.0)**	**(33.3)**
Planned Surplus / (deficit)	(16.8)	(19.9)	(27.8)

Table 41: WHH recent historic financial performance (I&E)

£m	**Actual**	**Actual**	**Actual**
I&E – BCH	2022/23	2023/24	2024/25
Income	97.0	101.9	107.6
Pay	(69.1)	(72.6)	(77.6)
Non pay	(27.5)	(30.6)	(31.2)
Non operating expenditure	0.6	1.3	(0.0)
Surplus / (deficit) as per accounts	**1.0**	**(0.0)**	**(1.2)**
Adjustments to Financial Performance	0.0	0.0	0.0
Adjusted Surplus / (deficit)	**1.1**	**0.0**	**(1.2)**
Planned Surplus / (deficit)	0.0	0.0	2.1

Table 42: BCH recent historic financial performance (I&E)

Delivery of the financial plans have become more challenging for both organisations, as shown by the deteriorating financial positions of both WHH and BCH over recent years. There has been increasing requirement for additional CIP, due to growth in staffing (see section 5.6) and reduction in productivity post-COVID.

WHH in particular has a historic underlying deficit position. Drivers of underlying financial deficit at WHH are predominantly operational and structural factors:

- Operational
  - Outpatient and Inpatient activity case mix changes are driving higher costs.
  - Authorised but unfunded pay increases to meet patient safety standards and increased clinical activity.
  - Savings being achieved non-recurrently
  - Impact of workforce challenges

    - High levels of premium pay spend due to vacancies and recruitment.
    - Winter
    - Acuity of patients post COVID
    - Infrastructure challenges

- Structural
    - Decrease in recurrent income, increased depreciation and amortisation costs due to significant levels of investment in plant and machinery and software in response to Covid. In 2021/22 & 2022/23 non-recurrent income was supporting recurrent costs. This income reduced in 2023/24 and further reduced in the 2024/25 plan.
    - Reduced out of hospital support facilitating timely discharge and care in the community.
    - Block contracts / PBR
    - PBR tariffs for DGH without specialist activity more likely to have a deficit
    - The reliance on non-recurrent income
    - Impact of industrial action

A number of the drivers behind the deficit position, such as infrastructure costs and reduced out of hospital support, can be addressed and improved through the integration programme.

13.2.2 Balance sheet positions

WHH and BCH balance sheet positions at the end of each year over the three years to 2024/25 are set out below.

Balance sheet - WHH - £m	2022/23	2023/24	2024/25
Non current assets	192	211	207
Current Assets	58	35	30
Current liabilities	(55)	(53)	(48)
Non current Liabilities	(11)	(10)	(9)
Net Assets Employed	**184**	**182**	**180**
PDC	215	240	264
Revaluation Reserves	41	41	36
I&E Reserve	(71)	(98)	(120)
Total taxpayers and others' equity	**184**	**182**	**180**

Table 43: WHH balance sheet positions at the end of each of the most recent three years

Balance sheet - BCH - £m	2022/23	2023/24	2024/25
Non current assets	51	51	48

Current Assets	33	27	23
Current liabilities	(22)	(15)	(14)
Non current Liabilities	(37)	(37)	(33)
Net Assets Employed	**26**	**26**	**25**
PDC	33	34	34
Revaluation Reserves	3	3	3
I&E Reserve	(10)	(11)	(12)
Total taxpayers and others' equity	**26**	**26**	**25**

Table 44: BCH balance sheet positions at the end of each of the most recent three years

BCH balance sheet position is largely unchanged over the period.

WHH balance sheet position has changed as a result of the following:

- Investment in WHH asset portfolio to deliver and improve patient care, and address mandated and business critical requirements linked to dated estate.
- Current Assets have declined as the cash position has followed the challenging I&E performance of the Trust.
- Main movement to note is the I&E reserve due to the deficit position which is offset by the PDC reserve.

Again, some of the negative balance sheet movement for WHH is a result of the deficit I&E position. This is something that the integration programme can help improve.

13.2.3 Cost improvement (CIP) delivery

Historic CIP performance for both WHH and BCH is shown below. BCH have achieved CIP in recent years albeit with the use of non-recurrent items. WHH have increased CIP delivery year on year with significant shift to recurrent delivery.

		WHH			BCH		
		Plan £m	**Actual £m**	**Var £m**	**Plan £m**	**Actual £m**	**Var £m**
2022/23	recurrent	15.7	1.5	(14.3)	1.9	1.6	(0.3)
2022/23	non recurrent	0.0	13.4	13.4	2.3	2.6	0.3
2022/23	**Total**	**15.7**	**14.9**	**(0.9)**	**4.2**	**4.2**	**0.0**
2023/	recurrent	17.9	7.3	(10.6)	5.2	1.7	(3.5)

24							
2023/24	non recurrent	0.0	8.2	8.2	0.0	3.6	3.6
2023/24	**Total**	**17.9**	**15.5**	**(2.4)**	**5.2**	**5.2**	**0.1**
2024/25	recurrent	19.4	12.7	(6.8)	4.9	1.7	(3.2)
2024/25	non recurrent	0.0	4.3	4.3	0.0	3.3	3.3
2024/25	**Total**	**19.4**	**17.0**	**(2.5)**	**4.9**	**5.0**	**0.1**

Table 45: WHH and BCH CIP delivery since 2022/23

13.2.4 Capital spend

Historically, both organisations have spent their planned capital allocation (see table 46 below).

Spend in WHH capital in previous years has been higher than plan due to additional national and regional funding received during the course of the year, including for the Community Diagnostic Centre (CDC) scheme, Targeted Investment Fund (TIF) schemes and IFRS16.

Actual spend in 2024/25 was lower than plan due to a deferral of frontline digitisation funds to 2025/26.

	WHH			BCH		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
2022/23	22.7	27.4	4.7	2.1	2.3	0.2
2023/24	26.9	31.6	4.7	2.4	2.4	0.0
2024/25	25.0	21.9	(3.1)	2.3	2.2	(0.1)

Table 46: WHH and BCH historic capital spend v plan

Future capital investment will be delivered through existing CDEL levels, no additional funding is assumed, except if targeted funding becomes available to support specific schemes.

13.3 Financial opportunities through integration

As individual stand-alone organisations, both WHH and BCH will have limited opportunities to deliver services more efficiently. Continuing to deliver annual CIP targets at current levels is not realistic unless the model of service provision is transformed and ongoing/future demand managed more effectively.

Table 47 below summaries the anticipated financial benefits from the integration over the coming years. This includes:

- £2.39m of recurrent financial benefits already realised during 2025/26 (as at month 7).
- A further £9.75m of recurrent financial benefits that can be realised across the next four years directly as a result of bringing the organisations together (£8.4m between 26/27 and 28/29).
- A further £21m of recurrent financial benefits that are *enabled* via the integration over the next four years (£18.2m between 26/27 and 28/29).

Note that a number of the financial opportunities linked to integration are profiled to deliver in later years. This aligns with the fact that we have limited transformation/programme support resources (see section 7.12) to deliver large-scale clinical change at pace. Delivery of some aspects of clinical redesign will be limited by our ability to divert programme resources away from other aspects of the programme, as and when they come to a conclusion (e.g. completion of the transaction, integration of corporate and clinical support teams as part of phase one and phase two of the programme.

	2025/26	2026/27	2027/28	2028/29	2029/30	Total
Direct financial benefits of integration						
Corporate services integration	0.30	1.05	3.30	2.75	0.60	8.00
Clinical service redesign	0.29	-	-	0.75	0.75	1.79
Re-align bank rates	1.80	-	-	-	-	1.80
Contract alignment (excl corporate)	-	0.05	0.05	-	-	0.10
Corporate hub	-	-	0.15	-	-	0.15
Operational management restructure	-	-	0.10	-	-	0.10
Community estates rationalisation	-	-	0.20	-	-	0.20
Community treatment rooms	TBC	TBC	TBC	TBC	TBC	0.00
	2.39	**1.10**	**3.80**	**3.50**	**1.35**	**12.14**
Indirect financial benefits of integration						
Place-based demand management	-	2.80	2.80	2.80	2.80	11.20
UEC improvement	-	0.39	-	-	-	0.39
CDC - Phase 4	-	-	0.96	-	-	0.96
Commercial clinical services	-	-	0.50	-	-	0.50
GIRFT productivity	-	0.86	0.84	-	-	1.70
Fragile service restructure	-	-	-	1.40	-	1.40
Car parking charges for BCH staff	-	0.45	-	-	-	0.45
BCH block contract review	-	-	2.20	2.20	-	4.40
	0.00	**4.50**	**7.30**	**6.40**	**2.80**	**21.00**
Grand Total	**2.39**	**5.60**	**11.10**	**9.90**	**4.15**	**33.14**

Table 47: £33m of financial benefit opportunities identified to date from integration (both direct and indirect)

13.3.1 Corporate services integration

National benchmarking information from the NHS Model Health System data identifies financial improvement opportunities that can be delivered through the integration of corporate functions between the two organisations. By reducing overall costs in line with national median levels, the potential financial improvement would equate to around **£8m** recurrently.

Both WHH and BCH have already launched mutually agreed resignation schemes (MARS) in order to create required vacancies across affected corporate services. The costs in the table above account for the payment of MARS costs, hence the delayed profiling of the main benefits into 2027/28.

The integration of WHH and BCH, and particularly the increased organisational scale that is created via the integration, is critical in terms of realising this benefit. The ability of both organisations to reduce corporate costs down to national median levels is restricted as stand-alone organisations. Nationally, the best performing Trusts in terms of corporate costs are those with the larger turnover. As figure 28 below shows, organisations with 19 times the revenue of BCH only report corporate costs to be around 5 times those of BCH. This is simply due to economies of scale within corporate teams.

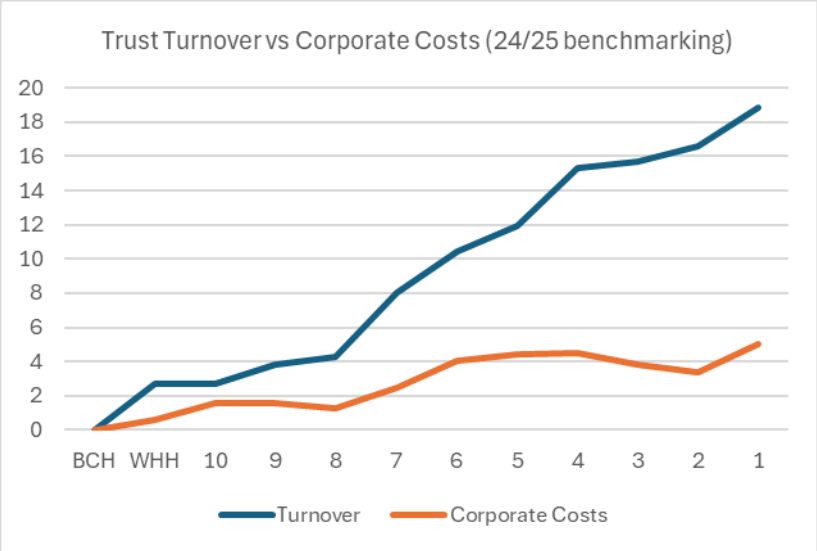


Figure 28: Total corporate service costs vs Trust turnover based on a sample range of Trusts from the NHS Model Health System benchmarking data

13.3.2 Clinical service redesign

There are a wide range of opportunities for financial improvement via integration of clinical services. The opportunities are all dependent upon transforming delivery of services aligned to the principles set out in chapter 10 of this document.

For example, the current model for the chronic pain management service at WHH is predominantly secondary-care based and consultant-led. Other similar services locally are predominantly community-based and non-consultant-led. The difference in cost between these two models of care is significant. The

integration of BCH and WHH creates the opportunity to shift the acute model to one delivered out in community. This would reduce costs and align with national strategic direction.

Similarly, evidence from the Getting It Right First Time (GIRFT) programme suggests that up to £2,000 of savings can be made by the organisation for every frailty admission to the hospital bed base that can be avoided. Based upon volumes of current (increasing) admissions for this group of patients, potentially between **£1.5m and £2m per year** could be saved if we were to avoid 10–15% of admissions. The management of frailty is a key clinical priority and the development of multi-agency, community-based model has significant potential to deliver the transformation required to unlock the financial improvement.

According to the NHS Model Health System data, the average cost of a weighted unit of activity (WAU) for dentistry at WHH is the highest in the country, as demonstrated by figure 29 below. Given the scale of the community dentistry service delivered by BCH, there is likely to be a number of opportunities created through integration of the services to drive financial improvement through accessing economies of scale.

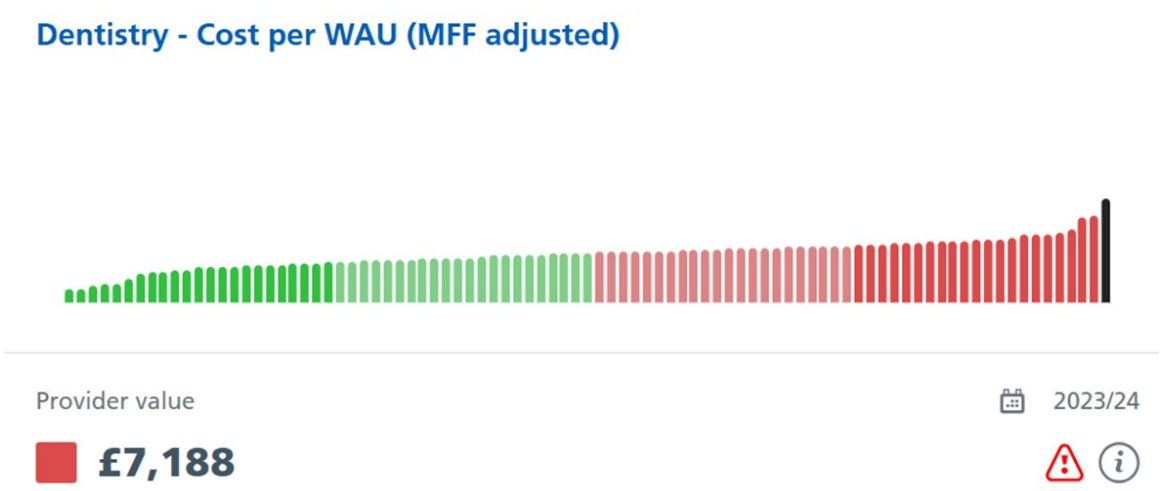


Figure 29: Cost per WAU for dentistry at WHH

The launch of the BCH AI-led dermatology service at WHH (see section 10.3.2.1) has already generated additional revenue of **£0.3m** in 25/26, which demonstrates that the opportunities to deliver services differently and improve profitability at the same time are real.

13.3.3 Re-align bank rates

Over **£1.8m** of pay cost savings have been delivered by WHH in 25/26 as a result of reviewing the payment of bank rates for temporary shifts and aligning them to the rates paid by BCH to their staff. The integration of BCH and WHH will help increase the volume of staff able to support with temporary staffing cover across both community and acute services. This will help the integrated organisation to provide greater resilience to the workforce numbers and keep temporary staffing costs as low as possible into the future.

13.3.4 Contract alignment

An initial review of the current contract registers across both BCH and WHH indicates approximately 34 ‘matched’ clinical or estates contracts between the two organisations[43]. These are contracts that appear to be for the same or similar goods and/or services. The total value of these matched contracts is around £2.8m. A 10% improvement in total cost as a result of the combined purchasing power of the integrated organisation and reduced duplication should be achievable and would equate to **£0.28m per year**.

13.3.5 Corporate hub

As part of the work to integrate corporate services (see section 13.3.1 above), there is a parallel piece of work to explore the creation of a single corporate hub as the central ‘home’ location for all corporate services in the integrated organisation.

Spencer House in Birchwood, Warrington is the current BCH corporate headquarters. At present, the building is under-utilised and regularly has significant space to accommodate more staff. Initial data and analysis suggests that the facility could accommodate all corporate teams from both WHH and BCH with minimal or no significant redesign. This would be achieved through a combination of expanding the current number of desk spaces at the facility and formalising agile working arrangements across all corporate teams. It would also require the creation of a small corporate ‘hot desk’ facility on the Warrington hospital site. This is described in more detail in section 18.6.1.

Co-locating all corporate functions would promote improved communication and connection between the various teams but it would also allow significant parts of the Kendrick wing space at Warrington hospital to be ‘mothballed’ in order to save money.

The impact of closing those spaces in Kendrick wing has been estimated to be around **£0.15m per year.** This is currently profiled as a financial opportunity in 2027/28.

13.3.6 Operational management structure

Phase two of the integration programme will see the integration of operational management structures currently overseeing the clinical services across both WHH and BCH.

The current annual budget (25/26) for operational management teams across both Trusts totals around £10m and includes 122 wte staff.

A prudent estimate of financial improvement that can be made through the integration of the operational management structures would be **£0.1m per year**.

As mentioned above, both WHH and BCH have already launched MARS schemes to help create required vacancies across affected services. The true financial value and profile linked to this opportunity will be known when the MARS schemes in early 2026.

13.3.7 Estates rationalisation

[43] There are a further 36 ‘matched’ contracts across corporate services but the cost, and therefore the opportunity, for financial improvement through these is included within the identified corporate services integration opportunity.

Chapter 18 of this case illustrates the current use of estate by both WHH and BCH across Warrington and Halton. In line with the development of the new clinical strategy, phased estates plan (see section 18.9) and the emergence of a local vision for neighbourhood health, there will undoubtedly be opportunities for the integrated organisation to look at rationalising the use of its current hospital and community estate over the short to medium term.

As leases for community facilities come up for renewal, our intention would be to review the requirements for every facility. We will look at whether our use of estate can be rationalised to deliver improved financial efficiency without compromising on the need to maintain core acute services on the hospital sites whilst also looking to move more non-acute care services away from the hospital and into community and domiciliary settings.

The initial financial benefit associated with the rationalisation of estate is estimated to be **£0.2m per year** from 2027/28.

13.3.8 Other, as yet unquantified, opportunities for financial benefits

13.3.8.1 Community treatment rooms

BCH currently deliver a range of low-risk elective procedures directly from treatment rooms across both Warrington and Halton. A review of capacity and demand for these facilities could help identify opportunities for procedures currently undertaken in theatres or outpatient clinics on the hospital sites to be more appropriately undertaken in these community facilities. This would create a financial opportunity around the use of the facilities potentially vacated by the shift of activity away from the acute setting.

13.4 Forecast medium-term financial outlook following integration

The table below shows the forecast abridged financial statements for the integrated organisation over the next three years assuming delivery of financial benefits as detailed in table 47 (above) and in line with all assumptions made in subsequent tables below.

£m	Actual	Actual	Actual	Underlying Position	Forecast	Forecast	Forecast
Abridged Income and Expenditure	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Income	444.06	458.05	499.55	491.70	478.68	498.60	505.34
Pay	(324.17)	(348.46)	(371.42)	(368.43)	(363.09)	(360.18)	(356.93)
Non pay	(122.53)	(134.42)	(148.80)	(147.90)	(144.64)	(143.22)	(140.24)
Non operating expenditure	(3.89)	(3.45)	2.30	(5.85)	(7.16)	(8.39)	(8.70)
Surplus / (deficit) as per accounts	**(6.53)**	**(28.29)**	**(18.37)**	**(30.48)**	**(36.22)**	**(13.18)**	**(0.54)**
Adjustments to Financial Performance	(0.32)	(1.66)	0.39	0.56	0.56	0.56	0.56
Adjusted Surplus / (deficit)	**(6.85)**	**(29.95**	**(17.99**	**(29.92)**	**(35.66**	**(12.62**	**0.02**

		)	)		)	)	
Exclude Deficit Support Funding (DSF)	0.00	0.00	(16.50)	(18.33)	0.00	0.00	0.00
Adjusted Surplus / (deficit) Excluding DSF	**(6.85)**	**(29.95)**	**(34.49)**	**(48.25)**	**(35.66)**	**(12.62)**	**0.02**
Planned Surplus / (deficit)	(16.80)	(19.86)	(25.65)	(30.25)			

Abridged Balance Sheet							
Non current assets	243.31	261.46	255.38	292.62	257.22	244.22	244.22
Current Assets	91.31	62.27	52.95	45.96	45.96	45.96	45.96
Current liabilities	(76.72)	(68.44)	(61.99)	(70.65)	(70.65)	(70.65)	(70.65)
Non current Liabilities	(47.73)	(47.06)	(41.49)	(38.68)	(38.68)	(38.68)	(38.68)
Net Assets Employed	**210.17**	**208.22**	**204.85**	**229.25**	**193.85**	**180.85**	**180.85**
PDC	248.05	273.34	297.87	336.73	336.73	336.73	336.73
Revaluation Reserves	43.42	43.28	38.79	43.64	43.64	43.64	43.64
I&E Reserve	(81.31)	(108.41)	(131.81)	(151.11)	(186.77)	(199.39)	(199.36)
Total taxpayers and others' equity	**210.17**	**208.22**	**204.85**	**229.25**	**193.60**	**180.98**	**181.00**

Abridged Cashflow Statement							
Cash flows from operating activities	11.34	(9.19)	(1.14)	16.07	22.32	31.83	40.11
Cash flows from investing activities	(24.33)	(27.27)	(21.33)	(50.29)	(50.29)	(50.29)	(50.29)
Cash flows from financing activities	1.42	12.18	11.66	24.29	51.29	57.41	53.39
Net cash flow for the period	**(11.57)**	**(24.27)**	**(10.81)**	**(9.92)**	**23.32**	**38.95**	**43.22**
Cash and cash equivalents at start of period	70.81	59.24	34.97	24.15	14.24	37.56	76.51
Cash and cash equivalents at end of period	**59.24**	**34.97**	**24.15**	**14.24**	**37.56**	**76.51**	**119.73**

Table 48: Abridged summary forecast financial position post-integration

As shown by table 48, the integration is expected to support a reduction in the deficit in 2026/27 and 2027/28 and deliver a small surplus in 2028/29.

The joint BCH and WHH 2025/26 underlying position of £48.3m deficit (see blue cell in table) for the combined organisation is driven by:

- BCH position of £4.5m deficit
- WHH position of £43.8m deficit

Note: by taking the £48.3m combined underlying deficit figure above, adding back the delivery of internal and system-supported CIP in year 2025/26 (£21.5m WHH and £5.35m BCH) and then adjusting to reflect £3.1m of non-recurrent

changes, you will arrive at the combined £72m planned 2025/26 deficit figure included in the strategic case for integration.

Table 49 below showing the key assumptions underpinning the financial modelling for the proposed integrated organisation is shown below.

Assumption	Assumption Scope	2025/26	2026/27	2027/28	2028/29
Weighted Inflation	Income	2.2%	0.0%	0.0%	0.0%
	Pay	3.3%	2.1%	2.1%	2.1%
	Drugs	0.0%	0.6%	0.6%	0.6%
	CNST	0.0%	0.5%	0.5%	0.5%
	Non-Pay	0.6%	2.2%	2.2%	2.2%
	Capital charges	0.2%	1.7%	1.7%	1.7%
CIP Efficiency	Opex	5.0%	5.0%	5.0%	5.0%

Table 49: Key financial assumptions for the modelling of the integrated organisation

Table 50 below shows the assumed level of CIP delivery for the combined organisations within the future financial modelling.

£m	2025/26	2026/27	2027/28	2028/29
Recurrent CIPs				
Pay Cost	16.1	14.5	12.1	12.9
Non Pay Cost	3.6	5.7	5.5	5.3
Income	4.3	5.2	18.1	6.6
Total recurrent CIPs	**24.0**	**25.4**	**35.7**	**24.9**
Non-recurrent CIPs				
Pay Cost	0.5			
Non Pay Cost	1.0			
Income	1.5			
Total non-recurrent CIPs	**3.0**	**-**	**-**	**-**

Total CIPs	**27.0**	**25.4**	**35.7**	**24.9**

Table 50: Assumed level of CIP delivery for the combined organisations over medium term

Figure 30 below shows the summary financial bridge diagram illustrating how the integrated organisation plans to move from a position of a £48.3m underlying deficit at the end of 25/26 to a small surplus/break even position by the end of 28/29.

The blue bar on the diagram constitutes the £8.4m anticipated financial improvement to be made as a direct result of the integration.

The orange bars illustrate where some of the non-direct benefits of the integration programme will support delivery of further financial improvement.

The integration of WHH and BCH is a critical enabler to both organisations' journey to financial sustainability over the coming years.

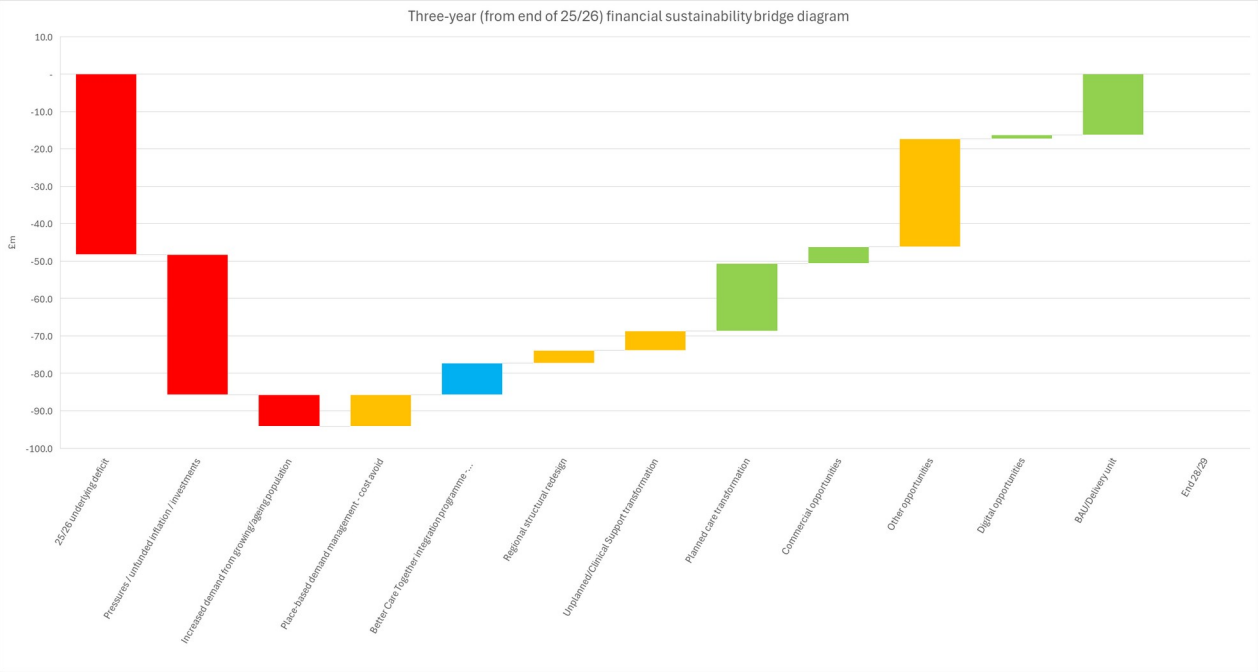


Figure 30: High-level financial sustainability bridge for the integrated organisation from the end of 25/26 to the end of 28/29

13.5 Costs associated with integration

Table 51 below details and profiles the total additional anticipated costs (i.e. not absorbed by the Trusts) associated with the integration programme totalling **£1,104,000**.

Programme requirement (additional)	Costs to be incurred during phase one of	Costs to be incurred during phase two of	Total additional costs anticipated

	integration programme (2025/26)	integration programme (2026/27)	
Programme leadership and programme management support	£0	£0	£0
Finance costs to support to the programme	£100,000	£40,000	£140,000
Communications and engagement costs to support to the programme (including signage)	£86,000	£24,600	£110,600
Dedicated clinical leadership to the programme	£0	£0	£0
External consultancy support to the programme	£415,000	£0	£415,000
Legal advice and support	£90,000	£50,000	£140,000
IT and system realignment costs	£97,500	£0	£97,500
Other costs	£80,000	£120,900	£200,900
Total anticipated additional programme costs	£868,500	£235,500	£1,104,000

Table 51: Estimated programme costs associated with each phase of the integration programme vs total costs identified to date

14.0 Inequalities

14.1 Chapter summary

This section highlights the Trusts' joint commitment to tackling health inequalities across Warrington, Halton and the wider system, addressing 6 priority areas:

- Restoring NHS services inclusively – after the COVID-19 pandemic
- Mitigating against Digital Exclusion
- Ensuring Data sets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability
- Tackling workforce inequalities

It identifies the current variation in health outcomes and access to services across communities and outlines how integration will enable targeted, data-driven interventions.

The section aligns with the NHS Core20PLUS5 framework, focusing on reducing unwarranted variation, improving prevention and supporting inclusive workforce practices.

It reinforces how integration provides the platform to address structural barriers to equity and deliver measurable improvements in population health outcomes.

Key message: Integration is a powerful enabler of equity and local data has suggested significant challenges across our local population including growing number of children and young people requiring mental health support; a growing ethnic minority population with language barriers and digital exclusion hindering preventative treatments; and bullying, isolation, and unmet mental health needs within the LGBTQ+ community to name a few.

By aligning community and acute services, the new organisation will target the root causes of inequality, deliver prevention-focused care, and strengthen partnerships with local authorities and the voluntary sector to close health gaps across populations.

14.2 Overview

This section outlines how the Trust is identifying and responding to health inequalities, using national dashboards and local data to target interventions in priority wards. It summarises variation in avoidable hospital admissions (ACSC rates) and inequality gradients (AGI values) across Halton and Warrington, highlighting areas of greatest need and opportunity for impact. This insight is being used to inform service redesign and transformation programmes as part of the clinical integration workstream.

System-wide opportunity through integration

- The integration of WHH and BCH enables a more cohesive, place-based approach to tackling inequalities, particularly through stronger integration with primary care networks, community assets, and neighbourhood teams.
- The most recent joint strategic needs assessments (JSNAs) for Warrington and Halton emphasise the importance of joined up working across sectors to address complex and overlapping health needs. This creates opportunities to align transformation efforts and reduce duplication across acute and community settings.

Population contrasts

- Warrington is growing and becoming more diverse, with 11.9% of residents from minority ethnic backgrounds and notable growth in Eastern European communities. This demographic shift highlights the need for culturally responsive services and inclusive communication strategies.
- Halton has higher levels of deprivation, poorer health outcomes, and lower ethnic diversity (~4.5%), with multiple communities ranked among the top 10% most deprived nationally. This reinforces the need for targeted interventions in priority wards and tailored support for communities facing multiple disadvantages.

Unplanned vs. planned care

- Both Warrington and Halton Joint Strategic Needs Assessments (JSNAs) highlight that residents in more deprived areas are more likely to access care through emergency departments and less likely to engage with preventative or planned services. This pattern reflects barriers to early intervention and continuity of care, particularly in areas with lower health literacy or limited access to primary care.
- The trend is especially pronounced in Halton, where urgent care use is higher and avoidable admissions are more frequent. This underscores the

importance of proactive, community-based approaches to reduce reliance on emergency services and improve long-term outcomes.

The creation of an integrated Trust serving both Warrington and Halton must navigate divergent health needs, access patterns, and community assets. The integration presents a strategic opportunity to:

- Align acute and community services to reduce fragmentation and improve continuity of care.
- Target resources proportionately, recognising Halton's deeper deprivation and Warrington's growing diversity.
- Embed equity into service design, ensuring that care models reflect local population profiles and lived experience.
- Leverage combined data intelligence to identify risk, predict demand, and personalise interventions.

As an integrated Trust (with a reach across both community and acute) we will seek to create seamless pathways and work more closely with the neighbourhood teams and our PCNs. We know this will provide a more holistic service for our populations and we will take strides to reduce inequalities in relation to access and prevention.

As NHS organisations, it is very easy to talk about 'hard to reach' groups, or communities that are not 'engaging' in healthcare, or accessing in the ways it has been designed. However, these communities more often than not, know what it is that they need, and have made a very valid decision based on their circumstances about how they are going to access care, and whether they have the resources or the time to engage in healthy living activities.

Both organisations are already involved in advancing focussed work with our communities, and we expect that this progress will be advanced as we become a single organisation.

14.3 Key priority areas for reducing inequalities

NHSE set out five key priority areas for reducing inequalities in healthcare, which underpin the work of the National Healthcare Inequalities Improvement Programme (HiQiP). These were reinforced through the 2024/2025 NHSE priorities and operational planning guidance, and they include:

- Restoring NHS services inclusively – after the COVID-19 pandemic
- Mitigating against digital exclusion
- Ensuring data sets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability

Through our joint Health Equity Group we agreed to add a sixth priority area:

- Tackling workforce inequalities

These six priorities provide a useful framework for our plan to reduce inequalities in our local population, with the BCT programme a key enabler for positive change.

We are working closely with the NHS Cheshire and Merseyside ICS and both WHH and BCH are key stakeholders in the Warrington and Halton Place Boards. These Boards are driving transformative change in services and patient outcomes, informed by insights from the Marmot altogether fairer report and Core20PLUS5 framework in Cheshire and Merseyside.

WHH and BCH are also making use of resources from public health teams at the Cheshire and Merseyside ICS, local authorities, and national tools such as the CIPHA dashboards and the NHS England health inequalities improvement dashboard, to guide and focus our programme of work on reducing inequalities and improving outcomes.

14.4 Deprivation and links to health service use

Details about our local populations and some of the high-level statistics about deprivation and life expectancy are included in chapter 5 of this document. These deprivation patterns are also heavily reflected in health service use.

Ambulatory care sensitive conditions (ACSCs) are health conditions like asthma, diabetes, or heart failure that can often be managed safely at home or in the community, without needing emergency hospital care. The rate of ACSCs tells us how many people per 100,000 population were admitted to hospital for these conditions.

AGI (Absolute Gradient of Inequality) shows how unevenly avoidable hospital admissions are spread across different neighbourhoods. A higher AGI means a bigger gap between the most and least deprived areas.

Halton has an ACSC rate of 3,236 per 100,000 population and an AGI of 4,389, indicating both a high burden of avoidable hospital admissions and a steep inequality gradient. This means that in Halton, people in more deprived areas are far more likely to be admitted for ACSCs than those in better-off areas. Halton has both a higher overall burden of avoidable hospital admissions and greater inequality in who is affected.

Warrington’s ACSC rate is 1,921 per 100,000, with an AGI of 1,309, suggesting lower overall demand and moderate inequality in access and outcomes.

In both areas, but particularly in Halton, there is a strong case for targeted health and wellbeing interventions—such as neighbourhood primary care interventions, health literacy support, and outreach in priority wards. As outlined earlier in the section describing the clinical vision, the integration of the community and acute Trusts will allow us to accelerate work in this area, including through the adoption of neighbourhood hubs as a vehicle for intervention.

14.5 Priority wards for intervention

The national Health Inequalities dashboard has identified small areas (wards or neighbourhoods) within Warrington and Halton where people are more likely to experience avoidable health problems—especially those that lead to emergency hospital visits. These areas are flagged as “priority” because they show:

- High rates of unplanned hospital admissions, especially for conditions that could be managed earlier or in the community (like asthma, diabetes, or heart failure).

- Wider health inequalities, often linked to deprivation, ethnicity, or access to care.

In Warrington, these areas include:

- Fairfield and Howley
- Birchwood
- Poulton North
- Burtonwood and Winwick

In Halton, these areas include:

- Halton Lea
- Appleton
- Ditton, Hale Village and Halebank

The areas above include a number of the most deprived areas within our local catchments. Deprivation is strongly linked to mental health need, substance misuse, housing insecurity, and child poverty—all of which compound health inequalities.

Deprivation intersects with other factors—ethnicity, gender, disability, LGBTQ+ identity, and age—to deepen exclusion and reduce access to care.

Residents in deprived areas often feel disconnected from mainstream services, citing lack of trust, cultural relevance, and continuity. This disconnect reinforces cycles of poor engagement and unmet need, particularly in areas with high AGI and ACSC rates. The opportunity to create a new community-focused model of care to provide greater reach into these areas is both exciting and also necessary.

14.6 Local challenges around health inequalities

The following sections detail some of the most significant health and wellbeing challenges across our local populations in Warrington and Halton. The opportunities to transform how care is delivered and make a significant impact on the lives of the local population are clear to see.

14.6.1 Children and young people (CYP)

- Halton has higher levels of child poverty, with several wards in the top decile of deprivation nationally. This is linked to poorer educational outcomes, increased safeguarding concerns, and higher rates of mental health need.
- Warrington shows growing diversity among CYP, particularly in urban wards, with increasing demand for culturally responsive services.
- CYP in both Places face rising mental health needs, including anxiety, depression, and self-harm—exacerbated by post-pandemic disruption and digital pressures.
- Halton reports higher rates of obesity, dental decay, and hospital admissions for asthma and respiratory conditions.
- Warrington's JSNA highlights gaps in neurodevelopmental pathways, including ADHD and autism diagnosis delays.
- CYP from deprived backgrounds are less likely to access early help, and more likely to present in crisis.

- SEND services face pressure across both Places, with long waits and fragmented transitions to adult care.
- Young carers, care-experienced children, and those from minority ethnic groups often fall through the cracks of mainstream provision.

14.6.2 Men

- The JSNAs and supporting public health intelligence indicate that men are less likely to engage with preventative services, have lower health-seeking behaviours, and are overrepresented in emergency care settings.
- In Halton, men have lower life expectancy and higher rates of premature mortality, particularly from cardiovascular disease and cancer.
- Non-attendance patterns are not always broken down by gender in JSNA summaries, but broader NHS data and local audits suggest that men are more likely to miss outpatient appointments, especially in deprived areas.

14.6.3 Women

- In both Places, women live longer than men but spend more years in poor health, especially in later life.
- Healthy life expectancy for women is lower in Halton (~62.1 years) than in Warrington (~64.8 years), and both trail national averages.
- Women in deprived areas experience earlier onset of long-term conditions, including musculoskeletal disorders, mental health issues, and cardiovascular disease.
- Women are more likely to be primary carers, which can limit their ability to attend appointments or prioritise their own health.
- In Halton, women in deprived areas are less likely to engage with preventative services (e.g. cervical screening, contraception reviews).
- In Warrington, language barriers and digital exclusion affect access for women from minority ethnic backgrounds, especially in Eastern European, Black African and Caribbean and South Asian communities.
- Halton JSNA highlights gaps in perinatal mental health support, especially for younger mothers and those experiencing domestic abuse.
- Warrington's JSNA notes rising demand for fertility, menopause, and gynaecological services, with variation in access by geography and ethnicity.

14.6.4 Ethnic minorities

- Warrington has a growing ethnic minority population, with 11.9% of residents identifying as non-White British. This includes significant Eastern European, South Asian, and Black African communities, particularly in central and southern wards.
- Halton remains less diverse, with around 4.5% of residents from minority ethnic backgrounds. However, Gypsy, Roma, and Traveller (GRT) communities are specifically noted in the JSNA as experiencing entrenched inequalities and poor access to services. Whilst Warrington JSNA does not specifically highlight Gypsy, Roma and Traveller communities recent outreach to two sites in Warrington has highlighted similar levels of inequalities and poor access to services.
- Ethnic minority residents in both Places face disproportionate barriers to accessing care, including:
    - Language and literacy challenges

    - Digital exclusion
    - Cultural stigma around certain conditions (e.g. mental health, reproductive health)
    - Lower trust in services, especially among newly arrived or marginalised groups

- These barriers contribute to lower uptake of screening, higher rates of late diagnosis, and greater reliance on urgent care pathways.
- Many services do not consistently record ethnicity, limiting our ability to tailor care and track outcomes.
- Ethnic minority communities are often underrepresented in patient feedback, co-production panels, and strategic decision-making forums.

14.6.5 LGBTQ+

- LGBTQ+ residents in both Places face disproportionate health inequalities, often rooted in stigma, discrimination, and systemic exclusion.
- National and local evidence shows higher rates of:
    - Mental health challenges (e.g. anxiety, depression, self-harm)
    - Substance misuse
    - Barriers to accessing primary and preventative care
- Trans and non-binary individuals experience particularly poor outcomes, including delays in gender-affirming care and lack of inclusive service environments.
- Sexual orientation and gender identity (SOGI) data is inconsistently recorded across services, limiting visibility and accountability.
- LGBTQ+ communities are often underrepresented in patient feedback, engagement panels, and strategic decision-making forums.
- LGBTQ+ people who are also ethnic minorities, disabled, or living in deprivation face compounded barriers to care. Young LGBTQ+ people in Halton and Warrington report bullying, isolation, and unmet mental health needs, especially in school and family contexts.

14.6.6 Veterans

- Warrington and Halton are home to a significant number of Armed Forces veterans, including older adults, reservists, and those recently discharged.
- Many veterans live in deprived areas, and some face challenges related to housing, employment, mental health, and physical rehabilitation.
- Veterans may not always self-identify in healthcare settings, leading to under-recognition of their needs.
- Veterans are more likely to experience:
    - Mental health conditions, including PTSD, depression, and anxiety
    - Musculoskeletal injuries and chronic pain
    - Substance misuse and social isolation
- Access barriers include:
    - Stigma around help-seeking
    - Fragmented care pathways between military and civilian services
    - Limited awareness among staff of veteran-specific entitlements and needs

14.7 Integrated, place-based care as an enabler for change

The integration between WHH and BCH creates opportunities for the development of seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home.

Our medium to long-term clinical vision (described in chapter 10) is to develop neighbourhood-based models of care, building on the successes of collaborative projects like the Living Well Hub and looking to expand this approach into other localities. This allows us to embed trauma-informed, culturally competent, targeted care for disadvantaged groups closer to where they live and help prevent deterioration of health conditions and reduce the number of people reaching crisis point.

The following sections describe how the integration programme can become a key enabler for change linking back to the priorities outlined in section 14.3:

14.7.1 Priority 1: Restore NHS services inclusively

We will review opening hours, locations, and transport links to ensure services are accessible, especially for those in deprived areas. We will consider delivery of services from community hubs across all of our places, as these develop as part of a neighbourhood health agenda locally. We will consider public transport routes and work with local authority partners to ensure access to locations is as good as possible.

We will adopt a population-health approach to service planning and delivery, looking to deliver targeted services in locations where specific health outcomes are notably worse than other areas. Where possible, we will look at ways to extend access for particular groups living in the most deprived areas, where engagement tells us that those communities experience difficulties in accessing services in certain facilities or at certain times.

The two Trusts are already working closely in partnership in delivering from shared community spaces, including the Warrington Living Well Hub.

14.7.2 Priority 2: Mitigate against digital exclusion

Increasing the use of our Patient Portal will be a priority for the integrated Trust – but also giving patients help to access and use it, regardless of language need. In order to support patients with accessing the portal, we will explore onsite presence in our clinics, to show patients how to access appointments, letters, and test results via the portal.

We will ensure we make full use of text reminders for appointments – but also giving patients the ability to change/cancel appointments via the patient portal – so they don’t have to spend money waiting for a long time on the phone to speak to someone, to cancel or re-arrange an appointment that they cannot make – because it doesn’t fit with when their carer is available, or their working hours for example.

Alongside partners at Place, we have recently invested UK Shared Prosperity Fund (UKSPF) funding to upgrade digital infrastructure in a number of community locations across Warrington. This ensures residents have places they can use to access digital health and wellbeing services if they are unable to access them at home.

14.7.3 Priority 3: Ensuring datasets are complete and timely

We are working with other NHS Trusts across Cheshire and Merseyside to create a dashboard on the CIPHA platform (a Cheshire and Merseyside specific population health database) that is transparent and easy to use. It will combine our acute and community datasets to build a richer, place-based understanding of need—enabling predictive modelling, targeted outreach, and real-time monitoring of Core20PLUS5 populations.

Shared analytics will support proactive identification of patients at risk of poor outcomes, especially those facing digital exclusion, housing insecurity, or multiple long-term conditions. For example, we are trialling using the data we have available to carry out active case finding of undiagnosed COPD patients to enable early outreach and support.

14.7.4 Priority 4: Accelerate preventative programmes

The integration enables seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home.

We will look to expand the model of co-locating connected services, making early support easier to find and easier to access for those who may need it.

In March 2025, we launched the Living Well Warrington digital platform[44] in partnership with numerous stakeholders from across Warrington. The new platform further strengthens the local offer around prevention, early intervention, and empowering self-care through a “community-led” approach. It empowers users to navigate their health and wellbeing journey more independently as the single digital entry point for any health and wellbeing-related enquiries for the whole of Warrington.

As at the end of September 2025 the platform included almost 700 individual support services and events on offer across the town and had received over 93,000 individual views.

14.7.5 Priority 5: Strengthen leadership and accountability

Each executive director in the new integrated organisation will have personal objectives to tackle health inequalities. This is a model that WHH executive directors currently follow.

We will explore the new integrated Trust Board taking responsibility for overseeing the health inequalities plan and that the Chair and each non-executive director will oversee components of the strategy.

The integration strengthens our role as an anchor institution within Warrington and Halton, deepening collaboration with local authorities, voluntary sector partners, and the ICS.

We will co-deliver population health programmes, support inclusive economic development, and embed community voice into governance and service design.

14.7.6 Priority 6: Tackling workforce inequalities

[44] Living Well Warrington (2025) *Live well in Warrington*. Available at: www.livingwellwarrington.org

Working as an integrated organisation, the combined Trust will extend already developed programmes supporting staff in a variety of areas, including:

- Mental health and wellbeing - counselling placements within mental health wellbeing hub to support staff.
- Occupational health and support- occupational health pre-employment process updated to reflect workforce needs aligned to the workforce equality and diversity and inclusion strategy.
- Reasonable adjustments- signposting to Maximus, an access to work mental health provider to support individuals with long term mental health conditions. Implemented a passport to support staff with the resources to remain in work and thrive.
- Prevention programmes- multiple prevention programmes and packages delivered focused on cardiovascular disease, menopause, mental wellbeing and musculoskeletal conditions.

15.0 Communications and engagement

15.1 Chapter summary

This section describes the comprehensive engagement undertaken with staff, patients, system partners and the public throughout the integration process.

It demonstrates how both Trusts have embedded transparency, inclusivity and co-production into all communications activity, aligned with the Better Care Together Communications and Engagement Plan.

The section evidences the ongoing collaboration with local authorities, primary care, voluntary and community sectors, and NHS England. It highlights the success of staff engagement sessions, leadership forums and stakeholder briefings in building shared understanding and support for the transaction, ensuring that change is developed with, not for, our people.

Key message: Continuous open communication has been fundamental to this programme's success. Alongside the Patient Experience team, we are working in partnership with Health Watch to ensure service users and partners have their voice heard and that it is central to our developing clinical integration workstreams and joint strategies.

We are continuing with stakeholder engagement meetings, events and activities, ensuring that the insight that we gather informs our integration plans. This has been carried out through a wide variety of channels, including websites, video content, case studies, social media channels, patient and public engagement sessions and surveys to ensure local people are aware of our plans to integrate, our name change, and the key messages that support our future as one organisation.

15.2 Approach to communications and engagement

There is a programme for ongoing two-way stakeholder communication and engagement regarding our partnership and the planned integration of the two organisations. An established and embedded communications and engagement plan has been developed and is being implemented to help us achieve the following:

To communicate proactively and inclusively about the integration to help both Trusts come together as one new organisation, supporting colleagues and ultimately improving patient care.

This plan will therefore enable audiences to:

- Engage with or understand changes in patient pathways and service improvements.
- Participate in or be informed about the integration process.
- Recognise integration benefits and have opportunities to ask questions and receive answers.

Our communications and engagement objectives are to explain how, in collaboration with local partners, patient pathways are being improved to deliver

integrated, comprehensive care that meets identified needs. This is achieved by the following:

- Outlining how integration supports this
- Detailing anticipated impacts of the integration for staff and communities
- Summarising the steps taken toward integration and noting key milestones

Further to the points mentioned above, we will also:

- Share information transparently about emerging issues and respond to stakeholder queries
- Ensure stakeholders understand how they can contribute their views, and clarify actions taken in response to feedback
- Offer stakeholders accessible information and opportunities for engagement through appropriate channels
- Make certain that patient and public perspectives are included in the development of patient pathways, and that they participate in changes affecting them

Our communications and engagement plan can be found within the supporting documents to the FBC.

15.3 Communication and engagement principles

At the heart of the developed communications and engagement plan, several well-established communication principles known to the NHS are used and embedded. These are as follows:

1. Clarity and trust

With the need to engage a broad audience, clarity and trust are essential to achieving our communication goals. Alongside the ‘Seven Cs of effective communication’ — clear, concise, concrete, correct, coherent, complete, and courteous — our messaging about Better Care Together must be strongly aligned with our key messages and personalised for different audiences.

We must be open and honest in line with our values to help build trust, communicating as much as we can, as soon as we can.

2. Compassionate and reassuring language

Change can often feel unsettling. A new partnership, like this one, may raise concerns about forced changes or, in the worst case, job security. Our language should reassure both colleagues and patients that they play a vital role in our mission and that we are working with them and for them, not against them.

We should select language that resonates with each audience, avoiding a one-size-fits-all approach. For internal communications with staff, consistency in language across both organisations is imperative.

3. Aspirational yet realistic

Our language should inspire hope and a sense of purpose, using active terms like "building", "strengthening", "combining", and "flourishing" to convey positivity, dynamism and purpose.

While Better Care Together is ambitious, aimed at long-term sustainability for our colleagues and patients, our communication must strike a balance between being aspirational and realistic. We should communicate our goals and processes in a way that is inspiring, beneficial and grounded in reality.

4. Accessible and timely

Information about Better Care Together should be available in various formats to ensure that all audiences can access it in the way that suits them best. Urgent or important information must be communicated internally within both organisations at the same time. Less important information should be timed to be issued as closely together as possible.

We commit to communicating internally with our staff before we communicate externally, so that staff hear news from us first, and not from external sources.

5. Start with people

Collaborative and meaningful partnerships should start with people and focus on what really matters to our communities and staff. There are clear benefits to working in partnership with people and communities:

- better decisions are made about service changes and how money is spent
- reduced risks of legal challenges
- improved safety, experience and performance
- helps address health inequalities by understanding communities' needs and developing solutions with them.

It is about shaping a sustainable future for the NHS that meets people's needs and aspirations. We commit to effective engagement with staff, stakeholders and communities, including people with lived experience.

6. Close the loop

Clear and consistent communication is essential for effective engagement. Beyond encouraging staff and patients to voice their opinions, our communications and engagement activity should also 'close the loop', clearly demonstrating how their input has influenced the outcomes of this new way of working together.

This applies not only when feedback has been implemented but also when we cannot make changes in line with the feedback received.

Our communications and engagement work is further guided by the following ideologies:

- Leadership is demonstrated through visible executive and clinical involvement
- Messaging remains consistent across both Trusts
- We maintain openness about each stage, acknowledging challenges honestly
- Patient and public feedback informs integration plans
- We clearly communicate the benefits of change

Our communications and engagement plan aims to keep staff, stakeholders, patients and the public informed about our joint work, including:

- Progress in partnership arrangements with real-life benefits
- Options considered for moving forward and reasons for integration, focusing on patient, community and staff advantages
- Impact of changes on colleagues, services and local residents
- Support for teams and individuals during adjustments, especially with new working arrangements
- Integration of strengths from both Trusts to maintain excellent care.

Our staff engagement initiatives are designed to further cultivate a unified organisational culture by facilitating consistent communication on integrated working, as well as coordinating collective events and activities such as the annual staff Thank You Awards, health and wellbeing programmes, and streamlined internal communications.

We are committed to actively listening to our staff, patients, the public and stakeholders, ensuring that the insights gained through our communications and engagement efforts directly inform the development of our integration strategies.

15.4 Key messages for the integration

Strong narrative and key messages are fundamental to all communication activity relating to our integration programme. Overarching messages form the basis of our communication with different stakeholder groups and are tailored as the integration progresses and for specific audiences and different communication channels / formats.

In line with our communications and engagement principles, the key messages (as outlined below) need to:

- be repeated often so that they become embedded in people's minds

- be simple and memorable so that they can be recalled and repeated

	Key message 1 (why) We want to provide better care together	Key message 2 (what) We are joining forces and working as one	Key message 3 (how) With shared leadership, we are integrating our services
Supporting messages	Warrington and Halton need strong and resilient clinical services	Together we will improve healthcare services for our communities	We have a joint CEO and shared executive team
	Our healthcare system must be sustainable for the future	We'll involve staff, partners and people with lived experience	We've established an integration programme called Better Care Together
	We can achieve more together for patients and staff	We will work and behave as a single organisation	We need your support to make it a success

Table 52: Our key message grid

This is articulated in narrative form as:

We want to provide better care together. Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the

future. We know that we can achieve more together for both our patients and staff.

We are joining forces and working as one. Together we will improve healthcare services for our communities. We'll involve our staff, partners and people with lived experience and we will work and behave as a single organisation.

With shared leadership, we are integrating our services. We have a joint chief executive and a shared executive team. We've established an integration programme called Better Care Together and we need your support to make it a success.

In addition to the key message grid, early messaging related to integration was published on our respective websites.

As the integration journey progresses, a dedicated partnership website has also been created and is available at www.northcheshireandmersey.nhs.uk.

A full staff microsite for the partnership has also been created for WHH and BCH colleagues. Like the partnership website, the dedicated staff microsite also contains a wealth of information from the latest integration news to frequently asked questions.

Over the past year, we have engaged extensively with colleagues, partners, governors, patients, and members of our local community regarding our strategic direction and the role our integration plans will play as a catalyst for positive transformation.

Our focus is now shifting towards a comprehensive information and awareness campaign designed to ensure that our integration into a new single organisation, its forthcoming name change and supporting key messages reach as many local residents as possible in the wide-ranging communities we serve.

This campaign will incorporate a variety of communication channels, including posters, website updates, social media posts, digital screens, media releases and short-form video content to name but a few. Any campaign will continue to be fluid in nature and will adapt as the need requires.

15.5 Clinical integration workstreams: patient engagement and involvement

An early deep dive into patient engagement and involvement of each Trust was undertaken at the very beginning of this integration journey. This helped set a benchmark of any potential gaps in assurance so these could be focused on quickly and efficiently.

From a BCH perspective, engagement and involvement is currently overseen by the Bridgewater Engagement Group. This includes patient, carer, public and staff engagement and includes public governors and representation from both Healthwatch Halton and Healthwatch Warrington. The main vehicles for supporting and facilitating co-design and involvement in projects within clinical services are through local Patient Partner projects.

Within WHH, engagement and involvement activity is co-ordinated within the Communications and Engagement Team, in partnership with clinical and corporate teams. Assurance on patient and public engagement and involvement

activity is also provided through bi-monthly high level briefing papers to the WHH Patient Experience and Inclusion Sub-committee and reporting to Board.

The main vehicle for supporting and facilitating co-design and involvement of service users, carers and advocates within projects and future developments is WHH's lived experience volunteer programme (Experts by Experience).

Foundation Trust public governors are engaged through the respective Council of Governor meetings, WHH's Governor Engagement Group and BCH's Public and Community Engagement group and via sharing information with Foundation Trust members through regular member newsletters.

Taking the above sovereign engagement channels into account, a community stakeholder mapping exercise has been completed, with the following being identified as key patient and public stakeholders.

People and carers:

- Patients / people
- Carers / guardians
- Advocates
- Families
- Patient groups
- Advocacy / support groups representing people with protected characteristics
- WHH Charity
- Warrington League of Friends
- Voluntary, Community, Faith and Social Enterprise (VCFSE) networks
- Community groups
- Patient Advice and Liaison Service (PALS)
- Volunteers
- Experts by Experience / Patient Partners
- Patient Safety Partners
- Veterans / armed forces members
- Wellbeing services (local authority commissioned)
- Hospital radio stations (ref HWH segment on Radio Halton)
- Wheelchair Users Group (St Helens)
- Local authority engagement networks, including those for marginalised / under-served communities

Influencers:

- Healthwatch organisations (Warrington and Halton)
- MPs
- Councillors
- Media/comms colleagues
- Public and partner governors
- Foundation Trust members

Following this stakeholder mapping exercise, our approach to patient engagement and involvement is clear:

1. We have established a BCT patient and public reference group (PPRG), independently chaired by our local Healthwatch partners, which will formally report into the BCT programme delivery group. This group will tap

into wider engagement networks and will help act as a critical friend to ensure that the voice of our patients and local public is heard. The first meeting of the PPRG is to take place in November 2025.

2. We will provide wider opportunities for local people to hear about our integration plans directly from senior leaders. We will support opportunities to ask questions, make suggestions and share thoughts and concerns, ensuring these are shared across the wider integration programme. Feedback received to date from our local public about the integration programme can be found later in this chapter and in the supporting evidence.

3. We will engage and consult as required on specific changes to clinical services which impact on how people and communities in the core areas of Warrington and Halton access services across both BCH and WHH.

4. We will engage with people and communities regarding services delivered outside of Warrington and Halton and over our wider geographical footprint:

    - BCH Community Dental Services (Bolton, Bury, East Cheshire, Halton, Heywood, Middleton, Oldham, Rochdale, Sandbach, St Helens, Stockport, Tameside & Glossop, Trafford, Vale Royal are of Cheshire, Warrington, Western Cheshire & Chester and Wigan Borough)

    - WHH Breast Screening Services (Warrington, Halton, St Helens and Knowsley)

    - BCH services delivered in St Helens (Paediatric Audiology / Hearing Screening, Community IPC, Community Equipment Service, Occupational Therapy for Assistive Technology, Wheelchair Service)

    - BCH Drive Ability North West

15.6 Integration of clinical and operational pathways

The progress to date around identifying priority clinical services for integration is described in detail in section 10.5.2. Public, patient and partner involvement will continue to be crucial in the next steps of the integration journey.

To support this activity and to ensure meaningful engagement informs any changes to services, patient and public engagement support will be provided via the BCT communications and engagement workstream. This will involve:

- Support to inform the completion of an Equality and Health Inequalities Impact Assessment for each element of proposed change
- Delivering a programme of in person and online awareness sessions for staff: ‘Engagement, involvement and public consultation duties in service change’

- Updated online ‘equality and health inequalities assessment (EHIA)’ training to include 'engagement, involvement and public consultation duties in service change'.
- Identification of key partners and stakeholders to involve in the development of proposals for change
- Benchmarking of patient experience metrics
- Identification and facilitation of appropriate mechanisms for engagement and involvement of patients and communities using the approaches outlined earlier in this section

15.7 Stakeholder communication and engagement methods

Keeping in line with our communication principles and overarching communications and engagement plan, our stakeholder map helps us to ensure we are communicating and engaging regularly with stakeholders.

15.7.1 Engagement tools

We have kept colleagues, partners, and the public informed about our vision to improve health outcomes by removing and respective organisational barriers to integration.

In addition to using our usual, and well-established communication channels, we continue to develop new resources to keep everyone updated and expand our audience reach where possible. A joint communications channel matrix can be found in the supporting documents to this FBC.

In addition to the matrix, several channels are highlighted in greater detail as follows:

a) Public website

As integration progresses, and communication becomes more coordinated between both organisations, a dedicated partnership website has been created.

This website contains a wealth of information to the public and wider stakeholders, such as information about the integration journey, frequently asked questions (FAQs) and latest news. The www.northcheshireandmersey.nhs.uk address will subsequently transform into our newly integrated public-facing website once the transaction is complete.

During this time of transition, each sovereign organisation will continue to promote the partnership website and will signpost to it from their respective site.

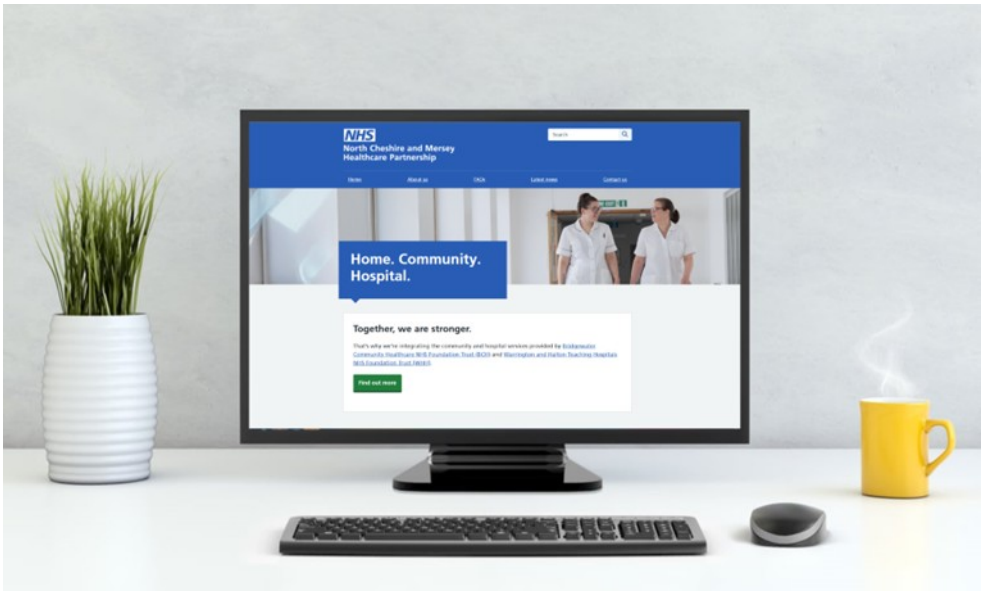


Figure 31: The public facing partnership website

b) Staff microsite

A bespoke staff microsite was created at the very beginning of our integration journey. Its purpose was to reduce duplication of resources and stop any potential misinformation between the two organisations, but more importantly a sole microsite would mean us having one consistent and strong message.

The staff microsite continues to grow in popularity and is very much the ‘go to’ destination for the latest information on integration. As such, it is promoted heavily at every opportunity.

The site contains sections such as information about the integration, details about the various programme workstreams, frequently asked questions, case studies and resources.

Alongside the joint staff microsite, a communication channel matrix has been developed to document the existing sovereign channels for each organisation and outline intended steps to integrate these channels. This matrix can be found in the supporting evidence section of this document.

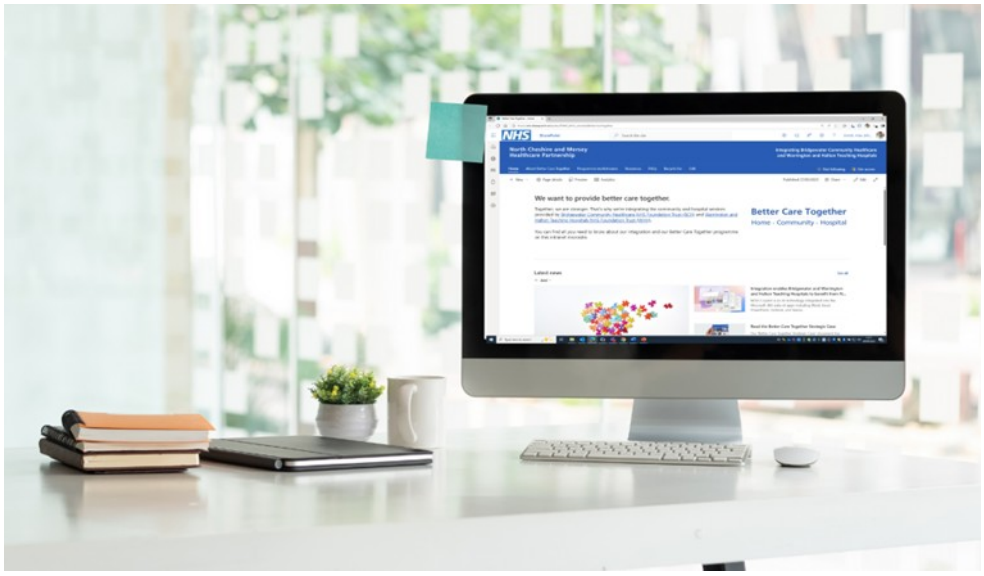


Figure 32: The staff facing microsite

c) Monthly staff engagement briefings

Since February 2025, we have held monthly one-hour staff engagement sessions to update staff on the Better Care Together programme and provide a forum for questions.

These well-attended sessions now include spotlights on relevant topics such as the joint culture plan and organisational change framework. Event details and joining links are shared in advance on the staff microsite and promoted through all communication channels.

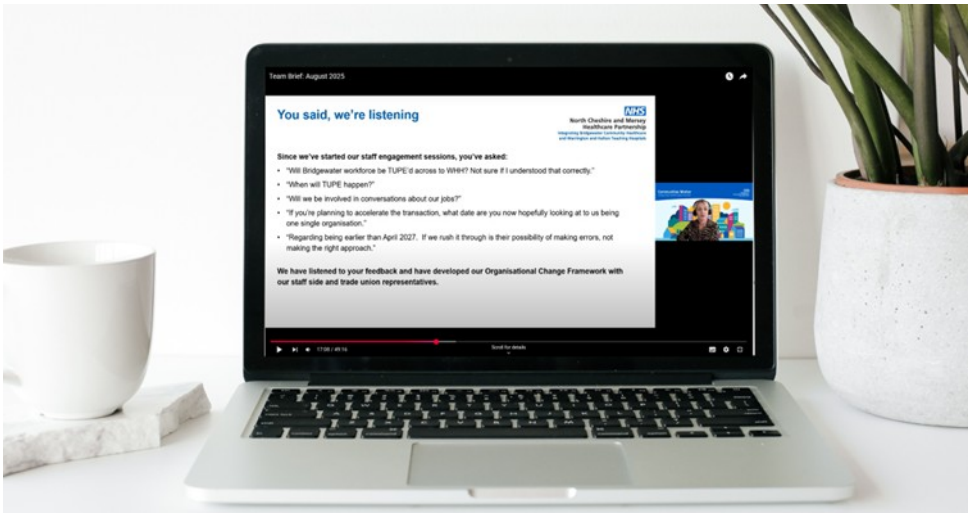


Figure 33: An example of the monthly staff engagement session

d) Partnership stakeholder update

Our joint partnership newsletter is continually evolving and distributed to stakeholders on a monthly basis.

In addition to providing updates regarding the progress of our integration efforts, the newsletter highlights broader initiatives and demonstrates areas where

services and pathways have started to converge to enhance patient care and expand staff development opportunities.

This regular communication serves to illustrate the value of integration by presenting concrete examples of the advantages associated with collaborative working, thereby offering stakeholders insight into how these changes may positively influence both the provision and experience of care.

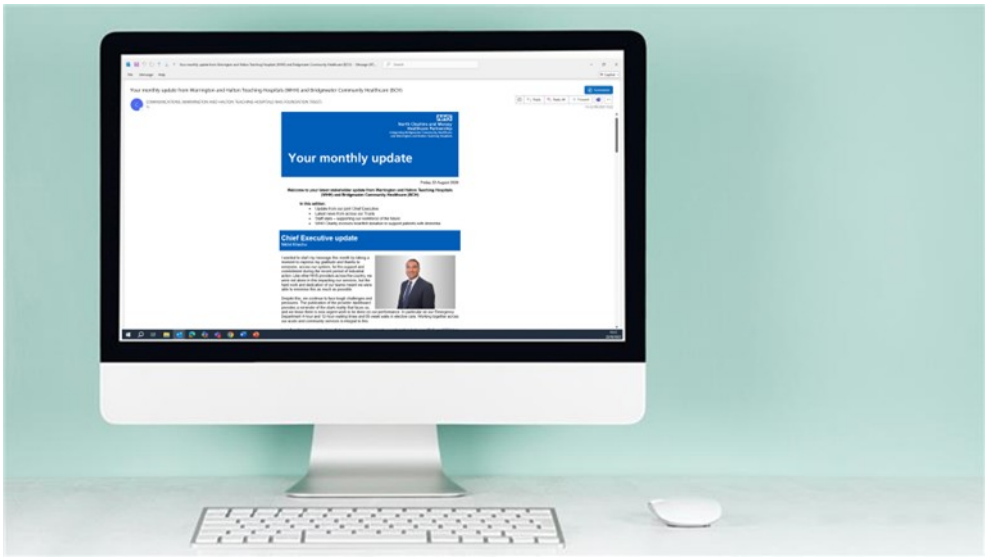


Figure 34: An example of the monthly stakeholder update

e) 60 second animation explainer

A 60-second animation has been produced to further explain the reasons for integration and its benefits. This short video is intended as a method to communicate the process in a clear and accessible manner. Additional animation and explainer videos will be created to provide further information about the advantages of integration for the public and stakeholders as we head ever closer to the proposed transaction date. This animation is prominent on the home page of the new partnership website (northcheshireandmersey.nhs.uk). It has also been shared on respective organisational websites, social media channels and in our joint stakeholder bulletin.

f) Community engagement activity

Our respective organisations coordinate attendance by a range of services at annual community engagement events.

In addition to raising awareness of specific services, these have been used as an opportunity to seek feedback from our communities on our integration proposals and to identify any key themes or considerations which have been detailed in section 15.8. A flavour of this community engagement activity is outlined as follows:



Figure 35: Public engagement at Disability Awareness Day 2025



Figure 36: Public engagement at Warrington Pride 2025



Figure 37: Public engagement at Chinese Lunar New Year Fun Day 2025

15.8 Staff engagement

Aligned to the Better Care Together workforce workstream, our approach to staff engagement will help ensure that staff feel valued, informed and engaged:

1. Collaborative engagement through joint staff engagement channels - we will establish joint engagement groups where this is appropriate, including representatives from both Trusts to collaborate on integration goals and share feedback. By involving staff in decision-making processes, we will ensure that integration respects and reflects the insights of our workforce.

2. Open and transparent communication forums - we will conduct regular, open forums with programme leadership, offering clear, transparent updates on the integration process. These sessions will include Q&A opportunities where staff can voice concerns and ask questions directly. The aim of this is to ensure that our staff remain informed and confident in the integration progress and are given a platform to express their views openly.

3. Consistent mechanisms to gather and act on staff feedback - we will establish reliable, easy-to-use feedback channels, such as surveys, suggestion boxes, and focus groups, to continuously gather staff input. Feedback will be reviewed, and outcomes will be shared to demonstrate how staff input informs integration decisions. With mechanisms such as the quarterly people pulse and staff survey in place, the review of this information will be themed and aligned to inform staff engagement plans.

4. Continuous and accessible communication channels - we will ensure that staff have access to regular engagement mechanisms in a variety of formats, ensuring all staff can access them and feel informed. Ensuring an open engagement approach when even if there are no new updates, we will maintain these channels to reassure staff and share progress reminders.

5. Taking a diversity and inclusivity approach - we will take an inclusive approach to engagement which respects the diversity of our workforce, the perspectives, roles, and contributions within both Trusts. Celebrating shared successes and addressing personal challenges collectively, aiming to create a positive environment where staff from all backgrounds feel welcomed and integral to our unified future.

15.9 Internal stakeholder analysis

A comprehensive stakeholder mapping exercise has been conducted, resulting in the identification of key internal stakeholders relevant to both organisations, unless otherwise specified. Additionally, it should be noted that communications and engagement activities - both internal and external - are systematically coordinated and aligned.

- Trust Boards
- Executive Management Team
- Council of Governors
- Trade unions
- Culture Champions (WHH)
- People Promise Champions (BCH)
- Culture, Inclusion and Engagement Teams (WHH)
- Staff Engagement Lead (BCH)
- Equality, Diversity and Inclusion Manager (BCH)
- People Promise Manager (WHH)
- HR Business Partners
- Staff network leads
- Operational and clinical managers who lead staff forums
- People Directorates’ senior leadership teams

- Wider senior leadership teams – clinical and corporate
- Operational and clinical managers
- Line managers
- Better Care Together programme workstream leads / delivery groups

15.10 Meeting governance

The following have been identified as key internal meetings / groups / forums that will need to be involved and engaged to varying degrees (applicable to both organisations unless otherwise stated).

- Trust Board meetings
- Board People Committees
- Sub-Board level People Committees
- Executive Management Team meeting
- Council of Governors meetings
- Better Care Together programme delivery group, executive delivery group and workstream delivery groups
- Joint Negotiation and Consultation Committee (JNCC)
- Joint Local Negotiation and Consultation Committee (JLNC)
- People Promise Champion meetings (BCH)
- Culture Champion Chats (WHH)
- Staff network meetings
- Staff network chairs and executive meetings (WHH)
- Staff Voice Forum (WHH)
- Leadership Forum
- Staff health and wellbeing groups
- People directorate forums
- Executive-led engagement groups (e.g. Chief Nurse Check In forum)

15.11 Stakeholder engagement on the integration

15.11.1 Stakeholder analysis

As outlined in section 15.5, an external stakeholder mapping exercise has been completed. To further expand on this, a large number of stakeholders and forums have been identified as key stakeholder to keep informed and engaged at the appropriate level required.

15.11.2 Our approach

We regularly produce presentations for partner organisations and forums to keep them informed of our integration plans and progress made. This ensures that consistent messaging is being given across the range of external forums attended, and that it is aligned to our internal communications.

Partner organisations have been involved as required throughout the duration of our integration, e.g. by attending clinical and operational services workstream workshops, or engagement events for our shared communities.

Key partners continue to be represented on the BCT ICS steering group, and we continue to discuss integration as part of our routine Trust stakeholder engagement meetings, with MPs for example.

In October 2025, we have reintroduced and refocused our monthly strategic stakeholder meeting to concentrate on integration and strategic estates developments. This meeting includes our local authority chief executives, local MPs, and councillors and provides a forum for sharing updates, answering questions and receiving feedback.

Our respective council of governors have been kept informed and updated on the integration programme and progress through various forums including WHH governor engagement group, council of governors and BCH public and communities' engagement group.

Following agreement at the BCH public and community engagement group and WHH governor engagement group in summer 2025, proposals were approved by the respective council of governor's meetings to bring together BCH governors with WHH governors in a 'governor engagement group in common'. A draft terms of reference and cycle of business for the combined group has been developed with input from both sets of governors and membership engagement leads.

15.12 What we have heard so far – key themes

Alongside the approach for individual clinical pathways set out earlier in this chapter, feedback is collected on an ongoing basis from multiple sources. This includes from public discussions at community engagement events such as disability awareness day, armed forces day, and Warrington mela. The BCT communications and engagement workstream reviews this feedback and has identified the following areas of feedback.

Trust-wide benefits

- Improved convenience and accessibility
- Better communication and coordination
- Enhanced service efficiency and quality

Location improvements

- Central hub locations for multiple services
- More venue choice and provision
- Local venues with adequate parking / public transport links

Service improvements

- Operational improvements
- Improved patient experience
- Reduced waiting times
- Reduced travel time, costs and parking

Concerns

- Resources and funding limitations
- Staffing levels / workload pressures
- Implementation challenges

Most staff and public feedback is positive, but concerns remain about implementation, especially around staffing and capacity. Respondents want assurance that the integration programme will be adequately resourced and

managed without harming staffing levels. This assurance will continue to play a part of our overall communications and engagement activity.

Feedback received informs the communications and engagement activity we undertake, with targeted communications implemented where required. It also contributes to our frequently asked questions, which are regularly updated, and is fed back to other integration workstreams where required for action.

15.13 New name for our joint organisation

An engagement exercise was carried out over four weeks from 10 January to 9 February 2025 to gather feedback on a new name for the Trust. The consultation included staff, members, governors, partners, and experts by experience panel members. Healthwatch networks and voluntary, community, and faith groups in Halton and Warrington were also invited to participate, along with attendees at events during the engagement period.

Feedback was collected through an online survey, accessible via a link or QR code displayed on posters in clinic spaces and waiting rooms, and through printed surveys distributed to community clinics. The survey was also shared internally via a chief executive message, regular Trust bulletins and the monthly joint staff brief.

The survey presented five possible name options, inviting respondents to comment on each and suggest alternatives. There were 370 individual responses. Analysis of the results included sentiment assessment and identification of common themes. Key themes identified included the challenge of representing the integrated Trust's entire geographical area and concerns about names implying takeovers rather than partnerships, as well as potential confusion with existing organisations.

A review of the 178 alternative suggestions showed that many did not meet NHS identity guidelines for naming conventions. After considering all feedback, the partnership name 'North Cheshire and Mersey Healthcare Partnership' was chosen, with plans for the future name of the integrated organisation to **'North Cheshire and Mersey NHS Foundation Trust'.**

To represent Bridgewater's community dental services provided outside the core Trust area, a standalone service name, 'North West community dental service', was agreed, in line with the naming approach used for other services covering a wider area.

Further details on the feedback analysis are available in the presentation which went to both Trust Boards. This can be found in the supporting documents.

15.14 Measuring the impact of our work

The communications team continues to track and analyse metrics to inform engagement efforts. These include:

- Webpage and microsite visits
- Attendance at events and meetings
- Readership of online newsletters (where possible) e.g. membership / staff news
- Social media engagement (where appropriate)
- Responses to surveys

- Feedback from rolling programme of internal and external engagement

An example of a recent communication and engagement activity log is included within the supporting evidence section of this business case. This is updated on a monthly basis and is discussed as a standing agenda item at the Communications and Engagement Workstream Delivery Group.

Risks identified through communication and engagement activities are communicated via the appropriate channels and reported to the Better Care Together Delivery Group as they arise.

Our communications and engagement approach is designed to provide thorough support throughout each phase of the integration process. We recognise that our approach needs to remain dynamic, allowing for ongoing review and necessary adjustments to ensure continued effectiveness.

15.15 Supporting evidence

The following evidence supports this section of the business case and is all included in the supporting documents:

- BCT - Communications and engagement plan
- BCT - Joint communication channels (as of 09/25)
- BCT - Partnership name engagement and recommendations
- BCT - Integration activity – engagement and communication update (September 2025)
- BCT – Public feedback (August 2025)
- BCT - Microsite database
- BCT - Engagement and communications activity log (August 2025)

16.0 People strategy

16.1 Chapter summary

This section sets out the vision for a single, empowered workforce that underpins the success of the new organisation.

It highlights how integration will strengthen recruitment, retention, training and career development through shared education pathways, joint policies and aligned workforce planning.

The section describes work already underway to develop a joint people strategy, organisational development framework, and culture plan, ensuring a positive, inclusive and resilient workforce and discusses the two-phased approach to organisational development, both pre and post transaction.

It reinforces that our people are at the heart of integration, and that by uniting teams, aligning terms and embedding shared values, we will build an organisation where everyone can thrive.

Key message: The people strategy section details the workforce approach to integration. It discusses the plans and activities already in place for staff engagement, with over 1,500 staff attending regular joint engagement sessions since February 2025.

A combined workforce planning approach has been adopted which will recognise and embrace innovation, develop a robust workforce supply chain and incorporate demand forecasting.

Training and development elements such as a joint corporate induction have already been introduced and a continued collaborative and co-production approach will continue to build a foundation for one inclusive, empowered workforce.

16.2 Our people

For the past 18 months staff across WHH and BCH have been working together more closely to enhance healthcare services for our communities, improve patient experience and drive forward benefits for our workforce.

Our organisations employ around 6,700 staff who reflect the diverse communities of Warrington, Halton, Cheshire, Merseyside and Greater Manchester. We deliver services across 98 sites, including our hospital sites, local clinics and dental clinics, out in community locations and through care provided directly in service users’ homes.

We recognise the commitment of our staff to deliver high-quality, compassionate care. Consequently, improvements in patient and service user care will further our objective to transition care from hospital settings to locations closer to service users' homes, thereby making roles more rewarding for our teams as we achieve the ambitions of the NHS 10-year plan[45].

Integration will also create expanded opportunities for career progression by providing shared training and educational resources, supporting workforce development and retention. This initiative will facilitate opportunities for individuals seeking career advancement, new challenges or internal movement within our organisations.

Acknowledging that organisational culture shapes behaviours, our integration aims to unify and leverage the strengths of both Trusts. The NHS staff survey remains an important measure of workforce experience and fostering a shared culture at both organisational and team levels is essential to ensuring a positive work environment. This has been a priority during our transition period, utilising the strengths of our workforce to deliver service transformation for the future which is reflective of the NHS 10-year plan as we prepare to transition into our new organisation.

These developments will enable us to optimise and realign resources, enhancing our attractiveness to prospective employees and supporting retention of current talent. This approach encompasses both clinical and support team roles across WHH and BCH and establishes the foundation for collaborative work throughout the region. Through these improvements, we will ensure staff have access to the necessary support and resources to provide exceptional care, whether in patients' homes, the community or in hospital settings.

Our workforce spans 80 nationalities, mirroring the diversity of our communities. We aim to strengthen equality of opportunity and tackle health inequalities for those we serve and employ. Our vision is to build an inclusive, empowered team where everyone feels they belong, enjoys their work and consistently delivers excellent care in line with the NHS People Promise.

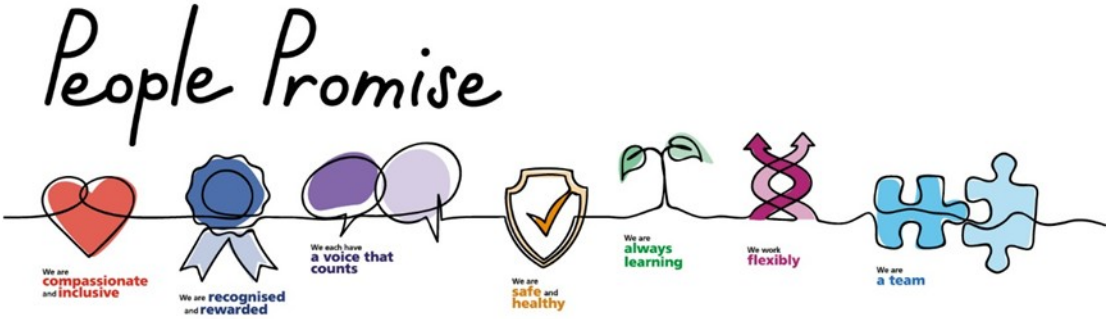


Figure 38: NHS People Promise

As a combined organisation delivering acute, elective, community and dental services, the integration offers a wide range of opportunities for the workforce to deliver effective care which impacts all areas of health. From listening to our

[45] Department of Health and Social Care (2025) *Fit for the Future: 10 Year Health Plan for England*. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

workforce during our Clinical Summits, they tell us they are excited by the opportunities that working closely together will bring. From seeking efficiencies in service delivery, proactively supporting health improvements and providing opportunities “to do things once”, our teams tell us that working closely together has already provided advancements in service delivery.

16.3 Staff engagement

Staff engagement is a key element of our integration plans; this is demonstrated in our Better Care Together Communications and Engagement Plan. Our commitment is to be open, transparent and inclusive in how we communicate, engage and co-create our future as one Trust.

Since February 2025, we have run Staff Engagement Sessions across both WHH and BCH, with over 1,500 attendees participating so far. These sessions form the backbone of our engagement strategy providing a consistent, large-scale platform to share updates, answer questions and gather feedback. They also allow managers to cascade key messages to their teams, ensuring alignment across the organisation while respecting employment law requirements and supporting staff through change.

In addition, we’ve held a monthly joint staff side meeting in place since December 2024, this has allowed us to engage in partnership and develop plans such as our organisational change framework, joint culture plan and discuss key matters which our workforce have raised.

In addition to these sessions, we’ve embedded engagement into our existing structures:

- Joint team briefs have spotlighted our progress on integration.
- Leadership forums have hosted dedicated sessions on the development of our organisational change framework and other key developments.
- Staff Network meetings have been vital in sharing messaging and gathering views to inform our plans and are now evolving into a staff network in common approach.
- We’ve actively involved our culture champions (WHH) and people promise champions (BCH) to listen and respond to staff voices and build momentum.
- We’ve used people pulse survey data to understand how staff are feeling and identify areas for support.
- Walkarounds across departments have provided invaluable anecdotal insights into how people are experiencing the integration process.
- Our Freedom to Speak Up guardians have been working collaboratively, increasing awareness of the processes under freedom to speak up.
- The BCH Deputy CEO has held a series of sessions to allow BCH staff to ask specific questions they may have relating to any potential or anticipated changes at BCH.

These multi-channel efforts ensure we’re engaging with our wider workforce, not just through formal sessions but also through everyday conversations and feedback loops.

Each staff engagement session includes a Q&A segment, with questions submitted in person or anonymously resulting in 142 questions, which have been

themed and compiled into a monthly FAQ sheet. This helps us respond meaningfully and transparently to the concerns and questions from our people.

We know that meaningful engagement is not a one-off, it's a continuous dialogue therefore we will continue to evolve our engagement plans and ensure these principles are embedded into consultation.

16.4 Workforce planning

As a combined organisation, we will establish a single, coordinated approach to workforce planning that aligns directly with our operational plans and long-term Trust strategic priorities. By bringing together expertise, systems and planning methodologies across the organisation, we will create an approach that ensures our workforce is optimally structured and equipped to deliver safe, effective and sustainable services.

This integrated approach will:

- Embed workforce planning as a core pillar of our people strategy – ensuring that our people agenda is not developed in isolation but is fully aligned with patient outcomes, service transformation, quality and financial sustainability.
- Recognise and embrace innovation – including the deployment of automated intelligence (AI), automation and digital tools to enhance service delivery, support staff and create new roles that will reshape how care and support are delivered in the future.
- Develop robust workforce supply pipelines – through targeted recruitment, retention and career development strategies that address current shortages, secure future talent and ensure a balanced skill mix across clinical and non-clinical roles.
- Incorporate demand forecasting and skills modelling – to ensure that our strategic workforce plan anticipates and responds to service demand, demographic change and evolving clinical models, rather than reacting to pressures as they arise.

By adopting this combined workforce planning approach, we believe the organisation will be well-positioned to meet the future demands of our population and drive forward clinical service transformation. It will provide clarity on how our people strategy directly enables operational delivery and ensures we are proactively shaping the workforce of today, not just meeting the challenges of today.

16.5 People services operating model

Work is underway to develop people service operating models for the new organisation as part of the corporate services integration workstream (see chapter 11). This will include structures, functions and principles for integration. It is recognised that this will involve meaningful consultation with our workforce and we anticipate this to take place between November 2025 and March 2026.

Our priorities since July 2024 have included scoping policy development and governance arrangements. By working collaboratively, we have already had opportunities to share best practice and implement policy improvements, including national policy frameworks, such as the sexual misconduct in the NHS

policy[46]. This work is continuing through the introduction of our joint staff side meeting on a monthly basis.

In addition, since April 2025, we have implemented a joint strategic people committee in common. This has allowed for opportunities to do things once where possible, align governance procedures and share the commonalities between both Trusts. This creates efficiencies as well as support the workforce at WHH and BCH in tandem.

The integration of the two organisations represents a key milestone in advancing the people strategy and workforce equality, diversity and inclusion strategy, as it will facilitate staff engagement and support the definition of new organisational ambitions which reflect the 'workforce standards' within the NHS 10-year plan.

16.6 Organisational culture – values for the new organisation

Since commencing our staff engagement sessions, we've had the opportunity to hear the thoughts and feedback of our workforce on our integration journey. Their insights have been important in guiding our principles as we come together.

In August 2025, we launched a values engagement exercise as an opportunity to co-create the values that will define our future as an organisation with effect from 1 April 2026. We recognise how our values lie at the heart of our Trust; shaping how we work, how we care and how we support each other. The aim of this exercise is to recognise the current values held by each organisation as well as seek an opportunity to develop something new which represents our future ambitions.

Our new values (detailed in section 8.6) will serve as the foundation for our future organisational strategy, culture and core business planning. We will actively embed them into a refreshed behavioural framework, our staff induction programme and organisational branding. By doing so, we will ensure that these values not only define who we are today but also guide our aspirations for the future, shaping how we work together and deliver care across the Trust.

Work to establish a new behavioural framework for the integrated organisation is progressing, building on the values developed through a staff engagement exercise. Feedback gathered from staff has been instrumental in shaping these values, which now serve as the foundation for the behavioural framework. To ensure the framework is meaningful and relevant, a working group is being set up, drawing on the involvement of staff side representatives, staff networks and champions from across the two Trusts. This collaborative approach ensures broad engagement and ownership.

A review of behavioural frameworks from other NHS Trusts and the private sector has been undertaken to identify best practice and avoid unnecessary duplication, with a clear focus on expanding and bringing our new values to life rather than reinventing them. The framework will be concise, memorable and simple, reflecting staff feedback and aligning with kindness research completed locally. It will also be designed to support the implementation of the NHS England

[46] NHS England (2024) *NHS England sexual misconduct policy*. Available at: NHS England » NHS England sexual misconduct policy

Leadership and Management Framework, while ensuring alignment with Medical Internal Professional Standards (MIPS).

The framework will be developed with reference to workforce policies, ensuring it supports standards of conduct and addresses misconduct appropriately. The plan is to ensure this is goes through governance processes and has a soft communications launch ahead of a formal go live on 1 April 2026. This structured and inclusive approach provides assurance that the new behavioural framework will be robust, relevant and ready to underpin the culture of the integrated organisation from day one.

Work to continue to build on the organisational culture, how this resonates with staff and new starters is noted within the post transaction integration plan (PTIP).

16.7 Organisational culture – organisational development (OD)

16.7.1 Phase one of integration - pre-transaction

Supporting our people through periods of change is fundamental throughout the integration. Creating our future organisational culture has so far been focused on understanding the cultures of both organisations. Since August 2024, the Organisational Development (OD) teams across both WHH and BCH have worked collaboratively to design packages which aim to build psychological safety and strengthen resilience to prepare people for a time of change.

The work of our people teams will continue to play a crucial role in supporting integration, transformation and cultural alignment. By developing behaviours, skills and culture, they will enhance the organisation's overall effectiveness, leading to better performance, employee experience, enjoyment and patient care.

This will create a workplace where both people and the business can thrive, promoting effectiveness and efficiency. To support our teams in their integration journey, OD has created a number of resources. They include a change management guide, team engagement strategies and a session facilitation toolkit. These initial management resources will help engage teams in the integration journey.

For teams anticipating high levels of change through the integration programme, OD offers facilitated sessions, including:

- Introduction to Leading Integrated Teams: Building trust and creating a shared purpose and vision to strengthen integrated teams.
- Team Integration and Managing Change: Exploring change and its impact on teams, using reflective thinking to enhance team integration.
- Creating Kinder Cultures: Developing professional workplace behaviours and fostering a culture of kindness within teams.

Additionally, OD will focus on leadership development, team building and resilience. Plans include measuring and evaluating culture over time to ensure continuous improvement and alignment with our organisational goals. Transition support will be provided to ensure a smooth integration process, helping our teams adapt and thrive in the new organisational structure.

To strengthen our OD plans, in July 2025 the Trusts implemented their first joint culture plan. As we move forward in our programme to become one Trust, we have taken a commitment to develop a shared culture that reflects the best of both organisations. Our plan sets out a clear and ambitious vision: to create one inclusive, empowered team where everyone has a good day at work.

To support this, cultural due diligence is already underway, with a strong focus on organisational development practices that help people navigate change. This includes exploring:

- How decisions are made across teams and services.
- What motivates our people and how we can harness that energy.
- The subcultures within teams, recognising that each has its own strengths and dynamics.

This work is not being done in isolation. We plan to continue to embed focus groups into the process to ensure that staff voices are central to shaping our future through channels such as the Culture Champions (WHH) and People Promise Champions (BCH), Freedom to Speak Up Champions as well as staff networks ‘in common’. These groups provide rich insights into lived experiences and help us understand what matters most to our workforce.

We’re also aligning our approach with the NHS cultural assessment toolkit, which has been used as a foundation for developing our joint culture plan (attached). This ensures our work is grounded in best practice and supports our ambition to deliver better care together.

Our staff survey results, with input collectively from over 3,000 colleagues, along with other engagement activities over the past 12 months, have shaped the three phases of our culture plan. We’re currently focused on ‘doing the basics brilliantly’, laying strong foundations for long term cultural transformation. We know this takes time and we’re not imposing a fixed timeline. Instead, we’re meeting teams where they are, recognising that different services will progress at different paces with a clear ambition for all our workforce to have a great day at work.

Ultimately, the aim of this has been about recognising the power of our people across both organisations. The culture we create together will not only shape our working lives, but it will also directly impact patient safety, experience and the success of our integration.

16.7.2 Phase two of integration programme – post-transaction

We anticipate that our targeted OD programmes will continue to run post-transaction for 18-24 months, ensuring that we have supported our workforce to thrive in the new organisation. We believe this will impact on:

- **Leadership Development** – Supporting our leaders and future leaders to have the skills to lead integrated teams. This will be focused on enhancing the current programmes which we offer to align with the needs of our workforce.
- **Structural Change** – As we review our structures to ensure that they work in an optimum manner, creating efficiencies whilst delivering high-quality patient outcomes, we recognise that targeted organisational design support is required post transaction. This will be strengthened by

reviewing governance arrangements to develop transitional structures in the first instance, potentially followed by wider organisational change through the Trusts policies and procedures.

- **Clinical Pathway Redesign** – In addition to structural change, we recognise that our services and clinical pathways will be required to transform to meet the needs of our communities. This work has already commenced with early scoping through our Clinical Summits which were held in early 2025. We recognise that it is imperative that OD support is provided through this process, strengthening the skills and abilities of our workforce to deliver this through quality improvement, designing services which work across the boundaries of healthcare.

16.8 Culture plan and development of the new clinical operating model

The joint culture plan is integral to the development and delivery of the Trust's new operating model, ensuring that cultural alignment underpins organisational effectiveness. It utilises key metrics, including workforce data and NHS staff survey results broken down by service and department, to provide a robust evidence base that aligns with the operating framework. This approach reflects the analysis undertaken across both Trusts and acknowledges the need to continue to develop the future organisational cultures post-transaction, aligning community and acute services.

The workforce due diligence exercise (see section 19.3.2) has included a review of staff survey performance and quarterly people pulse data, with clear actions for improvement to maintain alignment. With the 2025 staff survey currently live, the forthcoming results will inform further refinements to priorities, and the post-transaction implementation plan will be updated accordingly to embed cultural objectives within the wider operating model.

From April 2026, work aligned to cultural alignment and transformation will be completed and this will be reported through the Trust governance processes.

16.9 Training and development

The integration of WHH and BCH provides a significant opportunity to align and strengthen our approach to training and development. By working collaboratively, we can enhance the staff experience, maximise efficiency and ensure our workforce is fully supported to deliver safe, high-quality care. Key developments and anticipated opportunities are outlined below:

- **Joint corporate induction** – Colleagues from both Trusts have worked together to design a new joint corporate induction programme. This will reduce duplication in content, enable more efficient use of staff time and resources and provide all new starters with a consistent and high-quality introduction to our organisation. Implementing this ahead of the transaction will ensure alignment of existing and future values, as described in section 8.6 of this paper and will support a unified organisational culture from day one. The first joint corporate induction took place on 3 November 2025.

- **Apprenticeship Levy** – The integration creates opportunities to expand our widening participation agenda, using the Apprenticeship Levy to

support both current staff development and future workforce supply. Since September 2025 we have aligned levy funding and resources across both Trusts, we will maximise investment in skills development, strengthen workforce planning and reinforce our role as an anchor institution for the communities we serve. This will further enhance access to healthcare careers.

- **Continuing Professional Development (CPD)** – Our clinical and medical education teams are already working together to maximise CPD opportunities across the Trusts. Through our People and Workforce Equality, Diversity and Inclusion Strategies, we will embed clear and inclusive processes to ensure that staff from all protected characteristics can access CPD activities equitably. This will support personal development, improve retention and strengthen workforce capability across all areas.

- **Learning and Development Offers** – We will align and refresh leadership development resources to create a comprehensive and accessible package that supports individuals at all career stages to progress and thrive in their roles. This consistent leadership framework will help embed shared values, build resilience and ensure our leaders are well-equipped to manage change and deliver improvement across the new organisation.

- **Mandatory Training Review** – A joint review of mandatory training requirements will be undertaken to ensure compliance with national standards while reducing duplication and unnecessary burden on staff. This will support a more streamlined approach, enabling staff to move between sites and services with minimal disruption and enhancing workforce flexibility and efficiency.

The integration of our organisation provides a clear opportunity to strengthen our training and development infrastructure. By aligning induction, development pathways and mandatory requirements, we can create a more efficient, inclusive and supportive environment for our workforce. This investment will underpin delivery of our People Strategy and ensure we are well positioned to meet the future needs of our patients and communities.

16.10 Managing organisational change

Staff feedback gathered through engagement has played a role in shaping the development of our Organisational Change Framework and its supporting materials. The questions raised particularly around the process and implications of change have informed a co-development approach with Staff Side and Trade Union representatives, ensuring the principles of organisational change are meaningfully applied and clearly understood by those affected.

The framework is split into three phases:

- Phase One: Development of change readiness tools to support staff and managers in preparing for change – completed in January 2025.

- Phase Two: Development of an easy-read framework to support people in understanding the processes aligned with TUPE and organisational change – completed in August 2025.
- Phase Three: Development of a mirrored organisational change policy with dedicated resources to support Transfer of Undertakings (Protection of Employment) [TUPE] processes – planned to be finalised in December 2025.

Through the development of our resources, we have created a statement of transparency:

“The Trust is committed to managing organisational change in a fair, transparent and consistent manner in accordance with the principles of the NHS Constitution. The framework outlines the procedures for managing change processes affecting staff employed under Agenda for Change and Medical and Dental Terms and Conditions of Service, ensuring compliance with employment legislation and national NHS frameworks.”

In doing so, we have outlined six key principles agreed with our staff side colleagues which we will follow in accordance with staff consultation:

1. Early and meaningful consultation with staff.
2. Engage and work in partnership with staff side and trade union representatives.
3. Transparency and timely communication on the transaction through the provision of staff engagement sessions.
4. Minimising adverse impact on staff through training and redeployment, if required.
5. Quality / equality and health inequalities impact assessments conducted for all organisational change.
6. Compliance with national guidance, legal and statutory requirements.

Dedicated workforce support has been aligned to the programme in addition to business-as-usual support through the respective HR Business Partnering Teams at WHH and BCH. The workforce team is piloting tailored, face-to-face NHS leading for wellbeing sessions at WHH, offering leaders a space to reflect, share experiences, and gain practical tools to support team wellbeing. Focused on services identified as ‘developing’ or ‘fragile’ within the culture plan, the pilot targets first-line managers and supervisors to strengthen leadership and integration.

We aim to take a person-centred approach to the organisational change process by adapting to the needs of our workforce. To support this, staff engagement sessions will continue to be held monthly throughout the period, ensuring ongoing engagement and involvement with individual consultation meetings also in place.

As a result, we believe that we have developed a framework which will support consistency in approach, whilst meeting legal requirements as part of our TUPE processes. We anticipate that the TUPE consultation will commence in November 2025 and run to 31 March 2026.

17.0 Digital strategy

17.1 Chapter summary

This section outlines the digital transformation required to support integrated care delivery across acute and community settings. It highlights how digital alignment will improve data quality and clinical efficiency.

The section sets out how shared systems, electronic patient records and data analytics will underpin joined-up care, empowering clinicians and patients alike. It also aligns with national ambitions for digitally enabled care, supporting remote monitoring, virtual wards and population health management.

Integration provides the platform for a single, modern digital infrastructure that enhances safety, efficiency and patient experience.

Key message: The approach for digital integration has 2 underpinning focuses; technical integration (systems, data flows, interoperability) and the organisational integration (governance, culture, clinical workflows) and will cover 6 key areas:

- Governance and strategic alignment
- Current state assessment
- Data and technical enablers
- Clinical and operational engagement
- Programme management
- Risks and mitigations

A single digital ecosystem will unite the new organisation, enabling real-time data sharing, smarter decision-making, and more personalised care. Integration accelerates delivery of the NHS 10-year plan's 'analogue to digital' ambition, ensuring technology enhances, not replaces, human care.

17.2 Our vision for digital services

We will deliver highly effective, interconnected digital services that enhance care, communication, and operational efficiency across our health and care system. This vision directly supports the delivery of our developing clinical strategy by enabling integrated, patient-centred care across acute and community settings.

Our digital transformation will underpin the clinical strategy by:

- Enabling seamless care pathways across acute and community services.
- Improving access to real-time data for clinical decision-making and care coordination.
- Empowering patients to manage their health proactively, reducing unnecessary hospital visits.
- Supporting workforce efficiency and collaboration, freeing up clinical time for direct care.
- Creating resilient infrastructure that supports service continuity and future growth.

More details on how this will be achieved are included in the supporting documents.

While these aims set out a clear direction, it is important to acknowledge that progress will need to be incremental. These ambitions will not be realised immediately as they represent a progressive journey that will require time, investment, and continued collaboration across partners in the system.

A structured plan is being developed to phase implementation carefully, ensuring that each step is achievable, sustainable, and aligned with the needs of local communities.

17.3 Digital strategy

The development of our digital strategy for the integration of the two organisations is a cornerstone for delivering new models of care, supporting population health, and realising the ambitions of the NHS 10-year plan which places digital transformation at the heart of healthcare delivery.

Our new joint digital strategy will be aligned with national, regional, and local priorities, ensuring digital transformation underpins clinical and operational excellence. The strategy will be shaped by the NHS 10-year plan, the new strategy for the integrated organisation and the clinical strategy. It will bring to life the strategic plans to support the shift from analogue to digital services. The strategy will detail how digital services can support the delivery of one-stop neighbourhood health models, digital-first care, advanced EPR implementations, AI, and the NHS app as a 'front door' for patients.

It will also reflect our aim to wrap care around the holistic needs of individuals at the neighbourhood level, working in partnership with primary care networks (PCNs) and wider community services.

Our strategy will be further informed by the following:

- Our developing clinical and operational model and priorities
- Digital maturity assessment
- Model hospital system analysis
- Due diligence findings

Our strategic digital programmes that will form a core part of the strategy are described below:

	Programme
1.	Acute EPR Procurement (MWL Partnership)
2.	WHH & BCH integration : Digital Services, Systems & Infrastructure
3.	Acute EPR Readiness Programme (inc. Clinical Data Repository)
4.	Community EPR Procurement & Integration, C&M Shared Care Record
5.	Digital Diagnostics & Clinical AI (PACS,LIMS, "other ologies")
6.	AI, Automation & Employee Productivity Tools
7.	NHS App, Patient Engagement Platforms (PEPs) & Wearables
8.	FDP- Patient Flow, Data Warehouse & Real-time Analytics
9.	Network Convergence, Real-time location tracking & Device Integration
10.	IG, Cyber Security, Clinical Safety & Service Continuity

Table 53: Strategic digital programmes that will form a core part of the strategy

17.3.1 Digital strategic objectives

Key strategic objectives for the digital future of the integrated organisation will include:

- Empowering patients to manage their own health through digital tools such as the NHS App and Personal Health Records.
- Delivering care closer to home, supported by remote diagnostics, virtual consultations, and community-based services.
- Improving clinical outcomes and operational efficiency through AI-enabled diagnostics, shared care records, and streamlined digital workflows.
- Enhancing workforce capability with mobile access, digital training, and clinical decision support tools.
- Strengthening data sharing and interoperability to reduce duplication and ensure a single, accurate view of patient status across care pathways.
- Leveraging population health intelligence to target interventions, improve equity, and support proactive care planning.
- Ensuring cybersecurity and data governance to protect patient information and maintain public trust.

Our digital strategy will be delivered through a phased implementation plan, supported by robust governance, stakeholder engagement, and continuous evaluation. It will represent a bold step forward in our journey to become a digitally mature, patient-first organisation that is fit for the future.

17.3.2 How the digital strategy will enable the delivery of our clinical strategy

In an evolving healthcare landscape, our main goal is to transform how digital systems support clinical excellence. Our focus is clear: digital integration must not exist in isolation, but it must directly serve and enhance our clinical priorities. To achieve this, we are adopting an **Enterprise Architecture (EA) approach** which provides a structured methodology for modelling, aligning, and optimising our digital platforms, systems, devices, and data assets.

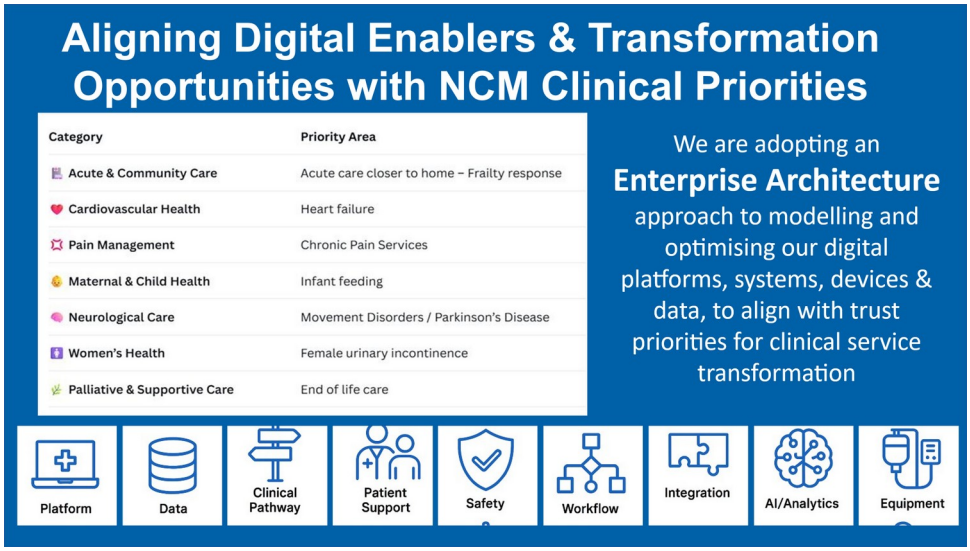


Figure 39: Adoption of enterprise architecture to support delivery of clinical strategy

The EA framework enables the Trust to establish clear linkages between digital capabilities and the organisation's overarching clinical transformation objectives.

Through this integrated approach, the Trust seeks to create a coherent and sustainable digital ecosystem that:

- Supports safe, effective, and efficient delivery of clinical services.
- Enhances interoperability and information flow across departments and care settings.
- Enables clinicians to access timely, accurate, and relevant data at the point of care.
- Provides a robust foundation for innovation, analytics, and continuous improvement.

For our new organisation, digital services will support integrated care delivery, workforce enablement, and improved patient outcomes. By implementing unified digital services, such as shared electronic patient records, leading to the implementation of a new combined EPR in the longer-term, patient engagement portals, and AI-driven tools like Ambient Voice Technology (AVT) we will ensure continuity of care, empower both staff and patients, and reduce administrative burdens whilst supporting efficiencies and reducing cost.

These digital initiatives will not only streamline access to information and enhance clinical decision-making but also foster innovation and resilience, aligning with national NHS priorities and the broader move towards community-based, preventative care. Our focus on digital skills development and clinical safety frameworks will further ensure that technology adoption will translate into safer, more effective, and patient-centred services for the new organisation.

By aligning digital enablers with clinical transformation goals, the Trust aims to reduce operational fragmentation, streamline workflows, and enhance decision-making processes. This alignment not only facilitates improved clinical outcomes but also underpins organisational resilience, cost-effectiveness, and compliance with national digital health strategies.

Importantly, this approach is designed to underpin and accelerate progress across the Trust's seven clinical priorities. The EA framework ensures that each clinical priority is supported by fit-for-purpose digital infrastructure and integrated data flows. By embedding interoperability, standardised data models, and advanced analytics capabilities, the Trust will enable each clinical area to measure performance, identify variation, and implement evidence-based improvements more effectively. More details on how this will be delivered are provided in the supporting documents.

17.4 Supporting neighbourhood health centres

The development of the new neighbourhood health centres offering diagnostics, treatment, rehab, mental health and pharmacy services will be digitally enabled to provide truly integrated, patient-centred care within local communities. A unified digital infrastructure will ensure that clinicians across all disciplines can access and share real-time information securely.

Interoperable electronic health records, digital appointment management, and shared care planning tools will enable seamless coordination and reduce duplication across pathways. Virtual consultation capabilities and remote monitoring technologies will extend access to specialist input and support ongoing care beyond the clinic setting. Data analytics and population health tools will inform proactive management of local health needs, while digital prescription and dispensing systems will improve safety and efficiency.

Collectively, these digital enablers will make neighbourhood health centres a cornerstone of the integrated, preventative, and accessible care that our new Trust will deliver, bringing diagnostics and treatment closer to home and improving patient outcomes across the continuum of care.

17.5 Digital integration

Successful digital integration between an acute and community NHS Trust is about creating clinically useful, interoperable pathways, underpinned by national standards, shared governance, and cultural alignment.

Integrating the digital systems of WHH and BCH will be a complex process, and its success will depend on both the technical integration (systems, data flows, interoperability) and the organisational integration (governance, culture, clinical workflows).

Our integration approach is summarised below:

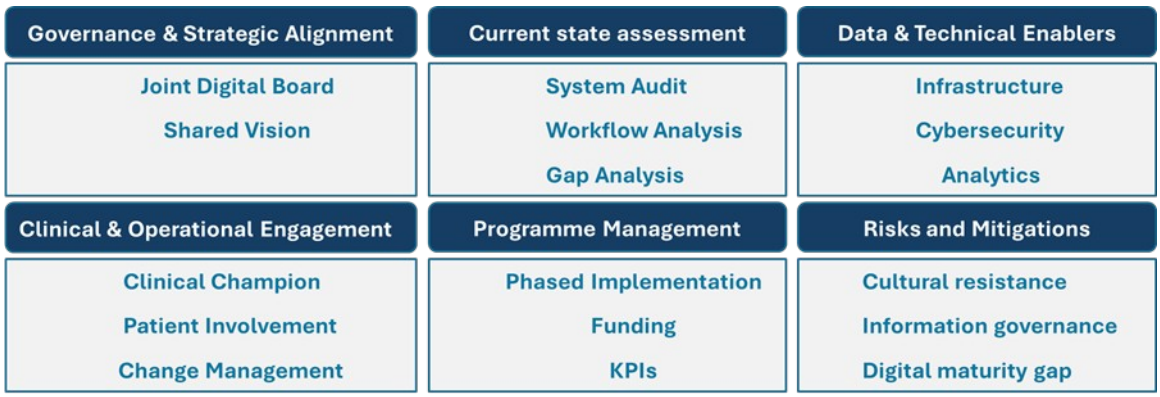


Figure 40: Digital integration approach

The key milestones for the digital integration and implementation of our digital strategy are described in more detail in the PTIP, section 5.8.

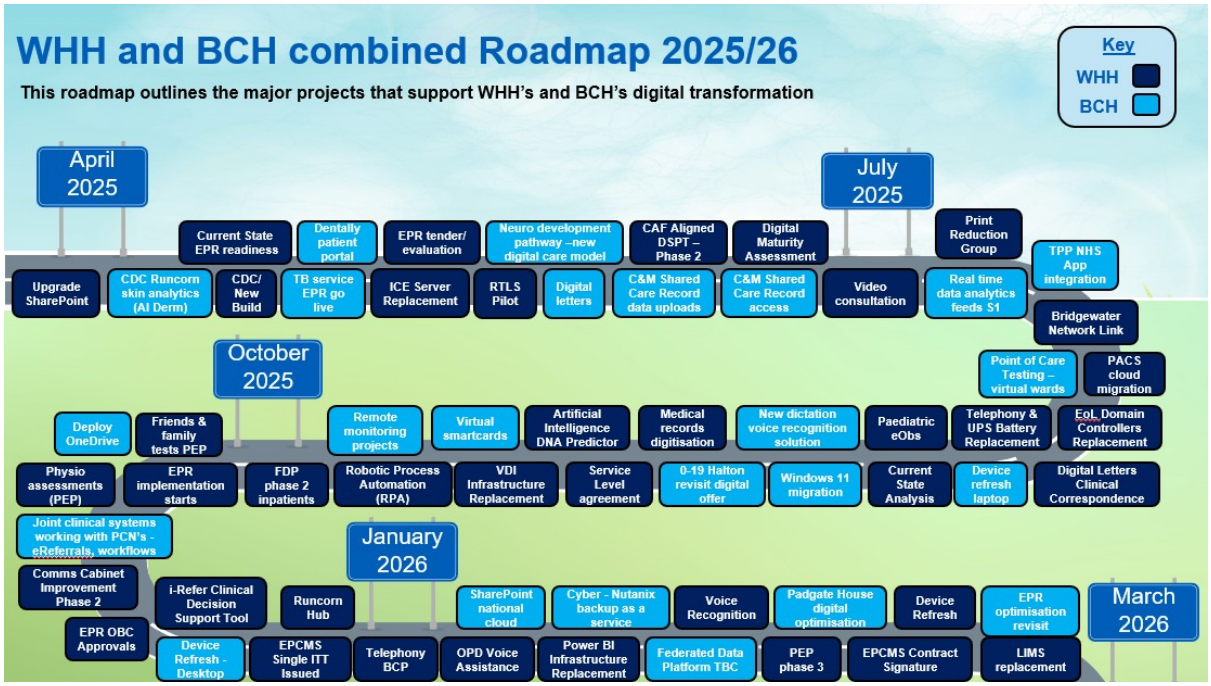


Figure 41: above illustrates the short-term digital roadmap for the two organisations

17.6 Access to EPR systems

17.6.1 Day one information sharing and communication plan

From the outset, staff in acute and community services will leverage existing reciprocal access arrangements to each Trust's systems, such as TPP SystmOne and Lorenzo. Additional/new user accounts will be provided as needed and within current license limits. Clinical teams will continue to share access where necessary, ensuring that information follows the clinical service and supports robust clinical decision-making and pathway redesign.

Immediate actions for the digital teams include reviewing policy statements and processes to accommodate any increase in user base and investigating technical solutions like click-through capabilities for launching alternative system views in context. Regional access to the CareCentric C&M shared care record will be prioritised, providing a broader platform for information sharing beyond the two EPRs, and supporting wider clinical collaboration.

17.6.2 Long-term vision to 2030

Looking ahead to 2030, the combined digital strategy is to progressively enhance interoperability using standards, enabling seamless exchange of records and discharge information between systems. The goal is to transition to a common system by 2030. In the interim, digital solutions will be aligned with evolving clinical strategies, with investments dependent on national funding allocations and a strong organisational commitment to digital transformation.

The plan includes deploying tools like Optima One (Federated Data Platform) for multi-agency bed management and discharge planning, expanding the use of patient portals and wearables, and standardising data structures to the NHS data dictionary. Ongoing refreshes of the digital strategy will ensure alignment with

clinical priorities and organisational operating models, supporting effective communication and information sharing across acute and community services.

17.7 System functionality

WHH completed a £3m IT network replacement in March 2025, providing a modern, cyber-secure and high-speed connectivity infrastructure for our hybrid cloud portfolio of applications, imaging modalities and medical devices. During 2025/26 we will migrate to the Cheshire & Merseyside regional PACS Cloud, providing consolidated, secure storage and improved data sharing in Radiology. In preparation we are trialling medical imaging AI solutions, including Annalise.AI for chest X-rays, to enhance diagnostic speed and accuracy.

As part of our EPR Readiness Programme we are commissioning a Clinical Data Repository (CDR) solution to facilitate digitisation of paper medical records and to provide a consolidated clinical data archive for legacy system data storage. This approach will facilitate consolidation of patient-related documents from multiple source systems and the transition to Digital Outpatients and Digital Wards in preparation for core EPR replacement.

As we continue our Federated Data Platform (FDP) programme, following the successful implementation of theatres scheduling we will onboard a PLICS solution as an early adopter, rename the WHH FDP tenant to NCM, and onboard Community Services, creating a shared secure data environment. We are assessing the viability of using the FDP tenant for future organisation-level data warehousing, alongside other options for an integrated data warehouse and BI reporting platform for NCM. Future reporting requirements include near-real time dashboards with a range of data visualisations and patient flow optimisation dashboards, linked to bed management and RTLS-based resource tracking.

Our Electronic Patient Record (EPR) strategy is focussed on procurement of a new shared instance solution in partnership with Mersey and West Lancashire NHSFT. This strategic investment will facilitate convergence of digital systems at scale, enabling the standardisation of clinical workflow processes via a flexible EPR platform. Following replacement of current core EPR systems, in 2030 we will re-tender the community EPR contract with an option for full consolidation into a single EPR platform for the integrated organisation.

17.8 Governance and assurance

We have established joint governance structures, robust risk management, and cyber assurance processes. Investments in network architecture and cyber security, SIRO/DPO registrations, and Board assurance on information risk ensure regulatory readiness and resilience. Our integrated digital service desk and technical support model underpin operational continuity. Key digital pre-requisites for “Go Live” in 2026 include integrated governance, service desk, updated policies, and technical architecture.

Maintaining robust cyber security defences throughout the transition period is critical to the safe and successful integration of the Trusts’ IT network and business-critical systems. We have established a joint Change Advisory Board (CAB) in advance of the transaction, to facilitate technical knowledge transfer and integration of IT Service Management processes, ensuring access, security and availability of systems used to support front-line service delivery.

We are also designing a new Digital Activity & Performance Framework as an integrated reporting platform, providing a consolidated view of our Service Desk, systems, data, cyber defences, and other key digital metrics.

17.9 Digital improvement programme

We are consolidating our IT service management toolsets and administration products, reducing variation by standardising items in the Digital Service Catalogue. The introduction of a new Digital Customer Portal for digital support, live system and incident status and self-service Service Requests will further streamline support processes and improve user experience.

These actions, combined with ongoing collaboration at the Cheshire & Merseyside level including consortium procurements, are enabling us to deliver more effective use of digital capital monies, reduce duplication, and ensure that cost savings are realised and sustained.

Our portfolio of digital transformation programmes also contributes to several Trust-wide productivity and improvement programmes, for example, DNA reduction via PEP and digital correspondence and theatres utilisation metrics via the FDP Theatres Scheduling system.

Our Digital Cost Reduction Programme is delivering sustainable efficiencies and maximising value from digital investments across the integration. We have already consolidated onto the same supplier contracts for mobile data, achieving immediate savings and simplifying management. Plans are in development to converge onto a single Managed Print Service (MPS), which will contribute to sustainable savings as part of a wider Print Reduction Strategy.

This approach ensures that digital transformation is not only innovative but also financially responsible, supporting the long-term sustainability of our services.

17.10 Building our digital culture

We are committed to digital upskilling, staff engagement, and supporting patients at risk of digital exclusion. NHS App uptake is above both national and C&M averages (Warrington 65%, Halton 62%), demonstrating strong population digital readiness.

Our Digital Champions, Information Asset Owners, and MDT-style digital teams foster a culture of inclusion, capability, and continuous improvement. Digital inclusion is a recognised priority, with targeted support for vulnerable groups and ongoing engagement with Place partners.

17.10.1 Population digital readiness and inclusion

We are proud of our above-average NHS App uptake and are committed to supporting patients at risk of digital exclusion through digital champions, assisted access, and tailored communications. Our digital inclusion work is recognised at place and system level, with ongoing engagement and support for vulnerable groups. Our updated Digital Skills and Culture programme will ensure our frontline clinicians are equipped to use digital systems efficiently, with a focus on data quality and continuous improvement.

WHH has an established Patient Engagement Platform (PEP) with above average NHS App uptake. Through our communications and stakeholder engagement

activities, with the support of Warrington Together and One Halton partners, we have developed a Digital Inclusion plan based on Population Health data including the Digital Exclusion Index (DEI). According to the DEI, Warrington is ranked as the most digitally inclusive Place in Cheshire & Merseyside.

To ensure all our community patients can benefit from digital healthcare, we will focus on improving both digital readiness and digital inclusion. We will work with local councils, voluntary sector organisations, and community groups to help patients build digital skills and confidence through training, digital champion schemes, and accessible support hubs.

We will also address barriers to access by providing support for devices, connectivity, and local Wi-Fi-enabled spaces, ensuring that patients can engage digitally regardless of circumstance. All new digital tools will be designed to be simple, accessible, and inclusive by default, with alternatives such as phone or face-to-face options for those who prefer them.

By combining inclusive design, practical support, and ongoing community engagement, we will ensure that everyone has the opportunity, skills, and confidence to participate in digital health services, helping to reduce health inequalities and improve access to care.

17.11 Patient benefits

Our emerging Digital Strategy will deliver a comprehensive set of benefits to patients by using digital innovation to improve care quality, accessibility, and experience. Key patient-focused benefits and outcomes include:

- **Holistically supporting people throughout their lives:** Patients receive continuous, personalized care that adapts to their evolving health needs throughout life.
- **Faster Diagnosis and Streamlined Pathways:** Advanced technologies such as AI-enabled imaging and integrated shared records accelerate diagnostic processes and improve clinical decision-making.
- **Enhanced Patient Empowerment and Access:** Tools like the NHS App and Personal Health Records (PEP) enable patients to manage appointments, view health information, and actively participate in their care.
- **Care Delivered Closer to Home:** Diagnostic services and routine tests are made more accessible by decentralising delivery, reducing travel and improving convenience.
- **Improved Data Sharing and Reduced Duplication:** Cloud-based Electronic Patient Records and shared care records ensure seamless information flow across providers, minimizing repetition and enhancing continuity of care.
- **Workforce Enablement and Digital Inclusion:** Patients benefit from a digitally confident workforce and inclusive services that ensure equitable access to care, regardless of digital literacy or socioeconomic status.
- **Measurable Improvements in Experience and Outcomes:** The strategy will drive quantifiable gains in operational efficiency, clinical effectiveness, and overall patient satisfaction.

17.12 Priorities for day one & transitional arrangements

As part of the Integration process, we are developing a comprehensive Digital transition plan to ensure that core systems and digital services are fully aligned and capable of supporting a single, integrated organisation. The transition is being designed to prioritise patient safety, continuity of clinical services, and minimal disruption to staff.

The plan is directly informed by findings from IT due diligence, ensuring that risks are addressed, legacy issues are managed, and opportunities for digital improvement are realised. Robust transition plans will be in place for all critical systems, including electronic patient records, clinical applications, risk management, workforce systems, and financial ledgers.

A phased implementation approach is being adopted, focusing first on areas where integration is most urgent and impactful, while carefully balancing available resources. This ensures a safe and controlled transition, with appropriate fallback measures where required.

On day one, the Trust's digital priorities will centre on ensuring continuity and reliability of all critical clinical/operational systems, such as the Electronic Patient Records (EPR), finance and human resource systems, analytics platforms, and the supporting secure infrastructure. This will include updating organisational identifiers (ODS codes, Trust names etc), harmonising cyber security and governance processes, and maintaining staff access to essential digital tools. Minimising changes with clear communication to our staff about necessary changes will be vital to maintain confidence and operational stability.

Future transitioning to any new systems will require detailed migration plans that map existing platforms, sets milestones for updates, and ensures secure data migration with robust quality checks. Stakeholder engagement will be crucial - forming transition teams with clinical, operational, IT, and governance leads to oversee the process and ensure buy-in. Comprehensive training and ongoing support for staff, alongside retaining access to legacy systems for a defined period, will help minimise disruption and support continuity.

Finally, aligning all policies, documentation, and registrations to the new organisation will ensure ongoing compliance with national standards requirements. This strategic, collaborative, and patient-centred transition will provide the basis for our integrated, future-ready digital services and ongoing operational resilience.

17.13 Resourcing and funding

The delivery of the digital integration plan is being resourced in a way that balances delivery of the digital transition with the need to maintain safe and effective business-as-usual (BAU) operations. Capacity has been freed up through reprioritisation of internal workloads, and additional temporary capacity may be sought through external recruitment and interim appointments where required. This ensures that transition activities do not compromise day-to-day service delivery.

We are currently completing a review of long-term contracts and licensing arrangements to fully understand any cost implications and build these into forward planning. Where opportunities exist to exit, consolidate, or renegotiate contracts, these are being pursued to release savings.

Achieving the digital transformation ambitions will require structured investment across multiple domains. Initial costs include capital funding for new platforms (such as EPR and AVT solutions), infrastructure upgrades, and integration efforts, while ongoing costs cover staff training, process change and adoption, system maintenance, compliance, and governance.

All one-off and ongoing costs associated with the digital integration transition are aligned to the broader integration plans. Assumptions will be validated against sector benchmarking data to ensure cost estimates are both realistic and defensible.

We will utilise national and regional funding opportunities, whilst also ensuring we maximise the benefits of our existing systems, developing standardised configurations throughout to control costs. We will ensure all investments are aligned with local, ICS and national programmes and supported by robust business cases, showing clear return-on-investment tracking, and sustainable resourcing plans to ensure long-term value and impact for the new organisation.

18.0 Estates Strategy

18.1 Chapter summary

This section describes how the combined estate of WHH and BCH will be optimised to support integrated service delivery, future sustainability and

support the production and delivery of the joint Clinical Strategy. It sets out the current estate footprint, utilisation levels and opportunities for rationalisation, co-location and community access.

The section highlights how integration enables a single estates plan aligned with clinical priorities and the NHS Net Zero agenda. It details how modernisation, investment and disposal strategies will ensure the estate is efficient, fit for purpose and environmentally responsible, providing high-quality care environments for patients and staff.

Key message: This section shows how the full extent of the new community and acute estate is being considered in relation to delivery of services. Outpatient locations, corporate spaces and relocation of corporate staff are a particular focus, looking at where best to deliver services across the 98 sites comprising of 75 buildings, including 45 leased spaces across Warrington, Halton, Knowsley, St Helens and Greater Manchester.

This section addresses the age and declining condition of the current estate, the increasing cost of backlog and impending backlog maintenance costs. Works identified include:

- Replacements to infrastructure including replacement windows
- Aged site drainage
- Building management system
- Ventilation systems
- Water distribution
- Electrical systems

Through robust risk management and future-focused planning, the integrated Trust will provide the right environments for patients and staff while safeguarding long-term value.

18.2 Estates strategy – supporting the integration

Estates has been identified as one of the key enablers to support the delivery of the joint strategic goals which forms the basis of the plan for the integration of WHH and BCH. The developing estates strategy will describe a vision for an integrated estates service to support the delivery of the clinical strategy through the effective supply of high-quality space for both clinical and non-clinical functions.

The estates strategy will be developed, prioritising effective space utilisation with the goal of providing a place of delivery as close to the service user as possible. This is in line with several local, regional, and national strategies, including the NHS 10-year plan. The benefit of the integration is being able to consider all the estate of an integrated organisation as one, and make informed decisions on space allocation, which best suit the needs of patients and the services they are accessing.

Currently, there are areas of estate across both organisations which require development to support the joint clinical strategy of the Trusts, and the delivery of the integration programme.

We know we can make more efficient use of the joint estate between WHH and BCH, taking a strategic approach based on patient, clinical, and organisational need to optimise the use of estates and capital expenditure.

Across both organisations, our staff currently operate from approximately 98 sites, comprising around 75 buildings which includes 45 leased spaces across Warrington, Halton, Knowsley, St Helens and Greater Manchester, that deliver a mixture of clinical, community, administrative, and support functions. This reflects the breadth of our combined estate, spanning hospitals, health centres, community clinics, and office accommodation.

Nationally since 2016, while the NHS estate has grown by 3%, patient attendances have risen by 11%, highlighting the need for efficient space management to meet rising demand and provide a safer and more compliant care environment for patients[47]. This provides an opportunity to align investment with clinical pathway transformation, identifying suitable and potential under-utilised space across our boroughs.

The condition and functionality of NHS estates are often constraints for NHS Trusts, with significant investment required to modernise and make the aging estate fit-for-purpose. This is certainly true of the hospital estate, where 50% of our buildings are more than 40 years old, and as such the case for new acute estate remains strong.

71% of the buildings occupied by WHH and/or BCH teams have been constructed within the past 30 years, including properties leased from other NHS sectors. That includes NHS Property Services, community health partnerships and GPs. Through integration, we will ensure that our portfolio across our boroughs aligns with our clinical strategy and national policy.

The focus of the estates strategy will be to support the delivery of a transformational clinical strategy and enable the integration of corporate services.

18.3 Current state

18.4 Age and condition

The buildings within the WHH estate portfolio vary in age as illustrated by figure 42 and figure 43 below.

[47] as per NHS England (2024) *Delivering productivity through NHS estate*. Available at: https://www.england.nhs.uk/publication/delivering-productivity-through-the-nhs-estate/

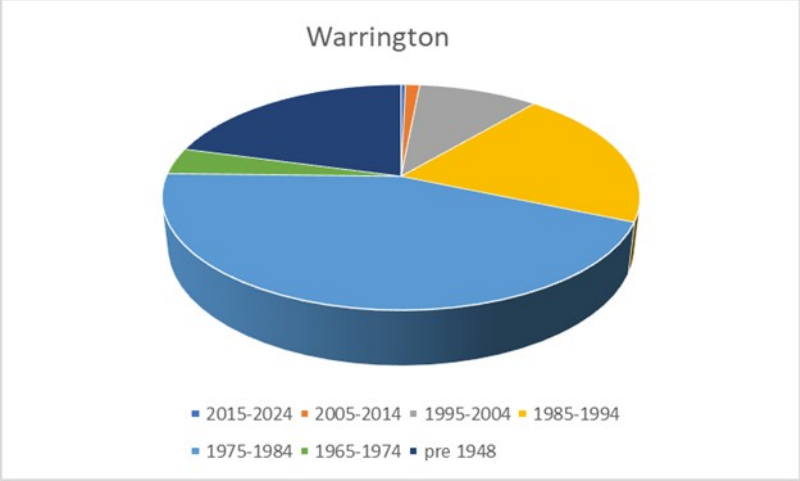


Figure 42: Age profile of buildings at Warrington General Hospital

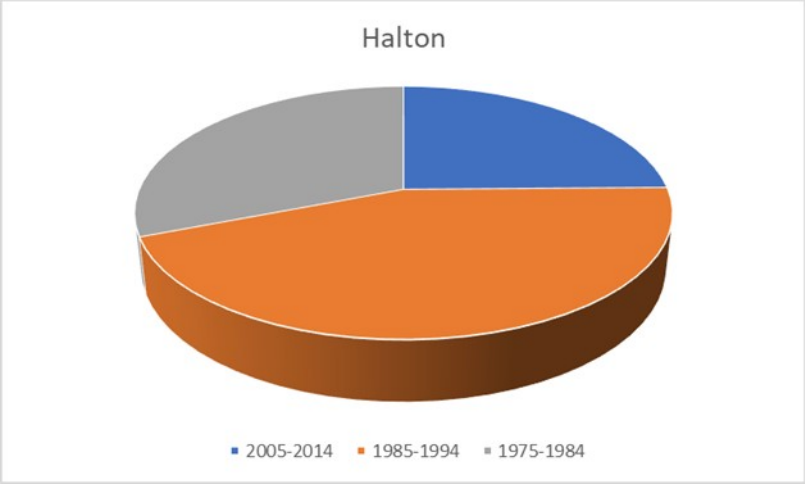


Figure 43: Age profile of buildings at Halton General Hospital

These figures can be compared with NHS England age data using the NHS Estates Return Information Collection (ERIC) (latest release covers period 2023/24).

Comparatively WHH estate is older than equivalent NHS estate when looked through “Trust Type” and regional averages. More than 56% of Trust estate is now aged more than 40 years old, compared with 43% of NHS estate nationally.

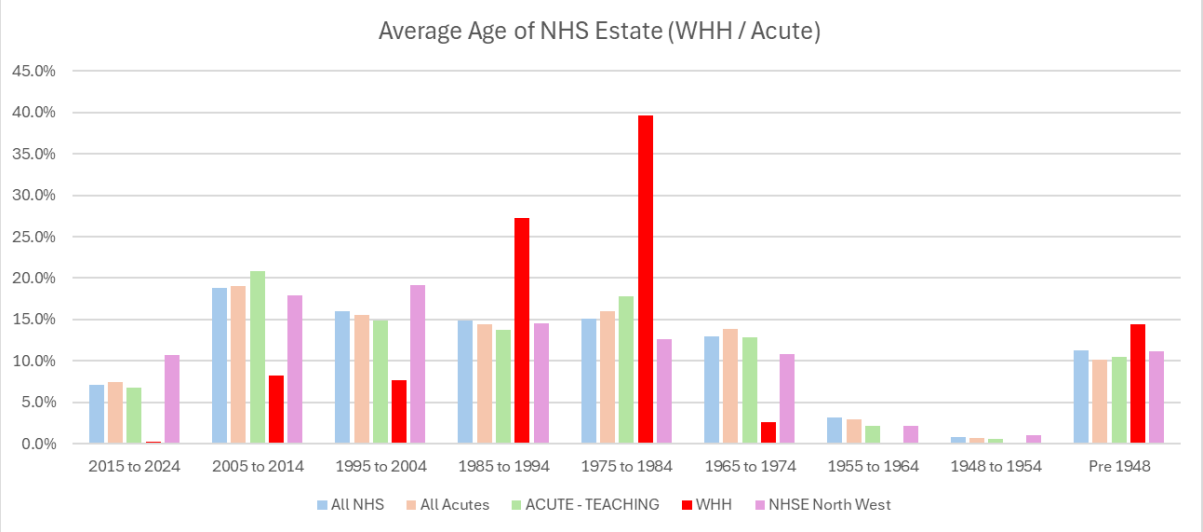


Figure 44: Average age of WHH Trust estate compared to NHS averages

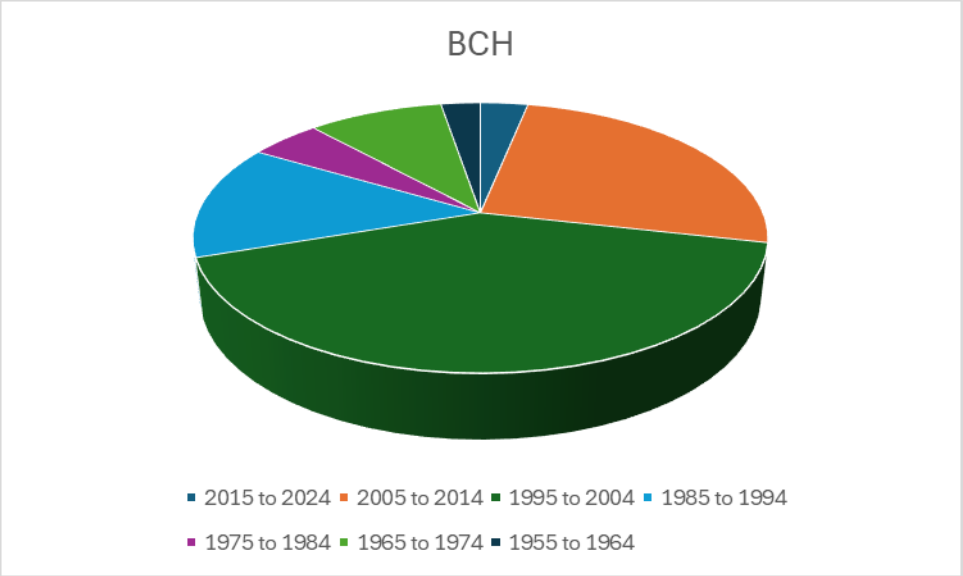


Figure 45: Age profile of buildings operated by BCH as reportable through to ERIC

In contrast, the age of BCH estate compares more favourably against peer organisations.

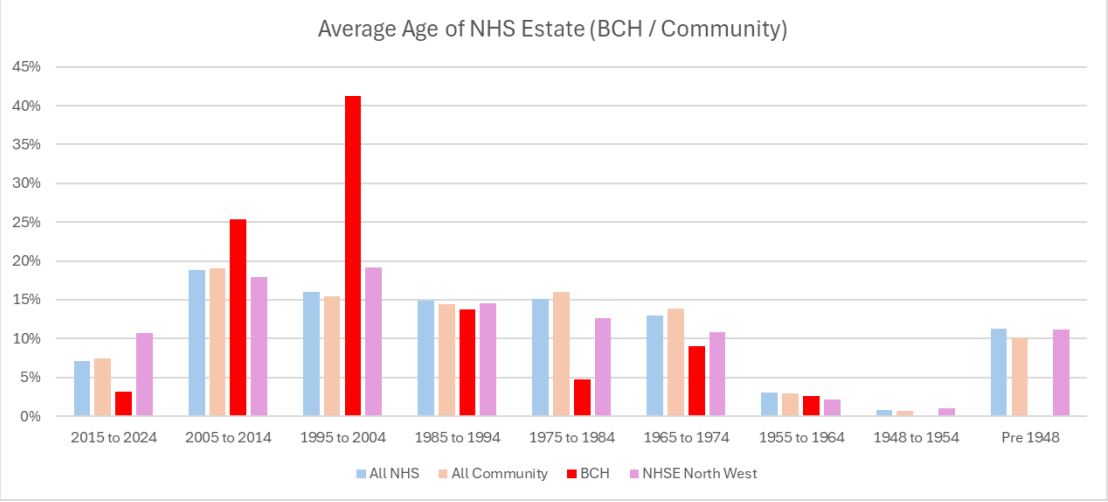


Figure 46: Average age of BCH Trust estate compared to NHS averages

18.4.1 Backlog maintenance

Backlog maintenance cost (backlog) is the cost to bring estate assets that are below a certain standard and make them operationally sound in terms of their physical condition, and/or compliance with mandatory fire safety requirements and statutory safety legislation.

Backlog and statutory compliance costs are classified as either low, moderate, significant or high risk.

The NHS Estates Guide 'A Risk-Based Methodology for Establishing & Managing Backlog[48]' is used to calculate the risks for each defect highlighted within the physical condition and statutory compliance.

Table 54 below shows a breakdown of the backlog costs (i.e. costs required to bring elements currently below condition grade 'B' up to condition grade 'B' immediately) by risk. As per Department of Health definitions, grade 'B' describes estate as "sound, operationally safe and exhibits only minor deterioration", and is the nationally recognised standard used across Department of Health.

In November 2024, the total backlog cost in relation to physical condition and statutory compliance was **£44,665,099** as per table 54.

Backlog by Site	Low	Moderate	Significant	High	Total
Halton Hospital	£1,787,588	£4,014,238	£7,218,212	£459,479	**£13,479,517**
Warrington Hospital	£5,084,047	£8,601,945	£16,201,756	£1,297,834	**£31,185,582**
Total	**£6,871,635**	**£12,616,183**	**£23,419,968**	**£1,757,313**	**£44,665,099**

Table 54: WHH backlog maintenance costs by category

Most of the facilities within the BCH portfolio are leased and therefore the majority of backlog liabilities fall with the property landlords. However, as per the latest (24/25) ERIC returns, the total value of backlog liability for BCH is £350,000. 91% of this liability falls within the 'low' or 'moderate' categories.

18.4.2 Impending backlog maintenance costs

Impending backlog relates to elements of the estate currently in condition grade B that will fall below condition grade B within 5 years, assuming no major investment in the interim.

The total impending backlog costs, for condition (including costs for site infrastructure) as at November 2024 were:

£10,266,918 – Warrington hospital site

[48] NHS Estates (2004) *A risk-based methodology for establishing and managing backlog*. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/05/Backlog_costing.pdf

£7,931,512 – Halton hospital site

The backlog figures in table 54 are likely to increase by the figures above (i.e. this is estate that is likely to deteriorate below condition grade B across the next reporting period with no investment.

In addition to backlog costs relating to physical condition and statutory compliance, WHH also calculate costs relating to the following facets on an annual basis:

- Functional suitability
- Space utilisation
- Quality of the environment
- Environmental management
- Equality Act

Some of these facets are difficult to address due to the nature of a building, the historical design and layout of rooms and wards, or the infrastructure unable to support new methods of building. It is therefore less likely that the costs will be addressed, and the organisation will focus primarily on the physical condition and statutory compliance.

The estimated costs to address these facets of backlog is currently £25.5m at Warrington Hospital and £4m at Halton Hospital.

Works identified include: -

- Replacements to infrastructure including replacement windows
- Aged site drainage
- Building management system
- Ventilation systems
- Water distribution
- Electrical systems

It is estimated that to effectively eradicate the total backlog, the integrated organisation will need to spend upwards of **£100m** over the next 10 years.

Whilst addressing the backlog can limit development and growth elsewhere, statutory compliance items will be addressed first, followed by high-risk backlog items under physical condition, followed by significant then moderate and low risk items. Future costs should be addressed as appropriate by risk as described for backlog items above.

This will be actioned in tandem with a review of current estate needs of the integrated organisation, identifying any opportunities to safely relocate services to improved environments where there is no or minimal impact on patient experience and care.

18.5 Outpatient space

The growth in demand for services over recent years has put increasing demand on the existing estate across both organisations, particularly in terms of ward and urgent care estate within the hospital. Space is in short supply, budgets are under pressure, and current access for patients needs to be improved. To meet these demands and deliver on the clinical vision for the integrated organisation, changes will need to be made at the point of delivery for outpatient services. The

integration presents an opportunity to transform the delivery of key services to shift away from a hospital-centric model towards a community-first model and ensure that the organisation’s estates strategy meets evolving needs, whilst making appropriate and efficient use of all available space.

Outpatient space is a consistent challenge at WHH, particularly when space is needed for additional clinics to help flexibly manage RTT and cancer standards. BCH has several community locations that can be factored into the wider underpinning estates strategy, supporting the workstreams identified from the new joint clinical strategy.

Approaches the estates strategy will take for the transformation of outpatient services include the following examples:

- Redesign how we deliver virtual and face-to-face outpatient clinics, making best use of available space.
- Make full use of the estates available across both community and acute to ensure point of delivery for outpatient services in the most appropriate location and ensure the most efficient use of space.
- Consider community locations within specific neighbourhoods and how clinical estate in those locations can best be used to deliver services targeted and the needs of the local populations in those neighbourhoods.
- Review utilisation of all current clinic space.
- Consider which services are best delivered in an outpatient community setting and which need to be on an acute site, for critical adjacencies.

Table 55 below shows the current delivery locations for outpatient services at WHH.

Specialty	Acute	Community	Primary Care	Telephone	Home	Appointments
650 – PHYSIOTHERAPY	38%	22%	0%	5%	35%	61,681
651 - OCCUPATIONAL THERAPY	69%	20%	1%	9%	1%	45,139
130 – OPHTHALMOLOGY	99%	1%	0%	0%	0%	42,685
110 - TRAUMA AND ORTHOPAEDICS	82%	0%	0%	18%	0%	32,472
320 – CARDIOLOGY	79%	2%	0%	19%	0%	25,494
120 – ENT	70%	27%	0%	2%	0%	21,086
560 - MIDWIFE EPISODE	89%	0%	0%	11%	0%	20,770
324 - ANTICOAGULANT SERVICE	75%	25%	0%	0%	0%	17,290
420 – PAEDIATRICS	81%	1%	0%	18%	0%	15,549
100 - GENERAL SURGERY	100%	0%	0%	0%	0%	13,743
658 – Orthotics	46%	53%	0%	1%	0%	13,231
340 - RESPIRATORY MEDICINE	88%	0%	0%	7%	5%	12,725
341 - RESPIRATORY PHYSIOLOGY	38%	54%	0%	7%	0%	12,655
307 - DIABETIC MEDICINE	88%	1%	0%	11%	0%	11,947
101 – UROLOGY	74%	0%	0%	26%	0%	11,689
422 – NEONATOLOGY	96%	0%	0%	4%	0%	9,067
103 - BREAST SURGERY	100%	0%	0%	0%	0%	7,876
327 - Cardiac rehabilitation	7%	91%	0%	0%	1%	7,497
104 - COLORECTAL SURGERY	68%	0%	0%	31%	0%	7,269
301 – GASTROENTEROLOGY	75%	0%	0%	25%	0%	7,253
652 - SPEECH AND LANGUAGE THERAPY	100%	0%	0%	0%	0%	6,925
502 – GYNAECOLOGY	100%	0%	0%	0%	0%	6,630
143 – ORTHODONTICS	100%	0%	0%	0%	0%	5,733
812 - DIAGNOSTIC IMAGING	100%	0%	0%	0%	0%	4,875
140 - ORAL SURGERY	100%	0%	0%	0%	0%	4,178
655 – ORTHOPTICS	32%	48%	0%	20%	0%	3,710
302 – ENDOCRINOLOGY	52%	0%	0%	48%	0%	3,450
303 - CLINICAL HAEMATOLOGY	79%	0%	0%	21%	0%	2,896
361 – NEPHROLOGY	15%	0%	0%	85%	0%	2,335
840 – AUDIOLOGY	92%	0%	0%	8%	0%	1,991
191 - PAIN MANAGEMENT	96%	0%	0%	4%	0%	1,967
328 - Stroke Medicine	13%	0%	0%	87%	0%	1,788
306 – HEPATOLOGY	93%	0%	0%	7%	0%	1,694
214 - PAEDIATRIC TRAUMA AND ORTHOPAEDICS	100%	0%	0%	0%	0%	1,567
300 - GENERAL MEDICINE	100%	0%	0%	0%	0%	1,491
144 - MAXILLO-FACIAL SURGERY	83%	0%	0%	17%	0%	1,397

Table 55: Current delivery locations for outpatient services at WHH

The estate locations currently utilised by WHH and BCH within Warrington and Halton are depicted in figure 47 below.

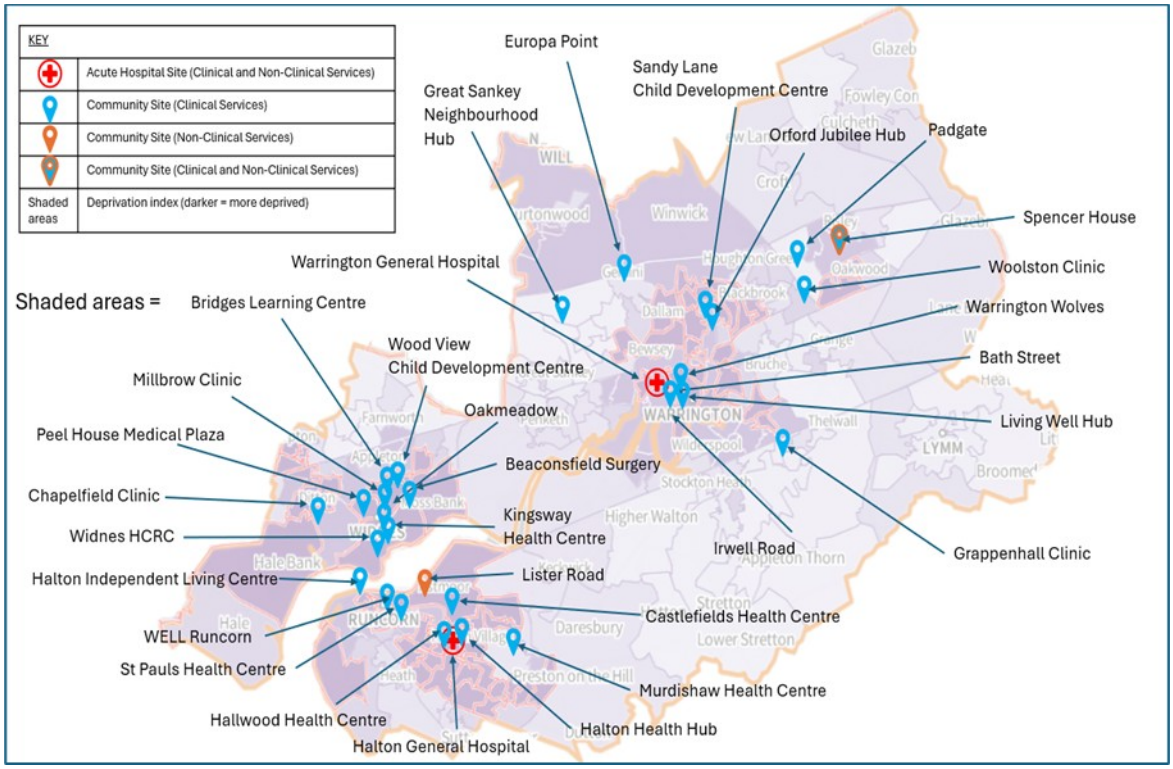


Figure 47: Current Warrington and Halton estate locations across both WHH and BCH

18.6 Estates integration priorities – outpatient spaces

There are several challenges to be taken into consideration when planning a transformation of outpatient estate across both Trusts:

- Main outpatient department capacity on the hospital sites is lacking for smaller specialties to expand and address growing waiting times.
- There is limited capacity in primary and community care settings to move activity from the acute site at present.
- A corresponding cultural shift may be required for some staff to deliver services away from the acute site.
- IT links and software functionality may need developing and upgrading in some facilities.

The draft estate strategy must support the requirements of the new integrated clinical strategy as it develops and estates will be a key enabler to the delivery of any future clinical model.

18.7 Estates integration priorities – corporate spaces

To support efficient delivery of a combined corporate service, changes are likely to be required with regards to the location of corporate teams. The integration presents an opportunity to ensure that corporate services support the integrated organisation, whilst making appropriate and efficient use of all available space.

Approaches the estates strategy will take for the transformation of corporate services include the following examples:

- Support digital transformation, making best use of available space for the delivery of corporate services.

- Make full use of the estates available across the combined organisation to ensure corporate teams can work in appropriate locations and make the most efficient use of space.
- Review utilisation of all current office space.
- Consider which corporate services are best delivered in a non-acute setting and which need to be on an acute site, for critical adjacencies and supporting operational teams.

18.7.1 Corporate space case study – relocation of corporate staff

The relocation of services from Kendrick Wing on the Warrington hospital site has long been a strategic intent of WHH due to the poor condition of large parts of the building and high running costs of the buildings.

Relocating significant numbers of staff away from Kendrick wing would also help address another long-standing challenge around car parking for patients and visitors, as it would reduce demand for parking spaces for staff on the site.

There is currently significant under-utilised space at Spencer House, the BCH corporate HQ. It is therefore prudent to explore whether the use of Spencer House as a main corporate hub for the integrated organisation would be feasible and beneficial. Several other Trusts locally have adopted an off-site base model for corporate functions without significant issues arising.

Consolidating corporate functions from both WHH and BCH in the same corporate base location will support improved integrated working, connection between staff and teams and create opportunities for future financial efficiency as noted in section 13.3.7.

The impact of Covid-19, and subsequent increase in agile working and virtual meetings has created an environment for change that perhaps did not previously exist when off-site working solutions have been tentatively explored.

At a high level, it appears that the current demise of Spencer House would be sufficient to use as a potential base location for all appropriate corporate teams from both WHH and BCH.

The analysis assumes current agile working patterns are not changed in any way. Although if the estimated desk demand proves to be significantly greater than calculated, there remains an option to review current working arrangements and promote/mandate increased working from home.

There would be a requirement to retain a corporate hot desk facility on the Warrington hospital and possibly the Halton hospital site. Further work is required to estimate the required size of this. There would also be a need to consider workforce implications associated with this exercise before proceeding any further.

The potential re-location of corporate staff out of Kendrick wing will not facilitate the full closure of that part of the hospital estate. There will be a further need to explore re-location of other non-corporate teams and services (e.g. stores). However, closing large sections of the building would enable delivery of cost savings through energy usage and facilities management services.

18.8 Developing an estates strategy

As illustrated in section 8.7, we will develop an estates strategy for the integrated organisation, which will align to the overall organisational strategy, clinical strategy and financial strategy. It will also align to most recent NHS Cheshire and Merseyside ICS Estates Strategy.

The 8 principles of the current C&M Estates Strategy are detailed in figure 48 below:



Figure 48: 8 principles of the Cheshire and Merseyside estates strategy

The NHS 10-year plan has several strategic estates implications, primarily driven by a planned shift in healthcare delivery from hospitals to community-based services. Supporting this, the Trust will undertake a review of its combined estates to ensure that its assets are able to align with this intent, identifying areas for investment (and routes to secure that investment), as well as opportunities for efficiencies across the portfolio.

Aligned with this, the integrated Trust must ensure that the areas from where care is delivered are not putting communities across Warrington and Halton at a disadvantage, especially when there are significant areas of deprivation across our catchment.

Supporting the focus on a move to community health, there will be a need to re-evaluate existing hospital assets to ensure that they support the move of services into appropriate infrastructure in community settings. The Trust must be well integrated into evolving governance at the Department of Health and Social Care, and at a local level through the devolution of Warrington and Cheshire, to ensure inclusion on local capital pipelines, and able to influence capital spending decisions in support of its programme.

The delivery of the estates objectives below will support the strategic aims which collectively underpin achievement of the Integrated Trust's strategic objectives: -

- Align the estate to the clinical strategies and underpin the Trust's values and objectives

- Support the ambitions of Warrington and Runcorn as growing towns, focusing on regenerating built and natural environment and reducing health inequalities
- Improve compliance with Health Building Notes and Health Technical Memorandums
- Provide a solid platform to prioritise investment and prepare for future opportunities
- Reduce Backlog Maintenance and Critical Infrastructure Risks
- Secure additional capital resources to fund the backlog maintenance program
- Enhance the tactical estates group (TEG) to provide oversight on the capacity
- Enable the delivery of clinical and operational services and sustainability
- Improve functional suitability and net zero target
- Improve utilisation of estates capacity
- Aid in the achievement of the financial plan

18.9 Green plan

Climate change plays a huge part in the future of our estate. The work towards achieving net-zero across both organisations is underpinned by Trust Board-approved green plans, which outline the objectives and goals to help us achieve this ambition. This plan is delivered through 117 actions across key priority areas, including governance and sustainable models of care. We are committed to reducing our carbon footprint and continue to pursue a wide range of projects and initiatives to make this happen, with an updated plan due to be launched in 2026. From an estates perspective, this ambition will be supported through a focus on the areas in details in figure 49 below:



Figure 49: Key areas of focus for the NHS green plan

The estates strategy will be finalised and presented as a key enabling strategy as part of the overall programme of strategy development following the integration of the two organisations. We expect the final strategy to be signed off in Q3 2026/27, as per figure 17, showing the high-level timeline for the development of the joint strategies.

18.10 Estates strategy - next steps

In order to assist with the development of a cohesive plan to deliver the strategic estates objectives, WHH have appointed a third party to help create a refreshed strategic estates development plan for both main hospital sites. This plan will be developed in line with the principles of the emerging clinical strategy across the combined organisation and follow the principle of ‘home first, then community and hospital only if needed’. Since the development of WHH’s previous strategic

estates development plan in 2015, much of the strategic landscape has changed, requiring a refreshed medium-term vision to be developed.

In 2022 WHH submitted a bid to the national Hospital Infrastructure Programme to create a new hospital in Warrington town centre and to undertake a major reconfiguration of the Halton General Hospital site. This bid was ultimately unsuccessful and given likely constraints upon NHS capital resources across the medium term, a more flexible and adaptive approach to the future provision of health care within our boroughs is required.

Additionally, WHH has seen significant site and service development in the intervening years, within both hospital and community settings. These developments are broadly in line with the principles of the NHS 10-year plan, as well as the emerging clinical strategy resulting from the integration of the acute and community trusts.

Resultingly, the updated strategic estates development plan must reflect these developments and provide a blueprint for our future estate requirements, ensuring a focus on:

- Utilisation of land and buildings already in use (including opportunities of an expanded estate via the integration programme).
- Development of agile, business-case-ready proposals, enabling the integrated Trust to respond promptly to calls for investment from the Department for Health and Social Care (DHSC) and other potential funders.

19.0 Risks

19.1 Chapter summary

This section provides a comprehensive overview of the key risks associated with the integration and the mitigation measures in place to manage them. It identifies clinical, financial, workforce, operational and reputational risks and demonstrates how these are being monitored through established governance frameworks.

The section highlights the proactive approach taken by both Trusts to risk management, ensuring issues are identified early, owned at the right level and mitigated effectively.

It concludes by affirming that, while risks exist, the robust governance, engagement and assurance mechanisms already established provide confidence in a successful transaction and future integrated delivery model.

Key message: This section outlines the approach to identifying and managing any potential risks that may arise as a result of the integration programme. An overarching programme risk register has been developed and a summary of key integration risks and mitigations scoring 9 or above are discussed.

Extensive and appropriate due diligence has been undertaken by WHH as the acquiring Trust as part of the process for compiling the FBC. A number of key areas of due diligence have been conducted primarily by KPMG as an external consultancy partner. Other areas of due diligence have been undertaken internally by Trust representatives and then subsequently reviewed by KPMG. Hill Dickinson solicitors completed the legal due diligence.

The due diligence findings were compiled into a single list and reviewed by both Trust Boards before appropriate mitigating actions were agreed and documented to address any agreed risks associated with the transaction.

19.2 Programme risk management

A robust risk management process is in place across the BCT programme with all ten core workstreams using the individual delivery trackers (as referenced in section 7.3.2) to capture, record, report, manage, and monitor all risks arising as a result of the integration work.

All workstreams capture and record both operational risks (risks within the workstream itself) and strategic, programme-level risks.

The risks being recorded and managed have been identified through a range of sources, including:

- Programme management team
- Better Care Together programme delivery group
- Executive management team (EMT) and Trust Boards/sub-committees
- Workstream leads
- Due diligence findings
- Risks arising from other organisations that have undertaken a similar form of integration

The standards, methodology, and operating principles applied to risk management within the programme are aligned with the recognised WHH organisational risk management strategy. The integration risk register mirrors the format and scoring methodology used in both Trusts' corporate risk registers.

Risks are initially captured within the delivery trackers, including any mitigating actions, risk scoring and relevant risk owner.

Table 56 below sets out the risk assessment and scoring criteria applied to programme risks based on likelihood and impact of risk.

		Likelihood				
		1. Almost never	2. Unlikely	3. Likely	4. Highly Likely	5. Almost Certain
Consequence	1. Insignificant	1	2	3	4	5
	2. Minor	2	4	6	8	10
	3. Moderate	3	6	9	12	15
	4. Severe	4	8	12	16	20
	5. Catastrophic	5	10	15	20	25

Table 56: Risk assessment criteria

Overall risk score	
1-3	Very Low risk
4-6	Low risk
8-12	Moderate risk
15-25	Extreme/High risk

Table 57: Risk scoring/grading

The current version of the transaction risk register is included within the supporting documents accompanying this document. A summary of the highest risks (i.e., those scoring 15 or above before mitigation) and the associated mitigations is presented in table 58 below. This excludes the highest rated due diligence risks, which are summarised in section 19.3.2.

Workstream	Risk description	Initial overall score	Please provide controls and assurance details	Current overall score
Digital	If the Trusts do not have a single EPR system in place from 1 April	20	The phased approach to the integration programme includes a	8

	2026, then this will present challenges to clinical teams around accessing the information required, resulting in potentially sub-optimal clinical decision-making		'lift and shift' approach for clinical services, meaning that there are no significant changes to pathways or clinical systems scheduled for day one of the integration. This should minimise risk and disruption for clinical teams in the short-term. Staff with existing access to Lorenzo/SystmOne/EMIS will continue to have that access and additional access will be granted if required within existing licencing limitations. Click-through capabilities to launch alternative systems from within others will also be explored. There is a high-level roadmap in place to progress towards a single EPR system for the integrated organisation by 2030.	
Strategic Programme Management	If the ICB do not agree to fully fund our request for additional resources to support the programme, then the programme will either need to be paused or any unfunded costs met from internal Trust resources, resulting in either a material delay to the programme or a material risk to delivery of the Trusts' in-year financial plan.	16	The ICB Board formally supported our strategic case, timeline and acceleration of the transaction in July, with full knowledge of the likely costs, which we had submitted a request for funding for to the ICB prior to July's Board meeting. The ICB have so far confirmed allocation of £200k to support delivery of our integration. We have formally written to the ICB to confirm that unless the remaining £900k funding is allocated, we will potentially go off plan by up to £900k due to integration in 2025/26. The funding we have requested of £1.1m is significantly less than that provided to other integrations completed locally in recent years. Our integration is forecast to deliver at least £2m CIP in 2025/26 and cost up to £1.1m in 2025/26, both costs and savings are reflected in our financial forecast.	16

Strategic Programme Management	If the transaction is accelerated, then there will be less time available; to complete a number of critical programme tasks, resulting in increased pressures on already stretched corporate teams (e.g. workforce colleagues supporting OD, staff engagement and TUPE processes).	16	In order to manage the additional workload created, corporate teams will look to reduce or reschedule as much existing work as possible in order to create capacity. Furthermore, we have agreed a phased approach to the integration programme that will allow us to delay commencement of some elements that will require more resource (such as clinical service integration). When the initial transaction phase of the programme is complete, we will look to divert programme support to other workstreams to allow them to commence in full.	8
Strategic Programme Management	If NHSE do not approve the transaction to proceed as planned on 1 April 2026, then the programme will be delayed for a period of time, resulting in significant additional costs being incurred and a material level of operational uncertainty across both organisations.	16	We will review all critical day one actions recorded within the programme in early January 2026 to help identify those that will be impacted negatively by a delay to the completion of the transaction. Those that will, will require a 'plan B' mitigation to be drawn up and agreed with the consequences fully identified and communicated. In the meantime, the Trusts are in close dialogue with NHSE around timeframes for approval and relevant detail and assurance required to ensure the transaction is approved and completed in time for 1 April 2026	8
Clinical and Operational	If high-risk policies across both organisations are not consistently updated, stored centrally in SharePoint, and effectively communicated to staff, there is a risk that staff may use outdated documents, potentially compromising patient, staff, and organisational safety	16	The process of reviewing, prioritising, and aligning all clinical policies ahead of the transaction date has already commenced. Relevant documents, SOPs, and policies are being updated and consolidated to ensure clarity, accountability, and robust governance structures. All processes will be concluded and fully communicated by 31 March 2026. All policies have been reviewed and categorised. All high-risk policies are now detailed on the clinical governance workstream delivery tracker with expected dates for revision of policies, approval of amendments and communication/training with	8

			staff.	
Strategic Programme Management	If the transaction is accelerated, then there will be less time available to engage and consult with our staff, our local communities and our wider stakeholders, resulting in less understanding and trust in the process.	16	The Communications teams from both BCH and WHH have diverted significant internal resources onto the integration programme to ensure all stakeholder communications are maintained and are thorough. We have included some designated additional resource to our communications teams as part of the Better Care Together programme resourcing plan to support regular and frequent engagement and two-way communication with multiple groups to ensure all stakeholders to the programme are kept informed and able to feed in their views. The public and patient forum will commence in December 2025 and will be independently led by Healthwatch.	6
Strategic Programme Management	If the transaction is accelerated, then there will be less time available prior to the transaction date to plan and engage with stakeholders resulting in a less effective integration of clinical services.	16	In order to mitigate the associated risk, it is proposed to bring BCH services across as a stand-alone care group within the existing WHH management structure in the short term (aka lift and shift). This will mean minimal or zero disruption and/or change to key clinical services in the short term.	4

Strategic Programme Management	If the integration programme timescales are accelerated then there will be less time to complete key actions and activities for regulatory and legal readiness such as consultation with staff re: TUPE transfer, organisational change processes, due diligence etc, resulting in a potential risk to legal compliance for the programme.	15	We have secured senior ICB and national support for the proposal in the short term to allow us to commence these actions. All required due diligence has now been completed and the results and risks identified have been fed back into our day-to-day planning via the workstream delivery trackers. Any decision to proceed with the transaction will need to be approved by both Trust Boards and verified by Council of Governors who will need to be assured that a robust and appropriate legal process has been followed by the Trusts along the way. As noted in other identified risks, there has been significant work undertaken to review current workloads and divert internal resources to support and prioritise the core tasks within the programme wherever required.	8
Estates	If a contracted service is brought in house without proper evaluation of TUPE risks, then there is a potential for the Trust to be in breach of law, resulting reputational and financial damage to the Trust	15	Workforce representative invited to all project meetings to ensure that due consideration is given by project leads regarding TUPE and staff implication. Issues highlighted to SROs and Workstream leads where appropriate Governance in place to reduce likelihood of occurrence	5

Table 58 - A summary of key integration risks and the associated mitigations

Figure 50 below illustrates the process for programme risk management, which was approved by the BCT programme delivery group.

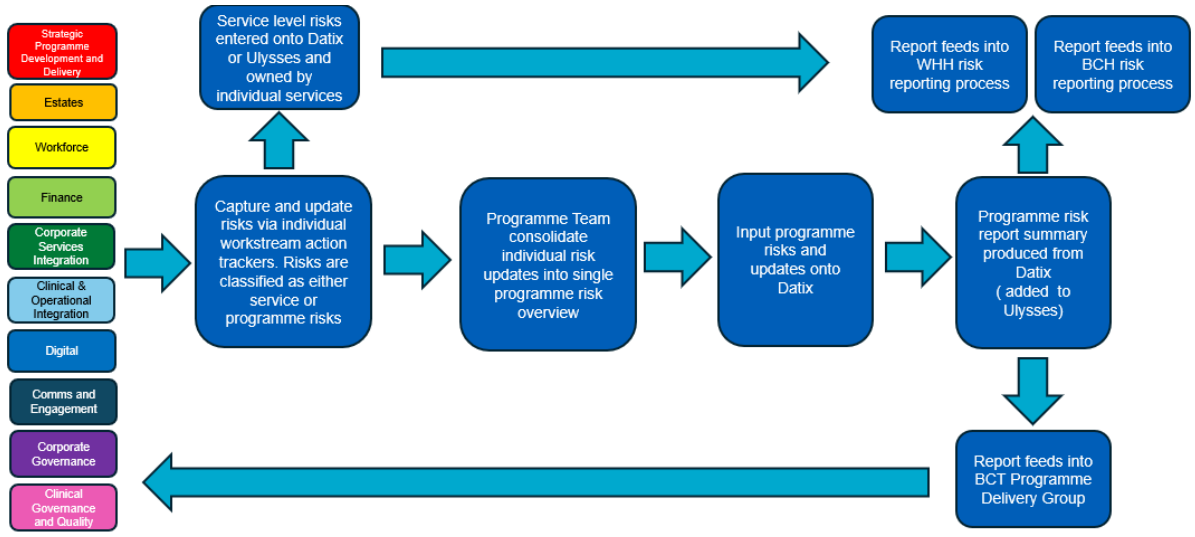


Figure 50: Process for capturing and reporting/managing risk associated with the BCT programme

All operational risks are added to the WHH Datix system and the BCH Ulysses system by the relevant operational/corporate teams. From there, they are managed via the established organisational risk management processes in place within both BCH and WHH.

All strategic programme-level risks are added to the WHH Datix system and the BCH Ulysses system by the BCT programme team and again, managed through established processes. These risks are also reviewed monthly at the BCT programme delivery Board.

The integration risk register is reviewed as a standing agenda item at the BCT programme delivery group, ensuring visibility, challenge, mitigation, and escalation. Where significant risks are identified, these are reported up to the Trust Boards.

19.3 Due diligence

All NHS Trusts undertaking a material transaction are required to complete a due diligence process. NHS England guidance makes clear that the scope of due diligence should be proportionate to the nature of the transaction.

The primary purpose of due diligence is to identify potential areas of risk, enabling the Trusts to make informed decisions about proceeding with the transaction and, where appropriate, embedding mitigation measures into integration planning.

In this case, as WHH is acquiring BCH, the due diligence exercise was unidirectional, with WHH conducting due diligence on BCH only.

To support this process, external consultants KPMG were engaged to conduct a detailed due diligence review, providing independent assurance and insight into operational, financial, and regulatory risks. Legal due diligence was undertaken by Hill Dickinson solicitors, ensuring all legal and contractual matters were fully assessed. Internal subject matter experts from WHH also reviewed specific areas of due diligence, offering in-depth knowledge and validation of findings. The outputs from their work were subsequently reviewed by KPMG.

A blended, proportionate approach was adopted, combining external assurance with internal expertise:

- **General due diligence (WHH on BCH):** Led by KPMG, supported by internal WHH teams, delivering external guidance, advice, and recommendations.
- **Legal due diligence (WHH on BCH):** Conducted by Hill Dickinson.

19.3.1 Due diligence process

The due diligence (DD) process was undertaken in line with NHS England requirements to ensure that all material risks associated with the integration were fully understood and assessed and could therefore be appropriately managed. Due diligence was completed across a range of areas, including

Financial, IM&T, Estates, Legal, Health and Safety, Workforce, and Clinical & Operational. The following structured approach was applied:

1. **Reviewed NHSE Mergers & Acquisitions DD Guidance**

The programme team completed a detailed review of NHSE's DD guidance to ensure the scope, methodology, and outputs of the process met all national expectations for transactions of this scale.

2. **Integrated Specialist Recommendations from External Advisors**

Areas of focus recommended by **KPMG** (operational/financial/regulatory) and **Hill Dickinson** (legal) were incorporated, ensuring that the DD scope was comprehensive and aligned with recognised best practice for NHS transactions.

3. **Designed Tailored DD Questionnaires**

Bespoke DD questionnaires were developed for each corporate, clinical, and operational area.

These were designed to ensure systematic collection of information relating to clinical governance, performance, compliance, risk, contracts, workforce, estates, digital, quality, and finance.

4. **Supported Workstreams Through Guidance and Engagement Sessions**

Introductory briefings and support sessions were delivered to workstream teams to ensure clarity of expectations, consistency of responses, and timely provision of evidence.

The programme team provided ongoing guidance throughout the data-gathering stage.

5. **Factual accuracy review of initial DD reports**

Once KPMG and Hill Dickinson produced their draft DD reports, Trust leads and workstream SROs conducted a detailed factual accuracy review. This ensured that all findings, assumptions, and interpretations were correct and aligned with internal records.

6. **Finalisation of DD reports**

All amendments arising from the factual accuracy review were incorporated into the final DD reports by KPMG and Hill Dickinson. The final outputs provide an accurate and validated assessment of risks.

7. **Risk review, scoring, and mitigation planning**

All identified risks were reviewed systematically RAG-rated in line with Trust risk management frameworks.

For each risk, mitigation actions were developed collaboratively with Workstream SROs and recorded within the integration risk registers.

8. **Identification of day one critical actions**

Specific high-priority actions required for day one readiness were extracted from the DD findings.

These actions are reflected in the workstream delivery plans and flagged as critical day one actions in relevant delivery trackers to ensure clear accountability, monitoring and timely implementation as part of the day one mobilisation meetings.

This comprehensive approach has enabled the identification, assessment, and planned mitigation of risks; informing our integration planning and ensuring that the new Trust will maintain strong governance, operational effectiveness, and patient safety throughout the transaction and beyond. By addressing risks proactively, the Trusts are positioned to deliver safe, sustainable, and high-quality services within the new integrated organisation.

Of the 151 identified DD risks across all categories, 111 require a further review or mitigating action to be taken forward. These actions have therefore all been incorporated back into the individual workstream delivery trackers to ensure visibility. Of those 111 actions, 81 have been classified as critical day one.

19.3.2 Due diligence findings

Full details of each risk identified through the due diligence exercise, including the original and residual risk scores, are documented in the supporting documentation for reference and assurance.

A summary of the top risks by each area is presented below:

Clinical & Operational Risks			
Risks identified	**33**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG057	Based on the 2025/26 Q1 NOF data, BCH has been assigned to segment 3 (“below average and/ or financial deficit.”). For two domains, Access to Services and Finance and Productivity BCH has been assigned to segment 4 (‘low performing’). The access to services segment 4 (‘low performing’) rating includes one indicator – the percentage of patients wating over 52 weeks for community services.	20	Targeted improvement plans are in place to address contributing to segment 3 rating, specifically within finance (strengthened recovery plans), productivity and efficiency action plans and access to services, validation of waiting list and action plans to ensure there are no patients waiting over 52 weeks by March 2026. Performance is monitored through performance council and Trust committees/Board. Robust improvement plans are in place to progress to segment 2 of the NOF.	16
KPMG065	Five services have been described as ‘fragile’ inpart due to staffing-related reasons. However, the action to support these services is not consistently reported to the Quality and Safety Committee.	20	Fragile services are identified within the organisation, service leads are developing targeted workforce and resilient plans, including recruitment, retention and skill mix plans to support performance and activity. Harmonising approach to fragile services reporting to quality committee in common pre transaction and QAC post transaction	8

KPMG069	Difficulties recruiting to certain posts is creating fragile services	20	Harmonising approach to fragile services reporting to quality committee in common pre transaction and QAC post transaction	8
HD034	BCH has confirmed it has taken one case to the Court of Protection over the last 3 years. This related to a patient with severe learning difficulties who required dental treatment under general anaesthetic. The outcome of this and whether any claim is likely to arise is unclear/ not specified.	20	Background: Concerns were raised by independent mental capacity advocate (IMCA) regarding proposed dental treatment. The Trust sought legal advice and initiated a court of protection application to ensure compliance with statutory requirements and safeguard best interests. Outcome: Dental treatment authorised by the court of protection. Conveyancing plan agreed and scheduled. Solicitor noted deprivation of liberty concerns, which commissioning bodies will address. Official solicitor visit completed following signed undertakings. Treatment successfully completed and patient recovered well. Patient now not showing any signs of pain. No risks identified and therefore no further action required.	6

Table 59 - Summary of the top Clinical and Operational due diligence risks

Commercial Risks			
Risks identified	**12**	**DD Completed By**	**KPMG**

	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG072	Cost reduction opportunities have been identified from the integration of corporate functions. The quantification of this opportunity has been based on benchmark data from the national model health system and represents a move to national median or lower quartile performance.	9	MARS scheme launched in November 2025 to help create early opportunities for reduction in headcount.	4
KPMG073	The population across Warrington and Halton is projected to grow by 11,300 between 2021 and 2033 (2.4%) due to population growth and inward migration. While this level of net population growth is modest the age distribution is forecast to shift significantly. The working age population (20-64) will decline over the 12- year timeframe, at the same time the number of people aged 65+ will increase by 23% for Warrington and 20% for Halton over the same period. These demographic changes will result in increased demand for community services provided under the block contract. There is a risk that it may not be possible to gain additional funding for projected increases in activity.	9	Action covered by KPMG023	1
KPMG074	Anticipated changes in demography will not only increase the demand for community services, but at the same time	9	As part of year 2 of 5 year plan, we will undertake robust capacity &	3

	will result in increased demand and greater pressure on acute services. A key aspect of Trust plans for the integration, in alignment with wider NHS and ICB priorities, is to develop models of care with the aim of increasing care in communities and at home. This will have the effect of further increasing the level of demand for community services within the integrated Trust. However, clinical integration planning has not yet reached the point where the specific impact of new models of care has been fully quantified, in terms of additional demand on community services		demand anaylsis covering both acute and community services.	
KPMG078	There has been a high level of increase in overall expenditure over the medium-term. BCH's total expenditure rose by 12.7% between FY23 and FY25 from £96.5 million to £108.8 million. This increase is primarily driven by rising employee expenses and increased spending on drugs and healthcare purchases.	9	No action required. Financial planning assumptions in FBC are based upon combined 25/26 planned deficit (before CIP) as a start point. Significant work has been undertaken to identify cost reduction opportunities and the integration programme is a key enabler to unlocking many of those opportunities.	1
KPMG079	A key strategic aim for the planned integration of WHH and BCH is to transform how and where services are delivered, with more care delivered at home or closer to home. However, there are currently significant pressures on community services. There are just under 8,500 adults and children currently on community waiting lists and almost 8,000 patients waiting for dental services. BCH also performs worse than peers for waiting list	9	No immediate action. Risk will be covered through the development of the detailed clinical strategy and the new integrated clinical model that will underpin it.	1

	performance based on NHS Oversight Framework ('NOF') metrics. BCH receives the lowest provider score of 4 (low performing) for percentage of people waiting over 52 weeks for community services.			

Table 60 - Summary of the top Commercial due diligence risks

Digital Risks			
Risks identified	**22**	**DD Completed By**	**KPMG/Hill Dickinson**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG030	Certain bespoke applications are managed solely by individual staff members, resulting in key person dependency within the IT team.	12	Code & Configuration Knowledge: There are three resources with knowledge of clinical systems code and configuration but within individual systems. BI & Qlik: Business Intelligence, Qlik applications and Infrastructure are highlighted as areas of expertise with key person dependency. Joining the BW/WHH teams provides more resiliency for key skills areas. Also, BCH CSOC Operations are disseminated as it's more cost-effective than employing multiple cyber analysts.	9
KPMG031	Certain roles/vacancies are being held due to cost improvement targets and uncertainty surrounding the potential integration. This creates instability in workforce planning and delays in recruitment.	12	Limited current vacancies exist. Categorise new vacancies by criticality to service continuity and digital transformation. Prioritise VAF's recruitment for roles essential to integration projects, digital operations and compliance (e.g., EPR, cybersecurity, IT support). Monitor throughout until new org models are completed	9
KPMG037	Completeness and currency of the disaster recovery documentation are not fully confirmed	12	Yes, DR Run books for all critical systems do exist and are regularly reviewed at CABIT meetings as part of their workplans. Updates are reported to the DIGIT governance group. BC testing needs to be more frequent.	8

Table 61: Summary of the top Digital due diligence risks

Environmental Risks

Risks identified	10	DD Completed By	Senior WHH Estates Manager

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KB002	No evidence that the Air conditioning F-Gas survey reports are available.	8	Surveys have been completed. Request copies of the survey reports and confirmation from FM provider for all sites.	2
KB003	Energy Certificates are not displayed in all BCH sites	8	Check lease status for Europa and Newton Road sites	4

Table 62 - Summary of the top Environmental due diligence risks

Estates Risks			
Risks identified	11	DD Completed By	KPMG/Hill Dickinson

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG045	10 contracts are due to expire within 12 months and a further 2 operate on a month-to-month basis. Discussions are underway between BCH and incumbent suppliers about renewing/rolling these contracts.	8	Work with WHH and procurement to novate/extend contracts at risk. PID documents submitted to programme delivery group.	4

Table 63 -Table of the top Estates due diligence risks

Finance Risks

Risks identified	38	DD Completed By	KPMG/Hill Dickinson

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
KPMG003	BCH's FY26 forecast outturn includes delivery of £5.5 million of CIPs, of which £5.4 million has been assumed to be delivered on a recurrent basis. We understand from BCH Management that delivery against these schemes is in line with plan and BCH have identified £6.5 million of schemes, including £4.8 million of schemes already implemented for FY26. However, we note that there is an additional CIP target of £2.4 million including in month 12 of the FY26 plan for FY26 (and forecast outturn) not reflected in the CIP plan, for which with schemes are yet to be identified.	15	Continue to work with ICB to identify schemes to achieve stretch target	12
KPMG004	There is an additional £0.5 million of CIP which was previously delivered by BCH, by reducing dermatology appointments. However, the realised saving has since been offset by an additional cost pressure (additional cancer appointments to reduce wait times).	15	Action covered by KPMG003	12

KPMG015	We note that £0.7 million of CIP schemes are planned to start delivering savings from month six onwards. We also note that an additional savings target of £2.9 million has been embedded in the month 12 expenses out of which £0.5 million savings have been achieved but now offset by additional expenditure	15	Action covered by KPMG003	12
KPMG017	The plan was prepared based on the forecast outturn for FY25 (as at month 11), rather than actual deficit as reported at month 12.	15	No action required. Financial planning assumptions in FBC are based upon 25/26 planned deficit (before CIP) as a start point. Whilst there will undoubtedly be some areas of spend within the plan that are underestimated, there are also elements that are undoubtedly overestimated. Overall we are confident that the opening plan is an accurate reflection of the true position of BCH.	6
KPMG020	BCH's planned other operating expenses for FY26 at £3.5 million are significantly lower than actual spend of FY25 at £6.8 million. This is due to removal of one-off items in FY25 spend and inclusion of a £2.9 million **additional savings** offset against the month 12 expenditure. Out of the £2.9 million saving target, £2.4 million has savings schemes yet to be identified, while £0.5 million saving has been assumed to be delivered. However, the realisation of the £0.5 million savings is dependent on successfully negotiating income of £0.5 million from the ICB.	15	Action covered by KPMG003	12

Table 64 - Summary of the top Finance due diligence risks

Health & Safety Risks			
Risks identified	**11**	**DD Completed By**	**Senior WHH H&S Manager**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
HW008	Incidents are managed by operational managers and reports are collated by the Head of Risk Management and Patient Safety.	9	Need to confirm there is a process in place at BCH for managing and monitoring incidents also confirm that a regular report on incidents is shared with the relevant H&S committee at BCH. Note that post-integration the process will become aligned.	3
HW009	Hazardous substances are managed via a electronic word template. Under the COSHH regulations the Trust is required to ensure all individual substances are risk assessed, have safety data sheets in places with details of any precautionary requirements and PPE required and training is in place.	9	Need to confirm there is a process in place at BCH for safe management of hazardous substances and confirm that a regular report is shared with the relevant H&S committee at BCH. Also need to confirm there is a process in place and review whether we will adopt a different system	3

Table 65 - Summary of the top Health & Safety due diligence risks

Workforce Risks			
Risks identified	**14**	**DD Completed By**	**Senior WHH People Manager**

NO	ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
AHM004	High sickness absence could impact assurance; off-plan absence may affect targets.	12	Work at a system level to address sickness absence and implement a new approach to supported attendance. This action is aligned to system controls outside of integration. Collaborative work to develop a new policy framework.	8
AHM010	Requires management of long-term absence and alignment of processes and policies post-transaction.	12	Aligned with risk 2 - Work at a system level to address sickness absence and implement a new approach to supported attendance. This action is aligned to system controls outside of integration. Collaborative work to develop a new policy framework. Review of sickness absence and management processes from April onwards to support timely and consistent case management post Regulation 11 timeframes in line with WHH information. Development of a policy roadmap for all	8

			people policies pre-April 2026 to support management of policy consistency (within TUPE frameworks).	
AHM011	Contract may cease after six months; increased usage could create cost pressures.	12	**Occupational Health:** Development of a combined in-house OH service for all staff within the cost envelope of the current external contract. Development of PID pre-integration to ensure a streamlined day one offer. Development of plan B option for continuity should the OH service contract no end in March 2026. **Resus:** Development of a plan to align Resus provisions for day one to support effective clinical services in the community and Acute. Development of combined governance procedures for Resus monitoring and reporting.	8
AHM012	Declining scores may increase sickness/turnover and bank/agency reliance.	12	Implementation of the Joint Culture Plan collaboratively based on NSS results for 2025. Targeted triangulation of OD activity and programme of activity aligned to staff survey results / OD activity at a local level. Alignment of sub-committee governance to ensure oversight and management of cultural alignment post integration.	8
AHM013	Tribunal awards can be unlimited; high disciplinary ratio (WRES) may impact future performance.	12	Review of employee relations and management processes from April onwards to support timely and consistent case management post Regulation 11 timeframes. Complete a review of casework capacity and themes for management.	8

Table 66 -Summary of the top Workforce due diligence risks

19.4 Risk management in the integrated organisation from day one

Risk management processes will remain robust throughout the integration period. WHH will continue to manage risk registers and incidents on the Datix system, while the new community and dental care group (BCH clinical services) will utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single data analyst governance team, which will produce joint reports for governance committees and care groups to ensure safe business continuity.

All risk registers will be overseen by a single risk review group, attended by the executive team, all care groups, and the corporate secretary. This group will ensure that all risks are managed, reviewed, and aligned with the corporate risk register and the Board assurance framework. The risk review group will report into quality committee and Trust Board by exception. The clinical governance managers/governance teams will be fully trained in both systems.

20.0 Conclusion

The integration of WHH and BCH marks a pivotal moment in our shared ambition to deliver a single, high-quality, sustainable healthcare system for the people of Warrington, Halton and the surrounding Cheshire and Merseyside footprint. This business case sets out a compelling strategic, clinical, operational and financial rationale for the transaction and demonstrates how our integration directly aligns with the NHS 10-year plan's three overarching priorities: shifting the focus from treatment to prevention; analogue to digital transformation; and integrated, personalised care from the hospital into the community.

Over the past 18 months, significant work has already been undertaken to lay the groundwork for a successful transaction. The appointment of a joint chief executive and executive team provides strong and consistent leadership across both organisations. Joint governance and decision-making structures are now embedded, including shared Board meetings, a strategic people committee in common, and a single BCT delivery group overseeing all aspects of the integration. Clinical leadership has been pivotal to the outcomes of the joint clinical summits to develop our clinical priorities and will be even more crucial as we progress the integration of the clinical services further. The national strategic direction to develop neighbourhood health models of care in collaboration with multiple partners across Place creates the perfect environment for our integration to drive improvement through a transformed clinical model and associated pathways. The opportunities to deliver sustainable and measurable benefits for patients, staff, and the wider regional NHS are huge.

Early progress and collaborative working between the two organisations is already delivering benefits and demonstrating the potential impact of integration on a larger scale. Our patients will experience smoother, more effective and compassionate care. We will be much better placed to manage demand for unplanned and planned care in future, and our combined organisational costs will reduce. This business case builds on early successes, setting out a roadmap for achieving a successful transaction by April 2026 and a firm foundation for fully integrated services and systems thereafter.

While the foundations for success are strong, further work is required to continue to develop our plans in partnership with stakeholders and then realise the full benefits of the opportunities that exist. The second phase of our programme will see us move into completion and delivery of our post-transaction implementation plan (PTIP), the production of new joint clinical and estates strategies and the continued alignment of digital infrastructure, workforce systems and governance frameworks. Continuous engagement with staff, system partners and our communities will remain critical to maintaining trust and ensuring delivery remains responsive to local needs and challenges.

Ultimately, this integration is not simply an operational necessity, it is the only sustainable route to delivering the safe, high-quality, equitable and financially viable services that our local population expect and deserve. The case for change is clear; by coming together as one organisation we create an environment for change and improvement, a platform from which we can deliver on the transformational vision of future collaborative care, and an opportunity to drive significantly improved value. Put simply, we will deliver better care together.

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Better Care together - Board certification

General		Response
1	**Considered a detailed options appraisal before deciding that the transaction delivers benefits for patients and the Trust**	A comprehensive and transparent options appraisal process was conducted to determine the best legal mechanism to integrate the two organisations. The process involved both executive teams, Boards, partners, and NHS England, who all endorsed the approach. The appraisal focused on the legal method of integration as a means to enable wider transformational change in service delivery. It involved identifying, developing, and assessing a long list of options before agreeing on a shortlist for detailed evaluation. All shortlisted options were assessed against agreed criteria, supported by evidence gathered from key stakeholders including local authorities, the ICB, voluntary sector, primary care, and NHSE. Four shortlisted options were then independently evaluated by a panel: -Shared leadership with joint operational governance -Merger of BCH and WHH -Acquisition of BCH by WHH -Acquisition of WHH by BCH Following evaluation, Option 6, the acquisition of BCH by WHH was approved by both Boards in February 2025. This option offered comparable patient, staff, and financial benefits to other options, the best value for money, and minimal delivery risks. It will fully integrate community and hospital services, improving care pathways and long-term health outcomes in line with the national 10-Year Health Plan.
2	**Conducted appropriate enquiry about the probity of any partners involved in the proposed transaction, taking into account the nature of the services provided and the likely reputational risk**	The Trusts have conducted appropriate enquiries into the probity of all partners involved in the proposed transaction. This has included comprehensive due diligence, aligned with NHSE transaction guidance. The nature of services and potential reputational risks have been considered. All identified due diligence risks have been considered and rated in line with an agreed risk scoring tool. These risks have been included within the integration risk register and will be managed through the integration programme governance structure. The integration risk register will be reviewed monthly (or more frequently if a new risk is identified) to ensure that they are being managed or mitigated appropriately. Where required, integration risks will also be reflected in the two Trusts' and subsequently new organisation's risk management systems, where risks and mitigating actions are reviewed regularly and escalated as appropriate. As progress against integration plans is made the risk owners will review and update the scores allocated to due diligence risks as necessary. Delivery of mitigating actions agreed against each due diligence risk will be tracked through robust risk management governance and through the Better Care Together programme governance.

3	**Received appropriate external advice from independent professional advisers with relevant experience and qualifications**	We have received appropriate external advice from independent professional advisers with relevant experience and qualifications.This includes: -Legal advisers with expertise in NHS transactions and regulatory compliance; -Consultants experienced in healthcare mergers and acquisitions. All advisers engaged are independent and have provided objective input that has informed key decisions and risk mitigation strategies throughout the transaction process. In addition, we also received advice and support from the NHSE Transaction team.
4	**Taken into account the good practice advice in NHS England's transaction guidance or commented by exception where this is not the case**	The transaction process has taken into account the good practice advice outlined in NHS England's transaction guidance. Where applicable, we have followed the recommended approaches across key areas including: -Governance and decision-making -Due diligence and risk management -Stakeholder engagement -Financial and workforce planning -Post-transaction integration
5	**Considered the implications of the proposed transaction on the Oversight Framework segment.**	Warrington & Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT have actively considered the implications of their proposed transaction on their NHS Oversight Framework segments. This includes recognising current segment scores, evaluating how integration may improve performance across key domains. The transaction is expected to support upward movement in segment rankings by addressing systemic challenges and aligning with NHS England's expectations for provider capability and financial discipline. Further work is being completed to model the impact of BCH's activity being assessed against acute Trust performance metrics, where this will be applicable. This may impact ratings for the new enlarged organisation on NOF metrics within the access domain (e.g. 18 weeks and 52 weeks). Ensuring our plans for 2026/27 reflect all activity appropriately for new enlarged organisation will be fundamental. Work has commenced to develop single reporting and it is an essential pre day 1 action being tracked through our mobilisation governance. We are also developing our 5 year plan, including the assessment of every key issue and opportunity reflected in the plan for their impact on finance, performance, activity and workforce. WHH is currently placed in segment 4 and BCHT in segment 3. The proposed integration between WHH and BCH has potential to improve segment performance medium to long term by addressing fragmented pathways, reducing duplication, and enhancing clinical and financial sustainability. Furthermore, integration will support mitigating reputational and operational risks through robust governance structures and Board-level oversight, and align with NOF expectations, including the requirement for breakeven or surplus financial performance.
Quality and patient benefits delivery		

6	**Developed detailed plans to deliver demonstrable and achievable benefits to patients and the wider population**	We have developed detailed plans to deliver demonstrable benefits to Warrington and Halton residents by combining the strengths of a single, integrated organisation. This will enable implementation of integrated clinical models, delivery of key clinical priorities, and realisation of substantial patient benefits through integrated, holistic care closer to home, with a focus on prevention and early intervention. We believe that the Integration will overcome current barriers, such as separate IT systems, governance, and clinical pathways, allowing services to collaborate more effectively, streamline processes, reduce duplication, and free up clinicians' time for frontline care. The plans also aim to improve staff satisfaction, expand professional opportunities, and achieve lasting improvements in population health, patient experience, and system efficiency. We continue to refine our expected benefits to ensure they are all measurable and maximised for patients and the wider system.
7	**Ensured that plans are ambitious for patients by considering a range of potential opportunities for benefits, including through reference to benchmarking data and views of system partners**	We have developed ambitious plans by systematically exploring opportunities to improve outcomes and efficiency across the enlarged organisation. The patient benefits identified are grounded in evidence and practice, drawing on information and data from the extensive clinical engagement process, lessons from other acute and community Trust mergers, NHS case studies, and published research. Benchmarking data and input from system partners, including local authorities, primary care, and third-sector organisations were also used to shape our patient-focused integration plans.
8	**Engaged and collaborated with system partners to ensure transaction plans are aligned to ICB priorities**	We have actively engaged and collaborated with system partners to ensure that transaction plans are fully aligned with ICB priorities. Regular meetings, joint workshops, and ongoing communications have been held with the ICB and key stakeholders to discuss integration plans, share progress, and gather input. This collaborative approach ensures that our transaction activities support wider system objectives, enhance patient care, and strengthen partnership working across the local health system. Examples of engagement with system partners include regular ICB led steering group meetings, regular updates and discussion in Place based Partnership Boards, updates to Health and Wellbeing Boards and Scrutiny Committees, partner involvement in clinical summits and options appraisal process and continued GP engagement. The Cheshire and Merseyside ICS strategic objectives are summarised in the FBC, including how our integration explicitly supports delivery of each of the objectives.
9	**Carried out a robust prioritisation process to determine which services require integration sooner, including a clear programme to integrate lower priority services at a later date**	We used a robust prioritisation process for integrating clinical services. This included starting with a senior clinical and operational leadership workshop to map services, identify overlaps, challenges and opportunities and agree five priority themes. These informed a phased integration programme of seven priority areas, approved by BCT programme delivery group and Trust Boards, balancing impact, clinical need, capacity, and readiness. We are currently developing our plans for the remaining lower-priority services which are scheduled for later integration.
10	**Conducted an appropriate level of clinical due diligence relating to the transaction, which has enabled an understanding of quality risks associated with the transaction or inherent in the transacting organisations**	We have conducted an appropriate level of clinical due diligence relating to the transaction to ensure a clear understanding of quality risks associated with the transaction and those inherent in the transacting organisations. To support this, we have engaged KPMG to carry out a detailed Clinical Due Diligence review, providing independent assurance and insight into clinical quality, patient safety, operational risks, and compliance with regulatory standards. The due diligence exercise has identified a range of risks, which have been reviewed and prioritised. We have worked with all relevant workstreams to define and start to implement mitigating actions to ensure these risks are effectively managed. This will ensure that the enlarged organisation will maintain high standards of care, robust governance, and patient safety throughout and beyond the transaction.

11	**Identified and mitigated to the extent possible quality risks, both pre-existing and arising from the transaction**	Yes, we have identified and mitigated, to the extent possible, quality risks both pre-existing and arising from the transaction. Through our comprehensive clinical due diligence process, supported by KPMG, we have identified and begun to address potential risks related to patient safety, clinical effectiveness, operational performance, and regulatory compliance. Pre-existing risks have been identified through the robust due diligence process, mitigating actions have been developed and agreed by the clinical and operational workstream working closely with teams to address gaps and strengthen existing controls, through existing governance processes. Transaction-related risks, such as those arising from organisational integration, changes in governance, or operational alignment, have been proactively identified and reflected in risk registers, with agreed mitigating actions incorporated into our delivery plans.
12	**Involved senior clinicians at the appropriate level in transaction planning, including involvement in the creation of patient benefits proposals**	Senior clinicians from both Trusts and external partners participated in clinical summits, workshops and planning sessions to map services, assess clinical alignment, and identify priority areas for integration. They were instrumental in developing patient benefits proposals, ensuring that plans were clinically sound, focused on improving outcomes, and designed to deliver tangible, measurable benefits to our populations.
13	**Assured itself that senior clinicians have been fully engaged and involved in developing the business plan and all the changes and improvements to clinical services, including integration and new configurations or models of delivery, and that there is no clinical practice reason to object to the plans**	We have ensured that senior clinicians were fully engaged throughout the development of our plans for integrating the clinical priority areas and in planning all proposed changes and improvements to clinical services. This engagement included discussions around service integration, new configurations, and alternative models of care delivery. Feedback from senior clinical staff has been thoroughly considered, and there are no clinical practice concerns or objections that would prevent the implementation of our integration plans. Our clinical integration programme is clinical led by our shared executive medical director and chief nurse.
14	**Effective governance arrangements that safeguard quality, for the purpose of monitoring and continually improving the quality of healthcare provided by the enlarged trust to its patients, including:** **– ensuring required standards are achieved (internal and external)** **– investigating and taking action on sub-standard performance** **– planning and managing continuous improvement** **– identifying, sharing and ensuring delivery of best practice** **– identifying and managing risks to quality of care** **– establishing robust quality governance procedures for the enlarged organisation.**	The governance structure for the enlarged organisation ensures that all aspects of performance, including quality of care, are appropriately governed by a committee of the Board. We have already implemented finance and people committees in common and a single quality committee will be in place from day 1. Performance will be monitored and managed through the committees and sub-committees, as described in the corporate and clinical governance sections of the FBC and supplementary governance paper. Dedicated improvement and project resource will be aligned to clinical integration in the 2 years following day 1 to enable improvement and delivery of best practice. We have established a joint risk management process for programme risks. For BAU risks we will have a single process from day 1 and are developing plans for a single risk management system. We will retain existing good governance, including Risk Review Group and Patient saftey and clinical effectiveness sub-committee, expanding the reach to the enlarged organisation.
14.1	**ensuring required standards are achieved (internal and external)**	Our dedicated Quality Assurance Committee, reporting to the Board, monitors performance, safety, patient experience, and compliance with internal policies and external standards such as CQC and other requirements. We will meet these standards through regular audits, benchmarking, clinical audits, performance monitoring, and action plans to address any gaps. Patient and staff feedback will be systematically gathered and used to drive continuous improvement. Through this structured approach, alongside active engagement with clinicians, patients, and system partners, the Trust will maintain high standards of care and a culture of safety, accountability, and excellence.
14.2	**investigating and taking action on sub-standard performance**	Sub-standard performance will be identified through a combination of quantitative and qualitative measures. Key sources include clinical audits, performance dashboards, patient outcomes, incident and near-miss reporting, complaints, staff feedback, and external inspections. Data will be systematically triangulated to detect early warning signs, trends, or outliers that may indicate areas of underperformance. Action plans will be developed collaboratively with relevant teams, setting clear objectives, timescales, and responsible leads. Progress will be monitored through follow-up audits, performance reviews, and regular reporting to the Quality Committee, ensuring that improvements are sustained and lessons learned are embedded across the organisation.

14.3	**planning and managing continuous improvement**	We will continue using and enhancing the Trusts' existing continuous improvement approach by planning and implementing initiatives and improvement projects under a single framework with clear objectives and measurable outcomes, expanding use of data and benchmarking. Frontline staff will be actively engaged and supported through training in improvement methods, while forums and digital platforms will facilitate sharing of best practice and innovation from other NHS trusts. Progress will be monitored through dashboards, audits, and Board reporting, ensuring lessons learned are embedded and sustained, fostering a culture of continuous improvement and excellence in patient care.
14.4	**identifying, sharing and ensuring delivery of best practice**	Best practice will be identified through clinical audits, benchmarking, patient and staff feedback, research evidence, lessons learned from incidents, external reviews, and by actively reviewing innovations and high-performing approaches from other NHS trusts and national guidance. This ensures that the enlarged Trust remains aligned with national standards and emerging evidence, which will be reflected in the 5 year plan for the enlarged organisation. We will ensure that we have mechanisms in place to share best practice across teams, departments, and sites, including learning forums, clinical networks, and digital platforms.
14.5	**identifying and managing risks to quality of care**	We will identify and manage risks to quality of care through a proactive and systematic approach to quality governance. A single risk management framework will be established, aligned with the organisation's Quality Strategy and Board Assurance Framework, to ensure clear accountability and oversight. Quality risks will be identified through multiple sources, including incident reporting, complaints, clinical audits, performance data, patient feedback, and staff engagement. Data from these sources will be triangulated to detect early warning signs and emerging themes. Risk management processes will remain robust throughout the integration period. WHH will continue to manage risk registers and incidents on the Datix system, while Bridgewater Care Group will utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single Data Analyst Governance Team, which will produce joint reports for governance committees and Care Groups to ensure safe business continuity. All risk registers will be overseen by a single Risk Review Group, attended by the Executive Team, all care groups, and the Corporate Secretary. This group will ensure that all risks are managed, reviewed, and aligned with the Corporate Risk Register and the Board Assurance Framework. The Risk Review Group will report into Quality Committee and Trust Board by exception. The Clinical Governance Managers/Governance Teams will be fully trained in both systems.

14.6	**establishing robust quality governance procedures for the enlarged organisation.**	The enlarged Trust will adopt a unified quality governance framework that ensures safe, effective, and person-centred care across acute and community settings. This framework will align with NHS England's quality governance principles and the requirements of the care quality commission (CQC), while supporting the Trust's strategic objectives and ICS priorities. A Quality Assurance Committee responsible for oversight of clinical quality, patient safety, and experience will be established building on the existing quality governance framework from each Trust. The Committee which will report to the Trust Board, will also oversee the development and implementation of quality strategies, monitor compliance with regulatory requirements, and ensure effective communication and learning frameworks are in place across the new Trust. The integration encompasses all governance functions, including risk and incident management, CAS alert management, policy, SOP and guideline oversight, legal and claims management, and complaints and PALS. To support this, relevant documents, SOPs, and policies are being updated and consolidated to ensure clarity, accountability, and robust governance structures. All processes will be concluded and fully defined by 31 March 2026, with joint governance meetings commencing from 1 April 2026. Many activities will begin ahead of full integration to maintain continuity and safety. Incidents will be managed collaboratively across both organisations on a daily basis. Clinical Governance Managers, aligned to care groups, will provide daily escalations to the Triage Meeting chaired by the Deputy Director of Governance. For any incidents of concern or interest, an SBAR report will be prepared and reviewed at the weekly Executive-led Safety Oversight Meeting (SOM), which is attended by Integrated Care Board colleagues. During SOM, proportionate learning responses will be agreed and subsequently presented back for review. SOM reports into the Quality Assurance Committee (QAC) through relevant governance reports and escalates to the Executive-led PSIRF Group. Learning will be monitored through the Sustained Learning Group, which will commence in Quarter 4 2025/26.
Integration delivery		
15	Developed a comprehensive plan to complete the transaction, integrate the organisations and transform services, including mitigations to associated risks	We have developed a comprehensive delivery plan to complete the transaction, ensuring continuity of care and minimal disruption, including mitigations for associated risks. Our plan includes initial actions required for full organisational integration and service transformation post day 1. We have established clear governance and oversight through the BCT Programme Delivery Group and developed a detailed list of Critical Day 1 tasks to ensure safe and uninterrupted services. Potential risks (clinical, operational, financial, and regulatory) have been identified and mitigating actions agreed. Service transformation will be guided by evidence-based approaches, benchmarking, and best practice, while staff, patients, and system partners are actively engaged to ensure collaboration and shared ownership throughout the integration process. This approach ensures a smooth transaction, effective integration, and sustainable improvements in service delivery and patient care. We have completed thorough due diligence, in line with NHSE transaction guidance. All identified due diligence risks have been considered and rated in line with an agreed risk scoring tool. These risks have been included within the integration risk register and will be managed through the integration programme governance structure. The integration risk register will be reviewed monthly (or more frequently if a new risk is identified) to ensure that they are being managed or mitigated appropriately. Where required, integration risks will also be reflected in the two Trusts' and subsequently new organisation's risk management systems, where risks and mitigating actions are reviewed regularly and escalated as appropriate. As progress against integration plans is made the risk owners will review and update the scores allocated to due diligence risks as necessary. Delivery of mitigating actions agreed against each due diligence risk will be tracked through robust risk management governance and through the Better Care Together programme governance.

16	Developed robust cultural integration and staff engagement plans that will enable the establishment of an integrated culture	Since February 2025, we have taken a proactive and inclusive approach to cultural integration and staff engagement, ensuring that our workforce is supported, informed and actively involved in shaping the future of our organisation. Based on the agreed workforce principles within the Better Care Together Communications and Engagement plan, monthly staff engagement sessions, open to all and led by Executive Team members, have provided regular updates on key transaction milestones and created space for open dialogue, questions and answers. These sessions have reinforced transparency, built trust and enabled staff to contribute meaningfully to the integration journey. In addition, feedback and questions from the session are incorporated into the 'staff FAQs' section of the Better Care Together microsite. A combined Culture Plan has been developed, launched in July 2025, drawing directly from staff feedback gathered through the Staff Survey and regular check-ins. This plan reflects the current organisational values and priorities of our workforce and includes a tailored organisational development offer to support teams in building collaborative and cohesive working relationships. The offer includes facilitated workshops, team-building activities and leadership support, all designed to help teams come together and foster a sense of belonging prior to the new integrated structure. The plan has been built as transitional and will be updated in line with the new combined organisational strategy and values. To further strengthen partnership working, joint staff side meetings have been established. These meetings support the alignment of discussions across staff groups and ensure that staff representation remains strong and unified. They play a critical role in embedding collaborative decision-making and reinforcing our commitment to a shared, inclusive organisational culture. This has now formed into the development of an Organisational Change Framework launched in August 2025. Together, these initiatives form a robust framework for cultural integration, grounded in staff engagement, partnership working and a collective commitment to achieving the Better Care Together case for change.
17	Developed robust digital integration plans that will ensure the safe, effective transition of key systems	We have developed digital integration plans to support the integration of the two Trusts, ensuring the safe, seamless transition of critical IT systems, patient records, and operational platforms. Plans are designed to minimise disruption to clinical services, maintain data security and compliance, and enable long-term operational efficiency across the enlarged organisation. This is being underpinned by both the technical integration (systems, data flows, interoperability) and the organisational integration (governance, culture, clinical workflows).
18	Developed a robust operating model for the enlarged organisation, based on careful consideration of a range of options	Transitional arrangements will be put in place to ensure a smooth transition from legacy structures to the new integrated operating model. This will involve the establishment of a transitional structure for both governance and staffing by day one of the enlarged organisation. We have developed a robust transitional operating model for the enlarged organisation, structured around integrated leadership and service delivery. The transitional model features integrated leadership and senior management at the top, supported by three core service pillars: Unplanned Care, Planned Care, and Community & Dental, ensuring comprehensive coverage across patient needs. Beneath these, integrated clinical support and corporate services provide essential infrastructure. The model blends existing WHH and BCH teams into newly integrated units, fostering collaboration, efficiency, and a seamless patient experience. Our future operating model will need to be developed as part of much broader operating model across our local Places and region, and we will continue to develop this with our internal and external stakeholders.
19	Ensured that staff have the capacity and capability to deliver the transaction and the benefits associated with it	Resource planning has been undertaken to assess current resources, identify gaps, and allocate sufficient staff to support the transaction and integration process. While capacity has been a significant challenge, we have developed a robust resource plan to ensure staff have the capability and capacity to deliver the transaction and realise its benefits. We have also established clear roles, responsibilities, and reporting lines within the Programme Governance and operational teams to ensure accountability and effective delivery. Ongoing engagement with staff will ensure that they are supported, motivated, and able to contribute to achieving the intended outcomes of the transaction, while monitoring mechanisms are in place to address capacity or capability issues proactively.

20	Conducted a robust programme of non-clinical due diligence that is consistent with the plan set out at strategic case stage and has enabled the identification and mitigation of material risks	We have conducted a robust programme of non-clinical due diligence (Finance, Workforce, Digital, Commercial, Estates, Legal, environmental, health and safety) in line with the NHSE transaction guidance to ensure a clear understanding of risks associated with the transaction and those inherent in BCH. To support this, we have engaged KPMG and Hill Dickinson to provide independent assurance and expertise. All identified due diligence risks have been considered and rated in line with an agreed risk scoring tool. These risks have been included within the integration risk register and will be managed through the integration programme governance structure. The integration risk register will be reviewed monthly (or more frequently if a new risk is identified) to ensure that they are being managed or mitigated appropriately. Where required, integration risks will also be reflected in the two Trusts' and subsequently new organisation's risk management systems, where risks and mitigating actions are reviewed regularly and escalated as appropriate. As progress against integration plans is made the risk owners will review and update the scores allocated to due diligence risks as necessary. Delivery of mitigating actions agreed against each due diligence risk will be tracked through robust risk management governance and through the Better Care Together programme governance.
21	Complied with all necessary regulatory and legal requirements	In line with NHSE transaction guidance, all necessary regulatory and legal requirements have been complied with throughout the transaction process. This includes robust due diligence, legal and regulatory approvals, ongoing risk management, and full engagement with staff and stakeholders. The Trusts' governance structures ensure ongoing oversight and assurance of compliance as the transaction progresses. Evidence includes: • Completion of a robust and comprehensive due diligence process • The Organisational Change Framework has been developed and signed off with staff side colleagues, ensuring compliance with employment law and best practice for staff transfers • The strategic case for the transaction has been approved by both Trust Boards and reviewed by NHSE, as required by national guidance. • The Board Assurance Framework (BAF) and Corporate Risk Register are regularly reviewed and updated to ensure all regulatory risks are identified, monitored, and mitigated. • All statutory and regulatory reporting (e.g., CQC, NHS England, GMC revalidation, annual reports) is up to date and compliant • Equality Impact Assessments are undertaken for all major changes, including the transaction and workforce integration • Meaningful consultation with staff and stakeholders has been undertaken, in line with legal requirements and best practice. • All staff affected by the transaction are being supported through clear communication, consultation, and access to advice.
22	Addressed any legal issues arising from the transaction, including those associated with the transfer of staff	Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare, have completed workforce due diligence internally, based on guidance from KPMG. This has identified risks and recommendations of which there are no known legal issues arising from the transaction at this current point. A high-level review of workforce employment tribunals has been completed and the capacity to manage employee relations is a planned requirements for the post transaction implementation plan. Consultation in line with the Transfer of Undertakings (Protection of Employment) Regulations has commenced in November.
23	In the case of a contract for a specified period, ensured appropriate legal protection in relation to staff, including on termination of the contract	All contracts are being reviewed in line with guidance, and this ensures that staff rights and terms and conditions are considered. This includes any contracts which are ending that have Transfer of Undertakings (Protection of Employment) Regulation implications. A workforce representative is aligned to the Better Care Together programme, this is to ensure that the management of contracts and appropriate recommendations for the new organisation consider the workforce legal protections under TUPE law.

24	Complied with any consultation requirements	The Trusts have developed an Organisational Change Framework; this aligns with legal requirements under the Transfer of Undertakings (Protection of Employment) Regulations and provides oversight of consultation requirements. Consultation commenced in November 2025 and to ensure it is meaningful it is taking place until February / March 2026. This then allows for the 28-day notice to be issued prior to the transaction date. The Transferee (WHH) submitted their Regulation 13(4) in September 2025, and the Transferor (BCH) completed their Regulation 13(2) in October 2025 to all Regional / Local Officers (Trade Unions). A consultation launch meeting with Trade Union representatives took place in November 2025 to ensure processes are following accordingly. A three-phase approach to consultation has been agreed - (1) Group consultation (2) Service consultation (3) Individual consultation / 1:1s. This approach will ensure that staff and their representatives are meaningfully engaged with a FAQ document updated regularly. An equality analysis review has additionally been completed.
25	Established the reporting lines, processes and accountabilities to deliver the planned benefits of the proposed transaction	The Trusts have established robust reporting lines, governance processes, and accountability structures to deliver the planned benefits of the proposed transaction. These include Committees-in-Common (pre-transaction), which will become singular Committees (post-transaction); a Post Transaction Integration Plan, and dedicated Better Care Together Programme Delivery Group, chaired by the Joint CEO. Several joint Executive Director roles are in place to support consistent reporting and accountability. The approach aligns with NHSE transaction guidance and ensures that strategic, operational, and financial responsibilities are clearly defined and monitored across both organisations. The programme has a benefits tracker and detailed KPIs are in development for the benefits described within the FBC. Post day 1 the programme governance will remain in place to monitor delivery of full integration and benefits.
26	Ensured that the board and senior management of the enlarged trust have the capability, capacity and experience to deliver the transaction successfully and lead the enlarged trust	The Trusts confirm that the Board and senior management of the enlarged trust have the capability, capacity and experience to deliver the transaction successfully and lead the future organisation. This is evidenced through stable leadership, joint Board development, strategic alignment, formal capability assessments, and robust programme governance. The leadership team is well-positioned to realise the benefits of integration and deliver improved outcomes for patients, staff and communities. Evidence includes: • WHH currently has a full and stable Trust Board and leadership team, which has been explicitly recognised in the Better Care Togeher Options Appraisal Information and Evidence Pack as a key factor in the deliverability of the preferred transaction option. • BCH has ensured continuity through planned leadership transitions, including the appointment of an Interim Chair and continued executive engagement. • The joint executive leadership team, including Nikhil Khashu as Chief Executive Officer, has experience leading both organisations and is actively involved in shaping the integration programme • Joint Board Development Sessions have been held that focussed on shared values, strategic intent, organisational strengths and risks, and leadership behaviours. The sessions included agenda items on: strategic case for change, communications and branding, ICB expectations and financial targets, leadership capacity and pace of delivery. The sessions helped align both Boards on the integration vision and confirmed their collective readiness to lead the enlarged trust. • The Trusts are participating in the NHS Oversight Framework Board Capability Assessment process, which includes a Board-level self-assessment of capability across six domains. This assessment is designed to ensure Boards are confident in their ability to deliver strategic plans, manage risks, and lead transformation. The process includes triangulation with third-party intelligence and historical performance, ensuring a robust and credible evaluation. • The options appraisal panel, comprising of executive and non-executive members from both Trusts, unanimously recommended the acquisition of BCH by WHH as the preferred option. The appraisal considered 19 criteria grouped into six key areas, including leadership capability and capacity.

27	Engaged with system partners to determine how all parties will work together to ensure the successful delivery of the transaction and the realisation of benefits.	We have actively engaged with our external partners since the start of our integration journey (For example via Warrington Together Partnership Board, One Halton Partnership, Warrington Health Scrutiny, Halton /Warrington Health and Wellbeing Boards, Clinical Care Advisory Group) providing regular updates about progress and opportunities to engage and influence appropriately. Senior managers and clinicians from external partners have also been involved in workshops for developing our clinical strategy and integrating our clinical services. Furthermore, our Integration Programme Steering Group is chaired by the Cheshire & Merseyside ICB CEO. We remain committed to continuing to work closely with system partners on the development of the long-term clinical strategy, model, and clinical priorities, some of which will be implemented in Phase 2 of our Integration programme. Mechanisms for regular communication, joint planning, and progress monitoring have been established to address any issues promptly and provide the appropriate updates. Our integration is supported by the ICB, both Local Authorities, our MPs, local GPs and voluntary sector partners.
Finance		
28	Developed a plan in which the deliverable financial benefits of the transaction outweigh the costs over the medium term	The forecast costs of our transaction are £1.1m. Forecast benefits (direct and indirect) are £33m, £12m of which are directly reliant upon integration. The benefits therefore far outweigh the costs.
29	Ensured that plans are ambitious by considering a range of potential opportunities for financial benefits, including through reference to benchmarking data	Model Health System benchmarking data identifies significant financial benefits to be accessed through increasing organisational size and accessing greater economies of scale across corporate functions. Move to median corporate cost will release up to £8m recurrently. Further financial benefits from corporate services as we move beyond median performance and towards lower quartile but likely to require further increase in scale or shared service models in future. Model Health data also suggests potential financial benefits from clinical services through transforming clinical model and shift towards community/out of hospital care. This will be factored into future plans as the new clinical strategy and clinical model starts to form (phase 2 of integration programme). Further direct financial benefits exist in terms of estates reconfiguration, contract alignment, potential alignment of employment Ts and Cs, detailed costing analysis of block contracts etc.
30	Identified robust mitigating actions against short-term financial deterioration	Short term financial deterioration will be offset by savings, in particular corporate. For example, the cost of moving to 1 ledger with be circa £150k (one-off fee) however once we have one ledger the annual costs will be lower than for 2 organisations, similar for audit fees. Therefore, in year 1 this might mean some savings are delayed to fund the additional cost and savings will fully deliver in year 2. More broadly the financial benefits forecast significantly outweigh costs, with projected (unabsorbed) costs of c£1.1m and savings either dependent upon or enabled by integration of c£33m. In 2025/26 we are currently forecasting costs of c£0.8m and savings of £2.4m.
31	Prepared a robust medium-term financial plan	We have prepared a 4 year financial plan, which delivers a break even position for the enlarged organisation at the end of 2028/29.
32	Made provision for the transfer of all relevant assets and liabilities	We have made provisions for the transfer of relevant assets and liabilities.
33	Resolved any accounting issues relating to the proposed investment or divestment and its proposed treatment	No accounting issues have been identified. Robust financial due diligence has been completed and mitigating actions agreed for all relevant risks identified.
34	Reviewed the working capital requirements of the enlarged trust, taking into account the new and existing working capital facilities, and is satisfied that the working capital available to the enlarged trust is sufficient to meet the trust's requirements for at least 12 months from the transaction date	The working capital requirements of the enlarged Trust have been reviewed in detail, taking into account both existing and new working capital facilities. Following this assessment, we are satisfied that the working capital available to the enlarged Trust is sufficient to meet its operational and financial requirements for a period of at least 12 months from the date of the transaction.
35	Established financial reporting procedures that provide a reasonable basis on which to reach proper judgement as to the financial position and prospects of the enlarged trust.	Financial accountants will review accounting treatments, should any differences be identified it is expected that the WHH treatment will be followed as the acquiring organisation. Month end financial procedures and budget setting have been reviewed. Once we are one organisation we will be on the same ledger and work to the same deadlines (e.g. working day 2 reporting).

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Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Better Care Together

Transaction documents for approval and next steps

Trust Boards, December 2025

Lucy Gardner, Chief Strategy and Partnerships Officer (WHH)

Better Care Together – Context

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

What is it?

Better Care Together is a programme of work being undertaken to integrate WHH (acute trust) and BCH (community trust) into a single organisation

Why is it so important?

- Improves care for patients e.g. 100 additional people per month accessing Urgent Community Response instead of attending Emergency Department
- Generates more efficient use of resources, estimated financial benefit up to £33m (£12m direct + £21m indirect)
- Supports staff development
- Enables sustainable services

Where are we now?

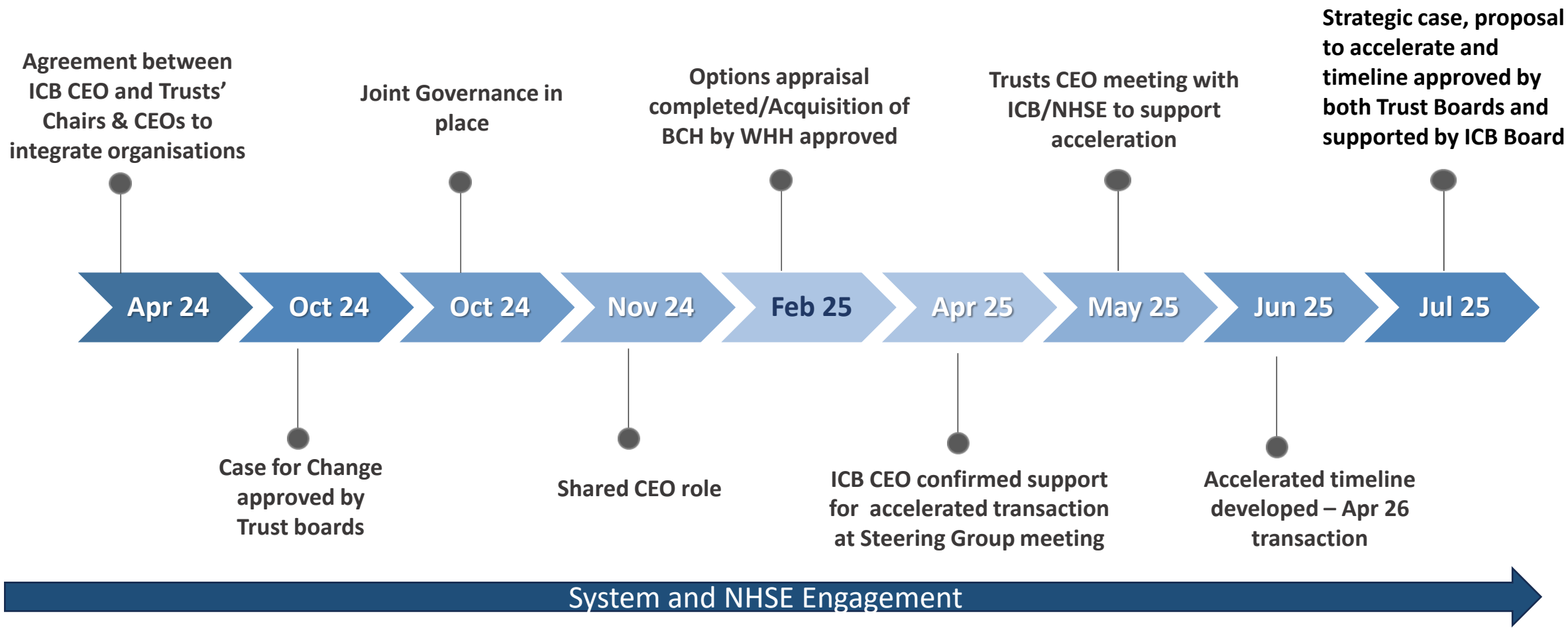
We have finalised the Full Business Case, which is being presented to both Trust Boards for approval. We hope to become a single organisation on 1st April 2026

What do we need to do today?

- Review transaction documents, including the final FBC
- Approve FBC and approve (WHH)/support (BCH) Board certification to enable submission to NHSE

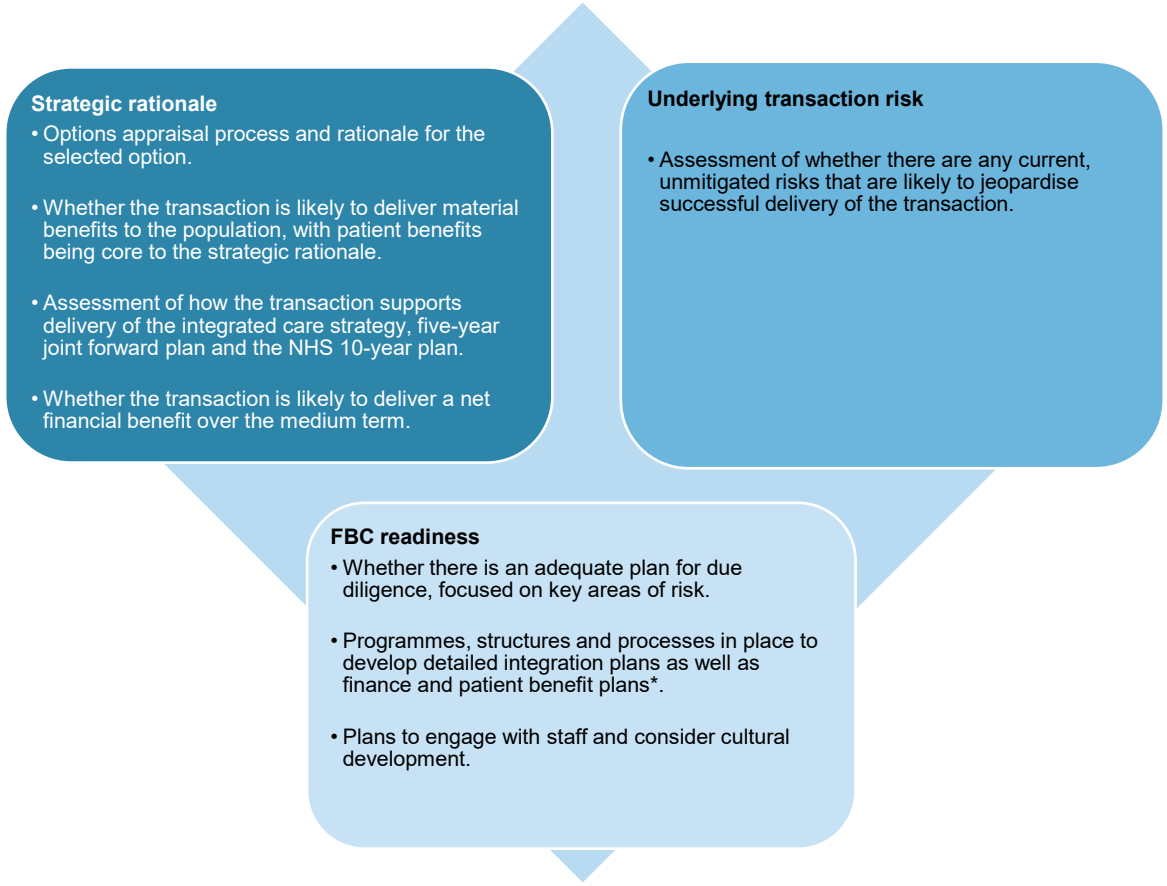
Our integration so far

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Strategic Case review

- Our Strategic Case was approved by both Trust Boards and supported by the ICB Board in July 2025.
- We submitted our Strategic Case and supporting documents to NHSE on 8th August 2025.
- NHSE then reviewed our Strategic Case in line with the NHSE transactions guidance and via a process summarised in the diagrams to the right. Many members of both Boards were involved in this review process and the detailed pack shared with NHSE to inform our final challenge meeting was shared at November Board meetings.
- On 14th November we formally received the outcome of the strategic case review – an amber risk rating.
- The recommendations from the strategic review and where we have and will address them are included on the next slide.



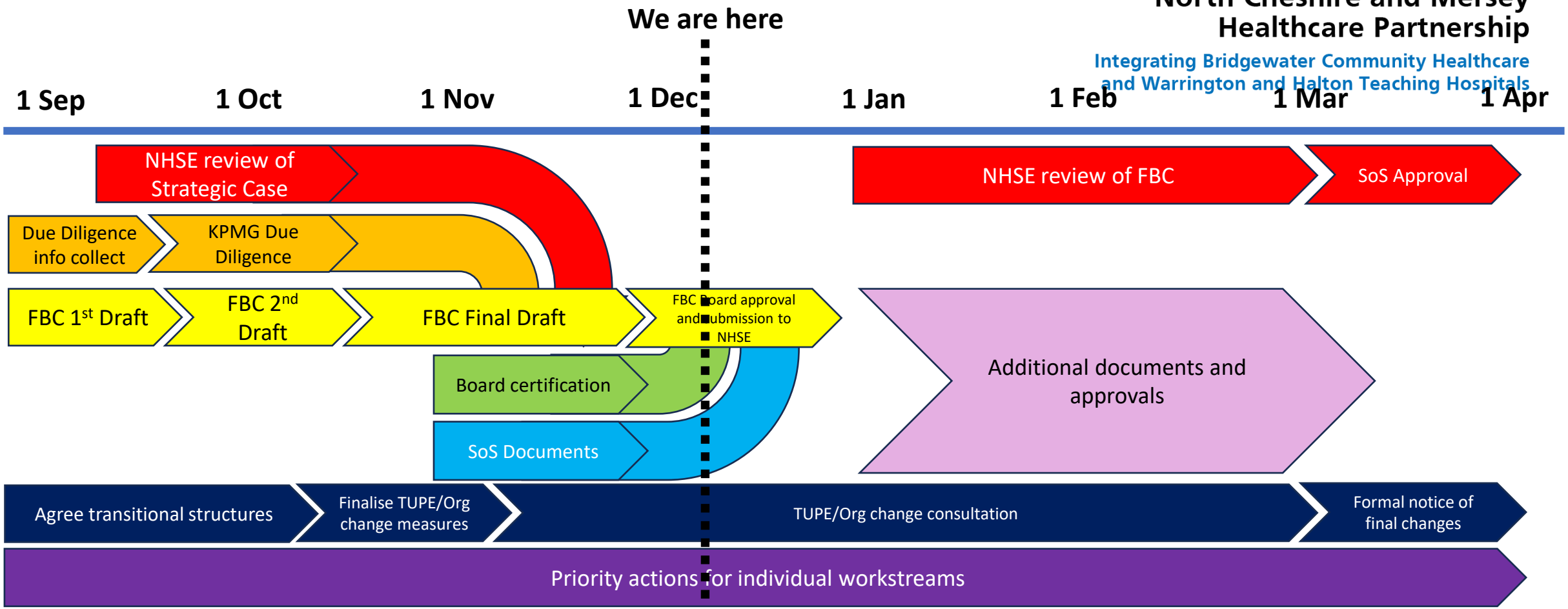


NHSE recommendations to support FBC development and transaction and integration planning following the strategic case review

No.	Recommendation	Priority	Included
1.	Clinical strategy – The trusts should set out a timeline against key actions identified in the trusts' BCT: Developing a Joint Clinical Strategy, with associated monitoring against the plan, in the FBC.	FBC development	Timeline for development of clinical strategy set out in FBC (section 8)
2.	Patient benefits – The trusts should develop detailed robust patient benefits plans to deliver improvements in the high priority pathways... [Resourcing – see Recommendation 5].	Ongoing transaction and integration planning	Detailed benefits and high level plans included in FBC for priority pathways. Timeline for detailed clinical integration planning included in PTIP.
3.	Financial benefit delivery plans – The trusts should further develop the financial benefits ahead of FBC submission... As part of the trusts' submission, we expect to see financial benefits fully profiled...	FBC development	Further detail added to section 13 of FBC.
4.	Transaction costs – The trusts should refine the transaction costs to ensure that all additional costs associated with the transaction and integration are identified and quantified...	FBC development	Added to finance section of FBC (section 13).
5.	Transaction resourcing – The trusts should ensure sufficient resourcing is maintained throughout the transaction period...	Ongoing transaction and integration planning	Section on programme resourcing added to FBC (section 7).
6.	Combined underlying financial position – The strategic case sets out the trusts' four-year financial plan to move the trusts from a combined underlying deficit of £72m...	FBC development	Underlying deficit figure throughout FBC now updated to £48.3m. Link back to £72m figure included in SOC added to section 13.
7.	EPR – Given there will not be a single EPR in the foreseeable future for the enlarged organisation, the trusts will need to have a clear plan outlined in the FBC...	FBC development	Section added into FBC (section 17).
8.	Cultural development plan – The trusts will need to continue to carefully monitor pre- and post-transaction cultural development work...	FBC development	Included in people strategy section of FBC (section 16).

Programme Critical Path

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Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals



Key documents required for transaction (1)

Document	Presented for approval today	Purpose
FBC, including due diligence.	✓	A formal document setting out the detailed case for integration which: -demonstrates how the transaction will be executed -outlines the benefits and how they will be delivered -identifies key risks -details the resources and processes in place to ensure both a safe landing of the transaction and the achievement of the intended benefits. Due diligence identifies areas of risk so that we can decide if we should proceed with the transaction and if so, what action to take to mitigate the risks as part of our integration planning.
FBC Supporting documents		We have developed over 50 supporting documents to support delivery of our integration and transaction and to provide assurance to Trust Boards and/or NHSE. These will be submitted to NHSE along with our FBC, Board Certification, PTIP and SoS documents. Many of the supporting documents have been previously shared with and/or approved by Trust Boards as part of our integration programme. Where necessary they will be reviewed by EMT prior to submission and shared at future Trust Boards as appropriate.
Board certification	✓	All Trusts undertaking material and significant transactions must complete a Board Certification as part of the transaction review process. It is submitted to NHSE alongside the FBC, to demonstrate the Board's confidence that the requirements of the transaction guidance have been met.
Post Transaction Integration Plan	✓	The PTIP is a roadmap that describes the process of integrating the 2 Trusts, from their current state to the integrated single Trust post-transaction. A "live" document that shows how the Trusts will achieve a safe transition but also continue to integrate and deliver the intended benefits. It focuses on aligning culture, integrating systems, and combining operations.

Key documents required for transaction (2)

Document	Presented for approval today	Purpose
Secretary of State for Health and Social Care (SoS) documents	✓ (bar qualitative submission)	These are documents that demonstrate how the transaction meets the four duties summarised on slide 26.
Management letter of representation		A key document that provides NHSE with assurance that: • All information supplied for the transaction is accurate and complete • The Trusts have disclosed all material risks, issues and liabilities • The Trusts have complied with all legal, regulatory and policy requirements
New constitution		A formal, legally binding document that defines the governance framework of the NHS Foundation Trust after the transaction. It sets out the organisation's structure, powers, membership rules, Board arrangements, accountability mechanisms, and decision-making processes. Once approved, it becomes part of the Trust's legal standing and must be adhered to by the Board, governors and members.
Application letter		An Application Letter is a Board-approved, formally signed request submitted by the Trust(s) to NHS England, confirming that they are applying for NHSE approval of the proposed transaction. It acts as the official notification that the Trust(s) have completed the required planning, due diligence and assurance steps, and now seek NHSE's authorisation to implement the transaction.
Transaction agreement		A legally binding contract between the Trusts involved in a merger or acquisition. It defines the terms, responsibilities, liabilities and arrangements under which one Trust acquires another. It ensures that both parties and NHS have absolute clarity about what is being transferred, how risks are managed, and what obligations remain before and after the transaction date.

Document submission and approvals timeline

Document	NHSE Submission deadline	Status	NHSE deadline to send to us	Papers due EMT	EMT	Papers due WHH Board	WHH Board	Papers due BCH Board	BCH Board	Papers due WHH CoG	WHH CoG	Papers due BCH CoG	BCH CoG	Notes
FBC	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025	11/12/2025	18/12/2025	03/12/2025	10/12/2025	For CoGs also include role of governors detail
PTIP	05/12/2025	On track		01/12/2025	02/12/2025	25/11/2025	03/12/2025	25/11/2025	04/12/2025					
Board certification	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025	11/12/2025	18/12/2025	03/12/2025	10/12/2025	
FBC supporting documents	05/12/2025	On track		01/12/2025	02/12/2025									
Management Letter of representation	06/02/2026	Not started				27/01/2026	04/02/2026	27/01/2026	05/02/2026					
Qualitative submission (SoS)	05/12/2025	Not started		01/12/2025	02/12/2025									
Environmental Principles policy statement duty (SoS)	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025					
Public sector equality duty (SoS)	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025					
Family test (SoS)	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025					
SoS Duty (SoS)	05/12/2025	On track				25/11/2025	03/12/2025	25/11/2025	04/12/2025					
NHSE Transaction rating	N/A	Not started	28/02/2026			04/03/2026	11/03/2026	04/03/2026	12/03/2026					Transaction rating from NHSE will need to be submitted in March for Board approval. Formal public Boards will need to be stood up w/c 9th March.
Draft new constitution	05/01/2026	Not started	26/01/2026			31/12/2025	07/01/2026	31/12/2025	08/01/2026					Requires legal advice both from us and NHSE. Draft to January Boards - not for approval. Any feedback from January Boards will need to be shared immediately with NHSE as they are reviewing simultaneously with legal.
New Constitution	16/03/2026	Not started				28/01/2026	04/02/2026	28/01/2026	05/02/2026	03/02/2026	10/02/2026	18/02/2026	25/02/2026	For WHH Board and CoG approval. Tight turnaround - 2 days for papers following NHSE comments.
Application Letter	N/A	Not started				28/01/2026	04/02/2026	28/01/2026	05/02/2026	03/02/2026	10/02/2026	18/02/2026	25/02/2026	For Boards' and CoGs' approval, pending risk rating
Application Letter inc New Constitution, evidence that the majority of the council of governors of each FT involved has approved the application	16/03/2026	Not started				04/03/2026	11/03/2026	04/03/2026	12/03/2026					May require legal advice. Formal public Boards will need to be stood up w/c 9th March.
Draft transaction agreement	06/02/2026	Not started				28/01/2026	04/02/2026	28/01/2026	05/02/2026					Requires legal advice
Transaction Agreement (supersedes HoT)	16/03/2026	Not started				04/03/2026	11/03/2026	04/03/2026	12/03/2026					Requires legal advice

Full Business Case summary

Purpose

- Comprehensive assessment of the proposed integration between WHH and BCH, covering 20 chapters on key areas including strategy, quality, workforce, finance, estates, digital, and risk management.
- Developed in line with NHSE guidance and informed by best practice from other NHS transactions.
- Authored by Better Care Together team, senior Trust staff and programme workstream SMEs to ensure alignment with operational and strategic priorities.

Review & Governance

- Reviewed by workstream SROs for completeness and assurance.
- Presented for feedback in November to:
  - Trust Boards
  - Quality Assurance Committee (WHH)
  - Finance Committee (In Common)
  - People Committee (In Common)
  - NHSE
  - KPMG
- Updated to reflect feedback, due diligence findings and mitigating actions and outstanding actions as detailed in November Board report

Today

- Presented to Trust Boards for final approval ahead of submission to NHSE on 5th December 2025

Full Business Case summary (Ch. 1-5)

Chapter 1 - Foreword
Chapter 2 – Executive summary

Chapter 3 - Our organisations
WHH and BCH deliver healthcare services covering different parts of clinical pathways to broadly the same population of 340,000 people in Warrington and Halton. Both Trusts have underlying financial deficits and challenges relating to growing demand. From the recent NHS oversight framework data, WHH has been placed in segment 4 of 5 in terms of overall performance and support needs with BCH in segment 3.

Chapter 4 - Background and history to the planned integration
The work to explore the integration of WHH and BCH dates back to 2018 and in February 2020, both Trusts formally communicated their intent to integrate to NHS England. Within weeks of that decision, the COVID-19 outbreak impacted and discussions around integration ceased while both providers focused on the requirements of maintaining their own services through the pandemic. Five years on, and all of the reasons why integrating the two partner organisations made sense in 2020 still apply. Therefore, the plans to bring together the two organisations have been reinvigorated and accelerated, supported by the ICB.

Chapter 5 - Strategic rationale
The strategic case for integration is clear. The combined organisation will address health inequalities, strengthen clinical sustainability, enhance patient experience and improve financial performance.
The growing demand for services, an ageing population, and system-wide inefficiencies require unified leadership and delivery.
Integration will deliver a single, resilient healthcare organisation capable of meeting both current and future population health needs.
Strategic direction locally, regionally and nationally (NHS Ten-Year Plan) focusses on a ‘left shift’ of care out of hospital into community

Full Business Case summary (Ch. 6-8)

and from ill-health to prevention as a way to manage future demand. The integration of WHH and BCH creates the perfect platform to make the required transformation of services happen.

Chapter 6 - Options appraisal

Following a robust appraisal process, the acquisition of BCH by WHH was approved as the most suitable legal mechanism for integration. Acquisition of BCH was selected due to its lower risk, value for money, and ability to deliver greater patient and staff benefits sooner.

Chapter 7 - Programme delivery and programme management

We have established a detailed and wide-reaching programme of work to drive delivery and governance of the integration. The programme is entitled 'Better Care Together' and consists of ten workstreams, each with exec-level leadership and programme support. The programme has been split into three phases: Phase 1 focusses on completing the legal transaction and setting up the critical infrastructure to ensure day one (1 April 2026) delivery and commence the integration of leadership, corporate services and some clinical support functions. Phase two (April 26 to Mar 27) focusses on embedding initial infrastructure changes and driving early benefits whilst commencing work on the longer-term clinical integration and priority services. Phase three (Apr 27 onwards) will see the transformation of remaining clinical services and the shift towards a new model of care.

Chapter 8 - Vision and strategies for integrated trust

Our vision for integration is to create a new single organisation which is greater than the sum of its parts, anchored with a core principle of **'Home first, community next and only then hospital'**. Throughout the initial phases of the programme, we will develop a series of formal and connected strategy documents to help define our future clinical and operational model and describe how that model will meet the needs of our local populations.

Full Business Case summary (Ch. 9-11)

Chapter 9 - Organisation design

Plans are in place for a single Board to lead the organisation, supported by elected governors and underpinned by a renewed constitution. Board committee structures and quality and financial governance structures are detailed within the FBC to ensure robust governance from day 1.

Draft transitional structures for all teams, clinical and corporate, have been developed for consultation, which commenced in November.

Chapter 10 - Clinical model

The future clinical model of the integrated organisation will be shaped in line with national and local strategic direction and developed in collaboration with local and regional partners. It will be clearly defined in a new clinical strategy to be published by the end of 2026. The clinical model will build on strong foundations of collaboration between the two organisations and a commitment to transforming clinical pathways and promoting localised, data-led health and wellbeing care. Seven clinical priorities have been identified from initial engagement. These will form the basis of the initial integration work focussed on clinical service redesign. The service level clinical strategy and transformation will align to the core principle of **'Home first, community next and only then hospital'**.

Chapter 11 - Corporate support functions

The most significant financial improvement opportunity that can be unlocked through integration is linked to corporate services where national benchmarking clearly demonstrates that benefits can be delivered through improved economies of scale. Our corporate services will come together from day 1 and draft transitional structures have been developed for consultation. Corporate teams have been working closely together, starting to align internal processes and streamline activities to make the transition as smooth as possible from day 1.

Full Business Case summary (Ch. 12-14)

Chapter 12 - Expected benefits and quality impact

There are a number of key areas that together, summarise the benefits of the integration to our patients and communities; a fundamental shift in care - Home first, community next and hospital only when needed, data-led local approaches to service design and delivery, streamlined clinical pathways, removal of organisational barriers, better use of resources, strengthening fragile services, and enhanced public and patient involvement.

Chapter 13 - Financial case

The combined planned deficit for the two organisations for 25/26 prior to in year savings and deficit support funding stood at £72m. This is reflective of a position that has been worsening year on year partly in response to growing demand and a need to increase capacity to meet it. The integration programme presents financial improvement opportunities totalling up to £33m (both direct and indirect opportunities) and is therefore a fundamental part of the journey towards longer-term financial sustainability. The estimated costs of the integration stand at around £1.1m, demonstrating the value in bringing the organisations together and the urgency to make this happen as quickly as possible.

Chapter 14 – Inequalities

Warrington and Halton have high levels of inequality across the populations, including significant variation in life expectancy and healthy life expectancy within each borough.

By aligning community and acute services, the new organisation will target the root causes of inequality, deliver prevention-focused care, and strengthen partnerships with local authorities, primary care and the voluntary sector to close health gaps across populations.

The integration between WHH and BCH creates opportunities for the development of seamless care pathways across hospital and community settings, with multidisciplinary teams delivering wraparound support closer to home, contributing to the development of neighbourhood health.

Full Business Case summary (Ch. 15-17)

Chapter 15 - Communications and engagement

Our new organisation will be known as North Cheshire and Mersey NHS Foundation Trust. We have commenced a large-scale programme of engagement with staff, patients, local stakeholders and the wider public around a number of elements of our approach to the integration and this will set the tone for how we aim to continue over the coming years as we bring the two organisations together. We have support for the integration from our local MPs, C&M ICB, both Local Authorities, GPs, Voluntary sector partners and NHS England.

Chapter 16 - People strategy

Between us, the two organisations employ over 6,700 staff from over 80 different nationalities. The vast majority of our staff are also Warrington and Halton residents. The success of our integrated Trust is important to them on many levels. Our teams tell us that working closely together has already provided advancements in service delivery and the energy and commitment to take the opportunity to make things better is tangible and a source of optimism. We have already developed a joint culture plan and consulted with staff around our core Trust values that we commit to keeping at the heart of our work as we progress.

Chapter 17 - Digital strategy

Nationally, the NHS Ten-Year Plan sets out an ambition to shift care away from traditional analogue systems and processes and towards digitally-enabled care. In order to maximise the benefits available to us through the integration, and truly seize the opportunity to transform services, digital services must be central to our ambitions. We have set out a roadmap for the integration of our digital systems, including interoperability of our EPR systems to support our clinical and operational vision. We have already demonstrated the benefits of our integrated use of digital through our new dermatology AI service at Halton Health Hub.

Full Business Case summary (Ch. 18-20)

Chapter 18 - Estates strategy

Across both organisations, our staff currently operate from approximately 98 sites across Warrington, Halton, Knowsley, St Helens and Greater Manchester. The quality of the estate varies greatly, creating variation in terms of staff and patient experience and financial efficiency. The development of a new clinical strategy and the evolving move for more services in community creates a platform for a transformational approach to the use of estate. A new estates strategy will be developed to support the organisation's strategic long-term ambition to deliver more care locally and redevelop the acute hospital sites to enable the delivery of modern-day healthcare that meets the growing demands of our local population. The estates strategy will be developed in collaboration with local partners and align to national and regional estates priorities.

Chapter 19 – Risks

The individual workstreams within the Better Care Together programme capture and record all operational and strategic programme-related risks. Robust governance is in place to ensure that programme risks feed into the existing organisational risk management processes within BCH and WHH. Alongside this, appropriate and detailed due diligence has helped us to improve visibility of some of the key risks, issues and challenges associated with the acquisition. We have clarity around the most significant risks, and we have plans in place to mitigate and manage these as we progress through each phase of the integration programme, including those risks that are critical to manage as part of ensuring a successful day 1.

Chapter 20 – Conclusion

The integration of BCH and WHH is essential to enable us to provide the seamless care our growing populations need and deserve. Joining together to form a single organisation allows us to deliver the left shift of care described in the NHS 10 year plan, as well as ensuring our services are clinically and financially sustainable for the future. Put simply we will provide Better Care Together, for our patients, our staff and our partners and communities.

Due Diligence

Purpose

- It is important that the acquiring organisation has conducted appropriate due diligence to understand the risks within the organisation being acquired so mitigating actions can be put in place
- NHS England requires comprehensive due diligence (DD) for all Trust integrations
- DD focused on BCH as the Trust being acquired

Scope of Assessment

- DD areas: Legal, Clinical & Operational, Finance, Estates, Digital, Workforce, Commercial, Pensions, Health & Safety, Environmental
- A total of 357 lines across the above areas were reviewed
- Independent external reviews:
  - KPMG: Clinical &operational, Estates, Finance, Commercial, Digital
  - Hill Dickinson: Legal and contractual
- Internal Trust experts reviewed 4 areas: Workforce, Pensions, Health & Safety, Environmental
- 151 risks/issues identified

Status & Next Steps

- DD risks have been reviewed by SROs and mitigating actions for each risk have been agreed. All identified risks have been incorporated into the integration risk register and will be managed through the integration programme governance structure, as well as the BAU risk management processes.

Due Diligence risk summary

NHS
North Cheshire and Mersey Healthcare Partnership
thcare spitals

AREA	CLINICAL & OPERATIONAL	RISKS IDENTIFIED	33	DD COMPLETED BY	KPMG/Hill Dickinson

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
Based on the 2025/26 Q1 NOF data, BCH has been assigned to segment 3 ("below average and/ or financial deficit."). **For two domains, Access to Services and Finance and Productivity BCH has been assigned to segment 4 ('low performing'). The access to services segment 4 ('low performing') rating includes one indicator – the percentage of patients wating over 52 weeks for community services.**	20	Targeted improvement plans are in place to address contributing to segment 3 rating, specifically within finance (strengthened recovery plans), productivity and efficiency action plans and access to services, validation of waiting list and action plans to ensure there are no patients waiting over 52 weeks by March 2026. Performance is monitored through performance council and Trust committees/board. Robust improvement plans are in place to progress to segment 2 of the NOF.	16
Five services have been described as 'fragile' inpart due to staffing-related reasons. However, the action to support these services is not consistently reported to the Quality and Safety Committee.	20	Fragile services are identified within the organisation, service leads are developing targeted workforce and resilient plans, including recruitment, retention and skill mix plans to support performance and activity. Harmonising approach to fragile services reporting to quality committee in common pre transaction and QAC post transaction	8

AREA	WORKFORCE	RISKS IDENTIFIED	14	DD COMPLETED BY	Adam Harrison-Moran

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
High sickness absence could impact assurance; off- plan absence may affect targets.	12	Work at a system level to address sickness absence and implement a new approach to supported attendance. This action is aligned to system controls outside of integration. Collaborative work to develop a new policy framework.	8
Requires management of long-term absence and alignment of processes and policies post- transaction.	12	Review of sickness absence and management processes from April onwards to support timely and consistent case management post Regulation 11 timeframes in line with WHH information. Development of a policy roadmap for all people policies pre-April 2026	8

Due Diligence risk summary

NHS
North Cheshire and Mersey Healthcare Partnership

AREA	FINANCE	RISKS IDENTIFIED	38	DD COMPLETED BY	KPMG/Hill Dickinson

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
BCH's FY26 forecast outturn includes delivery of £5.5 million of CIPs, of which £5.4 million has been assumed to be delivered on a recurrent basis. We understand that delivery against these schemes is in line with plan and BCH have identified £6.5 million of schemes, including £4.8 million of schemes already implemented for FY26. **However, we note that there is an additional CIP target of £2.4 million including in month 12 of the FY26 plan for FY26 not reflected in the CIP plan, for which with schemes are yet to be identified.**	15	Continue to work with ICB to identify schemes to achieve stretch target	12
There is an additional £0.5 million of CIP which was previously delivered by BCH, by reducing dermatology appointments. However, the realised saving has since been offset by an additional cost pressure (additional cancer appointments to reduce wait times).	15	Continue to work with ICB to identify schemes to achieve stretch target	12

AREA	DIGITAL	RISKS IDENTIFIED	22	DD COMPLETED BY	KPMG/Hill Dickinson

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
Certain roles/vacancies are being held due to cost improvement targets and uncertainty surrounding the potential integration. This creates instability in workforce planning and delays in recruitment.	12	Limited current vacancies exist. Categorise new vacancies by criticality to service continuity and digital transformation. Prioritise VAF's recruitment for roles essential to integration projects, digital operations and compliance (e.g., EPR, cybersecurity, IT support). Monitor throughout until new org models are completed	9
Completeness and currency of the disaster recovery documentation are not fully confirmed	12	Yes, DR Run books for all critical systems do exist and are regularly reviewed at CABIT meetings as part of their workplans. Updates are reported to the DIGIT governance group. BC testing needs to be more frequent.	8

Due Diligence risk summary

NHS
North Cheshire and Mersey Healthcare Partnership

AREA	HEALTH & SAFETY	RISKS IDENTIFIED	11	DD COMPLETED BY	Helen Wynn

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
Incidents are managed by operational managers and reports are collated by the Head of Risk Management and Patient Safety.	9	Need to confirm there is a process in place at BCH for managing and monitoring incidents also confirm that a regular report on incidents is shared with the relevant H&S committee at BCH.Note that post-integration the process will become aligned.	3
Hazardous substances are managed via an electronic word template. Under the COSHH regulations the Trust is required to ensure all individual substances are risk assessed, have safety data sheets in places with details of any precautionary requirements and PPE required and training is in place.	9	Need to confirm there is a process in place at BCH for safe management of hazardous substances and confirm that a regular report is shared with the relevant H&S committee at BCH.	3

AREA	COMMERCIAL	RISKS IDENTIFIED	12	DD COMPLETED BY	KPMG

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
Cost reduction opportunities have been identified from the integration of corporate functions. The quantification of this opportunity has been based on benchmark data from the national model health system and represents a move to national median or lower quartile performance.	9	MARS scheme launched in November 2025 to help create early opportunities for reduction in headcount.	4
Anticipated changes in demography will not only increase the demand for community services, but at the same time will result in increased demand and greater pressure on acute services. A key aspect of Trust plans for the integration, in alignment with wider NHS and ICB priorities, is to develop models of care with the aim of increasing care in communities and at home. **This will have the effect of further increasing the level of demand for community services within the enlarged Trust. However, clinical integration planning has not yet reached the point where the specific impact of new models of care has been fully quantified, in terms of additional demand on community services**	9	As part of year 2 of 5 year plan, we will undertake robust capacity & demand anaylsis covering both acute and community services.	3

Due Diligence risk summary

AREA	ESTATES	RISKS IDENTIFIED	11	DD COMPLETED BY	KPMG/Hill Dickinson

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
10 contracts are due to expire within 12 months and a further 2 operate on a month-to-month basis. Discussions are underway between BCH and incumbent suppliers about renewing/rolling these contracts.	8	Work with WHH and procurement to novate/extend contracts at risk. PID documents submitted to programme board	4

AREA	ENVIRONMENTAL	RISKS IDENTIFIED	10	DD COMPLETED BY	Kieran Beech

ISSUE	INITIAL RISK SCORE	MITIGATING ACTION	RESIDUAL RISK SCORE
No evidence that the Air conditioning F-Gas survey reports are available.	8	Surveys have been completed. Request copies of the survey reports and confirmation from FM provider for al sites.	2
Energy Certificates are not displayed in all BCH sites	8	Check lease status for Europa and Newton Road sites	4

Board certification

Purpose

- Required by NHSE for all material and significant transactions.
- Submitted alongside the Full Business Case (FBC) to demonstrate the Board's confidence that all NHSE transaction requirements have been met and the Board is satisfied to proceed with the transaction.

Scope of Assessment

- Covers 4 assurance domains and 41 questions, providing comprehensive scrutiny and alignment with national best practice:
  - **General** – Governance, compliance, and strategic alignment.
  - **Quality & Patient Benefits** – Impact on patient care, service quality, and benefit delivery.
  - **Integration Delivery** – Workforce, estates, digital, and operational readiness.
  - **Finance** – Affordability, sustainability, and financial assurance.
- Drafted by the Programme Delivery Team, informed by responses from workstream Senior Responsible Officers (SROs).
- Ensures an evidence-based and collaborative approach reflecting expertise across the programme.

Governance

- Draft version reviewed by both Boards in November. No feedback received.
- Updated to reflect changes to FBC and further progress on overall transaction programme.

Today

- Presented to WHH Board for approval and BCH Board for support, prior to submission to NHSE on 5th December.

Board certification

Governance & Strategic Assurance

Was a detailed options appraisal conducted?
✅ Yes — multiple options were evaluated; acquisition of BCH by WHH was selected for best value and minimal risk.
Was partner probity assessed?
✅ Yes — due diligence and governance reviews were completed.
Was NHS England's transaction guidance followed?
✅ Yes — best practices were applied across governance, risk, and planning.

Quality & Patient Benefits

Are there detailed plans for patient benefits?

✅ Yes — integrated care models and improved pathways are planned.
Was clinical due diligence conducted?
✅ Yes — KPMG supported a thorough review.
Were quality risks identified and mitigated?
✅ Yes — both pre-existing and transaction-related risks addressed.
Were senior clinicians involved and supportive?
✅ Yes — no clinical objections to integration plans.
Are quality governance arrangements robust?
✅ Yes — includes standards monitoring, risk management, and continuous improvement.

Board certification

Integration Delivery

Is there a comprehensive integration plan?
✅ Yes — includes governance, risk mitigation, and transformation.
Is there a cultural integration and staff engagement plan?
✅ Yes — includes workshops, feedback loops, and OD support.
Are digital integration plans in place?
✅ Yes — ensures safe transition of systems and data.
Is there a robust operating model?
✅ Yes — transitional structure with integrated service pillars.
Was non-clinical due diligence completed?
✅ Yes — across estates, finance, legal, workforce, etc.

Legal & Regulatory Compliance

Were legal, regulatory, and consultation requirements met?
✅ Yes — including TUPE, staff engagement, and statutory compliance.

Finance

Are financial plans robust and sustainable?
✅ Yes — Benefits (c£33m) significantly outweigh costs (c£1.1m).

Post Transaction Integration Plan

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Purpose

- Provides the roadmap for integration of WHH and BCH following completion of the transaction.
- Ensures a safe transition and continued integration to deliver the full range of intended benefits.

Describes

- How the organisations will integrate after completion
- What will happen on Day 1 and throughout the first 12–24 months
- How risks will be managed and mitigated
- How quality, safety and financial stability will be maintained
- How the benefits of the transaction will be delivered and monitored

Key Focus Areas

Planning Approach	Integration of Organisational Structures, Leadership, and Governance	Integration of Clinical Services
Integration of Corporate Services	Workforce Integration	Integration Delivery
Communications and Engagement	Risk Management	Benefits realisation

Today

- Submitted to December Boards for approval, ensuring alignment with the Full Business Case (FBC), Due Diligence findings, and NHSE assurance requirements. A “live” document, evolving throughout the integration journey.

Secretary of State documents

Purpose

- Required by **NHSE** as part of the Transaction Approval process.
- Demonstrates how the new organisation meets the **statutory duties** of the **Secretary of State for Health and Social Care** under the **NHS Act 2006**.
- Provides assurance that the integrated Trust will operate in line with **national legal, ethical, and policy obligations**.

Qualitative submission: A short narrative paper that provides the DHSC with an overview of the transaction. It includes the background and purpose of the transaction, the qualitative benefits for patients, service users and staff, the economic case and comms and engagement with MPs, staff and patients. This is summarised into a 2-page ministerial document.

Key Duties Covered

- **SoS Duties (NHS Act 2006)** – Promoting a comprehensive health service, improving quality, reducing inequalities, and ensuring strong governance.
- **Environmental Principles** – Assessing potential environmental effects of the transaction.
- **Public Sector Equality Duty (PSED)** – Ensuring equality, inclusion, and fairness in line with the Equality Act 2010.
- **Family Test** – Considering the impact of the transaction on families, patients, and staff wellbeing.

Today

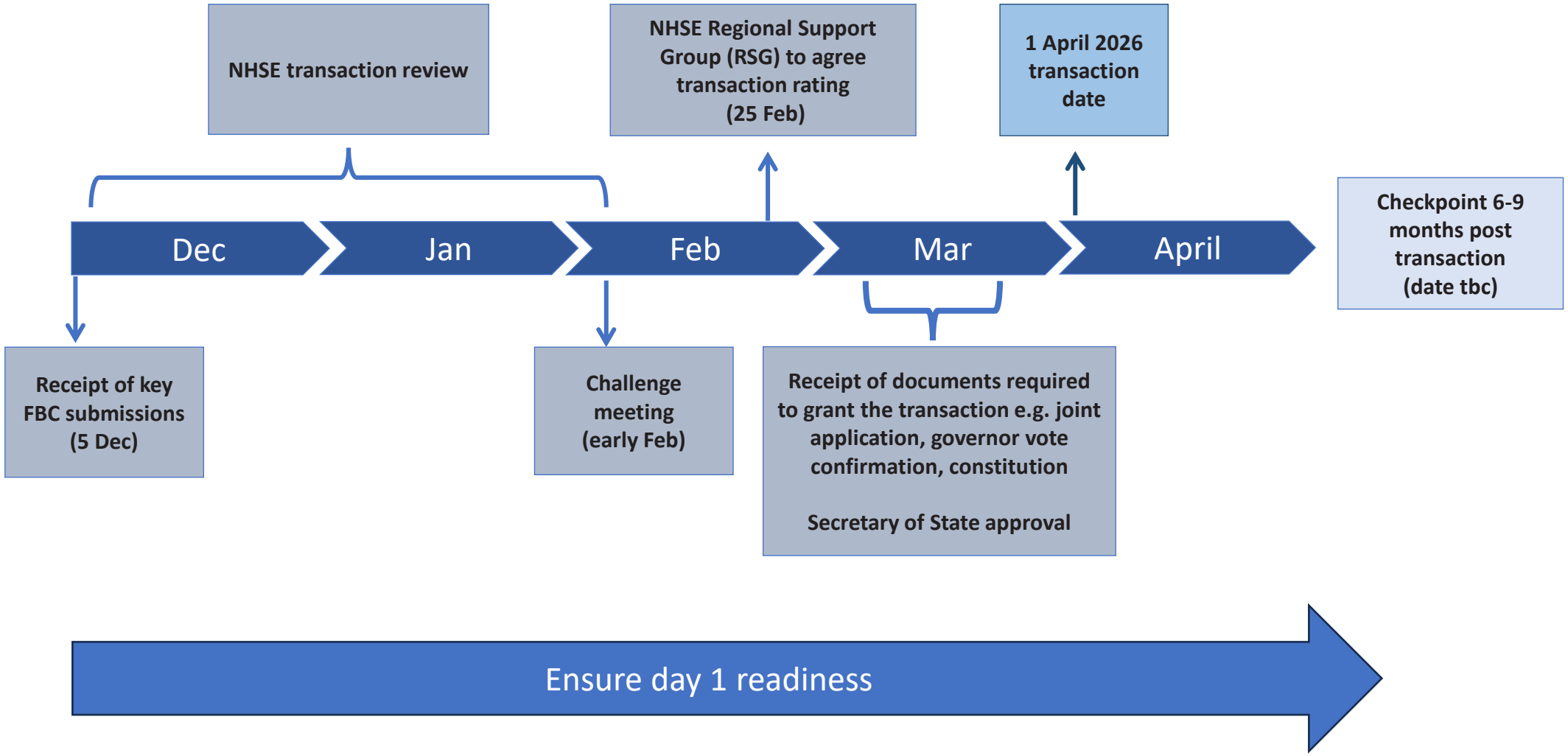
- All bar qualitative summary submitted to December Boards for approval prior to inclusion in the NHSE submission.
- Qualitative summary will be shared with EMT for approval prior to submission to NHSE.

Recommendations to Trust Boards

It is recommended that Trust Boards approve the following documents for submission to NHSE to continue to progress the transaction for WHH to acquire BCH as part of our integration programme:

- Full Business Case (FBC)
- Board Certification (Requires approval from WHH Board and support from BCH Board)
- Post Transaction Implementation Plan (PTIP)
- SoS Duties (NHS Act 2006) – Promoting a comprehensive health service, improving quality, reducing inequalities, and ensuring strong governance.
- Environmental Principles – Assessing potential environmental effects of the transaction.
- Public Sector Equality Duty (PSED) – Ensuring equality, inclusion, and fairness in line with the Equality Act 2010.
- Family Test – Considering the impact of the transaction on families, patients, and staff wellbeing.

Transaction next steps



Proposed transaction between Warrington and Halton Teaching Hospitals NHS Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH)

Post Transaction Integration Plan (PTIP)

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Abbreviations

Acronym	Description
A&E	Accident and Emergency
AHP	Advanced Health Practitioner
ANP	Advanced Nurse Practitioner
BAU	Business as usual
BI	Business Intelligence
CEO	Chief Executive Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
EQIA	Equality Impact Assessment
HR	Human Resources
ICB	Integrated Care Board
ICS	Integrated Care System
I&E	Income and Expenditure
IM&T	Information Management and Technology
IT	Information Technology
KPI	Key Performance Indicator
MDT	Multi-disciplinary Team
NED	Non-Executive Director
NHS	National Health Service
NHSE	NHS England
PAS	Patient Administration System
PTIP	Post Transaction Integration Plan
SC	Strategic Case
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SRO	Senior Responsible Officer

1 Introduction & Background

1.1 Introduction

This Post Transaction Integration Plan (PTIP) outlines our approach to integrating Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) as we progress towards a formal acquisition and beyond, setting out medium-to long-term plans for integration and benefits realisation.

While the Full Business Case (FBC) focuses on what the enlarged organisation will look like and deliver, this PTIP focuses on how integration will be achieved.

The document also sets out the governance structures for managing and monitoring the integration activity, along with our detailed plans to support delivery.

1.2 Background

In July 2025, WHH and BCH submitted a joint strategic case to NHSE, outlining the case for integrating the two organisations, proposed to be transacted through acquisition of BCH by WHH.

In November 2025, NHSE formally responded to the strategic case submission, and issued a rating of 'amber', meaning the partner trusts could proceed to the development of the FBC.

1.3 Purpose of the PTIP

A FBC for the transaction has now been developed, providing further detail on the opportunities and risks associated with the integration, the various options available, and the preferred direction of travel. This PTIP accompanies the FBC and is a required part of the transaction approvals process.

The PTIP has been developed in line with formal transaction guidance, describing the processes and detailed planning undertaken to bring together WHH and BCH to form a new integrated provider of acute and community healthcare.

It sets out anticipated:

- Overarching organisational structures.
- Leadership, governance, and management arrangements; and
- Clinical specialty and corporate service operating models

It also describes how:

- the integration process will be governed and managed, including planned communications, risk and benefits management processes etc. and
- the key steps that will be taken by clinical and corporate service teams pre- and post-transaction to achieve a safe transition to the new organisational operating model and achieve anticipated transaction benefits.

As is usual, this document has been prepared in support of the transaction process with the aim of providing further information about the proposed integrated operating model and assurance around the completeness, safety and ambition of plans.

Because it has, by necessity, been prepared in advance of the proposed transaction date (1 April 2026), it provides a view of the detailed integration activities undertaken and planned up to the point of writing. These plans will continue to be developed and evolve and therefore the PTIP is intended to be a 'live' document that will evolve alongside the plans.

1.4 Structure of the PTIP

Key topics are organised over subsequent chapters, as follows:

Table 1: PTIP sections

Chapter		Describes
Section 1: Overview of integration plans and the planning process		
2	Integration Planning Approach	The inclusive approach deployed to develop and evolve the plans outlined in this document
3	Integration of Organisational Structures, Leadership, and Governance	The transition to integrated leadership, governance and management arrangements
4	Integration of Clinical Services	How clinical services will integrate and transform within the first 100 days and beyond.
5	Integration of Corporate Services	The framework within which shared service changes have been and will be developed. Plans to prepare for day one and beyond across all shared services in order to effectively support clinical services
6	Workforce Integration	Plans for formal transition of the workforce and organisational development within the new Trust
Section 2: How integration plans will be delivered		
7	Integration Delivery	How the above integration plans will be delivered, including governance and management of the integration delivery programme
8	Communications and Engagement	Communications and engagement activities that will be undertaken to facilitate an effective transition
9	Risk Management	Key risks and how these will be managed
10	Benefits realisation	Benefits management processes

2 Integration planning approach

2.1 Introduction

The integration of WHH and BCH, and delivery of the anticipated transaction benefits is a complex process that will face significant challenges which will need to be overcome through robust planning.

Differences in organisational culture, leadership structures, and ways of working can slow alignment, while staff uncertainty may impact morale and retention. Integrating clinical services, pathways, and critical information systems requires careful co-ordination to maintain patient safety and operational efficiency.

Financial, contractual, and regulatory complexities add further strain, and clear communication with staff, patients, and stakeholders is critical to maintain trust. All of this must be managed while ensuring continuity of day-to-day services.

It is critical that these dependencies, risks and issues are identified, and that integration plans effectively respond to these challenges, achieving a safe, legal transition that delivers the benefits of the transaction without material risk to provision.

Successfully integrating the two Trusts requires careful planning, strong leadership, and clear communication. Cultural differences can be addressed through engagement, joint workshops, and visible leadership alignment. Staff uncertainty can be managed with transparent messaging, involvement in decision-making, and robust support. Clinical and operational integration will benefit from phased implementation, clear governance, and standardised pathways.

Medium to long-term investment in interoperable IT systems, careful financial planning, and proactive stakeholder engagement are also essential to maintain service continuity and build trust.

The following section describes the planning process that has been undertaken to achieve this.

2.2 The programme structure

The diagram below describes the transaction programme infrastructure that has supported the transaction planning and approvals process.

Ten core workstreams all maintain a detailed individual delivery tracker to record actions and milestones (including critical day one actions), risks and non-financial benefits. Each workstream reports into the Better Care Together (BCT) delivery group, which meets on a monthly basis.

Alongside the individual workstreams, there is also a focused ‘day one mobilisation’ group to provide assurance around delivery of a ‘safe day one’ for the new organisation. There is also a public and patient reference group, which is chaired independently by Healthwatch to gather feedback and comments from local residents about any plans for the new organisation and any potential changes to services in future that may require input from the public. Both of these groups also report into the BCT delivery group.

The BCT delivery group reports into both Trust Boards to ensure full oversight of the programme.

Overall, the governance structure in place draws together expertise from both Trusts and the general public, to provide the necessary input and oversight to ensure effective delivery of the programme. To date, the governance structures and various groups have supported the successful completion of the strategic case, FBC; this PTIP and the process of due diligence.

Figure 1: Programme Infrastructure

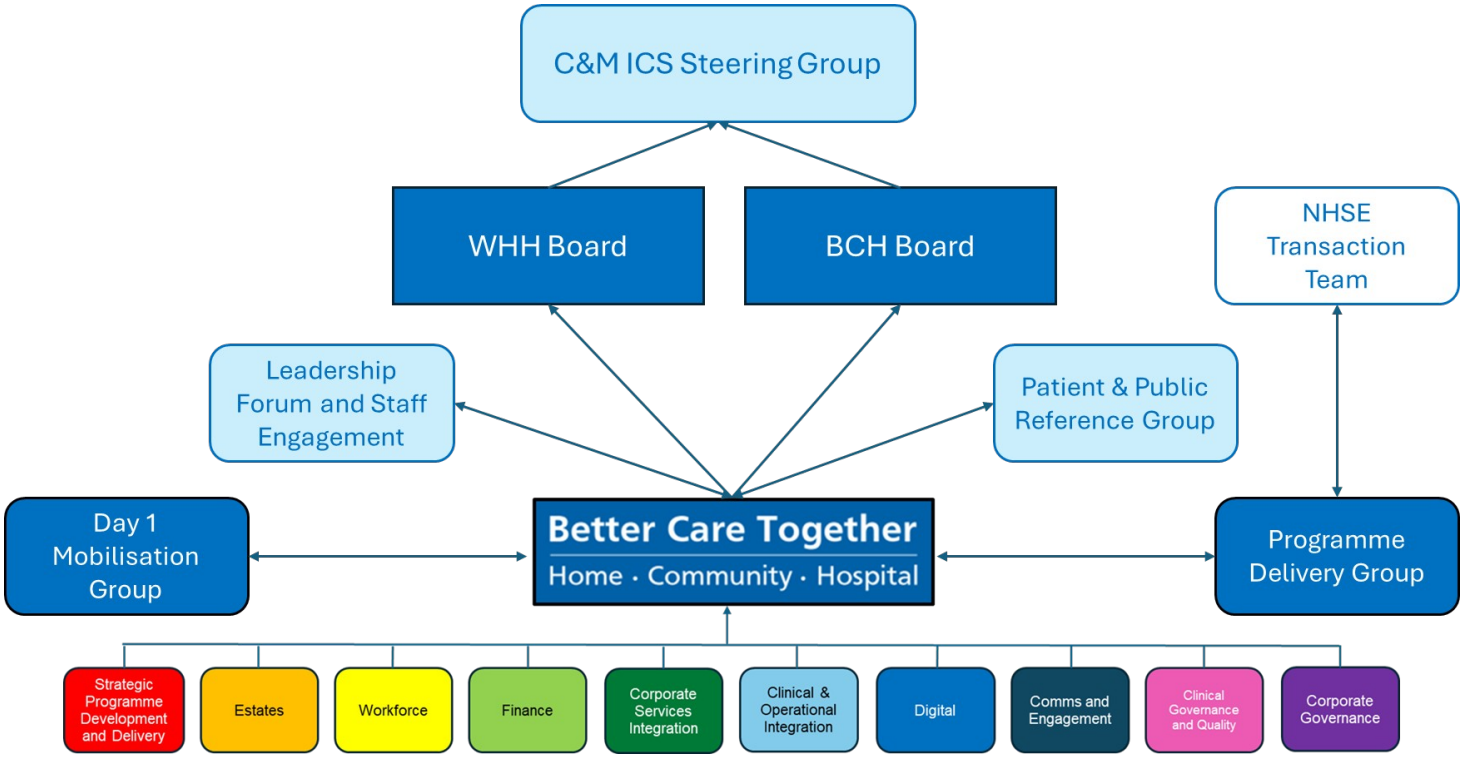


Table 2: Programme Workstreams - key areas of work

Workstream	Purpose/Output	Key milestones
Strategic programme development and delivery	To co-ordinate and progress the core aspects of the overall integration programme in line with the required timeframes. This includes the production of required business cases and supporting information, progression of the legal transaction, development and co-ordination of programme/project support, engagement with external professional support and overall programme governance and reporting.	Develop overall programme plan, governance, and resources to deliver. Creation and approval of strategic case. Creation and formal approval of Full Business Case (with accelerated timeline). Oversee transaction. Record, report and, where appropriate, manage all risks arising from the programme.
Estates	Integration of the estates department functions, contracts, and sites of WHH and BCH to appropriately serve the population of Warrington and Halton and further afield.	Integrate estates teams from WHH and BCH. Ensure all 'business as usual' compliance, maintenance and estates safety issues are identified and addressed alongside the integration programme. Review and make recommendations on the rationalised use of estate.
Workforce	The workforce workstream has the following responsibilities: • Enable staff from both organisations to work and behave as a single workforce. • Establish the leadership and organisational structure. • Align the vision and cultural behaviours. • Support workforce transformation arising from integration workstreams. • Develop effective change management and staff transition plans.	Develop organisational change framework. Agree required TUPE/organisational change measures and manage associated processes. Develop joint culture plan. Develop joint people strategy. Integrate workforce teams from WHH and BCH. Align all key workforce systems and processes across the two organisations.
Finance	Aim to make both Trusts more financially sustainable, create opportunities for efficiencies and productivity gains, and make the best use of our shared resources.	Develop joint financial strategy. Integrate finance teams from WHH and BCH. Align all key systems, processes and financial governance policies.

Corporate services	Develop and then implement plans to create single services for each corporate function serving a new integrated organisation between WHH and BCH. Ensure the corporate functions of the integrated organisation will be cost effective, efficient, and fit for the future.	Oversee integration of all corporate services and delivery of financial improvement through corporate service integration.
Clinical and operational services	The clinical and operational workstream has been established to support the overall delivery of the integration programme, with particular focus on: • Managing emerging clinical and operational risks. • Integrating teams to create clinically improved models of care and better outcomes for patients. • Improving urgent and emergency care pathways and delivery of flow. • Developing sustainable services which are delivered in settings which are accessible, and which facilitate the delivery of optimum care and ensuring financial and clinical sustainability of services.	Develop joint clinical strategy. Identify priority pathways and begin to integrate clinical and operational teams. Integrate all clinical and operational teams in line with phased plans. Develop future organisational form. Work with place partners to agree future clinical vision. Work to improve key organisational performance metrics through integration opportunities.
Digital	This workstream will develop and deliver a strategy for digital integration of WHH and BCH, ensuring the managed consolidation of systems and digital services to achieve quality improvements and efficiencies for both Trusts.	Develop joint digital strategy. Align all key systems and critical digital infrastructure. Integrate digital teams from WHH and BCH.
Communications and engagement	The communications and engagement workstream has the following responsibilities: • Maintain effective and appropriate comms around the programme with all key stakeholders. • Capture and respond to feedback from all stakeholders, especially staff from both organisations. • Lead on public engagement and any required public consultation. • Develop new organisational name and associated branding.	Oversee all internal and external communications linked to the BCT programme. Support monthly staff engagement sessions. Ensure all stakeholders are appropriately engaged. Develop and monitor communications and engagement plan for BCT programme. Integrate communications teams from WHH and BCH.

Clinical governance and quality	The clinical governance and quality workstream has been established to support the overall delivery of the integration programme, with particular focus on: • Risk management, inclusive of complaints, incident management, litigation and associated documentation, guidance and assurances. • identifying opportunities and efficiencies for improvement in clinical governance services pathways and functions. • Managing emerging risks of integration from a quality and operational standpoint. • Integrating teams to create improved working models of care and safer outcomes for patients • Developing aligned and sustainable services supporting patient experience such as bereavement, chaplaincy, and medical examiners.	Integrate clinical governance teams from WHH and BCH. Align all key systems, processes and clinical policies across the two organisations. Implement a single risk management system and supporting processes. Oversee quality impact assessment (QIA) for the programme and quality assurance processes for the new organisation.
Corporate governance	The programme is threefold. 1. To ensure both Trusts continue to remain well led during the integration programme, 2. To develop a strategy for greater collaboration between the Trusts, focusing on joint / shared governance where appropriate, and, 3. To safely guide the Trusts towards the formal legal mechanism and ensure the governance is in place post transaction.	Agree structure of new Trust Board for integrated organisation. Develop and implement committees in common for all key sub-committees of the board. Oversee new legal organisational form, membership of new organisation, and governance arrangements.

The development of the PTIP was a key workstream within the strategic programme development and delivery workstream but sought information and assistance from all other workstreams to develop the document.

2.1 Overview of the integration planning process

Integration planning included three connected activities:

- Development of design and planning principles to guide the process.
- Clinical and corporate integration and transformation planning
- Planning of OD activities and to mitigate additional risks and issues identified through due diligence.

Further detail on each activity is provided below.

2.1.1 PTIP design and planning principles

Design principles were developed at the outset of the integration programme by both Trust Boards and have guided the work to date:

- By working together as one, we will improve patient outcomes and service delivery.
- Services will be delivered as close to home as is feasibly possible and only centralised when necessary.
- We will bring together the best of both organisations
- Through integration, we will open up better opportunities for career development.
- We will leverage economies of scale, benefitting from the efficiencies of being a larger organisation.

These principles are reflected in our Case for Change and support the aim of both Trusts to move quickly, optimising benefits to patients, creating opportunities for staff and achieving a safe seamless transition.

To achieve this, three **planning principles** have been applied:

- **Phase 1** will focus on completing the acquisition and aligning systems by March 2026, including the safe and effective transfer of services on completion of the transaction.
- **Phase 2** will follow the transaction with the focus on operating as a single organisation with integrated leadership from day 1 and integrated and transformed corporate infrastructure and priority clinical services by March 2027.
- **Phase 3** will focus on delivery of fully integrated, transformed and reconfigured services, fully embedding a long-term clinical model focused on 'home first, then community and hospital only when needed' from April 2027 onwards.

Our planned phased approach will allow us to fully engage with the right partners at the right time to create the correct, sustainable, longer-term solutions, whilst simultaneously allowing us to progress critical improvement work that makes the most of the immediate opportunities created via the integration.

Figure 2 below, illustrates the three planned phases of our programme, summarising the key work that will happen during each phase to bring together the respective elements of the two integrating partner organisations.

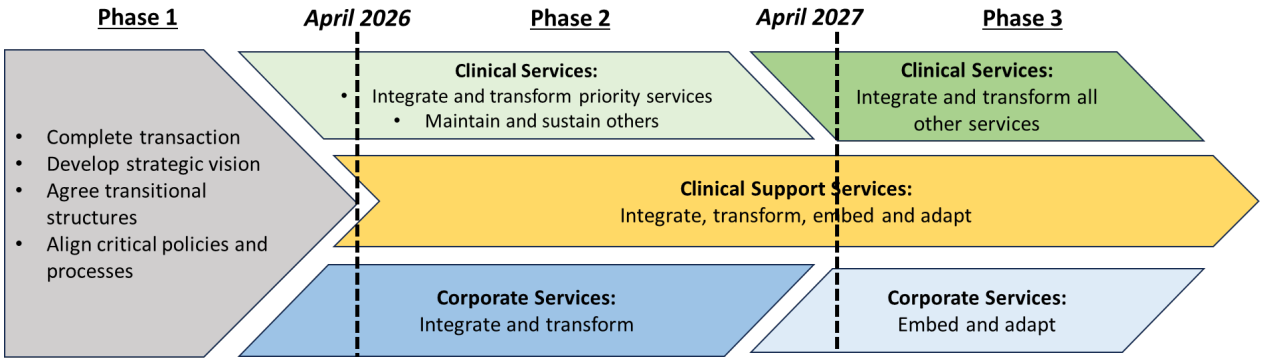


Figure 2: Three-phased approach to integration of services

Phase one: Period to 31st March 2026

In the short-term, our aim is to bring BCH and WHH together through a formal acquisition as quickly as is safely and effectively possible. We are aiming to complete the transaction in time to commence the new integrated organisation from 1st April 2026.

Completing the transaction quickly is more cost-effective, minimises disruption for patients and staff, creates the opportunities for improvement sooner and also makes them much easier to realise.

In the period leading up to the end of March 2026, we will focus on developing and agreeing initial integrated 'transitional' staffing structures for a number of services. These structures will create single teams and services across key parts of the organisation. The structures will come into effect from the first day of our newly integrated organisation on 1st April 2026.

In addition, we will work to align all critical policies, processes and operating systems between the two partners to ensure safe and seamless running of services from day one.

We will also continue to develop the strategic vision (along with supporting documents) and operating models for future services in collaboration with multiple local and regional partners, ensuring this is aligned to wider national strategic direction and the needs of our local communities.

Phase two: Period from 1st April 2026 to 31st March 2027

Figure 3 below illustrates the planned form of the integrated organisation, effective from 1st April 2026.

From this date, the organisation's senior leadership and senior operational management will operate as single integrated teams.

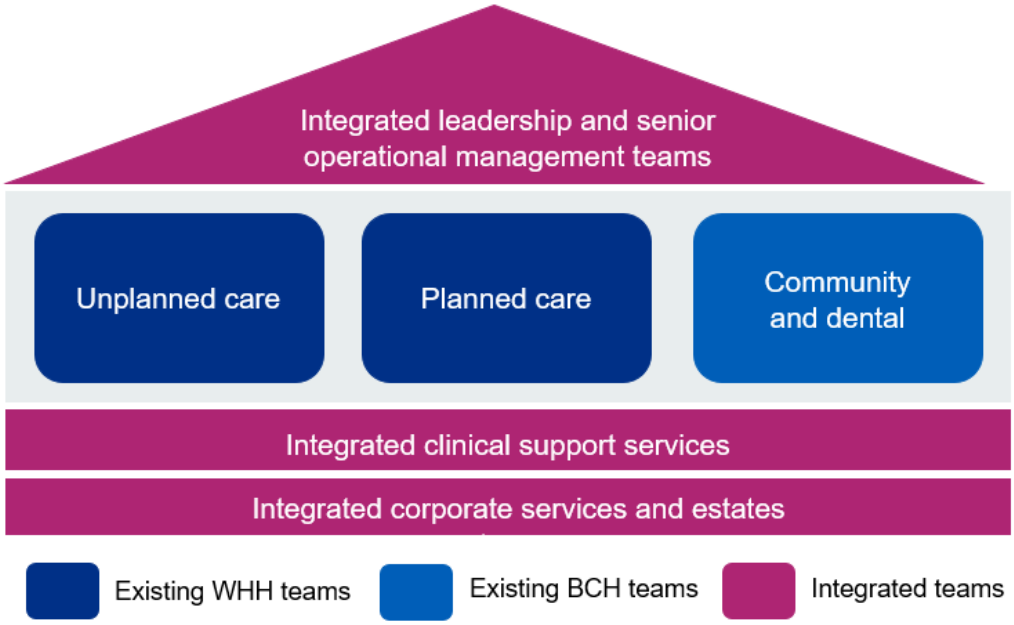


Figure 3: Proposed organisational form for integrated organisation, effective from 1st April 2026

The vast majority of clinical services from BCH will simply 'lift and shift' into the new integrated organisation, in the form of a new 'community and dental services' care group. This will operate alongside the existing WHH unplanned care and planned care groups.

The only exceptions will be where specific clinical support services have been identified as priorities for integration and therefore the aim would be to deliver required service redesign/transformation work in these areas during this phase of the programme.

There are also a number of priority clinical services that have been identified as the early places to start in terms of integrating clinical services. These clinical priorities are discussed in more detail in section 4 of this document and work to begin the redesign of these services is unlikely to commence in full until phase 2 of the integration programme.

The three main clinical care groups within the organisation will be supported by integrated corporate service and clinical support teams. More details on the plans to bring these teams together from 1 April 2026 is also included in later sections of this document (clinical support teams in section 4 and corporate teams in section 5).

Phase three: Period from 1st April 2027 onwards

The third phase of our planned integration programme will see the remaining (non-priority) clinical services brought together and the delivery of our long-term vision for a new clinical model.

The rest of the organisational infrastructure, key systems and processes should be in place and embedded at this stage and therefore allows for the redirection of service change/transformation/organisational development resources to support the necessary clinical change work.

The future clinical model will be firmly based on the principle of 'home first, then community and hospital only when needed' and will be grounded in the national strategic direction around developing neighbourhood health and data-led intervention.

2.1.2 Development of plans to integrate clinical services

The integration of our clinical services will follow a structured, risk-managed approach underpinned by clear governance and engagement. The key principles are:

- Service continuity and patient safety during transition.
- Alignment of governance and quality systems under established clinical governance frameworks.
- Operational efficiency through integrated management structures and shared resources.
- Improved patient pathways through more consistent diagnostic, therapeutic, and support service delivery across community and acute settings.
- Workforce alignment and engagement to ensure staff feel supported and valued during change.

Our approach to clinical integration has been to firstly focus on the four priority areas for early integration: starting well, ageing well, urgent and emergency care, and long-term conditions, and the subsequent seven priority pathways of focus: frailty response; infant feeding; heart failure; chronic pain services; movement disorders, female urinary incontinence and end of life care.

Our clinical integration process will be led and owned by the clinical services and based on principles of co-production, stakeholder engagement and quality improvement.

For every specialty/clinical function, plans to transition safely on day one and work in a more integrated way that delivers the benefits of the transaction soon after that, in line with the guiding principles outlined earlier were developed by senior clinicians and operational managers from both organisations, in consultation with their teams and in line with the principles and planning guidelines described.

2.1.3 Development of plans to integrate corporate services

Similarly, for every corporate service, senior leaders from both Trusts contributed to the development of integration and transformation plans.

Whilst the objectives were the same, corporate services needed to plan not only for the integration and transformation of their operating model, but also to complete the activities necessary to support and **enable** the integration of clinical services.

2.1.4 Planning OD activities

Additionally, there has been specific focus given to cultural alignment within the new Trust. The Culture plan for the new Trust considers a range of initiatives that will help to drive cohesion between the Trusts and support the workforce in managing the post-transaction change and transformation.

This approach will ensure the new Trust has the capability to undertake the required change management process and implement a new integrated organisation culture.

2.1.5 Planning for the risks and issues identified through due diligence

In addition to planning for the integration and eventual transformation of the two organisations, it has also been important to plan for the risks and issues identified in the due diligence reports that accompany this PTIP.

Formal due diligence was undertaken in the following areas to provide further detail on business-as-usual risks and build insight into the additional risks and issues associated with the transaction:

- Clinical and Operational
- Financial
- Digital
- Estates
- Workforce and Pensions
- Legal
- Health & Safety
- Environmental

The scope of the due diligence programme has been based on the model scopes within NHSE's transactions guidance and delivered by a combination of internal and external teams to ensure the best use of internal knowledge and expertise and external specialist knowledge and challenge where required, with the planned response to identified risks captured in integration plans.

This means that all identified due diligence risks have been considered and rated in line with an agreed risk scoring tool. These risks have been included within the integration risk register and will be managed through integration programme governance structure. The integration risk register will be reviewed monthly (or more frequently if a new risk is identified) to ensure that they are being managed or mitigated appropriately. Where required, integration risks will also be reflected in the two Trusts' and subsequently new organisation's risk management systems, where risks and mitigating actions are reviewed regularly and escalated as appropriate. As progress against integration plans is made the risk owners will review and update the scores allocated to due diligence risks as necessary.

Delivery of mitigating actions agreed against each due diligence risk will be tracked through robust risk management governance and through the Better Care Together programme governance.

2.1.6 Communications and engagement during the PTIP planning phase

Effective and timely communication and engagement with stakeholders have been crucial throughout this phase 1, pre-transaction, planning process, and will continue to be.

Activity has been led by Communications and Engagement Workstream, based on a Communications and Engagement plan, which has provided a framework for developing effective, structured, and appropriate means of engagement with stakeholders to meet their needs and expectations. This has been delivered with senior leaders and Board oversight.

2.2 Conclusion

This section has described how the PTIP workstream has been delivered within programme infrastructure and the approach to integration planning, including guiding and planning principles, and how clinical, corporate, OD and due diligence management plans have been generated and interrogated.

The following sections describe the plans that have been developed, following that approach, including:

- How organisational structures, leadership and governance (i.e. the overarching operating model)

- clinical specialties and
- corporate specialties will be integrated.

3 Integration of organisational structures, leadership, and governance

3.1 Introduction

Following a detailed Options Appraisal process, WHH is seeking to complete an acquisition of BCH that is consistent with paragraphs 28 and 29 of schedule 4 of the NHS Act 2006. This will entail the transfer of the entirety of the property, liabilities, and staff of the acquired Trust (BCH) to the acquiring Trust (WHH).

This section describes how the corporate governance structure and processes will be developed and implemented for the new Trust, including any changes to the existing processes in place at WHH.

3.2 Trust Board

Following the acquisition of Bridgewater Community Healthcare NHS Foundation Trust (BCH) by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), the Board of Directors of the new integrated Trust will be constituted as follows:

Following NHS England guidance 'Statutory transactions, including mergers and acquisitions', as the acquiring organisation, the structure of the Board of Directors for WHH will remain in place and continue to provide strategic leadership, oversight, and accountability for the integrated Trust, subject to consultation. This approach ensures continuity of governance and compliance with NHS regulatory requirements, while also enabling the integration of expertise and experience from both legacy organisations.

Proposed Composition:

- **Chair:** Independent Non-Executive Director
- **Chief Executive:** Accountable Officer for the Trust
- **Executive Directors:**
    - Chief Finance Officer
    - Chief Nurse
    - Chief Medical Officer
    - Chief Operating Officer
    - Chief People Officer
    - Chief Strategy & Partnerships Officer
    - Director of Communications & Engagement
    - Company Secretary / Director of Corporate Governance
- **Non-Executive Directors:** At least five independent Non-Executive Directors, appointed for their expertise in areas such as clinical quality, finance, legal & workforce.

This composition is consistent with the current structure of the WHH Board and reflects best practice in NHS governance. The Board will continue to operate with the statutory committees (Audit, Nomination & Remuneration, Charitable Funds) and three designated committees (Finance, Sustainability & Performance; Quality Assurance and Strategic People), each chaired by a Non-Executive Director.

While the Board of Directors will remain as per the acquiring Trust, the organisational structure and senior leadership teams will be integrated to ensure effective management of the expanded services and workforce. This will be supported by aligned policies, procedures, and assurance mechanisms.

3.2.1 Organisational structure

Figure 4 below illustrates the proposed high-level organisation structure for the new Trust, effective from 1st April 2026.

From this date, the organisation's senior leadership and senior operational management will operate as single integrated teams.

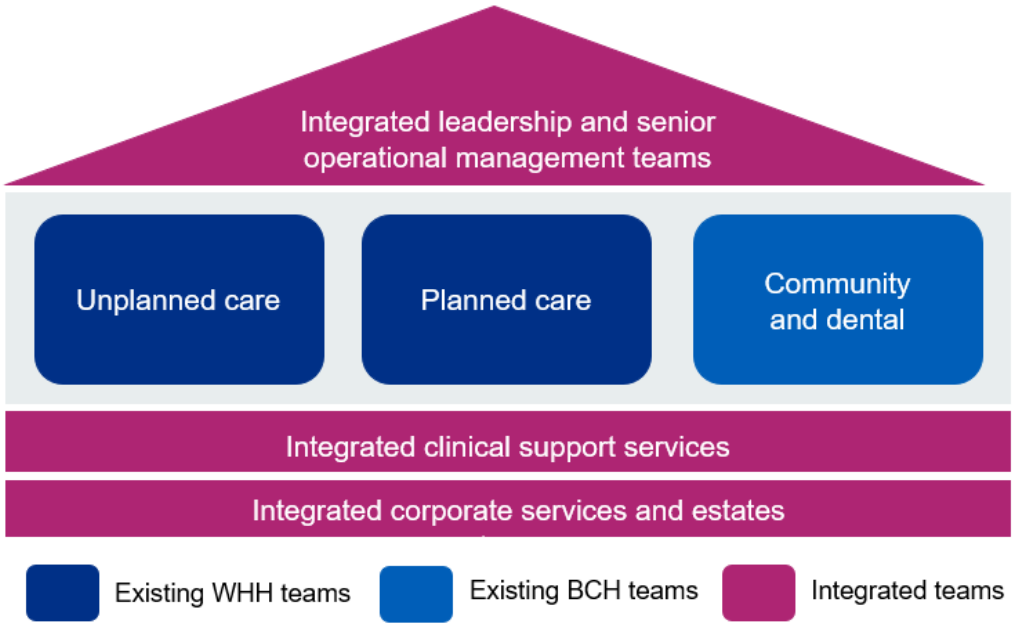


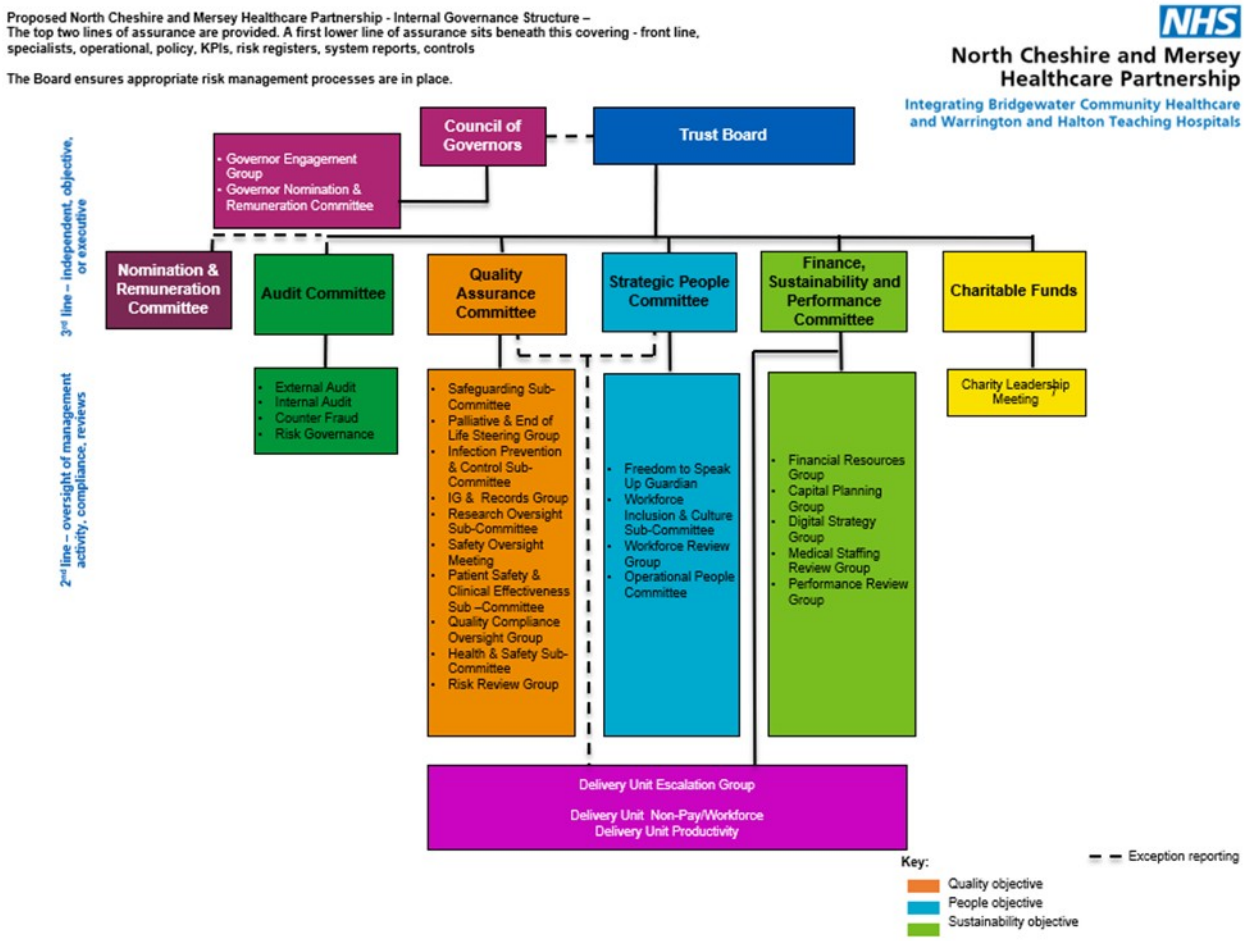
Figure 4: Proposed organisational form for integrated organisation, effective from 1st April 2026

The draft transitional structures for all teams within the enlarged organisation are included within the supporting documents accompanying the PTIP and FBC.

3.3 Corporate Governance and Committees

The new Trust will operate a single corporate governance structure from 1 April 2026. The Corporate Governance structure will be as follows:

Figure 2: Governance Structure



3.3.1 Board Committees

The Board will be supported by three statutory committees required by the NHS Act (2006), the Audit Committee, Nomination & Remuneration Committee and the Charitable Funds Committee. The Board will also comprise three additional designated sub-committees to augment its monitoring, scrutiny, and oversight functions, particularly with respect to financial management, quality and outcomes and workforce management. These are the Finance, Sustainability and Performance Committee, Quality Assurance Committee and the Strategic People Committee.

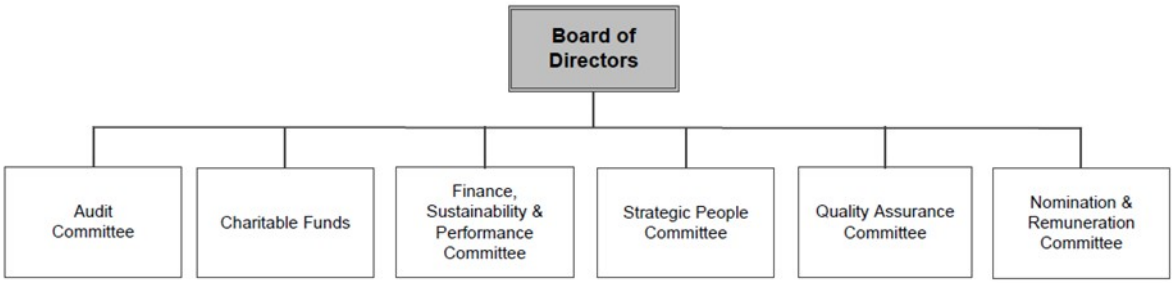


Figure 6: **Committee structure**

In addition to the above committees an Executive Management meeting will be retained. This meeting will consist of Executive Team members (with other senior staff invited to attend as appropriate) and will have responsibility, through its membership, for operational decision making and providing robust performance and quality information to the Trust Board.

It is not intended to change the principal objectives of the WHH Committees in response to the acquisition. However, an assurance mapping exercise will be undertaken to ensure there are no gaps in assurance post-transaction. This review will consider identified strategic risks for both existing Trusts, and where necessary the existing Terms of Reference of the Committees of the Board will be revised (either according to established annual review and self-assessment processes, or on an ad-hoc basis) to ensure that assurance mechanisms and internal control mechanisms remain appropriate.

Each Committee will continue to be chaired by a Non-Executive Director, except the Executive Team meeting which is chaired by the Chief Executive.

3.3.2 Actions prior to day one

The above Committees and Care group Structure will operate as part of a single integrated corporate governance structure from day one. Existing Terms of Reference of the Committees of the Board will be reviewed (either according to established annual review and self-assessment processes, or on an ad-hoc basis) to ensure that assurance mechanisms and internal control mechanisms remain appropriate. Where required Terms of References will be updated and submitted to the Board for approval.

The Corporate Governance team will work with identified Committee Chairs and Executive Leads to develop and agree a new Board and Committee calendar of business. This will seek to align meeting dates so that all committee meetings are due to take place ahead of Board meetings to allow for reporting to escalate appropriately through to the Board.

3.3.3 Actions post day one

Following the transaction each Committee may need to take reports from both legacy organisations during an interim period as teams are consolidated and become able to report jointly. Shadow joint reporting is also planned to take place in order to surface any issues around report production ahead of day one. Our quality governance and integrated performance reporting process is included in the supporting documents section.

3.4 Risk Management and Board Assurance Framework

Risk management is critical to good governance. The Board of Directors is the accountable body for risk and is responsible for ensuring that the Trust has effective systems for identifying and controlling all risks, whether clinical, financial, organisational or reputational.

The risk management framework for the new organisation will be broadly in line with existing WHH arrangements (which is similar to the risk management framework that is in place at BCH). From day one each of the new Care Group leadership teams, and Executive Directors, will be responsible for the identification and control of risks within their portfolio with assurance provided from operational meetings through to the Board and its committees. Risks scored as 14 or less will be managed in the Care groups/Services and risks of 15 or above will be escalated to the Corporate Risk Register.

Ahead of day one the existing WHH risk management framework will be reviewed against the current processes in place at BCH. Consideration will be given to where amendments might be required to the risk management framework to ensure that the key responsibilities for managing risk within the organisation, including ways in which risks are identified and escalated throughout the Trust are sufficiently clear and workable across the expanded sites and services.

3.4.1 Board Assurance Framework

The Board Assurance Framework (BAF) is the key mechanism that will support the Board to understand and manage strategic risks within the new organisation by ensuring there are sufficient controls and sources of assurance in place. The BAF will reflect the new Trust's strategic risk profile and provide a single comprehensive means to manage and mitigate principal risks to the Trust's strategic objectives.

Actions prior to day one

A single BAF will be in place for the new Trust in advance of day one. The Corporate Governance team has planned a review of both existing BAFs to see how these need to be aligned into a single document to ensure all strategic risks and retained and not lost in the transaction.

Actions post day one

Following the transaction date, the Trust Board will continue to keep the Risk Management Framework and BAF under review to ensure that it is effectively providing assurance that key risks have been identified and the relevant controls are in place to manage and mitigate these risks.

3.4.2 Risk registers

The new Trust will continue to use three levels of electronic risk registers to capture and manage risks:

- Corporate Risk Register – risks that have the potential to impact on the Trusts ability to meet its strategic objectives
- Care Group Risk Register – risks relevant to each Care Group
- Departmental/Service Risk Registers – risk registers maintained by each department/service of risks to departmental objectives

Local teams will remain responsible for identifying risks and capturing these within local risk registers. These teams will then take the lead on developing and reviewing risk action plans and monitoring completion through normal business management and governance processes.

Where any high risks are identified these will be escalated via the corporate risk register and monitored by the relevant Board Committee on behalf of the Trust Board. It will remain the responsibility of local leaders (either Executive Directors or Senior Leads) to manage those risks within their respective teams or workstreams and to provide feedback on progress to the Committee.

Currently the Trusts use different systems to manage risk and incident reporting. It is intended to replace the two separate systems with a new solution.

For any interim period, the teams will manage the alignment of risk registers and reporting manually to ensure no risks are missed when operating across two systems. This is already working effectively as the joint Chief Nurse regularly reviews risks across both organisations, via reports generated from both risk management systems.

3.4.2.1 Actions prior to day one to align risks into a single risk register

To support the Board to effectively manage risk from day one the Clinical and Corporate Governance teams will complete a review of existing risk registers to ensure that all risks are reviewed and updated in line with the new organisational structure with any duplicate risks removed. Any risks on the BCH risk registers assessed as having a significant impact on the achievement of the corporate objectives will be formally accepted to the corporate risk register of the new Trust and moved over to the new organisation.

Prior to day one the Corporate and Clinical Governance working groups will confirm arrangements for the reporting of Never Events and Serious Incidents, so this is clear and known across all teams.

3.5 Performance Management and assurance

In the new Trust performance management, both clinical and corporate, will be managed through the existing WHH Performance Management Framework underpinned by a unified Integrated Performance Report. At Committee level performance will be monitored and reported via the Finance, Sustainability and Performance, Quality Assurance and Strategic People Committees.

Performance will continue to be measured in the new Trust from operational teams through to the Board using the monitoring systems which already exist within current teams. Each Care Group will hold group performance, quality and financial governance meetings which will then feed up into the corporate governance structure and through to the appropriate Trust level Board committee.

These meetings will be held with standing agenda items and will follow a standard and consistent process for quality and performance reporting and management. There will also be regular Finance and Performance meetings with each Division and Team together with team meetings with the Executive to cover all aspects of quality and performance.

3.5.1 Integrated Performance Report (IPR)

The implementation plan for the Information team includes the plans for the integration and transformation of Business Intelligence (BI) function within the new Trust. The team are working to bring together current reporting processes so that a single combined view on performance is available from day one. There are technical complexities in aligning existing performance reporting systems and data sets ahead of day one and therefore reporting on key performance indicators will be brought together manually during any interim period to provide an integrated Trust position.

Since a number of WHH executives have dual roles across both Trusts there is a level of familiarity within the Board over financial, activity and quality performance data covering both organisations. This will act to reduce the level of risk in moving to a reporting a combined performance position on day one.

Additionally, a breakdown of Care group and site performance will continue to be available within key reports and more detailed data sets will be considered by relevant Board committees to ensure corporate oversight across key functions including all the quality and performance metrics.

Initial work has been undertaken to understand the impact of the combined Trusts' performance on key reportable performance indicators from day 1. This detail is included in the "quality governance and integrated performance reporting" process in the supporting documents.

3.5.1.1 Actions prior to day one

The existing WHH Board and Committees will take on responsibility for oversight across all quality and performance metrics for the new Trust on day one. Section 3.3 describes this process in further detail. This arrangement will continue through to day one to support a seamless transition to a single committee structure.

Key policies relating to performance management will also be reviewed and updated where required ahead day one. This will ensure that current BCH staff can become familiar with new processes ahead of them going live on day one.

4 Integration of clinical services

4.1 Strategic approach

Since planning began to form a unified organisation, significant progress has been achieved in understanding the combined clinical portfolio, identifying opportunities to improve quality and efficiency, and establishing priorities for the development of integrated, sustainable models of care.

As detailed in the full business case, a clinically led approach commenced in October 2024 with the first major engagement activity; a joint integration workshop bringing together over 50 clinicians and operational leaders. This session identified four initial priority themes for clinical integration:

- Starting Well
- Ageing Well
- Urgent and Emergency Care (UEC)
- Long-Term Conditions.

At this stage, the Urgent and Emergency Care (UEC) Improvement Programme was already delivering measurable benefits, including reductions in ED attendances, shorter corridor waits, increased utilisation of urgent community response pathways, and reduced inpatient length of stay. Building on this foundation, UEC improvement evolved into three integrated workstreams, pre-hospital, in-hospital, and post-hospital, supported by shared clinical leadership across WHH and BCH. In parallel, the remaining priority themes (Starting Well, Ageing Well, and Long-Term Conditions) progressed through a structured series of clinical summits.

Between February and May 2025, the first wave of clinical summits convened multidisciplinary teams from WHH, BCH, primary care, local authorities, and voluntary sector partners. These sessions mapped end-to-end pathways, identified unwarranted variation, and surfaced operational challenges. Importantly, they also identified a set of “quick wins” and highlighted priority pathways requiring whole-system redesign. Seven priority pathways were identified and across all themes, common needs emerged: improved information sharing, streamlined referral routes, more care delivered in community settings, and strengthened multidisciplinary collaboration.

Through this early engagement, clinicians and partners co-authored the shared clinical vision:

“Home first, community next, and only then hospital.”

This vision underpins the approach to integration and reflects the core principles agreed through the summits. These principles align closely with the NHS Long Term Plan, national integration policy, and the development of neighbourhood models of care, prioritising prevention, early intervention, and shifting care closer to home wherever safe and appropriate.

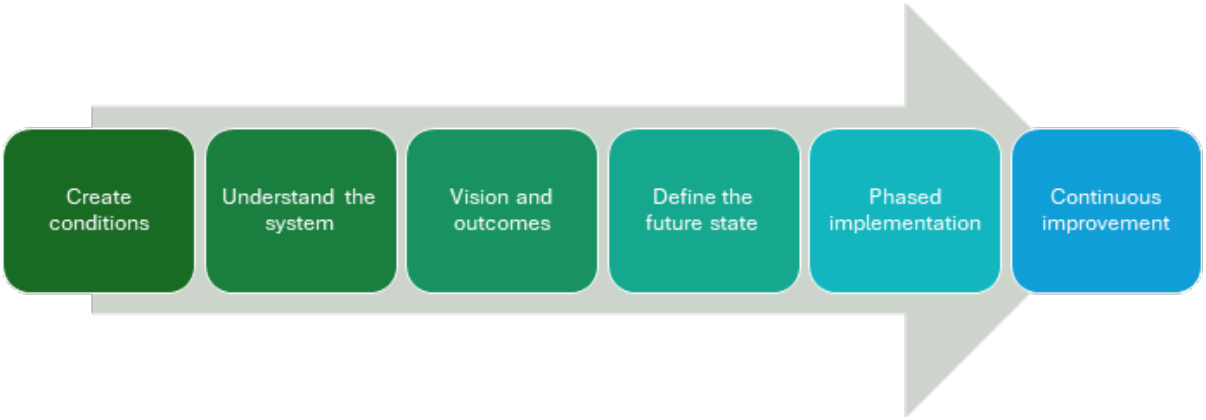


Figure 7: The Approach to Clinical Integration

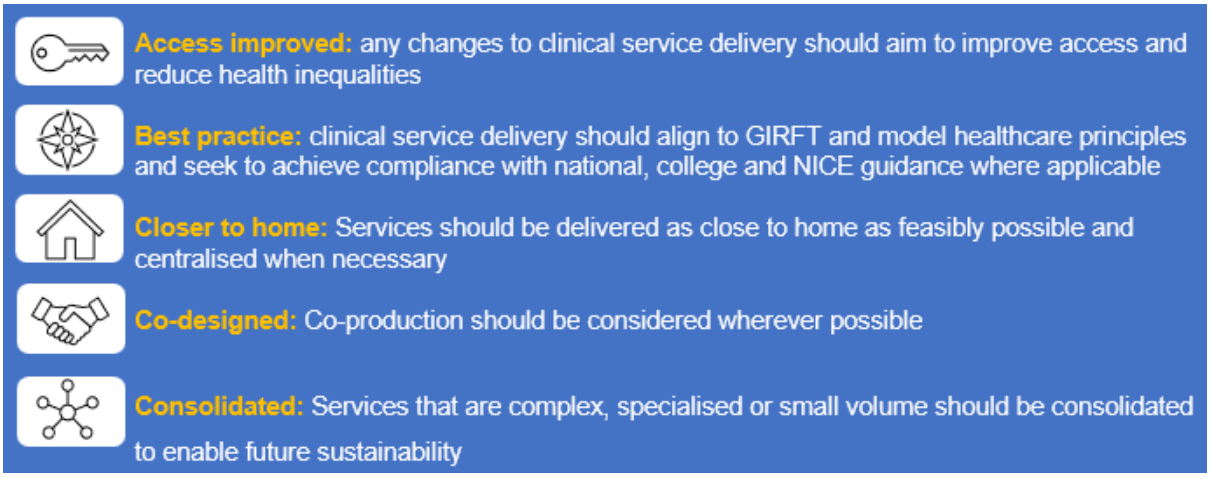


Figure 8: Core Principles for Clinical Integration

To embed this shared clinical vision, work has commenced to develop a Joint Clinical Strategy, scheduled for publication in December 2026. This strategy will formalise the agreed direction of travel and provide a framework for delivering integrated services across the system, ensuring alignment between strategic intent and day-to-day operational delivery.

Following the first clinical summits, work will continue on priority pathways, identifying quick wins and smaller-scale alignment opportunities. Clinical teams will progress these directly, supported by light-touch oversight from the central programme team via a standardised small scale integration project toolkit.

Overall, the work completed to date establishes a strong clinical foundation for integration, anchored in clear priorities, shared principles, and active engagement from clinicians and system partners. With the vision, priority pathways, and supporting governance framework in place, the programme is ready to move from planning to delivery. The next section outlines the high-level plan, including sequencing, objectives, and support structures required to implement integration at pace and scale.

4.2 High level plan and strategic oversight

The Clinical and Operational Oversight Delivery Group (CODG) was established to lead the implementation of clinical integration and ensure strong alignment between strategic objectives and operational delivery. CODG provides governance, coordinates resources, and tracks progress against the agreed priorities. The group has developed a high-level plan that focuses on delivering a safe day 1, managing early integration of clinical support services, and progressing work across the seven priority pathways. CODG also monitors benefits realisation and ensures we maintain momentum across all clinical and operational integration activity.

Figure 9 outlines the three-phase programme that will guide implementation of the new clinical operating model. The plan shows how we will move from early planning and transition activity through to full integration of pathways and services over the next three years and beyond.

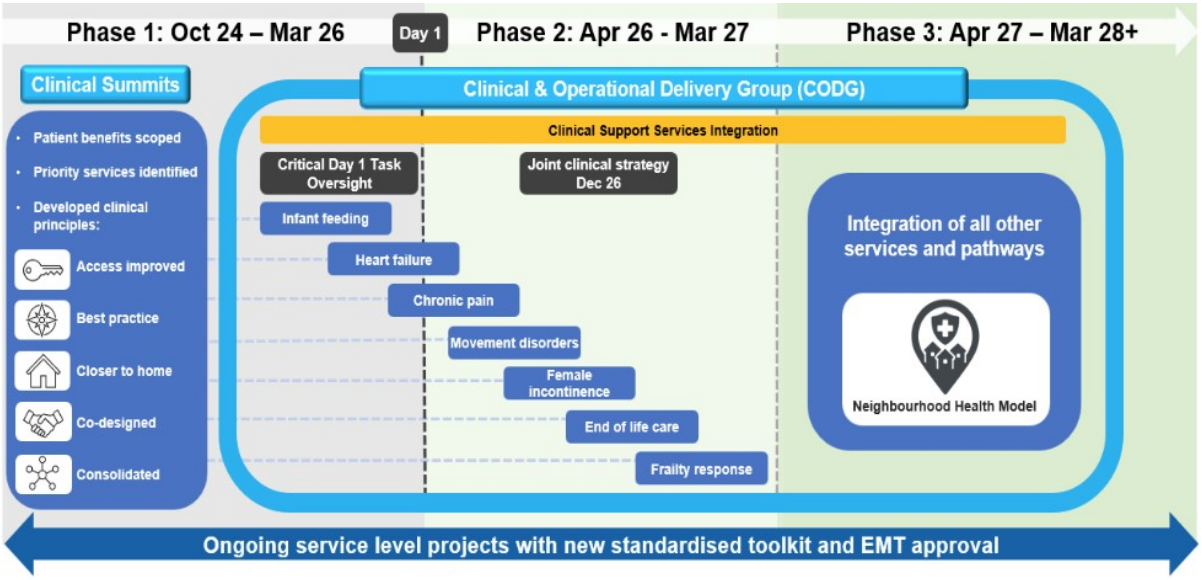


Figure 9: High Level Oversight Plan: Clinical Integration

The high-level oversight plan is designed to provide clear direction, maintain momentum, and ensure safe, effective, and sustainable clinical integration in alignment with the wider system integration programme. It is structured across three phases, each with defined objectives and deliverables:

- **Phase 1 – Pre-Transaction Preparation**
    - Establish Day One operational oversight and governance.
    - Begin initial integration of clinical support services.
    - Execute critical clinical and operational tasks required for safe service delivery.
    - Commence work on the seven priority clinical pathways.
- **Phase 2 – Post-Transaction Development**
    - Advance clinical priorities identified during Phase 1.
    - Finalise the Joint Clinical Strategy to provide a system-wide framework for integrated care.
    - Plan for broader integration of services across all Clinical Business Units (CBUs).
- **Phase 3 – Long-Term Transformation (from April 2027 onwards)**
    - Implement further integration following the organisational change framework.
    - Align services with the NHS Long Term Plan to embed sustainable, patient-centred, fully integrated models of care.
    - Review and refine service groupings and pathways to optimise outcomes, efficiency, and collaboration across the system.

This phased approach ensures continuity, provides a structured pathway for integration, and aligns operational delivery with strategic objectives across the organisation.

4.3 Phase 1: Pre-transaction clinical integration approach

As preparations are made for the completion of the transaction between WHH and BCH, the focus in Phase 1 is to establish the essential structures and safeguards required for safe, effective clinical integration from day 1. During this pre-transaction period, a clear operational framework with be produced to provide stability, clarity, and strong governance across the unified organisation. This includes completing the core enabling work needed to ensure safe operational functioning from the outset, such as developing a joint EPPR plan, aligning clinical governance arrangements, aligning on-call and escalation processes, and consolidating risk management and incident reporting systems where possible. Together, these actions will ensure the organisation is fully prepared to operate safely on day 1.

Following transaction completion, the immediate priority will be to integrate clinical services in a way that strengthens quality, improves patient outcomes, removes duplication, and supports sustainable models of care across the organisation. The day 1 operational structure established during Phase 1 will provide the stable and consistent platform required to begin this work safely and effectively. To support safe operational delivery from day 1, Care Group level planning has defined the structure, scope, and leadership model for each Care Group.

4.3.1 Care Group Level Planning

To ensure the organisation is operationally ready from 1st April, detailed planning has been undertaken to define the configuration, leadership, and scope of each Care Group. Figure 10 sets out the day 1 Care Group structure, providing a stable platform for safe service delivery while establishing the foundations for a more ambitious second phase of integration. This structure offers clarity for staff, supports operational resilience, and enables a smooth transition into the unified operating model.

Each Care Group will balance continuity with the flexibility required for future alignment, ensuring services remain stable while allowing for transformation where this delivers clear value for patients, staff, and the wider health and care system. The following sections outline the planned Day One arrangements for each Care Group.

Clinical Support Services Care Group:

On Day One, the organisation will establish an integrated Clinical Support Services Care Group. IPC and Pharmacy services will be integrated from the outset. All other services, including Breast Screening, Therapies, Outpatients and Medical Records, Pathology, and Radiology & Imaging, will transition into integrated models of care within the care group as part of the phased approach towards fully integrated services.

Services highlighted in green in figure 10 will represent fully integrated WHH and BCH functions from 1 April 2026, providing a consistent and unified management framework from the outset. A dedicated Radiology integrated governance function will oversee imaging services organisation-wide and collaborate with dental radiology teams within the Community and Dental CBU, ensuring consistent clinical standards from Day One and creating a clear pathway toward fully integrated radiology services in later phases. This structure ensures continuity of services and access to critical support services across all clinical areas, supported by clear leadership and strong operational coordination from the start.

Unplanned Care Care Group:

The existing Unplanned Care Care Group will continue to operate without structural change on Day One, which encompasses urgent, emergency, and acute medical services. This includes the Emergency Department, Urgent Treatment Centre, Same Day Emergency Care, Frailty, and key Medical Care specialties such as Cardiology, Respiratory, Endocrine, and Gastroenterology, alongside Integrated Medicine and Community services. This continuity safeguards resilience and stability across the organisation's most critical pathways.

Planned Care Care Group:

The Planned Care Care Group will also continue in its current form, overseeing elective and scheduled care. This includes Digestive Diseases, surgical specialties (General Surgery,

Orthopaedics, ENT, Ophthalmology), and Women's and Children's services (Maternity, Gynaecology, and Neonatal Care). Maintaining this structure ensures coordinated elective activity and stable patient flow during the transition period.

Community and Dental Care Group:

A new Community and Dental Care Group will be established on Day One, bringing together BCH community, children's, and dental services, including Warrington Adults Services, Halton Adults Services, Children's Services, and Dental Services. This new Care Group will provide immediate stability for these services and create the foundations for broader inter-service integration across all Care Groups during later phases.

This phased approach enables the organisation to introduce the new clinical operating model in a controlled and well-governed manner. It also provides the flexibility to review and refine service groupings over time, based on clinical priorities, operational interdependencies, and insights generated through the proposed Phase 2 Clinical Summits. This ensures that any future restructuring is carefully considered, evidence-driven, and aligned with the organisational change framework.

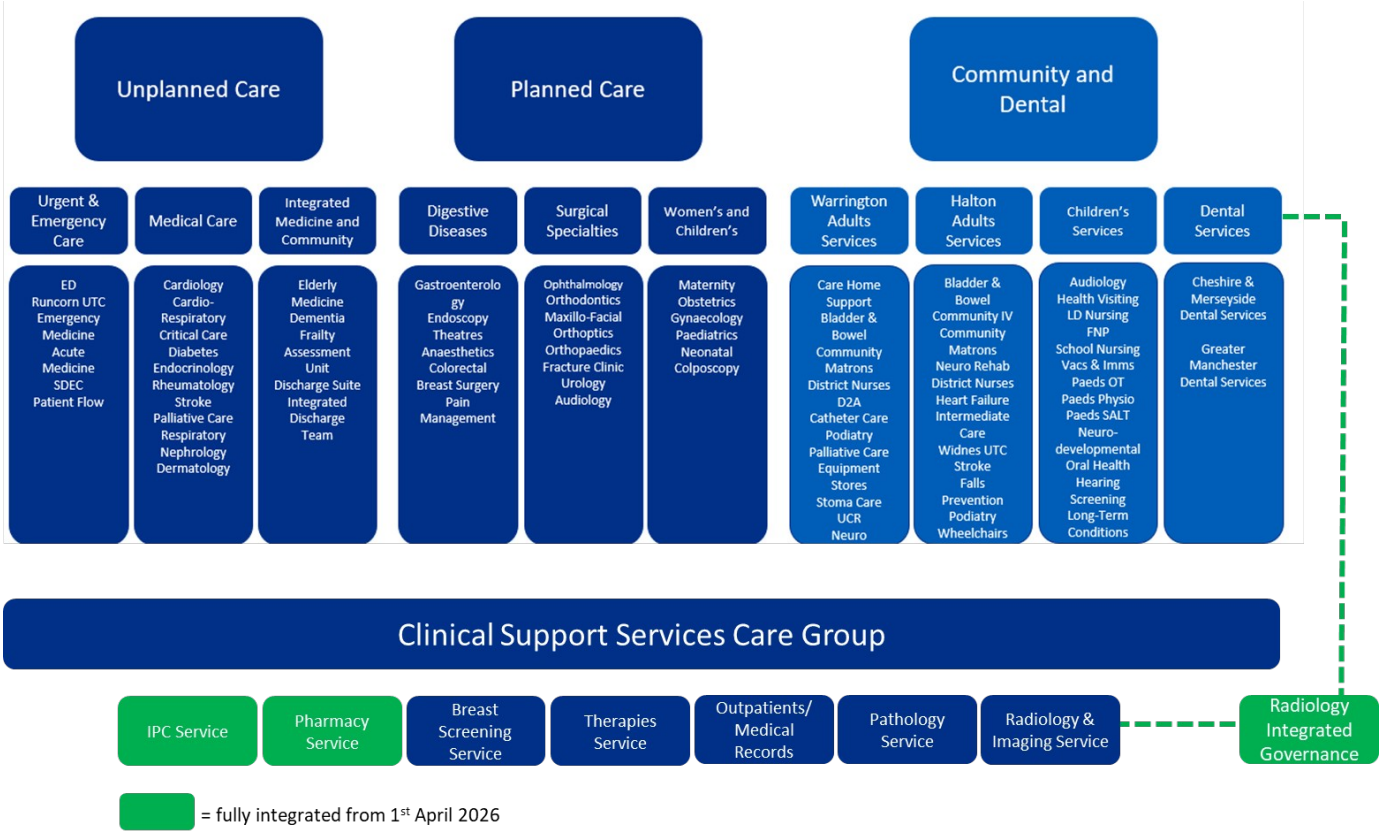


Figure 10: Day 1 Care Group Structure

4.4 Phase 2 and 3: Post-transaction clinical integration approach

On 1st April, 124 clinical services will come together under the newly formed North Cheshire and Mersey NHS Foundation Trust, with 21 of these already operating wholly or partially as joint services. This integration presents a significant opportunity to strengthen collaboration, streamline pathways, and reduce duplication, ultimately enhancing the quality of care, improving access, and delivering better outcomes for the populations of Warrington and Halton.

Phases 2 and 3 of the integration programme will build on phase 1 through a clinically led evaluation of the Day One Care Group structure. The purpose is to identify opportunities for greater alignment, more effective patient pathways, and operational efficiencies. This review will be guided by clinical

priorities, operational interdependencies, and insights gathered throughout the programme, ensuring that any changes are evidence-based, sustainable, and centred on improving patient care.

The organisational change framework will underpin the process, supporting structured decision-making, manage transition impacts, and embed new ways of working across services. This approach ensures consistent implementation, supports staff throughout the transformation, and keeps all activities aligned with the guiding vision, approach, and principles outlined earlier.

Phases 2 and 3 will adopt a dual approach strategy to drive both immediate integration and long-term transformation:

1. **Integration of the Seven Priority Clinical Pathways:** This phase will focus on embedding and strengthening the seven priority clinical areas identified, ensuring that care is coordinated, patient-centred, and aligned with best practice standards. Efforts will include refining current workflows, improving collaboration across teams, and leveraging data to track outcomes and identify opportunities for continuous improvement.

2. **Strategic Planning for Future Service Models:** Alongside pathway integration determined by clinical priorities, Phase 2 will also explore opportunities to optimise existing service arrangements. This includes evaluating current structures, defining the vision and scope for future service delivery, and mapping how teams and services can work more effectively together. The objective is to lay the groundwork for Phase 3, which will consider broader restructuring of services, Care Groups and Clinical Business Units (CBUs) to support a shared, cohesive operating model. This approach aims to move beyond pathway-driven silos toward integrated, efficient, and sustainable care models that place patients at the centre of decision-making.

4.4.1 Key objectives for phases 2 and 3:

1. Second wave of clinical summits to define vision and scope for priority pathway transformation (1–6 months)

- Build on insights from the initial summits that identified the seven priority areas: heart failure, infant feeding, chronic pain management, movement disorders, female urinary incontinence, end-of-life care, and frailty.
- Explore the current services and pathways supporting these areas to identify opportunities for closer alignment, reduced duplication, and improved patient outcomes.
- Define the vision and scope for transformation and set up project groups

2. Enhanced Clinical Support Services Alignment (1 to 12 months)

- Strengthen connections between the Clinical Support Services Care Group and other Care Groups to optimise access to diagnostics, therapies, and imaging services.

- Consider opportunities for more integrated approaches to radiology, pathology, and therapies across hospital and community sites.

3. Community and Dental Integration (1 to 12 months)

- Build on the newly established Community and Dental Care Group by assessing opportunities for greater integration with local community services, children's care, and dental services, aiming to provide seamless patient care across hospital and community settings.

4. Review clinical service alignments across Care Groups and pathways (6 to 12 months)

- Assess the existing Care Groups to identify opportunities for aligning pathways, improving coordination, and enhancing clinical efficiency.

- Explore potential ways to bring together overlapping services or create CBUs where this would support clinical and operational objectives.

5. Apply organisational design principles to continue to redesign clinical pathways and services (April 2027 onwards)

- Review leadership structures to ensure clear accountability and effective decision-making.
- Develop frameworks for cross-Care Group collaboration and structural changes to support high-quality care, patient safety, and sustainable service delivery.

Figure 11 is an illustrative example detailing the potential for realigning services and transformation of group structures across different Care Groups as part of the integration process. It shows how services that were previously siloed within individual Care Groups could be grouped under shared structures to enhance collaboration, streamline workflows, and reduce duplication. By aligning related services together, the model emphasises a more cohesive approach where teams operate collectively toward common patient-centred goals, rather than being constrained by traditional organisational boundaries.

Phase 2 and 3, therefore, balances immediate clinical priorities with strategic foresight, ensuring that the foundations for a more integrated and high-performing future state are clearly defined and actionable.

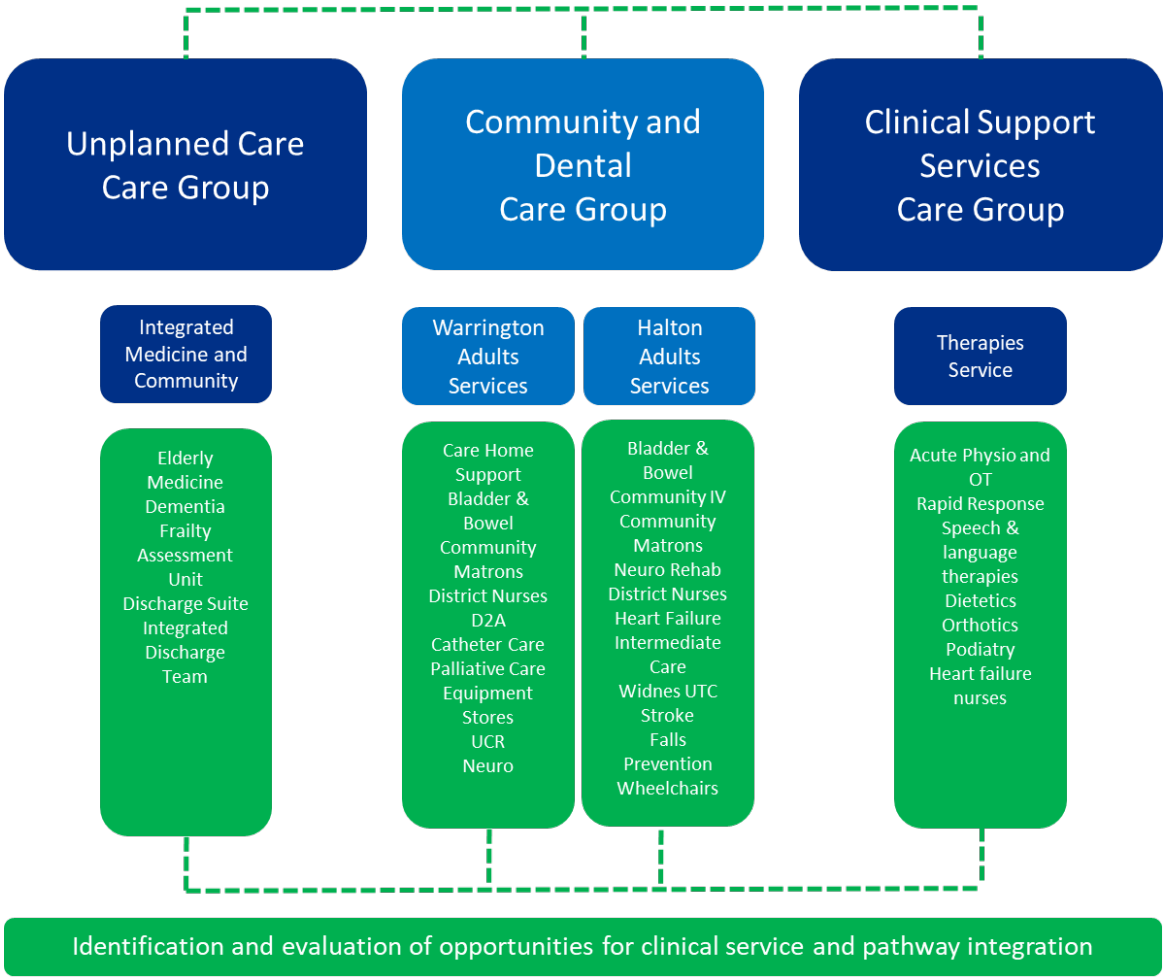


Figure 11: Illustrative example of identification and realignment opportunities for interdependent services to enable integrated, patient-centred care.

4.5 Summary

The work completed to date has established a strong, clinically led foundation for service integration. Extensive engagement, including the joint integration workshop and first wave of clinical summits, has brought clinicians, operational leaders, and system partners together. This collaboration has built a shared understanding of current pathways, identified priority areas for improvement, and co-authored a unifying clinical vision: “Home first, community next, and only then hospital.” Supported by clear principles aligned with national policy, this vision now guides a coherent approach to integration and the development of a Joint Clinical Strategy, scheduled for publication in 2026.

A structured governance framework will be in place from Day One to ensure safe, effective delivery that will serve as the transitional foundation to full integration of pathways, services, and operational processes across the organisation. The Clinical and Operational Oversight Delivery Group (CODG) provides strategic oversight, coordinates resources, and maintains momentum across the integration programme. The phased plan, moving from pre-transaction preparation, through safe Day One arrangements, and into longer-term transformation. ensures that early activity is tightly managed while creating the conditions for deeper, more ambitious service redesign.

From Day One, a transitional Care Group structure will provide clarity of leadership and continuity of care, with the immediate integration of key Clinical Support Services and the establishment of a new Community and Dental Care Group. This approach secures a safe operational environment while enabling future opportunities for increased alignment across services.

Phases 2 and 3 will build on this platform, focusing on both immediate pathway improvements and longer-term strategic redesign. The seven priority pathways (heart failure, infant feeding, chronic pain management, movement disorders, female urinary incontinence, end-of-life care, and frailty) will be taken forward through a second wave of clinical summits and targeted transformation work. Parallel activity will explore opportunities to strengthen cross-Care Group collaboration, enhance clinical support alignment, and consider future reconfiguration of services where this improves outcomes and efficiency.

Overall, the integration programme has progressed from early planning to a clearly defined, clinically endorsed roadmap for delivery. With shared priorities agreed, governance structures in place, and a strong commitment to collaboration across hospital, community, and system partners, the organisation is now well positioned to advance into implementation at pace and scale. The next stage of work will translate this solid strategic foundation into tangible improvements in care quality, patient experience, and population health.

5 Integration of Corporate Services

This section summarises the integration plans for Corporate Service functions to enable a seamless and safe transition to the new organisation, underpinned by the guiding principles described in section 3. Plans have been jointly developed by subject specific corporate service representatives from both Trusts. Draft interim integrated structures for all corporate teams are included in the supporting documents.

5.1 A three phased approach to integrating corporate services

Section 2.1.1 details the three-phased approach to the integration programme, the following sections detail how the plan for integrating corporate services will follow that approach.

5.1.1 Phase 1 – the period up to 31 March 2026

In the pre-transaction period, the focus of the work around integrating corporate services will be around planning and preparing the future service models. The key part of this will involve bringing the teams from the two partner organisations together to start to familiarise themselves with each other's services, processes and ways of working. All corporate teams will work to align business-critical systems and processes as part of phase one, to ensure a smooth transition into a single service supporting both acute and community services immediately following the transaction date.

Alongside the work to align processes, initial transitional structures for each service that will become effective immediately following the formal transaction date, will be developed and agreed following formal consultation.

5.1.2 Phase 2 – 1 April 2026 to 31 March 2027

In the 12-month period following the transaction, the challenge for all corporate services will be to embed all immediate changes and ensure smooth and effective delivery of all corporate support functions to the newly integrated organisation. In addition, each service will be expected to unlock the known financial opportunities and start to bring the combined corporate costs down to national median performance.

5.1.3 Phase 3 – 1 April 2027 onwards

By April 2027, it is expected that all corporate services will be running smoothy and cost-effectively, working towards national median levels based on Model Health benchmarking.

From this date onwards, the challenge will be to achieve median cost levels as quickly as possible and then look to drive further efficiency by exploring opportunities to move towards national lower quartile benchmarking levels. In order to achieve this, it is likely that further increase in organisational scale will be required and/or shared service corporate models, potentially as part of the work around the Cheshire and Merseyside provider blueprint.

5.2 Transitional arrangements and target operating models

Transitional arrangements will be put in place to ensure a smooth transition from legacy structures to the new integrated model. This will involve the establishment of a transitional structure for both governance and staffing by day one of the transaction, in line with TUPE law. Much of the transition will be a "lift and shift" process, ensuring minimal disruption to ongoing operations. Following this, a wider service redesign will be completed once the clinical structures have been finalised, ensuring that support functions are reflective of the organisation's needs and aimed at delivering high-quality patient outcomes.

5.3 Organisational change framework

An organisational change framework has been developed which includes comprehensive governance arrangements to ensure compliance and oversight. The ambition is to have a transitional structure in place for both governance and staffing by day one of the transaction, ensuring continuity and stability.

5.4 Governance arrangements

Governance arrangements are being incorporated into the integration process to ensure that all legal and statutory requirements are met. This includes the establishment of clear governance structures and processes to oversee the integration and ensure accountability across the length of the programme.

5.5 Staff consultation

Formal staff consultation around the initial integration of services will commence in November 2025 and run for a period of 3-4 months to ensure that it is meaningful and inclusive. During this period, transitional structures may adapt based on feedback and evolving needs. However, governance arrangements will remain in place to ensure stability and compliance throughout the transition.

5.6 Corporate Governance

The vision for the integrated corporate governance service is to create a single, resilient team that supports the enlarged organisation with robust governance, compliance, and assurance. By bringing together the expertise and resources of WHH and Bridgewater, the new service will enable effective decision-making, transparency, and accountability across all levels of the Trust. The integrated team will foster a culture of continuous improvement, partnership working, and shared learning, ensuring that governance arrangements are fit for the future and aligned with the strategic objectives of the new organisation.

This approach will help the Trust to meet statutory and regulatory requirements, support the Board and its committees to facilitate high-quality services to patients and communities. The integrated governance service will also play a key role in supporting transformation, risk management, and stakeholder engagement.

5.6.1 Actions prior to day one

The key activities that will be carried out by day one will be:

- **Integrated leadership and governance arrangements:** A new governance structure will be established, and existing teams will be integrated to support the new leadership structure and new board. Best practices from both organisations will be used to create a more robust governance and management system.
- **Organisational identity and team integration:** A single corporate identity will be developed for day one including branding and standardised documents. Ahead of day one, plans will be in place to implement the new name for the organisation, including a new logo and other aspects to create a single organisational identity. Board and executive office support functions from both organisations will be combined, creating a fully staffed team.
- **Alignment of processes and systems:** The ways of working across the sites will be evaluated and a single set of policies and standard operating procedures (SOPs) will be put in place for the new organisation for areas where this would be required for day one operations. A single reporting process will be in place for day one.

5.6.2 Benefits summary

Key benefits are shown below.

Table 3: Benefits – Corporate Governance

Benefits	Description of benefit
Operational Performance	• **Removal of duplicate working (time)** – reporting, committees (admin and support leading into these) which currently exist within the two Trusts. As members will not need to attend the same meetings for both organisations, there will be more capacity for additional responsibilities. There may be a transition period where separate reporting will still be needed for BCH, but this will be time limited. • **Value for money and efficiency from joint working** – Integration of the two teams will provide an opportunity to move towards an integrated governance model in accordance with best practice. • **Policies** – standardisation of all operational polices will reduce variation and lead to a consistent experience for all patients, staff and service users. • **Best practice improvements** – merging all teams will allow core standards and processes to be implemented across the two organisations which will drive quality and productivity improvements.
People	• **Improved resilience around succession planning and single points of failure** – scale enables the removal of single points of failure.
Financial	• **Savings in vacant areas** – as the two organisations come together there can be some rationalisation/amalgamation of the Executive/Board Governance support function over time which will release savings.

5.7 Finance

The current finance teams at WHH and BCH provide a similar range of services, support and advice to their respective organisations but differ in terms of their size. The integrated finance function will deliver services in the following areas:

- Business and financial planning
- Budget setting
- Budget reporting and monitoring
- Forecasting
- Cost improvement plans
- Service line reporting
- Financial governance
- Financial strategy

Potential benefits and service savings within the Finance function are largely dependent on integrating the two separate functions under a single set of operating processes and procedures. Reporting teams will bring together both sets of accounts into a single finance report during this transition period to provide a single financial report from day one. A single ledger will be created for the merged function, supported by the SBS project plan. There is a need to ensure that workstreams will feed into the structure planning, which will ensure that data is aligned between the two Trusts. Consolidated financial information for use by the Board and sub committees to allow for appropriate oversight including scrutiny of financial risks, cost improvement plans and a clear QIA process, will be key.

From a long-term perspective, automated financial reporting tools will be rolled out across the new organisation ensuring easy access to financial information to support decision making. There will be implementation of single systems across Finance in line with contract end dates and there will be appointment of internal and external audit providers along with a single audit plan that will be put in place.

Detailed integration plans are set out in the supporting documents and a summary of key activities pre and post day one is given below.

5.7.1 Actions prior to day one

The key activities that will be carried out by day one will be:

- **Unified financial management:** On day one of the new organisation, there will be provision for unified financial management providing the finance support and expertise needed for clinical and operational delivery and ensuring local alignment with the overarching finance strategy. Aligned budget setting process including fully articulated assumptions, clear definition of scope and which is integrated with workforce/activity plans will be in place. Financial timetables will be aligned to incorporate annual accounts for two separate organisations alongside in year reporting for the single organisation.
- **Single Financial Ledger:** On day one of the new organisation, there will be a single financial ledger.
- **Financial governance arrangements:** Standing orders, standing financial instructions, schemes of delegation and other associated governance documentation will be aligned. There will be integration of audit plans including action plans associated with results of 22/23 HFMA Self-assessment checklist. Consolidated financial information will be used by Board and sub committees to allow for appropriate oversight including scrutiny of financial risks, cost improvement plans and a clear QIA process.
- **Alignment of contracts and SLAs:** Formalised list of SLAs and contracts will be in place. Commissioners advised of future working model and any temporary changes in information flows because of the transaction. SBS project plan in place to achieve single bank account to ensure payroll and accounts payables are not impacted by the transaction. This project plan includes but is not limited to, providing notice of change to suppliers, updating details within ledger system, testing payroll.
- **Development of Financial Reporting/BI Processes:** SBS project plan will be put in place. Consolidated financial information for use by the Board, sub committees and commissioners where appropriate.
- **Setting up of Technology:** Financial systems will be reviewed, and a plan will be developed for future alignment linked to contract end dates. A mechanism will be devised to share large files.

A summary of the key pre day one milestones and supporting activities is outlined in the figure below. Further detailed milestones and activities required ahead of day one are outlined in the supporting documents.

5.7.2 Actions post day one

The key activities that will be carried out post day one will be:

- **Team Integration and estates:** Beyond day one there will be a single integrated finance team incorporating all areas within scope providing a unified service across the new organisation. Fit for purpose estate for workforce ensuring equality of workspace provision and hybrid working arrangements.
- **Staff development and training:** Standardised training for finance and non-finance staff regarding responsibility of budget holders that promotes a culture of financial control will be in place. A clear finance structure that incorporates all areas within scope supported by JDs incorporating finance skills development into roles and responsibilities. Staff skills development plans will be in place.
- **Setting up of integrated leadership and governance arrangements:** The focus will be to update policies and procedures for all areas of finance, ensure alignment of internal reports for committees, councils, and operational groups. There will be the appointment of internal and external audit providers and single audit plan will be put in place.
- **Finance team accreditation:** Accreditation of the finance team by Finance Skills Development Network. A new workforce model will be implemented addressing gaps including staff rotation and development.

- **Alignment of Contracts and SLAs:** Formalised list of SLAs will be in place and fully developed incorporating inflation impact and recharge. There will be a single lead commissioner contract and associated sub-contractors.
- **Development of Integrated Reporting/BI Processes:** Automated financial reporting tools to be rolled out across Trust ensuring easy access to financial information to support decision making. Alignment of information ahead of budget setting with validated activity assumptions in place.
- **System implementation:** There will be the implementation of single systems across Finance in line with contract end dates. Plans are to be developed to utilise robotic process automation across the finance function.

A summary of the key post day one milestones and supporting activities is outlined in the figure below. Further detailed milestones and activities required post day one are outlined in the supporting documents.

5.7.3 Benefits summary

Key benefits are shown below.

Table 4: Benefits – Finance

Benefits	Description of benefit	Benefit measure
Operational Performance	• Operational efficiency due to having a consolidated finance system. • Removal of process duplication, e.g. not requiring approval across both Trusts. • Time saving due to not having to apportion costs or raise invoices across Trusts. • Shared learning across sites will help implement best practice.	• Increased ability to measure organisational performance • Consistency of reporting, processes, and procedures across the teams • HFMA self-assessment score improvement
Quality and Safety	• A single Finance system and central reporting enable the production of improved management information to support decision making.	• Timely information
People	• Improved ability to recruit and retain key staff due to opportunities provided in a larger organisation. • Sharing talent and expertise between the Trusts. • The new model supports career development across the team.	• Reduced time taken to recruit • Reduced staff turnover rates • Reduced staff vacancy rates
Financial	• Savings through rationalisation of systems across sites. • Removal of duplication.	• Financial impact

5.8 Estates and facilities management

Our integrated estates and facilities team will provide operational support across the expanded organisation, ensuring that services are provided from clean, safe, and efficient spaces across our

portfolio. The team will be responsive to the needs of our staff across acute and community sites and ensure that all sites are accessible and welcoming for our patients. Strategically, our integrated team will work across our expanded geography, supporting the Trust's aim of home first, community second and hospital only when necessary.

In bringing together the two existing Estates and Facilities Management functions, the teams have a clear vision to combine to become a single function, under a single leadership and governance structure. This will enable the team to fully realise benefits and efficiencies by working together as a single cohesive team with standardised ways of working and to enhance performance delivery and a better patient experience. The integrated function will deliver services in the following areas:

Table 5: Estates & FM services

Service Area
Management and maintenance of new and existing Trust assets
Leadership and management of environmental sustainability
Compliance with all statutory and mandatory requirements
Management of the Trust's catering service
Management of site access and security
Management of patient movement and transport services
Management of equipment maintenance and storage
Management of linen and laundry services
Management of inbound telephony services

5.8.1 The key integration objectives for the integrated Estates team include:

- Align the estate to the clinical strategies and underpin the Trust's values and objectives.
- Reduce backlog maintenance and critical infrastructure risks.
- Enable the delivery of clinical and operational services and sustainability.
- Improve functional suitability and net zero target.
- Improve utilisation of estate.
- Improve compliance with health building notes and health technical memorandums.
- Provide a solid platform to prioritise investment and prepare for future opportunities.
- Support the ambitions of Warrington and Halton as growing boroughs, focussing on regenerating built and natural environment and reducing health inequalities.

As part of the integration planning programme, service contracts across all of Estates and Facilities Services will be reviewed to determine best value and quality improvements that can be made.

The aim of the merged function will be to provide patients, staff, and visitors with a safe, clean, high quality, fit-for-purpose environment within which high class clinical care can be delivered, and to provide a productive working environment for all its staff, meeting the needs of modern day working and delivering the services as effectively and efficiently as possible within the constraints of the capital and revenue budgets.

From a people point of view, there is need for developing skills and harnessing experience of its current workforce, employing the right people to do the right job to meet the organisation's needs and provide career development opportunities for all levels of staff.

The integrated team will be operating services in a proactive way to meet the needs of the organisation and will follow local and national governance protocols in relation to estates and facilities compliance. Where possible governance systems including meetings and governance structure will be brought together.

From a long-term perspective, the Estates and Facilities function will streamline reporting systems nationally with regards to ERIC and PAM, improving benchmarked performance and will seek opportunities to develop the organisation's clinical accommodation to ensure it complements the organisation's clinical strategy and national initiatives. The goal is to deliver the right care in the right place.

The function will rationalise the organisation's property portfolio to ensure value for money and accommodation efficiency. The team is already working towards keeping spend on leases within the public sector and maximising utilisation of the NHS estate across the ICB.

5.8.2 Actions prior to day one

- Transfer of all assets and novation of leases
- Ensure staff have physical access to all sites required through issuance of new ID cards for integrated organisation.
- Install new signage as necessary, for example with new trust logos
- Inform suppliers of the final date for sending invoices to the demising body
- Novate contracts to the new organisation, aligning end dates and setting out a timetable for review/renewal.
- Inform NHS Property Services regarding new organisation details
- Develop fire policy for the enlarged Trust
- Inform district valuer of organisational changes and consider revaluation of land and buildings
- Inform lessors of equipment of the transfer to new organisation
- Ensure that partner organisations involved in LIFT and/or PFI arrangements are informed of integration plans and progress
- Notify NHSE (Estates Team) regarding new organisation details
- Review all existing leases and terminate/ renegotiate as necessary
- Establish arrangements to enable service continuity i.e. reactive jobs, PPM, enquiries etc
- Establish arrangements re functional responsibilities
- Establish arrangements in respect of internal governance, care group representation etc
- Confirm Car parking arrangements
- New ODS (organisation data service) codes to be issued and CQC location database and departmental reporting structures updated

5.8.3 Actions post day one

The key activities that will be carried out post day one will be:

- **Service delivery model:** The function will work to modernise the Estates and Facilities service to ensure excellent service delivery of services within the organisation. This will include, streamlining service contracts and skilling the workforce to support the clinical teams throughout the organisation. There will be a need for operational management of the FM services on the different sites. All other functions will be combined into single teams as quickly as possible. This will effectively have the appropriate level of site management of services under a combined leadership structure. External stakeholders will need clear communication and change management regarding new lines of reporting. Prioritising and aligning the capital programmes

will need to take place as soon as possible to realise the organisation's revised clinical model and ensure effective use of resources. Movement to the agreed structure will be planned as soon as possible. This will enable the development of the right skills and will enhance the experience of staff, employing the right people for the right job to meet organisational needs.

- **Setting up of integrated leadership and governance arrangements:** The function will focus on developing a combined organisation estates strategy. Work will be ongoing to explore more effective ways of working and there will be continued alignment of policies and procedures across teams and joint training opportunities.
- **Alignment of Contracts and SLAs:** The function will focus on setting up joint SLAs where possible. Opportunities will be explored including the potential to release capital and create a pool of equipment of a higher standard with control measures in place over assets. Opportunities to align contracts where possible will be explored, including waste, energy, linen, grounds and gardens whilst also looking for ways to bring the delivery of services in house
- **Performance reporting and compliance:** The function will initially be submitting performance reports by manually consolidating data from the two separate systems across the new organisation. However, a single reporting approach will be in place (single helpdesk and E&FM reporting, asset registers, combined building/room identification systems etc.) different management tools that are available to bring data together from the various systems to ensure data gathering is relevant, accurate and efficient as possible. The switchboard hardware system integration will be led by the Digital team. In the longer-term systems will be merged where possible such as car parking; Implementing new technology that can produce efficiencies, quality improvements across estates and facilities. There will be review of all standards, compliance policies, gap analysis, streamlining of reporting systems (ERIC and premises assurance model) and benchmarking will be conducted.

5.8.4 Benefits summary

Key benefits are shown below.

Table 6: Benefits – Estates and Facilitates Management

Benefits	Description of benefit	Benefit measure
Operational Performance	▪ Efficiency savings of not having to manage multiple contracts ▪ Efficiencies realisable through joint procurement across the two Trusts ▪ Increased sharing of learnings, leading to adoption of best practice and improvements in services	▪ Reduced contract costs ▪ Improved Model Hospital and ERIC benchmarking data to demonstrate current position and opportunities
Quality and Safety	▪ Improved Estates and Facilities lead to better patient experience ▪ Improved facilities enable alignment with regulations and safety standards	▪ Improved patient feedback ▪ Improved patient flow ▪ Improved IPC

Benefits	Description of benefit	Benefit measure
People	▪ Enhanced recruitment and retention due to the scope available at a larger Trust ▪ Increased staff satisfaction due to improved quality of service from the estates function ▪ Increased resources give potential for improved business continuity arrangements	▪ Reduced time taken to recruit ▪ Reduced staff turnover rates ▪ Reduced vacancy rates ▪ Improved staff feedback ▪ Improved staff satisfaction
Financial	▪ Non-pay saving including, for example: ▪ Review of retail and accommodation income ▪ Energy efficient schemes such as Combined Heat and Power plant ▪ Contract renewals with associated cost savings	▪ Reduced non-pay costs

5.9 People services

The integration of workforce services across BCH and WHH is designed to deliver a comprehensive and consistent approach to people management, supporting the delivery of the workforce priorities within the 10 Year Health Plan for England, NHS People Plan, statutory requirements and organisational priorities. Following the release of the national workforce plan, anticipated in early 2026, the priorities for post transaction will be reviewed and adapted accordingly. In addition, the Trust and CEO are actively engaged with the national Transforming People Services work to ensure it is prepared for the national change programme which is associated with this.

The integrated service will continue to be responsible for providing core HR, organisational development, staff engagement, workforce planning, recruitment, education and training, workforce EDI and wellbeing functions, ensuring a positive and inclusive working environment for staff and high-quality care for patients.

Both organisations operate within a robust governance framework, with clear reporting lines, performance monitoring and a commitment to equality and health inequalities impact assessments. The integration will align systems, key performance indicators and leverage best practices from both organisations, ensuring efficient use of resources, improved service delivery and enhanced staff experience.

The workforce function across the new organisation will not see significant change on day one of the transaction, however the integrated workforce function will provide a service across the following areas:

Table 7: People services

Service Area
Apprenticeships and Widening Participation / Talent for Care
Employment Services
Human Resources (HR)
Learning and Development
Medical Job Planning
Mental Wellbeing Hub
Occupational Health and Wellbeing
Organisational Development (OD)
ESR Helpdesk
Culture and Equality, Diversity and Inclusion (Workforce)
Culture and Staff Engagement
Workforce Information
Clinical Education and Resus Services
Medical Education

In addition, there are outsourced services such as Payroll and Pensions whereby contract management will be managed internally.

5.9.1 Actions prior to day one

Table 8: Milestones

Milestone	Timeframe Start	Timeframe End
Sign off Joint Vacancy Review and Management Framework	01/06/2024	05/11/2025
Development of an Integrated Organisational Change Framework	01/07/2024	31/03/2026
Single ESR system in place	01/10/2025	01/04/2027
Sign off organisational development programme offer	01/10/2024	31/03/2025
Implement organisational development programme of focused support	01/04/2025	01/04/2027
Development of a Joint Culture Plan	24/01/2025	30/06/2025
Develop a staff engagement approach for the programme	01/07/2024	31/03/2025
Develop and approve our approach to partnership working with Staff Side	01/07/2024	31/03/2026
Integration of education procedures, processes and systems	01/06/2025	31/03/2026
Complete a review of workforce policies and develop a proposal to align policies and procedures (where possible) or identify policies and procedures which differ post transaction	01/04/2025	31/03/2026
Future Proofing of Service and Transaction Governance	01/03/2026	31/03/2026
Identification of payroll, recruitment and electronic staff record procedures which need to be managed	01/07/2025	01/04/2026
Provide notice and discuss new arrangements with ESR and determine their information requirements and timescales	01/07/2025	31/03/2026
Workforce Mobilisation (WHH Actions for Day One)	01/07/2025	31/03/2026
Workforce Demobilisation (BCH Actions for Close Down)	01/07/2025	31/03/2026
Implement the staff engagement approach for the programme	01/02/2025	31/03/2026
Create a common workforce IPR for both organisations so that performance can be	01/07/2024	31/03/2026

'benchmarked'.		
Undertake baseline assessment for potential workforce efficiencies in contract delivery and VfM	01/07/2024	31/03/2026
Development of a Joint People Strategy (initial 12-month interim plan)	01/08/2025	31/03/2026
Development of a Joint Workforce EDI Strategy (initial 12-month interim plan)	01/08/2025	31/03/2026
Review and collaborate on national and regional workforce priorities	01/04/2025	Ongoing
Apprenticeship Levy alignment	01/07/2025	01/04/2026

5.9.2 Actions deemed as critical to a 'safe' day one

Table 9: Day 1 actions

Action	Timeframe Start	Timeframe End
Arrange to have the new NHS body's name added to payslips	01/01/2026	15/03/2026
Ensure payroll system/ledger, personnel system interfaces are in place and operational	01/03/2026	30/04/2026
Letter required from NHSE/I confirming the merger of organisations to support the ESR request	01/02/2026	15/03/2026
Draft Regulation 13 letter to Regional and Local Trade Unions and plan timeline for consultation and TUPE	01/09/2025	15/10/2025
TUPE: when requested, provide 'Measures' letters to respective Transferors and continue to update as appropriate	15/10/2025	17/11/2025
Staff group consultation and engagement sessions	01/10/2025	31/03/2026
Receipt of the workforce employment liability list (WELI) - scrutinise and check/due diligence	01/03/2026	31/03/2026
Identify and develop on-boarding plan including e.g. induction, training, corporate services orientation	01/07/2025	01/04/2026
Receipt Occupational Health files from external contractor	01/03/2026	01/04/2026
Issues letters/ contracts of employment to any new starters	01/04/2026	07/04/2026
Within 60 days confirm right to work for TUPE staff	01/04/2026	30/05/2026
Notify UK Visas and Immigration (UKVI) of change in employer sponsorship details	01/03/2026	15/03/2026
Inform any partner education institutions of the	01/03/2026	15/03/2026

Action	Timeframe Start	Timeframe End
name change, and any planned changes		
Update licences for the new organisation name (e.g. NHS leadership academy / HPMA etc.)	01/03/2026	15/03/2026
Initial notification to Trade Unions and plan outline for consultation	15/10/2025	03/11/2025
Update letter sent to Trade Unions with proposed measures and list of staff names	15/10/2025	17/11/2025
Joint consultation meetings	01/10/2025	31/03/2026
Complete final consultation processes	31/03/2026	01/04/2026
Arrange transfer of occupational health records	01/03/2026	01/04/2026
Notify NHS Employers of the acquisition to update records	01/03/2026	15/03/2026

5.9.3 Actions post day one

The key activities that will be carried out post day one will be:

- **Development of a single integrated People function:** Work will be ongoing to developing a single integrated People directorate incorporating all areas within scope to provide a unified service across the new organisation as well as centralisation of key sub functions as described above. There will be greater emphasis on a proactive and agile model moving away from transactional processing, rather, focusing more on 'value add'.
- **Updating policies and procedures for all People areas:** There will be alignment of internal reports for committees, councils and operational groups and development of a long-term people and workforce EDI strategy to best support the new organisation to meet its ambitions.
- **Setting up of Estates, Equipment and Other facilities:** Estate requirements for the future structure will be compiled and articulated encompassing current hybrid working arrangements in place across both teams. A fit for purpose estate for ensuring equality of workspace provision and hybrid working arrangements will be in place.
- **Technology and processes:** A single ESR system will be in place, as NHS SBS are the current provider for both organisations, plans with SBS are continuing to support a de-merge in February 2027.

A summary of the key post day one milestones and supporting activities is outlined in the figure below. Further detailed milestones and activities required post day one are outlined in Appendix 2:

Table 10: Post Day 1 milestones and activities

Action	Timeframe Start
Alignment of non-contractual people policies and procedures	01/01/2026
Review of cultural intelligence tools (e.g. Staff Survey) to enhance the culture programme for the organisations	01/02/2026
Alignment of contracts and procedures for effective savings and efficiencies	01/04/2026
Development of an organisational design package to support clinical	01/01/2026

transformation	
Design, engage and deliver a long-term people strategy for the new organisation	01/04/2026
Design, engage and deliver a long-term workforce EDI strategy for the new organisation	01/04/2026
Alignment of rostering systems and services for acute and community (including Medical rostering)	01/04/2026
Development of a refreshed education and training plan, ensuring equity of access and standards across all sites	01/04/2026
Alignment of mandatory and role-specific training	01/04/2026
Alignment of health and wellbeing provisions, including Occupational Health and Wellbeing services	01/04/2026
Joint reporting for all KPIs and statutory reporting cycles, including the public sector equality duty	01/04/2026

5.9.4 Benefits summary

Key benefits are shown below.

Table 11: Benefits – People

Benefits	Description of benefit	Benefit measure
Operational Performance	• Improved ability to identify insights in data to drive effective decision making. • Improved resolution of issues with Finance/Ops/HR working together to address these. • Improved support to Care Groups, with dedicated expertise wrapping around to help provide individual workforce strategies. • Development of best practice through shared learnings. • A single operating process and alignment of policies/procedures thereby reducing variation in the service. • Economies of scale available through a larger merged organisation.	• Improvement of Trust wide performance metric • Improved staff feedback
Quality and Safety	• Improvements in resolving vacancy issues. • Improvements in patient care. • Improvements in resolving staffing issues in clinical and operational teams.	• Improved patient feedback • Reduced sick days

Benefits	Description of benefit	Benefit measure
People	• Reduction of vacancy rates. • Improvement in issue resolution using key insights to prevent this. • Improved career portfolio. • Improvement in recruitment and retention due to the scope available in the larger organisation. • Increased staff engagement, due to improved culture. • Clinical time reduced/ released through improved e-learning. • More responsive service due to better navigation of service through improved structure. • Efficient equality, diversity and inclusion programmes which are aligned and offer wider inclusive benefits to the workforce. • Overall improved health and wellbeing of staff, and improved team development through focused OD initiatives.	• Reduced time taken to recruit to target days • Reduced staff turnover rates to target • Increased number of apprentices • Reduced vacancy rates • Public sector equality duty reporting improvements
Financial	• Savings on contract/licence costs e.g. one rostering system rather than two. • Saving through implementation of a single booking platform for medical bank staff. • Alignment of Model Health median benchmarking through cost improvement programmes (pay and non-pay).	• Reduced external contract spend • Reduced agency costs due to improved fill rate through the medical bank app

5.10 Communications

The vision for the integrated Communications and Engagement team is to be the best-in-class comms function that efficiently and effectively delivers key messages to the new organisation's stakeholders, creating value through its messages. The ambition is to be recognised internally and externally as trusted partners, enabling growth and strengthening relationships within the organisation.

Core areas of service across the Communications and Engagement function are:

- Internal Communications, PR, Campaigns
- External Communications, Media, and Stakeholder communications
- Digital/social media
- Charity

Pre and post day 1 tasks are detailed in the integration delivery plan, which is included in the supporting documents.

5.10.1 Benefits summary

Key benefits are shown below.

Table 12: Benefits – Communications and Engagement

Benefits	Description of benefit	Benefit measure
Operational Performance	▪ Development of best practice through shared learnings. ▪ Improved community perception and trust through continued proactive communication. ▪ Centralised media management enabling a consistent message to be communicated and quicker response times. ▪ Improved staff and stakeholder engagement and buy-in due to proactive communications and engagement activities.	▪ Improved Trust reputation ▪ Increased positive media coverage ▪ Better handling of media coverage.
People	▪ Ability for greater specialisation due to functional focus and moving away from generalist roles. ▪ Increasing the standard and frequency of internal communications to drive inclusion and identity with staff. Keeping staff engaged and aware at every step of the way. ▪ Increased opportunities to widen experience and develop career	▪ Improved outcomes of staff surveys and pulse surveys ▪ Improved retention rate
Financial	▪ Potential reduced cost through the development of a single web presence and intranet ▪ Centralisation of various contracts and channels ▪ Potential reduction of outsourced contracts due to moving towards in house production	▪ Potential reduction of website/intranet maintenance costs ▪ Reduction in outsourced contracts.

5.11 Digital services

Our vision is to establish a fully integrated digital services that bring together acute and community capabilities under a single, collaborative digital team structure. Creating a single, seamless digital service that connects acute and community care, enabling our workforce to access the right information, in the right place, at the right time, delivering safer, more coordinated, and patient-centred care across the system.

The integrated service will deliver a unified digital infrastructure, shared data environment, and support services with a consistent user experience, allowing staff across all care settings to work as one team. By aligning technology, information, and processes, we will improve care continuity, efficiency, and population health outcomes, while reducing duplication and operational silos.

Through this approach, the digital service will function as an enabler for transformation, supporting the move towards integrated care delivery, data-driven decision-making, and a sustainable, paper-light Trust.

5.11.1 The key integration objectives for the integrated Digital team include:

The integrated digital team will deliver a unified, system-wide digital service that supports safe, efficient, and joined-up care for all stakeholders across acute and community settings.

The key integration objectives are to:

- Create a single, unified digital service - Establish one integrated digital operating model with shared leadership, governance, and standards.
- Enable seamless care through shared systems and data - Align clinical, corporate, and data systems to support continuity of care and improved access to information across all sites.
- Optimise resources and reduce duplication - Consolidate contracts, infrastructure, and support functions to improve efficiency, enable transformation, and maximise value for money.
- Provide a consistent user experience - Deliver standardised support, digital tools, and processes to ensure all staff receive the same high-quality service, empowering patients with access to their information.
- Strengthen data, security, and compliance - Align data governance, cyber security, and information management standards to ensure resilience and compliance.
- Drive innovation and digital maturity - Create capacity for innovation and transformation, supporting continuous improvement and readiness for AI and wider future system integration.

5.11.2 Key services

Table 13: Digital services

Service Area
Digital Strategy & Governance
Clinical Systems/EPR
Data & Analytics
Infrastructure & Networks
Desktop Support
Cyber Security & Information Governance
Unified Communications & Collaboration
Records Management & Scanning Services
Programme & Project Delivery

Service Management & Performance
Training and Digital Enabled Workforce

5.11.3 Actions prior to day one

The key activities that will be carried out by day one will be:

- **BAU service provision:** The focus on day one will be to stabilise platforms and optimise existing system capabilities. A programme plan will be put in place to mitigate all of the existing risks relating to the existing infrastructure.
- **Access to EPR systems:** Staff across acute and community services will continue using existing reciprocal access to both Trusts' clinical systems (TPP SystmOne and Lorenzo), with new accounts added where needed within current licence limits. Shared access will ensure information follows the patient and supports safe clinical decision-making and pathway redesign. Digital teams will review policies and processes to support a larger user base and explore technical options such as click-through access between systems. Priority will also be given to enabling regional access to the CareCentric Cheshire & Merseyside shared care record, providing a wider platform for information sharing and supporting broader clinical collaboration.
- **Setting up of integrated leadership and governance arrangements:** A digital leadership team will be in place to manage strategic requests and there will be points of escalation for operational issues. All teams will be integrated and will be working towards adopting a single set of policies and standard operating procedures based on best practice frameworks of IT Infrastructure Library (ITIL), PRINCE 2 and LEAN Six Sigma.
- **Team integration and ways of working:** The service will be working as an integrated team from day one. Staff will continue to work in an agile manner between sites / home where the role allows.

5.11.4 Actions post day one

The key activities that will be carried out post day one will be:

- **Team Integration:** The service will focus on the levelling up of the IT service to ensure consistent service provision across the new organisation with increased support across the BCH sites. This will ultimately ensure there will be consistency across the new organisation in terms of quality, capacity, capability and skills available. There will be a single digital strategy and consolidation of all other digital solutions and services where possible. This will ensure costs are minimised, the service attracts and retains technical and digital clinical experts, as well as ensuring there are resilient services which have strong clinical leadership embedded throughout.
- **Team development and succession planning:** An extended organisational development plan will be in place and will focus on setting staff expectations, ensuring all staff have a relevant development plan in place devised against their training needs assessment. The function aspires to ensure staff have or are working towards professional qualifications. Succession planning will also be a key feature of the work around team development.
- **Alignment of Contracts and SLAs**: There will be a single repository for all digital contracts which can be used for financial forecasts, identify areas for consolidation and manage upgrade plans. A single Information Asset Register will be in place. There will be a joined-up process to reviewing contracts and procure new systems with the procurement team. Relationships will continue to be maintained with clinical, operational and estates teams to understand transformation plans as it is expected that IT will be enabler for all of these.

5.11.4 Benefits summary

Key benefits are shown below.

Table 14: Benefits - Digital

Benefits	Description of benefit	Benefit measure
Operational Performance	▪ Larger teams therefore many benefits: ▪ Capacity ▪ No single person dependencies ▪ Sharing of skills / knowledge ▪ Increased level of skill available across the wider service ▪ Faster implementations ▪ Ability to support BAU more efficiently ▪ Increased in house development of systems/functionality ▪ Centralised system management function ▪ Increased development opportunities within the teams ▪ Improved staff recruitment and retention through opportunities available at a larger Trust. ▪ Greater opportunities for shared learning across the service. As a result, there will be additional skills that can be learnt and a greater opportunity for learning ▪ Improved engagement with clinical and operational staff ▪ Development of best practice through shared learnings. ▪ Less reliability on suppliers by increasing in house knowledge	▪ Improved patient outcomes ▪ Reduction of time taken to resolve IT issues raised by staff ▪ Mitigation of existing risk relating to end of life of the BCH infrastructure ▪ Improved staff retention ▪ Improved staff feedback ▪ Improved productivity as a result of increasing skills and enabling a shift left move of work
People	▪ Improved staff recruitment and retention through opportunities available at the new Trust. ▪ Greater opportunities for shared learning across the team due to the co-location of staff ▪ Agile working for staff improving work/life balance ▪ Staff development plans will be in place across all team members	▪ Reduced staff turnover rates ▪ Reduced vacancy rates ▪ Reduced recruitment costs ▪ Attract and retain highly skilled staff
Financial	▪ Reduced contract costs due to system consolidation	▪ Reduced pay and non-pay costs

6 Workforce integration

6.1 Introduction

One of the most critical aspects of any organisational integration is the effective consolidation of staff from the existing Trusts into the new entity. Such periods of transition can understandably generate uncertainty and disruption among staff. Both Trusts fully acknowledge these challenges and are dedicated to managing the process as smoothly as possible, aiming to minimise uncertainty and provide comprehensive support to all staff throughout the change. This approach is intended to safeguard service stability and maintain the high standards of patient care during the transition.

To achieve this, detailed integration plans are being developed collaboratively with service leads, ensuring that every service is transferred seamlessly into the new Trust.

This plan presents a comprehensive strategy for workforce integration and organisational development for North Cheshire and Mersey NHS Foundation Trust. It is designed to align with the national priorities set out in the 10-Year Health Plan for England and the NHS Long Term Workforce Plan, while addressing local challenges and opportunities.

Context from the Workforce Due Diligence and full business case have been incorporated into the plan. It outlines a phased approach to stabilising workforce capacity, embedding cultural change, align policies and deliver sustainable improvements in patient care and staff experience. It reflects our commitment to compassionate leadership, inclusive practices and operational resilience, ensuring that the organisation remains fit for the future and capable of meeting the evolving needs of our communities.

6.2 Strategic context

The 10-Year Health Plan for England sets out a vision for transforming health and care services through three fundamental shifts: moving care from hospitals into community settings, accelerating the adoption of digital technologies and prioritising prevention over treatment. These changes are essential to creating a health system that is proactive, patient-centred and sustainable.

Complementing this, the 10 Year Health Plan and NHS People Promise focus on training and retaining the workforce to meet future demand whilst ensuring staff voice and safety is a core component. It includes commitments to expand training places, introduce new apprenticeship routes and embed compassionate leadership across all levels of the NHS. Our organisational strategy aligns with these priorities and is underpinned by the future values of the organisation, which focus on being kind, open, fair and one team. Together, these frameworks provide the foundation for our transformation journey.

6.3 Objectives

The overarching objectives of this plan are to deliver a sustainable people strategy that supports both acute and community services, embed cultural integration and organisational development initiatives, align HR policies and processes and ensure compliance with TUPE requirements during workforce transition. We aim to create a unified organisation that values its people, fosters innovation and delivers high-quality care consistently across all sites.

Establishing a single, unified culture is essential for the successful consolidation of organisations. The Trusts each bring their own distinct cultures and sub-cultures, shaped by a range of complex factors. As such, it is crucial that the approach to cultural alignment is not uniform but instead operates at multiple levels and is responsive to the unique needs of individual teams across all sites. Ensuring the right resources are in place to support this work is equally important.

To address these requirements, a tailored model has been developed through the Joint Culture Plan that maximises the use of existing resources and expertise, supplementing them where necessary. This approach is designed to enable the new Trust to foster a culture that is welcoming and inclusive for all staff, supporting the organisation in achieving its vision and objectives.

6.4 Transition of staff and TUPE process

The transition of staff to the new Trust is being managed through the acquisition of Bridgewater Community Healthcare NHS Foundation Trust (BCH) by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

On 1 April 2026, all staff currently employed by BCH will formally transfer their employment to WHH. At this point, WHH will adopt a new name, ensuring that all staff become part of the newly enlarged Trust. This transition is underpinned by a set of guiding principles designed to ensure clarity, fairness and continuity throughout the process. These principles include maintaining clear and transparent communication at every stage, engaging regularly with staff through both informal and formal consultation and ensuring that the transition process is perceived as fair by all involved. Visible and accessible leadership, alongside strong governance, will oversee the transition, with a firm commitment to operational continuity and the plans that there will be no compulsory redundancies as a result of the integration.

The legal transfer of staff is governed by the Transfer of Undertakings (Protection of Employment) (TUPE) Regulations. The People Directorate, will manage the TUPE process for all specialties and corporate services, drawing on external expertise in employment law as required. Additional resources will be allocated during periods of intense activity to ensure the process runs smoothly and with minimal disruption to day-to-day operations. While the detailed changes to staffing structures are still being determined, the Trusts do not anticipate the need for redundancies and are committed to seeking redeployment opportunities for any staff identified as at risk.

The TUPE process will focus on two main elements:

1. **Comprehensive consultation with staff.**
2. **Thorough review and reconciliation of terms and conditions.**

Employers are required by TUPE regulations to inform staff representatives about the proposed transfer and to consult on any changes that may affect employees. As part of this process, staff side representatives will receive clear information regarding the timing and reasons for the transfer, the anticipated impact on staffing groups (such as changes to location, working hours, job descriptions, salary payment dates, or any risk of redundancies) and details of the proposed approach to the transfer and any organisational changes. Although the formal responsibility for consultation lies with BCH as the transferring organisation, both Trusts have agreed to work in partnership to ensure all affected staff receive appropriate information and consultation.

The consultation process is expected to include a range of activities, such as executive led briefings attended by key HR staff, as well as one-to-one meetings with line managers, staff side representatives and HR as needed. Staff will also be provided with FAQ documents, information packs and regular email communications to keep them informed throughout the transition.

Prior to day one, a key priority will be the review of terms and conditions within employment contracts to identify and reconcile any differences between equivalent roles. Both Trusts employ staff on standard NHS terms and conditions, so significant differences are not anticipated. However, a full review is already underway and will continue up to early 2026, with staff representatives fully engaged in the process for locally determined terms and conditions.

Areas under review include temporary bank payments, on-call payments, special leave, flexible working policies, career breaks, long service awards, grievance and disciplinary policies, maternity support and carers leave, travel expenses, sickness and attendance management and payroll dates. Alignment of any terms and conditions relating to pay will be linked either to a post-transfer review or to the timing of any proposed organisational structure or reconfiguration changes as part of the wider integration programme. Where necessary, alignment of such terms may be delivered after one year.

6.5 Working plan overview:

In addition to the day 1 actions identified in section five. An overview of the working plan for bringing together the workforce of both organisations can be found below:

Phase 1: Immediate actions (0–6 months)

In the initial phase, our priority is to stabilise workforce capacity and maintain operational continuity. This will be supported by dedicated teams and comprehensive training resources to ensure smooth adoption. Cultural integration has begun with the launch of our Joint Culture Plan which incorporates offers developed by both organisations, aiming to embed civility and compassionate leadership across the organisation.

These initiatives will be complemented by joint staff engagement activities and champions, including CEO team briefs and staff forums, to maintain transparency and trust post the transition period. Concurrently, we will complete all statutory TUPE consultations, ensuring that staff and their representatives are fully informed of the transfer process, timelines and implications. Our commitment to avoiding compulsory redundancies will be reinforced through robust processes and personalised support for at-risk staff as aligned with our Organisational Change Framework, developed in partnership with staff side representatives.

Phase 2: Medium-term initiatives (6–24 months)

The second phase will focus on embedding digital solutions and aligning organisational policies. We will expand the use of digital platforms to improve patient access and streamline administrative processes, fundamentally this incorporates the requirement to ensure a people approach to digital is pivotal to our clinical transformation.

Workforce development will be a key priority, with leadership and management programmes designed to build capability in change management, inclusive leadership and wellbeing. Staff engagement will be strengthened through targeted interventions in services with declining survey scores, informed by cultural analysis of staff survey data. Education and training strategies will be implemented to standardise mandatory training and align learning management systems, ensuring equity of access and compliance across all sites. Apprenticeship opportunities will be expanded and partnerships with higher education institutions will be strengthened to support enhanced training and development pathways.

Policy alignment will progress through a phased roadmap, prioritising areas with the greatest operational impact, such as absence management, disciplinary procedures and flexible working arrangements.

Phase 3: Long-term goals (2 years onwards)

The final phase of the plan looks towards achieving full integration of services and embedding a culture of continuous improvement in line with the 10 Year Health Plan for England by 2035. We will implement targeted recruitment campaigns to address critical vacancies and continue to introduce e-preference rostering systems to give staff greater flexibility and control over their working patterns. Workforce sustainability will be underpinned by expanded apprenticeship routes, continuous professional development and inclusive leadership frameworks that reflect the NHS People Promise and anti-racism commitments.

Cultural integration will be maintained through ongoing engagement initiatives and leadership development programmes, ensuring that kindness, openness and inclusivity remain central to our organisational identity. Our ambition is to create a flexible, resilient workforce that attracts and retains talent, delivers measurable improvements in patient outcomes and supports the long-term financial sustainability of the organisation.

6.6 Culture and organisational development

Cultural integration is a cornerstone of this plan. We will adopt a flexible, multi-level approach that recognises the unique needs of teams across all sites. The new behavioural framework being developed to launch in April 2026 will provide the foundation for a unified set of values and behaviours. The Joint Culture Plan will be monitored and reviewed to embed compassionate leadership and civility, in particular monitoring the Management and Leadership Framework to ensure alignment.

Staff engagement will be strengthened through the joint interpretation of staff survey results, using a cultural lens to identify priority areas for action. Targeted engagement strategies will be applied in directorates with declining scores, supported by regular communication through CEO team briefs, newsletters and staff forums.

Organisational development interventions will include leadership and management development programmes focused on organisational change, change management, inclusive leadership and wellbeing. We believe this is essential in the delivery of our clinical transformation to meet the ambitions of the Better Care Together programme. Coaching and mentoring will be aligned across the two legacy organisations and staff wellbeing will be monitored and supported through access to internal health and wellbeing resources including Occupational Health and the Mental Wellbeing Hub.

6.7 Workforce transition and TUPE

The workforce transition process will be managed with transparency and fairness. All statutory consultation requirements will be completed, ensuring that staff and their representatives are fully informed of the transfer process, timelines and implications.

Terms and conditions, including honorary contracts, will be reviewed and reconciled as part of the TUPE process. We will maintain our approach to reviewing the risk of redundancies through robust redeployment processes and personalised support for at-risk staff. Communication will be prioritised through leadership events, one-to-one meetings and regular updates to address staff concerns and maintain trust.

Induction and onboarding packages will be prepared, and line management structures will be updated as required. Employee relations casework will be reviewed in line with Regulation 11 notice, ensuring sufficient capacity and resource for ongoing and new cases. Disciplinary, grievance and performance management processes will be aligned to ensure fairness and consistency across the integrated organisation.

6.8 Policy alignment

Policy alignment will be delivered through a phased roadmap that prioritises areas with the greatest operational impact. All HR policies and procedures will be mapped, and contractual policies will be identified for transfer and alignment. Partnership agreements, including negotiation meetings with Trade Unions, will be reviewed and updated to ensure consistency and alignment post-integration. Salary sacrifice, benefit packages and schemes will be additionally aligned to provide a consistent, risk-managed offer for all staff from day one.

6.9 Education, training and development

A joint education and training plan will be developed and implemented to ensure equity of access and standards across all sites. This will be incorporated into a refreshed People and Workforce EDI Strategy from day one. Learning management systems will be standardised and core processes for accessing and delivering training will be brought together.

Mandatory and role-specific training programmes will be aligned from day one to ensure consistency in reporting and compliance. Apprenticeship contract management will be aligned with TUPE and educational requirements with placement capacity reviewed to support enhanced training and education benefits. A joint corporate induction process has already been implemented but this will be reviewed for day one to ensure that all new staff are oriented to the integrated organisation's values, policies and systems.

6.10 Occupational health and wellbeing

Occupational health services will be reviewed to ensure costs and resources align with budgets and activity levels. Wellbeing programmes will be integrated into the organisational development plan, with targeted support for staff during the transition.

Reasonable adjustments processes will be reviewed to ensure staff know how to access support from day one having a direct impact on improving sickness absence.

6.11 Workforce equality, diversity and inclusion

To achieve efficiencies while maintaining a robust and comprehensive approach to equality, diversity and inclusion, we will bring together the existing workforce EDI teams into a single, integrated function. This unified team will operate under a shared governance framework, ensuring clarity of roles, streamlined decision-making and consistent application of best practice across all sites. By consolidating resources, we will reduce duplication, optimise expertise and create a central point of accountability for workforce EDI delivery. Patient and public EDI will be delivered by the Corporate Nursing and Patient Experience functions.

The integrated workforce EDI function will design and implement a programme mapped directly to the Public Sector Equality Duty (PSED) and the NHS England EDI Improvement Plan. This programme will encompass statutory compliance, proactive initiatives to address health inequalities and cultural interventions that promote inclusivity and fairness. Activities will include conducting equality and health inequalities impact assessments for all major organisational changes, embedding inclusive recruitment practices and ensuring reasonable adjustments are consistently applied. The team will also lead on reporting requirements, producing transparent data and narrative analysis to demonstrate progress against PSED objectives.

The integrated team will collaborate with HR, OD and clinical leadership to embed workforce EDI principles into workforce planning, education and wellbeing strategies, ensuring that inclusion is not an isolated activity but a core organisational value.

This approach will deliver measurable efficiencies by reducing fragmentation and enabling shared learning, while maintaining the depth and breadth of activity required to meet legal obligations and drive meaningful cultural change.

6.12 Systems, contracts and data

HR systems and contracts will be reviewed against budget forecasts to ensure financial sustainability. Internal governance reporting will be aligned for the use of Apprenticeship Levy funding and other key contracts. Data integrity and consistency will be prioritised across all workforce systems to support robust reporting and compliance.

Additionally, work will continue to implement the new workforce solution from 2027 onwards with collaborative meetings already undertaken with the relationship manager in November 2025. The Trusts are continually reviewing the external contracts which are in place across both organisations to align this pre-transaction, where possible. This includes external education contracts, such as Universities and learning placements, whilst additionally reviewing processes to ensure the people function is aligned with the national target operating model.

6.13 Governance and reporting

Progress will be monitored through quarterly Strategic People Committee reports aligned with NHSE guidance, supported by integrated dashboards tracking key performance indicators such as sickness absence, turnover, appraisal rates and training compliance. These reports will provide meaningful metrics and narrative analysis to support assurance and decision-making.

6.14 Restructuring

The restructuring of the workforce into a single, unified organisational structure will be carried out in carefully planned stages to ensure that patient safety and operational performance are maintained throughout the transition. This phased approach is designed to minimise disruption and provide stability as the new organisation takes shape.

Work has already begun with the identification of transitional structures and the development of a new organisational form. The first stage of restructuring will focus on ensuring clinical safety and governance procedures within the organisation, as well as, identified opportunities for integration of services and teams within leadership positions, clinical support services and corporate services.

Following this, the second stage will involve reviewing clinical service alignments within the organisation. Identifying opportunities to align clinical structures and services to enable the benefits of

the integration programme. In alignment with this, a review of corporate services will additionally be completed. This phase is anticipated to take around 6 to 12 months. The third stage will be to apply organisational design principles and enact change over the course of the following 18 months.

Throughout the transition, it will be essential to make key workforce decisions that ensure continuity of operations and maintain business as usual. In preparation for day one, clear processes will be established for recruitment planning, creating transitional structure opportunities, retaining key skills and mitigating the risk of losing critical staff.

As clinical reconfiguration planning will occur after the transaction, most immediate changes will take place within corporate functions. The Trusts have developed an Organisational Change Framework which sets out the principles to this process. An organisational design, transformation and improvement lens will be applied to support people through change.

Each workstream has developed detailed integration plans, outlining the timeline for transitioning to their intended future state structures and will work closely with HR colleagues to deliver these changes according to the agreed timescales.

6.15 Conclusion

The aim of this plan is to set out a clear, phased roadmap to achieve a unified, resilient and future-ready organisation. By aligning with national priorities such as the 10-Year Health Plan for England and the NHS People Promise, the Trust is committed to delivering sustainable workforce integration, cultural transformation and operational excellence.

The plan's immediate focus is on stabilising workforce capacity and embedding compassionate leadership, while medium-term initiatives drive digital adoption, policy alignment and targeted staff development. Long-term goals centre on continuous improvement, inclusive leadership and the creation of a flexible workforce that supports both patient care and organisational sustainability.

Key enablers include robust organisational development, transparent workforce transition processes, aligned HR policies and a comprehensive approach to equality, diversity and inclusion. Governance and reporting structures will ensure progress is monitored and outcomes are measured.

Overall, the PTIP demonstrates a commitment to compassionate, inclusive and innovative practices, ensuring the Trust remains adaptable and capable of meeting the evolving needs of its communities, now and into the future.

7 Integration Delivery

7.1 Introduction

The Trusts recognise that transactions are significant and complex change programmes and as such require dedicated focus and capacity to deliver successfully. To ensure the delivery of transaction benefits and mitigate risk a structured integration programme has been developed and is in place.

This section outlines the agreed structure and governance framework for the integration programme that oversees the delivery of the new Trust.

7.2 Integration programme structure

The development of the FBC and integration planning process was delivered through a series of subject matter specific programme workstreams. This structure will continue through into the integration delivery phase with each team responsible for putting into action the integration plans they developed (albeit with a slight change in structure and focus).

The current Programme workstreams will continue to support specialist areas of the transaction. Additionally, each workstream will be required to take on responsibility for the delivery of integration plans in relation to their specific corporate function.

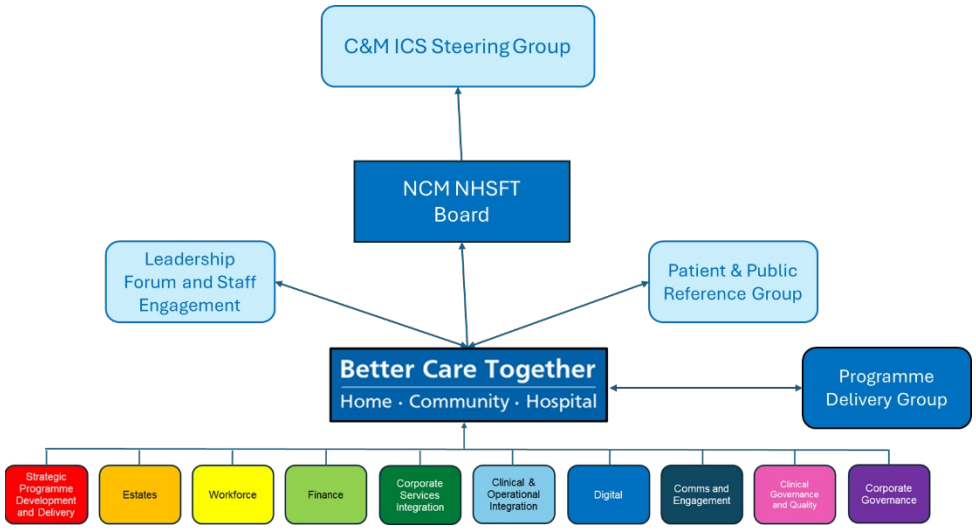
7.3 Programme governance and management

7.3.1 Programme governance

In order to provide oversight and direction to the integration programme a formal programme governance structure will continue to be in place for the first 24 months post-transaction. At this point an assessment will be made over whether the clinical and corporate integration workstreams will be governed by their separate Business As Usual (BAU) governance structures.

The below diagram at figure 54 describes the current governance arrangements that are in place to support and monitor the delivery of the clinical and corporate service integration plans.

Figure 12: Integration Programme Structure



7.3.2 Better Care Together programme delivery group

A BCT programme delivery group has been established to oversee the programme. The group is chaired by the joint CEO and consists of executive directors from both Trusts. Key responsibilities of the group include:

- Overseeing delivery of integration workstreams and benefits.

- Managing programme risks and issues.
- Ensuring open communication between organisations.
- Delivery of strategic and full business cases.
- Maintaining commitment to the programme plan.
- Ensuring delivery of the programme within scope, time, cost, and quality.
- Reporting progress to Trust boards and key stakeholders.

Key decisions relating to the integration are taken by both Trust Boards, and the Boards have been fully engaged and provided with regular progress updates since October 2024. We have also kept both councils of governors (COG) involved and informed of progress through the usual COG meetings.

7.3.3 Clinical and corporate integration programme workstreams

In addition to the Programme Delivery Group, a number of Integration Programme Workstreams have been established as described above in section 2.2. Each workstream holds a workstream delivery meeting that provides project management oversight of delivery in the specific workstream area.

7.4 Integration programme delivery responsibility

Integration, and change programmes more broadly, are most effective and sustainable when owned and delivered by the teams where the change is taking place. The responsibility for delivery of the integration will sit with corporate workstream leads (for corporate services) and the Care Group leadership teams (for clinical services and clinical support services).

7.4.1 Integration programme management support

It is recognised that there is a need for a central programme management resource in order to provide an approach that standardises the project-related governance processes and facilitates the sharing of resources, methodologies, tools, and techniques across the integration workstreams. Therefore, it is planned that the Programme Management Team will continue to provide the capacity required to support the management, tracking and delivery of the clinical and financial change benefits.

The Chief Strategy and Partnerships officer will continue to oversee the integration programme and integration Programme Management support will be deployed from the integration team to support each of the Care groups and corporate functions to deliver clinical and corporate service integration. They will also co-ordinate resource requirements to ensure that there is appropriate OD, recruitment and IM&T expertise to progress project actions effectively.

To support the accelerated transaction process and deliver the required activities, we have sought external funding from the ICS. This funding will enable us to progress and complete the transaction effectively. Both Trusts have also agreed to realign internal resources wherever possible, ensuring that a significant proportion of the work required to support the integration is delivered in-house. This approach reduces reliance on external support and helps to reduce overall integration costs.

Integration programme resourcing will be periodically reviewed to reflect the milestones and shifting pattern of work on this major transformation programme.

Our programme costs are included in the supporting document section.

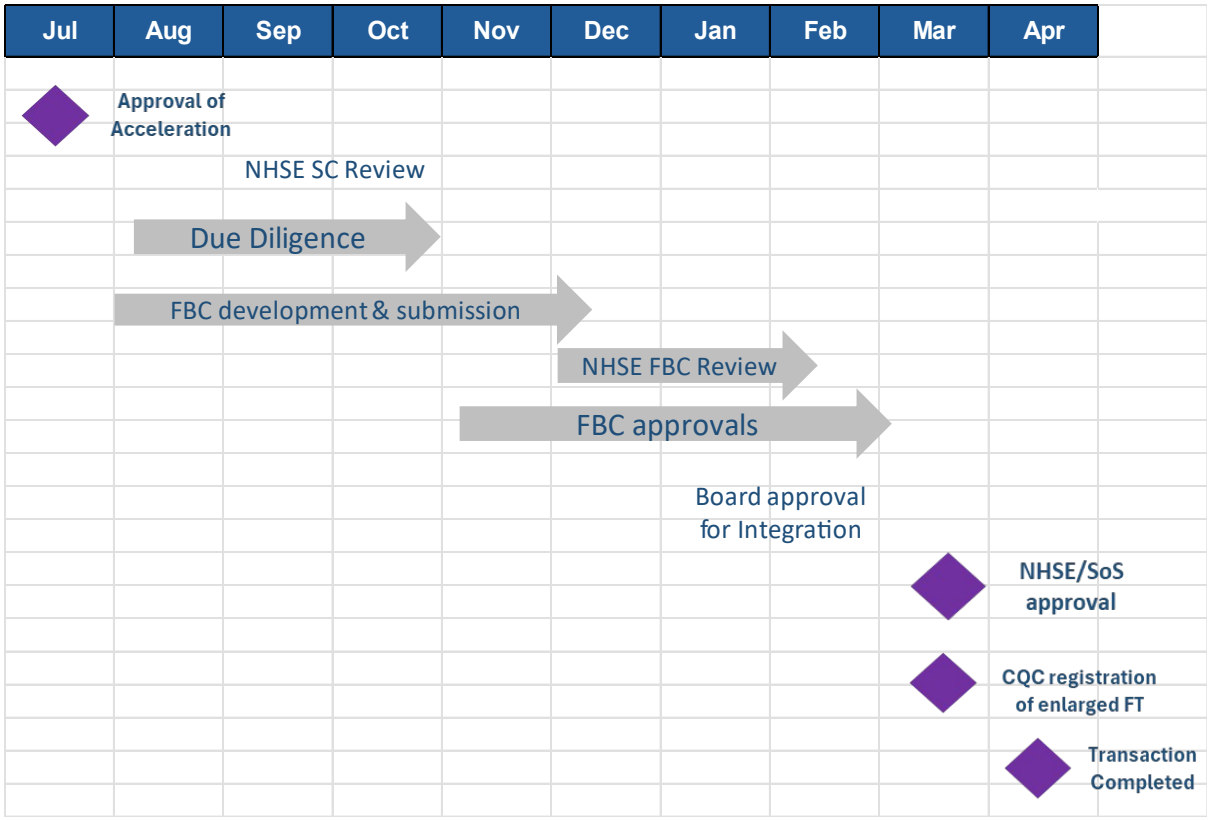
7.5 Programme timeline

The transaction programme timelines are developed and monitored centrally and approved via the BCT Programme Delivery Group as well as by both Trust Boards and supported by the ICB and NHSE. The full delivery plan is included in the supporting documents.

7.5.1 Overall programme timeline

The timeline below illustrates the key activities and milestones required for the transaction to proceed on the planned date of 1 April 2026. The timeline shows the projected time periods for each workstream, with key meetings marked with a diamond. The actual timings for some of these activities will depend on the completion of the NHSE review processes.

Figure 13: Integration Programme timeline



The key steps required to complete the transaction are:

- **NHE transaction review**: NHSE will review the FBC, PTIP, and various further submissions and will conduct a series of meetings with the Trusts and key stakeholders. The transaction will be allowed to precede if NHSE issues an amber or green risk rating.
- **TUPE transfer process**: the details of the TUPE process for BCH staff is described in Section Error: Reference source not found.
- **Ongoing monitoring of organisational risks:** risks to each Trust identified through the due diligence process will be monitored and reported to the Trust Board in the period leading up to the transaction.

7.5.2 Integration timelines

Figure 14 below sets out the critical path for the integration programme, detailing the key steps up to day one and the phasing of the programme following the transaction.

Phase 1 (Pre-April 2026) - This phase focuses on foundational activities:

- Completing the transaction
- Developing a strategic vision
- Agreeing on transitional structures
- Aligning critical policies and processes

Phase 2 (April 2026 – April 2027) - Integration begins with priority areas:

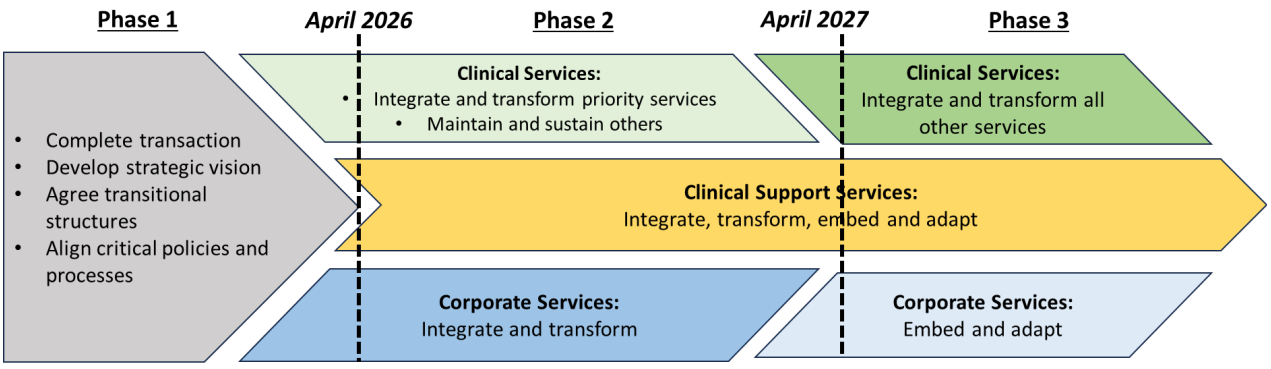
- **Clinical Services:** Integrate and transform priority services while maintaining and sustaining others.
- **Clinical Support Services:** Integrate, transform, embed, and adapt.
- **Corporate Services:** Integrate and transform.

This phase emphasizes operational alignment and embedding new structures.

Phase 3 (Post-April 2027) - Full transformation and adaptation:

- **Clinical Services:** Integrate and transform all remaining services.
- **Clinical Support Services:** Continue embedding and adapting processes.
- **Corporate Services:** Focus on embedding and adapting to ensure sustainability.

Figure 14: Integration programme critical path



8 Communications and engagement

8.1 Introduction

Effective and timely communication underpinned by meaningful engagement with stakeholders will be crucial throughout this period of change if the integrated Trust is to successfully implement its plans.

The communications and engagement workstream has managed the stakeholder engagement process in collaboration with senior leaders and other programme workstreams. This section describes the approach that will be taken to communications and engagement in the lead up to day one and beyond.

8.2 Communications and engagement plan

A communications and engagement plan provides a clear framework for engaging with internal and external stakeholders and driving consistency and clarity of message when communicating about integration plans. This is critical in ensuring that stakeholders receive the right information at the right time and in the right way.

The communications and engagement plan:

- Establishes a holistic communications and engagement approach that reaches all key audiences and stakeholders, taking into account the needs across all groups
- Ensures that stakeholders' opinions and attitudes are understood so that the approach taken can be responsive and collaborative
- Makes full use of the most appropriate, timely and relevant internal and external communications channels, to maximise reach and impact across the new organisation, to patients and out into the community
- Drives inclusivity, reflecting the diversity and different working patterns of our workforce and ensuring equitable provision and access to information
- Outlines the role of communications and engagement in supporting stakeholder engagement during integration and service redesign, highlighting roles and responsibilities across all teams.

The Comms and Engagement plan is included in the supporting documents.

8.2.1 Stakeholder engagement

Both Trusts are committed to actively engaging with stakeholders in a planned and systematic way to ensure the successful integration of the two organisations. The overarching aims of stakeholder engagement activities is to enable the Trusts:

- To engage wide range of stakeholders, including third parties and service providers to be made aware of and comment on the plans.
- To provide opportunities for people to express their views through various communications channels.
- To understand the issues of importance to stakeholders to be considered in the submission of the full business case to the board.
- To provide a structured and aligned approach to communication and engagement activities across and external to both organisations.

The Programme Delivery Team has taken an approach where they have actively engaged with and listened to key stakeholder groups. Approaching the transaction in this way will mean that the design of the integrated organisation will best meet the needs of the local population, both users of services and staff.

8.2.2 Internal stakeholder engagement

Staff have been engaged in a variety of different ways during the transaction programme and integration planning process. Engagement has been tailored across different staffing bodies (e.g., front line clinical staff, non-clinical staffing groups, corporate service teams) to ensure the approach was sensitive to the situational context for each group.

Additional engagement activities planned to take place in advance of day one will be developed in partnership with the People Workstream as staffing groups are identified for engagement and consultation.

8.2.3 External stakeholder engagement

Following our detailed stakeholder mapping exercise, the external stakeholder groups below have been identified:

- Patients / people
- Carers / guardians
- Advocates
- Families
- Patient groups
- Advocacy / support groups representing people with protected characteristics
- WHH Charity
- Warrington League of Friends
- Voluntary, Community, Faith and Social Enterprise (VCFSE) networks
- Community groups
- Patient Advice and Liaison Service (PALS)
- Volunteers
- Experts by Experience / Patient Partners
- Patient Safety Partners
- Veterans / armed forces members
- Wellbeing services (local authority commissioned)
- Hospital radio stations (ref HWH segment on Radio Halton)
- Wheelchair Users Group (St Helens)
- Local authority engagement networks, including those for marginalised / under-served communities
- Healthwatch organisations (Warrington and Halton)
- MPs
- Councillors
- Media/comms colleagues
- Public and partner governors
- Foundation Trust members

Keeping in line with our communication principles and overarching communications and engagement plan, our stakeholder map helps us to ensure we are communicating and engaging regularly with stakeholders.

A summary of communications and engagement activity to date and the latest engagement log are included as supporting documents.

8.2.4 Engagement tools

We have kept colleagues, partners, and the public informed about our vision to improve health outcomes by removing any respective organisational barriers to integration.

In addition to using our usual, and well-established communication channels, we continue to develop new resources to keep everyone updated and expand our audience reach where possible. A joint communications channel matrix can be found in the supporting documents section.

In addition to the matrix, several channels are highlighted in greater detail as follows:

a) Public website

As integration progresses, and communication becomes more coordinated between both organisations, a dedicated partnership website has been created.

This website contains a wealth of information to the public and wider stakeholders, such as information about the integration journey, frequently asked questions (FAQs) and latest news. The

www.northcheshireandmersey.nhs.uk address will subsequently transform into our newly integrated public-facing website once the transaction is complete.

During this time of transition, each sovereign organisation will continue to promote the partnership website and will signpost to it from their respective site.

b) Partnership stakeholder update

Our joint partnership newsletter is continually evolving and distributed to stakeholders on a monthly basis.

In addition to providing updates regarding the progress of our integration efforts, the newsletter highlights broader initiatives and demonstrates areas where services and pathways have started to converge to enhance patient care and expand staff development opportunities.

This regular communication serves to illustrate the value of integration by presenting concrete examples of the advantages associated with collaborative working, thereby offering stakeholders insight into how these changes may positively influence both the provision and experience of care.

c) 60 second animation explainer

A 60-second animation has been produced to further explain the reasons for integration and its benefits. This short video is intended as a method to communicate the process in a clear and accessible manner. Additional animation and explainer videos will be created to provide further information about the advantages of integration for the public and stakeholders as we head ever closer to the proposed transaction date. This animation is prominent on the home page of the new partnership website (northcheshireandmersey.nhs.uk). It has also been shared on respective organisational websites, social media channels and in our joint stakeholder bulletin.

d) Community engagement activity

Our respective organisations coordinate attendance by a range of services at annual community engagement events such as the Disability Awareness Day, Warrington Pride and the Chinese Lunar New Year Fun Day. In addition to raising awareness of specific services, these have been used as an opportunity to seek feedback from our communities on our integration proposals and to identify any key themes or considerations.

8.2.5 Staff engagement

Aligned to the Better Care Together workforce workstream, our approach to staff engagement helps to ensure that staff feel valued, informed and engaged:

1. Collaborative engagement through joint staff engagement channels - we establish joint engagement groups where this is appropriate, including representatives from both Trusts to collaborate on integration goals and share feedback. By involving staff in decision-making processes, we will ensure that integration respects and reflects the insights of our workforce.

2. Open and transparent communication forums - we conduct regular, open forums with programme leadership, offering clear, transparent updates on the integration process. These sessions include Q&A opportunities where staff can voice concerns and ask questions directly. The aim of this is to ensure that our staff remain informed and confident in the integration progress and are given a platform to express their views openly.

3. Consistent mechanisms to gather and act on staff feedback - we have established reliable, easy-to-use feedback channels, such as surveys, suggestion boxes, and focus groups, to continuously gather staff input. Feedback is reviewed, and outcomes shared to demonstrate how staff input informs integration decisions. With mechanisms such as the quarterly people pulse and staff survey in place, the review of this information will be themed and aligned to inform staff engagement plans.

4. Continuous and accessible communication channels - we ensure that staff have access to regular engagement mechanisms in a variety of formats, ensuring all staff can access them and feel informed. Ensuring an open engagement approach when even if there are no new updates, we maintain these channels to reassure staff and share progress reminders.

5. Taking a diversity and inclusivity approach - we take an inclusive approach to engagement which respects the diversity of our workforce, the perspectives, roles, and contributions within both Trusts. Celebrating shared successes and addressing personal challenges collectively, aiming to create a positive environment where staff from all backgrounds feel welcomed and integral to our unified future.

8.3 Communications

The communications and engagement plan endorses ongoing communication and engagement between the Trusts, NHS England and the ICB, ensuring that all communications are aligned with the strategic rationale for the transaction and delivered at the right time to ensure stakeholder buy-in, especially the staff that will be most impacted by the transaction. All sensitive communications (internal or external) are signed off by the relevant senior leaders as required, ensuring appropriate oversight and assurance of communications delivery, evaluation, and performance.

We regularly produce presentations for partner organisations and forums to keep them informed of our integration plans and progress made. This ensures that consistent messaging is being given across the range of external forums attended, and that it is aligned to our internal communications.

Partner organisations have been involved as required throughout the duration of our integration, e.g. by attending clinical and operational services workstream workshops, or engagement events for our shared communities. This involvement is expected to increase post integration as we turn our attention to clinical priority pathways.

Key partners have been represented on the BCT ICS steering group, and we continue to discuss integration as part of our routine Trust stakeholder engagement meetings, with MPs for example.

From October 2025, we have reintroduced and refocused our monthly strategic stakeholder meeting to concentrate on integration and strategic estates developments. This meeting includes our local authority chief executives, local MPs, and councillors and provides a forum for sharing updates, answering questions and receiving feedback.

Our respective council of governors have been kept informed and updated on the integration programme and progress through various forums including WHH governor engagement group, council of governors and BCH public and communities' engagement group.

Following agreement at the BCH public and community engagement group and WHH governor engagement group in summer 2025, proposals were approved by the respective council of governors' meetings to bring together BCH governors with WHH governors in a 'governor engagement group in common'. A draft terms of reference and cycle of business for the combined group has been developed with input from both sets of governors and membership engagement leads.

8.3.1 Activities planned to take place in advance of day one

While there has been a broad range of communication activity ongoing throughout the integration programme, several items have been planned as 'critical day one actions'. These include, but are not limited to:

- Introduce new trust name (North Cheshire and Mersey NHS Foundation Trust) via formal change of WHH Trust Constitution
- Preparation of news release and media opportunities ahead of day one
- Confirm updated social media accounts for the enlarged Trust

- Creation of a single public website for the enlarged organisation
- Creation of a single internal staff website for the enlarged organisation
- Development of new visual brand identity (outlined in more detail below)

8.4 Development of new organisational branding and identity

The key symbols and signifiers of the new Trust's identity have been planned to be in place for day one, where possible, to mark the transition and give staff a sense of immediate cohesion. This includes:

8.4.1 Naming the new Trust

The naming process for the new Trust reflects the aspiration for the new organisation and fully complies with NHS Identity Guidelines published by NHS England[1]. Extensive engagement was undertaken around the new trust name in which suggestions were sought. North Cheshire and Mersey NHS Foundation Trust was the name agreed and endorsed by both Trust Boards.

Branding

During the transitional period of change, a partnership name of North Cheshire and Mersey Healthcare Partnership has been established. At the point of day one, the new name of North Cheshire and Mersey NHS Foundation Trust will be rolled out. A new official NHS logo will be used across all official Trust channels. All material with the old logos will be updated as quickly and efficiently as possible, this will include the following:

- Uniforms
- Name badges
- Corporate communications templates and materials – printed and digital/online (including patient letters)
- Building signage and wayfinding and vehicle branding

Digital channels

Both Trusts have a social media presence and individual external websites. Work to align digital communications will take place across the following areas:

One website

As integration progresses, and communication becomes more coordinated between both organisations, a dedicated partnership website has been created.

This website contains a wealth of information to the public and wider stakeholders, such as information about the integration journey, frequently asked questions (FAQs) and latest news. The www.northcheshireandmersey.nhs.uk address will subsequently transform into our newly integrated public-facing website once the transaction is complete.

During this time of transition, each sovereign organisation will continue to promote the partnership website and will signpost to it from their respective site.

[1] NHS England (2022). NHS Identity Guidelines – Naming principles

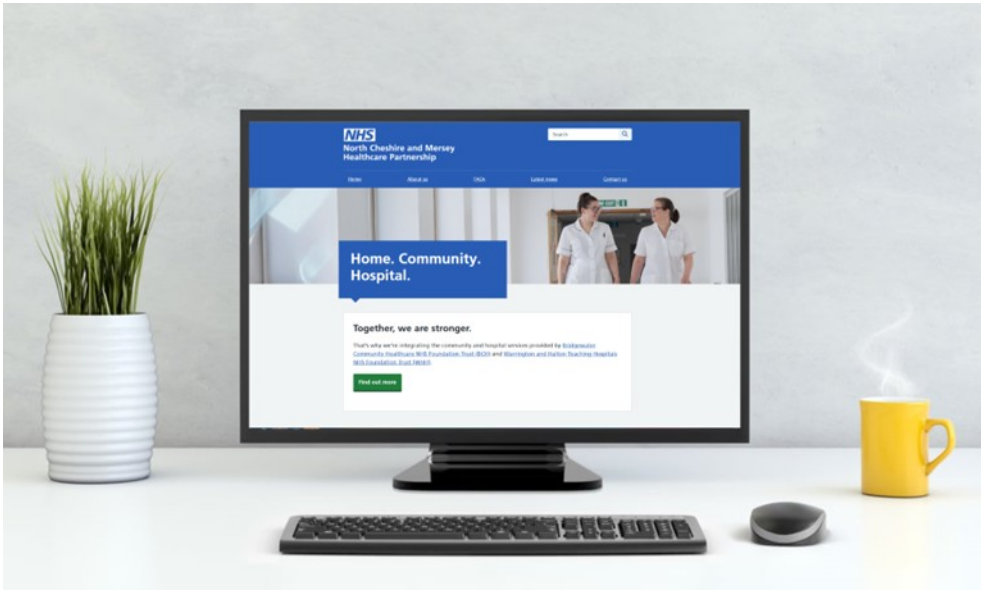


Figure 15: The public facing partnership website

Social media

In advance of day one the communications team will work to update and align the Trust's social media presence to include X (formally Twitter), Facebook, Instagram, TikTok, LinkedIn and YouTube. This will involve consolidation of major Trust accounts and consideration of any sub-account strategies for local sites. The team will continue to develop social media communications up to and beyond day one.

9 Risk Management

9.1 Introduction

This section summarises the robust risk management processes currently in place and which will be in place ahead of day 1 to ensure that:

- Risks to the delivery of the programme are identified, captured, reported, mitigated and managed.
- Risks identified through due diligence are identified, captured, reported, mitigated and managed.
- Robust risk management processes for BAU risk management in the enlarged organisation are established and effectively communicated ahead of day 1

9.2 Transaction programme risks

The Integration programme team has set up comprehensive risk management approach to monitor and manage the programme risks. This section details the key areas of risk identified and the processes in place to mitigate, manage and monitor these risks.

The key transaction programme risks (risks related to achieving the transaction) have been identified, discussed, documented, and monitored throughout the development of the SC, FBC and PTIP. Each workstream is required to capture risks identified, along with owners and mitigating actions at least monthly via the live risk register and monthly highlight reporting process.

Risks are captured within the transaction risk register which includes mitigating actions, risk scoring and relevant risk owner.

The below table sets out the risk assessment and scoring criteria applied to programme risks based on likelihood and impact of risk.

Figure 3: Risk assessment criteria

		Likelihood				
		1. Almost never	2. Unlikely	3. Likely	4. Highly Likely	5. Almost Certain
Consequence	1. Insignificant	1	2	3	4	5
	2. Minor	2	4	6	8	10
	3. Moderate	3	6	9	12	15
	4. Severe	4	8	12	16	20
	5. Catastrophic	5	10	15	20	25

Figure 4: Risk scoring criteria

Overall risk score	
1-3	Very Low risk
4-6	Low risk
8-12	Moderate risk
15-25	Extreme/High risk

The current version of the transaction risk register is included within the supporting documents and the key strategic programme risks identified are summarised below. Please note that the table below does not include issues identified via the due diligence review at this stage. These are captured separately.

Workstream	Risk description	Initial Overall Score	Please provide controls and assurance details	Current Overall Score

Digital	If the Trusts do not have a single EPR system in place from 1 April 2026, then this will present challenges to clinical teams around accessing the information required, resulting in potentially sub-optimal clinical decision-making	20	The phased approach to the integration programme includes a 'lift and shift' approach for clinical services, meaning that there are no significant changes to pathways or clinical systems scheduled for day one of the integration. This should minimise risk and disruption for clinical teams in the short-term. Staff with existing access to Lorenzo/SystmOne/EMIS will continue to have that access and additional access will be granted if required within existing licencing limitations. Click-through capabilities to launch alternative systems from within others will also be explored. There is a high-level roadmap in place to progress towards a single EPR system for the integrated organisation by 2030.	8
Strategic Programme Management	If the ICB do not agree to fully fund our request for additional resources to support the programme, then the programme will either need to be paused or any unfunded costs met from internal Trust resources, resulting in either a material delay to the programme or a material risk to delivery of the Trusts' in-year financial plan.	16	The ICB Board formally supported our strategic case, timeline and acceleration of the transaction in July, with full knowledge of the likely costs, which we had submitted a request for funding for to the ICB prior to July's Board meeting. The ICB have so far confirmed allocation of £200k to support delivery of our integration. We have formally written to the ICB to confirm that unless the remaining £900k funding is allocated, we will potentially go off plan by up to £900k due to integration in 2025/26. The funding we have requested of £1.1m is significantly less than that provided to other integrations completed locally in recent years. Our integration is forecast to deliver at least £2m CIP in 2025/26 and cost up to £1.1m in 2025/26, both costs and savings are reflected in our financial forecast.	16
Strategic Programme Management	If the transaction is accelerated, then there will be less time available; to complete a number of critical programme tasks, resulting in increased pressures on already stretched corporate teams (e.g. workforce colleagues supporting OD, staff engagement and TUPE processes).	16	In order to manage the additional workload created, corporate teams will look to reduce or reschedule as much existing work as possible in order to create capacity. Furthermore, we have agreed a phased approach to the integration programme that will allow us to delay commencement of some elements that will require more resource (such as clinical service integration). When the initial transaction phase of the programme is	8

			complete, we will look to divert programme support to other workstreams to allow them to commence in full.	
Strategic Programme Management	If NHSE do not approve the transaction to proceed as planned on 1 April 2026, then the programme will be delayed for a period of time, resulting in significant additional costs being incurred and a material level of operational uncertainty across both organisations.	16	We will review all critical day one actions recorded within the programme in early January 2026 to help identify those that will be impacted negatively by a delay to the completion of the transaction. Those that will, will require a 'plan B' mitigation to be drawn up and agreed with the consequences fully identified and communicated. In the meantime, the Trusts are in close dialogue with NHSE around timeframes for approval and relevant detail and assurance required to ensure the transaction is approved and completed in time for 1 April 2026	8
Clinical and Operational	If high-risk policies across both organisations are not consistently updated, stored centrally in SharePoint, and effectively communicated to staff, there is a risk that staff may use outdated documents, potentially compromising patient, staff, and organisational safety	16	The process of reviewing, prioritising, and aligning all clinical policies ahead of the transaction date has already commenced. Relevant documents, SOPs, and policies are being updated and consolidated to ensure clarity, accountability, and robust governance structures. All processes will be concluded and fully communicated by 31 March 2026. All policies have been reviewed and categorised. All high-risk policies are now detailed on clinical governance workstream delivery tracker with expected dates for revision of policies, approval of amendments and communication/training with staff.	8
Strategic Programme Management	If the transaction is accelerated, then there will be less time available to engage and consult with our staff, our local communities and our wider stakeholders, resulting in less understanding and trust in the process.	16	The Communications teams from both BCH and WHH have diverted significant internal resources onto the integration programme to ensure all stakeholder communications are maintained and are thorough. We have included some designated additional resource to our communications teams as part of the Better Care Together programme resourcing plan to support regular and frequent engagement and two-way communication with multiple groups to ensure all stakeholders to the programme are kept informed and able to feed in their views. The public	6

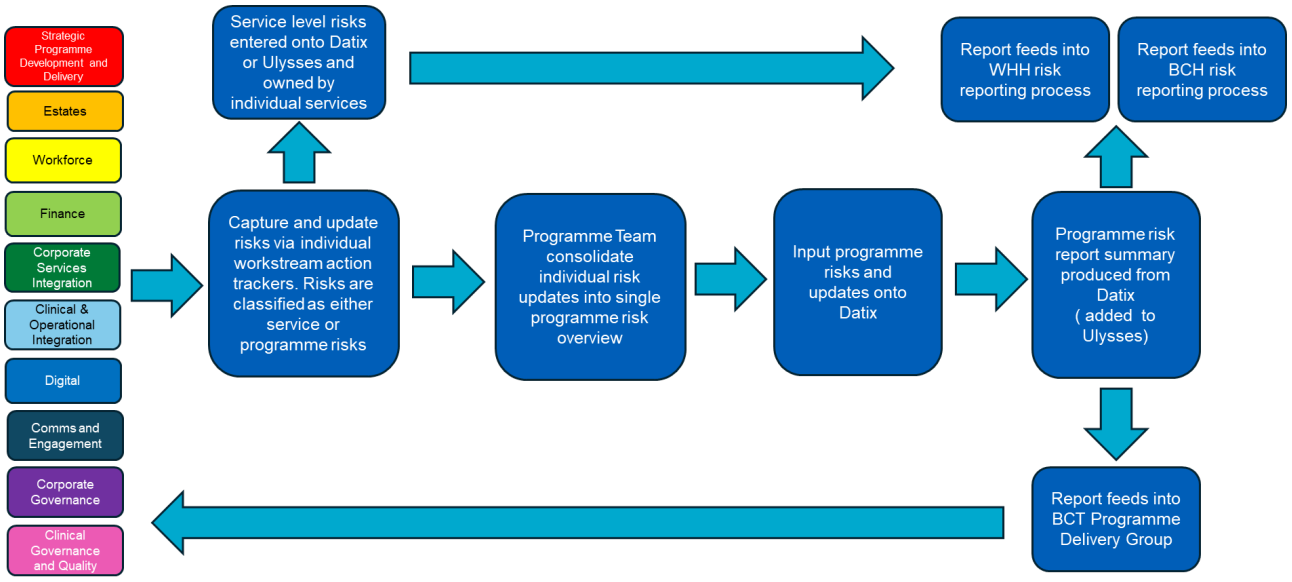
			and patient forum will commence in December 2025 and will be independently led by Healthwatch.	
Strategic Programme Management	If the transaction is accelerated, then there will be less time available prior to the transaction date to plan and engage with stakeholders resulting in a less effective integration of clinical services.	16	In order to mitigate the associated risk, it is proposed to bring BCH services across as a stand-alone care group within the existing WHH management structure in the short term (aka lift and shift). This will mean minimal or zero disruption and/or change to key clinical services in the short term.	4
Strategic Programme Management	If the integration programme timescales are accelerated then there will be less time to complete key actions and activities for regulatory and legal readiness such as consultation with staff re: TUPE transfer, organisational change processes, due diligence etc, resulting in a potential risk to legal compliance for the programme.	15	We have secured senior ICB and national support for the proposal in the short term to allow us to commence these actions. All required due diligence has now been completed and the results and risks identified have been fed back into our day-to-day planning via the workstream delivery trackers. Any decision to proceed with the transaction will need to be approved by both Trust Boards and verified by Council of Governors who will need to be assured that a robust and appropriate legal process has been followed by the Trusts along the way. As noted in other identified risks, there has been significant work undertaken to review current workloads and divert internal resources to support and prioritise the core tasks within the programme wherever required.	8
Estates	If a contracted service is brought in house without proper evaluation of TUPE risks, then there is a potential for the Trust to be in breach of law, resulting reputational and financial damage to the Trust	15	Workforce representative invited to all project meetings to ensure that due consideration is given by project leads regarding TUPE and staff implication. Issues highlighted to SROs and Workstream leads where appropriate Governance in place to reduce likelihood of occurrence.	5

These risks are reviewed monthly at the Programme Delivery Board.

Risks are also captured on both Trusts' risk management systems and risk registers, where they are monitored and managed via the BAU risk management processes.

The process for programme risk management, which was approved by the BCT Programme Delivery Group, is summarised in the diagram below.

Figure 18: Programme risk management



9.3 Due diligence risks

The primary purpose of due diligence is to identify potential areas of risk, enabling the Trusts to make informed decisions about proceeding with the transaction and, where appropriate, embedding mitigation measures into integration planning.

As WHH is acquiring BCH, the due diligence exercise was uni-directional, with WHH conducting due diligence on BCH only.

To support this process, KPMG was engaged to conduct a detailed due diligence review, providing independent assurance and insight into operational, financial, and regulatory risks. Legal due diligence was undertaken by Hill Dickinson, ensuring all legal and contractual matters were fully assessed. Internal subject matter experts from the Trusts also reviewed specific areas, offering in-depth knowledge and validation of findings.

A blended, proportionate approach was adopted, combining external assurance with internal expertise:

- **General due diligence (WHH on BCH):** Led by KPMG, supported by internal WHH teams, delivering external guidance, advice, and recommendations.
- **Legal due diligence (WHH on BCH):** Conducted by Hill Dickinson.

The due diligence programme comprised:

- Reviewing NHS England Mergers and Acquisitions due diligence guidance
- Incorporating areas of focus recommended by KPMG and Hill Dickinson
- Designing tailored questionnaires for each corporate and operational area
- Supporting teams through introductory and guidance meetings

Due diligence was completed across a range of areas, including Financial, IM&T, Estates, Legal, and Clinical & Operational. Each identified risk was RAG-rated to reflect its criticality, with any ‘high’ risks prioritised for day-one readiness and supported by specific recommendations and mitigation plans. These actions are reflected in the clinical and corporate delivery plans, and the Integration Programme Team has mapped all due diligence risks to corresponding mitigating actions, including owners, timeframes and residual risk ratings.

This comprehensive approach has enabled the identification, assessment, and planned mitigation of risks, informing integration planning and ensuring that the enlarged organisation will maintain strong governance,

operational effectiveness, and patient safety throughout the transaction and beyond. By addressing risks proactively, the Trusts are positioned to deliver safe, sustainable, and high-quality services within the new integrated organisation.

All identified risks have been incorporated into the integration risk register and are managed through the integration programme governance structure (as set out in section 7.3). All due diligence risks and corresponding details, including mitigating actions, are also being captured on both Trusts' BAU risk management systems and risk registers, as appropriate, ensuring reporting through BAU risk management processes, including escalation as required.

The key due diligence risks and mitigating actions are summarised in section 19 of the FBC. The full table of due diligence risks and mitigating actions, which has been appropriately incorporated into risk registers as summarised above, is included in the supporting documents.

9.4 Day 1 BAU risk management in the enlarged organisation

Risk management processes will remain robust throughout the integration period. WHH will continue to manage risk registers and incidents on the Datix system, while Bridgewater Care Group will utilise the Ulysses system for incidents and risk registers. Both systems will be governed and managed by a single Data Analyst Governance Team, which will produce joint reports for governance committees and Care Groups to ensure safe business continuity.

All risk registers will be overseen by a single Risk Review Group, attended by the Executive Team, all care groups, and the Corporate Secretary. This group will ensure that all risks are managed, reviewed, and aligned with the Corporate Risk Register and the Board Assurance Framework. The Risk Review Group will report into Quality Committee and Trust Board by exception. The Clinical Governance Managers/Governance Teams will be fully trained in both systems.

10 Benefits Realisation

10.1 Introduction

Both Trusts have acknowledged the importance of being clear about both the quantitative and qualitative benefits of the transaction and putting in place a rigorous approach to monitoring and tracking the realisation of these expected benefits.

The approach to benefits realisation consists of the following key steps:

1. **Identification and Quantification:** Teams will identify benefits through discovery workshops, benefit dependency mapping and stakeholder insight. All benefits identified will be quantified (where they produce a financial benefit) so that any forecasting of the scale of anticipated benefits has been included within the FBC.
2. **Plan and Realise:** Validation of the benefits forecast, management of pre-transition activities, selecting appropriate benefit metrics and planning effective stakeholder engagement.
3. **Review:** Assess and update the individual benefit profiles and the benefits realisation plan to ensure the planned benefits remain achievable and have not changed in scope or value.

10.2 Monitoring and review of benefit delivery and realisation

Each identified integration programme workstream will be responsible for the day-to-day monitoring and delivery of integration plans and the realisation of corresponding individual service benefits.

Benefits are currently captured on 3 trackers. Patient, performance and people benefits are captured and tracked via the patient, performance and people (PPP) benefits tracker which is input into by all workstreams and maintained by the integration programme team. The current live PPP benefits tracker is included in the supporting documents.

Financial benefits are currently captured on both Trusts' CIP trackers; this is key to comply with financial reporting requirements and also ensures there is no double counting of benefits. The CIP trackers are maintained by the management accounts teams ensuring individuals with appropriate financial qualifications track the financial benefits. A summary of the financial benefits is regularly collated from the CIP trackers and reported through BCT Programme Delivery Group by the Programme Director, who is also a qualified accountant.

The latest financial summary is included in the supporting documents. The financial benefits expected in 2026/27 and beyond are currently being incorporated into operational plans and 5-year plan submissions, which will be reviewed and ultimately approved via the Finance and Performance Committee in Common and both Trust Boards.

The Programme Team will track and monitor the achievement of benefits centrally in line with the frequency and information sources set out within the benefits tracker. Tracking of benefits at a programme level will help to ensure consistency in monitoring and reporting as well as remove any possible 'double counting' of benefits (e.g., between integration benefits and wider clinical benefits).

The Programme Team will provide a monthly progress update on the achievement of transaction benefits to the BCT Programme Delivery Group. Any concerns or issues identified in the delivery of transaction benefits will be managed through the Delivery Group who will make decisions about any changes that might need to be made to existing plans or whether additional input or support needs to be provided to ensure timely realisation of benefits.

At one year post transaction a more detailed review will take place to measure and evaluate the impacts of the integration programme. This will provide the Trust Board with a view on whether plans are on track and align with the progress being made against the timelines set out in the PTIP. This annual evaluation will also be available to be shared with regional and central NHSE colleagues through agreed reporting mechanisms as required.

Department of Health & Social Care

Consideration of the Secretary of State for Health and Social Care's Duties under the NHS Act 2006

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is proposing to acquire Bridgewater Community Healthcare NHS Foundation Trust (BCH) on the 1st of April 2026.

The transaction creates a single organisation to provide acute and community care to the population of Warrington and Halton, strengthening the delivery of our vision of world class expertise and local care delivered in, and tailored to, the communities we serve. This vision and approach maintain our commitment to deliver outstanding care to our population.

The increased scale of the new Trust, and the removal of cross-organisational barriers, will allow the organisation to go further in redesigning services, reducing unwarranted variation, improving quality and productivity, and sharpening focus on prevention and population health.

The Full Business Case sets out the benefits of the integration for the Trusts' patients, staff and local populations. These benefits have been identified and developed through engagement with staff including clinicians, and wider stakeholders.

Section 1 of the NHS Act 2006 - duty to promote a comprehensive health service

Section 1(1): The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness.

Will the new organisation continue to provide a comprehensive health service as shown above? How will it do this?

The new Trust will continue to provide a comprehensive health service. There are no service reductions planned as a result of the integration.

At our Warrington Hospital site, we deliver A&E, maternity, intensive care, paediatrics, acute surgery and medicine, and community services. At our Halton hospital site, we deliver inpatient, outpatient and elective care services and have an Urgent Treatment Centre.

From our network of more than 50 community sites, we will continue to deliver adult and children's community nursing and therapy services across Halton and Warrington. In addition, we will provide specialised community dental services, supporting over 18,500 people across Cheshire, Merseyside and Greater Manchester.

Being part of a larger organisation means that we can deliver the best care possible, operate at scale to get the best investment and quality services, and ensure that patients receive the same high standards of care whichever part of our Trust they visit.

Will the new organisation see services change immediately or integrate over time, and at a pace appropriate to those services?

There will be no immediate change to service delivery model of the new organisation. The focus is on a safe day one transition to ensure we have continued statutory and regulatory compliance and to successfully integrate corporate services under the Executive Team. This will enable the new organisation to manage the risks around the corporate transition, while allowing time to further develop integration and clinical operating model plans that maximise the opportunities of the integration, ensuring that we are able to appropriately engage with staff, service users and other stakeholders.

Changes to clinical services will be led by the clinical teams and will start to be implemented in the first year after the acquisition, but there are no clinical changes planned on day one.

Seven early integration opportunities have been identified where the Integration can deliver greater benefits for patients. These are listed below:

- Acute care closer to home – Frailty response
- Infant feeding
- Heart failure
- Chronic Pain Services
- Movement Disorders / Parkinson's Disease
- Female urinary incontinence
- End of life care

How has this approach been made? Feedback from clinical staff at both trusts? Best practice and lessons learned from other integrations of physical/mental health?

Our approach has been developed through detailed engagement with clinical staff at both Trusts, alongside sessions with wider stakeholders. An initial workshop with senior clinical and operational leaders took place in October 2024. Its purpose was to map services across both Trusts, identify where patient populations overlap, explore opportunities for clinical alignment, and agree priority areas for integration.

Around 50 senior leaders from both organisations, as well as primary care, Local Authority and third sector partners, participated in the workshop. Four priority themes initially emerged: Starting Well (women, children and families), Ageing Well, Urgent and Emergency Care and Long-Term Conditions.

As urgent and emergency care already had a joint improvement programme underway, no further summit was required in this area. Long-term conditions were subsequently split into physical and neurological conditions, and women's and children's services were also separated. This resulted in five themes being taken forward, forming the basis for the next stage of planning and the identification of phase-two priority services through a series of clinical summits.

Furthermore, our approach has been informed by the experience of other Trusts, particularly Kingston and Richmond NHS Foundation Trust, whose successful integration of acute and

community services has provided valuable insights that have shaped our programme.

Will there be benefits to patients – how have these been assessed?

The benefits of the integration are significant and measurable. Patients will experience more consistent, joined-up care; staff will benefit from expanded opportunities and shared learning; and the system will achieve greater efficiency and resilience. The benefits realisation framework ensures delivery is tracked, quantified, and sustained over time.
The table below details the cross-cutting benefits that the Trusts have identified as critical benefits from integration:

Benefit	Measure
Patient and Population Benefits **Improved patient experience** by creating services that are less fragmented, across both clinical pathways and geographic areas.	Improved equity of access to health and care services across our places; pooling our resources to remove existing 'post-code lotteries', particularly where current disparities and/or health inequalities exist because of historic commissioning decisions.
	Improved patient experience by simplifying pathways and reducing hand-offs.
	Improved accessibility of our services by reducing the number of interfaces encountered by patients and their carers that can act as barriers to the provision of fast and easy access to care.
	Improved continuity of care by aligning the geographic coverage of our service teams and reducing the number of interfaces across care pathways.
	Improved communication with patients, their carers, and across clinical teams by reducing the inter-organisational boundaries along patient pathways that can act as barriers to the provision of consistent and complete information.
Patient and Population Benefits Improvements to patient safety and outcomes	Working with primary care and other partners to support multi-disciplinary team working, so that when people do require care, this is delivered at home or as close to home as possible through a model that has the benefit of 'acute oversight' where required, allowing a greater degree of clinical risk to be managed locally. **Home first, then community, and hospital only when needed**.
	Establishment of a universal, Trust wide approach to Quality Improvement (QI) and transformation that utilises our combined expertise and recognises the importance of both standardisations to reduce unwarranted variation, and adaptation to meet the needs of Warrington and Halton.
	Improving the quality of patient care by improving clinical

	information sharing, enhancing access to specialists in community settings and reducing gaps in specialist clinical knowledge by sharing resources more widely and improving knowledge transfer within teams.
	Sharing resources more effectively to maintain sustainable staffing levels, service delivery integrity and reducing gaps in specialist clinical knowledge, particularly of smaller services.
Wider Benefits to Health and Care System	Simplifying and integrating our care pathways and making it easier for primary, social care and other partner colleagues to access and work with our services to support people in the community to avoid unnecessary deterioration and admissions to hospital.
	Reducing A&E attendances and avoidable admissions to secondary care through reducing the complexity and duplication of our care pathways to always care for patients in community settings when appropriate.
	Inform and shape future system and place strategy development, particularly neighbourhood models, from an integrated acute/community Trust perspective.
	Simplify governance and commissioning arrangements with place and ICB with a single Trust being held accountable for the delivery of equitable safe and high-quality acute and community services.

Section 1A – Duty as to improvement in quality of services

Will the transaction provide improvements to the quality of services? If yes, what will they be?

Delivering these benefits will significantly enhance the quality of clinical services by creating a more coordinated, consistent and patient-centred model of care.

Streamlined pathways and reduced organisational hand-offs will minimise delays, duplication, and variation, ensuring patients receive timely and coherent care regardless of where they enter the system.

Improved equity of access will support earlier intervention and reduce avoidable deterioration, particularly for groups historically affected by health inequalities.

Strengthening multidisciplinary working and embedding an integrated Quality Improvement approach will raise clinical standards by enabling shared learning, consistent practice and evidence-based care across all services.

Better information sharing and wider access to specialist expertise will enhance clinical decision-making, reduce risk and support safe management of more complex patients in community settings.

Consolidating staffing and specialist resources will also improve service resilience, reduce gaps and support sustainable, high-quality service provision.

Together, these changes will deliver a more reliable, integrated and outcomes-focused clinical service for patients across the new Trust.

Section 1B – Duty as to the NHS Constitution

Will the transaction be consistent with and support the principles in the NHS Constitution? i.e will it continue to ensure that NHS services are available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. (You can summarise and refer to the PSED).

The transaction is consistent with and supports the principles in the NHS Constitution. One of the core benefits of our integration will be to enable more co-ordinated action to improve the health of the local population through greater focus on understanding and addressing inequalities in care. The enlarged trust will continue to ensure that NHS services are available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

The current plans for clinical service change are focused on seven early integration opportunities and equality impact assessments will be completed as plans progress to an appropriate stage. Staff, service users and other stakeholders will be engaged and consulted with as part of this process. There is no indication or expectation that these will negatively impact any of the protected characteristic groups.

Will NHS services in question continue to be free of charge (except to the extent that any legislation provides otherwise)?

NHS services will continue to be free of charge (except to the extent that any legislation provides otherwise).

Will the patient continue to be at the heart of everything? If there are changes to services will the public and other users be consulted

Yes, patients will continue to be at the heart of everything we do. The changes proposed through the integration are driven first and foremost by the desire to improve patient experience, safety, access and outcomes.

Our shared vision is to bring the very best of the NHS to every patient, regardless of which of our services they access, through world-class care, delivered locally, supported by leading research, education and clinical excellence.

In order to ensure that we have formal and robust mechanisms in place for consulting with patients, we have established the Patient and Public Reference Group (PPRG).

The PPRG will serve as a key conduit for patient and public feedback, to inform the integration process and strategic decisions. The key functions of the PPRG include:

- The PPRG will support the embedding of strong communication and engagement between communities and the new Trust leadership.

- The PPRG will support wider engagement with the communities of Halton, Warrington-and other areas covered by the Trust, including community dental services in Greater Manchester, to support development of and feedback on proposals to integrate hospital and community services and develop or change patient facing services.

- The PPRG will represent and provide insight into the communication and engagement needs of the wider communities to ensure information is accessible.

- The PPRG will recommend and deliver initiatives to facilitate effective engagement and involvement between members, patients and the wider public to enable stakeholders' views to be heard.

We are engaging with patients as part of the development of our plans. Because the current integration plans do not involve any specific changes to services that require formal public consultation, our engagement to date has focused on raising awareness, providing reassurance and responding to any questions or concerns.

If any future proposals involve changes to services, we are fully committed to undertaking appropriate engagement and, where required, formal public consultation with patients, carers, partners and wider stakeholders.

This ensures that future service redesign is shaped by the people who use our services, and that patient voice continues to guide our decision-making at every stage.

Section 1C - Duty as to reducing inequalities

Will the transaction maintain/improve outcomes for those across the local society and population, reflecting dimensions such as socio-economic status, area deprivation, educational attainment, income, and occupational group.

Yes. The transaction is expected to maintain and, in most areas, significantly improve outcomes across the local population, particularly for groups adversely affected by socio-economic inequality, deprivation, low educational attainment, low income and occupational disadvantage. The integration of WHH and BCH directly supports a more equitable, prevention-focused and coordinated health and care system, enabling earlier intervention, simplified access and greater consistency in care quality across Warrington, Halton and the wider system.

- **Improving access and reducing barriers linked to deprivation and socio-economic status**: The alignment of community and acute services will reduce fragmentation, simplify pathways and bring care closer to home. Reviewing opening hours, service locations and transport links, combined with the expansion of community hubs means that people living in deprived areas, those with limited mobility and individuals facing financial barriers will find it easier to access timely care. Mitigation of digital exclusion (e.g., patient portal support, multilingual assistance, community digital access points) ensures that lower-income households and people without digital skills are not disadvantaged when booking, managing or receiving care.

- **Targeting the root causes of poor outcomes through system-wide integration**: The JSNAs for Warrington and Halton highlight that the most significant drivers of poor health outcomes are complex, overlapping and concentrated in areas of socio-economic deprivation. Integration enables a unified, place-based response to these drivers. Working more closely with primary care networks, neighbourhood teams, local authorities and the voluntary sector strengthens the collective ability to address social determinants such as housing, employment, income insecurity and access to education or support services. A single integrated Trust simplifies governance and supports fair, consistent commissioning across communities, reducing historic postcode variation created by differing commissioning decisions.

- **Earlier intervention and stronger prevention for at-risk groups**: Accelerating preventive programmes supported by initiatives such as the Living Well Warrington platform, expanded wraparound support and co-located community resource creates more touchpoints for early help. This is particularly beneficial for people with long-term conditions, chronic illness, poor health literacy or unstable employment patterns, all of whom are disproportionately affected by deprivation. Predictive analytics, population health dashboards, and active case finding will help identify vulnerable groups earlier (e.g., those with undiagnosed COPD, frailty or mental health risks), preventing deterioration and reducing avoidable admissions.

- **Reducing unwarranted variation and improving consistency of care**: A Trust-wide Quality Improvement (QI) approach will reduce variation in clinical outcomes by standardising pathways while allowing local adaptation for Warrington and Halton's distinct needs. Better information sharing and access to specialists particularly in community settings improve continuity and safety for people who may struggle to navigate complex systems, such as low-income families, older adults, carers and those with limited health literacy. Strengthened multidisciplinary working enables more complex clinical risk to be managed closer to home, reducing inequalities in outcomes between communities with different resource levels.

- **Strengthening economic and social wellbeing through anchor institution commitments**: The new organisation's commitment to tackling workforce inequalities, supporting local employment and improving staff wellbeing contributes directly to the wider determinants of health. Creating a stable, equitable employer across both places supports inclusive economic development, benefiting communities where unemployment, low pay or insecure work impact health outcomes.

- **Embedding community voice and accountability for reducing inequalities**: Executive-level objectives for tackling health inequalities, alongside the embedding of community voice in governance and service design, ensure that the needs of diverse and disadvantaged groups (including Core20PLUS5 populations) directly shape clinical and organisational decisions. This maintains focus on improving outcomes for those most at risk of poor health due to deprivation or socio-economic disadvantage.

Overall, the integration is expected to significantly improve outcomes across all dimensions of socio-economic inequality by creating a more integrated, equitable, accessible and prevention-focused care system.

Through strengthened partnerships, targeted interventions, streamlined pathways and clear organisational accountability for reducing inequalities, the new organisation will be better positioned to address the complex social and economic factors that shape health across Warrington, Halton and the wider region.

What plans are there to reduce inequalities for service users?

We are committed to tackling health inequalities across Warrington, Halton and the wider system, focusing on six priority areas:

- Restoring NHS services inclusively – after the COVID-19 pandemic
- Mitigating against Digital Exclusion
- Ensuring Data sets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability
- Tackling workforce inequalities

By aligning community and acute services, the new organisation will be better placed to address the root causes of inequality, deliver prevention-focused care and strengthen partnerships with local authorities, primary care and the voluntary sector to reduce health gaps across our populations.

The integration of WHH and BCH provides a significant system-wide opportunity to take a more cohesive, place-based approach to improving population health. Bringing acute and community services together enables closer working with neighbourhood teams, primary care networks and community assets, ensuring services can be designed around the needs of local people.

Recent Joint Strategic Needs Assessments (JSNAs) across Warrington and Halton highlight the importance of joined up working to address overlapping and complex health needs, and the acquisition allows us to align transformation efforts, reduce duplication and improve access to coordinated support.

As an integrated Trust, we will create seamless pathways across acute and community settings, working collaboratively with neighbourhood teams and PCNs to deliver more holistic care and reduce inequalities in access, outcomes and prevention.

Delivering on the areas below will support meaningful and measurable improvements in reducing inequalities for patients:

- **Inclusive Service Restoration**
  Reviewing service locations, opening hours and transport links will ensure care is accessible to communities with greater deprivation, mobility challenges or limited public transport. Providing care from community hubs and aligning our work with neighbourhood priorities will bring services closer to patients, while collaboration with local authorities on travel routes will help remove geographic and financial barriers.

- **Mitigating Digital Exclusion**
  Supporting patients to use the Patient Portal—including onsite assistance, multilingual support and community digital access points—will ensure that those with limited digital skills, language barriers or no home internet can continue to access appointments and information. Text reminders and online appointment management will further ease financial and time pressures.
- **Complete and Timely Datasets**
  Developing a population health dashboard will enable targeted outreach to higher-risk groups, including Core20PLUS5 populations. Predictive analytics and active case finding will help identify conditions earlier—such as undiagnosed COPD—ensuring timely intervention for vulnerable patients.
- **Accelerating Preventative Programmes**
  Co-locating services and expanding wraparound support closer to home will make early help easier to access, especially in deprived areas. Platforms such as Living Well Warrington will support people to self-manage their health and wellbeing, reducing reliance on hospital care and improving access to prevention resources for all socioeconomic groups.
- **Strengthening Leadership and Accountability**
  Setting executive-level objectives for tackling health inequalities will ensure sustained focus and responsibility. Embedding community voice within governance and service design will ensure our services genuinely address the needs of diverse populations. As an anchor institution, the Trust will work with local authorities and the voluntary sector to support inclusive economic development and promote health equity.

Together, these actions demonstrate our commitment to embedding health equity at the heart of service transformation, ensuring that all residents regardless of background, circumstance or location can access safe, high-quality and fair care.

By integrating acute and community services, strengthening collaboration with neighbourhood teams and primary care and aligning our work with system priorities, we will deliver more holistic, accessible and equitable services for the populations we serve.

What plans are there to reduce inequalities amongst staff?

The proposed integration provides an unparalleled opportunity to advance both organisations' ambitions around inclusivity and anti-discrimination for colleagues and patients alike. The expanded workforce of around 6,500 employees will be amongst the most diverse in the UK and the enlarged organisation will harness the potential of all colleagues to deliver world class healthcare outcomes by broadening the scale of existing and successful interventions for the benefit of all.

The following initiatives aimed at reducing inequalities and promoting inclusion among staff:

1. **Commitment to Equality and Inclusion**
   - The organisation explicitly states its aim to strengthen equality of opportunity and tackle health inequalities for both the communities it serves and its workforce.
   - It envisions building an inclusive, empowered team where everyone feels they belong and can thrive, aligned with the NHS People Promise.

2. **Integration and Shared Resources**
   - Integration between WHH and BCH will create expanded opportunities for career progression, shared training, and educational resources. This helps ensure fair access to development and advancement for all staff.

3. **Staff Networks and Culture Champions**
   - Staff Network meetings are being used to share messaging and gather views, evolving into a common approach across both organisations.
   - Culture champions and People Promise champions are actively involved to listen to staff voices and promote inclusivity.

4. **Engagement and Transparency**
   - A robust Staff Engagement Plan includes sessions, forums, and surveys to ensure staff voices are heard and acted upon.
   - Freedom to Speak Up guardians are collaborating to increase awareness and provide safe channels for concerns.

5. **Workforce Planning**
   - A single, coordinated approach to workforce planning will ensure equitable access to roles and opportunities, supported by demand forecasting and skills modelling.
   - Recruitment and retention strategies will focus on creating balanced skill mixes and addressing shortages fairly.

6. **Diversity Recognition**
   - The workforce spans **80 nationalities**, and the organisation acknowledges this diversity as a strength, aiming to reflect it in its culture and practice

Furthermore, working as an integrated organisation, the combined Trust will extend already developed programmes supporting staff in a variety of areas, including:

- Mental health and wellbeing - counselling placements within mental health wellbeing hub to support staff.
- Occupational health and support- occupational health pre-employment process updated to reflect workforce needs aligned to the workforce equality and diversity and inclusion strategy.
- Reasonable adjustments- signposting to Maximus, an access to work mental health provider to support individuals with long term mental health conditions. Implemented a passport to support staff with the resources to remain in work and thrive.
- Prevention programmes- multiple prevention programmes and packages delivered focused on cardiovascular disease, menopause, mental wellbeing and musculoskeletal conditions.

Section 1D - A duty to promote autonomy within the health service

Following the transaction will the new organisation continue to have the freedom to make its own decisions, including whether to make and invest surpluses, and to manage its own affairs? Will it remain subject to statutory requirements and will it have a duty to exercise its functions effectively, efficiently and economically.

The enlarged trust will remain a foundation trust. Recognising the need to work as part of the Cheshire and Merseyside ICB, it will continue to have the freedom to make its own decisions and to manage its own affairs.

North Cheshire and Mersey NHS Foundation Trust will remain subject to statutory requirements and will it have a duty to exercise its functions effectively, efficiently and economically.

Section 1E - To facilitate or otherwise promote a) research matters relevant to the health service, and b) the use in the health service of evidence obtained from research

Applies to organisations which have research functions and where this is not the case it should be marked as not applicable.

As part of our integration programme, we are establishing a joint research growth strategy designed to strengthen, expand and align research capability across acute and community settings. The Integration represents a key opportunity to create a single, system-wide approach to research delivery that enhances patient outcomes, attracts investment and supports long-term sustainability.

The integration presents multiple opportunities to expand and enhance the research capabilities of the new organisation through:

- **Expanding patient access** to clinical research opportunities across both hospital and community settings, ensuring equitable participation for all populations, including underserved groups.
- **Improving the ability to apply for and deliver a greater volume of clinical trials**, supported by integrated governance, streamlined processes and shared expertise.
- **Developing multidisciplinary staff** to increase the number of qualified principal investigators and strengthen the overall research leadership pipeline.
- **Growing the academic portfolio** to support recruitment, retention and professional development of clinicians, nurses, midwives and Allied Health Professionals.
- **Expanding the research footprint** by leveraging WHH's infrastructure such as the Halton Clinical Research Unit (HCRU), alongside BCH's access to diverse community populations.
- **Increasing the number of HCRU-delivered trials** and extending capacity to host high-value, phase II/III studies.
- **Growing annual commercial research income**, enabling continued reinvestment into infrastructure, workforce and study delivery.

WHH brings a proven track record in commercial research, having generated over £4.8 million since 2021 through delivery of large-scale industry-sponsored trials across specialties including gastroenterology, respiratory medicine, rheumatology and maternity.

BCH complements this with recognised expertise in community-based and oral health research, as well as strong engagement of NMAHPs in early-career research and education. Together, these complementary strengths create a balanced and scalable platform for future growth.

Ultimately, the integration will deliver a more connected and equitable research ecosystem that drives innovation, improves patient outcomes and contributes to workforce development across the health system.

The combined strengths of both organisations will enhance the position of the new Trust in clinical and applied research, capable of delivering sustainable income growth, supporting national NIHR priorities, and embedding research as a core component of high-quality patient care.

Section 1F – A duty to secure an effective system for educating and training NHS workers, or people who might work in the NHS

Will the new organisation provide opportunities for the combined workforce, including improved education and training through standardised training programmes and a wider offer of training across the combined organisation? Provide examples.

Our mission is to put excellence in education, training, learning and development for all at the heart of the Trust's approach to delivering:

- excellent health outcomes
- outstanding experience of care
- outstanding experience for our people
- a sustainable organisation
- developing the practitioners of the future

Excellent health outcomes

- Providing a workforce that responds to innovation, is research-active and reflects the needs of changing clinical pathways.
- Supporting the development of a learning organisation, driving quality improvement and patient safety.

Outstanding experience of care

- Enabling true patient-centred care through shared learning with patients and carers.
- Ensuring our staff have the required knowledge, skills, behaviours and values needed to deliver world class care and communicate effectively with patients and carers.

Outstanding experience for our people

- Helping to make North Cheshire and Mersey NHS Foundation Trust a great place to work by supporting career development for all, being inclusive and offering wellbeing initiatives.

A sustainable organisation

- Supporting sustainable practices within our services and enabling an agile, resilient and entrepreneurial organisation.

A joint education and training plan will be developed and implemented to ensure equity of access and standards across all sites. This will be incorporated into a refreshed People and Workforce EDI Strategy from day one. Learning management systems will be standardised and core processes for accessing and delivering training will be brought together.

Mandatory and role-specific training programmes will be aligned from day one to ensure consistency in reporting and compliance. Apprenticeship contract management will be aligned with TUPE and educational requirements with placement capacity reviewed to support enhanced training and education benefits.

A joint corporate induction process has already been implemented but this will be reviewed for day one to ensure that all new staff are oriented to the integrated organisation's values, policies and systems.

Section 1G - A duty to report upon and review treatment of providers

This section is not relevant in this instance.

Section 1GA – Secretary of State's duty to report on workforce systems

Could the transaction affect the trusts' ability to assist in the preparation of any workforce reports?

No. We have integration plans which will support delivery of combined workforce reporting from day one of the integration enabling us to prepare required workforce reports.

Department of Health & Social Care

Environmental Principles Assessment form

To aid consideration of the Environmental Principles Policy Statement

October 2023

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Introduction

The Environment Act 2021 requires Ministers of the Crown, and those making policy on their behalf, to have '*due regard*' to the Environmental Principles Policy Statement (EPPS) when making policy. The duty will come into force on 1 November 2023. To have due regard, you will need to:

- Identify the potential environmental effects (positive and negative) of your proposed policy
- Consider the environmental principles, and incorporate the relevant principles in a proportionate manner
- Communicate your consideration to ministers and decision makers.

The EPPS sets out five internationally recognised environmental principles to be considered. The five principles work together to help create opportunities to avoid, minimise and remedy environmental damage to improve environmental protection.

The 5 principles are:

- Integration – environmental protection should be integrated into the making of policy
- Prevention – damage to the environment should be prevented before it has occurred, or existing damage should be contained
- Rectification at source – damage to the environment should be tackled at its origin
- Polluter pays – those who cause pollution or damage to the environment should be responsible for mitigation or compensation
- Precautionary – where there are threats of serious or irreversible environmental damage, you must not use a lack of full scientific certainty as a reason for postponing cost-effective measures to prevent this damage

Whilst the duty to have due regard is new, the principles are not; it is likely that the intentions of the principles have already been incorporated into health policies.

The duty aims to create opportunities to guide policymakers and ministers towards opportunities to prevent environmental damage and enhance the environment. The five environmental principles will support the Government's Environmental Improvement Plans and to deliver on our net zero commitment to tackle climate change by ensuring the environment is proactively designed into the policymaking process.

Policymakers should consider and use the principles iteratively from the outset and during subsequent stages in policy development. The following template supports policymakers to demonstrate their consideration of the Environmental Principles Policy Statement.

The EPPS does not specify how ministers and those making policy on their behalf should analyse the effect of their policies on the environment but doing so is an important part of complying with the duty. You may wish to consult with analysts to support evaluation of

your policy's environmental effect. For further guidance on considering the environmental effects of your policy, please see Defra's toolkit

Key Definitions:

Environment:
In the context of the environmental principles policy statement, references to the environment mean the natural environment.
As defined in section 44 of the Environment Act, the natural environment means:

a) plants, wild animals and other living organisms
b) their habitats
c) land (except buildings or other structures), air and water

and the natural systems, cycles and processes through which they interact.

Environmental effect:
An environmental effect means a change to the environment which can be:

- a primary effect or secondary (direct or indirect)
- occurring once, repeatedly, or cumulative
- local, regional, national or transboundary
- short-term, medium-term or long-term
- permanent or temporary
- positive or negative

THIS SECTION IS FOR INTERNAL USE ONLY

Please complete the form by following the instructions in each box. If you have any questions or suggestions on this form, please contact environmental.hazards@dhsc.gov.uk.

Environmental Principles Assessments should be cleared with your legal advisors before being sent to Ministers.

END OF SECTION

Environmental Principles Assessment

Policy	Warrington and Halton Teaching Hospitals NHS Foundation Trust's proposed acquisition of Bridgewater Community Healthcare NHS Foundation Trust
Contact	Lefteris Zabatis Lefteris.zabatis@nhs.net
Cleared by	Lucy Gardner, lucy.gardner5@nhs.net
Date	24/11/2025

The duty is to have due regard to the Environmental Principles Policy Statement. You are recommended to read the policy statement and use the below template to demonstrate your consideration.

Please confirm:
☒ I have read the policy statement

Section 1: Defining scope

1.1 **Is this a new or revised policy, signed off by, or made on behalf of, a Minister?**

☒ Yes, it is a Document prepared by public bodies that ministers are required by statute to approve and thereby in scope of the duty.
☐ No, it is an Choose an item. and not in scope of the duty.

If 'no', then please record your decision and rationale here. No further action is required.

If 'yes', please continue to the below questions.

Further information on policy v individual decisions can be found in DEFRA's toolkit of resources. If you are unsure if your policy is in scope, you should consult your legal adviser.

1.2 **What is the policy objective?** *You should outline the main aims of the policy, the proposed changes, and their rationale.*

Warrington and Halton Teaching Hospitals NHS Foundation Trust is proposing to acquire Bridgewater Community Healthcare NHS Foundation Trust on the 1st April 2026. There will be limited immediate change to the new organisation.

The focus is on a safe 'day one' transition, ensuring continued statutory and regulatory compliance as well as bringing the leadership and corporate functions together under a single organisation.

This will enable the enlarged organisation to manage any risks around the corporate transition, while allowing time to further develop integration and clinical operating model plans that maximise the opportunities of the transaction.

Clinical changes will start to be implemented in the first-year post-merger but there are no significant changes to clinical services planned to happen prior to day one.

We will ensure that the appropriate assessments on environmental impacts of any changes are carried out at relevant times across development of the integration programme beyond 1st April 2026.

The environmental principles should be considered iteratively from the outset and during subsequent stages in policy development. *You may wish to outline the milestones or dates where you might review the environmental principles in your project plan.*

Milestone	Provisional date	Template Version
Consultation		
Drafting		

Section 2: Consideration of environmental effects

You should consider the positive and negative environmental effects of your policy on a case-by-case basis. This assessment should be conducted in a proportional manner, relative to the likelihood and/or significance of the potential environmental effects, using a common-sense approach.

It may be helpful to use the Green Book 4-step approach, which is set out in more detail in the Enabling a Natural Capital Approach (ENCA) guidance. You may also find it helpful to consult analysts or other contacts with relevant environmental expertise to help you assist in identifying potential effects.

If your policy could produce greenhouse gases, it may be useful to use the published supplementary guidance to HMT's Green Book on Valuation of energy use and greenhouse gas emissions for appraisal. When appraising policy you should consider the requirements for carbon budget accounting and reporting, that go beyond the minimum required for impact assessments. Appraisals should avoid double counting where emissions are considered elsewhere. It may be disproportionate to quantify some costs and benefits where there is unsufficient evidence.

2.1 **Could your policy have any environmental effects (positive or negative)?**

☐ Yes, the policy could have environmental effects
☒ No, the policy has *no/negligible* environmental effects

If ‘no’, please record your decision and rationale here. No further action is required.

If ‘yes’, please continue to the below questions.

As above, the integration of the two organisations does not immediately result into any changes to the services being provided. Over time we will look to integrate services, and this may change the location where part of a clinical service is being provided or where a member of staff is required to work. The travel arrangements for individuals may therefore vary.

For some this may increase travel distance and for others reduce it. Our ambition is to provide greater choice of where patients can receive treatment which may reduce travel (and therefore carbon emissions) but this may be partly offset by requirement to travel to a specialised centre for certain part of the treatment. The environmental impact will be assessed as part of each service change proposal.

We do not consider there to be an environmental impact from the proposals. We recognise that changes to the location of services in the future could potentially have an impact on transport emissions and could be marginally positive or negative.

2.2 **What are the potential environmental effects associated with your policy?** *You may wish to seek analytical support to identify potential environmental effects.*

Please provide a summary here.

You should consider:

2.2.1 **Type:** ☐ positive ☐ negative ☐ primary (direct) ☐ secondary (indirect)

2.2.2 **Frequency:** ☐ once ☐repeatedly ☐ cumulative (may become substantial when considered together)

2.2.3 **Duration:** ☐ permanent ☐ temporary

2.2.4 **Location:** ☐ England ☐Wider UK ☐ Overseas

2.3 **Could your policy produce greenhouse gas emissions?**

☐ Yes, the policy could produce greenhouse gas emissions
☐ No, the policy will not produce greenhouse gas emissions

If ‘no’, please record your rationale here and continue to 2.5.

If ‘yes’, please complete 2.4.

2.4 **What is the extent of the greenhouse gases that may potentially be produced?**

Please provide a summary here.

You should consider whether these emissions are:

☐ **Scope 1:** direct emissions (e.g. fuel combustion, company vehicles, fugitive emissisons)

☐ **Scope 2** – indirect emissions from the generation of purchased energy (e.g. purchased electricity, heat and steam)

☐ **Scope 3** – all other indirect emissions (e.g. purchased good and services, travel, employee commuting, waster disposal, use of sold products, transportation and distribution, investment, leased assets and franchises, imported materials)

2.5 **Does your policy offer an opportunity to contribute to wider Government targets/commitments on the environment?** *Select all that apply*

☐ Environmental Improvement Plan
☐ Environmental targets
☐ Net Zero Strategy
☐ Biodiversity duty
☐ Greening Government Commitments
☐ Climate change mitigation
☐ Climate change adaptation
☐ Other

If you have selected other, please provide further detail on the wider Government tagets/commitments your policy could contribute to here.

Section 3: Identifying relevant environmental principles

If your policy does have significant environmental effects, you should consider each of the principles and incorporate within policy development, where possible. It may be that some of the principles may not be relevant to your policy.

For each principle, describe how the principle applies/does not apply to your policy, provide additional information about potential actions you might take to adjust your policy following consideration of this principle and explain how you arrived at your policy recommendation. Suggestions to prompt consideration are included alongside each principle.

The *Green Book* and *ENCA* guidance on natural capital assessment can support consideration of these principles.

3.1 **Integration Principle:** ☐ Applicable ☒ Not Applicable
Environmental protection should be integrated into the making of policies
Questions to consider as prompts:

- *Are environmental considerations integrated throughout your policy?*
- *What opportunities are there for your policy to protect the environment from harm, and to maintain, restore, or enhance the environment?*
- *Can nature-based options support your (non-environmental) policy goals or complement other options?*

Please explain your consideration and any potential actions here.

3.2 **Prevention Principle:** ☐ Applicable ☒ Not Applicable
Policy design options that prevent environmental damage before it has occurred, or to contain existing damage should be sought.
Questions to consider as prompts:

- *Could potential environmental damage be caused as a result of your policy?*
  - *If so, what can you do to prevent it before it has occurred?*
  - *If damage is already occurring, how can your policy prevent further damage and/or ensure it doesn't spread?*

Please explain your consideration and any potential actions here.

3.3 **Rectification at Source Principle:** ☐ Applicable ☒ Not Applicable
Environmental damage should, as a priority, be addressed at its origin to avoid the need to remedy its effects later.

Questions to consider as prompts:

- *What is the damage?*
- *Where is it originating from?*
- *What can be done to address or manage the environmental damage, or potential environmental damage, at source to avoid the need to remedy the effects later? Consider this versus other options, and the costs and benefits of doing so.*

Please explain your consideration and any potential actions here.

3.4 **Polluter Pays Principle:** ☐ Applicable ☒ Not Applicable

The costs of pollution should be borne by those causing it wherever possible.

Questions to consider as prompts:

- *Who is the polluter? (e.g., the manufacturer, retailer, or the consumer)*
- *Why is the pollution being caused?*
- *Who would it be most effective to charge to bring about a change in the behaviour that causes pollution?*
- *Is it fair to charge that group or should it be distributed across the sector responsible?*
- *How much should they pay? This should be proportionate to the damage being caused.*
- *How should they pay? (e.g., directly through fees or charges, or indirectly through regulatory or contractual requirements, such as fines or penalties for breaches)*
- *How will this prevent or deter environmental damage?*
- *How could this restore or redistribute the costs of environmental damage?*

Please explain your consideration and any potential actions here.

3.5 **Precautionary Principle:** ☐ Applicable ☒ Not Applicable

Policymakers need to make a reasonable assessment of the environmental risk, particularly where there is a lack of scientific certainty.

Questions to consider as prompts:

- *Is there plausible evidence of a risk that your policy could cause serious or irreversible damage to the environment, alongside a lack of scientific certainty?*
- *How will you manage any risk?*

Please explain your consideration and any potential actions here.

Section 4: Proportionality

The principles are not rules and cannot dictate policy. You should take a proportionate approach in the application of the policy statement, balancing the social, economic, and environmental considerations. If the potential environmental effect is limited, you may apply the policy statement in a lighter touch way.

For further information on appraising policies, please refer to the HMT's Green Book for further guidance.

4.1 ***In light of all the evidence you listed in the above sections, please consider whether any proposed actions would be proportionate:***

You should consider:

- *Is the action likely to result in significant environmental benefit?*
- *Is the action proportionate to the environmental benefit? Have you appraised the social and economic benefits and costs throughout your consideration, as well as the scale of any potential environmental damage.*
- *Does the action balance the environmental effects in relation to broader considerations and/or government objectives?*

Please explain your consideration here. You should consider all of your policy options.

4.2 ***If applicable,*** **please outline how your policy will be amended following incorporation of the principles:**

Please provide a summary here.

4.3 **Please outline how you will monitor the policy**, **including the environmental effects set out in this assessment, once it is implemented:**

Please provide a summary here.

Section 5: Informing Ministers

It is best practice to keep a record showing that your Minister, and those making policy on their behalf, have considered the duty with substance, rigour and an open mind.

Records may include (but are not limited to) this template, submissions, notes, correspondence or minutes of meetings where decisions were made. You may wish to include links to these documents or details of decisions made by the Minister.

There is no legal requirement for records relating to the duty to be recorded in a specific format or to publish the documentation.

There may be cases where keeping a specific record may be considered unnecessary, for example where there are no potential environmental effects. We would still recommend noting that this has been considered.

Further information on the duty to have due regard and demonstrating compliance, monitoring and enforcement, can be found in the toolkit of resources.
Information that DHSC hold in a recorded format is subject to the Environmental Information Regulations 2004 and the Freedom of Information Act 2000.

END OF TEMPLATE

Supporting Materials

Environmental Principles Assessment One-page overview

This template is designed to provide Ministers and decision makers a high-level overview of the consideration of the duty. It should be used alongside the Environmental Principles Assessment template provided above.

You may wish to use it as part of the annex to when providing policy options for ministerial decision making.

Environmental Principles Assessment Overview *Duty to have due regard to the Environmental Principles Policy Statement*	
Title	*Policy title*
Contact	*Name, Title, Number*
Clearance	*Name, Title*
Date	*Date*

1. The policy Choose an item. in scope of the duty to have due regard to the Environmental Principles Policy Statement.

2. There are Choose an item. environmental effects associated with this policy.
   Please provide a summary of potential environmental effects

3. Which principles are relevant to the policy?
   - ☐ Integration
   - ☐ Prevention
   - ☐ Rectification at Source
   - ☐ Polluter Pays
   - ☐ Precautionary

4. How will the principles be incorporated into the policy?
   Please provide a summary of how the principles will be incorporated.

5. Are the above actions proportional to the policy objective?
   Please provide a summary

Environmental Impacts – Examples to consider:

Question	Examples / things to consider
Will this policy involve actions that will: • Cause physical changes to the landscape • Use natural resources which are non-renewable or in short supply • Negatively impact areas that contain important, high quality or scarce resources	• Building a facility in a protected area • Purchasing MRI scanners that use a lot of helium
Will this policy result in waste products that could have an environmental impact?	A policy that involves purchasing products that use a large amount of non-recyclable packaging
Will this policy release pollutants or any hazardous, toxic or noxious substances into the air?	Policies that would result in an increase in transporting goods via road would contribute to an increase in air pollution due to exhaust fumes, use of fossil fuels etc.
Will this policy lead to risks of contamination of land or water from releases of pollutants onto the ground or into surface waters, groundwater, coastal waters, or the sea?	
Are there any areas on or around the location which are already subject to pollution or environmental damage e.g., where existing legal environmental standards are exceeded, which could be affected by the project?	Service users of a facility located in an area that regularly exceeds the legal limits for air quality could be at risk of negative health impacts from air pollution, especially if they already have certain pre-existing conditions
Are there any protected areas which are designated or classified for their terrestrial, avian and marine ecological value, or any non-designated / non-classified areas which are important or sensitive for reasons of their terrestrial, avian and marine ecological value, located on or around the location and which could be affected by the project? e.g. wetlands, watercourses or other water-bodies, the coastal zone, mountains, forests or woodlands, undesignated nature reserves or parks.	
Will this policy make it difficult for people to access routes or places used for recreation or leisure?	
Will this policy result in an increase in	Building a new hospital in an area with

congestion or make using public transport difficult?	poor public transport connections, including at evenings and weekends, would encourage patients, visitors and staff to use their own cars to reach the site.
Are there existing land uses or community facilities on or around the location which could be affected by the policy? E.g., housing, densely populated areas, industry / commerce, farm/agricultural holdings, forestry, tourism, mining, quarrying, facilities relating to health, education, places of worship, leisure /sports / recreation.	
Is the location susceptible to extreme /adverse climatic conditions, e.g., temperature inversions, flooding, severe winds, which could cause the project to present environmental problems?	Flooding is an increasing risk and locations of new services should take this into consideration Average temperatures are increasing and the risk of over-heating in hospitals/care homes etc should be considered

Department of Health & Social Care

The Public Sector Equality Duty – Acquisition of Bridgewater Community Healthcare NHS Foundation Trust by Warrington and Halton Teaching Hospitals NHS Foundation Trust

1. Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is proposing to acquire Bridgewater Community Healthcare NHS Foundation Trust (BCH) on the 1st of April 2026 to create North Cheshire and Mersey NHS Foundation Trust.

The transaction will create a single organisation that will provide acute and community services to the population of Warrington and Halton, strengthening the delivery of our vision of world class expertise and local care delivered in, and tailored to, the communities we serve.

The increased scale of the enlarged Trust and the removal of cross-organisational barriers will allow us to go further in redesigning services, reducing unwarranted variation, improving quality and productivity, and sharpening our focus on prevention and population health.

1.1 Will there be immediate changes to services or will these be evolutionary?

Most service changes will be evolutionary rather than immediate. We have developed plans for seven priority integration opportunities.

These are in: Frailty response, Heart Failure, Chronic Pain services, Infant Feeding, Movement disorders / Parkinson's disease, Female urinary incontinence, and End of Life Care.

1.2 Where post acquisition changes to the new trust do occur will the new organisation carry out engagement in any service improvements and ensure good outcomes for seldom heard service users / people protected under the Equality Act 2010? This will include equality feedback from service users and their carers.

In order to ensure that we have formal and robust mechanisms in place for consulting with patients, we have established the Patient and Public Reference Group (PPRG).

The PPRG will serve as a key conduit for patient and public feedback, to inform the integration process and strategic decisions. The PPRG will actively engage with people protected under

the Equality Act 2010 to ensure their voices are heard. The key functions of the PPRG include:

- The PPRG will support the embedding of strong communication and engagement between communities and the new Trust leadership.

- The PPRG will support wider engagement with the communities of Halton, Warrington- and other areas covered by the Trust, including community dental services in Greater Manchester, to support development of and feedback on proposals to integrate hospital and community services and develop or change patient facing services.

- The PPRG will represent and provide insight into the communication and engagement needs of the wider communities to ensure information is accessible.

- The PPRG will recommend and deliver initiatives to facilitate effective engagement and involvement between members, patients and the wider public to enable stakeholders' views to be heard.

We are engaging with patients as part of the development of our plans. Because the current integration plans do not involve any specific changes to services that require formal public consultation, our engagement to date has focused on raising awareness, providing reassurance and responding to any questions or concerns.

If any future proposals involve changes to services, we are fully committed to undertaking appropriate engagement and, where required, formal public consultation with patients, carers, partners and wider stakeholders.

This ensures that future service redesign is shaped by the people who use our services, and that patient voice continues to guide our decision-making at every stage.

1.3 Has any proposed service change affecting the location of service delivery involved appropriate public engagement and consultation?

Formal consultation has not yet been required as significant changes to the location of service delivery are not yet planned.

While our aim is to provide better, more joined-up and sustainable services for our patients and communities, our plans do not involve any specific service change proposals that would require formal consultation at this stage.

As we develop our integration plans, we will be talking with our staff, patients and local communities to explain our plans so they can help shape the improvements made possible by our new shared future and undertake consultation where appropriate.

1.4 Have employees of the new organisation shared an equal responsibility for ensuring that their day to day working practices and relationships with colleagues and service users reflect the trusts' commitment to non-discrimination? Will this change post acquisition?

Both trusts are committed to non-discrimination and ensuring equality, diversity and inclusion (EDI). The transaction offers an opportunity to redouble our commitment to being an anti-racist organisation and embedding an inclusive culture to improve patient care and staff experience.

1.5 Will the new organisation have mandatory training requirements for E&D training for existing and new starters?

Both trusts have a common employee equality, diversity and inclusion policy which is designed to ensure that all staff and users of the trusts' services are valued as unique individuals and treated with dignity and respect in compliance with the Equality Act 2010. The policy demonstrates the trusts' commitment to eliminating discrimination, encouraging and valuing diversity and inclusion.

Completion of mandatory equality, diversity, inclusion and human rights training will continue to be required for existing staff and new starters. Existing staff are required to complete this training every three years, and new starters are required to complete their training within the first week of starting in their role.

1.6 What plans are there to reduce inequalities amongst staff? Can we give any specific examples?

Part of the workforce integration plans have been to set out a clear commitment to reducing inequalities amongst staff as part of the integration programme. Due regard has been applied to all protected groups, with a scoring criterion used to assess workforce and culture impact, and this analysis will continue through individual EHIAs for workforce and service delivery programmes.

The Trust's approach includes ensuring equitable employment practices, transparent decision-making in integration arrangements (such as TUPE) and careful consideration of staff benefits, culture and practice where policies may differ. There is a strong focus on promoting equality of opportunity and removing disadvantages between those who share a protected characteristic and those who do not, by identifying potential impacts and taking steps to meet the needs of diverse staff groups, including the significant international workforce (WHH) and geographically spread services (BCH).

The development of a Joint Culture Plan is centred on making staff voice integral to organisational change. The plan is designed to eliminate disparities between staff arising from protected characteristics and to ensure that all actions are guided by the principle of "delivering the basics brilliantly". The aim is for every member of staff to experience "a good day at work", with an inclusive culture where everyone feels valued, heard and supported.

A key part of the Trust's integration is the alignment of the Occupational Health and Wellbeing services across both organisations to ensure all staff have equal access to a high-quality, SEQOHS-accredited service. This includes the proposal to extend in-house health surveillance, such as regular screening for occupational risks and health promotion, through the provision of information, resources and skills to empower all staff to make positive decisions about their own health. The new proposed model ensures timely access to physiotherapy and counselling services, through both management and self-referrals. The services have clear KPIs for referral times, ensuring support for both physical and mental health needs is available to all staff.

Additionally, the plan involves collaboration between existing wellbeing teams to deliver a comprehensive wellbeing strategy, which will ensure that no staff group is disadvantaged during the transition. Consideration has been applied to deliver actions from the NHS Health

and Wellbeing Framework[1], the Darzi Report[2] on staff wellbeing and the prevention of sickness, as well as the Growing Occupational Health and Wellbeing Strategy[3], improving and sustaining the health and wellbeing of our NHS people. These measures directly target health inequalities by providing consistent, proactive support and monitoring for the entire workforce.

Through the completion of the equality and health inequalities impact assessment (EHIA), it has highlighted the importance of fostering good relations between staff with different protected characteristics, encouraging participation where it is disproportionately low and supporting the development of staff networks and engagement activities.

Ongoing engagement and consultation with staff, trade unions and representative groups are embedded to understand and address the needs of all staff, including those with intersectional identities (e.g., gender, ethnicity, disability, neurodiversity).

Monitoring and review of the impact of integration on staff will be maintained through regular updates to the EHIA, use of workforce demographic data and annual equality reporting.

Practices are aligned with national EDI standards and improvement plans and all actions are quality assured and signed off by senior leadership. These measures directly target health inequalities by providing consistent, proactive support and monitoring for the entire workforce.

Engagement and involvement

2. Will patients be adversely affected by the transaction, for example through a reduction in patient facing clinical staffing or a reduction in the scope or quality of clinical services as a result of the merger, or will patients see an improvement, due to improved staffing continuity, increased provision, and a wider range of services?

We expect patients to see a benefit from the transaction. These benefits include:

- Opportunities to improve standardised models of care – reducing unwarranted variation in pathways and improving clinical outcomes and patient experience.
- Better access to high-quality care – we can integrate care where appropriate, building stronger multi-disciplinary teams and providing care in optimal care settings. Operating with single waiting lists will allow us to use our resources more efficiently to treat patients faster.
- Better patient experience – strengthened resilience in service provision will help us deliver high-quality care to more patients more frequently.

Our staff will benefit from:

- A wider range of career opportunities in a trust which covers a greater range of clinical specialities across both acute and community settings, as well as corporate and non-clinical functions.
- A wider range of education, training and development programmes.
- An organisation that has the capacity and resilience to respond to changes in demand, sustaining services for patients while supporting staff health and well-being.

[1] NHS England » NHS health and wellbeing framework
[2] Independent Investigation of the National Health Service in England
[3] NHS England » Growing occupational health and wellbeing together strategy

This will improve the quality of care for patients and patient experience as we should be able to better attract, retain, motivate and engage staff.

2.1 Has the trust set actions to ensure the delivery of a diversity and equality agenda for staff? Does it include engaging with staff, trade unions etc to support individual colleagues to discuss their own circumstances?

Yes, the Trust has set clear actions to ensure the delivery of a diversity and equality agenda for staff. The joint equality and health inequalities impact assessment (EHIA) process, approved by the Executive Team, provides a robust framework for managing equality analysis across both organisations, ensuring that equality considerations are embedded in all decision-making.

In September 2025, the Trust launched "Staff Networks in Common" to support joint engagement, consultation exercises and to provide a platform for staff to share their views and receive responses. These networks are designed to facilitate open dialogue and ensure that staff voices are heard and acted upon.

Equality, Diversity and Inclusion (EDI) functions in both organisations are working closely together to respond to staff feedback, drive efficiency and enact change through cultural awareness initiatives, statutory reporting and the development of joint plans. There are also plans to finalise a new interim 12-month EDI strategy with updated specific duties.

This interim approach is intended to ensure that, following the transaction date, meaningful engagement can be completed as one organisation, supporting the delivery of the diversity and equality agenda.

The Trust's approach includes active engagement with staff, trade unions and other representative groups to support individual colleagues in discussing their own circumstances and needs. Practices are being aligned with the National EDI Improvement Plan, the workforce standards outlined in the 10-Year Health Plan for England and the new Medium Term Planning Guidance, ensuring that the Trust's agenda is both locally responsive and nationally compliant.

2.2 Has the trust considered how staff and patients with protected characteristics might be affected by this transaction? What was the conclusion?

Yes. The Trust has carefully considered how staff and patients with protected characteristics might be affected by the integration.

The equality and health inequalities impact assessment (EHIA) reviews each protected characteristic in detail, drawing on local and national data, workforce reports and engagement activities. It identifies both potential positive impacts, such as opportunities for improved access to integrated services, greater inclusion and opportunities for targeted support and possible risks including digital exclusion, centralisation of services or unmet needs for smaller or less visible groups.

For staff, the EHIA specifically considers how the integration may impact those with protected characteristics, such as age, disability, race, religion or belief, sex, gender identity, sexual orientation and pregnancy or maternity. It highlights opportunities for greater inclusion, improved access to support services (for example, chaplaincy, menopause support and staff networks) and enhanced career development through a larger, more resilient workforce.

At the same time, it acknowledges possible risks, including digital exclusion, changes to working patterns or the loss of tailored support for smaller staff groups.

The Trust recognises that ongoing engagement, monitoring and further detailed assessments are essential to ensure that all staff and patients with protected characteristics are supported throughout the integration.

While the integration is expected to have a positive effect overall, the EHIA highlights that continuous review, both at the programme level and within individual clinical services, is necessary to identify and address any negative impacts as they arise.

This approach ensures that the needs of all groups are considered and that any issues affecting staff or patients are promptly mitigated as the integration progresses.

3. Religion or belief

3.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment (EHIA) demonstrates that the local population's religious and belief profile has been thoroughly considered. In Warrington and Halton, approximately 65% identify as Christian, 27% as non-religious, with smaller but notable Muslim, Hindu and other faith communities.

The integration aims to widen the offer of services and facilities that respect religious and cultural practices, such as spaces for prayer and spiritual support. Notably, Bridgewater Community Healthcare (BCH) does not currently have a Chaplaincy and Spiritual Care service, so integration is expected to have a positive impact by extending these services to BCH staff and patients.

The EHIA also recommends centralised policies and estate planning to ensure religious spaces are available and accessible across sites. Importantly, ongoing engagement and consultation with staff, patients and communities will be undertaken and completed in line with individual clinical transformation workstreams, including a separate EHIA for the Estates group to ensure chaplaincy and spiritual care needs are met as services develop.

3.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage. Patients and staff will continue to have access to existing menus and religious facilities at our sites.

As plans develop, we will consult as appropriate with patients, the public and stakeholders.

3.3 Will the new trust have an Equality duty in place?

Yes. The Trust will be completing a light touch review of its specific equality duties in 2025/26 to support implementation in 2026/27. A more thorough engagement exercise with staff will be completed in 2026/27 and this will support the development of a three-year equality, diversity and inclusion plan. In addition, statutory reporting will be in place in line with the general and specific duties of the Public Sector Equality Duty.

For the workforce, the plan for 2026/27 is intended to focus on 'Belonging in Our Organisation' with the following focus:

- Delivering the national EDI improvement plan at a local level for our workforce and communities.
- Workforce safety and wellbeing, including a focus on bullying, discrimination, harassment and victimisation.
- Zero tolerance and anti-racism.
- Allyship and staff voice.

In addition, collaboration has already commenced on statutory reporting for equality, diversity and inclusion within 2025/26, ensuring alignment and efficiency in planning.

3.4 If there will be changes to services, then impacts on religion or people's beliefs need to be shown i.e has there been changes to way religious beliefs are catered for, such as chapels, prayer rooms, trust chaplaincy services and similar services for other religions. Any changes to religious ceremonies upon death.

N/A – there is no significant change to service provision planned and these changes will not have any impact on the religious beliefs including places of worship provided for staff on trust premises.

3.5 Will an Equality Impact Assessment (EIA) be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

Yes. An equality and health inequalities impact assessment (EHIA) has already been undertaken for the integration, and the process is embedded as an ongoing requirement throughout the programme.

The EHIA sets out that, for all protected characteristics, there is a clear expectation of full engagement and consultation with patients, the public and staff in both organisations. This is not a one-off exercise, the EHIA is a live document, to be reviewed and updated as consultation takes place and as the programme evolves.

The EHIA specifically recommends that further, more detailed EHIAs are completed for individual workstreams and for any specific changes proposed to services or corporate functions. To support service leads in completing this, a bespoke e-learning package has been developed focused on the role of equality analysis and public consultation in service redesign and workforce transformation.

This ensures that equality impacts are considered at every stage of clinical transformation and service redesign. Organisational data, including workforce demographics and service user profiles, is used to evidence current access and to identify gaps or risks. The EHIA also outlines that monitoring and review are planned post-implementation, with responsibilities assigned to programme leads and regular reporting to governance groups.

The Trust's approach is to ensure that equality analysis, engagement and consultation are integral to all stages of service redesign and transformation. This is to make certain that any planned changes do not have a negative impact on people with protected characteristics and that any issues are identified and addressed through ongoing review and targeted action as the programme progresses.

3.6 Has there been impacts/mitigation on staff religious beliefs?

Yes. The assessment highlights the need for broader, consistent training in religious and spiritual cultural sensitivities for staff, promoting respectful care mindful of religious practices and beliefs. The integration is expected to positively impact staff by extending chaplaincy and spiritual care services to BCH and ongoing engagement and consultation are recommended to further understand and mitigate impacts.

3.7 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Yes, the integration programme has an equality and health inequalities impact assessment (EHIA) process in place. This has been signed off by the joint executive team to ensure that equality analysis is completed as part of the programme.

An EHIA will be completed and continually reviewed for the TUPE consultation as part of the Organisational Change Framework developed in partnership with staff side representatives.

The EHIA will also form part of the consultation paperwork shared with Trade Union representatives and staff.

3.8 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Both organisations have appropriate equality, diversity and inclusion mandatory training in place. In addition, all managers are required to undertake the recruitment and selection training before commencing a diverse interview panel. The training covers how to eliminate discrimination from the recruitment process for all protected groups and embed a fair and inclusive recruitment process.

The commitment of both trusts for the enlarged organisation is that its **l**eaders are visible, demonstrate behaviours that are consistent with the trust values and that they inspire others to develop with diverse representation at all levels of the trust. Examples of existing practices which will continue in the enlarged organisation to support equality, diversity and inclusion are:

- the embedding of an inclusive end to end recruitment process, including debiasing job adverts and role criteria, using values-based approaches, and ensuring inclusion champions will continue to be an integral part of our policies and processes including developmental feedback when unsuccessful.
- all recruiting managers continue to be required to undertake the recruitment and selection training, and all interview panels are required to be diverse. This is aimed at improving our recruitment practices and the diversity of our workforce.
- through structural processes and behavioural changes, the commitment to being an anti-racist organisation will continue.
- improvements and embedding of a positive and disability confident working environment at all levels for all staff and candidates will continue.

4. Disability (including learning disability)

4.1 Has the local population been considered under this characteristic?

Yes. The EHIA explicitly considers disability as a protected characteristic and uses local population data to inform its analysis. Census 2021 data shows that 22.1% of Halton residents (approximately 28,382 people) and 17.7% of Warrington residents (around 37,266 people) identify as disabled. This includes a wide range of conditions such as physical, sensory, psychosocial, neurodiversity, hidden disabilities and mental health conditions. The assessment recognises that these groups experience significant health inequalities, including lower life expectancy, deprivation and barriers to accessing services.

The integration proposal aims to address these issues through positive actions, such as extending SEQOHS-accredited occupational health services for staff, embedding reasonable adjustment processes (including the NHS Digital Reasonable Adjustment Flag) and improving accessible communication formats.

Risks such as digital exclusion, where disabled staff may struggle to access consultation meetings or resources, are acknowledged and mitigations include manager briefings, alternative formats and one-to-one support to ensure participation.

The EHIA recognises a commitment to a person-centred approach and continuous review throughout the TUPE and organisational change process, ensuring that disabled staff and service users are fully supported and that any emerging barriers are promptly addressed.

Additional population benefits include potential positive impacts through provision of care close to home provided in extended hours, supporting those impacted by barriers to access, including travel or caring responsibilities and potential positive impacts on partnership working with local disabled groups and communities through collaborative approach, including embedding legal requirements re co-design.

4.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage. As plans develop, we will consult as appropriate with patients, the public and stakeholders.

4.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3

4.4 Will an EIA be undertaken to ensure that planned changes will not have a negative impact?

Yes. Please see answer to section 3.5

4.5 Will service user engagement and consultation be undertaken as part of service redesign process and plans?

In order to ensure that we have formal and robust mechanisms in place for consulting with patients, we have established the Patient and Public Reference Group (PPRG).

The PPRG will serve as a key conduit for patient and public feedback, to inform the integration process and strategic decisions. The key functions of the PPRG include:

- The PPRG will support the embedding of strong communication and engagement between communities and the new Trust leadership.

- The PPRG will support wider engagement with the communities of Halton, Warrington- and other areas covered by the Trust, including community dental services in Greater Manchester, to support development of and feedback on proposals to integrate hospital and community services and develop or change patient facing services.

- The PPRG will represent and provide insight into the communication and engagement needs of the wider communities to ensure information is accessible.

- The PPRG will recommend and deliver initiatives to facilitate effective engagement and involvement between members, patients and the wider public to enable stakeholders' views to be heard.

We are engaging with patients as part of the development of our plans. Because the current Integration plans do not involve any specific changes to services that require formal public consultation, our engagement to date has focused on raising awareness, providing reassurance and responding to any questions or concerns.

If any future proposals involve changes to services, we are fully committed to undertaking appropriate engagement and, where required, formal public consultation with patients, carers, partners and wider stakeholders.

This ensures that future service redesign is shaped by the people who use our services, and that patient voice continues to guide our decision-making at every stage.

4.6 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Please see answer to section 3.7.

4.7 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training.

Please see answer to section 3.8.

5. Race

5.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment uses Census 2021 data to evidence the ethnic makeup of the local population: ethnic minority populations are about 6.5% in Warrington and 3.5% in Halton. The partnership is recognised as an opportunity to enhance access for diverse racial communities by consolidating resources and providing more culturally sensitive care.

The EHIA highlights that centralised services could support easier access to translators, collaboration with cultural competency training for staff and targeted outreach in higher-need areas. However, it also identifies risks, such as potential disadvantage if services are centralised away from minority communities or if cultural competency is not prioritised, which could impact both patients and staff (noting WHH has a significantly higher representation of different nationalities compared to BCH).

Ongoing engagement and consultation will be undertaken and completed alongside individual clinical transformation, with a full review of services and benefits to support identification of positive impacts and a separate EHIA for the clinical and operational working group to ensure the needs of all racial and ethnic groups are understood and reflected in service changes.

5.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage.

As plans develop, we will consult as appropriate with patients, the public and stakeholders.

5.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3

5.4 Has the trust developed a detailed profile of the trust's population regarding race? Outline if there are further plans to integrate/align services post transaction that affect

people of different race. Will an EIA be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

Both trusts have a detailed profile showing proportions of employees by ethnic groups. These data are held on the Electronic Staff Record (ESR).

There are plans to integrate corporate services and some clinical services post transfer. Detailed EIA will be completed at the appropriate time, alongside a process of engagement and consultation with staff and service users.

5.5 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Please see answer to section 3.7.

5.6 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

6. Age

6.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment considers all age groups, including children, young adults, older people and the elderly. It highlights positive impacts such as improved access to care close to home, potentially provided in extended hours, supporting those impacted by barriers to access (e.g., travel, ill-health, disability, caring or employment responsibilities) and high-quality integrated services for older and frail elderly people.

The assessment also addresses the needs of children and young people, including SEND and complex illness, transition to adult services, neonatal and infant mortality, looked after children, care leavers and young carers.

Risks include possible negative impacts from relocation or centralisation of services outside local communities and digital exclusion, particularly for older people or those in deprived areas. The EHIA also notes the importance of supporting carers and addressing intersectionality in marginalised communities.

Ongoing engagement and consultation will be undertaken and completed in line with each clinical transformation workstream, with specific EHIAs ensuring that the needs of all age groups are considered and addressed as services are redesigned.

6.2 Is there any immediate change to services?

There are limited immediate changes to services for patients and there are no plans to change the core location of service provision at this stage.

As plans develop, we will consult as appropriate with patients, the public and stakeholders.

6.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3

6.4 Has the trust developed a detailed profile of the trust's population regard to age? If there are further plans to integrate/align services post transaction that affect people of different ages, Will an EIA be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

Both trusts have a detailed profile showing proportions of employees by age groups in five-year segments. These data are held on the Electronic Staff Record (ESR).

There are plans to integrate corporate services and some clinical services post transfer. Detailed EIA will be completed at the appropriate time, alongside a process of engagement and consultation with staff and service users.

6.5 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Please see answer to section 3.7.

6.6 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

7. Gender reassignment (including transgender)

7.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment notes that 0.4% of Halton and Warrington residents identify as a different gender to that assigned at birth, including trans men and women, non-binary and other gender identities. It identifies potential positive impacts through collaborative partnerships, improved access and inclusive staff communications, such as supporting patients and staff to self-identify gender and pronouns and have these consistently recorded and used.

The EHIA also highlights the potential for the Trust to influence outcomes for trans people through partnerships and engagement and to further develop a culture of civility and respect via staff networks and training. Risks include failure to engage with this small and often hidden group, leading to continued inequalities and the need to address intersectionality (e.g., racially minoritised trans people).

Both organisations are Navajo Charter Mark holders, demonstrating commitment to LGBTQ+ inclusion. Ongoing engagement and consultation will be undertaken and completed as part of individual clinical transformation workstreams, with specific EHIAs ensuring that the needs and experiences of transgender and non-binary people are identified and addressed.

7.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage.

As plans develop, we will consult as appropriate with patients, the public and stakeholders.

7.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3.

7.4 Has the trust developed a detailed profile of the trust's population regarding gender reassignment? If there are further plans to integrate/align services post transaction that affect people of gender reassignment Will an EIA be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

ESR currently does not have a field to record gender reassignment. We will undertake work to align processes for staff reassigning, including support available for staff members and their teams.

7.5 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Please see answer to section 3.7.

7.6 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

8. Sex

8.1 Has/ the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment highlights that both organisations have a higher proportion of female workers (78% WHH, 89% BCH). The integration could help identify and address gender-specific health needs by allowing more consistent data-sharing and resources and support menopause-related services for women, especially given the increased age of the workforce.

The EHIA notes that existing services for male and female patients may continue at the same levels, enhanced by opportunities to explore community and acute services through clinical transformation post transaction. It is also noted that sex should be considered alongside other protected characteristics, such as age and disability, particularly in relation to menopause and reasonable adjustments.

Therefore, alignment of staff guidance and policies will ensure streamlined support to all staff. Ongoing engagement and consultation will be undertaken and completed in line with individual clinical transformation and workforce programmes, with specific EHIAs ensuring that the needs of all sexes are considered and addressed.

8.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage.

As plans develop, we will consult as appropriate with patients, the public and stakeholders.

8.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.8

8.4 If there will be changes to services, then impacts on sex need to be shown.

N/A

8.5 Has the trust developed a detailed profile of the trust's population regarding sex? If there are further plans to integrate/align services post transaction that affect people of different sexes, Will an EIA be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

Both trusts have a detailed profile showing proportions of employees by gender. These data are held on the Electronic Staff Record (ESR). An EIA will be undertaken for any changes that may have an impact.

8.6 Has there also been an assessment of impacts/mitigation on staff? Will the trust have an HR equality and diversity framework in place?

Please see answer to section 3.7.

8.7 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

9. Sexual Orientation

9.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment notes that neither organisation currently provides specific LGB-associated services, which is a known gap, especially in Warrington (Halton residents can access services in the Liverpool City Region). Both Trusts hold the Navajo Charter Mark, demonstrating a commitment to LGBTQ+ inclusion.

The EHIA highlights the potential for collaboration and partnerships, including relevant staff networks, to further develop and embed a culture of civility and respect and to support and develop staff awareness and understanding through engagement, communications and training delivered in partnership with LGB staff.

Risks include increased vulnerability to stigma if LGBTQ+ needs are not explicitly addressed, as highlighted in the LGBT Foundation's 'Hidden Figures' report. Actions are in place aligned to the Navajo Charter Mark to ensure equitable access and inclusive policies and practices.

Ongoing engagement with relevant groups and consultation will be undertaken and completed in line with individual clinical transformation workstreams, with specific EHIAs ensuring that the needs of people of all sexual orientations are identified and addressed.

9.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage. As plans develop, we will consult as appropriate with patients, the public and stakeholders.

9.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3.

9.4 If there will be changes to services, then impacts on sexual orientation need to be shown.

N/A

9.5 Has the trust developed a detailed profile of the trust's population regarding sexual orientation? If there are further plans to integrate/align services post transaction that affect people of different sexual orientation, will an EIA be undertaken to ensure that planned changes will not have a negative impact? Will service user engagement and consultation be undertaken as part of service redesign process and plans?

Both trusts have a detailed profile showing proportions of employees' sexual orientation. These data are held on the Electronic Staff Record (ESR).

The trust records sexual orientation data on ESR. Both organisations have active LGBT+ staff lead equality groups as well as policies which support staff.

A full EIA will be completed for any future planned service change, ensuring that any changes do not have a negative impact on people because of their sexual orientation. The Patient Public Reference Group will actively engage individuals of all sexual orientations to ensure all voices are heard as we develop service improvements.

9.6 Has there also been an assessment of impacts/mitigation on staff? Will the trust have HR equality and diversity framework in place?

Please see answer to section 3.7.

9.7 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

10. <u>Pregnancy and maternity</u>

10.1 Has the local population been considered under this characteristic?

Yes. The equality and health inequalities impact assessment considers borough inequalities in teenage conception rates, smoking at delivery, breastfeeding rates and maternal/neonatal deaths, especially in racially minoritised communities.

It references Marmot's findings on the link between good maternal health and school readiness and the importance of good employment in relation to maternal and paternal pay and support. The EHIA also notes higher rates of maternal and neonatal death in racially minoritised communities, including Gypsy, Roma and Traveller (GRT) groups and links between neonatal death and deprivation, mental health, obesity and multiple disadvantages.

The integration offers opportunities to improve maternal health and outcomes through collaboration and partnership, including with wider health and public health partners.

Risks include missing intersectional impacts, particularly for racially minoritised and trans communities and barriers such as low literacy, language, digital exclusion and discrimination.

Ongoing engagement and consultation will be undertaken and completed in line with individual clinical transformation workstreams, with specific EHIAs ensuring that the needs of those who are pregnant or on maternity are identified and addressed.

10.2 Is there any immediate change to services?

There are no immediate changes to services for patients and there are no plans to change the core location of service provision at this stage. As plans develop, we will consult as appropriate with patients, the public and stakeholders.

10.3 Will the new trust have an Equality duty in place?

Please see answer to section 3.3.

10.4 If there will be changes to services, then impacts on pregnancy and maternity need to be shown.

N/A

10.5 Has there also been an assessment of impacts/mitigation on staff? Will the trust have HR equality and diversity framework in place?

Please see answer to section 3.7.

10.6 Will managers undertake appropriate Equality and Diversity training and in addition may have been trained in selection / interview training?

Please see answer to section 3.8.

11. <u>Conclusion</u>

A concluding paragraph is required on whether the transaction will have any negative impact on protected groups under the Act and a summary of any mitigating actions that will be put in place.

Based on the equality and health inequalities impact assessment undertaken, the transaction is not expected to have any negative impact on individuals or groups with protected characteristics under the Equality Act 2010.

Where potential risks have been identified, such as digital exclusion, the needs of smaller or seldom-heard groups, and the possibility of inconsistency in support during the transition, these are being proactively managed through a comprehensive programme of mitigation.

This includes:

- Ongoing engagement and consultation with staff, patients and communities.
- The completion of detailed EHIAs for all clinical and organisational changes.
- The alignment of policies, training and support services across the new organisation.
- Strengthened commitments to inclusive practice, anti-discrimination and equitable access.

These measures will ensure that equality considerations remain embedded throughout implementation and that any emerging impacts are identified early and addressed effectively, supporting positive outcomes for all protected groups.

Department of Health & Social Care

The family test - acquisition of Bridgewater Community Healthcare NHS Foundation Trust by Warrington and Halton Teaching Hospitals NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust is proposing to acquire Bridgewater Community Healthcare NHS Foundation Trust on the 1st of April 2026.

What kind of impact might the policy have on family formation?

Consider how the transaction might be supporting or constraining couples in making the right choices for them and their families, for example access / availability of maternity or family planning services.

We do not expect there to be a material impact on family formation. The transaction will not directly impact the scale or location of maternity or other children services. However, we anticipate the transaction to have a positive impact on families and their experience of our services through the reduction of boundaries across care sectors, reducing duplication, improving and streamlining pathways. As we seek to improve services post transaction we will also seek to improve access to all the services we provide in line with the key principle of our integration, home first, then community and only hospital when necessary.

What kind of impact will the policy have on families going through key transitions such as becoming parents, getting married, fostering or adopting, bereavement, redundancy, new caring responsibilities or the onset of a long-term health condition?

Consider what particular transitions might be relevant to the transaction, the nature and scale of the potential impact, and whether any negative impacts can be mitigated in any way, for example becoming parents (e.g. in perinatal mental health), bereavement (supporting palliative care at or near home), new caring responsibilities (co-production of care packages) or the onset of long-term conditions (integration of care).

We do not expect there to be a material impact on families going through key transitions. We are not currently planning significant changes to the location of services. Our clinical strategy is underpinned by distinct priorities for each of our services, reflecting their unique service configurations, population demographics and relationships within local borough-based partnerships.

In combination, these priorities describe our approach to maintaining secondary care services for our populations, and to developing collaboration in local place-based

partnerships to prevent avoidable illness and hospital admission by providing people with the right care at the right time in the right place. Successful delivery of these priorities will strengthen services for patients in each of our local boroughs.

What impacts will the policy have on all family members' ability to play a full role in family life, including with respect to parenting and other caring responsibilities?

Factors for consideration include how the transaction might impact family members' ability to balance work and family life, the time families can spend together, and the competing demands of caring for elderly family members and children.

We do not expect there to be material impact on family members' ability to play a full role in family life as there are no material changes planned to the location of service provision. As we seek to improve services post transaction we will also seek to improve access to all the services we provide in line with the key principle of our integration, home first, then community and only hospital when necessary. Improving access to services and reducing "hand-offs" should support all family members to play a full role in family life.

How does the policy impact families before, during and after couple separation?

Consider how new policy might impact families at particular stages and look beyond intact families or households when thinking about impacts.

There is unlikely to be any direct impact, however integrated care and greater awareness across disciplines may help identify stressors and other potential health impacts.

We do not expect there to be material impact on families before, during or after couple separation. Bridgewater Community Healthcare NHS Foundation Trust provide community services, and the enlarged organisation intends to learn from their experience as we work to reduce barriers between secondary care and the community.

Greater awareness of community services as we look at vertical integration of services may help identify stressors and could support improvement in this area.

How does the policy impact those families most at risk of deterioration of relationship quality and breakdown?

Will the transaction have any potential direct or indirect impact on families most at risk and think about whether the transaction could support these families.

There is unlikely to be any direct impact, however improved mental and physical health may better equip families experiencing deterioration in their relationship. Improved support to carers is likely to, in some cases, reduce one of the stressors leading to the relationship deteriorating.

We do not expect the transaction to have a direct impact on families most at risk of deterioration of relationship quality and breakdown. There may be an indirect impact as the expected benefits of the transaction include benefits for patients, staff and our local population.

These include building on our existing roles as anchor institutions providing employment opportunities for local people, improving the quality of services delivered and focusing on reducing inequalities. These benefits may in some case reduce stressors.

Mitigating actions

Provide a summary of the proposed mitigations from any negative impact of the transaction on families.

We do not consider there to be a negative impact from the transaction on families.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/25/12/129**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	Claire Leather – Head of Finance – Improvement and Performance Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover,	

<table>
<tr><td></td><td>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</td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>ü</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>ü</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>ü</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td>The Trust has 63 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance. Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>2 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

• 58. Capital Programme – % delivered against plan
• 59. Better Practice Payment Code – % cumulative performance

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

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

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

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

	All 6 of these metrics were also highlighted in the escalated metrics section at the October 2025 Trust Board meeting, and none have been removed from reporting. **Financial Position** At Month 7 the Trust has recorded a deficit position of £24.6m (before deficit support) which is £9k better than plan. After deficit support funding the deficit reduces to £20m which is £6.1m worse than plan. This relates to not receiving deficit support funding between July and October 2025. The Trust is currently forecasting deficit of £41.6m compared to an original plan excluding deficit support funding of £28.7m. The main driver is the Level 3 CIP shortfall of £11.2m. The Trust underlying deficit is £43.8m.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £13.237m from NHSE for Q4 2025/26. 2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common. 3. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance, Sustainability and Performance Committee in Common	
	Agenda Ref.	FSPCiC/25/11/127 FSPCiC/25/11/129	
	Date of meeting	24/11/2025	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Changes to the capital contingency supported and approved.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/25/12/129

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**	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & NO SPC**
	Finance 58. Capital Programme ***(£3.7m - £13.7m target)*** 59. Better Payment Practice Code ***(54% - 95% target)***	**Quality** 1.Incidents 8. VTE Assessment ↓ 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 26. MUST nutritional assessment completion ↓ **Access & Performance** 27. A&E Wait Times - % patients waiting under 4 hours (including WUTC) 28. A&E Wait Times - % patients waiting under 4 hours (excluding WUTC) 29. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 31. Ambulance Handovers within 15 minutes 32. Ambulance Handovers within 30 minutes 33. Ambulance Handovers within 45 minutes 37. Referral to treatment Open Pathways 38. RTT - Number of patients waiting 52+ weeks 39. 28 Day Faster Cancer Diagnosis Standard 41. Cancer 62 Days First Treatment 51. Capped Theatre Utilisation **Workforce** 52. Supporting Attendance	**Quality** 22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ↓ **Workforce** 55. PDR compliance	**Finance** 61. Cost Improvement Programme (recurrent forecast) – % delivered against plan 63. Bank Reduction

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & NO SPC**
Inconsistently Passes/Fails the Target	**Access & Performance** 35. Patients seen in the Fracture Clinic within 72 hours ↓ 45. Elective Outpatient Activity ↓	**Quality** 2.Healthcare Acquired Infections (MRSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 9. Inpatient Falls & harm levels 10. Pressure Ulcers 23. Acute Kidney Injury 24. Maternity Postpartum Haemorrhage **Access & Performance** 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 PASSING TARGET & DECLINING PERFORMANCE	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
Consistently Passes the Target (based on the last 7 months)		**Quality** 16. Friends and Family (Inpatients & Day cases) **Access & Performance** 36. Diagnostic Waiting Times 6 Weeks 40. Cancer 31 Days First Treatment 49. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. **Finance** 60. Cost Improvement Programme – In year performance to date (£m)	**Workforce** 53. Turnover 54. Core/Mandatory Training	

	NO ASSURANCE SPC & DECLINING PERFORMANCE	NO ASSURANCE SPC & VARYING PERFORMANCE	NO ASSURANCE SPC & IMPROVING PERFORMANCE	NO ASSURANCE SPC & NO SPC
No SPC/Not Enough Datapoints/Not Applicable	**Quality** 13. Mortality ratio – HSMR 14. Mortality ratio - SHMI	**Quality** 3. Healthcare Acquired Infections (MSSA) 25. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 30. Average time in department ED 46. Super Stranded Patients 47. No Criteria to Reside (NCTR)	**Access & Performance** 34. Type 5 attendances 42. Reduction in Outpatient Follow Ups 48. % Patients discharged to their usual place of residence	**Quality** 12. Staffing - Average Fill Rate **Access & Performance** 43. Elective Recovery Activity (Grouped SPCs) 44. Elective Recovery Diagnostic Activity **Finance** 56. Trust Financial Position (£m) 57. Cash Balance (£m)

Areas requiring focus – areas are failing to meet the target and declining in performance

Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either:
- **indicators not meeting (failing) their set target**
- **declining nature of the performance**

Improved category from previous IPR
Declined category from previous IPR

* **New metric**

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

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

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

The Trust submitted a deficit plan of £28.7m before deficit support funding of £18.3m which reduces the deficit to £10.4m. There are several risks to the achievement of the planned deficit. The key risks are as follows:

- Delivery of the high-risk CIP (£5.1m) from the level 1 & 2 CIP plan.
- Delivery of the unidentified system wide savings (£11.2m) (level 3 CIP).
- Ability to mitigate risk in CIP plans has been reduced due to needing to use these schemes to offset the July Industrial Action and pay award costs in excess of plan due to additional funding not being received. Currently there is no mitigation for the financial impact of further industrial action.
- 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 also present a challenge to future sustainability if they are not addressed.

The Trust is currently forecasting deficit of £41.6m compared to an original plan excluding deficit support funding of £28.7m. The main driver is the shortfall of £11.2m relating to the additional 3% CIP target.

The Trust underlying deficit is £43.8m which is mainly driven by the additional 3% CIP target and non-recurrent benefits in 2025/26. This assumes that the 2025/26 non-recurrent CIPs are mitigated by the full year effect of the part year recurrent CIPs, which is a significant risk to the current plan.

Cash

The cash balance at the end of October is £11.9m of which £3.8m relates to capital creditors. Given the current cash position and the planned deficit for 2025/26 the Trust requires cash support in Q4 2025/26 of £13.237m. The Finance, Sustainability and Performance Committee in Common discussed and supported the Q4 application for cash support from NHSE. The Trust Board is asked to approve up to £13.237m cash support for Q4 2025/26. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (54% against a target of 95%, 88% cumulative position in March 2025). Cash days are at 11 days which is an improvement from last month (9 days) due to the quarterly receipt from NHSE for training and education. However, this is a reduction from April 2025 (18 days) due to the decreasing cash balance.

CIP

At 31 October 2025, the Trust has delivered a CIP of £10.8m which is £9k better than plan. However, it should be noted that £5.6m has been achieved from non-recurrent vacancies and central items.

Full year CIP plans of £21.5m have been identified against the £21.5m levels 1 and 2 CIP target. Of the £21.5m identified £6.8m is non recurrent, presenting an ongoing challenge to finance sustainability. There is a significant risk to the Trust if it cannot deliver recurrent CIP in 2025/26 therefore further work is required to identify recurrent CIP. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.

In addition to the £21.5m CIP, there is a £13.1m target relating to the additional 3% CIP. 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. Plans are still being developed to further support delivery of this CIP target, which will be led, coordinated and developed at system level and delivered at Trust level. A number of suggestions have been shared with C&M providers and these have been reviewed to determine any schemes that are not currently included within the Trust's CIP plans and have potential to support delivery. The Trust is committed to working with the ICS and other System Providers on this.

Capital Programme

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

The Trust capital spend for month 7 is £3.64m which is £10.1m below the plan of £13.74m. This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, and late confirmation of additional capital. The plan is expected to be fully delivered by year end.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 7		**100**
Proposed changes in month		
Emergency Request:-		
Maxillo Facial surgical drill	- 15	
ENT outpatient microscope	- 11	
A10 Refurbishment - Fixtures and fittings	- 11	
Sub Total		**- 37**
Requests supported at CPG 14/11/25		
IR addendum	- 23	
Soundproof booth addendum	- 5	
		- 28
Contingency as at end of month 7		**35**

The Trust Board is asked to:

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve cash support of up to £13.237m from NHSE for Q4 2025/26.
2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common.
3. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

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

		Latest				Previous		
	QUALITY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
1	Incidents	0	29	Oct-25		48	Sep-25	F
2	Healthcare Acquired Infections (MRSA)	0 (for 2025/26)	0	Oct-25		0	Sep-25	?
3	Healthcare Acquired Infections (MSSA)	no threshold set	3	Oct-25		4	Sep-25	No SPC
4	Healthcare Acquired Infections (CDI)	60 (for 2025/26)	0	Oct-25		9	Sep-25	?
5	Healthcare Acquired Infections (Ecoli)	79 (for 2025/26)	8	Oct-25		7	Sep-25	?
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2025/26)	4	Oct-25		1	Sep-25	?
7	Healthcare Acquired Infections (PA)	8 (for 2025/26)	0	Oct-25		2	Sep-25	?
8	VTE Assessment	95.00%	93.03%	Oct-25		94.42%	Sep-25	F
9	Inpatient Falls & harm levels	10% reduction from 2024/25	34	Oct-25		36	Sep-25	?
10	Pressure Ulcers	20% reduction from 2024/25	11	Oct-25		14	Sep-25	?
11	Medication Safety Reconciliation within 24 hours	80.00%	37.70%	Oct-25		36.47%	Sep-25	F
12	Staffing - Average Fill Rate	90.00%	N/A - grouped indicator	Oct-25	No SPC	90.43%	Sep-25	No SPC
13	Mortality ratio - HSMR	No target set	97.96	Oct-25	H	97.96	Sep-25	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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14	Mortality ratio - SHMI	No target set	105.56	Oct-25	H	105.56	Sep-25	No SPC
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Oct-25		1	Sep-25	F
16	Friends and Family (Inpatients & Day cases)	95.00%	95.97%	Oct-25		96.18%	Sep-25	P
17	Friends and Family (ED and UCC)	87.00%	69.91%	Oct-25		70.35%	Sep-25	F
18	Mixed Sex Accommodation Breaches (ITU)	0	10	Oct-25		11	Sep-25	F
19	Sepsis - % screening for all emergency patients.	90.00%	70.00%	Oct-25		74.00%	Sep-25	F
20	Sepsis - % screening for all inpatients	90.00%	75.00%	Oct-25		76.00%	Sep-25	F
21	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	52.00%	Oct-25		64.00%	Sep-25	F
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	75.00%	Oct-25	H	84.00%	Sep-25	F
23	Acute Kidney Injury	Less than previous month	130	Oct-25		155	Sep-25	?
24	Maternity Postpartum Haemorrhage	3.70%	6.60%	Oct-25		3.93%	Sep-25	?
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	34%	Oct-25		32%	Sep-25	No SPC
26	MUST nutritional assessment completion	above > 85%	73.52%	Oct-25		75%	Sep-25	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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- 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%	62.95%	Oct-25		65%	Sep-25	F
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	67.69%	Oct-25		69%	Sep-25	F
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	23.63%	Oct-25		22.4%	Sep-25	F
30	Average time in department ED	No Target	403	Oct-25		395	Sep-25	No SPC
31	Ambulance Handovers within 15 minutes	65%	41.83%	Oct-25		42.16%	Sep-25	F
32	Ambulance Handovers within 30 minutes	95%	74.45%	Oct-25		74.39%	Sep-25	F
33	Ambulance Handovers within 45 minutes	100%	83.78%	Oct-25		83.76%	Sep-25	F
34	Type 5 attendances	No Target set	2339	Oct-25	H	2242	Sep-25	No SPC
35	Patients seen in the Fracture Clinic within 72 hours	95%	0.00%	Oct-25	L	0%	Sep-25	?
36	Diagnostic Waiting Times 6 Weeks	95.00%	96.36%	Oct-25		96.20%	Sep-25	P
37	Referral to treatment Open Pathways	92.00%	60.08%	Oct-25		59.39%	Sep-25	F
38	Referral to treatment - Number of patients waiting 52+ weeks	0	1279	Oct-25		1293	Sep-25	F
39	28 Day Faster Cancer Diagnosis Standard	75%	74.30%	Sep-25		72.00%	Aug-25	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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40	Cancer 31 Day Wait	96%	98.90%	Sep-25		97.20%	Aug-25	P
41	Cancer 62 Day Wait	85%	77.30%	Sep-25		79.10%	Aug-25	F
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	81%	Oct-25	L	85%	Sep-25	No SPC
43	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
44	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
45	Elective Outpatient Activity	104%	87%	Oct-25	L	85%	Sep-25	?
46	Super Stranded Patients	Trajectory	125	Oct-25		156	Sep-25	No SPC
47	No Criteria to Reside (NCTR)	No Target set	162	Oct-25		207	Sep-25	No SPC
48	% Patients discharged to their usual place of residence	No Current Threshold	96%	Oct-25	H	96%	Sep-25	No SPC
49	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.99%	Oct-25		1.31%	Sep-25	P
50	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	2	Oct-25		3	Sep-25	?
51	Capped Theatre Utilisation	85%	79.30%	Oct-25		82%	Sep-25	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

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- Special Cause Variation of a improving nature.
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- Consistently fails the target

		Latest				Previous		Assurance
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
52	Supporting Attendance	5.00%	6.44%	Oct-25		6.03%	Sep-25	
53	Turnover	Below 13%	11.48%	Oct-25		11%	Sep-25	
54	Core/Mandatory Training	85.00%	90.80%	Oct-25		90.40%	Sep-25	
55	PDR compliance	85.00%	82.16%	Oct-25		81.76%	Sep-25	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

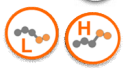
Key:



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



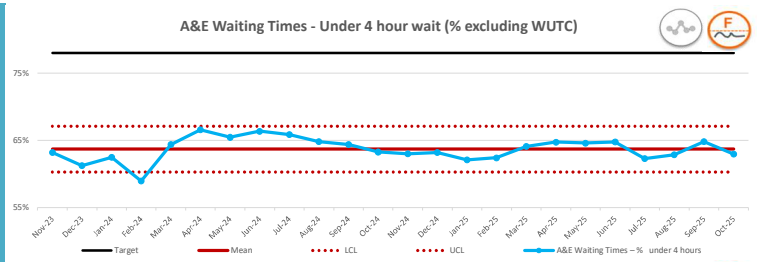
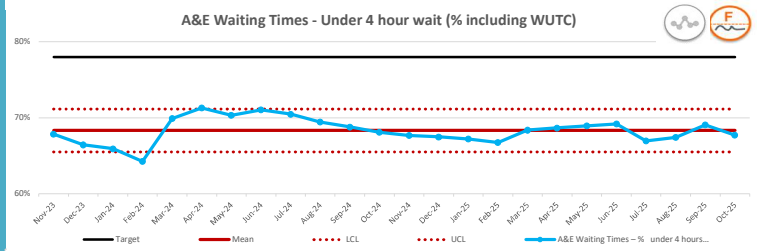
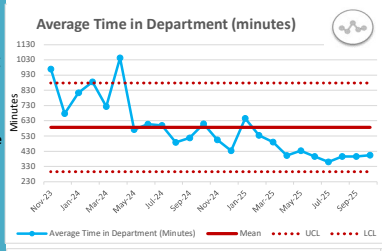
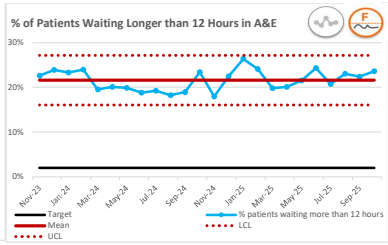
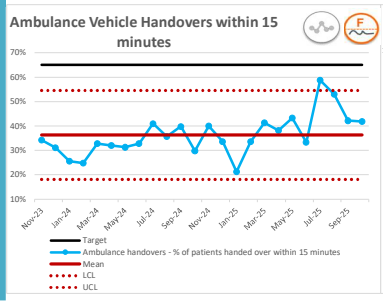
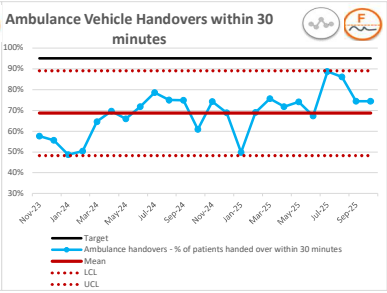
Consistently fails the target

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
56	Trust Financial Position (£m)	-£2.54	-£2.54	Oct-25	No SPC	-£2.67	Sep-25	No SPC
57	Cash Balance (£m)	£3.38	£11.93	Oct-25	No SPC	£9.69	Sep-25	No SPC
58	Capital Programme (£m)	£13.74	£3.66	Oct-25	L	£2.44	Sep-25	F
59	Better Payment Practice Code	>95%	63%	Oct-25	L	61%	Sep-25	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Oct-25		100%	Sep-25	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	48%	Oct-25	No SPC	45%	Sep-25	F
62	Agency Reduction (£m)	£1.69	£1.56	Oct-25	No SPC	£1.23	Sep-25	?
63	Bank Reduction (£m)	£15.85	£18.11	Oct-25	No SPC	£15.58	Sep-25	F

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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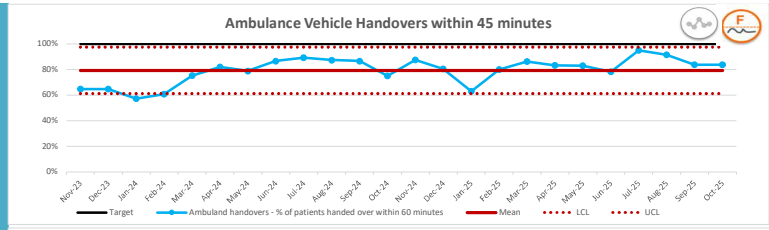
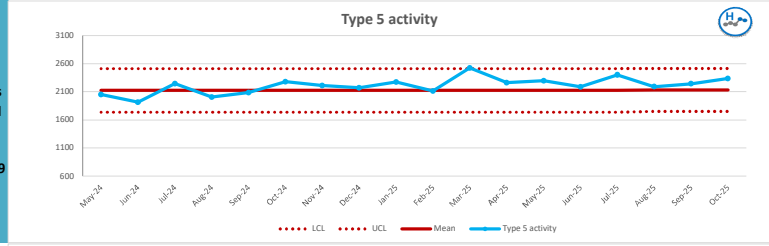
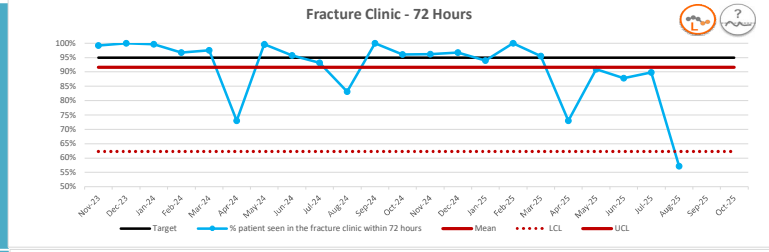
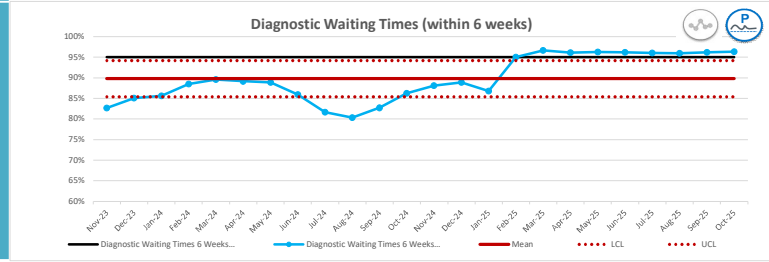
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC)	**The Trust achieved 62.95% 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.** **• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance** **• A review of the ED staffing model to realign rota's with demand using the ECIST methodology has been completed. The new rota template is set to start 1st January 20026**
28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 78%	**The Trust achieved 67.69% excluding Widnes UTC in month.** **The target is set at 78%, which is the national aspiration for 2025/26**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**		
29. Average time in department ED No Target	**23.63% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 403 minutes.**		**Assurance: No Target set** **Variation: Common cause (normal) variation**	**12 hour performance continues to be challenged. Key themes for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED. Non admmitted breaches have been improving supported by the ED improvement group**	**The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 2024/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 2025/26 has been relaunched to support improvement** **A reduction in non admitted breaches has been realised however admitted breaches continue to be a pressure**
30. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less			**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**		
31. Ambulance Vehicle Handovers within 15 minutes Target: 65%	**In month the Trust achieved:** **- 41.8% Ambulance Handovers within 15 minutes (65% target)**		**(15) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**		
32. Ambulance Vehicle Handovers within 30 minutes Target: 95%	**- 74.5% Ambulance Handovers within 30**		**(30) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**	**The Trust continues to work with NWAS to support improving this metric. A QA project has been initiated to support improving this metric, areas of concern are mainly out of hours.** **Please note that ambulance handover metrics are now measured to the point of vehicle handover, rather than patient handover.**	

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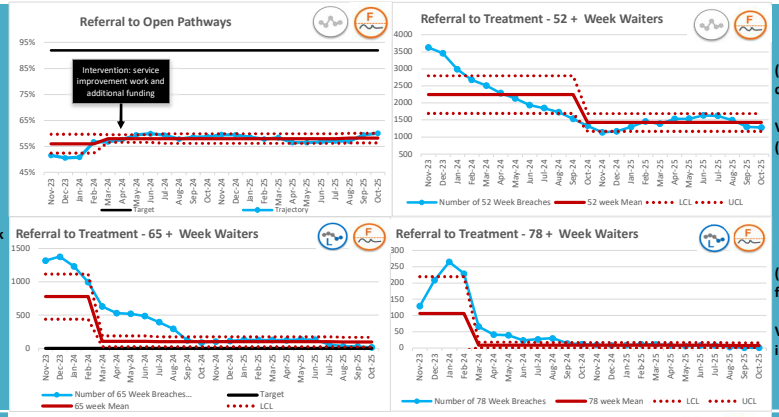
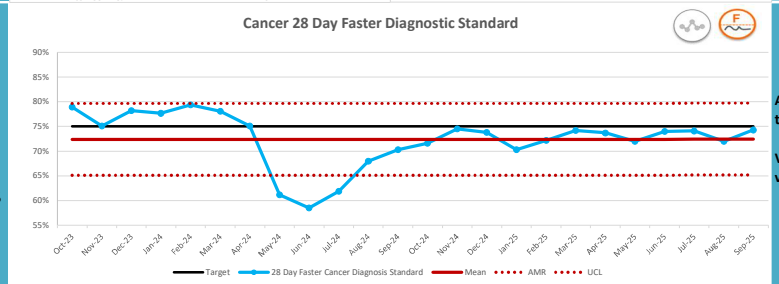
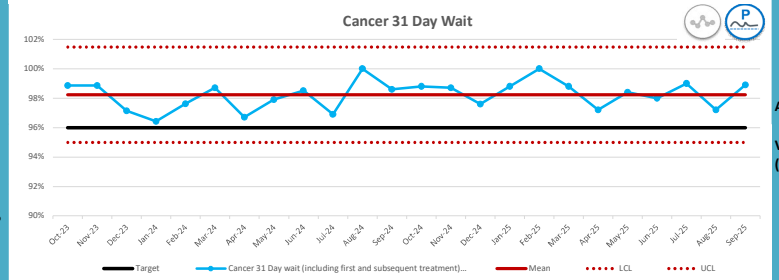
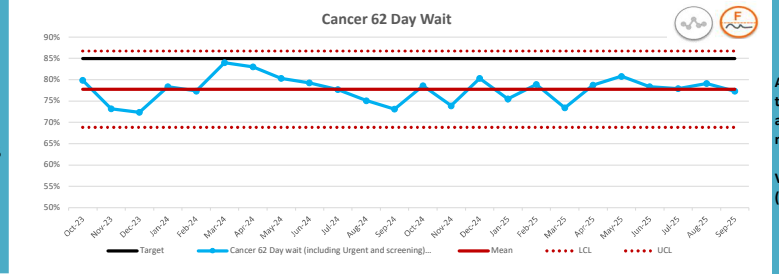
Access & Performance - Trust Position

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) - 83.8% 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 2339 Type 5 Attendances.		'Type 5' activity includes SDEC and ACC activity. FAU, GAU and PAU are also included within Type 5 Activity from July 2024. Assurance: N/A Trajectory Not Agreed. Variation: Special Cause variation of an improving nature.	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 57.2% of patients within 72 hours.		Assurance: The Trust inconsistently passes and fails the target. Variation: There is special cause variation of a concerning nature.	Compliance was challenged in August as a result of unplanned workforce challenges and high demand, this has since improved.	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 95.94% in month.		Assurance: The Trust consistently passes the target. Variation: There is common cause (normal) variation.	The diagnostic target has been maintained for 9 consecutive months	This recovered position will continue to be monitored through Performance review group to ensure continued achievement.

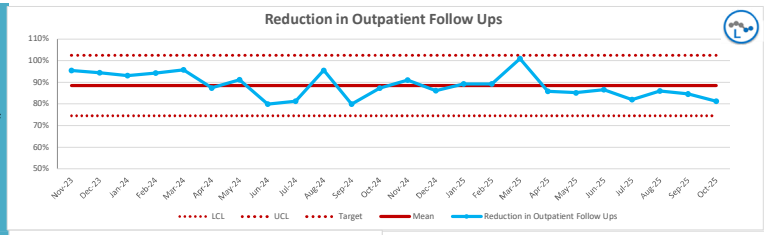
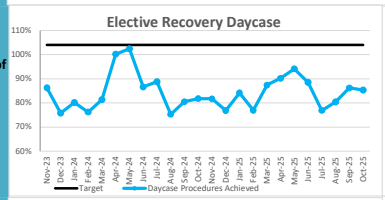
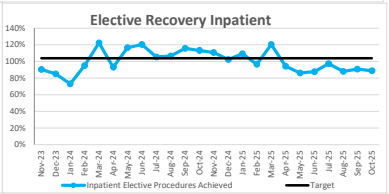
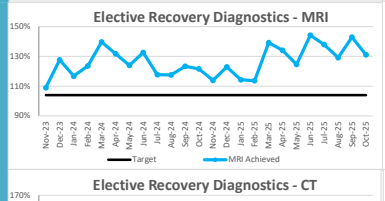
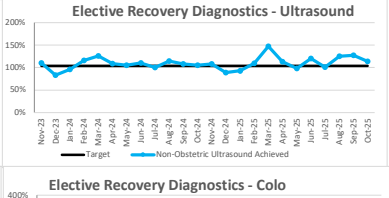
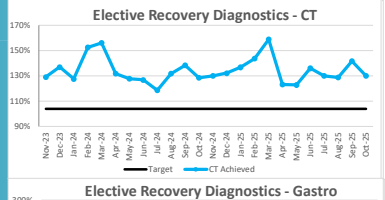
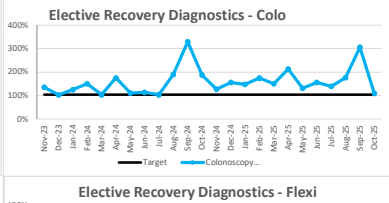
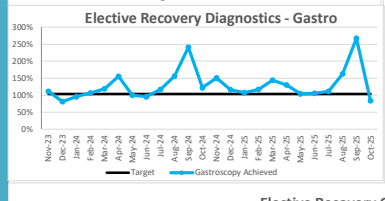
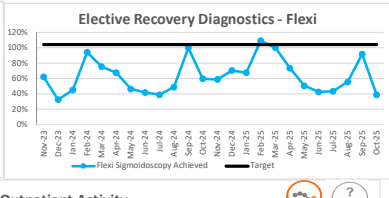
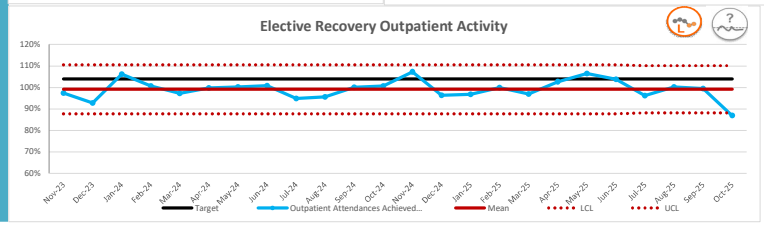
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Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
37. Referral to treatment Open Pathways Target: 92% 38. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 60.08% in month. There were 1279, 52 week breaches, 1, 78 week breaches and 17, 65 week breaches.		(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is common cause (normal) variation. (52+) Assurance: The Trust consistently fails the target. Variation: There is special cause of improving nature.	RTT performance - 52 weeks is behind trajectory, mainly in unplanned care. 65 weeks has a small residual number of patients remaining with 17 submitted for October. This continues to be within a few specialties, T&O, Gynae, and Max Fax.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Restoration and recovery plans for 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 74.3% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance for the Faster Diagnosis Standard is at 74.3% 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 98.9% in month for Cancer 31 Day Wait.		Assurance: Target met consistently. Variation: There is Common Cause (normal) Variation.	The Trust achieved the 31 day target.	
41. Cancer 62 Day wait Target: 85%	The Trust achieved 77.3% in month for Cancer 62 Day Wait.		Assurance: The Trust consistently fails the target. There is a commitment to achieveing 70% at March 25 required nationally. This is currently being met. Variation: There is Common Cause (normal) Variation.	62-day wait for first treatment performance is at 77.3%%. The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85%, Operational Planning guidance for the this financial year indicates a commitment to reach 75% by March 2026, nd a trajectory has been developed with the Cancer Alliance to achieve this.	

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Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 81.2% 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 89% of Inpatient Elective Procedures.**	 	**N/A - Grouped indicator.**	**Day case is behind plan predominately as a result of referrals not being received into the Endoscopy Hub this is being addressed through the C&M diagnostic network**	**The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.**
44. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20	**In month, the Trust achieved the following % of activity against 2019.** **This included:** **131% of MRI** **130% of CT** **114% of Non-Obstetric Ultrasound** **39% of Flexi Sigmoidoscopy** **110% of Colonoscopy** **84% 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 86.9% of Outpatient activity.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of concerning nature.**	**The Trust continues to deliver Outpatient activity in line with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.** **The position will improve following completion of coding of OPD procedures.**

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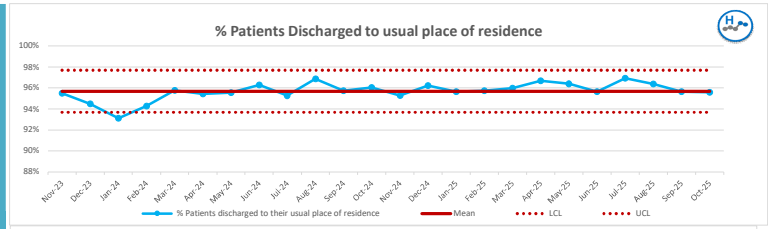
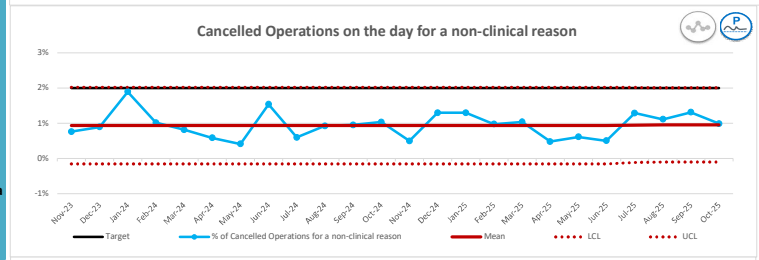
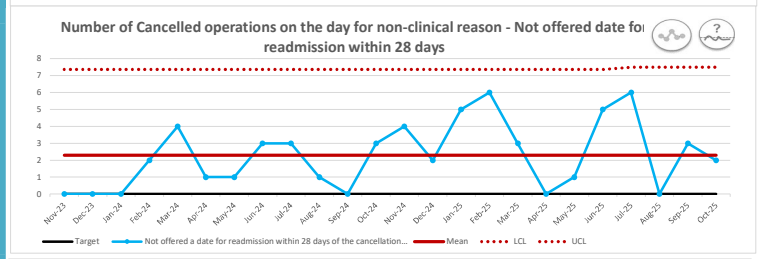
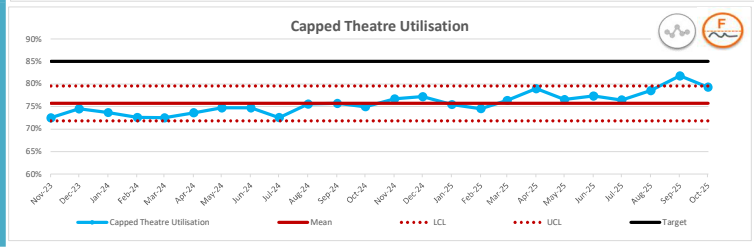
Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
46. Super Stranded Patients Target: Trajectory 47. No Criteria to Reside (NCTR)	Super Stranded Patients Stranded Patients No Criteria to Reside Right to Reside Super stranded - NCTR/RTR Stranded - NCTR/RTR	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The Trust continues to monitor this inline with the operational planning guidance	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
There were 273 stranded and 125 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2025/26.				

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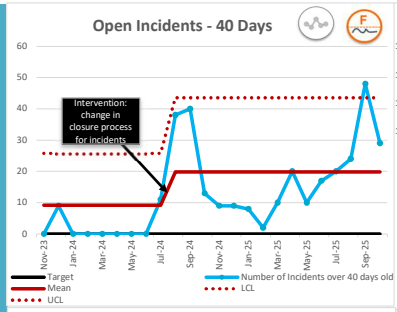
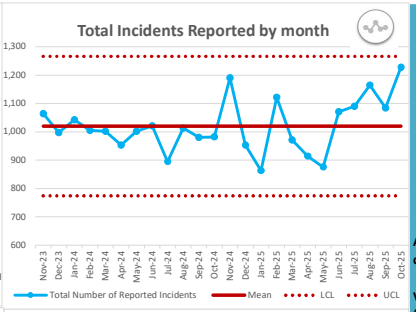
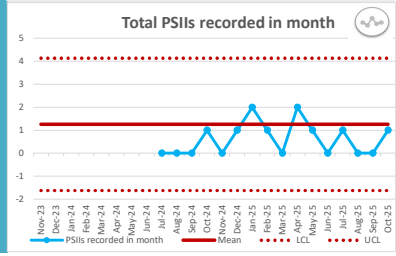
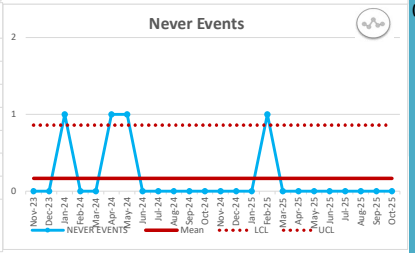
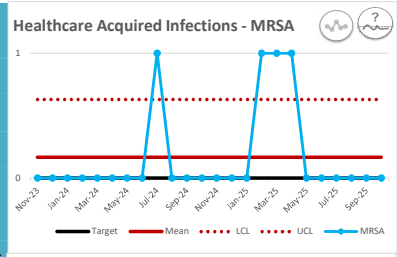
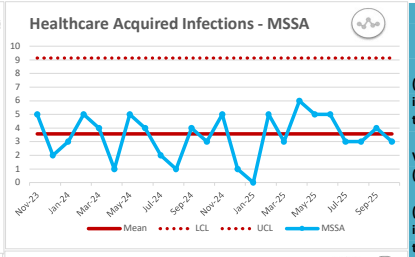
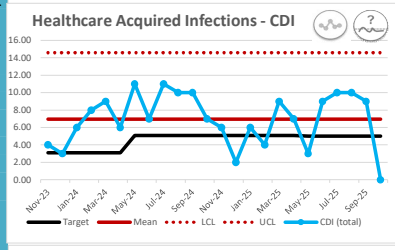
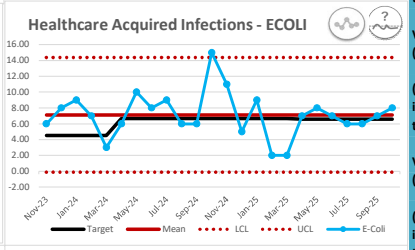
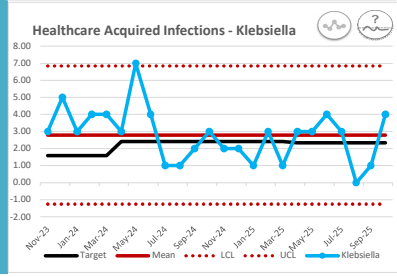
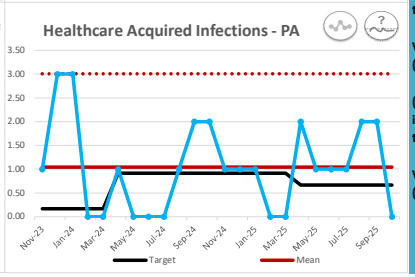
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.59% 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 0.99% in month. 2 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 79.3% in month**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Capped theatre utilisation is improving following intensive transformation work, challenges remain on the Nightingale site whilst the working out of a reduced theatre template due to the completion of estates work, all theatres have become fully operational from 12/11**	**The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates.** **Areas of focus are on Urology, Urology & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.**

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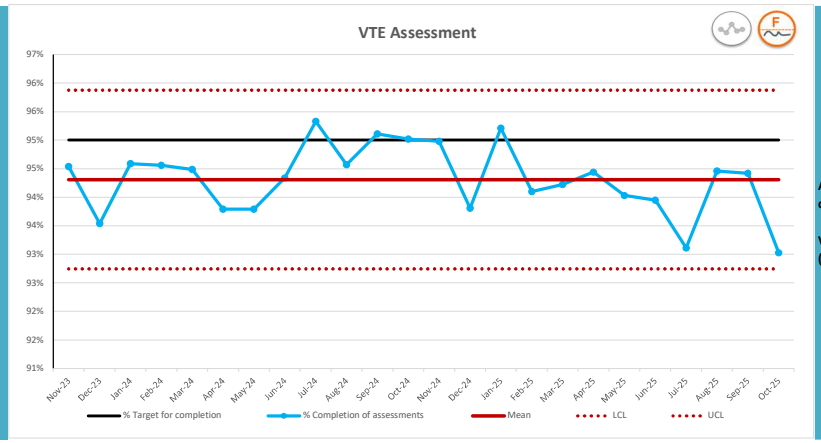
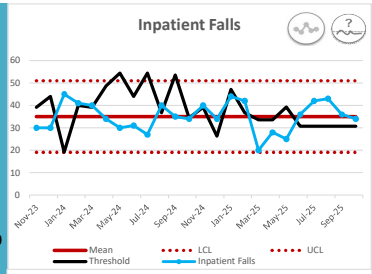
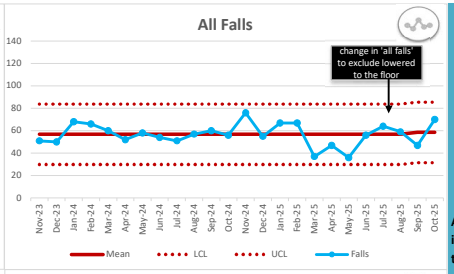
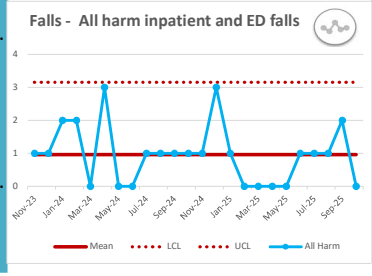
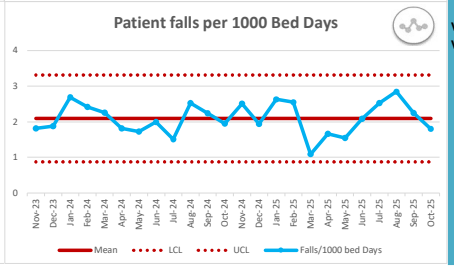
Appendix 2

	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	There was 29 incident over 40 days old.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	In October 2025, there was one Patient Safety Incident Investigation (PSII) and no Never Events identified. At the time of reporting on 03 November 2025, there were 29 incidents open for more than 40 days, which represents a significant improvement compared to the previous month.	A weekly governance dashboard continues to be overseen by the Executive Team, monitoring reporting trends and triangulating incidents, complaints, claims, and inquests. Each Clinical Business Unit (CBU) is supported by a designated member of the Governance Team to ensure consistency. As of 03 November 2025, there were 29 incidents open beyond 40 days, which is a significant improvement from last month. The incident position is escalated daily to the relevant triumvirates, and this work remains a priority. The Datix system now triggers alerts at an additional lower threshold of 30 days to enable earlier intervention and support, and this will be monitored closely. A daily report of learning response and action positions is in place for Care Group Triumvirates oversight. Improvements have been noted following the initiation of Governance Recovery Meetings led by the Deputy Chief Nurse. For October 2025, there was one Patient Safety Incident Investigation (PSII) and no Never Events identified. Weekly monitoring of PSIIs continues through the Executive-led Safety Oversight Meeting, with appropriate escalation to CBU leads
2. Healthcare Acquired Infections (MRSA) 3. Healthcare Acquired Infections (MSSA) Threshold for 2025/26: no threshold set 4. Healthcare Acquired Infections (CDI) Threshold for 5. Healthcare Acquired Infections (Ecoli) Threshold for 6. Healthcare Acquired Infections (Klebsiella) Threshold for 7. Healthcare Acquired Infections (PA) Threshold for 2025/26: 8	MRSA cases YTD annual threshold exceeded by 1 MSSA 29 cases YTD no threshold set CDI 48 cases YTD annual threshold exceeded by 0 E. coli 49 cases YTD annual threshold exceeded by 0 Klebsiella spp. 18 cases YTD annual threshold exceeded by 0 P. aeruginosa 9 cases YTD annual threshold exceeded by 1 cases	     	(MRSA) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (CDI) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (ECOLI) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (K) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (PA) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Since April 2024, revised reporting rules now use the decision-to-admit date rather than admission date, resulting in an increase in HCAI cases apportioned to acute Trusts. There is a regional and national rise in C. difficile cases, with UKHSA declaring this a national standard incident. The Trust remains a low outlier for C. difficile compared to other North West Trusts as of August 2025. Nationally, MSSA cases have also increased; NHSE is reviewing this and further guidance is awaited. The Trust is not flagged as a high outlier for HCAI cases or rates. Multiple primary sources for these infections exist, some deep-seated and likely unavoidable. Changing population demographics, particularly an increase in older age groups is felt to be contributing to the rise in GNBSI cases. no CDT cases were reported in October.	MRSA/MSSA: Action plan includes review of peripheral cannula dwell times in line with EPIC 3 guidance and revision of the Trust cannulation policy. Training for peer ANTT assessors is underway with a target to achieve compliance by the end of Q3. CBUs are working to improve competency assessments compliance Additional support from the Quality Academy has been requested to address barriers to documentation completion. C. difficile: Prevention plan in place with no cases reported in October. Reviews of recurrent CDI cases are ongoing, and DIPC-led review meetings have been reinstated. Plans include exploring probiotics for prevention, hosting a system-wide CDI seminar, and delivering GP training sessions. Antimicrobial Stewardship: Activity has increased following return to baseline Consultant Microbiology staffing. Ward rounds have resumed, and project plans for Model Ward and Well Organised Ward campaigns are being revised. GNBSI Prevention Group relaunched in August with medical staff involvement, focusing on wards with ≥2 cases per month. QI projects include timely catheter removal post-surgery and reducing catheter use in elective joint replacement.

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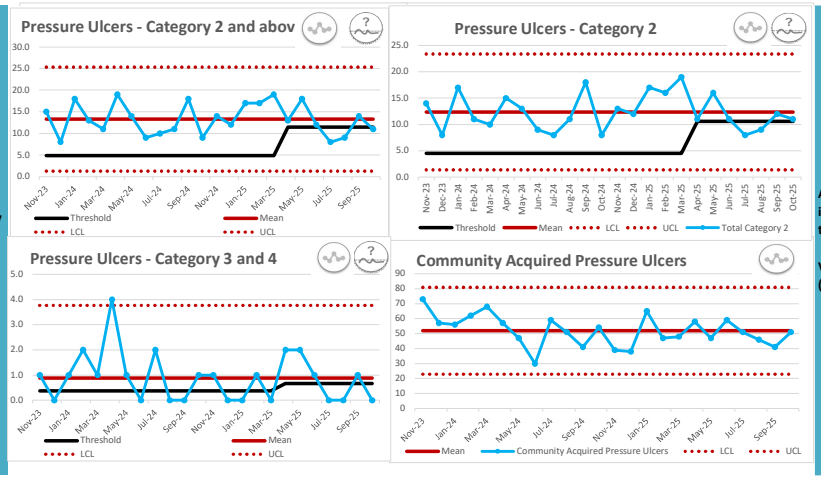
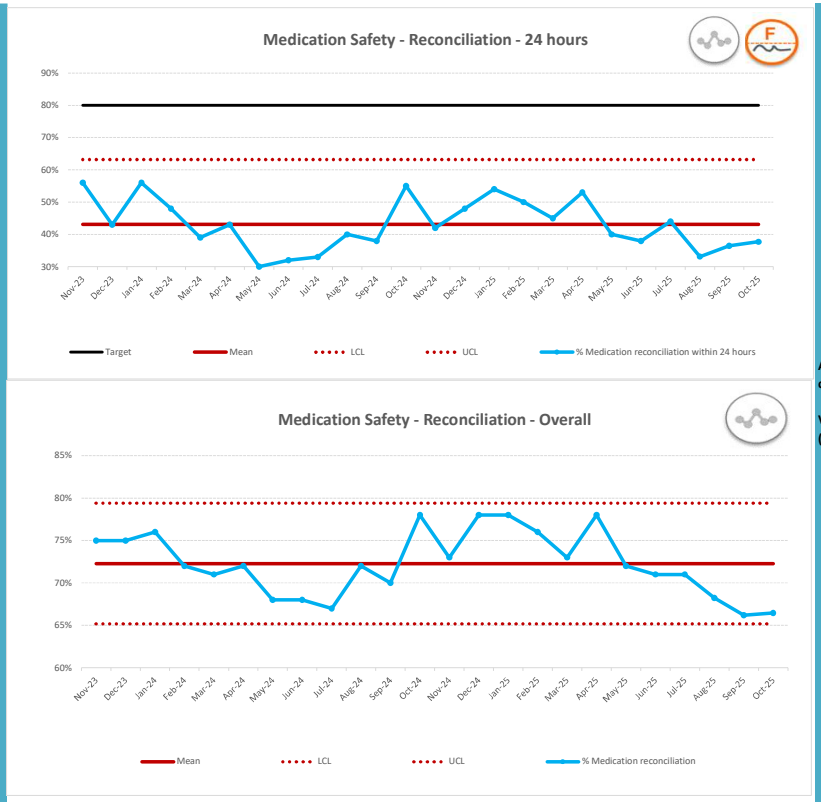
Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
8. VTE Assessment **Target: 95% (quarterly position)** **The Trust did not achieve the required target at 93.03% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**VTE risk assessment (RA) performance target in October 2025 was below the mandatory threshold at 93.03%. No single factor has been identified.**	**Actions already taken:** **Ward teams encouraged to use real-time data via the GIRFT Inpatient Ward Productivity Dashboard to complete outstanding VTE risk assessments. Feedback from CBUs sought to address non-compliance using the VTE dashboard embedded in monthly Clinical Governance agendas.** **Further improvement actions:** **Clinical leads, Directors, CBUs, and Care Groups receive monthly compliance updates to drive improvement.** **CBUs asked to liaise with ward managers/clerks to use real-time dashboard data and ensure "VTE not completed" numbers are reset to zero during morning board rounds to meet the >95% mandatory target. Thrombosis Group continues to monitor trends and develop further improvement plans**
9. Inpatient Falls & harm levels **Target: 10% reduction from 2024/25** **70 total falls were reported in month. 34 of these were inpatient falls. There was 0 fall(s) in month with harm.** **There were 295 total falls in 2023/24. There have been 690 total falls YTD in 2024/25. We are expecting a 6% decrease in falls from last year.** **There were 186 inpatient falls in 2023/24. There have been 411 inpatient falls YTD in 2024/25. We are expecting a 8% decrease in falls from last year.**	   	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause Variation.**	**In October 2025, there were 34 inpatient falls: 27 resulted in no harm and 7 in low harm, which remains within normal variation and represents a reduction from last month. There was one incident of a patient being lowered to the floor, which resulted in moderate harm due to a fractured neck of femur.** **Themes from falls reviews continue to include the assessment and implementation of appropriate enhanced care levels and the impact of challenging patients on staff focus**	**Falls Alarm Support: Turun (falls alarm representative) continues monthly ward visits with PSIN support to educate staff on correct use of falls alarms.** **Targeted Training: Patient Safety Improvement Nurses (PSINs) delivers bespoke falls training to wards with high fall rates and addresses area-specific themes identified during Harm Free Care Meetings. Data Triangulation: PSIN has begun triangulating falls data with staffing red flags to identify potential correlations.** **Single Point Lesson (SPL): Following an incident involving incorrect use of clip-and-cord alarms, PSIN collaborated with Clinical Education to develop and circulate an SPL on identifying alarm types and indications for use. This is now promoted during educational sessions.**

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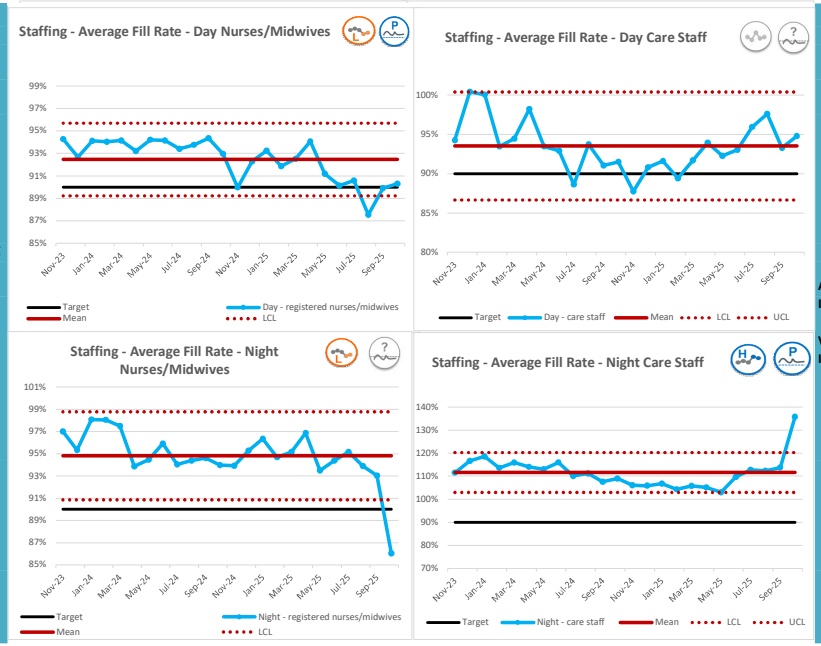
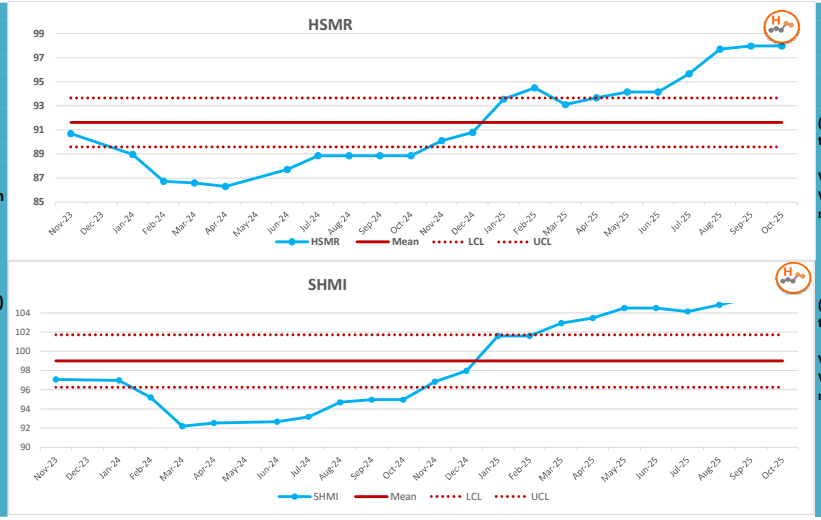
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. Pressure Ulcers (Category 2 and above) **Target: 20% reduction from 2024/25**	**In month there were 11 hospital acquired category 2 pressure ulcers, 0 Category 3 pressure ulcers and 0 Category 4 ulcers in month.** **There were 51 community aquired pressure ulcers in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In October 2025, there were 11 category 2 pressure ulcers. A focused improvement programme led by the Associate Chief Nurses is ongoing with wards that have higher incidence rates until sustained improvement is achieved.** **There were no category 3 or 4 pressure ulcers during the month.** **Three device-related pressure ulcers were reported, linked to TED stockings, catheter tubing, and oxygen mask elastic straps**	**After Action Reviews with lessons shared via ward teams and the Operational Patient Safety Group.** **MDT reviews for all Category 3 and above cases.** **Improvement plans in place for Unplanned and Planned Care Groups, overseen by the Associate Chief Nurses.** **Compliance/review meetings with the Deputy Chief Nurse to share lessons learned.** **Essential Healthcare has deployed an extra technician to check mattress pumps and replace faulty units.** **Film dressings applied to patients' heels in ED to reduce friction and shear damage.** **Safety brief message circulated on TED stockings, including a Single Point Lesson; staff asked to retain stockings causing damage for review by the Tissue Viability team.** **QI Pressure Ulcer Collaborative launched across AMU, A4, A8, B18, ITU, and ED**
11. Medication Safety **Reconciliation within 24 hours** **Target: 80%**	**Medicines reconciliation was completed within 24 hours of admission for 37.7% of patients. 66.44% of patients had MR completed during inpatient stay.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Pharmacy staffing does not allow full coverage of all inpatient areas; resources are deployed based on patient acuity and activity, prioritising ED, AMU, ICU, and ACCU. Lower priority areas include elective surgery and maternity. Deployment is supported by audit data.** **Analysis shows 62% of patients on one or more high-risk medicines received medicines reconciliation within 24 hours, and 91% at some point during their stay. Of those not reconciled, 65% were in W&C and SS CBUs, primarily maternity patients, where only 5% were on high-risk medicines and 90% had no regular medication. For surgical specialties, 69% of unreconciled patients were discharged by day 2; these cases are addressed during TTO clinical checks to optimise resource use.**	**Maternity SOP: Relaunched w/c 20 October for midwife-led MR1 documentation.** **Performance Monitoring: Pharmacy/Executive meeting on 03 November agreed to add KPIs to the IPR to track MR1 completion for patients on high-risk medicines alongside overall performance.** **Prioritisation Tool: Deployment across all Pharmacy Teams during November–December to enable prioritisation of highest-risk patients rather than by area.** **Governance: Progress monitored via Pharmacy Performance Meeting and Medicines Safety & Optimisation Group.**

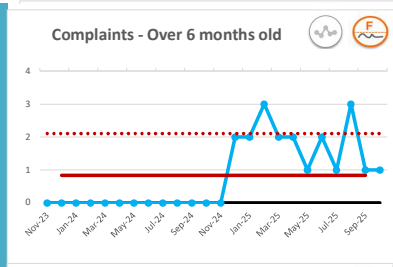
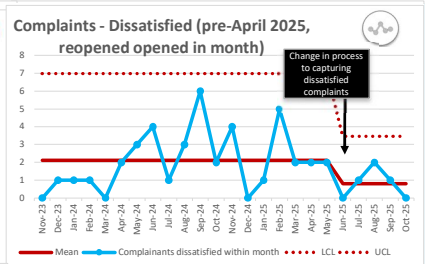
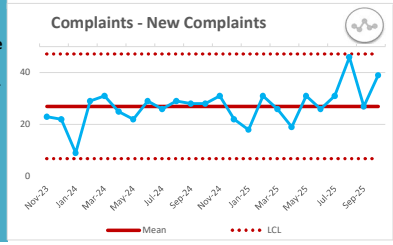
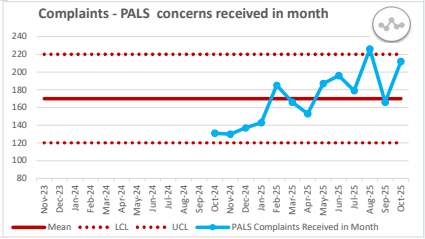
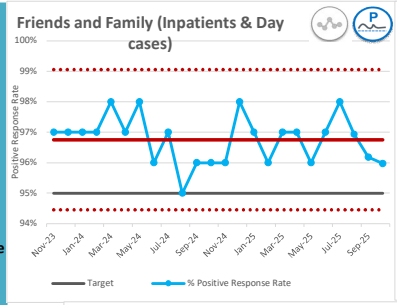
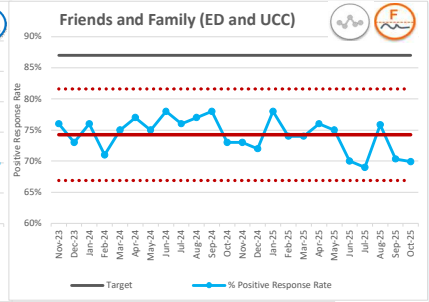
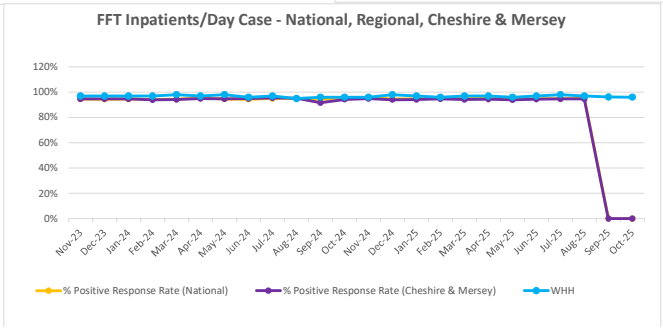
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 90.3% Day (Care Staff) 94.8% Night (Nurses/Midwife) 86.04% Night (Care Staff) 135.72%		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds are in use across the Trust due to increased Emergency Department demand, higher patient acuity, and a significant number of patients with no criteria to reside. A10 was opened as an escalation ward in November. Lower fill rates have been noted on night shifts due to increased cancellations by registered staff after booking; however, higher ratios of care support staff have been deployed to help maintain safety.	Staffing is reviewed twice daily by the Senior Nursing Team, with acuity and activity monitored to ensure safe care. All wards have senior nurse oversight by a <matron and Lead Nurse. Registered Staff: Vacancy rate for October is 8.02% (up from 7.30% in September) but remains below the 9% Trust threshold. The increase is mainly due to ED establishment changes and a remaining 25.0 WTE Band 5 vacancy. Posts have been re-advertised. Most 3rd-year students appointed have now commenced. Remaining vacancies are primarily in ED, with small pockets elsewhere that are supported by specialist recruitment. Unregistered Staff: Vacancy rate is 13.09% (up from 10.63% in September) against a 9% target. Recruitment continues monthly, supported by NHSP CSWD appointments. Recruitment Activity: 6 HCAs started in September, 4 in early October, and 7 appointed following interviews on 12 November. 15 NHSP CSWDs began training in August; the next cohort of 15 will start December/January.
13. Mortality ratio - HSMR Target: Plan 14. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are not within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 97.96. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 105.56.		(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.	SHMI figures for Warrington are 'green rated' which is within the expected range. HSMR is not an outlier.	Due to changes in data submission processes for Same-Day Emergency Care and related assessment activities, patients with a low risk of mortality are now excluded from mortality calculations. This has caused a baseline increase in the Summary Hospital-level Mortality Indicator (SHMI), which is being closely monitored.

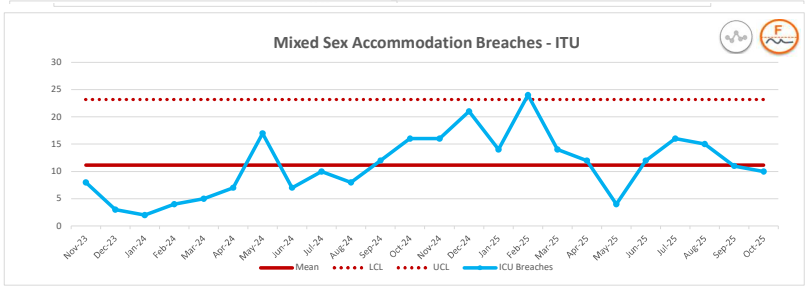
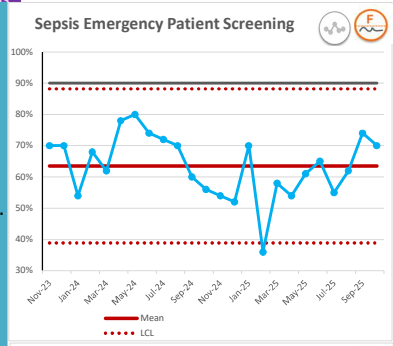
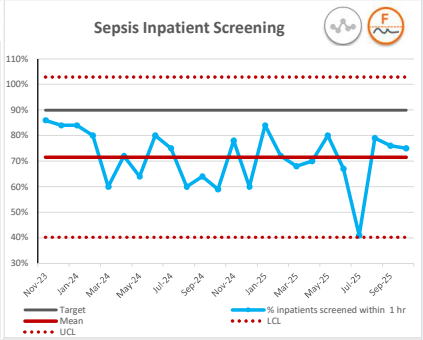
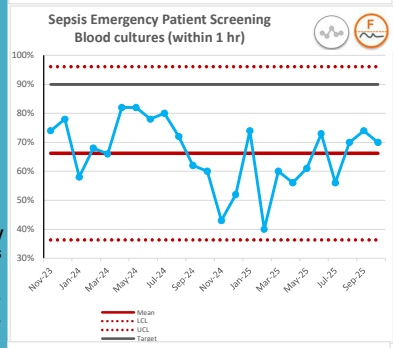
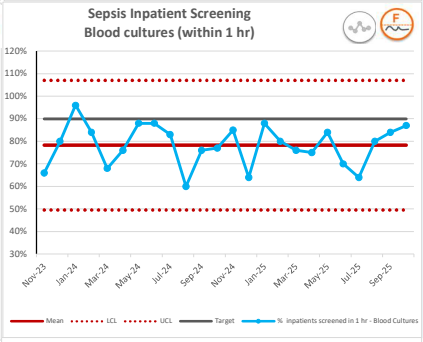
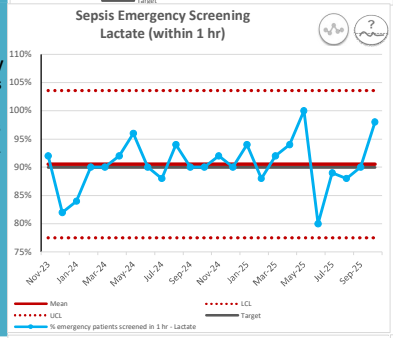
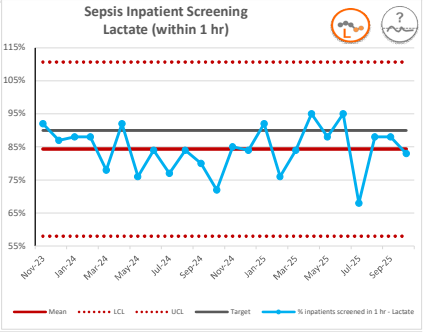
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
15. Complaints Target: Zero complaints open over 6 months old/in the backlog	In month, 46 new complaints were received to the Trust which was an increase of 15 from the previous month. There was 1 case reopened in month, which is the same as the previous month. 7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. Please note: Prior to April 2025, the Complaints 'dissatisfied' graph reported 'reopened complaints'.	The Trust continues to sustain strong performance in the timely completion of complaints. In October 2025, there were zero dissatisfied complaints, reflecting the high quality and clarity of responses. There is one complaint over six months old, due to the family requesting two meetings and a full written response. The "stop the clock" has been applied while these arrangements are coordinated.	At the time of reporting, there are 102 open complaints, all of which continue to be closely monitored to ensure timely responses. Where appropriate, complaints are redirected to PALS for local resolution. All complainants are offered an initial meeting with clinical teams and follow-up meetings after receiving the response letter. Each Care Business Unit has a designated complaints case handler to ensure consistency. New approaches are being explored to allow senior nursing and clinical teams to be available at designated times for families to discuss concerns, aiming to reduce complaint volumes. Additionally, weekly themes from received and closed complaints are being analysed to identify areas for improvement.
16. Friends and Family (Inpatients & Day cases) Target: 95% 17. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 95.97% in month for Inpatient & Day case FFT and 69.91% for ED/UCC FFT.	  	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: Common Cause (Normal) variation. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: Common Cause (Normal) variation.	Inpatient/Day Case: The Trust achieved a 96% positive response rate in October 2025, continuing to exceed the recommended target. For comparison, the Trust's average from November 2024 to August 2025 was 97%, higher than both the regional (94%) and national (95%) averages. Emergency Department/Urgent Care: Positive feedback was 70% in October 2025, slightly below the 12-month average of 73% and lower than regional (74%) and national (78%) benchmarks for the same period. Key negative feedback themes include staff attitude, waiting times, environment, and implementation of care.	All Areas: Monitoring themes via the Friends and Family Test (FFT) dashboard at Trust and CBU level, with actions identified and shared through the Patient Experience and Inclusion Sub-Committee. Observations from Trust Board, Governors, Senior Leaders, PLACE, and the Patient Experience Team are fed back to wards with action plans monitored through governance structures. Quality priority set around Accessible Information Standard (AIS) to support patients requiring reasonable adjustments. FFT programme continues to focus on increasing response rates, moving toward digitalised responses for real-time feedback. Healthcare Comms will cease FFT services in August 2026; options for integration are under review. ED/UCC Specific: Improvement projects target waiting times and environment. Actions include: Digital information screens (charity-funded) are being provided for Warrington ED, Halton UCC, and main entrances to promote AIS rights, service details, and FFT. Launch of "About Me" card in Q3 with Healthwatch Warrington to support trauma-informed care. Increased FFT opportunities via volunteers and fixed digital stations for visitor/carer feedback. Volunteers assisting with care, comfort, and refreshments. PLACE assessments and Healthwatch Enter & View observations. Redline toolkit introduced for corridor care improvements; bottled water available and bid in progress for clip-on trays for food/drinks.

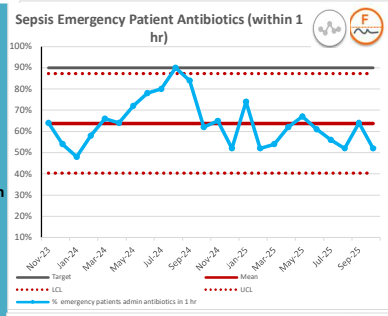
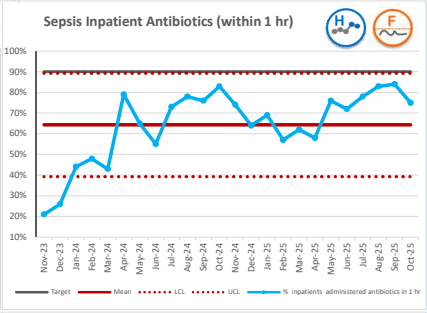
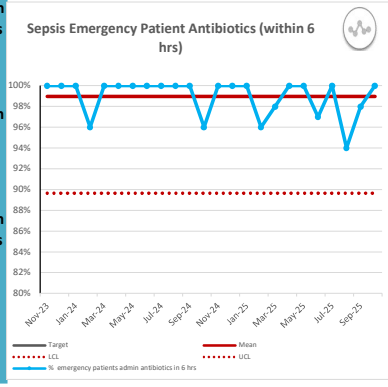
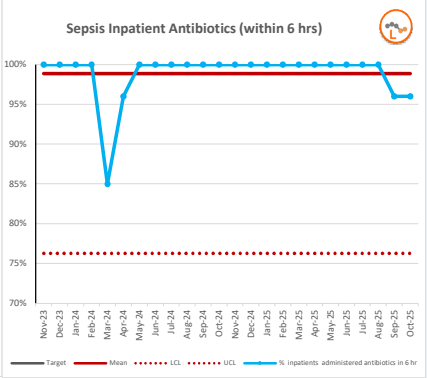
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
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 10 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	In October 2025, there were 10 mixed-sex breaches, all within the Intensive Care Unit. This represents a decrease of seven compared to September. There were no breaches in other ward areas. Any delays in discharge are escalated to the Patient Flow Team and the Tactical Manager of the day and discussed at each bed meeting throughout the day	Work continues within the Care Group and Patient Flow Teams to prioritise step-down of level 1 patients from Intensive Care to appropriate areas. A high number of patients who have no criteria to reside remains a contributory factor. The Trust policy on mixed-sex accommodation breaches is currently under review and will be updated to strengthen compliance and escalation processes.
19. Sepsis - % screening for all emergency patients. **Target: 90%** **20. Sepsis - % screening for all inpatients** **Target: 90%**	The Trust achieved: • 70% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 75% screening for all inpatients with suspected sepsis within 1 hour. Blood Cultures: • 70% screening for Emergency patients with suspected sepsis within 1 hour. • 87% screening for Inpatients with suspected sepsis within 1 hour. Lactate: • 98% screening for Emergency patients with suspected sepsis within 1 hour. • 83% 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.	Inn October 2025, sepsis screening compliance in the Emergency Department was 70%, with blood cultures taken within one hour also at 70%, both remaining within expected variation. Lactate measurement within one hour reached 98%, an improvement of 7% compared to the previous month. High attendance and occupancy rates in the Emergency Department continue to impact timely completion of sepsis screening. For inpatient areas, October 2025 audit data showed 70% compliance for sepsis screening, 87% for blood cultures, and 83% for lactate measurement within one hour, with blood culture performance improving steadily over the past three months.	The Trust Sepsis Policy has been updated to align with current national guidelines across Adults, Paediatrics, and Maternity. A Trust-wide action plan is in place to improve compliance with the Sepsis Six bundle, monitored through the Sepsis Improvement Group (SIG). Two dedicated working groups have been established—one for inpatient areas and one for the Emergency Department—each overseeing a Test of Change tailored to its setting, supported by the Quality Improvement Team. Emergency Department: Increasing Health Care Support Workers trained to take blood cultures. Identifying a Medical Lead for Sepsis and adjusting skill mix to ensure timely screening. Sepsis included in daily safety huddles; teaching sessions for Resident Doctors expanded. Inpatient Areas: Reviewing sepsis practices across four wards to identify barriers to completing screening within the first hour. Findings will inform targeted actions for timely recognition and treatment. Across both settings, use of the Sepsis Tool remains lower than screening compliance, indicating clinicians complete actions without routinely using the tool. Tests of Change will explore barriers and make the tool more accessible and aligned to clinical needs. Several key initiatives are underway to enhance the prompt administration of

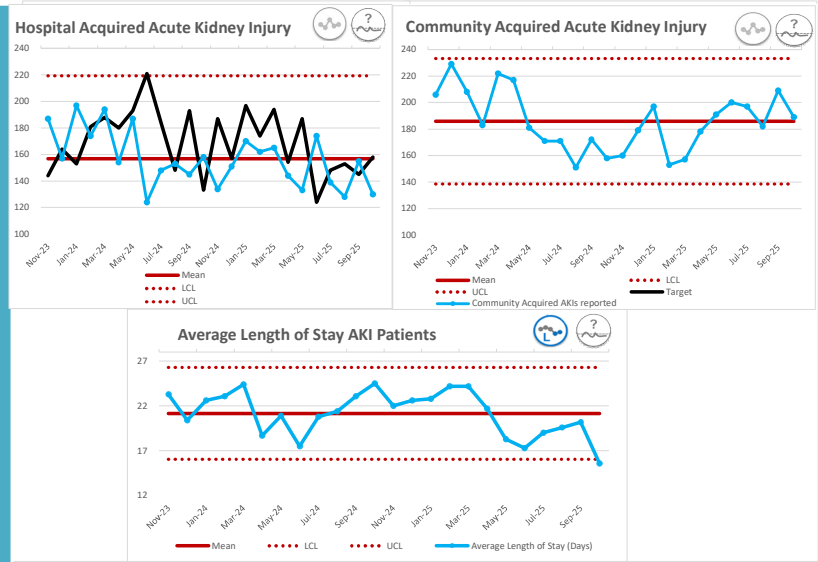
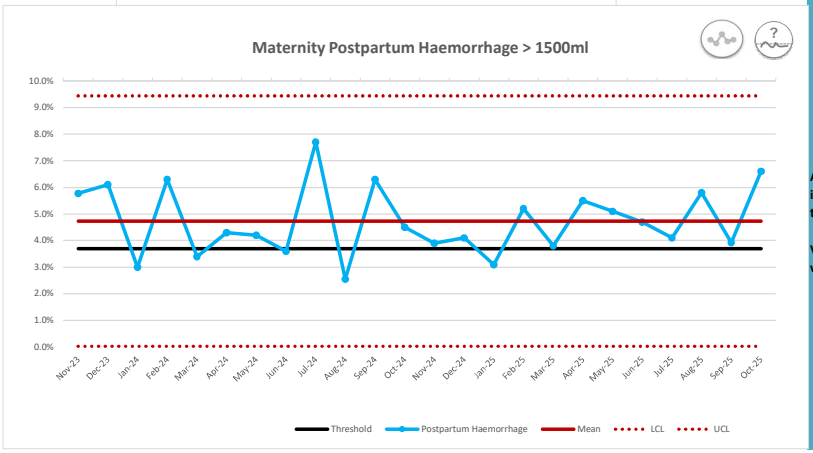
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%**	**The Trust achieved:** **• 52% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 100% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made.** **• 75% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.** **• 96% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made.**	   	**(Emergency 1hr) Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) cause variation.** **(Inpatient 1hr) Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**In October, 52% of Emergency Department patients received antibiotics within one hour, a decrease from the previous month. While this remains within expected variation, there is an emerging trend of lower compliance. This is reflective of the acuity and activity that has been high in the previous month.** **However, administration within six hours was consistently high at 100%, ensuring timely treatment overall.** **For inpatients, 75% received antibiotics within one hour in August, representing a slight decline compared to previous months, though still within expected variation.**	**antibiotics:** **Sharing Audit Results: Findings are being disseminated to Clinical Business Units (CBUs) to support local learning and enable targeted discussions and education with relevant clinical teams.** **Tests of Change: These will focus on communication processes between staff to identify and resolve delays between prescribing and administering antibiotics.** **Training and Education:** **The Trust's Medical Lead for Sepsis has delivered training to Resident Doctors to strengthen understanding of the Sepsis Six key performance indicators and promote consistent clinical practice.** **Plans are in place to extend this training to Consultants and Registrars.** **Ongoing education emphasizes the importance of timely antibiotic prescription and administration.** **Direct Feedback: Following audits by the PSIN team, doctors who did not prescribe a STAT dose of antibiotics have been contacted individually to reinforce its importance.** **Sepsis Tool Promotion:** **Services are encouraged to launch the Sepsis tool when sepsis is suspected to support timely decision-making.** **A single-point lesson on accessing the tool continues to be promoted Trust-wide.** **The new e-learning package is actively promoted for completion.** **Laptop aids with instructions for launching the tool have been recirculated.** **Monitoring and Governance: Compliance data is shared monthly with Lead Nurses and reviewed at the Operational Patient Safety Group and Sepsis Improvement Group meetings.**
22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis **Target: 90%**					

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

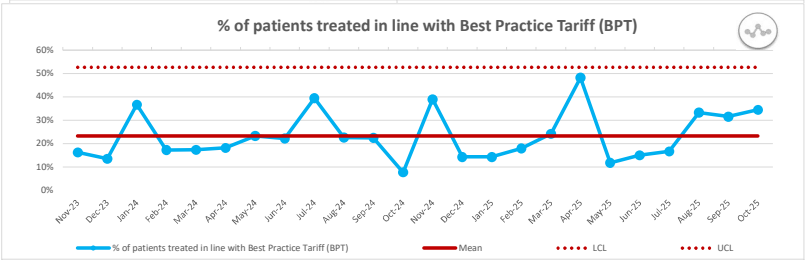
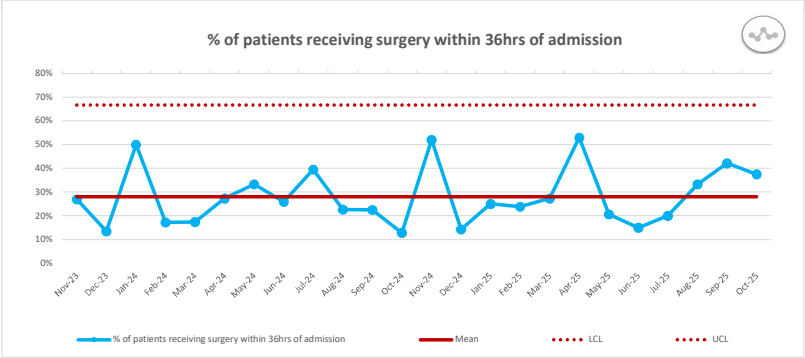
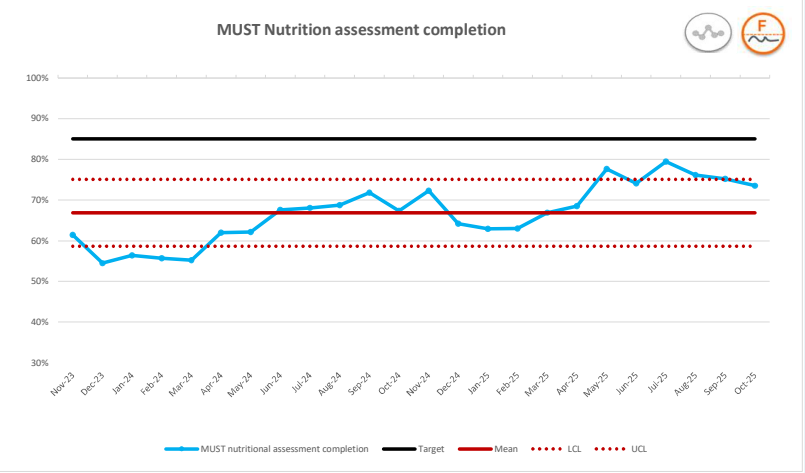
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Acute Kidney Injury **Target: Less than month in previous year**	**There were 130 acute kidney injuries reported in month compared to 155 last month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**No Variation with LOS and HA-AKI with both being below the mean and HA-AKI below target. - This Target is being reviewed as National data informs us that HA-AKI should be equivalent to 1/3 of all AKI .**	**Collaborative Engagement: The AKI team recently attended the North West AKI Network Collaboration Meeting, supporting shared learning and best practice exchange.** **Plans are in place to review current AKI targets to align with national data, which suggests HA-AKI should represent approximately one-third of all AKI cases.** **Continued focus on Discharge Quality Improvement (QI) and increasing pharmacy engagement.** **Additional efforts will target admissions to further reduce AKI incidence.**
24. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 6.6% Postpartum Haemorrhages >1500ml in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**Rates of postpartum haemorrhage (PPH) greater than 1500 ml continue to fluctuate. Comparator data from the Cheshire and Mersey (C&M) LMNS indicates an average rate of 32 cases per 1,000 births, whereas the WHH rate currently stands at 66 cases per 1,000 births**	**PPH cases greater than 1500ml will continue to be reviewed individually through governance processes and additionally by the Intrapartum Incident Review Group, which meets regularly to identify patterns and themes. A dedicated PPH Quality Improvement (QI) Group is actively working to refine processes, and a new regional guideline on PPH has recently been implemented. WHH colleagues contributed to the development of this guideline through participation in the regional working group, and several change ideas proposed by WHH have been incorporated. The Trust's position on PPH is reported monthly to QAC, supported by an SPC chart that currently indicates common cause variation with some stability**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

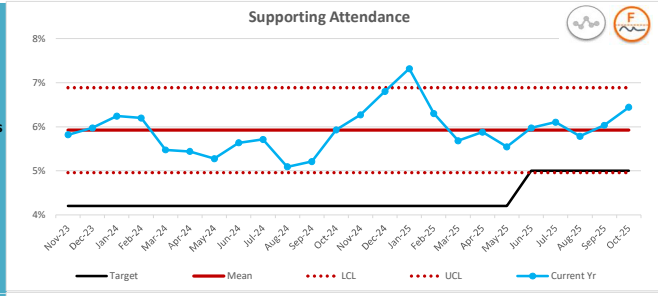
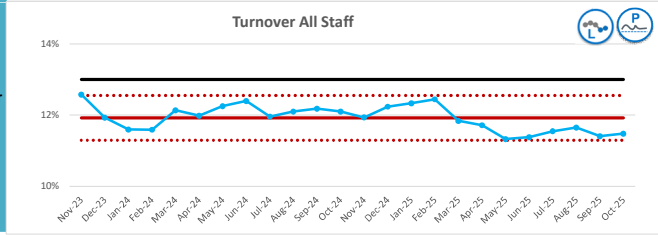
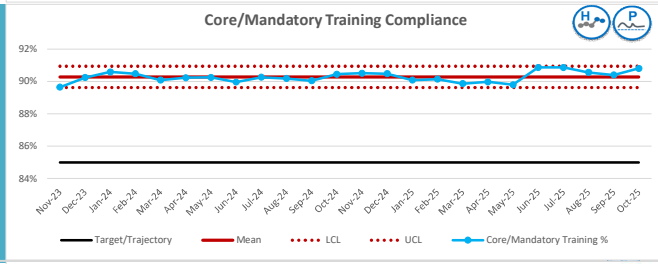
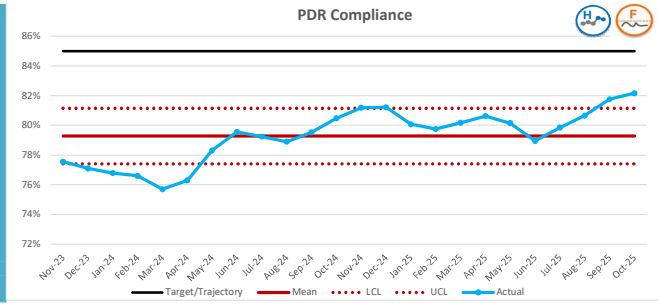
Appendix 2

	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**	**34.48% of patients were treated in line with Best Practice Tariff (BPT) in Oct-25.**	 	**Variation: Common Cause (Normal) variation.**	**In October, 36 patients were included on the National Hip Fracture Database, of which 29 qualified for the Best Practice Tariff (BPT). The majority of these patients (35 out of 36) were admitted in September or October. There was improvement noted in direct admissions from A&E to the Orthopaedic ward, rising to 86% in October—an increase of 4% compared to September. Additionally, 80% of outlying patients were transferred to A6 during this period.** **However, timely access to surgery remains a challenge, with only 41% of eligible patients operated on within the recommended timeframe, similar to the previous month. Senior Orthogeriatric reviews were completed within 72 hours for 75% of patients, a slight decrease from 78% in September. Post-operative day-one mobility also dipped slightly, with 70% of patients mobilised the day after surgery.**	**Performance against KPIs and Best Practice Tariff (BPT) continues to be monitored and presented to the Neck Of Femur and Patient Safety and Clinical Effectiveness groups(PSCESC). A robust action plan has been shared with PSCESC to drive improvement.** **A new NOF escalation SOP is now live on the intranet policies page to support timely surgery within 36 hours, and bed escalation is being added to facilitate quicker admission to the Orthopaedic ward. Plans are underway to launch a Hip Fracture Awareness Day to improve team education on the importance of NOF care. The ACP Lead recently attended the Hip Fracture Summit, where it was widely acknowledged that direct admission to an Orthopaedic Ward improves outcomes. In response, the Hip Fracture Lead is working closely with the Planned Care Triumvirate and Trust Executives to identify strategies for performance improvement. Continued focus is required to ensure NOF patients are admitted directly to the Orthopaedic Ward and that sufficient theatre capacity is available.**
26. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 73.52% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance continues to show natural variation, with ongoing work across clinical teams to maintain performance. Year-to-date (YTD) for 2025/26 indicates differences compared to 2024/25 of 7% in the six-hour assessment metric, 8% in the 24-hour assessment, and 14% in the seven-day assessment, all within expected variation.**	**The addition of MUST as a clinical indicator on Lorenzo has supported ward teams in identifying patients requiring assessment or reassessment. The indicator turns orange to provide a 24-hour warning for the seven-day reassessment, contributing to improved compliance with this metric. The Nutrition, Food & Hydration monthly meeting continues to drive a multidisciplinary approach to enhancing nutritional support for patients. Clinical Business Units (CBUs) and key stakeholders produce high-level briefing papers outlining local action plans and quality improvement initiatives for Trust-wide sharing. MUST remains a quality priority for 2025/26, with ward teams presenting compliance data and improvement plans at Quality Summits. It is also embedded within the PSIRF approach for harms such as falls and pressure ulcers, ensuring a whole-systems methodology to identify learning and opportunities for improvement.**

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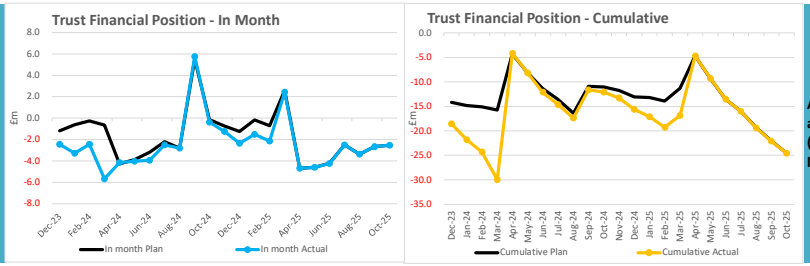
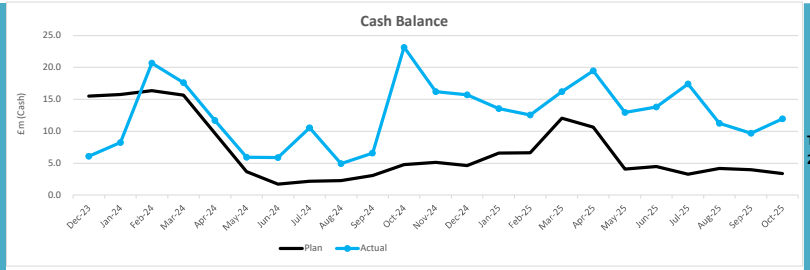
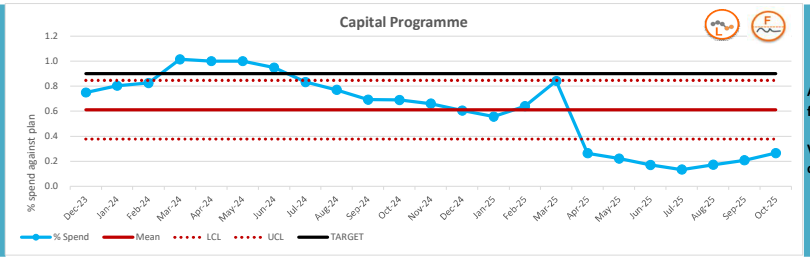
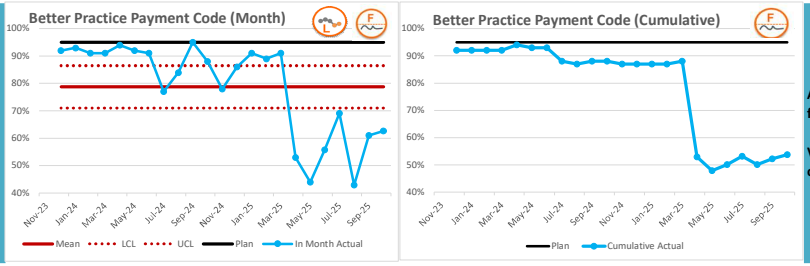
Workforce - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Supporting Attendance **Target: Below 5%**	**The Trust's sickness rate was 6.44% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**The Trust has seen a significant improvement in long term sickness absence rates following transition on to the new Supporting Attendance policy, reducing from 4.39% in April 2022 to 3.1% in October 2025.** **Short-term sickness absence is of concern with data analysis undertaken to identify areas of specific concern across the Trust.** **Sickness absence is part of the National Oversight Framework (NOF).**	**The organisation has launched the "Be Present, Be Here, Be WHH" campaign and is developing a new regional Supporting Attendance Policy to further strengthen attendance management.** **Digital tools and targeted interventions are being introduced to improve compliance and reduce absence-related costs, with enhanced HR and OH support focused on high-impact areas.** **A targeted approach is addressing the top 10 areas with the highest absence-related temporary staffing costs. These areas will receive enhanced HR and Occupational Health support, including: detailed case reviews, KPI monitoring, and leadership engagement. Additional initiatives include wellbeing sessions, manager training on workforce intelligence, and practical guidance to promote compassionate leadership.**
53. Turnover **Target: Below 13%**	**The Trust's turnover of all staff was 11.48% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of an improving nature.**	**Turnover is showing an improving nature and performing in line with Trust target and monthly average. It consistently passes the Trust target of 13%.**	**Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to support this. Following successfully launching an e-preference rostering approach in two Ward areas and preference rostering into two further clinical areas, options to rollout this approach have been developed and the Trust awaits a decision from the national team on potential resources available to support.** **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).**
54. Core/ Mandatory Training **Target: 85%**	**Core/Mandatory training compliance was 90.8% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**CSTF Mandatory Training compliance is consistently above the Trust target and shows an improving nature.**	**Care Groups report compliance at Operational People Committee with actions required to ensure targets are met.** **A Mandatory Learning Oversight Group (MLOG) has been established which ensures oversight of all CSTF and role specific training. It reviews training outcomes to ensure training has an impact on measurable outcomes and is fit for purpose, as well as approving any new role specific requests or national CSTF amendments.** **National changes are being mandated to how Trusts deliver CSTF training, there will be limited changes to WHH as the Trust has always closely followed the national guidance using the systems provided.**
55. PDR **Target: 85%**	**Annualised PDR compliance was 82.16% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a improving nature.**	**PDRs have continued to consistently to fail to meet the 85% target however, are now demonstrating variation of an improving nature.** **A number of corporate areas and staff groups are now achieving target following achievement of the trajectories set, and a number of CBUs have improved significantly over the last 12 months, but still perform below target.**	**Significant actions have been taken to strengthen appraisal compliance and improve quality. Three new Appraisal Guides have been developed to support managers and staff.** **The Appraisal Roadshow is actively engaging teams to drive consistency and uptake. A Group Appraisal test of change is being implemented, and an options analysis has been completed.**

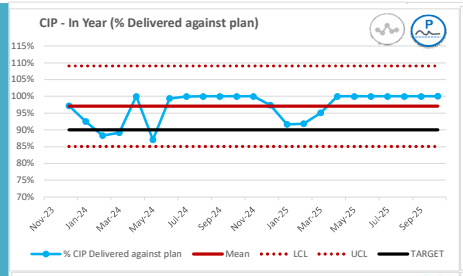
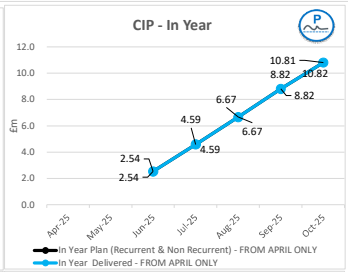
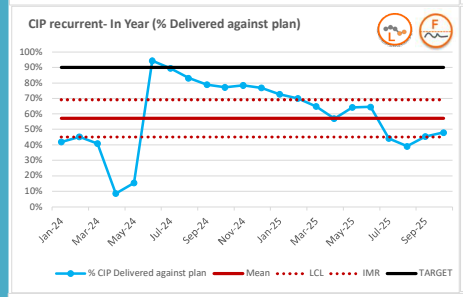
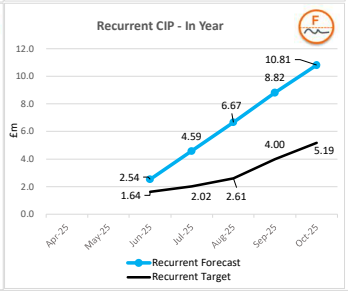
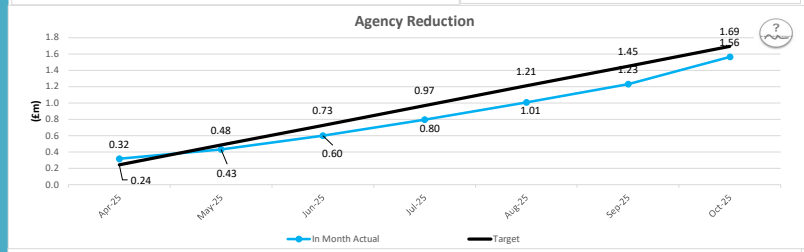
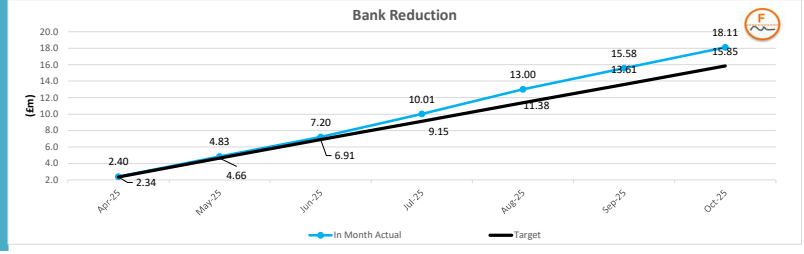
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
56. Trust Financial Position **Target: Plan**		At month 7 the Trust has recorded a deficit position of £24.6m (before deficit support) which is in line with plan.	At month 7, the deficit position is £9k better than plan due to £9k of CIP delivering earlier than planned.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
57. Cash Balance **Target: On or better than plan**		The cash balance at 31 October 2025 is £11.9m.	The current cash balance is £11.9m which is £8.5m higher than the cash plan. This is predominantly due to a larger than planned cash balance at the end of 2024/25 and the implementation of cash management measures for 2025/26. Of the £11.9m cash, £3.8m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £4.897m is required for December 2025 and a further £13.237m for Q4, approval is sought from the Trust Board. The finance team produces a daily cashflow and before payment runs are made a senior review is undertaken. Weekly reviews of non-NHS and NHS payments are being undertaken to determine whether payments can be deferred without incurring late payment interest charges.
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 7 is £3.7m against a plan of £13.7m (in month 7 spend is £2.1m which is in line with plan). This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, and late confirmation of additional capital. The plan is expected to be fully delivered by year end.	The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.
59. Better Payment Practice Code **Target: Cumulative performance 95%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Cumulative BPPC performance is 54% which is below the national target of 95%. The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.	BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
60. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**At month 7, CIP is £9k better than plan due to delivering earlier than planned.**	**CIP progress is reviewed internally and externally on a weekly and monthly basis with oversight from the Delivery Unit. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Work continues on identification of additional schemes to mitigate against high risk schemes.**
61. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**£5.2m CIP has been delivered recurrently against the target of £10.8m.** **The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.** **Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.**	**Work continues to identify recurrent CIP schemes. 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 £1.6m at month 7 compared to a plan of £1.7m.**	**At month 7, agency expenditure is underspent by £0.1m compared to budget.**	**Although agency expenditure remains below plan it is increasing each month. Agency expenditure will continue to be reviewed throughout the year to ensure that it stays below the target set.**
63. Bank Reduction **Target: 10% reduction of 2024/25 plan**		**Bank expenditure is £18.1m at month 7 compared to a plan of £15.9m.**	**At month 7 bank expenditure is overspent by £2.2m. £0.8m is due to the impact of July Industrial Action and the remainder is mainly driven by A&E medical staffing vacancies and sickness.**	**A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. The nurse bank rate was reduced during 2024/25 and has reduced again from 1 May 2025. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.**

Appendix 3 – Trust IPR Indicator Overview

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

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

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

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

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

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

Workforce

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

Appendix 4 - Statistical Process Control

1.0 What is SPC?

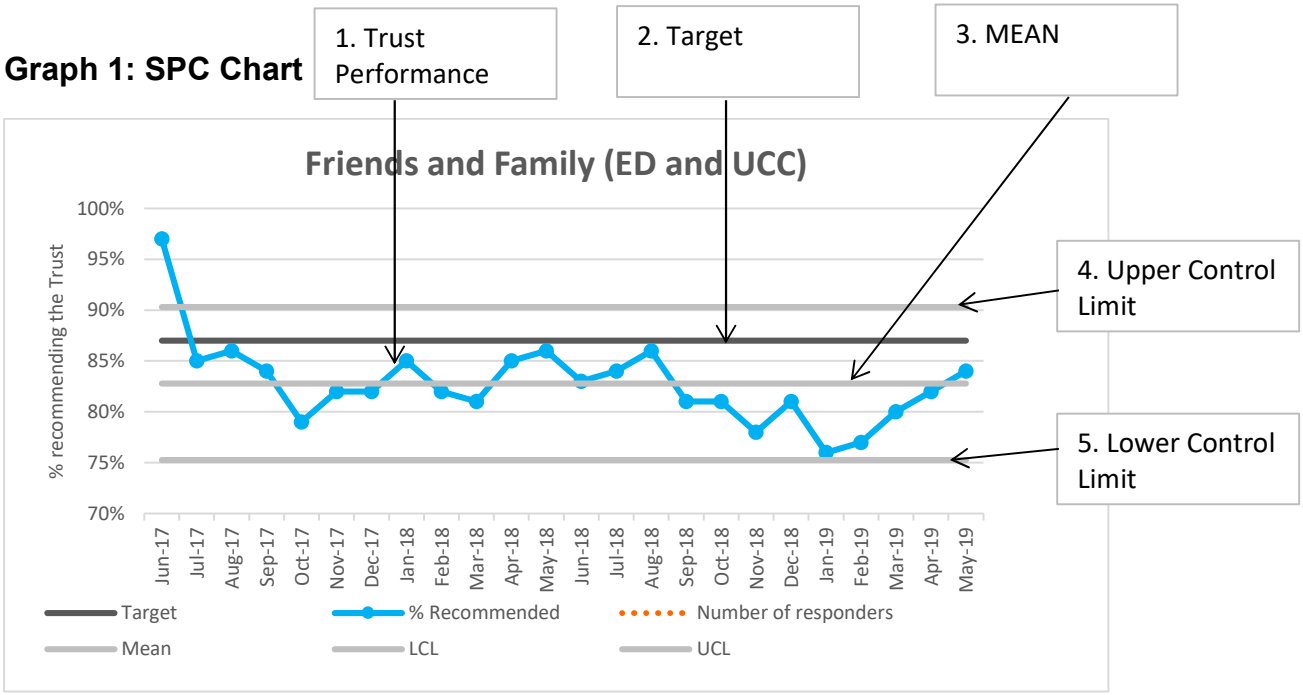
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

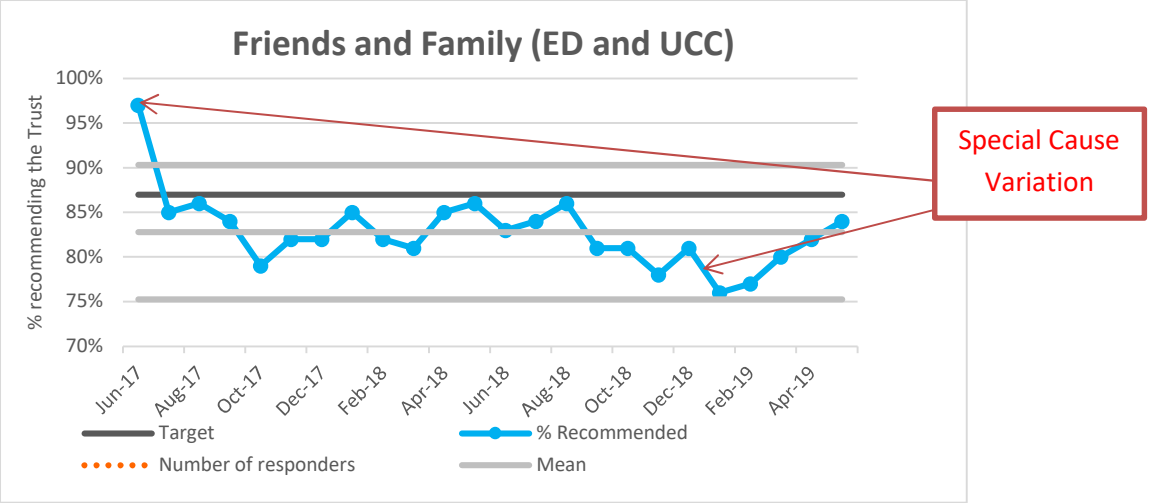


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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



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

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

Income Statement at 31st October 2025

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income							
Elective Inpatients	45,167	4,215	3,364	-851	25,759	22,870	-2,890
Outpatient Firsts & Procedures	34,256	3,120	2,905	-215	20,147	19,625	-523
Other Variable Activity	30,406	2,677	2,635	-42	17,894	18,794	899
Deficit Support Funding	18,327	1,527	0	-1,527	10,689	4,582	-6,107
Other income (including fixed element of contract)	238,818	19,796	20,330	535	139,653	137,774	-1,878
Sub total	**366,974**	**31,335**	**29,235**	**-2,100**	**214,143**	**203,644**	**-10,499**
Non NHS Clinical Income							
Private Patients	8	-2	1	3	3	5	2
Non NHS Overseas Patients	70	5	96	91	40	126	86
Other non protected	750	62	51	-11	437	481	44
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**828**	**65**	**148**	**83**	**480**	**611**	**131**
Other Operating Income							
Training & Education	10,663	889	1,312	423	6,220	7,320	1,099
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	14,919	1,245	1,702	457	8,696	10,135	1,439
Sub total	**25,582**	**2,133**	**3,013**	**880**	**14,916**	**17,454**	**2,538**
Total Operating Income	**393,384**	**33,533**	**32,396**	**-1,137**	**229,539**	**221,709**	**-7,830**
Operating Expenses							
Employee Benefit Expenses	-284,113	-24,186	-24,637	-452	-172,206	-172,614	-409
Drugs	-23,121	-1,919	-1,706	212	-13,525	-13,229	297
Clinical Supplies and Services	-27,038	-2,490	-2,574	-85	-16,821	-16,230	590
Non Clinical Supplies	-47,403	-4,114	-4,210	-96	-27,999	-27,271	728
Depreciation and Amortisation	-17,659	-1,472	-1,472	0	-10,301	-10,301	0
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-399,333**	**-34,179**	**-34,600**	**-420**	**-240,852**	**-239,646**	**1,206**
Operating Surplus / (Deficit)	**-5,950**	**-646**	**-2,203**	**-1,558**	**-11,313**	**-17,936**	**-6,624**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	13	13	0	27	27
Interest Income	520	43	74	31	303	803	500
Interest Expenses	-138	-11	-21	-10	-80	-80	0
PDC Dividends	-5,501	-458	-458	0	-3,209	-3,209	0
Total Non Operating Income and Expenses	**-5,119**	**-427**	**-392**	**35**	**-2,986**	**-2,459**	**527**
Surplus / (Deficit) - as per Accounts	**-11,068**	**-1,072**	**-2,595**	**-1,523**	**-14,299**	**-20,395**	**-6,097**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	669	56	61	5	392	391	-1
Total Adjustments to Financial Performance	**669**	**56**	**61**	**5**	**392**	**391**	**-1**
Adjusted Surplus / (Deficit) as per NHSI Return	**-10,399**	**-1,016**	**-2,535**	**-1,518**	**-13,907**	**-20,005**	**-6,098**
Deficit Support Funding	-18,327	-1,527	0	1,527	-10,689	-4,582	6,107
Adjusted Surplus / (Deficit) - without deficit support funding	**-28,726**	**-2,543**	**-2,535**	**9**	**-24,596**	**-24,587**	**9**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR – October 2025 Detail
3rd December 2025

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **2 indicators that are both failing and have special cause variation of a concerning nature**, these are:

- **58. Capital Programme** – % delivered against plan
- **59. Better Practice Payment Code –** % cumulative performance

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

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

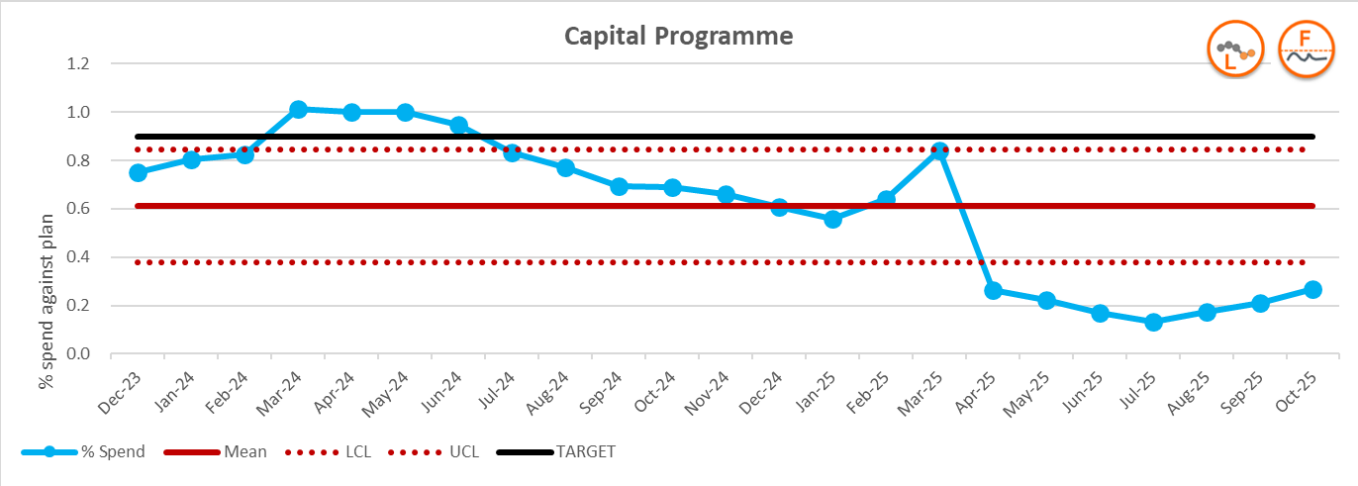
There are **2 indicators that consistently fails and cannot be measured for variation,** these are:

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

October 2025 IPR by Exception – Finance

58. Capital Programme – % delivered against plan

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Capital expenditure at the end of month 7 is £3.7m against a plan of £13.7m. In month spend is £2.1m which is in line with plan.

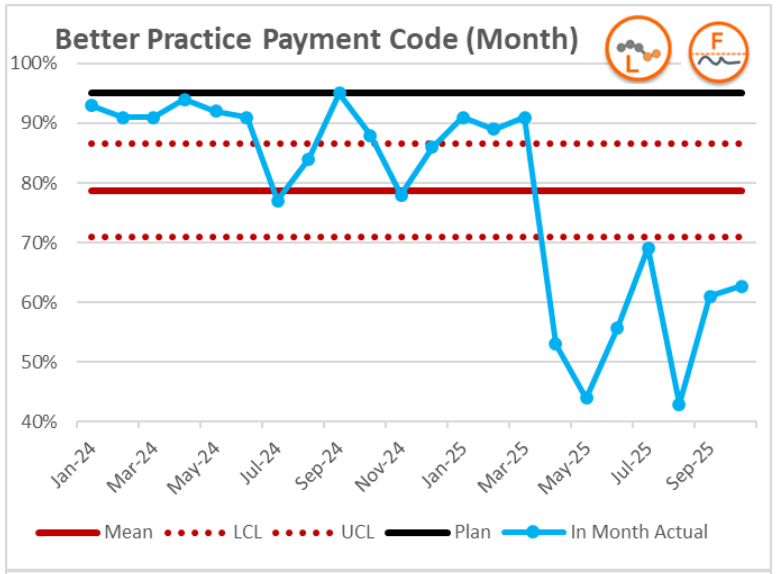
This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, and late confirmation of additional capital. The plan is expected to be fully delivered by year end.

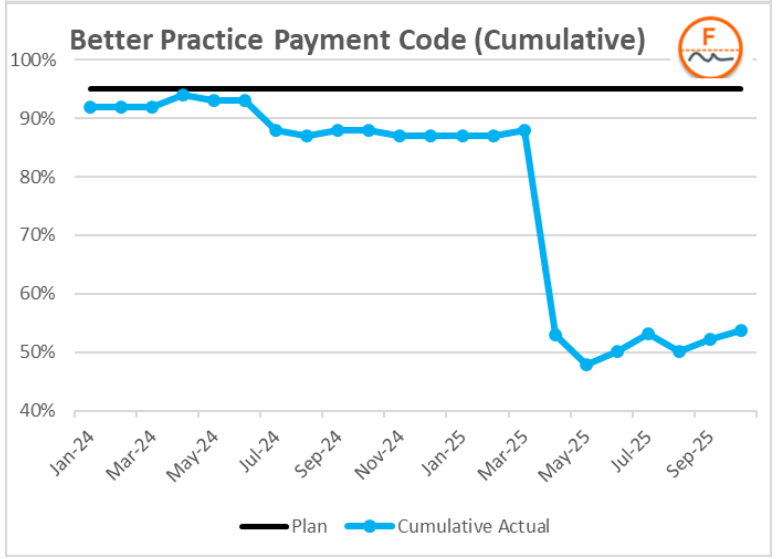
The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.

October 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

59. Better Practice Payment Code –% cumulative performance





Cumulative BPPC performance is 54% which is below the national target of 95%.

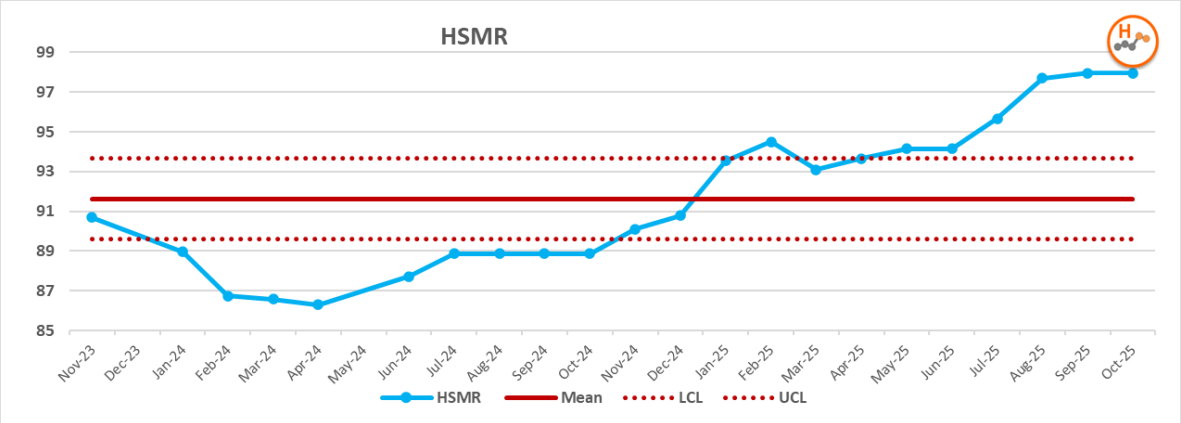
The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.

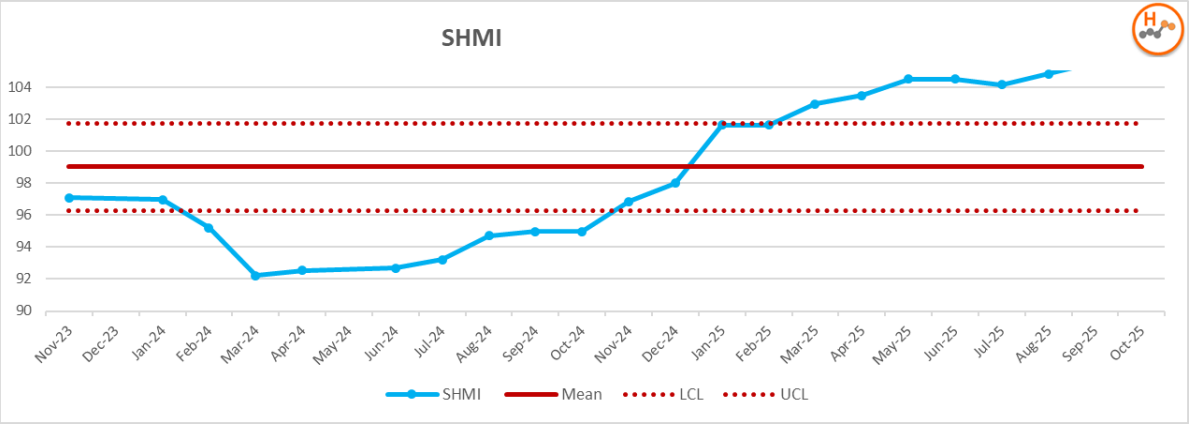
BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

August 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

13,14. Mortality ratio – HSMR and SHMI





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

There has been a rise in SHMI and HSMR due to coding changes in SDEC activity (low risk patients' exclusion from 'admitted patients' dataset due to a progressive move to type 5 UEC activity coding) from October 2023

HSMR and SHMI are reported by HED on a 12 month rolling basis, which explains the stabilisation (at a higher level) which has been seen from October 2024 as SDEC activity has been fully excluded from the dataset

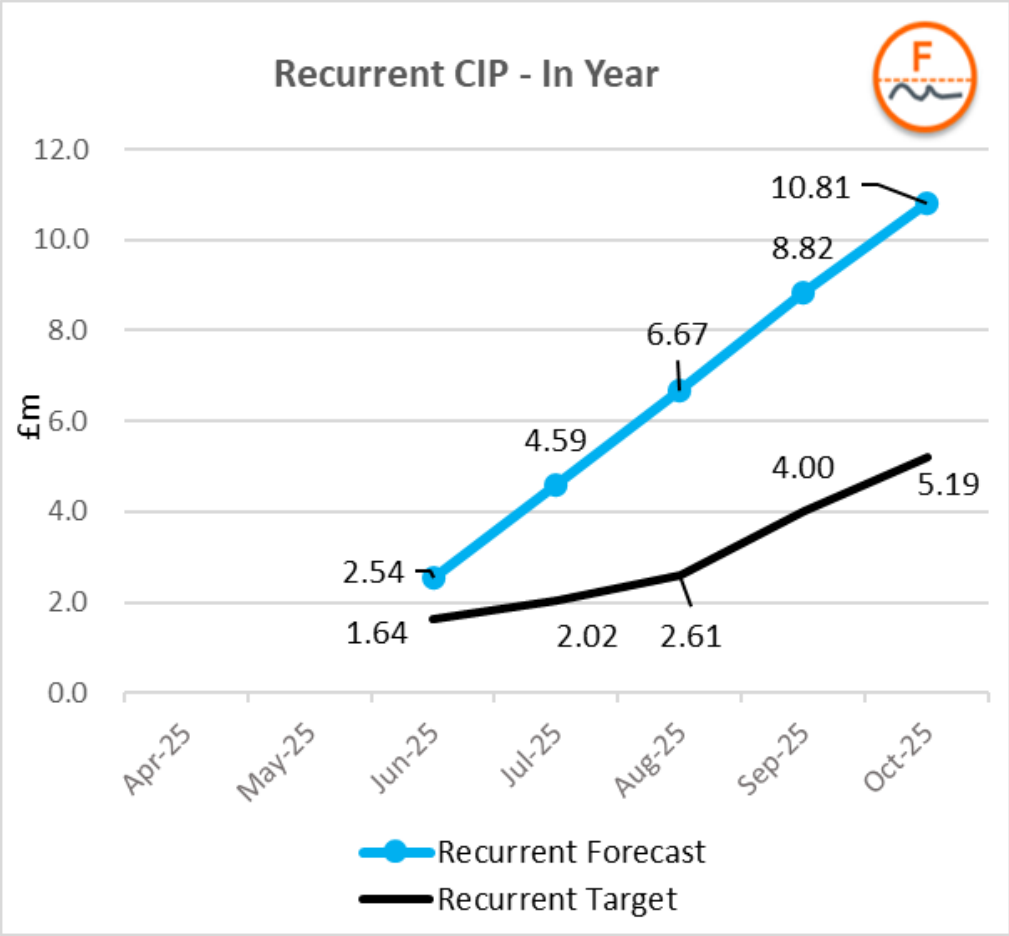
Whilst it is acknowledged that the data does not fall within the set control limits on the SPC chart, mortality is within the expected range and the Trust is not an mortality outlier

Assurance paper presented to Board on SHMI August

October 2025 IPR by Exception – Finance

61. CIP – % delivery against plan (recurrent)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



£5.2m CIP has been delivered recurrently against the target of £10.8m.

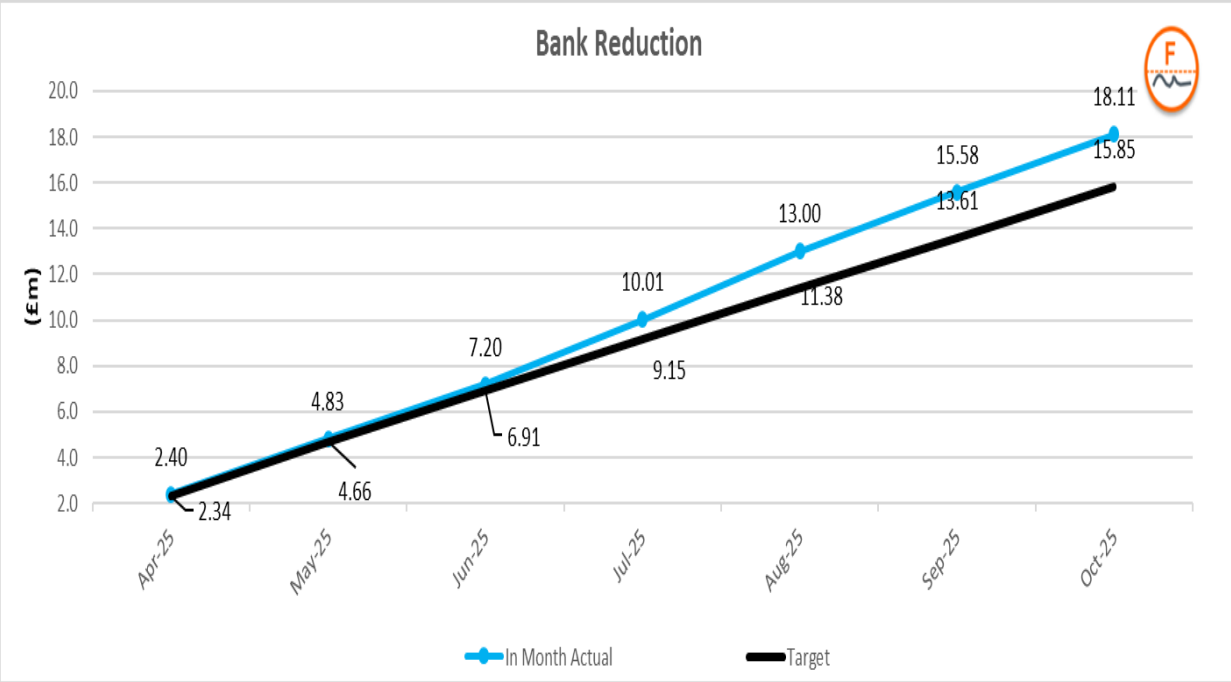
The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all. Providing the full year effect of schemes delivering later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

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

October 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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



Bank expenditure is £18.1m at month 7 compared to a plan of £15.9m (overspend of £2.2m).

£0.8m is due to the impact of July Industrial Action and the remainder is mainly driven by A&E medical staffing vacancies and sickness.

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

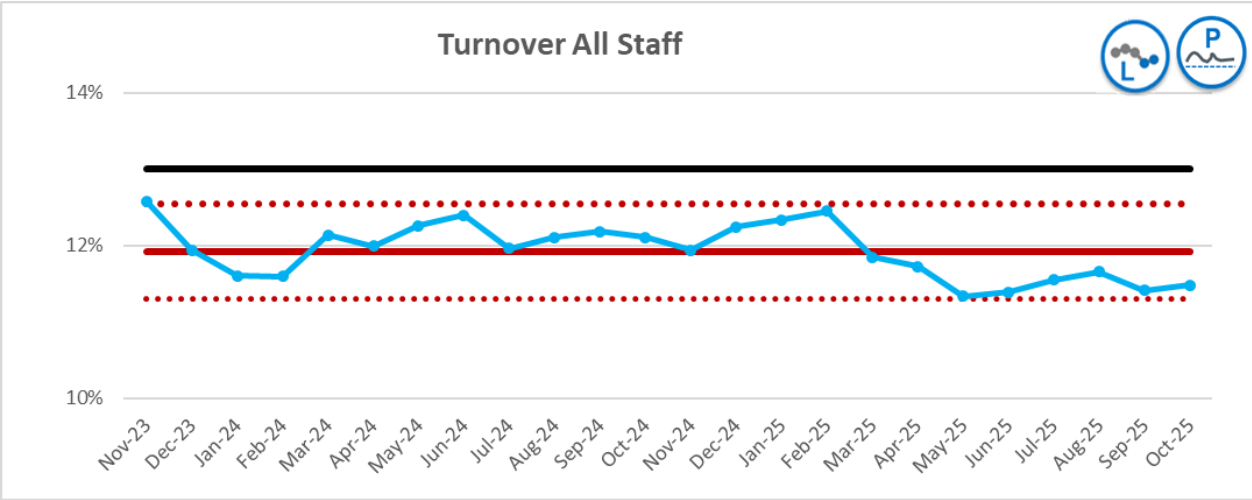
Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

Improving metrics

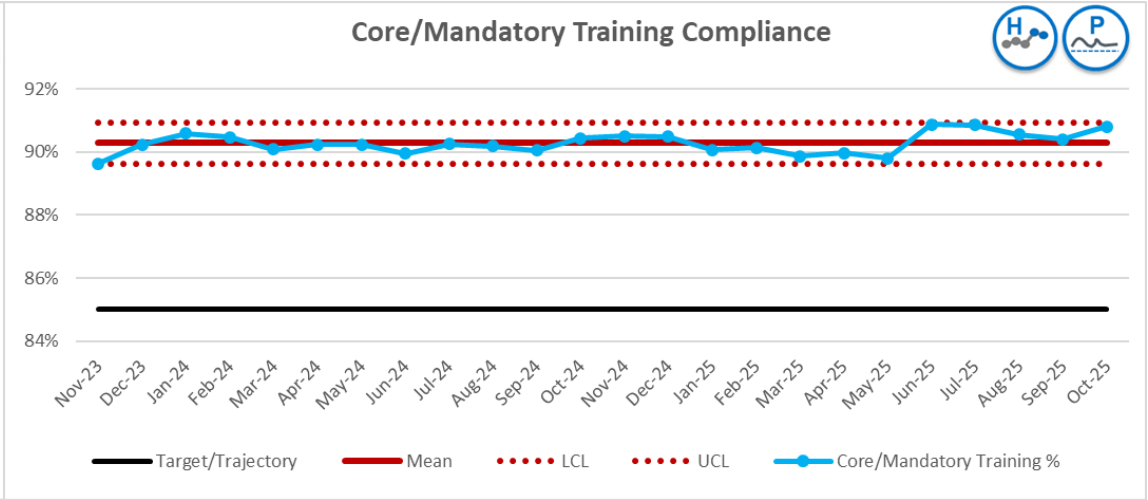
Metrics consistently passing target & maintaining/improving performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

53. Turnover



54. Core/Mandatory Compliance



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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 6 IPR indicators.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129 (i)	Meeting	Trust Board	Date Of Meeting	3 December 2025

Date of Meeting	14 October 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/25/10/155	**Hot Topic – Cancer Escalation Dip Audit**	The Committee received a presentation noting • Overview of escalation policy • Dip audit of 50 Patients – 24 required escalation (100% escalated appropriately) • 14 escalation provided desired result /10 ineffective • Overall, 29/50 patients breached their target • Areas affecting delays include capacity issues and complex pathways, diagnostic reporting times (e.g. MRI) • Overview of surveillance mechanisms for all tumour sites • Noted further work required within Urology(prostate)and Gynaecology – Plans agreed	**limited Good Assurance regarding escalation 100% compliance. Unable to address some issues relating to patient choice/ capacity of tertiary centre. Plans in place to address areas within WHH control for escalation. Limited assurance regarding surveillance**	**Substantial: Review via Quality Assurance Committee Quarterly, monthly oversight via Patient Safety and Clinical Effectiveness Committee (PSCESC)**	**Follow up detailed plan to return to Executive Management Team in November. Progress report to QAC in November** **Monthly oversight via Patient Safety and Clinical Effectiveness Committee (PSCESC)**

QAC/25/10/156	**Deep Dive – Typing Backlog**	The Committee received a presentation noting • Challenges to retrieve data easily without manual process • Improvement of 1420 cases since previous report • Plan for AI technology to reduce backlog, noted this will take time to implement • Staff overtime being used to support reduction • 5 incidents in 6 month – low harm • Current backlog circa 12k letters – trajectories in place	**Moderate** **Assurance has been received regarding progress to date; however trajectories need to be achieved to ensure risks are mitigated.**	**Substantial: Review via Quality Assurance Committee Quarterly,**	**Update to QAC Quarter 4**
QAC/25/10/157	**ED Improvement update**	The Committee received a presentation noting- • 12-hour time in Department remains a challenge • Achieved trajectory in month despite an increase in attendances • Slight deterioration in ambulance handover – QI project ongoing • Time to assessment – sustained improvements • Deterioration in time however a reduction in the number of patients nursed within the corridor • 2nd triage and Striage implemented from September • Overview of incidents – top themes include safeguarding and medication	**Moderate** **Clearer plans noted with some improvements in performance Further evidence of outputs of quality and safety required.**	**Substantive** **Monthly Oversight at QAC**	**Update to** **QAC November 2025**
QAC/25/09/138	**Patient Safety**	An update from Patient Safety and Clinical	**Moderate**		**Update to QAC**

	and clinical Effectiveness Sub Committee (PSCESC) Report.	Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note • Cardiology – one issue left to resolve, improvements continue • Chronic Pain – limited progress, discussions with new clinical lead re future state • Cancer – progress required, a number of issues identified • Urology – Medical capacity plans improved • Plans in place to address key issues. • Rheumatology escalated into fragile service – deep dive to come back next month	**Assurance has been received regarding progress to date; however, sustained improvements are required to ensure long-term impact and consistency.**	**Substantial** **Monthly oversight at QAC** **Executive oversight monthly of all fragile services is conducted through PSCESC**	**November 2025**
QAC/25/09/138	**Fractured Neck of Femur**	The Committee received a report noting • Spike in attendance • Post operative mobilsiation improved • Best Practice Tariff dropped by 1% • Remain on trajectory • Pain relief improvements launched preoperatively • Staff training in place to enhance staff confidence with mobilising patients post operatively • Deterioration in September on the time patients are admitted to orthopaedic ward • Average time to surgery deteriorated in month due to increase in attendances	**Limited** **Small improvements noted by the Committee. More detail requested on medically fit patients, SPC charts and aims to be quantified. More assurance required regarding capacity of theatres.**	**Substantive** **Oversight at QAC monthly.** **Monthly at Patient Safety and Clinical Effectiveness (PSEESC)**	**Update to PSCESC in October 2025**

The Committee also received the following items.

QAC/25/10/159 Quality/IPR
QAC/25/10/160 Type 5 Assessment
QAC/25/10/162 Maternity Update
QAC/25/10/163 Cardiopulmonary Resuscitation (CPR decisions) report
QAC/25/10.164 Patient Experience and Inclusion BiAnnual Report
QAC/25/10/165 Ward Accreditation Report
QAC/25/10/166 Claims Report
QAC/25/10/167 Quality Impact Assessment High level briefing
QAC/25/10/168 Committee Effectiveness Report
QAC/25/10/169 Quality Academy/Research Oversight minutes

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129a (ii)	Meeting	Trust Board	Date Of Meeting	3 December 2025

Date of Meeting	11 November 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Cliff Richards
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/25/11/176	**Hot Topic – Rheumatology/ Big Hand EPRR incident**	The Committee received a presentation noting • Increase in Pals/complaints/ delays in prescriptions • Issues re shared care agreements • Risk noted on risk register • Immediate tracker put in place • Backlog being monitored • Introduced Nurse led clinics • Reviewing GIRFT guidance to benchmark current pathways • Plan to move to electronic oversight programme **Big Hand EPRR incident** • 15 October issue identified with intermittent login issues leading to delays in transcriptions and distribution of clinical letters and operation notes • Backlog has been cleared • Automatic monitoring has been implemented – to detect issues • Teams calls held 3 x daily to address any issues	**Moderate** **Plans in place need to monitor improvements.** **More detail to be provided to PSCESC**	**Substantial: Review via Quality Assurance Committee Quarterly, monthly oversight via Patient Safety and Clinical Effectiveness Committee (PSCESC)**	**Progress report via fragile services to QAC in December** **Monthly oversight via Patient Safety and Clinical Effectiveness Committee (PSCESC) as part of fragile services reports**

		• AVT pilot commenced on 1 November			
QAC/25/11/177	**Deep Dive – MIAA update re Theatre safety**	The Committee received a presentation noting • Update following concerns raised in previous MIAA report • Governance structure strengthened • Observational audits undertaken weekly • Documented audits undertaken 3 x weekly • Digital audit tool being developed • Training developed- 72 staff completed • Action plan fully completed • 1 further Never Event noted	**Limited** **Despite actions being complete, further Never Event reported. Further work required regarding culture.**	**Substantial: Review via Quality Assurance Committee Quarterly,**	**Update to QAC in December 2025. Monthly monitoring via PSCESC**
QAC/25/11/182	**Patient Safety and clinical Effectiveness Sub Committee (PSCESC) Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note • Cardiology – looking to step down from fragile services– staffing issues addressed • Chronic Pain – limited progress, new clinical lead appointed, validation exercise ongoing • Cancer –SOP approved and in place • Urology – improved outpatient waiting list position. P2, 3 and 4 lists have reduced. • Plans in place to address key issues. • Rheumatology escalated into fragile service – deep dive to	**Moderate** **Assurance received, areas of concern have plans in place and are being monitored monthly via PSCESC.**	**Substantial** **Monthly oversight at QAC** **Executive oversight monthly of all fragile services is conducted through PSCESC**	**Update to QAC December 2025**

		come back next month • Fractured neck of femur- mortality has increased to 99 centile – submitted data incomplete which can affect data, crude mortality remains high.			
QAC/25/11/183	**Integration Full Business Case**	The Committee received a report noting • Working draft document was presented to the Quality Committee • The draft Full Business Case has been presented to both Board of Directors • Draft due diligence reports have been shared with boards • Further feedback requested from all sub committees • Mitigating actions against all key risks to be monitored via relevant sub committees	**Moderate** **Clear governance and actions in place to meet requirements.**	**Substantive** **Oversight at QAC (all sub committees) and both Board of Director meetings.**	**Update to Board of Directors in November 2025. Mitigation of risks to be managed by relevant sub committees.**
QAC/25/11/184	**Fractured neck of femur – future plan**	The Committee received a report noting • October position for time to Theatre has decreased to 38% • Time to ward has noted no significant improvement • Average time to surgery is 42 hours (this is an improvement from previous months) • Deterioration in post operative mobilisation KPI • Crude mortality above upper control limit	**Limited** **Despite actions being complete, further deterioration noted.**	**Substantive** **Oversight at QAC monthly.** **Monthly at Patient Safety and Clinical Effectiveness (PSEESC)**	**Update to QAC in December 2025. Monthly monitoring via PSCESC** **Full details plan to be presented at the Executive Team Meeting in 1 week.**

The Committee also received the following items.

QAC/25/11/178 Compliance update
QAC/25/11/179 Board assurance framework

QAC/25/11/180 Sepsis High level update
QAC/25/11/185 Maternity update
QAC/25/11/187 Infection Control Q2 Update
QAC/25/11/188 Dementia and Delerium Update
QAC/25/11//189 High level enquiries and external Assessment/Inspections
QAC/25/11/191CIP/GIRFT Quality Impact Assessment Biannual Report

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129b (i)	Meeting	Trust Board	Date of Meeting	3rd December 2025

Date of Meeting	Wednesday 15 October 2025
Name of Meeting and Chair	Strategic People Committee in Common, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPCIC/25/10/128	**Welcome, apologies and opening comments**	The Committee acknowledged the current landscape and recent events which impacts on staff wellbeing and belonging, both internally and externally to the organisation. Specifically, the Committee noted the anxiety which is created for some of our staff in relation to the rise in racist remarks and actions nationally. The Committee noted actions being taken at a Trust level in relation to this and offered their support to Trust staff.	No assurance was noted for this item.	No assurance was noted for this item.	N/A
SPCIC/25/10/131	**Hot Topic – Mental Health Hub – 10 Year Fit for the Future Plan**	The Committee received a presentation on the work undertaken to support the Trust workforce through a mental health and wellbeing lens. The presentation outlined the alignment to the 10 Year Health Plan for England: Fit for the Future Plan as well as regional priorities for sickness absence reduction. Members noted a new model which is being introduced called the “Stratified Stepped Care Model”. This ensures efficient use of resources, a focus on prevention and early intervention and the mirroring of the 10-year plan’s emphasis on	The Committee received **assurance** on the delivery of the Mental Health Hub and model for supporting staff wellbeing.	The Committee received **assurance** on the governance aligned to the Mental Health Hub and alignment with the 10 Year Fit for the Future Plan.	N/A

		prevention and targeted support. The Committee discussed: • Resource and alignment for OH and Mental Wellbeing Hub • Capacity and demand • Integration			
SPCIC/25/10/132(i)	**Chief People Officer Report**	The Committee received the report and noted: • The completed provider self-assessment return for approval • Staff Survey compliance • Staff Safety • Flu vaccination The Committee noted the significant volume of system pressures and financial actions and agreed for a monthly report to be added to the Cycle of Business regarding the Workforce from the Delivery Unit.	The Committee approved the Provider Self-Assessment Return.		N/A
SPCIC/25/10/134	**Better Care Together Update**	The Committee discussed current progress in relation to the Better Care Together integration programme. Specifically, members discussed the workforce and corporate service integration progress. Discussions included: - Sessions held with clinical staff and their feelings were noted as positive. - Corporate services feeling disengaged with slightly lower morale however this is being managed locally by teams. The Committee noted that this is reflective of the national picture where there is increased pressure on corporate team reduction and the impact that this has locally on staff morale.	The Committee received **moderate assurance** on the delivery of the programme because of the context of risk	The Committee received **assurance** on the governance of the programme and steps being taken to ensure a fair, consistent approach.	November 2025

SPCIC/25/10/136	**Flu Campaign (2025-26)**	The Committee received a report on the flu campaign for 2025/26. Members noted the work being undertaken to address the hesitancy to flu vaccination and changes to practices across the Occupational Health and Wellbeing service. Members noted that the Trust has a 5.2% target for improvement, set nationally and by the ICB to achieve at least 50% overall of frontline staff vaccinated.	The Committee received **assurance** on the delivery of the flu vaccination programme for 2025/26.	The Committee received **assurance** on the governance of the flu vaccination programme for 2025/26.	November 2025
SPCIC/25/10/183	**WHH Assessment of Compliance – Working Lives of Resident Doctors 10 Point Plan**	The Committee noted that Dr Eshita Hasan, Deputy Medical Director will be the senior responsible officer for the programme. Members noted the appointment of a Peer Resident Doctor - Medical Leadership Fellow Role. Actions with high / medium assurance were discussed by members. Specifically referencing areas of **moderate assurance**: • On-call parking arrangements • Notice period for all rotations going forward • Expense payments for approved study leave **Areas of limited assurance:** • Resident Doctor annual leave payments (NHS England) • The management of rotational changes (NHS England) • Minimising the practical impact for Resident Doctors to move employers when they rotate (NHS England).	The Committee received **moderate assurance** on the delivery noting a lot is out of control as sits with NHS England	The Committee received **assurance** on the governance of the Improving Working Lives of Resident Doctors 10 Point Plan	Follow up to be scheduled

Other reports received by the Committee:

- SPCIC/25/08/093 – Workforce Brief on National, Regional, ICB or Local Workforce Issues

- SPCIC/25/08/095 – Workforce Equality, Diversity and Inclusion Strategy Update
- SPCIC/25/08/097 – Safer Staffing Report
- SPCIC/25/08/098 – Midwifery Staffing Report – Q1 – approved for submission to Trust Board

Chairs Logs received by the Committee:

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

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129b (i)	Meeting	Trust Board	Date of Meeting	3rd December 2025

Date of Meeting	Wednesday 19th November 2025
Name of Meeting and Chair	Strategic People Committee in Common, Chaired by Abdul Siddique
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPCIC/25/11/147	**Deep Dive – Corporate Services Workstream**	The Committee received a presentation on the 2024/25 Corporate Benchmarking for WHH and BCH, as well as the approach for the TUPE process for Better Care Together. The Committee noted the significant reductions required in workforce for BCH to achieve the national median for Corporate Benchmarking across all corporate portfolios. Risks identified included the ability to achieve reductions with the current turnover rate. The Committee requested the need for a more thorough financial understanding of the benchmarking data and how reductions can be achieved. The presentation was referred to FSCIC for further review.	The Committee received **no assurance** on the delivery of Model Health Corporate Benchmarking	The Committee received **moderate assurance** on the governance of Model Health Corporate Benchmarking	For further review at FSCIC
SPCIC/25/11/149	**Chief People Officer Report**	The Committee received an update on: • Resident Doctor Industrial Action	The Committee received	The Committee received	To be scheduled

		• Mutually Agreed Resignation Scheme • 'Be Present, Be Here, Be WHH' attendance campaign • Your Future, Your Way Cohort 3 update • Staff Survey Update • Flu Campaign Update • WRES and WDES Quarterly Oversight Meeting The Committee noted the lower response rate for Staff Survey compared to last year, with a discussion regarding targeted work to develop our leaders to support teams, noting the critical role of leadership. The Committee noted the impact of the current NHS national operating environment and its negative impact on staff morale. The survey closes on 28 November 2025. In addition, the Committee noted the national Flu Vaccination target of 50% uptake for patient facing staff and a local ICB target of a least a 5% improvement since 2024/5 (WHH 44.8% to 50% and BCHT 53.1% to 58.1%) and noted that there continued to be active engagement with staff to encourage uptake including taking vaccine clinics into wards and departments in both WHH and BCHT, but despite this the uptake remained slow. The campaign continues until 31 March 2026.	**moderate assurance** on delivery due to the current low response rate to Staff Survey and morale of staff and uptake for the Flu Vaccination.	**assurance** on the governance of the topics reported.	

SPCIC/25/11/153	**Better Care Together**	The Committee received the Better Care Together full business case with a specific focus on the 'People' section. The Committee noted the thoroughness of the report and detail regarding supporting our people before, during and after the transaction. The Committee approved the full business case noting the pace at which it had been completed to meet 1st April 2026 deadline.	The Committee received **assurance** on the delivery of the full business case.	The Committee received **assurance** on the governance of the full business case.	N/A
SPCIC/25/11/158	**WHH & BCH Joint Safer Staffing Report (including red flag data)**	The Committee received the report highlighting fill rates, bank and agency usage and challenges in ward management, with discussion on the need for updated nursing indicators and the impact of moving staff between teams.	The Committee received **moderate assurance** on delivery due to some red flags, staffing and fill rate issues identified.	The Committee received **assurance** on the governance of Safer Staffing.	December 2025
SPCIC/25/11/159	**Midwifery Safe Staffing report (Q2)**	The Committee received the report which provided assurance on midwifery staffing, red flag incidents and action plans with assurance provided that current gaps are being managed without impacting continuity of care, and that recruitment and retention remain positive. The Committee noted how proud they were of Maternity Services and the support provided by Tina Moors, Interim Director of Midwifery.	The Committee received **assurance** on the delivery of Midwifery Safer Staffing.	The Committee received **assurance** on the governance of Midwifery Safer Staffing.	As per Cycle of Business

Reports received by the Committee for assurance:

- SPCIC/25/11/148 – Board Assurance Framework and Corporate Risk Register

- SPCIC/25/11/150 – ICB Workforce Programmes
- SPCIC/25/11/151 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/11/152 – Workforce Integrated Performance Reports
- SPCIC/25/11/154 – Equality, Diversity and Inclusion Strategy Update BCHT Bi-Annual Update
- SPCIC/25/11/155 – Workforce Policies and Procedures Overview Report
- SPCIC/25/11/156 – Freedom to Speak Up Bi-Annual report
- SPCIC/25/11/157 – Improving Working Lives Update Report
- SPCIC/25/11/161 – Guardian of Safe Working Q2 Report

Chairs Logs received by the Committee:

- SPCIC/25/11/162- WHH Operational People Committee
- SPCIC/25/11/163 – Workforce Review Group
- SPCIC/25/11/164 - BCH POD Council

Assurance Key:

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129c (i)	Meeting	Trust Board	Date Of Meeting	3 December 2025

Date of Meeting	27 October 2025
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by Bob Chadwick
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSPCiC/ 25/ 10/93	**Deep Dive –Level 3 CIP (long list)**	The Committee in Common received the presentation noting:- • £8.8m CIP delivered at month 6 in line with plan, however £4m delivered recurrently. • All schemes now fully developed however delivery risk remains with £5.4m in high risk (£6.9m in month 5 and £8.4m in month 4). • Level 3 CIP will be led, coordinated and developed at system level and delivered at Trust level - £11.2m unidentified of £13.1m target • Productivity improving, however three compounding factors driving ERF down – TIF theatres delayed (activity expected to start from November), unplanned workforce challenges in T&O (locums now in post), lack of referrals into Endoscopy Hub (conversations around disinvestment if referrals don't increase) • List of stretch schemes provided by the ICB (£4.9m), £3.7m already in BAU CIP plans, opportunities of up to £1m are being considered further, remainder not deliverable • Long list developed by the Executive Team, risks exist around patient care, patient flow and performance targets • A number of external reviews underway and being responded to including NHSE, ICB and PwC reviews	The Committee received **no** assurance	The Committee **noted** the report and is **assured**	**FSPCiC November 2025**
FSPCiC/ 25/ 10/95	**Finance Report**	The Committee in Common received the report noting:- • Month 6 deficit position is on plan at £22.1m (before deficit support funding (DSF)), after DSF the deficit is £17.5m (£4.6m worse than plan).	The Committee received **moderate** assurance recognising	The Committee **noted** the report and is **assured**	**FSPCiC November 2025**

		• Risk adjusted forecast excluding DSF has been submitted at a £41.8m deficit compared to a plan of £28.7m. The variance consists of £11.2m level 3 CIP and risk assessed CIP delivery based on PFR percentages of £1.8m. • Bank not meeting 10% reduction, due to Industrial Action and the impact of the pay award.	achievement of plan to date but risk of overall plan delivery		
FSPCiC/ 25/ 10/97	**Cash Support Update**	The Committee in Common received the report noting:- • October cash application approved by NHSE • Notification of the November cash application is pending. • Total Q3 submissions anticipated to be less than the Board approved £12.9m • Cash management measures continue to be in place	The Committee received **moderate** assurance due to the Trust financial position and requirement for cash support.	The Committee **noted** the report and is **assured**	**FSPCiC Novembe r 2025**
FSPCiC/ 25/ 10/102	**Corporate Performan ce Report**	The Committee in Common received the report noting:- • ED 4 hour performance 69% (including Widnes UTC), three months of improvement however remains a concern (101 out of 118 – circa 80 out of 118 if Widnes UTC included) • Percentage waiting over 12 hours remains a challenge • RTT performance 59%, 52 week wait is the biggest challenge, 65 week wait ahead of plan at September and expected to be 0 by the end of October (ahead of December deadline) • Strong performance in diagnostic performance nationally • Cancer performance – 97% 31 day wait consistently achieved, 79% 62 day wait continues to be a challenge, 28 day Faster Diagnosis is 72% and is not currently meeting the target.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC Novembe r 2025**
FSPCiC/ 25/10/108	**Monthly Productivit y Update**	The Committee in Common received the report noting:- • Theatres – improvement in theatre productivity over the last few months, particularly capped utilisation. Late starts continue to be an issue, the reasons for this are multifactorial and continues to be an area of focus. Delivery Unit continues to monitor and this will be now reviewed on a weekly basis • Outpatients – metrics have worsened since the beginning of the financial year. Concern raised about whether the metrics are too challenging or whether more can be done to achieve the metrics set	The Committee received **moderate** assurance given the progress that has been made	The Committee **noted** and discussed the report receiving **moderate** assurance given plans in place are not delivering to expectations	**FSPCiC Novembe r 2025**

Items for noting

FSPCiC/25/10/96 Cost Pressures
FSPCiC/25/10/98 Monthly CIP Updates
FSPCiC/25/10/99 Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency
FSPCiC/25/10/105 Pay Assurance Report
FSPCiC/25/10/106 Revenue Request – no requests for approval
FSPCiC/25/10/107 EPRR Annual report & Annual assurance Letter Statement of Compliance – to progress to Trust Board
FSPCiC/25/10/109 Elective Recovery Update
FSPCiC/25/10/110 Integration Update
FSPCiC/25/10/111 Sustainability Strategic Objectives Bi-Annual Report
FSPCiC/25/10/112 Delivery Unit 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;
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	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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129c (ii)	Meeting	Trust Board	Date Of Meeting	3 December 2025

Date of Meeting	24 November 2025
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSPCiC/ 25/ 11/122	**Deep Dive – Productivity – Specialty Level**	The Committee in Common received the presentation noting:- • £2.6m underperformance at M7 in Planned Care of total £3.4m, mainly driven by Endo Hub due to referrals not being sent from across C&M. £1.5m risk of underperformance has been flagged to the ICB. • Consideration being given to closing the Hub however some costs are fixed, only variable can be turned off, review underway. • Theatre productivity target of £0.9m for 2025/26, capped utilisation and cases per sessions exceeding plan and opportunity in cancellations on the day based on benchmarking. However, given underperformance in core activity this can't be recognised as additional income. • Dynamic plans produced and demonstrate that income will be recovered, with the exception of Endoscopy (£1.5m).	The Committee received **moderate** assurance	The Committee **noted** the report and received **moderate** assurance	**FSPCiC December 2025**
FSPCiC/ 25/ 11/123	**Hot Topic – CIP (Long List / PwC List)**	The Committee in Common received the presentation noting:- • CIP risk of £16.3m (£5.1m risk in BAU risk and £11.2m stretch) with £5.6m of £10.8m achieved non-recurrent. • Recommendations received (131) from a number of areas totalling £18.6m and all being reviewed, however some are already in plans (51). • Grip and control report identified 48 recommendations of which only two were high priority that weren't already in plans. • Suggested principles taken to Extraordinary Board and agreed, the	The Committee received **no** assurance given the gap to the financial plan	The Committee **noted** the report and is **assured** given the challenging conversations and difficult decisions taking place	**Trust Board December 2025**

		likely value for the remainder of the financial year is circa £1.4m.			
FSPCiC/ 25/ 11/125	**Finance Report**	The Committee in Common received the report noting:- • Month 7 deficit position is £9k better than plan at £24.6m (before deficit support funding (DSF)), after DSF £20m deficit (£6.1m worse than plan). • Risk adjusted forecast excluding DSF has been submitted at a £41.6m deficit compared to a plan of £28.7m. The variance consists of £11.2m stretch target and PFR risk assessed CIP delivery of £1.7m. • The Trust underlying deficit is £43.8m with the variance to plan mainly driven by stretch target as well as non-recurrent benefits in 2025/26. • Bank not meeting 10% reduction, mainly due to Industrial Action and the impact of the pay award. • Agency remains below plan however has increased significantly in month 7 mainly due to requests only going out last minute when deemed to be absolutely required meaning it has to go to agency rather than bank. • One revenue request supported by the EMT meeting.	The Committee received **moderate** assurance recognising achievement of plan to date but risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC Decembe r 2025**
FSPCiC/ 25/ 11/131	**Corporate Performan ce Report**	The Committee in Common received the report noting:- • ED 4 hour performance 67% (including Widnes UTC), improvement hasn't continued into October after three months of continued improvement, November is looking better and likely to recover the 2% reduction. • Percentage waiting over 12 hours remains a challenge. • Continued improvement in RTT performance 60%, 52 week wait is the biggest challenge, 65 decreased in month but did not achieve a zero position (17 patients remaining), 10 forecast for November with clearance expected by 21 December deadline. • Strong performance in diagnostic performance nationally • Cancer performance – 99% 31 day wait consistently achieved, 77% 62 day wait continues to be a challenge, 28 day Faster Diagnosis is 74% and is not currently meeting the target, recovery plan in place.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC Decembe r 2025**
FSPCiC/ 25/11/136	**5 Year Plan /**	The Committee in Common received the report noting:- • Exit run rate submission due 24 November with first full draft due	The Committee received **moderate**	The Committee **noted** the report	**Trust Board**

	Operational Plan Update	on 15 December (ICB) and 17 December (NHSE). • Board Assurance statements included with further discussion required at Trust Board.	assurance given this is just the start of the process	received **moderate** assurance given this is just the start of the process	**December 2025**

Items for noting

FSPCiC/25/11/124	*Board Assurance Framework*
FSPCiC/25/11/126	*Cost Pressures*
FSPCiC/25/11/127	*Cash Support Update – Q4 request of £13.237m supported for Trust Board approval.*
FSPCiC/25/11/128	*Monthly CIP Update*
FSPCiC/25/11/129	*Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPCiC/25/11/133	*Pay Assurance Report*
FSPCiC/25/11/134	*Revenue Request – Planned Care Quality and Safety Waiting List Initiatives 2025/26 – supported the non recurrent funding for Trust Board approval*
FSPCiC/25/11/135	*Integration Update*
FSPCiC/25/11/137	*Monthly Productivity Update*
FSPCiC/25/11/139	*Benefits Realisation Q2*
FSPCiC/25/11/140	*Elective Recovery Update*
FSPCiC/25/11/142	*Joint Estates Strategy Progress Report*
FSPCiC/25/11/143	*Medical Workforce Review Group Q2 Report*
FSPCiC/25/11/144	*Delivery Unit Update*

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

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

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/12/129d	Meeting	Trust Board	Date Of Meeting	3 December 2025

Date of Meeting	20 November 2025
Name of Meeting & Chair	Audit Committee, Chaired by Mike O'Connor
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/25/11/66	Clinical Typing Backlog/ Big Hand	The Committee received a detailed update as escalated from the Quality Assurance Committee regarding the ongoing clinical risk posed by the backlog of untyped letters, which had been exacerbated by a recent outage of the Big Hand digital dictation system. Assurance was provided that actions are underway, including the rollout of ambient voice technology and repurposing of typing staff to address the backlog. The Committee requested continued reporting and a further update in the coming months.	**Moderate** – Concerns remain regarding the pace of improvement and the need for sustained focus, but clear actions and escalation are in place.	***Assured* -** The Committee received high assurance on governance, escalation, and oversight mechanisms through the Quality Assurance Committee.	**Updates to be received at QAC and Audit Committee throughout Q3 and 4**
AC/25/11/67	Fractured Neck of Femur Performance Assurance & future plan	The Committee received a detailed update as escalated from the Quality Assurance Committee. The Committee scrutinised the service's performance following a national alert on mortality rates. There was robust discussion about theatre capacity, consultant variation, and the need for improved operational management. Immediate actions were agreed, including daily reporting, formal performance management, and escalation to the CEO. The Committee emphasised the need for ongoing scrutiny and improvement, with further assurance to be	**Moderate** – Concerns remain regarding the pace of improvement and the need for sustained focus, but clear actions and escalation are in place.	***Moderate* -** The Committee received moderate assurance on governance, escalation, and oversight mechanisms through the Quality Assurance Committee, given	**Updates to be received at QAC and Audit Committee throughout Q3 and 4**

		sought at future meetings.		that less progress had been made against actions than expected	
AC/25/11/68–70	**Internal Audit Progress and Follow Up Reports**	The Committee received comprehensive reports on internal audit progress and follow-up actions. The follow-up review included all recommendations past their original or revised review dates, providing a position statement on implementation. Most recommendations had been implemented, with outstanding items subject to revised timelines and ongoing monitoring. Particular attention was given to consultant job planning, where significant progress has been made, and to cyber/data security risks, which are being addressed with a target completion date of February 2026.	**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	**Further update to be provided to Audit Committee in Feb 2026.**
AC/25/08/50	**Review Losses & Special Payments**	The Committee reviewed the quarterly report on losses and special payments, noting a significant reduction compared to the previous year. The decrease was attributed to improved risk management and fewer claims, with two notable employee liability claims partially reimbursed. The Committee agreed that the figures reflected positive progress and effective 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	**Update to be provided to Audit Committee in November 2025**
AC/25/08/52	**Review of Scheme of Reservation & Delegation (SoRD) and Standing Financial Instructions (SFIs)**	The Committee received and noted the review of SoRD and SFIs, confirming that changes had been approved and that the Trust's model would be adopted post-integration.	**Assured –** the Committee agreed that All required updates completed and approved to support integration	***Assured -*** the Committee received assurance on robust governance and compliance.	**n/a**

Other agenda items:
AC/25/11/64– Board Assurance Framework

AC/25/11/65– Committee Assurance Updates
AC/25/11/71– Report and Update External Audit
AC/25/11/73 - Review of Quotation & Tender Waivers

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/130**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	Y
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper serves to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: Orthopaedics – Fractured Neck of Femur Urology Cancer Services Chronic Pain Service Services de-escalated from Fragile Services oversight since last report: Cardiology and Cardiorespiratory Services Services entering Fragile Services oversight since last report: Rheumatology			
PURPOSE: ***(please select as appropriate)***	approval	To note ✓	Decision	
RECOMMENDATION:	Trust board is asked to: • Note the current list of Fragile Services, associated clinical risk and high-level progress updates • Note the de-escalation of Cardiology and Cardiorespiratory services from Fragile Services Oversight • Note the escalation of the rheumatology service into Fragile Service Oversight • Note that National Hip Fracture Database data has continued to flag fracture mortality as a concern and receive assurance that the service is under direct executive oversight with daily reporting, weekly performance meetings and monthly reporting to QAC. Improvement in mortality has been seen in published data or Q1 2025 • Receive further Fragile Service Oversight reports			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF	Release Document in Full			

INFORMATION STATUS (FOIA):	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Fragile Services Oversight**	**AGENDA REF:**	**BM/25/10/xx**

1. BACKGROUND/CONTEXT

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

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

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

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

Cardiology and Cardiorespiratory Services

Following a detailed job planning exercise including alignment of consultant capacity to demand and recruitment to vacancies the service is now in a sustainable position. Concerns regarding the management of patients on 'investigation pending' access plans have been resolved.

Cardiorespiratory capacity remains challenged, but has improved due to successful recruitment, introduction of the Watch-Pat IA sleep study device and consultant recruitment (through resource released by job planning and a reduction in WLI). No patient harm has been seen.

3. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

Rheumatology

Escalated to Fragile Service Oversight following presentation at QAC November 2025 following concerns raised regarding delays with prescribing and responses to

patient queries. Issues driven by current workforce constraints and suboptimal processes

Key areas of risk identified for improvement include:

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

Detailed improvement plan to be presented at December PSCESC

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Orthopaedics – Fractured Neck of Femur

Summary

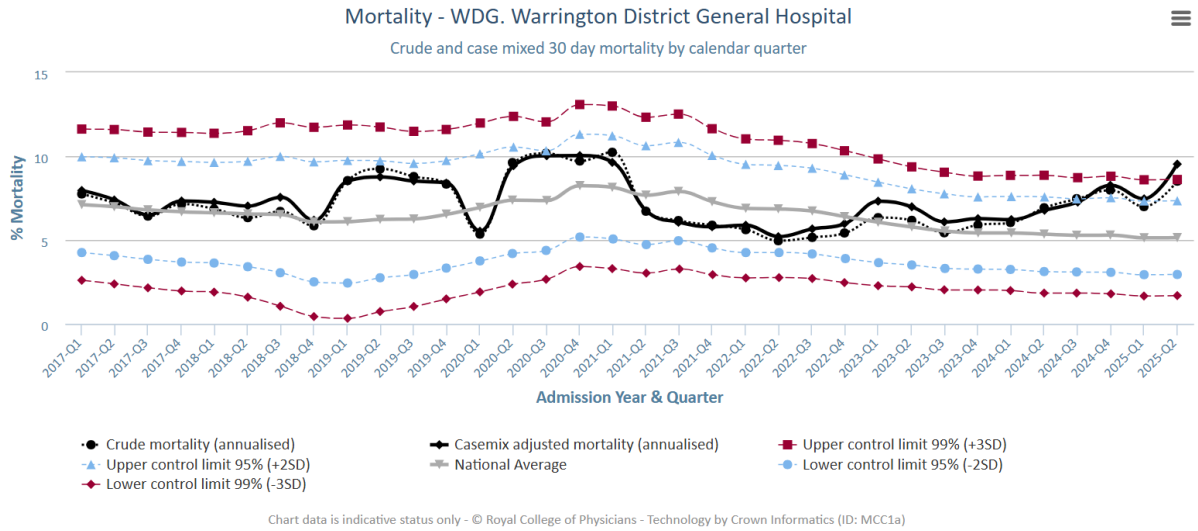
After improvement in Q1, National Hip Fracture Database data has demonstrated a deterioration in mortality in Q2 2025/26.

Prompt surgery and prompt mobilisation remain an unresolved quality and performance issue. This has been escalated through QAC to Audit Committee and a recovery plan with direct executive oversight is in place.

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

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

Figure 1 – Hip Fracture Crude and Case Mix Adjusted Mortality



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

Performance reporting has been stepped up to daily with a weekly executive chaired formal performance management meeting now in place. The service will continue to report to PSCESC and QAC monthly.

Urology

Summary

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

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

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

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

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

- P2 – waiting list has reduced over the last quarter and shows a reducing trend
- P3 waiting lists have reduced after increases during summer 2025
- P4 waiting lists have shown improvement following increases over summer 2025
- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance cystoscopy position very significantly improved from peak, and continues to improve with waiting list now fewer than 25 patients (from a peak >200)
- Tier 2 doctor staffing issues progressed with HR processes reaching a conclusion

  Completed Actions
  - Increased endoscopy cystoscopy capacity by 40/week
  - OP Clinic template standardisation completed
  - Additional middle grades recruited
  - Locum consultants commenced in post
  - Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.
  - Prostate triage nurse now in place supporting effective and timely management within the prostate pathway
  - Survaillance waiting list processes for prostate and kidney cancer enhanced – validation of patients on surveillance lists underway

  Current mitigations
  - Stent register process in place – further failsafe refinements made, with process audited for assurance
  - Hot stone list implemented at Warrington site with hot slots on elective lists when weekly hot stone list unavailable
  - PCNL Stone patients transferred to Chester as required – no wait at present
  - Specialist nurse delivered cystoscopy training underway with 2 nurses now practitioners undertaking an independent list each week
  - WLI and outsourced sessions approved where required to support activity and safety

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

- Urology likely to be included in system work on sustainability of fragile services

Chronic Pain Service

Summary

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

Initial Progress against initial actions was not timely, and following escalation to the MD has resulted in a change of clinical lead with additional support put in place. New Clinical Lead now progressing actions with support from CBU and Care Group Team

Completed Actions

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

Outstanding Initial actions

- Service Gap analysis against NICE guidelines
- Standardised GP and patient letter format
- Develop clear directory of non-medical options for referral
- Meet with Primary Care to agree pain SOPs before implementation

Medium term actions

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

Long term actions (12+ weeks)

- Service prioritised for integration and transformation with Bridgewater Community Health - moving from a secondary care medical based illness management service to a community-based MDT re-enablement health improvement service.

Cancer Services

Summary

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

Priority workstreams identified and underway to standardise and improve key cancer processes:

- **Cancer patient tracking escalation**
- **Consultant upgrade process**
- **Investigation and results tracking and management**
- **Cancer surveillance tracking and standards (speciality level)**
- **MDT standardisation**

Completed actions

- Updated robust SOP for cancer pathway escalations implemented
- Updated Consultant Upgrade process with single point of access
- ICE referral for ED Suspected Cancer/Diagnosed Cancer live August 2025
- Mapping and baseline assessment of tumour site specific cancer surveillance pathways – reported to EMT and QAC October 2025 – improvement plan in place and dedicated cancer surveillance access plans implemented in gynaecology and urology in November 2025

Ongoing improvement plan actions:

- Complete standardisation of Cancer MDTs across Trust
- Delay in automating referrals/upgrades of malignancy identified via histology results – escalated to report to PSCESC November 2025
- Scoping for automation of referrals/upgrades from radiology reports
- Optimisation of tumour site specific surveillance pathways

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note that National Hip Fracture Database data has identified hip fracture mortality as a concern and receive assurance that the service is under direct executive oversight with weekly performance meetings and monthly reporting to QAC.
- Note the de-escalation of Cardiology and Cardiorespiratory services from Fragile Services Oversight
- Note the escalation of the rheumatology service into Fragile Service Oversight
- 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 patients	June 2022	Ongoing
Histopathology Turnaround Times	July 2022	June 2023
Paediatric Ophthalmology	Feb 2023	May 2024
Diabetic Foot Clinic	April 2023	June 2023
Age-Related Macular Degeneration	May 2023	Sept 2023
Gynaecology	July 2023	Sept 2024
Urology	Jan 2024	Ongoing
ENT	Nov 2023	March 2025
Stroke Services	May 2024	Sept 2024
Theatres (procedural safety)	Jun 2024	Nov 2024
Cardiology and Cardiorespiratory	Sept 2024	Nov 2025
Cancer Services	June 2025	Ongoing
Chronic Pain Service	June 2025	Ongoing
Rheumatology Service	Nov 2025	Ongoing

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/131**	
SUBJECT:	**Maternity & Neonatal Update September to November 2025**	
DATE OF MEETING:	**3 December 2025**	
AUTHOR(S):	Helen Wall Assurance and Improvement Manager Tina Moors Deputy Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will… Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff.	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those	✓		

	who do not			
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of activity, performance and quality within the maternity and neonatal services for the period July – September 2025. 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. This report provides a summary of the following: • Perinatal Mortality Review Tool Q2 2025/26 • Maternity Incentive Scheme Year 7 position • November Maternity Quality & Safety update • Maternity Self-Assessment Tool Update WHH Q2 PMRT audit recorded two babies reported to MBRRACE born between 01/07/2025 and 30/09/2025. • WHH stillbirth rate for Q2 2025/26 was 1.53 per 1000 births. • WHH annual Mean stillbirth rate is 1.6 per 1000 births which is below the 2024 MBRRACE-UK national rate 3.9 per 1000 births. • WHH Neonatal mortality rate during Q2 2025/2026 was 1.50 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births. • There were two babies requiring PMRT review panel in Q2. • Full compliance reported in relation to Maternity Incentive Scheme; Safety Action 1 standards are being met. There are 10 safety actions from the Maternity Incentive Scheme (MIS). WHH is compliant with 5 safety actions and on track to achieve compliance for the remaining 5			

	safety actions. There were 153 patient safety events reported across the CBU in September 2025. There were no fatal or severe harm events in September 2025 in the maternity or neonatal services. There were 8 moderate harm events. OASI rate for September is 1.75%, which is a reduction from August. The top three themes from Maternity/Neonatology patient safety events in September 2025 were: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) 1000ml-1500ml • Postpartum Haemorrhage (PPH) >1500ml In September 2025, 15 term babies were admitted to the Neonatal Unit, mirroring admissions of 15 in August 2025. All term admissions are reviewed through the ATAIN process. An action plan is in place to address emerging themes. Respiratory distress continues to be the predominant reason for admission. There were **21** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and the learning is shared. There were **7** cases of **PPH ≥1500mls** in September. Data continues to show common cause variation, however a reduction in September is noted compared to August. Improvements have been made in mandatory and role specific training, both currnetly above Trust target. PDR compliance is 78%. Work continues to achieve full compliance by the end of December 2025, and progress is being monitored on a weekly basis. Turnover for maternity and child health staff (permanent staff) in September 2025 is 10.8%, 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 Maternity self-assessment tool identifies 159 criteria. As at 31st October 2025, WHH is fully compliant with 138/159 criteria. This equates to 87% of the criteria, an improvement from 84% when the last assessment was completed.

	Two complaints were received relating to care in the maternity and neonatal services in September 2025. No regulation 28 enquiries have been received		
PURPOSE: ***(please select as appropriate)***	For approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/25/11/185i QAC/25/11/185ii QAC/25/11/185iii QAC/25/11/185iv	
	Date of meeting	11 November 2025	
	Summary of Outcome	Noted and approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update September to November 2025	AGENDA REF:	BM/25/12/131

1. BACKGROUND/CONTEXT

This paper provides an overview of activity, performance, and quality within the Maternity and Neonatal Services for the period September to November 2025.
The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7, and local improvement actions.
This paper provides a summary in relation to the following reports which have been presented and discussed to Quality Assurance Committee oversight:

- Perinatal Mortality Review Tool Q2 2025/26
- Maternity Self-Assessment Tool Update
- Maternity Incentive Scheme Year 7 position
- November Maternity Quality & Safety update

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

2. Perinatal Mortality Review Tool (Quarter 2)

There were two cases to report to MBRRACE-UK during Q2 reporting period.

One Stillbirth:
One baby born at 27+2 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 17 November 2025 and will be included in the Q3 2025/26 Perinatal Mortality Review Audit report to QAC.

One Neonatal Death:
One baby born at 39+1 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 17 November 2025 and will be included in the Q3 2025/26 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 2. WHH Stillbirth Rate:

- WHH Q2 stillbirth rate for 2025/2026 is 1.53 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH annual stillbirth rate for Q1-Q4

2024/25 is 1.6 per 1000 births. The WHH stillbirth rate over 12 months Q3 24/25-Q2 25/26 is 2.08. The MBRRACE-UK national rate is 3.9 per 1000 births.

2.2 Q1. WHH Neonatal Mortality Rate:

WHH neonatal mortality rate during Q2 2025/2026 was 1.50 per 1000 live births. The MBRRACE-UK national rate is 3.0/1000 live births.

2.3 Quarter 2 PMRT Review Panel Key Findings
Synopsis of Findings

There were two babies reviewed in Q2 and the surveillance findings were:

- Both babies were of a singleton pregnancy.
- Both women were aged between 24-30 years.
- Both women were identified as white ethnicity.
- Neither woman had any communication problems because of learning difficulties/hearing problems.
- Both women had a normal BMI.
- One woman was a smoker and engaged with Stop Smoking services.
- In both cases there were no issues identified with the care provided in relation to safeguarding.

2.4 PMRT Grading of Care – Stillbirth

During Q2 two PMRT review panels took place. Parental perspective of the care received was sought.

In both cases there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would not have made a difference to the outcome for the baby.

In both case there were no issues identified with the care of the mother following confirmation of the death of her baby.

2.5.1 PMRT reporting for Saving Babies Lives Care Bundle v3- Q2 2025/26:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum monitoring were a contributory factor to perinatal mortality. PMRT reviews no concerns were raised in relation to FGR and RFM management.

2.6 Maternity Incentive Scheme Year 7 Compliance

WHH is compliant with all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 7.

2.7.1 Learning and Good Practice

- It was noted in both cases that the death was confirmed following the first episode of reduced fetal movements. Both cases had documented discussions for safety netting when fetal movements were changed or reduced.
- In one case, the baby was found to be small on a private scan, and this was not escalated to the ultrasound department.
- In one case, the parents described a lack of communication from the obstetric team when the fetal heart could not be found.
- It was noted that bereavement care was good in both cases.
- Parental involvement was sought in all cases as part of PMRT panel review.
- Both cases of stillbirth which occurred in the quarter have been notified to MBRRACE-UK and surveillance completed within the required timescale.

2.8.1 Summary

WHH Q2 PMRT audit recorded two babies reported to MBRRACE born between 01/07/2025 and 30/09/2025.

- WHH stillbirth rate for Q2 2025/26 was 1.53 per 1000 births. WHH annual Mean stillbirth rate is 1.6 per 1000 births which is below the 2024 MBRRACE-UK national rate 3.9 per 1000 births.
- WHH Neonatal mortality rate during Q2 2025/2026 was 1.50 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- There were two babies requiring PMRT review panel in Q2.
- Full compliance reported in relation to Maternity Incentive Scheme; Safety Action 1 standards are being met.

The PMRT position is monitored at the monthly Women's & Children's (WCH) Governance Meeting.

3 Maternity Incentive Scheme (MIS)

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.

The first quarterly meeting with the Local Maternity and Neonatal System (LMNS) took place in June, focusing on the Trust's progress against the Saving Babies' Lives care bundle and the Maternity Incentive Scheme (MIS). The second quarterly meeting was held on 17 September 2025, during which the Trust received encouraging feedback regarding the evidence submitted to date for the MIS. The LMNS commended the quality and completeness of the documentation, reflecting the Trust's commitment to continuous improvement in maternity safety and governance.

3.2 Safety Action progress

Table 1 details progress against the MIS safety actions

Safety action number	Safety action description	Progress
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	Compliant
2	Are you submitted data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	Compliant
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	On track to achieve compliance
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	On track to achieve compliance
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Compliant
8	Can you evidence the following 3 elements of local	On track to

	training plans and 'in-house', one day multi-professional training?	achieve compliance
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?	On track to achieve compliance
10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?	On track to achieve compliance

WHH is compliant with 5 safety actions and on track to achieve compliance for the remaining 5 safety actions. The progress against MIS continues to be reviewed at the monthly Women's and Children's CBU governance meeting.

4 Quality & 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.

4.1 Patient Safety Events

There were 153 patient safety events reported across the CBU in September 2025. There were no fatal or severe harm events in September 2025 in the maternity or neonatal services.

There were 8 moderate harm events,

- 4 cases of 3rd/4th degree tear (OASI). A reduction from 6 in August 2025. These cases were reviewed by the maternity MDT through Intrapartum Review Group (IRG).
- Cooling babies (2) Both reported to MNSI and accepted.
  MI-047285 Shoulder Dystocia (immediate learning - no referral to obstetrics for counselling for AC >97 centile)
  MI-047288 Normal birth on the NEST (immediate learning - approximate FH during second stage)
- ITU admissions (2) both has Immediate Safety Reviews completed (ISR)
  1x 28/40 PET requiring inotropic support following Cat 2
  1x 27/40 Varicella pneumonia IUD & EMCS – Reported to MBRRACE

OASI rate for September is 1.75%, which is a reduction from August but is within common cause variation.

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

of key matters relating to themes identified from patient safety events are detailed below.

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

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

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

In September 2025, 15 term babies were admitted to the Neonatal Unit, mirroring admissions of 15 in August 2025. All term admissions are reviewed through the ATAIN process, which reports quarterly to the Quality Assurance Committee. An action plan remains in place to address emerging themes. Respiratory distress continues to be the predominant reason for admission.

In response, clinical teams are maintaining positive end-expiratory pressure (PEEP) at 30, actively researching the use of Continuous Positive Airway Pressure (CPAP) a non-invasive respiratory support method used in neonatal care to help babies breathe more effectively. In addition, a key area of improvement has been the development and implementation of the Transitional Care (TC) model. Since July 2025, dedicated staff have been consistently rostered to support TC provision, ensuring that all identified cases have received appropriate care without exception. This has contributed positively to reducing maternal–neonatal separation. However, the impact on the Avoiding Term Admissions into Neonatal units (ATAIN) rate has been minimal to date.

Separately, findings from a recent 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.

4.3 Postpartum Haemorrhage

There were **21** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and the learning is shared.
There were **7** cases of **PPH ≥1500mls** in September.
Data continues to show common cause variation, however a reduction in September is noted compared to August.

- **Regional Guideline Implementation:** The Northwest Regional PPH guideline V1 was ratified in September and will be disseminated to clinical teams ahead of its publication on the hub. It introduces revised recommendations for third stage management, which are anticipated to contribute to a reduction in postpartum haemorrhage (PPH) rates and enhance overall maternal outcomes.
- **September Data Trends:** September continues to demonstrate common cause variation, with a noted decrease compared to previous months. This remains under close surveillance to ensure appropriate escalation if required
- **Postpartum Haemorrhage (PPH) Quality Improvement:** The PPH QI initiative has temporarily reverted to a working group status. It will be reinstated as a formal QI project following the implementation of the newly ratified regional guideline
- **Ongoing Data Collection:** Data collection remains active and robust, supporting continuous monitoring and analysis of outcomes
- **Case Review and Learning:** Individual cases are consistently reviewed within the Intrapartum Review Group to extract learning and inform practice improvements.
- **ReAudit –** 6-month Audit to be completed after implementation of PPH Guideline (Nov 2025 – May 2026)

4.4 Workforce metrics

Work remains ongoing across the Maternity and Neonatal teams to sustain compliance with mandatory training and completion of staff appraisals.
At the end of September compliance for mandatory training across maternity and child health is 91% for Trust mandatory training (including safeguarding training) and 90% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long-term basis.

Compliance with PDR completion remains a challenge, currently positioned at 78%. However, a positive trajectory has been observed over recent months, with incremental improvements recorded. Work continues to achieve full compliance by the end of December 2025, and progress is being monitored on a weekly basis. Good compliance with maternity specific training standards is largely being sustained with further improvement in particular Obstetric colleagues K2 compliance.

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	Maternal AIMS
Midwives	97.7%	98.4%	90%	97.7%	91%
Obstetric Consultants	100%	100%	75%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	83.6%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	n/a
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data	n/a

Turnover for maternity and child health staff (permanent staff) in September 2025 is 10.8%, 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%.

4.5 Service user and staff feedback

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

4.6 Maternity Triage

There has been significant regional and national scrutiny of triage services.

4.6.1 Current performance

In September 2025, 623 triage attendances were recorded, maintaining the average number of attendances per day of 20 seen since the beginning of 2025.

- 17.17% of attendees in August were seen immediately on arrival.
- The longest wait recorded for initial review was 73 minutes.
- 90% of attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- 95% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 100% of attendees (1 woman) categorised as red on arrival and seen within 15 minutes of arrival for initial triage.
- 17.65% of attendees were categorised orange on arrival. Similar trend to August 2025 when the proportion was 17.52%.

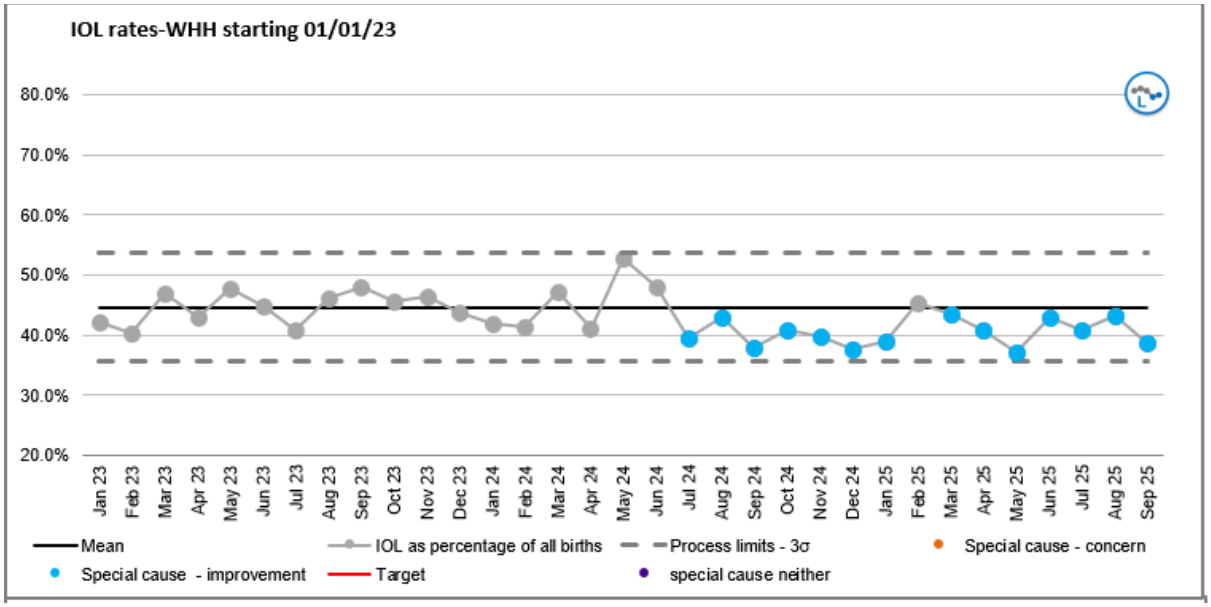
4.6.2 Triage action plan

- 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.
- Audit category of women not seen within 15/30 minutes.

4.7.1 Induction of labour

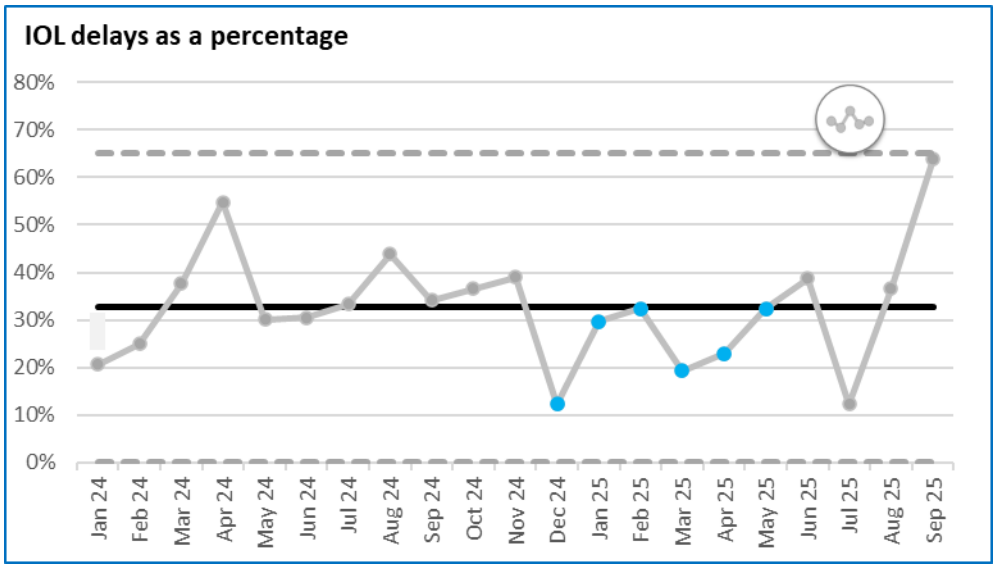
The service was identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes. As a result, a significant IOL workstream is underway.

As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. In September the induction of labour rate at WHH was 33.9%, (77 inductions out of 227 births) compared with 43.35% in August, which is demonstrating continuous improvement.



4.7.2 Induction of labour delays

During September 2025, there was an increase in delayed IOL at 64.94%. The data shows that the WHH Maternity Unit is a regional outlier.



A deep dive commenced and identified that the reasons for potential delays in Induction of Labour (IOL) during September were:

- 15% Increase in Births based on Yearly Birth Rate
- 5.9% Increase attendances into Triage
- Increased Sickness 8.8%
- Escalation 9 times. OPEL AMBER x6. RED x3
- 1 x High Risk Patient for 15 days on Birth Suite impacting bed flow.
- 2 Birth Suite Rooms out of use due to estate work required.

Improvement plans have been developed and include:

- **Re-circulation of the Regional IOL guideline**, with clear emphasis on Bishop Score assessment, and suitability for ARM
- **Deep dive into September IOL data** to review decision-making, delay causes, and Bishop scores to determine whether women were suitable for ARM or would have benefited from an alternative approach.
- **Implementation of a daily IOL floorwalker** from 3rd November to observe live activity, identify barriers to progression, and collect qualitative data on decision making, communication, and operational pressures that are not captured through the bleep paperwork or quantitative reports.
- **Day in the Life** to be undertaken by Assurance and Improvement Manager to explore cultural and behavioural barriers influencing transfer decisions and escalation.
- **LMNS Network** Intrapartum Matron and IOL Lead Midwife will visit other units within the LMNS to observe how they manage and report IOL activity. This will include reviewing their documentation processes, digital systems, and escalation frameworks.
- **Measure -** Continue to monitor KPIs using balanced scorecard and Audits to monitor effectiveness of measures put in place.

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

4.8 Maternity and Newborn Safety Investigation (MNSI) position

Two new maternity cases – Four cases in progress:
Referred April 2025 (HIE/NND) in progress – Draft report delayed until COD from PM
Referred August 2025 (Shoulder Dystocia HIE) in progress
Referred September 2025 (Shoulder Dystocia HIE) in progress
Referred September 2025 (Pool birth HIE) in progress

4.9 Update on other workstreams

4.9.1 The Nest

Team Lunar operates a Midwifery Led Continuity (MLC) model designed to provide personalised, relationship based care for women planning home births and those accessing The Nest. The model prioritises continuity across the antenatal, intrapartum, and postnatal periods, with a strong emphasis on reducing maternal and neonatal separation and supporting informed choice.

The team comprises 11 midwives (8.92 WTE), including a Band 7 team leader. A Maternity Support Worker has been recruited to support community care. Since June 2025, four midwives (3.15 WTE) have joined the team. A vacancy of 1.55 WTE is

pending financial approval before advertisement. When fully staffed, each shift will include two midwives based at The Nest: one Nest Community Midwife and one Nest Midwife. Some night shifts are currently covered by a single midwife, supported by on-call arrangements. The aim is to phase out on-calls as staffing stabilises.

The team is currently providing continuity of care to 61 women, primarily those planning home births. Most antenatal and postnatal appointments are conducted in women's homes, with The Nest also available for appointments. Women who change their mind about home birth and opt for The Nest may continue to be case loaded by Lunar. Consultant Midwife support enables the team to care for women planning births 'out of guidance'. Since June 2025, seven Lunar women have birthed at home. There has also been a noticeable rise in births at The Nest, reflecting growing confidence in the model and increased uptake of the service.

Aromatherapy clinics have been established to support holistic care. Local promotion of the team is underway to raise awareness and improve access to the service.

Future plans include:

- Finalise recruitment to fill the remaining 1.55 WTE vacancy.
- Continue weekly monitoring of staffing and service coverage, with a goal to eliminate on-call reliance.
- Maintain and expand community-based care delivery, ensuring flexibility and continuity.
- Strengthen clinical governance through ongoing training and audit. Evaluate service impact on outcomes including ATAIN rates, maternal satisfaction, and home birth access.
- Enhance visibility and engagement with local communities to promote the MLC model.

4.10 Complaints

Two complaints were received relating to care in the maternity and neonatal services in September 2025.

ID	Specialty	Description	Complaint Received in the Trust
252377	Maternity	Patient presented with coffee ground vomit throughout her pregnancy, and after her pregnancy and states her symptoms were not investigated properly. She was later found to have stage 4	17.09.25

		cancer.	
25209	Maternity	Appendicitis not acted on quickly, caused rupture, early labour and sepsis. Lack of medication, MH support and advice.	22.09.25

4.11 Coroner Regulation 28 enquiries
No Regulation 28 enquiries have been received.

5 Maternity self-assessment tool

The revised Maternity self-assessment tool is a national assurance tool introduced to maternity providers in response to the Kirkup Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) to support trusts to benchmark their services against national standards and best practice guidance. Evidence of completion of the tool is also required as part of the North West Region Maternity Performance Oversight Panel assurance process.

The Maternity self-assessment tool identifies 159 criteria. As at 31st October 2025, WHH is fully compliant with 138/159 criteria. This equates to 87% of the criteria, an improvement from 84% when the last assessment was completed. Actions are ongoing to achieve full compliance. It is anticipated further progress will be made against all ongoing actions by the end of Q4 2025/26.

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

12. ASSURANCE COMMITTEE

The contents of this report have previously been noted and discussed at Quality Assurance Committee on 11 November 2025.

13. RECOMMENDATIONS

The Trust Board of Directors is requested to note the content of this paper for information.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD REPORT

AGENDA REFERENCE:	**BM/25/12/131i**			
SUBJECT:	**Quarter 2 2025-26 Perinatal Mortality Review/Audit**			
DATE OF MEETING:	**3 December 2025**			
ACTION REQUIRED:	**For information and to note**			
AUTHOR(S):	Tina Moors, Deputy Director of Midwifery, Lisa Davies Governance Quality Lead – Women's & Children's CBU			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will … Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and focusses attention on improving outcomes for this protected group.			
EXECUTIVE SUMMARY:	The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 7) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports. This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 2 (Q2) PMRT report for the period covering 01/07/2025 – 30/09/2025. During Q2, WHH reported two babies to Mothers and			

	Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): **One stillbirth:** • Baby was born at 27+2 weeks gestation. **One neonatal death:** • Baby was born at 39+1 weeks gestation. The key findings, learning, good practice, and action plan for these cases will be reported in Quarter 3 (Q3) 2025/26 QAC, and subsequently to the Board following a PMRT review panel. WHH stillbirth rate for Q2 2025/26 was 1.53 per 1000 births. WHH annual mean stillbirth rate (2024/25) is 1.6 per 1000 births. The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births. WHH Neonatal mortality rate during Q2 2025/2026 was 1.53 per 1000 live births. The MBRRACE-UK national neonatal rate is 3.0/1000 live births. During Q2, WHH undertook two PMRT review panels. Parental perspective of the care they received was sought in both cases. The panels reviewed: Two stillbirths: • One baby was born at 24+4 weeks • One baby was born at 40+5 weeks In both cases, there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would not have made a difference to the outcome for the baby. In both case, there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee.

	Full compliance is reported in relation to the Maternity Incentive Scheme; Safety Action 1 standards being met.		
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision
RECOMMENDATION:	For the Board of Directors to receive and discuss this report .		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/25/11/186i	
	Date of meeting	11 November 2025	
	Summary of Outcome	noted	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Submit to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

TRUST BOARD REPORT

SUBJECT	Quarter 2 2025-26 Perinatal Mortality Review/Audit	AGENDA REF:	BM/25/12/131

1. BACKGROUND/CONTEXT

The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 7 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 2 PMRT audit data for 2025/2026 and highlights good practice and lessons learned identified through the mortality reviews completed during the period.

Definitions:

- **Perinatal mortality** refers to the number of stillbirths and early neonatal deaths in the first week of life.
- **Late Fetal Loss** is when a baby is born between 22+0 weeks and 23+6-weeks' gestation showing no signs of life.
- **Stillbirth** is when a baby is born showing no signs of life after 24+0 weeks of pregnancy.
- **Early Neonatal death** occurs when a baby is born after 20+0 weeks gestation or weighs 400grams or more and lives but dies within 7 days of being born.
- **Neonatal Mortality Rate** refers to the number of babies which have died within the first 28 days of life.
- **Perinatal Mortality Review Tool (PMRT)** is a national standardised approach to systematically review circumstances and care leading up to and surrounding each stillbirth and neonatal death. The review should incorporate a multidisciplinary approach which includes communication with parents on their experience of care provided and any questions they may have. Following the review, a grading of care is provided by the multidisciplinary review team.

2. QUARTER 2 2025/26 STILLBIRTHS & NEONATAL MORTALITY

The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland, and Wales. This paper has extracted the key findings of the report for information and noting.

There were two cases to report to MBRRACE-UK during Q2 reporting period.

One Stillbirth:
One baby born at 27+2 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 17 November 2025 and will be included in the Q3 2025/26 Perinatal Mortality Review Audit report to QAC.

One Neonatal Death:
One baby born at 39+1 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 17 November 2025 and will be included in the Q3 2025/26 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 2. WHH Stillbirth Rate:

- WHH Q2 stillbirth rate for 2025/2026 is 1.53 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH annual stillbirth rate for Q1-Q4 2024/25 is 1.6 per 1000 births. The MBRRACE-UK national rate is 3.9 per 1000 births.

N.B., There were two stillbirths recorded in Q2 – only one reported to MBRRACE as the other case recorded was a 27+2 feticide for fetal abnormality (fetal hydrops) and therefore does not meet the criteria for PMRT.

Table 1: WHH Stillbirth Data Over 12-month Period:

Metric	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	12-month total
Number of live births	599	580	567	653	2399
Total number of stillbirths >24 weeks	0	2	2	1	5
Total Stillbirth Rate >24 weeks (per 1000 births)	**0.00**	**3.44**	**3.50**	**1.53**	**2.08**
Number of intrapartum still birth rate	0	0	0	0	0
Number of stillbirths >37 weeks	0	1	1	0	2

2.2 Q1. WHH Neonatal Mortality Rate:

- WHH neonatal mortality rate during Q2 2025/2026 was 1.53 per 1000 live births.
- The MBRRACE-UK national rate is 3.0/1000 live births.

3. QUARTER 2 2025/26 PMRT REVIEW FINDINGS

3.1 Quarter 2 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 24+4 weeks gestation was a stillbirth. This mother reported the first episode of reduced fetal movements when attending for a planned antenatal appointment and fetal death in utero was confirmed. The cause of death was confirmed as fetal vascular malperfusion with a hyper-coiled cord.

One baby born at 40+5 weeks gestation was a stillbirth. This mother reported the first episode of reduced fetal movements and attended the maternity triage department where fetal death in utero was confirmed. The parents declined post-mortem, and the placental histology returned the cause of death as undetermined. A second opinion was requested, and the placenta was re-examined by a panel of pathology consultants. This returned some evidence of a condition called delayed villous

maturity. The panel felt that this was likely to have contributed to the death and can be found in women with diabetes. There was no evidence of diabetes in the pregnancy.

Surveillance Findings:

- Both babies were of a singleton pregnancy.
- Both women were aged between 24-30 years.
- Both women were identified as white ethnicity.
- Neither woman had any communication problems because of learning difficulties/hearing problems.
- Both women had a normal BMI.
- One woman was a smoker and engaged with Stop Smoking services.
- In both cases there were no issues identified with the care provided in relation to safeguarding.

3.2 PMRT Grading of Care

Each PMRT review panel consists of senior obstetric, midwifery, bereavement, and governance representation from WHH and external peer review members from another maternity provider within Cheshire and Mersey Local Maternity and Neonatal System (LMNS). Parental perspective is also included as part of the PMRT review and contributes to the grading of care.

The PMRT review concludes with each panel member reporting if, in their professional opinion, the care given up to the point where the baby was confirmed as having died and or care provided following the birth of the baby could have made a difference.

3.2.1 PMRT Grading of Care – Stillbirth

During Q2 two PMRT review panels took place. Parental perspective of the care received was sought.

In both cases there were issues with care identified for the mother and baby up to the point that the baby was confirmed to have died that would not have made a difference to the outcome for the baby.

In both case there were no issues identified with the care of the mother following confirmation of the death of her baby.

Table 2: Q2 WHH Grading of care following a Stillbirth.

PMRT grading	Care provided to the mother up to the point that her baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A The review group concluded that there were no issues with care identified	-	2
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	2	-
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	-	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-
Not Graded	-	-
Total Cases	Two cases	Two cases

3.2.2 PMRT reporting for Saving Babies Lives Care Bundle v3- Q2 2025/26:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum monitoring were a contributory factor to perinatal mortality. Table 5 details the outcome of the PMRT reviews completed in Q2 assessed against these interventions:

Table 3 – Saving Babies Lives interventions.

Intervention		**%**
Intervention 2.8	Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue	0.0%
Intervention 3.2	Percentage of stillbirths which had issues associated with RFM management identified	0.0%
Intervention 4.3	Percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0.0%
Intervention 5.2	Percentage of late second trimester singleton births and preterm births (using PMRT) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared, and percentage of late second trimester singleton births and preterm births	0.0%

3.2.3 WHH PMRT Panel Attendance

There have been two PMRT panel reviews in Q2 which were attended by multidisciplinary internal and external panel members.

Table 4: Q2 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/07/2025 – 30/09/2025 = 2			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	2	-	2
Admin/Clerical	0	-	0
Bereavement Midwife	2	-	2
External Rep	2	-	2
Management Team	0	-	0
Midwife	2	-	2
Neonatal Nurse	0	-	0
Neonatologist/ Paediatrician	-	-	-
Obstetrician	2	-	2
Other	0	-	0
Governance Manager	2	-	2
Safety Champion	0	-	0

3.3 Maternity Incentive Scheme Year 7 Compliance

WHH is compliant with all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 7 as per table 5.

Table 5: PMRT MIS Safety Action 1 Compliance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Standard Required		**Compliant Y/N**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days	Assessed as compliant
b)	For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	Assessed as compliant
c)	For deaths of babies who were born and died in your Trust from 1 December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multidisciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	Assessed as compliant
d)	Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.	Assessed as compliant

3.4 Learning and Good Practice

- It was noted in both cases that the death was confirmed following the first episode of reduced fetal movements. Both cases had documented discussions for safety netting when fetal movements were changed or reduced.
- In one case, the baby was found to be small on a private scan, and this was not escalated to the ultrasound department.
- In one case, the parents described a lack of communication from the obstetric team when the fetal heart could not be found.
- It was noted that bereavement care was good in both cases.
- Parental involvement was sought in all cases as part of PMRT panel review.
- Both cases of stillbirth which occurred in the quarter have been notified to MBRRACE-UK and surveillance completed within the required timescale.

3.5 Action Plan Summary

All actions identified following PMRT reviews are recorded in full on the Trust incident reporting system and monitored through Women's and Children's CBU Governance Meetings.

Table 6: PMRT Action Plan

Action	Lead	Due Date	RAG rating
To identify and share the pathway of escalation of concerns for private providers to maternity care providers	Dr Arya, Consultant Obstetrician and Gynaecologist	30/09/2025	
Share the feedback from the parents with the obstetric and midwifery teams for learning	Dr Arya, Consultant Obstetrician and Gynaecologist	31/07/2025	

4. SUMMARY

WHH Q2 PMRT audit recorded two babies reported to MBRRACE born between 01/07/2025 and 30/09/2025.

- WHH stillbirth rate for Q2 2025/26 was 1.53 per 1000 births. WHH annual Mean stillbirth rate is 1.6 per 1000 births which is below the 2024 MBRRACE-UK national rate 3.9 per 1000 births.
- WHH Neonatal mortality rate during Q2 2025/2026 was 1.53 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- There were two babies requiring PMRT review panel in Q2.
- Full compliance reported in relation to Maternity Incentive Scheme; Safety Action 1 standards are being met.

5. MONITORING/REPORTING ROUTES

This Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting and Quality Assurance Committee in November 2025.

6. RECOMMENDATIONS

The Board of Directors are asked to note the findings of this paper.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD REPORT

AGENDA REFERENCE:	**BM/25/12/131ii**			
SUBJECT:	**Maternity Incentive Scheme Year 7 Update**			
DATE OF MEETING:	**11 November 2025**			
ACTION REQUIRED:	**For information, discussion and to note**			
AUTHOR(S):	Helen Wall - Assurance and Improvement Manager (Women's and Children's)			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will … Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
EXECUTIVE SUMMARY:	This paper outlines the Trust's position and progress in relation to the NHS Resolution's Maternity Incentive Scheme (MIS), which aims to support the delivery of safer maternity care across NHS Trusts in England. The scheme provides financial incentives for meeting ten safety actions designed to improve clinical governance, workforce planning, and patient outcomes in maternity services. These safety actions align with the national maternity ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries by the end of 2025, compared to the 2010 baseline. This paper provides an overview of current progress and incorporates feedback received from the Local Maternity and Neonatal System (LMNS) The Trust has undertaken a detailed self-assessment			

against all ten safety actions for the current reporting period. Progress is summarised below:

- **Safety Action 1 – PMRT**: Requirements met.
- **Safety Action 2 – MSDS**: Requirements met.
- **Safety Action 3 – Transitional Care**: On track; action plan in place and QI project scheduled for presentation to safety champions and Local Maternity and Neonatal System (LMNS) in November 2025.
- **Safety Action 4 – Medical Workforce**: Requirements met.
- **Safety Action 5 – Midwifery Workforce**: On track to meet requirements.
- **Safety Action 6 – Saving Babies' Lives**: 96% compliance in Q2; improvement plans in place for MDT support in diabetes care and symphysis-fundal height (SFH) measurement.
- **Safety Action 7 – MNVP**: Unable to meet requirement for MNVP attendance at PMRT meetings; escalated to LMNS and ICB.
- **Safety Action 8 – Training**: Requirements met for fetal monitoring and neonatal resuscitation; full compliance expected following anaesthetist attendance in November 2025.
- **Safety Action 9 – Board Oversight**: Maintained through regular reporting and scrutiny.
- **Safety Action 10 – MNSI/EN**: Requirements met; external review by Maternity and Neonatal Safety Improvement Programme and NHS Resolution is pending.

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

The Board is asked to:

- Note the current status of the MIS submission.
- Endorse the Trust's declaration of compliance, subject to final validation.
- Support ongoing improvement initiatives within maternity services.

- Approve the submission data to date noting actions are on track for compliance against the Safety Actions

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

RECOMMENDATION:	For the Board of Directors to receive and discuss this report as part of the quarterly maternity and neonatal overview.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/25/11/86ii
	Date of meeting	11 November 2025
	Summary of Outcome	noted
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Submit to Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

TRUST BOARD REPORT

SUBJECT	Maternity Incentive Scheme Year 7 Update	AGENDA REF:	BM/25/12/131ii

1. BACKGROUND/CONTEXT

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

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

2. CURRENT POSITION

2.1 Current position against MIS Year 7

The Board have been updated that the first quarterly meeting with the Local Maternity and Neonatal System (LMNS) took place in June, focusing on the Trust's progress against the Saving Babies' Lives care bundle and the Maternity Incentive Scheme (MIS). The second quarterly meeting was held on 17 September 2025, during which the Trust received encouraging feedback regarding the evidence submitted to date for the MIS. The LMNS commended the quality and completeness of the documentation, reflecting the Trust's commitment to continuous improvement in maternity safety and governance.

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

This safety action requires that:

- All notifiable perinatal deaths are reported to MBRRACE-UK within seven working days.
- At least 95% of Perinatal Mortality Review Tool (PMRT) reviews incorporate parental feedback.
- Reviews are completed within defined timeframes.
- Findings are reported to Trust executives.

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

To date, the Trust has demonstrated full compliance with the requirements within Safety Action 1.

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

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

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

The Trust is compliant with Safety Action 2.

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

Safety Action 3 requires the Trust to have a transitional care pathway in place and to undertake a quality improvement (QI) project focused on transitional care. Warrington and Halton Hospitals (WHH) has an established transitional care pathway that includes babies born between 34+0- and 35+6-weeks gestation, in alignment with the Maternity Incentive Scheme (MIS) requirements. An action plan is also in place, with a particular focus on reviewing and strengthening the staffing model to support safe and effective care delivery.

A QI project has been formally registered and is being led by the Neonatal Matron. An update on the project's progress is scheduled to be presented at the November Safety Champion meeting, followed by a presentation to the Local Maternity and Neonatal System (LMNS) at the end of November. This will ensure the Trust meets the compliance criteria for this element of the safety action

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

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

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

Safety Action 4 addresses staffing requirements across obstetric, anaesthetic, neonatal medical, and neonatal nursing disciplines.

Key requirements include compliance with Royal College of Obstetricians and Gynaecologists (RCOG) guidance on the use of long-term and short-term locums. The

Associate Clinical Director has completed the required audit for short-term locum usage, with no concerns identified. The service does not currently employ any long-term locums.

While compensatory rest is not directly measured within Safety Action 4, the MIS guidance highlights its importance. At WHH, a compensatory rest policy is in place for Consultants and Specialty Doctors undertaking non-resident on-call duties. This is actively managed by the rota coordination team within the Clinical Business Unit (CBU), and feedback has been sought from consultants to ensure effective implementation.

In relation to obstetric staffing, the Trust is required to demonstrate compliance with consultant attendance in clinical scenarios outlined in the RCOG guidance *'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology'*. Monthly audits are conducted and reviewed by the Associate Clinical Director, with quarterly reports submitted to the LMNS via the Maternity Performance Oversight Panel (MPOP). The Trust consistently achieves compliance above the required 80% threshold.

For anaesthetic staffing, the Trust must evidence 24-hour availability of a duty anaesthetist. This has been confirmed through submission of the anaesthetic rota to the LMNS.

Regarding neonatal medical staffing, the Trust is required to meet British Association of Perinatal Medicine (BAPM) standards. As previously reported to the Strategic People Committee, the Trust is not fully compliant with BAPM standards in respect of providing dedicated 24 hour cover at Tier 1. This has been added to the risk register and there is a neonatal workforce action plan in place to drive improvement, which is regularly reviewed by the CBU.

For neonatal nursing, compliance with BAPM standards is also required. Where full compliance is not achieved, an action plan must be shared with the LMNS and the Operational Delivery Network (ODN). The Director of Midwifery outlined the Trust's position, including the neonatal nursing action plan, in the *Biannual Review of Obstetric, Anaesthetic, Neonatal and Midwifery Staffing* presented to the Strategic People Committee in July 2025.

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

This safety action requires completion of a Birthrate+ assessment within the last three years. The Trust's most recent Birthrate+ report was completed in March 2025 and as previously reported to the Board, identified a shortfall in the funded midwifery establishment at WHH. In accordance with MIS guidance, where a shortfall is identified, an agreed mitigation plan must be in place. This plan was presented to Board in August 2025 and will be shared with commissioners to demonstrate full compliance.

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

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

The Trust is currently on track to meet the requirements of Safety Action 5.

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

The Trust will achieve compliance with Safety Action 6 if the ICB confirms it ensures that best endeavours and sufficient progress has been made.

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

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

Areas identified for improvement include the frequency of fundal height measurements and the multidisciplinary team (MDT) approach to supporting women with pre-existing diabetes through a one-stop clinic model. Action plans are in place to address both areas and drive further improvement.

To meet the requirements of this safety action, the Trust must participate in quarterly LMNS reviews. These have been completed for both June and September 2025

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

As previously reported to the Board, WHH does not currently have the infrastructure in place to support the attendance of Maternity and Neonatal Voices Partnership (MNVP) leads at Perinatal Mortality Review Tool (PMRT) meetings. In line with the Maternity Incentive Scheme (MIS) guidance, where this requirement cannot be met, Trusts must escalate the issue to the Board and the Integrated Care Board (ICB) to achieve compliance.

This escalation has now taken place, and the Trust is therefore deemed compliant with this safety action. It is important to note that this does not detract from the strong and positive collaboration between the Trust and the MNVP, which continues to support service improvement and user engagement.

The Trust is compliant with Safety Action 7.

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

Upon Anaesthetist attendance at the training day, the Trust will meet the requirements of Safety Action 8.

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

The Trust currently meets the compliance threshold for both fetal monitoring and neonatal resuscitation training. However, compliance for multi-professional emergencies training is currently below target for Anaesthetists. A dedicated training day has been scheduled for November 2025, and Anaesthetist attendance at this session is expected to bring the Trust into full compliance with this safety action.

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

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

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

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

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

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

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

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

The Trust will meet the requirements of Safety Action 9 if the information sharing of quality and safety issues continues for the remainder of the reporting period.

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

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

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

Through previous reports to the Board, the Trust has demonstrated ongoing compliance with these requirements. This reflects a continued commitment to transparency, family engagement, and regulatory adherence in the management of serious incidents.

To achieve compliance with Safety Action 10, the Trust must continue reporting to the end of the reporting period. This safety action is also externally reviewed by MNSI and NHSR.

3 MONITORING/REPORTING ROUTES

Progress relating to the Saving Babies' Lives Care Bundle version 3 (SBLCBv3) and Maternity Incentive Scheme (MIS) Year 7 is regularly reviewed and discussed at Clinical Business Unit (CBU) Governance meetings. The content of this report will be formally presented at the Women's Health Governance meeting in November 2025 to ensure continued oversight and alignment with service improvement priorities.

4 RECOMMENDATIONS

The Trust Board of Directors are requested to

- Note the current status of the MIS submission.
- Endorse the Trust's declaration of compliance, subject to final validation.
- Support ongoing improvement initiatives within maternity services

- Approve the submission data to date noting actions are on track for compliance against the Safety Actions

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD REPORT

AGENDA REFERENCE:	**BM/25/12/131iii**			
SUBJECT:	**Maternity & Neonatal Quality Review – September 2025**			
DATE OF MEETING:	**11 November 2025**			
ACTION REQUIRED:	**For information, discussion and to note**			
AUTHOR(S):	Tina Moors Deputy Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah – Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will … Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		√		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum 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 The Board with oversight of key matters to provide assurance to the Board of Directors on Maternity and Neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and then to the Trust Board of Directors on a quarterly basis. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Maternity & Neonatal Safety Investigations			

	(MNSI) update • Complaints • Coroner Regulation 28 position In September 2025 there were no fatal or severe harm events in the maternity or neonatal services. There were eight moderate harm events, 4 cases of 3rd/4th degree tear (OASI). 2 Patients transferred to ITU and 2 babies transferred for cooling. Themes from Maternity/Neonatology patient safety events in September 2025 are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) 1000ml-1500ml • Postpartum Haemorrhage (PPH) >1500ml At the end of September mandatory training compliance and role specific training across maternity and child health colleagues is above 91%. Compliance with PDR completion is a challenge with a position of 78%. Work continues to achieve full compliance by the end of December 2025, and progress is being monitored on a weekly basis. Good compliance continues with maternity specific training standards can be noted with an improvement following a slight deterioration in position reported to QAC in June 2025. Turnover for maternity and child health staff is below the Trust target. The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target. The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work is ongoing with regard to induction of labour (IOL) particularly in reducing delays. This change highlights the need for renewed

<table>
<tr><td></td><td colspan="3">scrutiny of the IOL process

An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight.

An update regarding Maternity Worsktream MLU Model
• The Nest

There were 2 complaints were received in the Maternity and Neonatal Services in September 2025.

No Regulation 28 enquiries have been received.</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 of Directors are asked to receive and discuss 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">QAC/25/11/186iii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11 November 2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">noted</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>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO BOARD

SUBJECT	Maternity & Neonatal Quality Review – September 2025	AGENDA REF:	BM/25/12/131iii

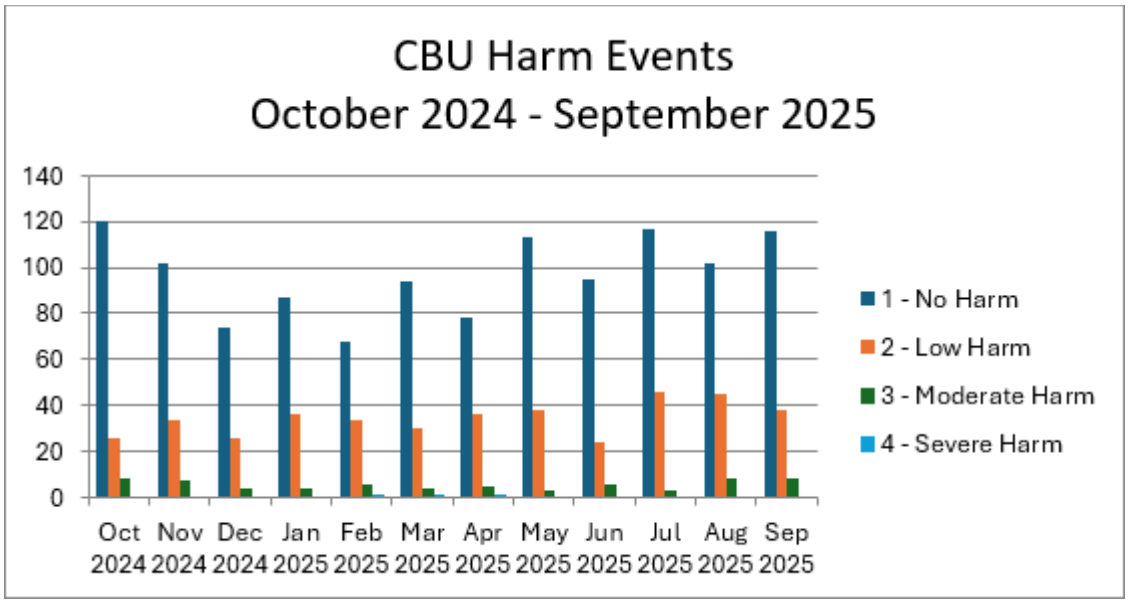
1. BACKGROUND/CONTEXT

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

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

2. HARM EVENTS

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



There were 153 patient safety events reported across the CBU in September 2025.

There were no fatal or severe harm events in September 2025 in the maternity or neonatal services.

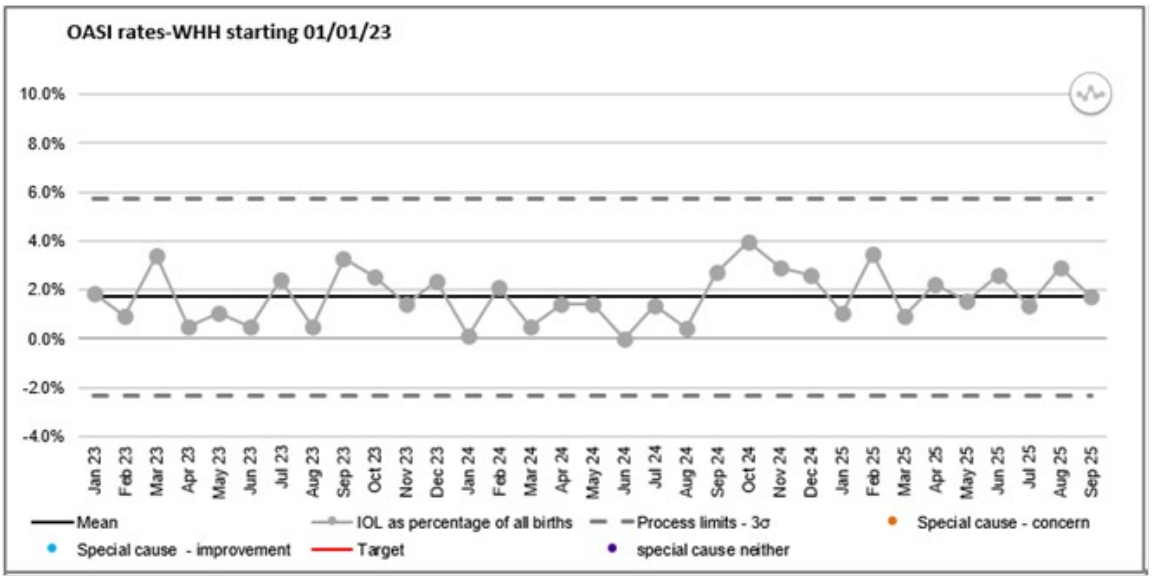
There were 8 moderate harm events,

- 4 cases of 3rd/4th degree tear (OASI). A reduction from 6 in August 2025. These cases were reviewed by the maternity MDT through Intrapartum Review Group (IRG).

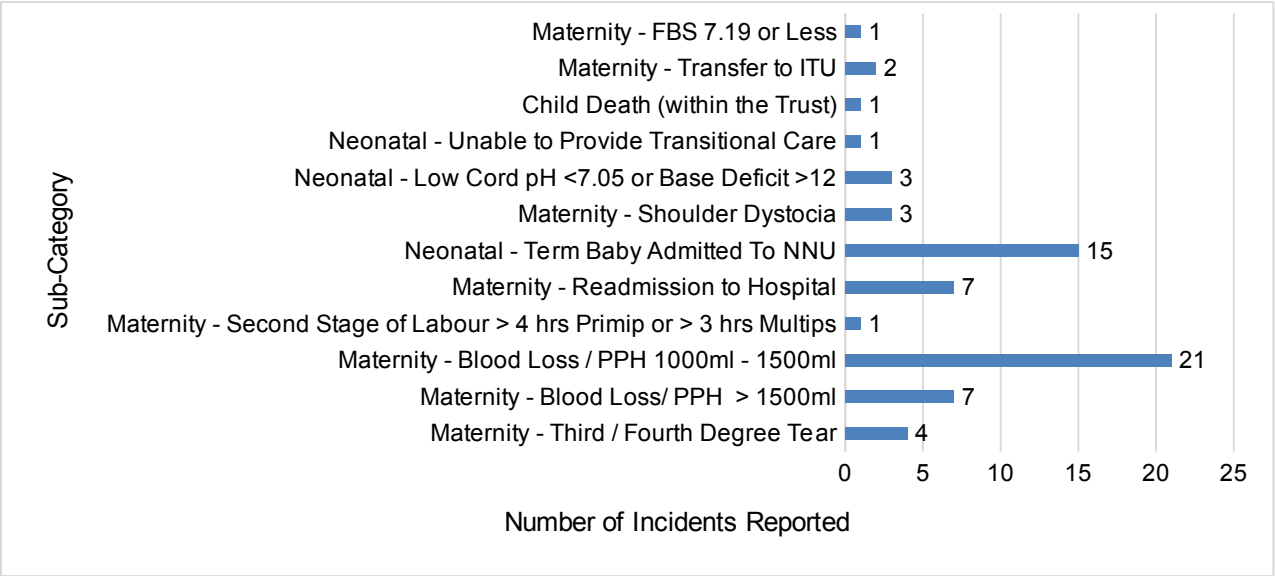
- Cooling babies (2) Both reported to MNSI and accepted.
  MI-047285 Shoulder Dystocia (immediate learning - no referral to obstetrics for counselling for AC >97 centile)
  MI-047288 Normal birth on the NEST (immediate learning - approximate FH during second stage)
- ITU admissions (2) both has Immediate Safety Reviews completed (ISR)
  1x 28/40 PET requiring inotropic support following Cat 2
  1x 27/40 Varicella pneumonia IUD & EMCS – Reported to MBRRACE

OASI

OASI rate for September is 1.75%, which is a reduction from August. Overall, the chart continues to show common cause variation.



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



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

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

Admission of term babies admitted to Neonatal Unit (NNU)

In September 2025, 15 term babies were admitted to the Neonatal Unit, mirroring admissions of 15 in August 2025.Respiratory is the highest theme. All term admissions are reviewed through the ATAIN process, which reports quarterly to the the Board. An action plan remains in place to address emerging themes. Respiratory distress continues to be the predominant reason for admission. In response, clinical teams are maintaining positive end-expiratory pressure (PEEP) at 30, actively researching the use of Continuous Positive Airway Pressure (CPAP) a non-invasive respiratory support method used in neonatal care to help babies breathe more effectively. In addition, a key area of improvement has been the development and implementation of the Transitional Care (TC) model. Since July 2025, dedicated staff have been consistently rostered to support TC provision, ensuring that all identified cases have received appropriate care without exception. This has contributed positively to reducing maternal–neonatal separation. However, the impact on the Avoiding Term Admissions into Neonatal units (ATAIN) rate has been minimal to date.

Separately, findings from a recent 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.

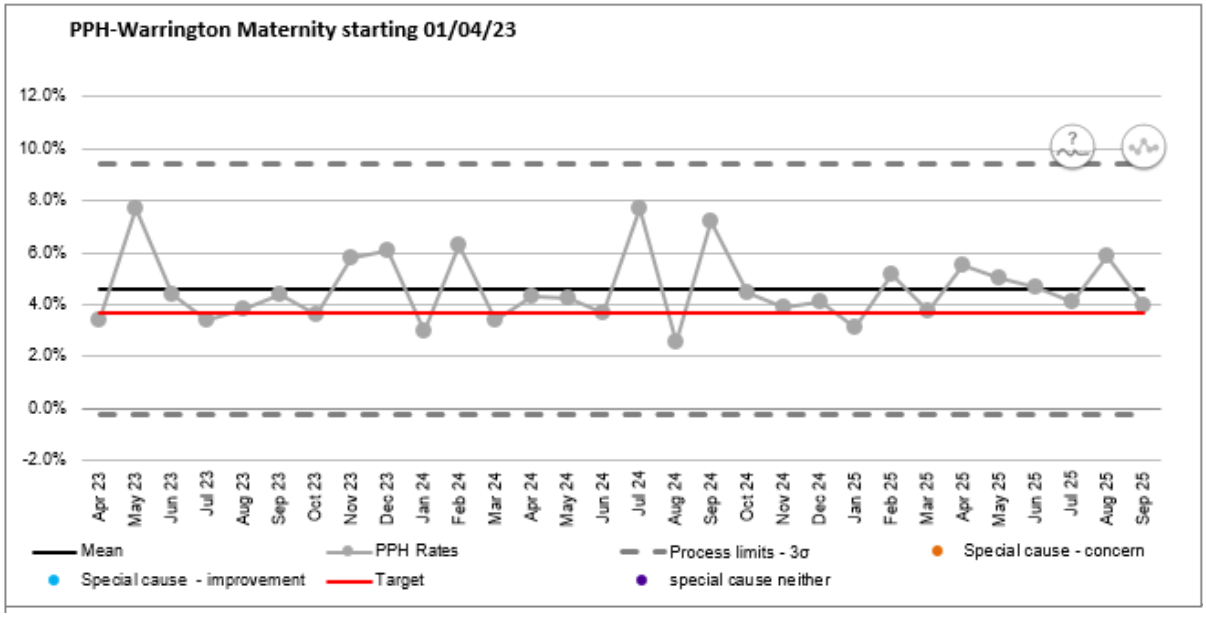
Post Partum Haemorrhage

There were **21** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and learning shared.

There were **7** cases of **PPH ≥1500mls** in September.

Data continues to show common cause variation, however reduction in September noted compared to August.

- **Regional Guideline Implementation:** The Northwest Regional PPH guideline V1 was ratified in September and will be disseminated to clinical teams ahead of its publication on the hub. It introduces revised recommendations for third stage management, which are anticipated to contribute to a reduction in postpartum haemorrhage (PPH) rates and enhance overall maternal outcomes.
- **September Data Trends:** September continues to demonstrate common cause variation, with a noted decrease compared to previous months. This remains under close surveillance to ensure appropriate escalation if required
- **Postpartum Haemorrhage (PPH) Quality Improvement:** The PPH QI initiative has temporarily reverted to a working group status. It will be reinstated as a formal QI project following the implementation of the newly ratified regional guideline
- **Ongoing Data Collection:** Data collection remains active and robust, supporting continuous monitoring and analysis of outcomes
- **Case Review and Learning:** Individual cases are consistently reviewed within the Intrapartum Review Group to extract learning and inform practice improvements.
- **ReAudit –** 6-month Audit to be completed after implementation of PPH Guideline (Nov 2025 – May 2026)



3. WORKFORCE METRICS & MEASURES

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

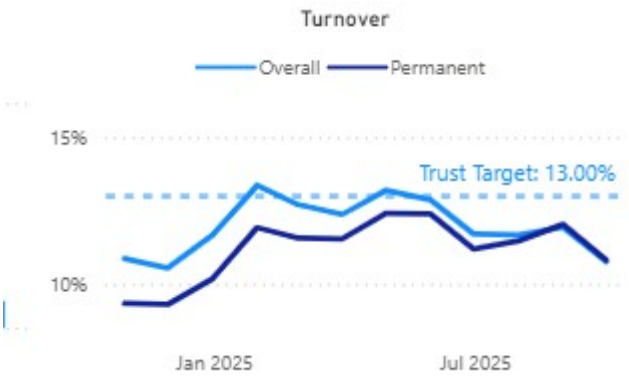
At the end of September compliance for mandatory training across maternity and child health colleagues is 91% for Trust mandatory training (including safeguarding training) and 90% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long-term basis.

Compliance with PDR completion remains a challenge, currently positioned at 78%. However, a positive trajectory has been observed over recent months, with incremental improvements recorded. Work continues to achieve full compliance by the end of December 2025, and progress is being monitored on a weekly basis.

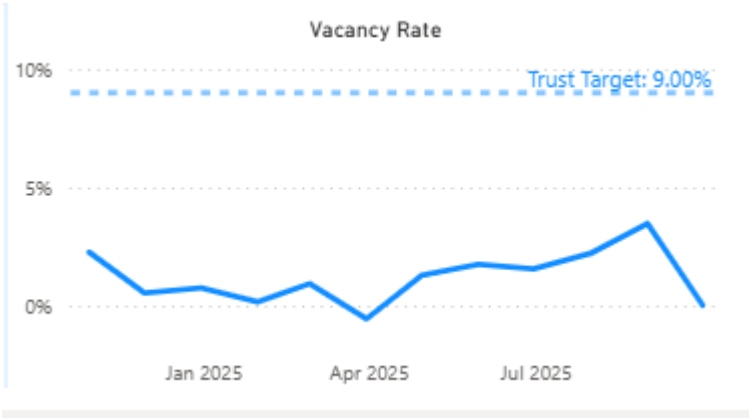
Good compliance with maternity specific training standards is largely being sustained with further improvement in particular Obstetric colleagues K2 Compliance

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	Maternal AIMS
Midwives	97.7%	98.4%	90%	97.7%	91%
Obstetric Consultants	100%	100%	75%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	83.6%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	n/a
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data	n/a

Turnover for maternity and child health staff (permanent staff) in September 2025 is 10.8%, below the Trust target. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 0.2%. This is illustrated in the graph below:



4. SERVICE USER AND STAFF FEEDBACK

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

5. MATERNITY TRIAGE

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

Current performance

Triage attendances September 2024-September 2025	
Month	**Attendances**
September	556
October	545
November	539
December	531
January	621
February	547
March	638
April	521
May	577
June	587
July	602
August	588
September	623

- In September 2025 623 triage attendances were recorded on the BadgerNet patient record system maintaining the average number of attendances per day of 20 seen since the beginning of 2025.
- 17.17% of attendees in August were seen immediately on arrival.
- The longest wait recorded for initial review was 73 minutes.
- 90% of attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- 95% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 100% of attendees (1 woman) categorised as red on arrival and seen within 15 minutes of arrival for initial triage.
- 17.65% of attendees were categorised orange on arrival. Similar trend to August 2025 when the proportion was 17.52%.

<u>Triage Action Plan</u>

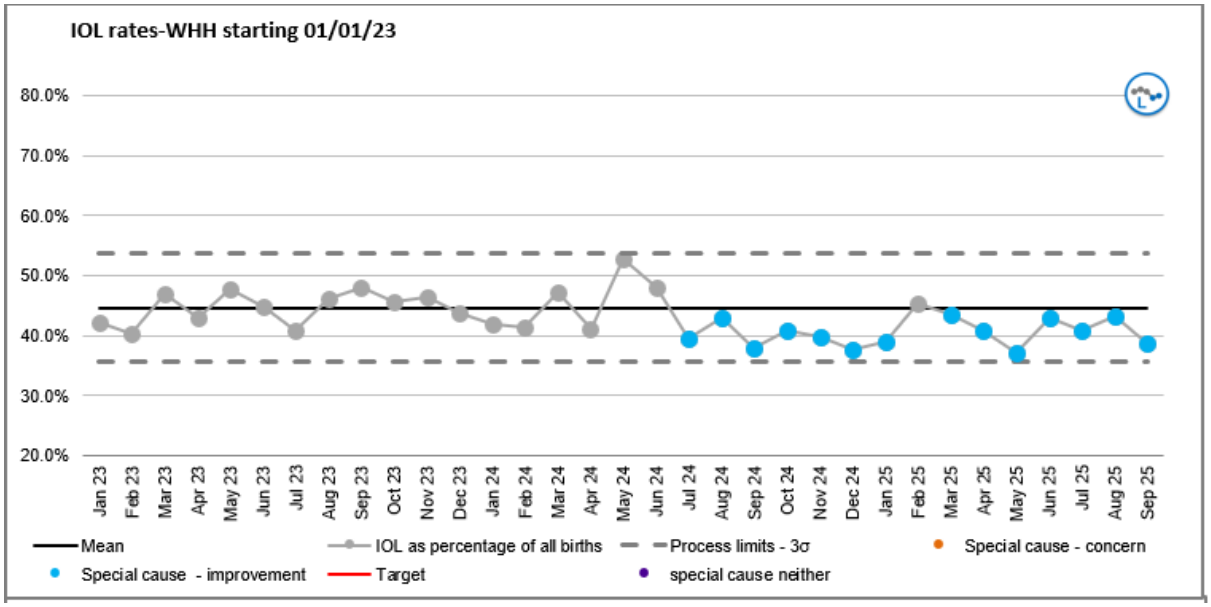
- Categorisation of urgency, full holistic triage assessment and SBAR audits all ongoing
- Triage CISCO phone line continues to be explored to ensure best practice
- Benchmarked to C&M triage summary and recommendations to ensure triage best practice is incorporated into workstreams/action plans
- Audit category of women not seen within 15/30 minutes.

6. INDUCTION OF LABOUR (IOL)

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

As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at WHH from January 2023 to September 2025, presented as a percentage of all births. The SPC chart continues to show common cause variation.

In September the induction of labour rate at WHH was 33.9%, (77 inductions out of 227 births) compared with 43.35% in August.



Inappropriately booked IOLs were recorded at 1.2% (1 IOL) out of 77 commenced. This improvement has been supported by the IOL Bleepholder role, which continues to strengthen planning, communication, and consistency in managing the pathway.

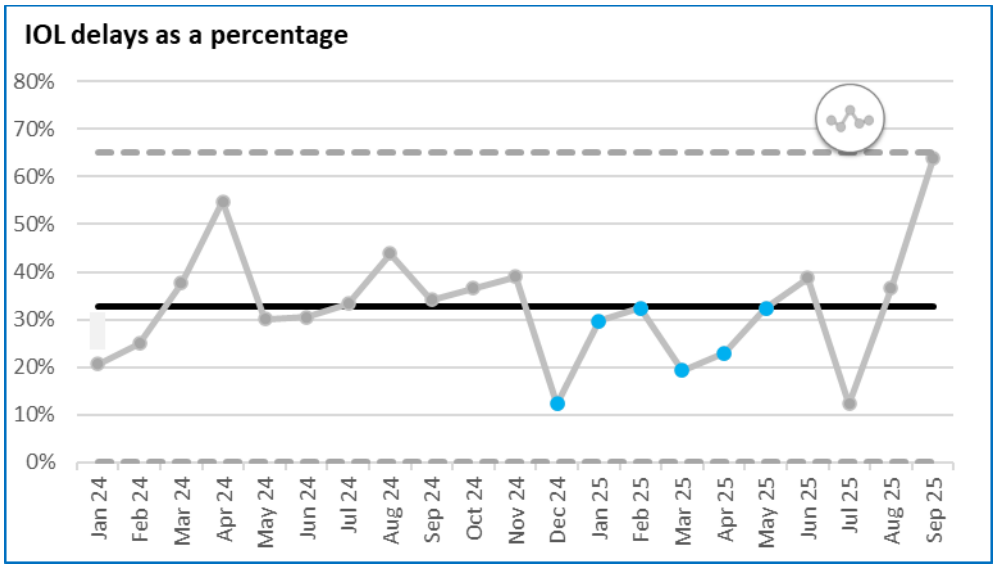
Currently on Badgernet NHS Choices leaflet is available, and leaflets specific to WHH have also been developed and will be available via BadgerNet. These are designed to inform patients about the IOL process, associated risks and benefits, declining IOL, and induction prior to 39 weeks. They are scheduled for review by the maternity guideline review group and the readers panel in October 2025. Filming for the new IOL information videos is planned for the first week of November, with voiceovers to be added later. These 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

In September IOL delays for over 12 hours were 18%, and delays over 24 hours were 46%. This reflects a significant increase from August 2025, when delays over 12 hours were 25% and delays over 24 hours were 13.4%.

During September, we have seen an increase in delayed IOL. The position with regard to delay in IOL is demonstrated via a SPC chart. Total number of delays is 64.94%. The data shows that our unit is an outlier across the region.



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

	COC	LWH	MCHT	MWLS&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	30	123	56	38	114	140	54	555
Total Delayed	13	23	9	0	32	80	9	166
%of Total	43.33%	18.70%	16.07%	0.00%	28.07%	57.14%	16.67%	29.91%

Variation in metrics collection methodologies between WHH and LMNS impacting data consistency and comparability.

<u>Potential impact of delays in Induction of Labour (IOL) during September, linked to early identification challenges</u>

- 15% Increase in Births based on Yearly Birth Rate
- 5.9% Increase attendances into Triage
- Increased Sickness 8.8%
- Escalation 9 times. OPEL AMBER x6. RED x3
- 1 x High Risk Patient for 15 days on Birth Suite impacting bed flow.
- 2 Birth Suite Rooms out of use due to estate work required.

Our aim is to reduce the percentage of total delays in IOL, we will be conducting an immediate deep dive to better understand the challenges contributing to these delays and to identify any potential 'quick wins' for improvement. To help achieve this, we are going to implement the following.

- **Re-circulation of the Regional IOL guideline**, with clear emphasis on Bishop Score assessment, and suitability for ARM
- **Deep dive into September IOL data** to review decision-making, delay causes, and Bishop scores to determine whether women were suitable for ARM or would have benefited from an alternative approach.
- **Implementation of a daily IOL floorwalker** from 3rd November to observe live activity, identify barriers to progression, and collect qualitative data on decision making, communication, and operational pressures that are not captured through the bleep paperwork or quantitative reports.
- **Day in the Life** to be undertaken by Assurance and Improvement Manager to explore cultural and behavioural barriers influencing transfer decisions and escalation.
- **LMNS Network** Intrapartum Matron and IOL Lead Midwife will visit other units within the LMNS to observe how they manage and report IOL activity. This will include reviewing their documentation processes, digital systems, and escalation frameworks.
- **Measure -** Continue to monitor KPIs using balanced scorecard and Audits to monitor effectiveness of measures put in place.

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

7. MNSI POSITION AND REPORTS RECEIVED

7.1 Background

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

7.2 Current position

<u>Two new maternity cases – Four cases in progress</u>

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

Referred August 2025 (Shoulder Dystocia HIE) in progress

Referred September 2025 (Shoulder Dystocia HIE) in progress

Referred September 2025 (Pool birth HIE) in progress

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
28/04/2025	MI-041711	HIE/Cooling	In progress	Awaiting			
06/04/2025	MI-041411	Maternal death	In progress	Awaiting			
02/08/2025	MI-045085	HIE/Cooling	In progress	Awaiting			
25/09/2025	MI-047285	HIE/Cooling	In progress				
26/09/2025	MI-047288	HIE/Cooling	In progress				

8. UPDATE ON OTHER WORKSTREAMS

8.1 The Nest

Team Lunar: Midwifery-Led Continuity Model, Service Update and Forward Plan

Team Lunar operates a Midwifery Led Continuity (MLC) model designed to provide personalised, relationship based care for women planning home births and those accessing The Nest. The model prioritises continuity across the antenatal, intrapartum, and postnatal periods, with a strong emphasis on reducing maternal and neonatal separation and supporting informed choice.
The team comprises 11 midwives (8.92 WTE), including a Band 7 team leader. A Maternity Support Worker has been recruited to support community care. Since June 2025, four midwives (3.15 WTE) have joined the team. A vacancy of 1.55 WTE is pending financial approval before advertisement. When fully staffed, each shift will include two midwives based at The Nest: one Nest Community Midwife and one Nest Midwife. Some night shifts are currently covered by a single midwife, supported by on-call arrangements. The aim is to phase out on-calls as staffing stabilises.

Service Delivery and Impact

The team is currently providing continuity of care to 61 women, primarily those planning home births. Most antenatal and postnatal appointments are conducted in women's homes, with The Nest also available for appointments. Women who change their mind about home birth and opt for The Nest may continue to be case loaded by Lunar. Consultant Midwife support enables the team to care for women planning births 'out of guidance'. Since June 2025, seven Lunar women have birthed at home. There has also been a noticeable rise in births at The Nest, reflecting growing confidence in the model and increased uptake of the service.

Quality and Safety

All Team Lunar midwives have completed Neonatal Life Support (NLS) training or attended a home birth-specific neonatal resuscitation update. Only one midwife is

pending NLS completion, expected by the end of 2025. The team leader is supporting ongoing learning through targeted skills drills tailored to the home birth setting.

Enhancements and Community Engagement

Aromatherapy clinics have been established to support holistic care. Local promotion of the team is underway to raise awareness and improve access to the service.

Action Plan and Next Steps

Finalise recruitment to fill the remaining 1.55 WTE vacancy. Continue weekly monitoring of staffing and service coverage, with a goal to eliminate on-call reliance. Maintain and expand community-based care delivery, ensuring flexibility and continuity. Strengthen clinical governance through ongoing training and audit. Evaluate service impact on outcomes including ATAIN rates, maternal satisfaction, and home birth access. Enhance visibility and engagement with local communities to promote the MLC model.

9. COMPLAINTS

Two complaints were received relating to care in the maternity and neonatal services in September 2025.

ID	Specialty	Description	Complaint Received in the Trust
25237	Maternity	Patient presented with coffee ground vomit throughout her pregnancy, and after her pregnancy and states her symptoms were not investigated properly. She was later found to have stage 4 cancer.	17.09.25
25209	Maternity	Appendicitis not acted on quickly, caused rupture, early labour and sepsis. Lack of medication, MH support and advice.	22.09.25

10. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

11. RECOMMENDATIONS

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

Maternity Self-Assessment tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership		Trust and service organograms showing clinically led directorates/care groups	G	Organograms in place
	Clinically-led triumvirate	Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	Quadrumvirate in place comprising CBU Business Manager, Director of Midwifery, Lead Nurse for Gynaecological and Paediatric Services and Clinical Director. All share responsibility for attending specialty, operational and governance meetings within the CBU and Trust wide.
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined	G	Director of Midwifery job description clearly defines the professional accountability for midwifery.
		Agenda for change banded at 8D or 9	G	Position currently filled
		In post	A	The Director of Midwifery post has been vacant since 5 September 2025. A recruitment campaign took place in September. Following the campaign the decision was made to readvertise the role at Band 9. The role is currently being advertised and interviews are scheduled to take place on 13 November 2025.
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	In place
		Clinical director to executive medical director	G	In place
		DoM to executive director of nursing	G	In place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		General manager to executive chief operating officer	G	In place
		Maternity services standing item on trust board agenda as a minimum three- monthly. Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups. • Clinical outcomes such as SB, NND HIE, ATAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions	G	Monthly Quality & Safety report provided for Quality Assurance Committee for: - • Governance Overview (including Complaints, Patient Safety events) • Maternity Safety & Experience (including Safety Champion themes, FFT, MVP Feedback • MNSI cases • Key safety risks and workplans e.g. PPH, IOL, diabetes • Workforce metrics and training compliance • Coroner Regulation 28 position Quarterly report: • Transitional care • PMRT • ATAIN Monthly report provided for Quality Assurance Committee for: - • MIS including SBLCB progress. Quarterly Staffing Paper provided to Strategic People Committee including NICE red flags audit, workforce metrics. All papers are also taken to Trust Board
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	DoM presents to Board at each Board meeting as per Perinatal quality surveillance model as per above

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	In place. 2 PAs for Clinical Director role, 1 PA for Assoc Clinical Director role.
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	Yes.
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate. Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	HR Business Partner for W&C CBU is Jo-Ann Murphy Matron/Ward Manager 1:1 meetings in place to monitor recruitment, retention, sickness, vacancy, and maternity leave. HR support as per Sickness and Absence Policy.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	Senior Business Accountant for W&C CBU is Denise Dugdale.
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Monthly meetings in place with Finance.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	Senior operational support in place: Planned Care Group triumvirate consisting of Associate Medical Director, Associate Director and Associate Chief Nurse

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	G	Monthly Women's Health and CBU Governance meeting. Meetings consist of multiprofessional groups to discuss and agree collaboratively on all clinical decisions. Other regular MDT meetings where governance and safety matters are discussed and decisions made: • Intrapartum Review Group • ATAIN Review group • Guideline Review group • Audit meetings
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly	G	• Incident Reporting Group, Audit, PMRT are all multidisciplinary and have identified Chairs. • Matrons chair ward Manager & Specialist Midwives meeting.
		Leadership culture reflects the principles of the '7 Features of Safety'. **7 features of safety in maternity units** 1. commitment to safety and improvement at all levels, with everyone involved. 2. technical competence, supported by formal training and informal learning. 3. teamwork, cooperation, and positive working relationships. 4. constant reinforcing of safe, ethical and respectful behaviours. 5. multiple problem-sensing systems, used as basis of action. 6. systems and processes designed for safety, and regularly reviewed and optimised. 7. effective coordination and ability to mobilise quickly.	G	Various forums for MDT working in place with a focus on safety and improvement (ATAIN, PPH, IRG, ORG). Programme of formal training in place complemented by informal training opportunities such as C Shop, Trainer train and schedule of SIMs Formal workstream in place to support improved culture and further develop working relationships. PSIRF model fully embedded and tools such as cluster review, SEIPS used as routine. Triangulation of data and themes from learning responses completed to inform new workstreams and to ensure a holistic approach to safety.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	Trust-wide leadership and development team in place	G	Senior leaders are visible to frontline staff. Listening opportunities are provided to staff from both the Quadrumvirate Team and also the Chief Nurse and Non Exec Safety Champion.
		Inhouse or externally supported clinical leadership development programme in place	G	Ward Managers attend monthly Trust Ward Managers Meeting and also attend a Maternity Managers and Specialist Midwives Meeting facilitated by Maternity Matrons. Matrons attend Trust Nursing and Midwifery Forum. Matron opportunities to attend ad hoc leadership and development training days. Opportunities to complete external leadership educational programmes. Midwifery workforce development guideline to be launched Q1 2025/26 which will provide overview of development pathways for midwives from band 5 to aspiring senior leaders. Workforce development guideline now in place supported by 'This is Your Journey' document. Project to implement national Labour ward (Birth Suite) Coordinator framework underway. Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed Development of Deputy Manager Band 6 roles for aspiring Band 7. Trust Matron development programme to be launched July 2025. Launch has been delayed. Meeting to discuss 30th September, likely to launch Autumn 2025 – Sonia Griffin.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership and development programme for potential future talent (talent pipeline programme)	G	Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed This is Your Journey programme for midwifery colleagues which includes Trustwide offer.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	Coaching and mentoring are available on an individual need's basis. Service supportive of leadership programmes such as masters level study, nominations to the Florence Nightingale programmes.
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	Trust/CBU organograms in place to demonstrate lines of accountability.
		Organisational vision and values in place and known by all staff	G	Trust values are published and well understood by staff. Values merit badges are awarded to staff who have demonstrated a high standard for an individual Trust value. Trust wide vision and values strategy is in place. Ward Accreditation programme is used to monitor staff understanding of the Trust vision and values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	Contractual Code of Conduct HR Policies and Process in place. HR full support for advice and escalation where needed.
		Maternity strategy in place for a minimum of 3–5 years	G	In place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	G	In place
	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	G	Maternity and neonatal strategy was developed with input from staff, MNVP and experts by experience.
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	MNVP in place. Meets quarterly with rep from Midwifery SLT at each meeting. Consultant Midwife works closely with MNVP on key projects. MNVP workplan in place which includes regular 15 Steps challenge. From October 2024 MNVP invited to following: • Monthly Safety Champions Walkaround • Quarterly NED/Quad Meeting • Guideline Review Group • LMNS MNSOG
		Maternity strategy aligned with trust board LMNS and MVP's strategies	G	Complete
		Strategy shared with wider community, LMNS and all key stakeholders	G	Complete
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	Jayne Downey is the nominated Non Executive Maternity Safety Champion
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	Director of Midwifery and Neonatal Safety Champion participate in the Safety Champions walk arounds. Director of Midwifery and Obstetric Safety Champions attend WH Governance Meetings.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	Programme of 15 Steps Challenge in place Monthly Safety champion walkaround sin place which now include MNVP co-chairs
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Maternity Safety Champion (Director of Midwifery) attends QAC. Agenda item to present Maternity update report of achievements and challenges. Discussion and actions are recorded in the QAC minutes.
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	Organogram available
		Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans	G	Quarterly audit days, Obs & Gynae away days and other senior maternity meetings all in place.
	Multiprofessional training programme	Record of attendance by professional group and individual	G	In place and reported monthly to Quality Assurance Committee
		Recorded in every staff member's electronic learning and development record	G	In place
		Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	In place
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	In place.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All staff given time to undertake mandatory and job essential training as part of working hours	G	Yes
		Full record of staff attendance for last three years	G	Yes
		Record of planned staff attendance in current year	G	Yes
		Clear policy for training needs analysis in place and in date for all staff groups	G	Yes
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	Yes – recorded in ESR. Compliance for training not accessible in ESR is monitored by the Practice Development Midwife.
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	Yes, Exception Report provided for CBU Governance meeting and discussed at management meetings.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	Yes – PROMPT training. Skills and Drills. MAMU 2 (CTG training).
	Clearly defined appraisal and professional revalidation plan for staff	Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	G	Training meets all current NMC revalidation requirements and supports GMC educational requirements.
		All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Trust standard job descriptions and role profiles in place.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance with annual appraisal for every individual	A	Trust standard in place for all staff to have annual appraisal. PDR compliance is reviewed by Line Managers and levels of compliance monitored at CBU Management meetings. Current compliance is below 85% threshold. PDR trajectory to achieve full compliance in place.
		Professional validation of all relevant staff supported by internal system and email alerts	G	HR process in place to support monitoring of compliance and notification when professional registration has lapsed, or validation is overdue.
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	HR guidelines in place to support monitoring of capability and performance in the workplace. Staff supported to identify opportunities for professional education and development as part of PDR process. Senior Managers and Leaders accessible at clinical level for staff to discuss training and development opportunities. Rotational midwifery posts support maintenance of midwifery clinical skills
	Multiprofessional clinical forums	Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Dates set annually for GRG, PMRT, WHGG, WACHGG, Departmental Audit
	Multiprofessional inclusion for recruitment and HR processes	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	Interviews for senior leadership posts are conducted with an MDT interview panel
		Organisational values-based recruitment in place	G	All job descriptions and interview processes follow values based principles

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	Investigation panels have an MDT review process for incident claims and complaints. External representation requested as appropriate. Families are included in investigations where there has been a suspected poor outcome.
				No SOP however staff have access to support from Health and Wellbeing Department, Mental Health First Aiders and Counselling Services. Senior Managers and Clinicians offer debriefing opportunities for staff in group settings or on an individual basis following incidents and complaints. Develop local guidance on multiprofessional debriefing of staff. Provide debriefing training for senior leaders and managers who lead formal debriefing sessions. Trustwide debriefing improvement in place
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	A	
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	G	Process in place as part of implementation of PSIRF framework
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Schedule of attendance from multiprofessional group members available	G	In place and evidence available
		Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	In place and evidence available
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	MNVP and service users have been consulted on development of relocation of Triage and IOL. CQC Maternity Service Survey report shared with MNVP, and actions/next steps discussed. MNVP leads invited to attend Safety Champion walkarounds, quarterly QUAD/NED meetings and Guideline Review Group.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Collaborative multiprofessional input to service development and improvement	Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	A	In progress, completion by end of March 2026.
		Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility	A	In progress, completion by end of March 2026.
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	A	In progress, completion by end of March 2026.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	A	In progress, completion by end of March 2026.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that has appropriate shared access	G	Trust Knowledge & Evidence Service in place. Includes quarterly Maternity, Obstetrics & Gynaecology Evidence Update Bulletin
		Clear communication and engagement strategy for sharing with key staff groups	A	In place but not formalised
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	A	In progress, completion by end of March 2026.
	Multiprofessional approach to positive safety culture	Weekly/monthly scheduled multiprofessional safety incident review meetings	G	Initial Safety Review and Intrapartum review group meetings take place weekly led by Trust Governance and includes CBU Ward Managers, Senior Managers, Clinical Staff – Midwifery, Gynaecology and Neonatal. Monthly Operational Review Group established to review operational patient safety events.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	G	Quarterly Trust shared learning forum in place. Maternity included on agenda. Maternity also standing agenda item at Patient Safety & Experience Committee. LMNS invited to trustwide shared learning forum.
		Positive and constructive feedback communication in varying forms	G	SCORE Survey completed and Perinatal Cultural Leadership action plan in place. Trust Values badges awarded for exemplary behaviour. Safety Huddle Meeting highlights areas of good practice to be shared trust wide. Weekly Safety Brief provided to staff via Ward Managers. DOM monthly update provided to all staff. Ward Managers and Senior Leaders provide written and verbal feedback to individuals. Case on a page tool used to share feedback along with patient stories
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	All incident reviews have the opportunity to identify good practice. This is fedback to staff at the time of the review.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience.	G	Line managers and Matrons will link in with more junior colleagues following complex cases.
	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	G	
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they do not become normalised.	G	In place.
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	All policies and procedures align with the trust's board assurance framework (BAF)	G	Yes
		Governance framework in place that supports and promotes proactive risk management and good governance	G	Dedicated Governance Lead for Women's and Children's Health Department. Obstetrics and Gynaecology Governance Leads in place. Trust wide governance strategy in place. Governance activities and outcomes at speciality and CBU level meetings.
		Staff across services can articulate the key principles (golden thread) of learning and safety	G	Monthly newsletter circulated to staff with maternity lessons learned. Single point lessons developed to support ad hoc learning for incidents. Action plans are developed in response to lessons learned from incidents claims and complaints. Action plans are monitored through departmental governance meetings. Our Wise Learning (OWL) and learning from MNSI case on a page shared with staff.
		Staff describe a positive, supportive, safe learning culture	G	CQC report provided positive evidence of this. Feedback from Safety Champion walkaround would further support this. Culture workstream will further embed this.
	Maternity governance structure within the directorate	Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	G	Corporate Governance Team in place with identified WCH Governance Leads. Corporate governance systems and practices are followed at Departmental level.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife. Clinical educators to include leading preceptorship programme. Appropriate Governance facilitator and admin support	G	• Integrated Governance Lead in post (current RM with NMC pin) • Consultant Obstetrician governance lead in post • Specialist Midwife - Audit & Assurance in post • Specialist Midwife - Practice Development in post • Specialist Midwife Retention in post (supporting preceptorship programme) • Specialist Midwife - Practice education in post • MDT Intrapartum group in place to lead and review patient safety events. • Maternity risk manager - not in post however management of risk by the Deputy DoM and DoM (both NMC registrants)
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	G	Governance responsibilities are clearly described in Job Plans. Individuals are allocated as leads in maternity specific improvement initiatives such as MIS, SBL, ATAIN.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales	G	CBU and Corporate Governance monitoring systems in place to monitor compliance with deadlines and authorise extensions as required.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity-specific risk management strategy	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	G	Maternity Risk Management Strategy is included in the Trust Risk Management Strategy. Discussed at Trust Board and Trust position is standalone document not required as appropriate risk management regarding maternity services is included in Trust risk management strategy which provides sufficient assurance.
	Clear ward-to-board framework aligned to BAF	Clearly defined in date trust wide BAF	G	Yes
		Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	Reporting templates are available for all trust wide meetings. Work plan in place to highlight when specific reports are required for meeting agendas.
	Proactive shared learning across directorate	Mechanism in place for trust-wide learning to improve communications	G	Learning shared via daily safety meeting and safety brief to all staff. Various meeting forums to share learning and good practice. .
		Mechanism in place for specific maternity and neonatal learning to improve communication	G	**Various tools used:** • SEE Boards • Our Wise learning • Single point Lessons • Training Train • Area specific safety briefs • MNSI Case on a page • Face to face listening and learning sessions held following adverse events
		Governance communication boards	G	Safe, Effective, Experience (SEE) boards provided in all clinical areas by Integrated Governance Lead – sharing all information and learning relating to Governance.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Publicly visible quality and safety boards outside each clinical area	G	All wards have quality safety boards visible.
		Learning shared across local maternity system and regional networks	G	DoM, Dep DoM, and other members of the senior team will attend a variety of LMNS/regional quality/improvement meetings including: • LMNS Maternity and Neonatal safety Group with shared learning key aspect of meeting • WHAM operational group
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	Maternity Service has participated in safety collaborative initiatives and learning events. Staff attend LMNS learning events and safety initiatives
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	A	Overarching Trust communication plan in place but formal strategy paused due to Bridgewater transition process
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Multi-agency input evident in the development of the maternity specification	G	ICB engagement meetings in place via CQFG to discuss maternity performance and quality outcomes.
		Approved through relevant governance process	G	In place
		In date and reflective of local maternity system plan	G	In place
	Application of CNST 10 safety actions	Full compliance with all current 10 standards submitted	G	Achieved full MIS Year 6 compliance in 2025. Year 7 on track for meeting all 10 safety actions.
		A SMART action plan in place if not fully compliant that is appropriately financially resourced.	N/A	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	Yes
		Clear process for multiprofessional, development, review, and ratification of all clinical guidelines	G	Guideline Review Group in place with guidelines circulated for MDT comment prior to approval
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 month programme.	G	Multiprofessional meetings in place. Schedule available.
		All guidance NICE complaint where appropriate for commissioned services	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed
	Saving Babies Lives care bundle implemented	All five elements implemented in line with most updated version	G	Saving Babies Lives Care Bundle v.3 (SBLCBv3) implemented.
		SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	G	The latest external review took place of Saving Babies Lives Care Bundle v.3.2 in September 2025. Current compliance at 96% and action plans in place.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	Action plans and ongoing audits in place to sustain compliance

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of the four key action points to reduce inequality for BAME women and families	All four key actions in place and consistently embedded	G	Local maternity systems are asked to increase support for at-risk pregnant women (Covid) – complete. Reach out and reassure pregnant BAME women with tailored communications (Covid) - complete. Minimise the risk of Vitamin D insufficiency – in place and monitored as part of Saving Babies Lives Care Bundle v.3
		Application of equity strategy recommendations and identified within local equity strategy	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.
	Implementation of 7 essential learning actions from the Ockenden first report	All actions implemented, embedded and sustainable	G	Action Plan for the 7 essential learning actions from Ockenden first report complete.
		Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	Fetal Surveillance midwife post well established.
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	In place
	A-EQUIP implemented	Plan in place for implementation and roll out of A-EQUIP	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway
		Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Service provision and guidance aligned to national bereavement pathway and standards	G	Regional Pathway in place.
		Bereavement midwife in post	G	7 day service in place
		Information and support available 24/7	G	Bereavement Champions have received training from Bereavement Midwife to ensure 24 hour support for staff and families.
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	Dedicated Family Rooms available.
	Quality improvement structure applied	Quality improvement leads in place	G	Deputy Dom is lead within the Maternity service. Maternity team also work closely with the Trust Quality Academy.
		Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	A	QI lead via Deputy Director of Midwifery Support provided from the Quality Academy. Formal plan underway. Completion by 31/3/2026
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	Safety Collaborative focussed on QI methodology and some staff have attended the trust wide QI training sessions provided by the Quality Academy, utilising recognised and approved quality improvement tools and frameworks.
		Established quality improvement hub, virtual or otherwise	G	Trust wide Quality Academy in place, plus monthly Maternity QI meetings established.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	MatNeoSip embedded in service delivery	Listening into action or similar concept implemented across the trust	G	Trust engages with varied MatNeoSip project. NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture. Programme of ideas sessions completed with staff in Autumn 2024 to inform programme of improvement. Actions underway.
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture.
	Maternity transformation programme (MTP) in place	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	A	QIP underway. Completion by 31/03/2026
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	A	Will be included as part of QIP underway. Completion by 31/03/2026.
		Standing agenda item on key directorate meetings and trust committees	A	Once QIP in place will report quarterly to speciality governance and Quality Assurance Committee/Board. Completion by 31/3/2026
		Human factors training lead in post	A	External training completed. No formal human factors training lead
	Freedom to Speak Up (FTSU) guardians in post	FTSU guardian in post, with time dedicated to the role	G	Trust wide guardians in post with identifiable lanyards. Guardians receive time to support role Anonymous reporting system in place.
	Human factors training available	Human factors training part of trust essential training requirements	A	Human factors training programme is being implemented as part of the PSIRF implementation

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Human factors training a key component of clinical skills drills	G	Human factors included as part of Prompt training
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	Key aspect within PSIRF. SEIPS methodology being used routinely.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Multiprofessional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas e.g., antenatal/postnatal ward/triage.	G	SOP in place, regular audits undertaken
		Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	In place
	Safety huddles	A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	In place
		Guideline or standard operating procedure describing process and frequency in place and in date	G	Need evidence to support

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Audit of compliance against above	A	In place, evidence to be collated
	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	R	Not yet in place
		Multiprofessional attendance recorded and supported as part of working time	R	As above
		Broad range of specialties leading sessions	R	As above
	Trust-wide safety and learning events	Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	Weekly safety Oversight meeting in place
		Robust process for reporting back to divisions from safety summit	G	Weekly meetings between Governance lead for Women's & Children's CBU and director of Midwifery including reporting back
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	G	Quarterly Trust wide Shared Learning Forum in place
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	In place
Comprehension of business/ contingency plans impact on quality.	**Business plan in place for 12 months prospectively**	In date business plan in place	G	Included in Trust business plan
		Meets annual planning guidance	G	Included in Trust business plan
		Business plan supports and drives quality improvement and safety as key priority	G	Included in Trust business plan

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	G	Mat workforce not included in Trust business plan but measures to ensure workforce needs are met and safe staffing is in place are included with the Maternity & Neonatal Workforce Strategy, reported to QAC and Strategic People Committee and included in assurance related to the Maternity Incentive Scheme.
		Consultant job plans in place and meet service needs in relation to capacity and demand	G	Yes, monitored by CBU Business Manager
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	Yes, monitored by CBU Business Manager
		Business plans ensures all developments and improvements meet national standards and guidance	G	Yes, monitored by CBU Business Manager/quadrumvirate
		Business plan is aligned to NHS 10-year plan, specific national initiatives, and agendas.	G	Included in Trust business plan
		Business plans include dedicated time for clinicians leading on innovation, QI, and Research	R	Formal plan will be developed for 2025/26
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	G	Included as part of Maternity & Neonatal Strategy 2024-26
		Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan including key workstreams related to pelvic health, infant feeding, smoking, and enhanced provision for BME women and women in the most deprived deciles.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/132**			
SUBJECT:	Compliance Assurance Report Q2 2025/26			
DATE OF MEETING:	11 November 2025			
ACTION REQUIRED:	The members of the Board of Directors are asked to note the contents of the report.			
AUTHOR(S):	Jen McCartney, Interim Head of Compliance			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will … Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper provides the members of the Board of Directors with an overview of quality compliance activity for Quarter 2 (July–September 2025), outlining progress made in strengthening regulatory readiness, governance oversight, and assurance processes across the Trust. During the quarter, the Care Quality Commission (CQC) Preparedness and Mobilisation Plans were reviewed and approved, biweekly Compliance Summits were established, and planning commenced for mock CQC interviews for Executives, Non-Executives and Senior Leaders. The Safeguarding and Medicines Management mock assessment findings were presented to Quality Compliance Oversight Group (QCOG), with refinement of action plans continuing into Quarter 3. Regulatory liaison performance improved, with open CQC enquiries reducing from 13 in July to 1 by the end of October 2025 and no enforcement actions received. CQC engagement meetings held in July and November 2025 were positive, with CQC recognising sustained improvement in leadership, governance, and quality performance, confirming confidence in the Trust's			

<table>
<tr><td></td><td colspan="3">direction of travel and inspection readiness.

The Trust successfully completed two external inspections retaining a 5-star Food Hygiene Rating at Halton Hospital and achieved a positive IR(ME)R outcome, both providing external assurance of compliance.

Looking ahead to Quarter 3, the Trust will embed updated mobilisation arrangements, deliver mock CQC interviews for Board of Directors, finalise the Medicines Management Action Plan, and maintain oversight of regulatory enquiries to ensure sustained readiness for the anticipated CQC Well-Led inspection later in 2025.</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 members of the Board of Directors are asked to note the contents of this paper.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2"></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">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Compliance Update Q2 2025/26	AGENDA REF:	BM/25/12/132

1. BACKGROUND/CONTEXT

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its role is to ensure that services provide safe, effective, compassionate, and high-quality care, while supporting continuous improvement. The CQC monitors, inspects, and regulates providers, publishing its findings to promote transparency. Where standards are not met, the CQC has the authority to take enforcement action where appropriate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) remains committed to delivering services that are safe, effective, caring, responsive, and well-led. Continuous monitoring, measurement, and assessment of quality and compliance are essential to provide assurance that the Trust meets all regulatory requirements and to evidence readiness for external inspection, accreditation, and re-accreditation processes.

To support this, the Quality Compliance Oversight Group (QCOG) meets monthly to review performance, track progress against compliance objectives, and provide assurance that regulatory and quality standards are being maintained across all clinical and corporate areas.

2. QUALITY COMPLIANCE OVERSIGHT GROUP OVERVIEW

During Quarter 2, the Quality Compliance Oversight Group (QCOG) met monthly with strong multi-disciplinary engagement, providing assurance on regulatory compliance and inspection readiness.

Key activity focused on CQC Well-Led preparedness and ongoing alignment of divisional Single Assessment Framework (SAF) evidence. A CQC engagement meeting in July provided positive feedback, and planning commenced for mock CQC interviews for Executive, Non-Executive and senior leaders.

The Trust underwent two external inspections:

- **IR(ME)R inspection (Aug 2025):** positive findings; action plan due for submission to CQC in October 2025.
- **Environmental Health inspection (Aug 2025):** Halton Hospital retained its 5-star food hygiene rating.

Compliance systems strengthened across the quarter:

- CQC enquiries reduced from 13 in July to 1 open cases by October 2025.

- Policy compliance remained stable (84%) with weekly monitoring through the Policy Review Group.
- Risk register management improved, with risks mapped to CQC quality statements and overdue items reduced.
- The Ward Accreditation Programme is aligned to CQC standards, weighted scoring has been introduced weighted scoring for key questions relating to well led and safety components.
- The Maternity Policy process was identified as a best-practice model for adoption Trust-wide.
- Communication and staff engagement continued through divisional Quality Summits, reinforcing inspection readiness and learning from improvement activity.

2.1 CQC ENGAGEMENT MEETING 2025 UPDATE

A CQC Engagement Meeting took place on 17 July 2025, attended by CQC representatives and the Trust's Senior Leadership Team. The meeting provided a constructive opportunity to share progress, highlight key improvement initiatives, and discuss inspection planning and regulatory updates.

CQC feedback was positive, recognising strong progress in leadership, quality improvement, and openness. Particular assurance was noted in relation to the Older Persons Short Stay Unit, Maternity Culture Action Plan, d/Deaf Action Plan, and Freedom to Speak Up activity.

A further meeting was held in November 2025, where the Trust presented additional evidence demonstrating improvement in clinical governance and operational performance, including strengthened arrangements for sepsis management, medicines safety, rapid tranquilisation oversight, and falls prevention. The CQC acknowledged continued progress in risk management, Bridgewater integration planning, and the significant improvement in the management of CQC enquiries, confirming confidence in the Trust's direction of travel and readiness for inspection.

The CQC commended WHH's proactive approach, transparency, and improvement culture, noting continued confidence in the Trust's governance and inspection preparedness.

2.2 Update on CQC preparedness

During Quarter 2, significant progress was made to strengthen the Trust's preparedness for an anticipated CQC Well-Led inspection. Work was coordinated through the Quality Compliance Oversight Group (QCOG) and structured against the CQC Preparedness Action Plan and Mobilisation Plan. Collectively, these provided clear governance, accountability, and operational readiness arrangements.

Key achievements and assurance include but are not limited to:

1. Strengthened Leadership and Mobilisation Framework

- A comprehensive CQC Mobilisation Plan has been finalised, setting out clear leadership arrangements, Gold Command protocols, communication pathways, and defined responsibilities for all teams before, during, and after inspection.
- Gold Command arrangements were established, with supporting WhatsApp groups created for Executives, Senior Operational Leads, and Clinical Business Units (CBUs) to ensure rapid communication and escalation.
- Divisional and corporate CQC action cards were refreshed, clarifying immediate expectations and inspection-day procedures.
- An inspection readiness checklist and top tips for staff were issued to all wards and departments, reinforcing consistent standards across the Trust.

2. Progress Against the Well-Led Action Plan

- A draft Well-Led Gap Analysis and evidence directory were produced, collating assurance across all CQC quality statements. These are now under executive review ahead of validation in November 2025.
- Weekly Compliance Summits were introduced with representation from the Chief Nurse, Deputy Chief Nurse, Associate Chief of Nursing (Corporate), and Care Group Triumvirates to review evidence, identify gaps, and track actions.
- Compliance Panels were established to validate ward accreditation assessments triangulated with divisional self-assessments.
- Mock interview sessions for Executives, Non-Executives, and senior leaders are planned for late October and early November 2025.
- Dedicated executive time has been incorporated into diaries to enable regular ward and departmental visits, enhancing visibility, engagement, and real-time assurance of inspection readiness.

3. Enhanced Assurance Through Risk, Policy, and Governance Workstreams

- Risk register position reviews are embedded in the QCOG cycle of business, with improved triangulation between local and corporate risks and clearer alignment to CQC domains.
- Policy compliance remained stable at approximately 84%, with weekly oversight through the Policy Review Group and continued integration work with Bridgewater policies.
- An estates prioritisation process was agreed to ensure that environmental and “first impression” issues are addressed as top-priority jobs during inspection readiness.

4. Staff Awareness and Communication

- The CQC Staff Guide was updated and widely disseminated via the intranet, Chief Nurse Check In, and weekly communications.
- The Trust-wide CQC communications plan has been developed, with weekly messages reinforcing inspection themes and frontline expectations.
- CQC training sessions were delivered Trust-wide and recorded for staff unable to attend.

Key next steps in Quarter 3 include

- Continued development of evidence directory to support self-assessments.
- Complete mock interviews and review Well-Led compliance
- Maintain monthly divisional assurance through QCOG.

2.3 UPDATE ON THE MOCK ASSESSMENT PROGRAMME

During Quarter 2, the Trust continued to monitor progress against the outcomes and actions arising from the Safeguarding and Medicines Management Mock Inspections, which had been undertaken in Quarter 1 as part of the Trust's proactive CQC inspection preparedness programme.

Both exercises were designed to benchmark practice against the CQC Single Assessment Framework (SAF), identify areas of good practice, and address any gaps ahead of the anticipated Well-Led inspection. Oversight of progress continues through the Quality Compliance Oversight Group (QCOG), with actions additionally tracked through established governance routes.

Safeguarding Mock Inspection – Outcomes and Progress
The mock inspection, undertaken in June 2025, provided assurance of safeguarding systems and staff awareness across adult and children's services.

Key strengths included staff confidence in recognising and escalating concerns, effective Mental Capacity and DoLS processes, and strong partnership working with external agencies.

Areas for improvement were identified around consistency of MCA documentation, timeliness of DoLS reviews, visibility of the Safeguarding Team within clinical areas, and uptake of supervision and training.

In Quarter 2, a comprehensive Safeguarding Action Plan was initiated through the Safeguarding Committee, with regular progress updates to QCOG. Actions delivered include:

- Review of a DoLS reminder system to prompt timely reviews.
- Review of MCA refresher training and case-based workshops.
- Improved ward visibility of Safeguarding Leads.
- Development of a quarterly Safeguarding newsletter to share learning, legislative updates, and best practice examples.

These actions strengthen compliance with MCA/DoLS and visibility of Safeguarding leadership ahead of any forthcoming inspection.

Medicines Management Mock Inspection – Outcomes and Progress

The mock inspection, undertaken between May and June 2025, provided moderate-to-good assurance regarding medicines governance, storage, and safety culture across the Trust.

Strengths included secure storage practices, accurate controlled-drug checks, visible pharmacy support in several clinical areas, and evidence of an open and learning culture in relation to medication incidents.

Areas requiring improvement included variation in prescribing and documentation standards, limited patient involvement in medicines decisions, timeliness of TTOs, inconsistent staff awareness of PGDs, and gaps in weekend pharmacy cover.

Following the report a Medicines Management Action Plan was developed and presented to QCOG in September 2025. This plan is now being refined to address specific governance, training, and system improvements, and a finalised version will be submitted to QCOG in November 2025 for formal monitoring.

The refined Medicines Management action plan will be submitted to QCOG in November 2025, providing a monitored route to address prescribing, documentation, and weekend cover themes.

2.4 CQC ENQUIRIES AND NOTIFICATIONS

Significant progress has been made since the Quarter 1 Compliance Update report to QAC in strengthening oversight, governance, and timeliness of responses to all CQC enquiries. The position demonstrates a marked improvement in both the volume of open cases and the speed and quality of information shared with the regulator. Oversight continues through the Quality Compliance Oversight Group (QCOG), with clear executive visibility and assurance of progress across all Clinical Business Units.

As shown in Figure 1, the Trust currently has one open CQC enquiry, which remains on track for completion within the expected timeframe and is dependent on the outcome of the multidisciplinary-team (MDT) outcome for a Never Event.

In addition, 6 further enquiries have been fully completed and submitted to the CQC and are awaiting formal confirmation of closure, as detailed in Figure 2. These submissions have been quality-assured through the central governance process, with all evidence and supporting documentation verified before submission.

The Trust’s overall position has continued to improve during Quarter 2. The total number of open CQC enquiries has reduced significantly since Quarter 1, with older and more complex cases resolved through strengthened coordination. The refined tracking process has ensured consistent updates, improved accuracy, and timely responses to all CQC requests.

As reflected in Figure 3, 15 enquiries were closed during Quarter 1 and Quarter 2, covering themes including Urgent and Emergency Care, safeguarding, medicines management, infection prevention, and patient experience. The CQC has not issued any enforcement actions or formal escalations during this period, and feedback from CQC officers has been positive regarding the clarity and completeness of Trust responses.

Overall, the Quarter 2 position provides strong assurance that the Trust's regulatory liaison and enquiry management processes are robust, responsive, and increasingly efficient, reflecting a culture of transparency, learning, and continuous improvement in the Trust's engagement with the CQC.

Figure 1. Open CQC Enquiries

Clinical Business Unit	CQC Enquiry Number	Query	Date Received	Comments/ Update	Completed date
Specialist Surgery	CAS 1089766	Wrong Site Surgery Never Event.	24/09/2025	CQC notified 24 September 2025. Awaiting outcome of investigation. MDT to take place and shared with CQC once complete **On track**	

Figure 2 - Enquiries closed by WHH, awaiting CQC confirmation

Clinical Business Unit	CQC Enquiry Number	Query	Date Received	Comments/ Update	Completed date
Urgent and Emergency Care	CAS-506098	Concerns – Patient care in ED	30/07/2024	Additional info requested by CQC – Headache Proforma sent to CQC 10/07/25. CQC internal meeting due to take place wk. comm 3.11.25 when enquiry is expected to be closed	**10.7.25**
	CAS-988871	Complaint received (JS) CQC is aware of the ongoing complaint relating to JS and requests the outcome of the complaint.	21/07/25	The complaints team is aware and will share the response once finalised. Complaint received by department and sent to CQC 21/10/25	
Clinical Support Services	CAS-984156	Complaint received. CQC requests the outcome of	21/07/2025	The complaints team is aware and will share the response once finalised.	

		the complaint. Complaint relates to concerns with diagnosis and treatment plan.		**On track**	
Cancer Services / Breast Screening	CAS 1013448	Request for initiation of an action plan folllowing ombudsmen review of a complaint. Action plan to be shared once completed	11/08/2025	4.9.25 – action plan and Trust response shared with CQC. CQC internal meeting due to take place wk. comm 3.11.25 when enquiry is expected to be closed	**4.9.25**
Trust Wide	CAS-986791	Ligatures: StEIS: 2025/3256 2025/1908 PSII/ISR: 203630 PSII/SBAR: 206171	15/07/2025	Case opened to track Trust investigations into 2 recent ligatures – PSII's to be shared once completed. **203630** **206171** Enquiry formally closed by CQC 31.10.25 however require corresponding PSII's for completeness	
Integrated, Medicine & Community	CAS-1046169	Concerns have been raised in relation to rapid tranquilisation processes	01/09/2025	Enquiry response shared with CQC – Enquiry to remain open pending engagement meeting on 4.11.25	**29.9.25**

Figure 3: Closed enquiries in 2025

Clinical Business Unit	CQC Enquiry Number	Query	Date Received	Comments/ Update	Completed date
Urgent and Emergency Care	CAS-1010173	Concerns – restraint	05/08/25	**Summary** The patient visited Urgent Care multiple times from July 27 to August 1, 2025. No clinical hold was found in the ED. Security was called twice—once on June 27 during the ED visit and again on July 28 at SDEC—but no clinical hold was documented. The patient remained calm during both incidents. They witnessed another patient	**05/08/2025**

				requiring a clinical hold. The ED was busy with 11 patients with acute mental health needs, prompting extra staff and security for 24 hours.	
	CAS-881098	Mental Health Patient in ED (170hr wait)	12/05/25	Trust response sent and ED system checked re: 20224/2025 clarification **Case closed by CQC 09/09/25**	
	CAS-927627	Anonymous concerns re. Staffing levels & patient care (A1/AMU)	06/06/25	Response sent to CQC 03.09.25 **Case closed by CQC 04/09/25**	
	CAS-1066258	Concerns/ Complaint – Safeguarding Failure/Concerns	09/09/25	Email received from CQC, awaiting information from departments and a response to CQC by midday 12/09/25. **Case closed by CQC 18/09/25**	
	CAS-899008	Patient care & IPC concerns in ED	16/05/25	Information received from department. **Case closed by CQC 19/09/25**	
	CAS-1032107	Concerns re. Rapid Tranquilisation ***150593836 / 151102770 / 150970071*** Ongoing concerns raised by the daughter of (LC) ref. 24185	01/09/25	Datix Information received in folder re: incidents Trust response saved in folder for Complaints re. 24185 **Case closed by CQC 29/09/25**	
Digestive Diseases	CAS-764344	Notification of MRSA Bacteraemia (A5G)	06/02/25	Reported a Hospital Onset Healthcare Associated MRSA Bacteraemia; CQC requested the 'Post Infection' review. Sent the review, but delays occurred as CQC couldn't open the attachment. **Attachment re-sent 08/07/25 & 16/07/25 as PDF – Await formal closure**	
Specialist Surgery	CAS-903889	Unsafe discharge (A6) Request to provide 'Discharge policy' and address specific issues re. medications and dressings.	22/05/25	Information received from department. **Case closed by CQC 09/09/25**	
Medical Care	CAS-905105	Care and Treatment concern for a family member following a heart attack.	21/05/25	Draft response complete undergoing internal quality checks to ensure factual accuracy prior to CQC submission **Case closed by CQC 04/09/25**	
Integrated Medicine and Community	CAS-105420	Subject: Urgent in Ward A7 A verbally abusive patient has made threats;	02/09/25	Information sent over to CQC in a timely manner	

		family is worried. The mental health team knows but hasn't supported. The patient stole items and threatened another with a walking aid. Nursing staff are doing well. Immediate action is needed by 4 PM to protect patients.			
	CAS-963500	Formal complaint from patient - Dear Complaints Team, I am writing to formally raise concerns about the mismanagement of my respiratory condition and diagnosis of pulmonary hypertension under the care of Dr. Ambrose.	07/07/25		**15/07/25**
Bridgewater	CAS-985185	<u>Concerns – Pressure Ulcers</u> Culture between DN team leaders and TVN, where leaders report incidents as pressure ulcers listed as "trauma" on completion of Ulysses incident reporting. Ongoing since 2022	17/07/25	Added to the tracker at the Chief Nurse's request. Query in relation to the incorrect recording of pressure ulcers as trauma. Audit underway.	
Women and Children	CAS-1017332	Anonymous concerns re. Neonatal Unit. Incorrect baby given to parents after birth on the Neo Natal unit.	07/08/25	Information sent to CQC – response received back – For closure purposes to send '*Audit of adherence to the policy for the identification and care of the newborn in a secure environment*'. **Case closed 19/09/25** **08/09/25 – Emailed Erica/Kathryn for the audit**	

				report to send onto CQC.	
Trust Wide	NOT-013167 80	Care Home Notification of Death The care home did not provide details, stating the hospital didn't inform them of the death or its cause. There's no indication of poor care; we're just following up to close the notification. Can you check if this death is under review or referred to HM Coroner?	13/10/ 25	I have made the necessary enquiries and can confirm that this gentleman sadly passed away in the Emergency Department at Whiston Hospital on 24 September 2025 and not Warrington Hospital as indicated to you by the Care Home. On speaking to the medical examiner officer who covers this hospital, I can confirm this gentleman's death was considered to be due to natural causes and has not been referred to HM Coroner at this point.	**16/10/25**
	CAS-988111	Medication, IPC & Care Mixed Wards (A & B) Anonymous concerns relating to A9, A6, A7, B14, A8, B12 & B19 – care provided to 2 patients who are 1:1 & COVID patients, keeping doors open and using the same bathroom.	17/07/ 25	Final trust response sent to CQC 03/10/25 – await closure	

2.5 HEALTH & SAFETY INSPECTIONS

Since the Quarter 1 report, the anticipated unannounced Environmental Health inspection at the Halton site was completed in August 2025, confirming that the site successfully retained its 5-star Food Hygiene Rating, providing clear external assurance of compliance with environmental and food-safety standards.

To ensure equivalent readiness at Warrington Hospital, the Trust commissioned an external Food Safety Consultant to undertake an independent food safety inspection of ward kitchens on 23 September 2025. The findings identified generally good standards of cleanliness and safe food handling, alongside a number of areas for improvement. These included minor environmental maintenance, food-labelling consistency, temperature-recording gaps, allergen matrix updates, and staff refresher training on fridge management.

A comprehensive Food Safety Action Plan (October 2025) was developed directly from the consultant's report, setting out all legal requirements and good-practice recommendations.

Each action has been assigned an accountable lead and completion timescale, with monitoring through the Health and Safety Sub-Committee and oversight by QCOG.

In addition, Arjo will commence lifting equipment inspections from 31 October 2025, covering all hoists and slings within clinical areas to ensure the Trust remains fully compliant with the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.

3. CQC PLAN NEXT STEPS

During Quarter 3, the Trust will continue to strengthen inspection readiness and deliver the remaining actions within the CQC Preparedness Plan, with ongoing oversight through the Quality Compliance Oversight Group (QCOG).

Key areas of focus will include:

- Embedding and monitoring the updated CQC mobilisation plans, including communication protocols and Gold Command arrangements to ensure clear leadership and coordination on the day of inspection.
- Continuing the biweekly CQC Compliance Summits, chaired by the Chief Nurse / Deputy Chief Nurse, to monitor divisional progress against the Well-Led Action Plan and evidence development for the CQC Single Assessment Framework (SAF).
- Delivering the mock interview and preparation programme for Executive and Non-Executive Directors in November 2025.
- Continuing implementation of the Trust-wide CQC Communications Plan, reinforcing inspection awareness through ongoing messaging and staff briefings.
- Finalising and submitting the refined Medicines Management Mock Assessment Action Plan to QCOG for formal approval and monitoring.
- Maintaining robust oversight of CQC enquiries, ensuring timely completion of the two open cases and confirmation of closure for the five previously submitted to the CQC.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/133**	
SUBJECT:	**Communications and Engagement Update (bi monthly) September to October 2025**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department. **1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **2273** If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	

<table>
<tr><td></td><td>115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care

1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff

1757 If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust’s ability to maintain safe, effective, and timely patient care.

2253 If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts’ decision-making and service management</td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table></td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>This report updates on communications and engagement activity during September to October 2025.
The report covers a two-month period to ensure alignment of communications and engagement activity reporting with the Board meeting cycle.

It incorporates reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report.

Key highlights from the report include:

• Communications Activity: The Communications and Engagement Team managed 27 job requests, issued 6 media releases and published 23 stories across various Trust websites during September and October 2025</td></tr>
</table>

	• **Campaigns:** Key campaigns included the MaDE campaign (20 to 24 October) • **Training:** Online EHIA training is now available to all staff, with bi-monthly awareness sessions on public consultation being delivered until May 2026 • **Community engagement:** Encouragement for local residents to join the Council of Governors and participate in the Annual Members' Meeting • **Better Care Together:** BCT programme updates shared included microsite updates and support for staff engagement sessions • **Accessibility and inclusion:** Efforts to improve accessibility resulted in improved website accessibility scores and the team is now incorporating health literacy checks on patient leaflets as business as usual The report also includes details of engagement events which the Trust is hosting or planning to attend during 2026		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the period.		
PREVIOUSLY CONSIDERED BY:	**Committee**	EMT	
	Agenda Ref.	EMT/25/605ii	
	Date of meeting	25 November 2025	
	Summary of Outcome	To note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update
Bi-monthly report (September to October 2025)

Trust Board meeting

3 December 2025



Our role within WHH

The Communications and Engagement Team remit covers:

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

During the period (September to October 2025) the Communications and Engagement Team…

- processed and allocated **27** communications 'job requests' for design, film, photography and communications campaign support
- issued **6** Trust media releases (plus **1** WHH Charity media release)
- published **23** stories across our main Trust website, charity website and breast screening services website
- prepared / issued **5** media statements
- handled **13** enquiries from local, regional and national print and broadcast media

September / October activity and achievements overview

- Promoted new campaign materials and resources for Martha's Rule, including a dedicated webpage, screensavers, posters and a patient information leaflet
- Provided internal and external communications for our Annual Members' Meeting (1 October)
- Continued to improve accessibility of the Trust website, with the site now rated 'Excellent' with a 96% accessibility score on Silktide
- Supported development and promotion of WHH Charity's annual Impact Report
- Shared national resources and promoted Trust activity for our annual flu vaccination campaign e.g. roaming clinics, drop-in sessions
- Promoted the national Staff Survey 2025 across all internal platforms and channels
- Encouraged all staff to encourage patient activity, in line with WHH's Active Hospitals initiative



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

Media

Media releases issued during September and October 2025, including:



WHH HR Team shortlisted for excellence in people award

Read the release



Work to support d/Deaf community at Warrington and Halton Teaching Hospitals shortlisted for award

Read the release



WHH invites local residents to join Council of Governors and help shape healthcare services

Read the release



Healthwatch Warrington launches awareness card pilot to support inclusive healthcare

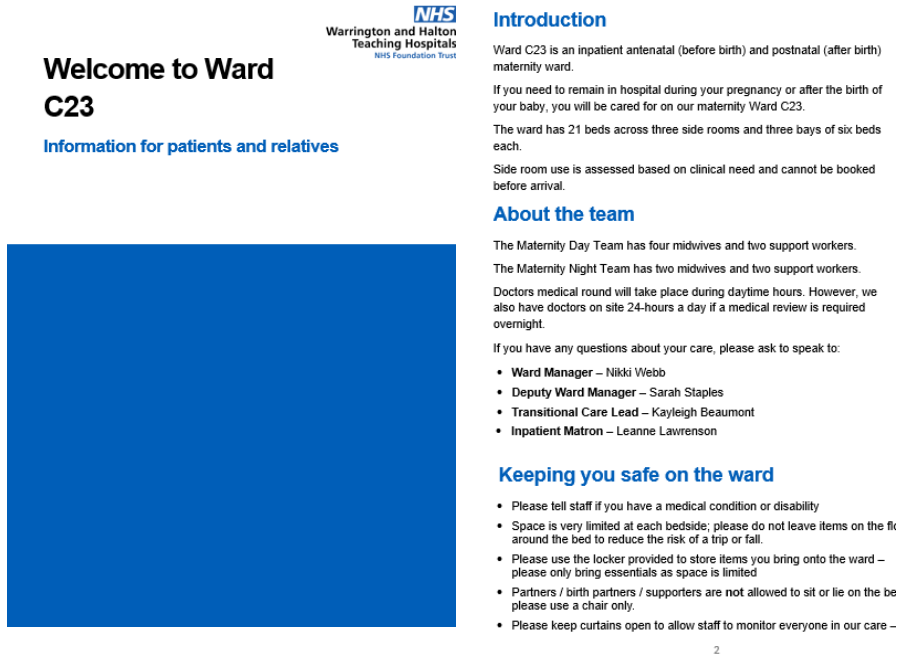
Read the release

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

Production of Patient Information (PINFO)

From September to October the Communications and Engagement Team:

- supported clinical teams in putting 5 new leaflets through the PINFO process
- reviewed and edited **18** existing leaflets to ensure content remains clinically appropriate and reflects WHH style guidelines
- identified a total of **137** expired leaflets
- archived **35** leaflets
- reviewed the process and carried out a benchmarking exercise to inform how we approach integration with BCH patient information process



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Welcome to Ward C23

Information for patients and relatives

Introduction

Ward C23 is an inpatient antenatal (before birth) and postnatal (after birth) maternity ward.

If you need to remain in hospital during your pregnancy or after the birth of your baby, you will be cared for on our maternity Ward C23.

The ward has 21 beds across three side rooms and three bays of six beds each.

Side room use is assessed based on clinical need and cannot be booked before arrival.

About the team

The Maternity Day Team has four midwives and two support workers.

The Maternity Night Team has two midwives and two support workers.

Doctors medical round will take place during daytime hours. However, we also have doctors on site 24-hours a day if a medical review is required overnight.

If you have any questions about your care, please ask to speak to:

- **Ward Manager** – Nikki Webb
- **Deputy Ward Manager** – Sarah Staples
- **Transitional Care Lead** – Kayleigh Beaumont
- **Inpatient Matron** – Leanne Lawrenson

Keeping you safe on the ward

- Please tell staff if you have a medical condition or disability
- Space is very limited at each bedside; please do not leave items on the fl around the bed to reduce the risk of a trip or fall.
- Please use the locker provided to store items you bring onto the ward – please only bring essentials as space is limited
- Partners / birth partners / supporters are **not** allowed to sit or lie on the be please use a chair only.
- Please keep curtains open to allow staff to monitor everyone in our care –

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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key campaigns / highlights from September to October 2025

MaDE campaign

Internal communications support provided to the Multi Agency Discharge Event (MaDE), held from 20 to 24 October.

Communications included:

- Good Morning Messages on 10 and 17 October
- content in The Week on 10 and 17 October
- intranet article (13 October)
- a digital homepage banner with MaDE branded images and
- a safety hot topic in The Week



Better Care Together (BCT) – internal update

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

Microsite activity

- September: 1,534 visits (341 unique)
- October: 3,188 (813 unique)
- Most viewed page: workstreams
- Total site visits: 22,399

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

Engagement activity

- September: 188 staff (44% BCH staff and 56% WHH staff)
- October: 270 staff (Team Brief as no engagement session held)

North Cheshire and Mersey Healthcare Partnership website

Launched on 24 October, the North Cheshire and Mersey Healthcare Partnership (NCMHP) public website provides a space for the public, partner organisations and stakeholders to keep up to date with the integration programme.

Site feedback
Feedback from Experts by Experience (EbyEs) on the new website has been very positive, with users praising the website's clear, concise messaging, professional design and engaging video.

Several respondents suggested further explanation around what is coming together and what the new name represents, including a request to expand on abbreviations where possible and reference previous trust names within any media.

Respondents also recommended broadening communication beyond the website / digital media, through local hard copy media, printed flyers, posters and information desk materials to reach those who may be digitally excluded.

EbyEs also encouraged highlighting the tangible benefits of integration, such as improved access and reduced waiting times.

Awareness sessions on engagement, involvement and public consultation in service change

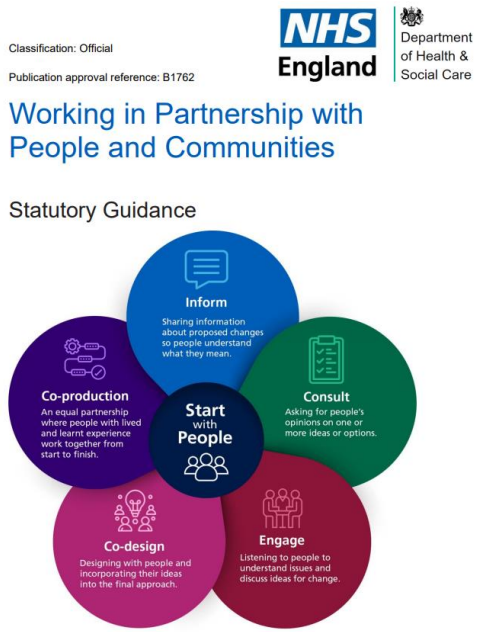
The team are now delivering a 90-minute session to improve understanding and awareness of:

- how to effectively work with people and communities
- statutory involvement duties and
- other key legal considerations when proposing service changes, which may impact on day-to-day work.

Overall satisfaction rating: 4.6 / 5

Feedback

- ✓ “The session’s real-life examples really helped my understanding and put the knowledge that we had learned about engagement and public consultation to the test.”
- ✓ “The session was useful for highlighting statutory requirements and good practice around public and patient engagement and consultation.”
- ✓ “I thought the themes were very interesting, especially the case studies. It goes to show how wrong things can go if you don’t follow correct processes – time well spent.”

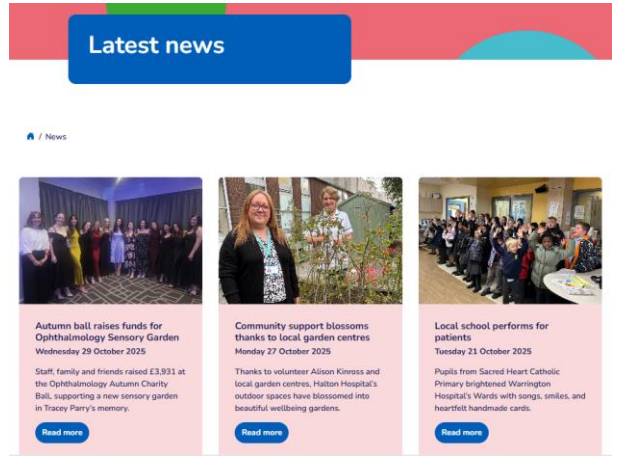


WHH Charity

We published our annual WHH Charity Impact Report, highlighting the achievements made possible by community support over the past year.

Funded projects have enhanced patient care, upgraded hospital facilities, provided equipment and supported staff wellbeing. Despite challenging economic times, contributions from residents, staff and businesses have remained strong. Read the report.





Website activity

- September: 1,600 visits (808 active)
- October: 1,907 visits (1,077 active)
- The most viewed pages were home, crafters and news.

Newsletters

- Two newsletters were published: September 2025 and October 2025

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
September to October 2025

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 25 Experts by Experience recruited during 2025-26 (2 during September to October). • 214 Experts by Experience (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs. • Delivering bi-monthly staff 'engagement, involvement and public consultation in service change' awareness sessions.	• Ongoing
2. Support EbyE recruitment and retention	• 13 EbyE projects delivered in 2025-26 (plus 3 extended projects – health literacy, site map updates and WELL Runcorn). • 29 EbyEs participating in September and October projects (plus 5 EbyEs participating in PLACE assessments).	• 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 Q4 projects including Better Care Together Patient Public Reference Group and clinical and operational services integration workstreams. • Communications and Engagement support provided to Better Care Together Clinical and Operational Integration workstream and training.	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy / equality groups. • Better Care Together continues to be supported in partnership with Bridgewater colleagues.	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient letters	• Working with Patient Experience and Inclusion and Digital Services to ensure accessibility functionality in the PEP / EPR is maximised before launching the 5 Rights campaign. All communications are ready to go. • Easy Read version of supplementary information distributed with patient letters is in development.	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Trust website accessibility recorded in the Silktide index, has achieved a rating of 'Excellent' with a 96% accessibility score and is currently 27th place in the NHS sector rankings (October 2025).	• Ongoing
3. Accessible content creation	• Close working between WHH and Bridgewater communications and corporate governance teams has supported the development of new accessible policy and standard operating procedure (SOP) templates.	• Ongoing
5. Patient information	• The Production of Patient Information Policy includes references to making information accessible and a new accessible Information and communication policy is being updated by the patient experience and communications teams.	• Ongoing
7. Signage/wayfinding	• Delivered via Wayfinding and First Impressions Task and Finish Group. Estates are progressing updated maps are in development 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 2025-26. • Planning an updated events plan and schedule with Bridgewater Community Healthcare for 2025-26.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. showcasing their roles, sharing info, speaking with visitors about the constituencies they represent, collecting details of visitors interested in becoming WHH Foundation Trust Members. No community events were undertaken in this period.	• Ongoing
3. Support Place Based activity and other key local events	• Content upload process for Living Well Warrington website is now co-ordinated within the Communications and Engagement Team. Ongoing promotion of Living Well Warrington continues via WHH communication channels.	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key campaigns, health improvement and economic wellbeing initiatives. • Promotion of WHH volunteering opportunities with the EbyE membership, via networking and through social media.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer to enhance the aspirations and life chances of local people. • Job of the Week highlighted every Friday via social media. • Level of engagement with social media and websites.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Continue work with the charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at the Patient Experience and Inclusion Sub-Committee. • Charity stakeholder newsletters shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2026

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/134**			
SUBJECT:	**Freedom to Speak Up**			
DATE OF MEETING:	3 December 2025			
AUTHOR(S):	Alison Jordan Freedom to Speak up Guardian			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	To the end of Quarter two 2025/26 Freedom to Speak up (FTSU) has managed 63 cases of disclosure. In 2024/25 87 cases, in 2023/24 31 cases and 42 in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU Guardian (FTSUG) continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR,OD and corporate services to support individuals and teams to resolve the issues that are highlighted. The FTSU team continues to engage with colleagues across the organisation including medical students, preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of			

	FTSU. In June 2025 the FTSUG ran a Trust wide survey to gather information on specific barriers to speaking up in the Trust. The results have been shared at OPC, WICSC and at a Board development session in September 2025. The main reasons highlighted as barriers to speaking up were fear of breach of confidentiality and becoming involved in a lengthy HR process. The survey respondents would feel as confident to speak up to a manager as they would to the FTSUG. Having a protected characteristic did not feature as a barrier to speaking up. The two yearly FTSU toolkit self-assessment has been completed and the improvements reported to Trust Board at a development session 3 September 2025. FTSU week was 13-17 October 2025. The theme was 'Follow up in Action'. The engagement from staff who visited the stands at both Warrington and Halton sites was positive. With most of the staff already being aware of FTSU and a lot of staff also mentioned having seen the good morning message on the subject. The communications for the week included the follow up actions that have been undertaken because of staff speaking up.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.		
	Date of meeting	19 November 2025	
	Summary of Outcome	Noted.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/25/12/134

1. BACKGROUND/CONTEXT

To the end of Quarter two 2025/26 Freedom to Speak up (FTSU) has managed 63 cases of disclosure. In 2024/25 87 cases. In 2023/24 FTSU 31 cases and 42 in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU Guardian (FTSUG) continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR,OD and corporate services to support individuals and teams to resolve the issues that are highlighted.

The FTSU team continues to engage with colleagues across the organisation including medical students, preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU.

2. KEY ELEMENTS

Table 1 sets out the number of disclosures for up to end quarter two 2025/26.

The table represents the number of disclosures by individual so even if several themes form the disclosure this is counted as one.

Table 1 Number of disclosures by individual

	2022/23	2023/24	2024/25	2025/26
Quarter 1	17	6	15	19
Quarter 2	5	6	15	44
Quarter 3	13	9	36	
Quarter 4	7	10	21	
Total	**42**	**31**	**87**	**63**

Table 2 and 3 includes the themes contained within an individual disclosure. Up to end Q2 2025/26 there have been 63 individual disclosures containing overall 76 recorded themes. This equates to 13 of those individual disclosures including more than one of the six listed recordable themes.

Table 2 Themes from disclosures
*In Q4 2023/24 national reporting changes were made to allow for more than one area of disclosure to be reported per case, and worker safety was also included.
**introduced in Q4 23/24.

	2022/23	2023/24*	2024/25*
Behaviour, culture and relationships	31	26	72
Process	3	1	
Patient safety/Quality	5	7	14
Staff levels / patient care	2	1	10
Communication	1		
Worker Safety/Wellbeing**		6	24
Total	**42**	**41**	**120**

Table 3 Themes from disclosures against NGO reportable themes 2025/26

Trust reporting themes were aligned to match NGO themes to include the recording of detriment through speaking up from Q1 2025/26

Reportable themes	Q1 2025/26	Q2 2025/26
Worker wellbeing	16	28
Bullying harassment	2	7
Other inappropriate behaviour	1	0
Pt Quality	3	13
Pt Safety	1	4
Detriment	1	0
Total	**24**	**52**

The FTSUG and Champions continue to present at events across the Trust, to the medical students, rotational doctors, preceptorship staff and international nurses.

National Update

National Guardians Office (NGO) survey for temporary nurses

The National Guardian's Office is reviewing the Speak Up experiences of nursing temporary workers. As vital members of our healthcare workforce, temporary workers must feel safe to voice concerns and confident they'll be heard.

This review will strengthen the Speak Up culture for nursing temporary workers, delivering actionable recommendations for a more inclusive and supportive NHS environment that enhances both staff wellbeing and patient safety.

The NGO has had over 800 people take part in the survey. Currently, the NGO are in the process of interviewing organisations, including NMC and NHS Professionals. Here at Warrington and Halton information about this survey and the link to complete has been sent out via ‘The Week’. To ensure our temporary nurses voices are heard nationally.

The NGO will publish their findings in February 2026.

3. DEVELOPMENTS

In June 2025 the FTSUG ran a Trust wide survey to gather information on specific barriers to speaking up in the Trust. The results have been shared at OPC, WICSC and at a Board development session in September 2025. The main reasons highlighted as barriers to speaking up were fear of breach of confidentiality and becoming involved in a lengthy HR process. The survey respondents would feel as confident to speak up to a manager as they would to the FTSUG. Having a protected characteristic did not feature as a barrier to speaking up.

The two yearly FTSU toolkit self-assessment has been completed and the improvements reported to Trust Board at a development session 3 September 2025. **Table 4** identifies the areas that require development. **Table 5** identifies areas of strength identified and actions are in place to sustain these.

Table 4 Areas for development

Development areas to address in the next 6–24 months (Only to April 2026 then to be reviewed as 1 Trust)	Target date	Action owner
1 Promote FTSU training for all staff – helping managers understand the valuable learning. (Bridgewater FTSU training is mandated)	December 2025	FTSUG/Exec Lead
2 Input to the programme to reduce Bullying and harassment/increase sexual safety	March 2026	FTSUG
3 Support to five identified areas of Trust from data gleaned from staff survey and FTSU disclosures	March 2026	FTSUG
4 Follow up on results of Barriers to speaking up Survey	March 2026	FTSUG
5 Develop plan to integrate FTSU in line with BCH acquisition timeline	1 April 2026	FTSUG/Exec Lead/ NED Lead
6 Improve sharing of FTSU impact by working with Communication Team / good morning / you said we did	December 2025	FTSUG

Table 5 Actions to sustain improvements

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Continue to recruit more champions - Aim for a FTSU Champion in every area	Ongoing	FTSUG
2 Ensure FTSU remain prominent in everyday ward business – poster, ward accreditation, Governor walk rounds, Champions visible	Ongoing	FTSUG
3 Maintain visibility of Exec, NED, FTSUG and Champions	Ongoing	FTSUG
4 Maintain visibility with the Board through development sessions and reports	Ongoing	FTSUG
5 Maintain regular meeting between FTSUG and Board members	Ongoing	FTSUG
6 FTSUG maintain network links and attend regional meetings	Ongoing	FTSUG
7 Maintain a presence at inductions	Ongoing	FTSUG
8 Engage in the National FTSU week	October 2025	FTSUG

FTSU week was 13-17 October 2025. The theme was ‘Follow up in Action’. The engagement from staff who visited the stands at both Warrington and Halton sites was positive. With most of the staff already being aware of FTSU and a lot of staff also mentioned having seen the good morning message on the subject. The communications for the week included the follow up actions that have been undertaken because of staff speaking up.

- Supported teams with Organisation Development to improve the culture and staff retention Using staff survey triangulation and HR knowledge

- Cultural reviews have been undertaken following disclosures and triangulation with HR data
- Being part of the development of 'See it Report it Stop it'. To promote sexual safety in the workplace and reduce Bullying and harassment
- Supported the development of return to work plans when staff have been displaced during HR processes
- Supported changes in follow up and lessons learnt following patient death
- Increased awareness of the importance of incident reporting and use of safe care system
- Education around different cultural needs of team members.

4. RECOMMENDATIONS

The Trust Board is asked to note the report and the information provided regarding the developments and progress of Freedom To Speak Up within the organisation.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/135**			
SUBJECT:	Bi-monthly Strategic Projects Highlight Report (September and October)			
DATE OF MEETING:	3rd December 2025			
AUTHOR(S):	Megan Wainwright, Strategy Project and Team Support Officer			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
			✓	✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those	**Yes**	**No**	**N/A**
				✓

	who do not			
	Further Information:			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	• WHH and BCH continue to work towards becoming a single organisation. NHSE have been completing their review of our strategic case throughout October, with recommendations expected early November. We have been developing the draft full business case (FBC) and working with external consultants and legal advisors to complete due diligence.
	• The Runcorn Health and Education Hub is due to start to open services from February 2026.
	• A new Council led strategic Board has been established to lead the development of Widnes town.
	• The Living Well Warrington online platform went live to the public on 26th March. The site has received over 126,000 views with the membership growing daily. The platform showcases over 700 activities that support living well across Warrington.
	• 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
	A first submission is due in December 2025, with a revision and expanded submission due in January/February 2026.			

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note this report for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Strategic projects update
September-October 2025

Section 1 - Key messages	
Slide 2	Summary of key developments this reporting period
Section 2 - Stakeholder engagement	
Slide 3-4	Summary of key stakeholders engaged during the reporting period
Section 3 - Key strategic projects	

Page	Project	Strategy Lead	Status
Slide 5-6	WHH/BCH Integration programme	Stephen Bennett	
Slide 7-8	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 9-10	New hospitals programme and strategic estates	Carl Mackie	
Slide 11-12	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 13	Completed projects	Strategy team	

Key messages

- WHH and BCH continue to work towards becoming a single organisation. NHSE have been completing their review of our strategic case throughout October, with recommendations expected early November. We have been developing the draft full business case (FBC) and working with external consultants and legal advisors to complete due diligence.

- The Runcorn Health and Education Hub is due to start to open services from February 2026.

- A new Council led strategic Board has been established to lead the development of Widnes town.

- The Living Well Warrington online platform went live to the public on 26th March. The site has received over 126,000 views with the membership growing daily. The platform showcases over 700 activities that support living well across Warrington.

- 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

A first submission is due in December 2025, with a revision and expanded submission due in January/February 2026.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Warrington neighbourhood health plan, UEC system improvement
Alex Kirkpatrick	Deputy DoF, NHSE NW	Integration
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Naz Ghodrati	CEO, Warrington Voluntary Action	Integration and partnerships with VCFSE sector
Pip Morrant Lesley Platt	Director of Community Services, Mid Cheshire Hospitals Transformation lead, Mid Cheshire Hospitals	Living Well Hub and Living Well in Warrington programme and potential to develop similar model in Crewe
Sarah Hall MP	MP	Urgent treatment centre
Linda Buckley	Managing Director, CMPC	C&M blueprint
Christina Banerji Katherine Golding	Mergers and acquisitions team, NHS England	NHS England Strategic Case review
NHSE NW leadership team	NHSE NW leadership team	NHS England Strategic Case review
Brian Pilling	Chair of Trustees, Burtonwood Community Centre	Development of community facilities in Burtonwood via UK Shared Prosperity funds and potential links with neighbourhood health agenda
Amanda Ridge	C&M ICB	Neighbourhood health plans in Warrington
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal, Widnes town centre strategic Board
Michael Allen	Partner, KPMG	Due diligence for production of full business case for integration
Fiona Watson	Consultant & Deputy director of public health, Halton Borough Council	One Halton cardio-vascular disease steering group
David Wilson	One Halton Clinical director	Clinical services integration
CEOs Cheshire, Warrington and Wirral Trusts	CEOs Cheshire, Warrington and Wirral Trusts	C&M blueprint

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Tony Leo	Place Director, Halton	Place development and integration programme
Matthew Swanborough Jon Develing	Chief Strategy and Partnerships Officer, Wirral University Teaching Hospitals Director of Strategy, Countess of Chester Hospitals	Integration, C&M strategy
Carl Marsh	Place Director, Warrington	Integration, C&M strategy
David Cooper	Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Runcorn Health and education Hub, One Halton delivery plan, Warrington neighbourhood health
Cathy Elliott	CEO, NHS Cheshire and Merseyside	Integration
Sarah Pochin MP	MP	Runcorn Town Board
Steve Park	Interim CEO, Warrington Borough Council	Integration, estates development, urgent treatment centre
2025 HSJ Awards Panel	Various national representatives from healthcare organisations across the country	Judging of HSJ awards entry: Living Well in Warrington in the category of ‘Integrated Care Initiative of the Year’
Richard Rout	Chief Executive, Halton Borough Council	Strategic Estates and Integration, HBC CEO interviews
Sally Yeoman	CEO, Halton and St Helen’s Voluntary Action	Runcorn Town Board, HBC CEO interviews
Andrew Jones	Service improvement and change manager, Mersey Care	Runcorn health and education hub
Mary Murphy	Principal and CEO Riverside and Crompton Colleges	Runcorn health and education hub, HBC CEO interviews

Integration – part 1



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Programme Overview

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is planning to formally acquire Bridgewater Community Healthcare NHS Foundation Trust (BCH) on 1 April 2026, bringing both partners together to create a single organisation **'North Cheshire and Mersey NHS Foundation Trust'.** The integration will support both individual Trusts with long-standing challenges around clinical and financial sustainability and create a wealth of opportunities to improve access to services, quality of care and overall patient experience.

The integration programme- entitled 'Better Care Together' is well established and consists of ten workstreams: Strategic Programme Development, Estates, Workforce, Finance, Corporate Service Integration, Clinical and Operational Services Integration, Digital Services, Communication and Engagement, Clinical Governance and Quality, and Corporate Governance. Each workstream has a detailed delivery plan and are working with partners to deliver objectives.

What does this mean for WHH?

Over the last decade, both WHH and BCH have seen demand for services continually increasing due to a growing and ageing population locally, living longer with complex and often chronic conditions. This increasing demand has steadily led to a need to increase non-elective capacity at the acute sites, which has led to increasing financial challenges. In line with the NHS Ten-Year Plan and strategic direction regionally, the integration creates the opportunity to develop a model with greater emphasis on preventative health and community services, which together, can improve both quality and sustainability of services.

Progress:

- Completion of NHS England review of strategic case, with a formal outcome expected in early November.
- Second draft of Full Business Case (FBC) is complete and due to be shared with Trust Boards and selected partners for feedback in November.
- Due diligence work undertaken in house and by KPMG and Hill Dickinson is now complete and work is ongoing to review outputs and incorporate plans into FBC.

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
Submission of Full Business Case first draft to WHH and BCH Trust Boards for review/comment	5/6 November 2025
Receipt of formal outcome letter from NHS England following review of strategic case	6 November 2025
Commence staff consultation around TUPE/organisational change	10 November 2025
Submission of Full Business Case and supporting documents to Trust Boards for approval before submission to NHSE	3 /4 December 2025

Better Care Together

Home · Community · Hospital

Integrating community and hospital services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contact details
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Chief Strategy and Partnerships Officer WHH
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Stephen Bennett
Head of Strategy and Partnerships WHH
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Runcorn town deal-part 1

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

- Branding concept chosen. Brand and logo concept being developed further.
- First-fix water inspection carried out, with no major issues identified.
- Commissioning and handover plan in development.

Runcorn town deal- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people ✓**	**Working in partnership✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Construction complete	Dec 2025
Services go live	Feb 2026







Contact details
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Carl Mackie
Halton Healthy New Town and Strategy Manager
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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

- First meeting with key internal stakeholders WHH Estates and Strategy Teams with Keir and Gilling Dod to develop the Strategic Estates Development Plan
- Confirmation of appointment of resource to develop Clinical Strategy and Strategic Estates Development Plan
- Continued discussion with NHS C&M around progression of case for co-located Urgent Treatment Centre

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Delivery of updated strategic estates masterplan	October 2026
Notification of UTC Bid outcome	TBC





Contact details
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Living Well Virtual Hub- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- To lead the development of new Living Well Virtual Hub for Warrington place in partnership with stakeholders across Warrington.
- To replace previous council run “Mylife” service directory with a modern, accessible multi-functional online platform that serves as a one stop shop for many more service providers from across the borough ranging from small grassroots organisations to larger statutory providers.
- The new virtual hub forms part of a growing programme of work at Place to strengthen the offer around prevention, early intervention and empowering self-care through a “community-led” approach.
- The new platform empowers users to navigate their health and wellbeing journey more independently and is the single digital entry point for any health and wellbeing-related enquiries for the public and staff working in Warrington.

What does this mean for WHH?

- Delivery of a new digital product under the Living Well umbrella which supports a broader shift from analogue to digital, hospital to community, and reactive care to prevention. It also supports the development of a digital blueprint for delivering the new neighbourhood health model across Warrington.
- Longer term, the online platform will support improving health outcomes, reducing inequalities and help reduce future demand and pressure on statutory health and care services across the Borough.

Progress since last report

- Presented the Living Well Programme to national panel of judges for the HSJ awards- results announced 20th November.
- New map search feature live and updates to search function. AI search tool in development to further improve search results available on the platform.
- 413 new members to platform, 702 live activities, increase to 4,500 monthly active users, 126, 088 page views.
- Developed a multisector partnership agreement to oversee the longer- term direction and support of the platform.
- New pages on Living Well with Dementia and Early Years support published on platform in collaboration with multi-sector subject matter experts, cancer support page in progress.
- Winter campaign page in development, being led by voluntary sector-to contain curated content about support available over winter.
- Pilot business model has been launched together with update to membership options to allow eligible businesses to support Living Well in Warrington via the platform.

Living Well Virtual Hub- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	Growing our workforce for the future	**Sustainable estate and digitally enabled** ✓
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Ongoing network development and onboarding to platform	April-Dec 25
One year pilot business subscription model	1st Sept 25- 1st Sept 2026
Content review and subject matter expert engagement workshops	Sept-Dec 25
Sustainability planning and evaluation	Sept 25- Jan 26

LIVING WELL IN WARRINGTON

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Completed Projects

Halton Health Hub

- Halton Health Hub Phase 1 was completed in November 2022, enabling the delivery of orthoptics, optometry, audiology, and dietetic therapy services from within the Runcorn Shopping City centre in Halton Lea.
- Services in Phase 1 have since been expanded to add MSK therapies, a GP out-of-hours service, public health services, including weight management and smoking cessation, and a Wellbeing Service delivered by Wellbeing Enterprises CIC.
- In November 2023, Phase 2 opened. Phase 2 comprises a Community Diagnostics Centre, offering residents improved access to range of diagnostics and treatments usually only accessible via an acute hospital.

Warrington Living Well Hub

- Over 35,000 have attended the Living Well Hub since the facility opened in March 2024. 88% of visitors to the Hub live in and around the central wards of the borough which are the most deprived areas of the town.
- The service model continues to evolve with the following new services commencing during the report period:
    - WBC Youth Service – “Get to Know” Drop-In: Every other Wednesday evening and alternate Friday afternoons.
    - WHH Phlebotomy - Now expanded service offer to full-day sessions on Tuesdays and Wednesdays in response to growing demand.
    - Kit 4 All – taking place on the first Friday afternoon of each month, offering new and pre-loved sports kit to help reduce barriers to physical activity.
- The Warrington Living Well programme (Living Well Hub, digital platform and Talking Points projects) has been shortlisted in the 2025 HSJ awards as an exemplar programme of work demonstrating a high-quality integrated care approach and provider collaboration. Representatives from each of the three projects within the programme presented to the judging panel in October 2025. The winner will be revealed in November.

Community diagnostic centre

- Over 120,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1, 2 & 3) since Phase 1 went live in May 2023.
- Potential opportunity to expand the CDC development at the Halton Health Hub with further allocation of funding from the national programme. Business case has been developed. If successful, this would secure a further £2.5m of capital funding to progress a fourth phase of the programme and provide ophthalmology assessment services at the site in Runcorn Shopping City.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/136**	
SUBJECT:	**Emergency preparedness, resilience and response (EPRR) annual Core Assurance outcomes**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	Rachel Clint, Head of EPRR	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **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. **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 **2253** If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The EPRR Core Assurance Board Report presents the annual outcomes of the Emergency Preparedness, Resilience and Response (EPRR) Core Assurance for Warrington and Halton Teaching Hospitals NHS Foundation Trust. • **Compliance & Assessment:** The Trust achieved an 85% self-assessment rating, classified as partially compliant, reflecting significant progress from previous years. No standards were found to be non-compliant, and most domains were fully compliant, with targeted improvements underway in areas rated as partially compliant. • **Key Areas for Improvement:** Partially compliant standards include evacuation and shelter planning, aspects of business continuity (e.g., business impact analysis, testing, data protection), and CBRN equipment and training. Action plans are in place to address these gaps, with ongoing collaboration across • **Integration & Future Planning:** The upcoming integration into the North Cheshire and Mersey Healthcare Partnership in 2026 presents both challenges and opportunities for harmonising EPRR policies and procedures. The Trust is committed to maintaining robust emergency preparedness during this transition and embedding refreshed plans into operational activity.			

PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the EPRR assurance outcomes and the continued improvement in compliance with NHS Core Standards		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance, Sustainability and Productivity Committee in Common	
	Agenda Ref.	**FSPCiC/25/10/107**	
	Date of meeting	27/10/2025	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None		

REPORT TO TRUST BOARD

SUBJECT	Emergency preparedness, resilience and response (EPRR) annual Core Assurance outcomes	AGENDA REF:	BM/24/12/136

1. BACKGROUND/CONTEXT

Under the NHS Act 2006, NHS England has a statutory duty to ensure that the NHS in England is properly prepared for dealing with an emergency. This includes monitoring the compliance of each ICB and service provider with EPRR requirements via the NHS EPRR annual assurance process.

NHS providers are asked to undertake a self-assessment against individual core standards relevant to their organisation type and self-assess their compliance with these standards.

All Trusts are required to self-assess against the national EPRR framework, consisting of core standards split into the functional domains of: governance, duty to assess risk, duty to maintain plans, command and control, training and exercising, response, warning and informing, co-operation, business continuity and Hazmat/CRBNe.

In October 2025, the Head of EPRR at Warrington and Halton Hospitals NHS Foundation Trust completed the self-assessment for the Trusts.
For acute providers, there are 62 standards included within the self-assessment process.

There is normally a deep dive into a particular domain. NHS England decided not to conduct a deep dive this year.

Since this submission, the Cheshire and Merseyside Integrated Care System (ICS) EPRR team assessed a sample of the core standards and provided feedback based on their sampling. The ICS agreed with the self-assessment based on the evidence supplied.

'The documentation supplied is of a consistently good standard. It is clear that significant time and effort has been dedicated to continuously improving EPRR processes across Warrington and Halton.' Anthony Middleton Director of Performance and Planning / AEO NHS Cheshire and Merseyside.

Upon review of the feedback received, the Head of EPRR and the Trust Accountable Emergency Officer (Chief Operating Officer and Deputy Chief Executive) have reflected on the outcomes and are pleased with the feedback received.

2. KEY ELEMENTS

Table 1 outlines the agreed compliance scores between 2022 and 2025.

Trust	2022/2023	2023/2024	2024/2025	2025/2026
Warrington and Halton Teaching Hospitals	94% Substantially compliant	5% Non-compliant	68% Non-compliant	85% Partially compliant

Table 2 shows the domain related self-assessments for WHHFT

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	8	4	0
Total	62	53	9	0

Table 3 shows the national organisational assurance rating criteria

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS Core Standards for EPRR
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards for EPRR
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards for EPRR
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards for EPRR

Nationally, the three-year cycle for EPRR Core Assurance is due to be refreshed for the next cycle. Updates to the domains and process are likely and should be communicated 12-months prior to the start of the next cycle of assurance. The Head of EPRR will remain vigilant of any updates.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Accountable Emergency Officer supports the self-assessment rating of 85% (WHHFT), and notes the improvements made from the previous rounds of Core Assurance.

The Accountable Emergency Officer continues to support the Head of EPRR with the continuous improvement work in place and the workplan for EPRR across both Trusts.

The AEO is asked to present the results of the annual EPRR assurance process and compliance position to the Public Board.

For 2026, it is likely that the assessment will take place for one single organisation and will be assessed as North Cheshire and Mersey Healthcare Partnership. This will create some challenge as there are several EPRR policies and procedures, along with training needs requirements associated with the function. Until 1st April 2026, each trust is legally required to have plans in place and up to date as a single organisation. However, the integration process will provide a valuable opportunity to refresh all EPRR related plans and policies, with shared learning across both organisations. Respective leads have been collaborating since 2024 with the view to start planning integrated standard operating procedures and guidelines ahead of 1st April 2026.

The Accountable Emergency Officer will continue to monitor the domains that have partially compliant status, along with all the EPRR workstreams.

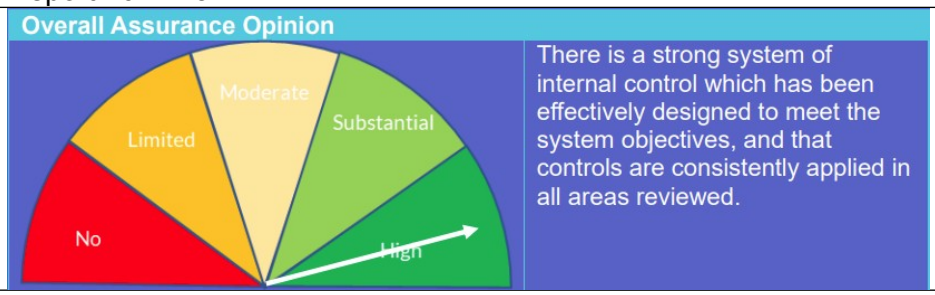
4. IMPACT ON QPS?

As identified in the outcomes of the assurance process.

5. MEASUREMENTS/EVALUATIONS

The Head of EPRR will continue to collaborate with key stakeholders to support moving towards achieving substantial compliance in the next core assurance cycle.

An internal audit conducted by MIAA within the last 12 months indicate good practice in EPRR at the Trust.

Trust	MIAA Audit - Emergency Preparedness, Resilience & Response (EPRR) Report 2024/25
Warrington and Halton Teaching Hospitals	

Where there are gaps identified, the Head of EPRR will monitor action plans so that compliance can be improved within the next 12 months.

Partially Compliant Standards
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Duty to Maintain Plans (1 standard partially compliant)	• **Evacuation and Shelter**	Refreshed national guidance is anticipated and this will support internal planning. The Head of EPRR will

		collaborate with colleagues in Estates and Facilities Management and Care Group leads to refresh the Trust's plans.
Business Continuity (4 standards partially compliant)	• **Business Impact Analysis** • **Testing and Exercising** • **Data Protection and Security Toolkit** • **BCMS Monitoring and evaluation**	Training materials are in situ. EPRR has been placed on the cycle of business for each Care Group. The Terms of reference for EPRR Group have been refreshed and Care Groups and Departments will be asked to report into EPRR Group with updates to support improvement.
CBRN (4 standards partially compliant)	• **Equipment and supplies** • **Equipment – preventative programme of maintenance** • **PPE Access** • **Exercising**	NWAS will conduct an annual review of the CBRN / Hazmat capabilities at WHHFT in December 2025, this should enable more learning and improvement in that domain for the next cycle of assurance. Replacement PRPS suits have been procured and are expected to be received by the end of November.

6. TRAJECTORIES/OBJECTIVES AGREED

- To maintain the standards agreed to be considered as fully compliant.
- To address the gaps identified though the partially compliant assessments and work towards achieving full compliance
- To continue to improve across all domains ensuring that plans and procedures are up to date and tested
- To collaborate across both trusts to ensure plans are aligned as per the requirement
- To embed refreshed policies and plans into trust activity.

7. MONITORING/REPORTING ROUTES

EPRR updates will continue to take place through the EPRR Groups that occur at both trusts. The Head of EPRR and Deputy Director of Estates/ EPRR attend both sets of meetings. EPRR Group reports into the Finance, Sustainability and Performance Committee in Common. Matters relating to EPRR are also shared at the Executive Meeting Team meetings as appropriate (e.g. Creamfields preparation and impact, Industrial Action planning).

There is a bi-annual EPRR report provided to Board, in addition if there are any significant business continuity incidents, critical incidents or major incidents impacting upon the Trust, the Board will be appraised and provided with a full incident report and debrief.

The Head of EPRR will continue to keep up to date with any national, regional and Integrated Care System changes following the Government's announcement of the abolition of NHS England in March 2025.

8. TIMELINES

There will be a joint EPRR report presented to Board in July 2026.
The next self-assessment will be presented in November 2026 providing national and regional timescales remain in place.

9. ASSURANCE COMMITTEE

EPRR Group

10. RECOMMENDATIONS

The Trust Board is asked to note the EPRR Annual Assurance self-assessment rating as partially compliant, however recognise a significant amount of work has been put in to support progress towards substantial compliance at each Trust.

It is important to note that where there have been partially compliant ratings, the Trust does have resilience, and work continues to fulfil the requirements in line with current legislation and guidance.

The Board is asked to recognise the functions at both WHH and BCH are under-resourced when benchmarking against other providers.

The Board is asked to support the workplan in moving towards full compliance with all standards, and the additional work the integration workstream will create within the EPRR function.

Appendices

a. Statement of Compliance for WHH is attached



000 APPROVED
WHHFT Statement of

b. The EPRR Core Assurance Review outcomes for WHH is attached



EPRR Core Standards
Assurance Review Ou

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

Warrington and Halton Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Warrington and Halton Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed, and this will be shared with the organisation's board / governing body on the dates below, along with the enclosed action plan and governance deep dive responses.



Signed by the organisation's Accountable Emergency Officer

03/12/2025	03/12/2025	01/04/2026	19/09/2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report	Date signed

NHS
Cheshire and Merseyside

To:
Daniel Moore
Accountable Emergency Officer (AEO)
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Date: 20th October 2025

Dear Daniel,

NHS Cheshire and Merseyside are responsible for gaining assurance on the preparedness of the NHS Trusts within Cheshire and Merseyside, to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the NHS EPRR Annual Self-Assessment Assurance process, which was reviewed by the NHS Cheshire and Merseyside EPRR Team, with the aim to provide constructive feedback to allow for continuous development. This process was achieved by reviewing the evidence submitted for 5 randomly selected core standards from your Trust.

The 5 core standards that were randomly selected for your Trust were:

Core Standard:	Title:	Standard detail:
3	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
19	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
36	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
56	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type

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The outcome of the review can be found in appendix 1, whereby we agree with the self-assessment rating based on the evidence supplied.

The documentation supplied is of a consistently good standard. It is clear that significant time and effort has been dedicated to continuously improving EPRR processes across Warrington and Halton.

Next Steps:

1. The AEO is asked to note the outcome of the review and ensure learning is incorporated within the EPRR Work Programme.
2. The AEO is asked to present the results of the annual EPRR assurance process and compliance position to the organisations Public Board.

The final detail will be included within the Cheshire and Merseyside Assurance Report which will be presented at the Strategic Local Health Resilience Partnership meeting on Tuesday 11th November 2025, prior to submission to NHS England North West.

Yours sincerely



Anthony Middleton
Director of Performance and Planning / AEO
NHS Cheshire and Merseyside

Appendix 1

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Agree	Substantial evidence supplied to support.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities,	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment	Agree	Updated evidence supplied.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
			including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	• tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required		
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Agree	Substantial evidence supplied to support.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media	Agree	Noted the extension to the Policy review date due to integration with Bridgewater Community Health Trust, and many Trust policies are set to be aligned by 31/12/2025, others by 31/3/2026.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
				to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response		
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Agree	Evidence supplied.

Please select type of organisation: **Acute Providers**

Click button to format the workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	8	4	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	53	9	0

Overall assessment:	Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
			Fully compliant				
The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	001 Emergency Preparedness Resilience and Response (EPRR) Policy 002 Strategic LRHP ToR 003 Chief Operating Officer Job Description 004 Director of Operations and Performance Job Description	Fully compliant				
The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	001 Emergency Preparedness Resilience and Response (EPRR) Policy	Fully compliant				
The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	001 Emergency Preparedness Resilience and Response (EPRR) Policy 005 Public Board Minutes 006 Board Report 007 Winter Planning Example FSCIC report 008 FSCIC EPRR Annual Report 009 Example Executive Meeting Team Summary 010 Board Paper - Core Assurance 011 FSCIC ToR	Fully compliant				
The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	001 Emergency Preparedness Resilience and Response (EPRR) Policy 012 EPRR Work Plan 013 Training Needs Analysis and Exercise Plan 014 Sample EPRR Group agenda 015 Sample EPRR Group minutes	Fully compliant				
The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	001 Emergency Preparedness Resilience and Response (EPRR) Policy 006 Board Report 016 ToR for EPRR Group 014 EPRR Group agenda 017 Sample agenda for FSCIC 011 FSCIC ToR 015 Sample EPRR group minutes 018 DipHealth certificate 019 Head of EPRR Training records	Fully compliant				
The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	001 Emergency Preparedness Resilience and Response (EPRR) Policy 006 Board Report 020 Lessons identified and action log from EPRR Group 021 Debrief report example 022 Communications exercise report 007 Winter Planning Example FSCIC report 16 FO08 FSCIC EPRR Annual Report 009 Example Executive Meeting Team Summary 023 Debrief Creamfields 024 Debrief report - multi-agency Creamfields 137 Debrief Guidelines	Fully compliant				
The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	001 Emergency Preparedness Resilience and Response (EPRR) Policy 025 Incident Response Plan 026 Business Continuity Plan 027 Industrial action risk 028 EPRR risks WHHFT 029 Access to CRF Risk Register 030 National Risk Register 031 BAF Risks 031 NW EPRR Risk Register / NW Risk dashboard 032 CRF Risk register 033 Risk Management Strategy 125 CBRN Risk Assessment	Fully compliant				
The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	001 Emergency Preparedness Resilience and Response (EPRR) Policy 025 Incident Response Plan 026 Business Continuity Plan 015 Sample EPRR Group minutes 027 Industrial action risk 028 EPRR risks WHHFT 034 IT Communication examples 032 BAF risks 033 Risk Management Strategy	Fully compliant				
Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	035 Example of email consultation and feedback 025 Amends tracked in polices - examples in IRP 036 LHRP attendance 037 Strategic attendance record 146 Exercise Pegasus collaboration	Fully compliant				
In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	025 Incident Response Plan 038 Major Incident Plan 039 Industrial Action Response Plan 155 MI Exercise and Comms exercise 040 Major Incident Mass Casualty Exercise Plan 041 Examples of Trustwide comms during BC incidents 042 ED MI Tabletop 043 Exercise plan 044 Tabletop exercise 045 Incident response matrix 138 Exercise plan Exercise	Fully compliant				
In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • consistent of extreme events e.g. drought, storms (including dust storms), wildfire	046 Adverse Weather Plan 047 Adverse weather advice / communications	Fully compliant				
In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	048 IPC Policy 049 Measles Swarm meetings 050 SOP on Management of Mpox (formerly Monkeypox) 051 Non-Elective Patient Testing for Respiratory Viruses 052 Major Outbreak of Infection Guidelines 053 Uniform and Workwear Policy 054 Hand Hygiene Policy 055 Influenza (Pandemic and seasonal policy) 056 Bronchiolitis in Infants 057 Measles Policy 058 IPC Winter Plan 007 Winter Plan for FSCIC	Fully compliant				

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In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	048 IPC Policy 052 Major Outbreak of Infection Guidelines 055 Influenza (Pandemic and seasonal policy) 058 IPC Winter Plan 007 Winter Plan for FSCIC 059 New and emerging pandemics operational policy 025 Incident Response Plan 065 Exercise Nexus 146 Exercise Pegasus collaboration	Fully compliant				
In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally; this will be dependent on the incident	060 Countermeasures Plan 025 Incident Response Plan	Fully compliant				
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	025 Incident Response Plan 038 Major Incident Plan 039 Industrial Action Response Plan 040 Major Incident Mass Casualty Exercise Plan 041 Examples of Trustwide comms during BC incidents 042 ED MI Tabletop 043 Exercise plan 044 Tabletop exercise 045 Incident response matrix 061 Mass Dispersal Plan for C&M 062 Major Incident Mass Casualty Exercise Plan 063 Concept-operations-management-mass-casualties.pdf 064 ICB Mass Casualties Exercise	Fully compliant				
In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	065 Evacuation and Shelter Plan Awaiting updated national guidance	Partially compliant	A working group will be established to refresh the Trust Evacuation and Shelter Plan winter 2025/26	Head of EPRR Associate Director of Estates and Facilities Management Associate Directors of Care Groups Associate Chief Nurses	To be refreshed by 31st July 2026	Awaiting updated national guidelines
In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	066 Lockdown Plan 025 Incident Response Plan	Fully compliant				
In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs);high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	067 Handling VIP Celebrity and Media Visits and Endorsements Policy 068 Media and Social Media Policy	Fully compliant				
The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	069 Mortuary Capacity Reports 070 Mass Fatalities Plan 071 Cheshire Mass Fatalities Plan	Fully compliant				
The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	045 Incident response matrix 072 Trust Escalation Policy 073 Tactical on-call Handbook 001 EPRR Policy 013 Training Needs Analysis and Exercise Plan 074 Example of weekend plan 075 Tactical Commander Resources 076 Creamfields weekend plan - example of weekend / BH plan including action cards 022 Communications exercise report 077 Communications evidence 078 Tactical and Strategic on-call rota 148 Weekender handover	Fully compliant				
Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	001 EPRR Policy 013 Training Needs Analysis and Exercise Plan 045 Incident response matrix 025 Incident Response Plan 038 Major Incident Plan 079 Tactical Commander Training 080 Tactical Commander training 081 Training log 082 Sample CPD portfolios 078 Tactical and Strategic Rotas 075 Tactical Commander Resources 157 METHANE training	Fully compliant				
The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	001 EPRR Policy 076 AEO Training 013 Training Needs Analysis and Exercise Plan 018 DipHealth certificate 019 Head of EPRR Training records and certificates 079 Tactical Commander Training 080 Tactical Commander Training 081 Training records _ EPRR held 082 Sample CPD portfolios 078 Tactical and Strategic Rotas 083 POHC certificate sample 084 Loggist training materials 042 ED MI Tabletop 155 MI Exercise and Comms exercise 043 Exercise plan 157 METHANE training	Fully compliant				

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	001 EPRR Policy 013 Training Needs Analysis and Exercise Plan 079 Tactical Commander Training 080 Tactical Commander Training 081 Training records _ EPRR held 082 Sample CPD portfolios 078 Tactical and Strategic Rotas 083 POHC certificate sample 084 Loggist training materials 064 ICB Mass Casualties Exercise 044 Tabletop exercise 076 AEO Training 042 UEC tabletop exercise 043 Exercise plan 145 Exercise Aegis participation 099 Kaos Australis exercise material 155 MI Exercise and Comms ----------	Fully compliant			
The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	001 EPRR Policy 013 Training Needs Analysis and Exercise Plan 079 Tactical Commander Training 080 Tactical Commander Training 081 Training records _ EPRR held 082 Sample CPD portfolios 078 Tactical and Strategic Rotas 083 POHC certificate sample 084 Loggist training materials 064 ICB Mass Casualties Exercise 155 MI Exercise and Comms exercise 044 Tabletop exercise 076 AEO Training 042 UEC tabletop exercise 043 Exercise plan 147 LHRP Training & Exercise schedule 006 Annual EPRR board Report 045 Incident response matrix 064 ICB Mass Casualties Exercise 044 Tabletop exercise 025 Major Incident Plan 076 AEO Training 015 Incident Response Plan 074 Example of weekend plan 075 Tactical Commander Resources 155 MI Exercise and Comms exercise 076 Creamfields weekend plan - example of weekend / BH plan including action cards 022 Communications exercise report 079 Tactical Commander Training 080 Tactical Commander training 042 UEC tabletop exercise 043 Exercise plan	Fully compliant			
There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board		Fully compliant			
The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	015 Incident Response Plan 085 Incident Coordination Centre SOP 086 ICC audit tracker 079 Tactical Commander Training 080 Tactical Commander training 087 WHH ICC	Fully compliant			
Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	001 EPRR Policy 015 Incident Response Plan 073 On-call handbook 088 Commander grab bag 085 Incident Coordination Centre SOP 086 ICC audit tracker 152 OPEL Escalation Processes	Fully compliant			
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	015 Incident Response Plan 026 Business Continuity Plan 089 MS form debrief form example 090 Digital incident and learning 021 Debrief report example 152 OPEL Escalation Processes 153 NWAS Escalation tool 157 Debrief - incident declared	Fully compliant			
To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	084 Loggist materials 025 Loggist action card in MI Plan 084 Example of Loggist certificates 081 Training register - EPRR version	Fully compliant			
The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	008 Incident Response Plan 091 WHH Sitrep Guideline Template 025 METHANE template in Major Incident Plan 025 Telecommunications action card in MI plan 093 Creamfields situation reports 094 NHS England SBAR template 095 Example SBAR submissions 030 Information sharing	Fully compliant			
Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	096 Hard copy available in ED, on Sharepoint and in Commander on-call handbook Copy of the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook – hard copy in ED/UTC and electronically accessible location. 098 Referenced in MI Plan	Fully compliant			
Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	097 Hard copy available in ED, on Sharepoint and in Commander on-call handbook. Copy of the 'CBRN incident: Clinical Management and health protection' guidance – hard copy in ED/UTC and electronically accessible location. 124 Referenced in CBRN plan	Fully compliant			
The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	022 Communications Exercise report 098 Comms exercise internal plan and debrief 099 022 Communications exercise report 077 Communications evidence SOP for bleep / telephony failure - comms embedded 025 Major Incident Plan 015 Incident Response Plan 100 Example of stakeholder briefing 047 Adverse weather comms	Fully compliant			

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	022 Communications Exercise report 098 Comms exercise internal plan and debrief 099 022 Communications exercise report 077 Communications evidence 025 Major Incident plan - Telecommunication Action Card V3 101Examples of Trustwide incident communications 015 Incident Response Plan 076 Creamfields weekend plan - example of weekend / BH plan 039 Industrial action response plan 156 MI declaration and learning	Fully compliant			
The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	022 Communications Exercise report 098 Comms exercise internal plan and debrief 099 022 Communications exercise report 077 Communications evidence 025 Major Incident plan - Telecommunication Action Card V3 101Examples of Trustwide incident communications 015 Incident Response Plan 076 Creamfields weekend plan - example of weekend / BH plan 039 Industrial action response plan	Fully compliant			
The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	067 Handling VIP Celebrity and Media Visits and Endorsements Policy 068 Media and Social Media Policy	Fully compliant			
The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	036 LHRP attendance 037 Strategic attendance record 102 LHRP minutes 103 Tactical LHRP ToR	Fully compliant			
The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	104 CRF Concept of Operations 105 EPRR Weekly Round Up CRF/MRF meetings example 106 Access to RD CRF, MRF, RD updates-Pages and relevant alerts (example included 023 Debrief Creamfields 024 Debrief report - multi-agency Creamfields 107 Attendance of Bridgewater EPRR Meetings and Bridgewater attend WHHFT 144 System Winter Plan	Fully compliant			
The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	108 Mutual aid C&M agreement	Fully compliant			
The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	109 MOU for C&M 110 Data Protection Policy 111 Access to health records policy	Fully compliant			
The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	026 Business Continuity Plan 015 Incident Response Plan	Fully compliant			
The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organization.	026 Business Continuity Plan 112 Priority Services 113 Example BCP and associated documents	Fully compliant			
The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	114 BIA standard template 115 BIA for BC event 116 Digital Services BIA 113 Example BCP and associated documents 026 Business Continuity Plan	Partially compliant	All services must ensure BIA is documented in local BCPs this will be monitored by the Head of EPRR	Head of EPRR All service leads	30th April 2026
The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	026 Business Continuity Plan 015 Incident Response Plan 112 Priority Services 117 Digital Services Incident 118 Digital Services timeline and incident notes 113 Example BCP and associated documents	Fully compliant			
The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	026 Business Continuity Plan 119 Business Continuity Exercise Guidelines 039 Industrial action planning examples 113 Example BCP and associated documents 141 Business continuity training materials 142 BC training materials 143 BC training materials 079 Tactical Commander training 137 Debrief guidelines 095 Example SBAR submissions 157 Debrief - incident declared	Partially compliant	All services to test their BCPs annually and ensure exercises are recorded and shared with the Head of EPRR	All Service Leads	30th April 2026
Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	119 DSPT status 110 Data Protection Policy	Partially compliant	Partial compliance achieved, continued work through Digital Services to work towards full compliance	Head of Digital Compliance	30th August 2026
The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	026 Business Continuity Plan 113 Example BCP and associated documents	Partially compliant	Ongoing support and development of BCMS with services	Head of EPRR All Service Leads	30th April 2026

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme • process documented in the EPRR policy/business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability	121 EPRR Audit 120 NWAS CBRN audit 026 Business Continuity Plan 119 DSPT status 120 PAM submission 113 Example BCP and associated documents	Fully compliant				
There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	026 Business Continuity Plan 113 Example BCP and associated documents	Fully compliant				
The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	122 Standing Financial Instructions 123 PAM Submission	Fully compliant				
The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	124 CBRN and Hazmat Plan 120 NWAS CBRN audit	Fully compliant				
Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	124 CBRN and Hazmat Plan 125 CBRN risk assessment	Fully compliant				
Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	124 CBRN and Hazmat Plan	Fully compliant				
The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident	124 CBRN and Hazmat Plan 150 CBRN TNA	Fully compliant				
The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	128 Decontamination tent manual 081 Training records _ EPRR held 124 CBRN and Hazmat Plan 129 Example CBRN / PRPS training certificates 150 CBRN TNA	Fully compliant				
The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	128 Decontamination tent manual 124 CBRN and Hazmat Plan 130 CBRN equipment storage 150 CBRN TNA	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place
There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	124 CBRN and Hazmat plan 130 Decontamination Room and storage 150 CBRN TNA	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month Annual services of suits and Ramgene in place	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place
The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	124 CBRN and Hazmat Plan 132 NWAS / Veolia MOU	Fully compliant				
The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken	124 CBRN and Hazmat Plan 081 Training records 133 Training slides 120 NWAS CBRN audit 150 CBRN TNA	Fully compliant				
The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Developed training programme to deliver capability against the risk assessment Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	124 CBRN and Hazmat Plan 081 Training records 133 Training slides 120 NWAS CBRN audit 150 CBRN TNA	Fully compliant				
Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	134 Face Filtering Piece FFP3 Policy 124 CBRN and Hazmat Plan 135 Fit Testing database 130 Decontamination Room and storage	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place
Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	124 CBRN and Hazmat Plan 081 Training records 133 Training slides 120 NWAS CBRN audit 138 CBRN Exercise Plan 150 CBRN TNA	Partially compliant	training exercises within ED taking place September / November - a tabletop is scheduled for October	Head of EPRR UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place

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			Fully compliant				
In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	065 Evacuation and Shelter Plan Awaiting updated national guidance	Partially compliant	A working group will be established to refresh the Trust Evacuation and Shelter Plan winter 2025/26	Head of EPRR Associate Director of Estates and Facilities Management Associate Directors of Care Groups Associate Chief Nurses	To be refreshed by 31st July 2026	Awaiting updated national guidelines
The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	114 BIA standard template 115 BIA for BC event 116 Digital Services BIA 113 Example BCP and associated documents 026 Business Continuity Plan	Partially compliant	All services must ensure BIA is documented lin local BCPs this will be monitored by the Head of EPRR	Head of EPRR All service leads	30th April 2026	
The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	026 Business Continuity Plan 119 Business Continuity Exercise Guidelines 039 Industrial action planning examples 113 Example BCP and associated documents 141 Business continuity training materials 142 BC training materials 143 BC training materials 079 Tactical Commander training 137 Debrief guidelines 095 Example SBAR submissions 157 Debrief - incident declared	Partially compliant	All services to test their BCPs annually and ensure exercises are recorded and shared with the Head of EPRR	All Service Leads	30th April 2026	
Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	119 DSPT status 110 Data Protection Policy	Partially compliant	Partial compliance achieved, continued work through Digital Services to work towards full compliance	Head of Digital Compliance	30th August 2026	
The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	026 Business Continuity Plan 113 Example BCP and associated documents	Partially compliant	Ongoing support and development of BCMS with services	Head of EPRR All Service Leads	30th April 2026	
The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	128 Decontamination tent manual 124 CBRN and Hazmat Plan 130 CBRN equipment storage 150 CBRN TNA	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place
There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	124 CBRN and Hazmat plan 130 Decontamination Room and storage 150 CBRN TNA	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month Annual services of suits and Ramgene in place	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place
Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	134 Face Filtering Piece FFP3 Policy 124 CBRN and Hazmat Plan 135 Fit Testing database 130 Decontamination Room and storage	Partially compliant	WHHFT is awaiting a delivery of 16 suits to achieve the full inventory of 24, WHH currently holds loan suits that will be returned once the delivery takes place. The delivery is expected within the next month	UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	124 CBRN and Hazmat Plan 081 Training records 133 Training slides 120 NWAS CBRN audit 138 CBRN Exercise Plan 150 CBRN TNA	Partially compliant	training exercises within ED taking place September / November - a tabletop is scheduled for October	Head of EPRR UEC Decontamination Nurse Leads	31st October 2025	CBRN leads established Working Group in place

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/137**			
SUBJECT:	**Scheme of Delegation and Reservation (SORD) and Standing Financial Instructions (SFIs) Update**			
DATE OF MEETING:	3 December 2025			
AUTHOR(S):	Karen Spencer, Head of Financial Services			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance Officer			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **2253** If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A** ✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A*** ✓
	Further Information:			
	3. Foster good relations	**Yes**	**No**	**N/A**

	between people who share a protected characteristic and those who do not			✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The SORD and SFIs are updated every two years. With changes reflected in the intervening period. Since November 2023, the following changes have been made and approved either at Board or Audit Committee: SORD Changes: • Removal of £5k and £10k authorisation limits for expenditure. Previously approved at April 25 Audit Committee. • Changes to delegate powers. Previously approved at July 25 Board. SFI Changes: • Change to the threshold obtaining three quotations is increased from • £10,000 to £12,000 inclusive of VAT. • Change to the starting value for obtaining three quotes from £10,000 to £12,000 • Changes to procurement narrative as a result of new procurement regulation introduced on 24 February 2024 known at the Procurement Act. All previously approved at April 25 Audit Committee. A review has also been completed of the SORD and SFIs in relation to the integration of WHH and Bridgewater. The WHH documents are more comprehensive than Bridgewater's. Therefore, intention is that this revised document is to be used post integration.			
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**	
RECOMMENDATION:	The Trust Board is asked to review the SORD and SFIs and agreed to extend them for two years to December 2027.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee		
	Agenda Ref.	**AC/25/11/74**		
	Date of meeting	20 November 2025		
	Summary of Outcome	approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION (SORD)

Lead executive	Chief Finance Officer/Deputy Chief Executive		
Author's details	Karen Spencer		
Type of document	Policy		
Target audience	All Executive Directors, budget holders and managers		
Document purpose	Scheme of Reservation and Delegation (SORD)		
Ratification meeting	Executive Team Meeting		
Approval meeting	Trust Board		
Implementation date	~~Monday, 06 January 2025~~Monday, 01 December 2025	Review date	~~30 November 2025~~30 November 2027
WHH documents to be read in conjunction with			
Document change history			
Version	1~~0~~1		
What is different?	~~Changed Chief Finance Officer & Deputy Chief Executive to Chief Finance Officer throughout the document.~~ ~~Table a, page 35, section 34, item d, taken out first two points re waiving the requirement to request tenders and quotes. This has been replaced with, one that covers both.~~ ~~Table b, page 46, section 8, added in a section for waivers which links to the change above in table a. This was previously missing from table b.~~ Removal of £5k and £10k authorisation limits for expenditure. Previously approved at April 2025 Audit Committee. Made changes to delegate powers. Previously approved at July 2025 Board		
Appendices/electronic forms	n/a		
What is the impact of change?	n/a		
Training requirements	n/a		
Keywords	n/a		

Taxonomy	Type	Policy category non-clinical	Policy category clinical
	Non-Clinical	Finance & Procurement	Choose an item.

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1. Executive Summary

The Standing Orders provides that "The Board of Directors may delegate any of its powers to a Committee of Directors or to an Executive Director". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust.

2. Purpose and Scope

Reservation of Powers

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to Committees, Sub Committees, individual Directors or Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an Executive Committee or Sub-Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying which functions they shall perform personally and which functions have been delegated to other Directors and Officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

Caution over the Use of Delegated PowersB

Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director or Officer's Line Manager unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated Officer(s) acting in their absence after taking appropriate advice if required. If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Deputy Chief Executive, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

To maintain business continuity and regulatory compliance in the absence of both the Chief Executive and the Deputy Chief Executive, the order of delegation is as follows:

1. Chief Finance Officer – Given the CFO's primary accountability for financial oversight, internal control, and budgetary performance, they are well-positioned to discharge Accounting Officer responsibilities as a first alternative.

2. Executive Medical Director – As a clinically qualified executive, this individual brings assurance in relation to the safety, effectiveness, and governance of clinical operations, complementing the duties of the Accounting Officer role.

3. Chief Nurse – Providing a safety net in the third instance, the Chief Nurse offers a robust understanding of operational delivery, regulatory compliance, and quality assurance.

Each delegated Officer will be expected to discharge the Accounting Officer duties with due diligence and must seek appropriate legal, financial, or corporate governance advice where necessary. The Board should be notified promptly of any such delegation in effect.

Delegated Executive Lead

The Chief Finance Officer has been delegated by the Chief Executive to take the Executive ownership for this procedural document in accordance with standard practice.

3. Duties and Responsibilities

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

Accountability

2

Those matters reserved to the Board of Directors are set out below: Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders (SOs), a schedule of decisions reserved to the Board and Standing Financial Instructions (SFIs) to reflect these;
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to Executives for the main programmes of action and for performance against programmes to be monitored and Senior Executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;

- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; and
- establish Audit and Nomination and Remuneration Committee on the basis of formally agreed Terms of Reference that set out the Membership of the Committees, the limit to their powers, and the arrangements for reporting back to the main Board.

4. Policy Details

General Enabling Provision

2

The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.

Regulations and Control

3

The Board of Directors remain accountable for all of its functions, even those delegated to individual Committees, Sub-Committees, Directors or Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. The following are decisions reserved to the Board.

- Approval, suspension and variation/amendment of the Trust's Standing Orders (SOs);
- Approval of the Trust's SFIs for the regulation of its proceedings and business;
- Approval of the SoRD of powers;
- Ratification of any urgent decisions taken by the Chair and Chief Executive in accordance with the Standing Orders.
- Requiring and receiving the declaration of Board members' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.3
- Approval of arrangements for dealing with complaints.7
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree any significant modifications. *For the purpose of the Scheme of Reservation and Delegation, 'significant modifications' are those in excess of Executive Director's delegated limits.*
- To receive reports from Committees including those required by the Foundation Trust Constitution and NHS Act 2006 or other regulation.
- To receive reports from committees including those which the Foundation Trust is required by regulation to establish and to take appropriate action on other reports as requested.
- To confirm the recommendations of the Foundation Trust's Committees where the Committees do not have Executive powers.

- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a Corporate Trustee for funds held on Trust.
- To establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailee for patients' property.
- Authorise use of the seal.
- Ratify or otherwise, instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
- Approve a list of employees authorised to draw down loans on behalf of the Foundation Trust.
- Receive of such reports as the Board of Directors sees fit from committees in respect of their exercise of powers delegated.

- Continuous appraisal of the the affairs of the Foundation Trust through receipt of management reports and policy statements;
- Receive reports from the Chief Finance Officer on financial performance against the agreed annual financial plan.
- Disciplining Board members or employees who are in breach of Statutory Requirements or Standing Orders.

Appointments/Dismissal4

The appointment and dismissal of Committees that are directly accountable to the Board of Directors. 1

The appointment, disciplining and dismissal of Executive Directors. 2

Confirm the appointment of members of any Committee of the Foundation Trust as representatives on outside bodies.

The appointment, appraisal, discipline and dismissal of the Board Secretary.

Approve proposals received from the Nomination and Remuneration Committee regarding the Chief Executive, Directors and senior employees.3

Strategy, Plans and Budgets6

- Set the strategic aims and objectives of the Foundation Trust.1
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any guidance issued by the Secretary of State for Health and Social Care or the Independent Regulator.

- Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk.
- Approve Outline and Final Business Cases for Capital Investment greater than £0.5m (up to the thresholds delegated by NHS England and Improvement (NHSE/I) and the Department of Heatlh)
- Approve revenue and capital budgets.
- Approve annually Foundation Trust’s Operational Financial Plan and Financial Strategy
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

- Approve proposals for capital investment, for example Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) proposals.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer .
- All special payments over £95,000 must be sent to HM Treasury for approval.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or is contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review use of NHS risk pooling schemes and risk management cover.4
- Approve the opening of bank accounts.
- Approve individual compensation payments.

Audit Arrangements9

- To receive recommendations from the Council of Governors regarding the appointment (and where necessary dismissal) of the external auditors.
- Receive the annual management letter received from the External Auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
- Receive an Annual Report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.3
- Annual Reports and Accounts9
- Receipt and approval of the Foundation Trust's Annual Report. Annual Accounts and Quality Account before being laid before Parliament, and presentation to the Governors' Council at a Members' Meeting.
- Receipt and approval of the Annual Report and Accounts for Charitable Funds.

DELEGATION OF POWERS

Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and Terms of Reference of such Committees shall be that determined

by the Board of Directors. The Board of Directors shall determine the reporting requirements. Committees may not delegate Executive powers to Sub-Committees unless expressly authorised by the Board.

Delegation to Officers

The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the Foundation Trust as a whole;
- financial systems and procedures promote efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and
- financial considerations are fully taken into account in decisions on Foundation Trust policy proposals.

The specific personal responsibilities of an NHS Foundation Trust Accounting Officer:

- the propriety and regularity of the public finances for which they are answerable;
- the keeping of proper accounts;
- prudent and economical administration;
- the avoidance of waste and extravagance; and
- the efficient and effective use of all the resources in their charge.

The Accounting Officer must:

- personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by NHS Improvement;
- comply with the financial requirements of the Terms of Authorisation;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts;
- ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;

- ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;

- ensure that any protected property (or interest in) is not disposed of without the consent of NHS Improvement;
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Governors' Council or in the actions or advice of the NHS Foundation Trust staff, including themselves; and
- ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

The Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems have been established.

An Accounting Officer should ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well defined responsibilities for making the best use of resources including a critical scrutiny of output and value for money; and
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

Schedule of Delegation - Appendices

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. The 'Delegated to' authority is in accordance with the Standing Orders and Standing Financial Instructions. The 'Operational Responsibility' shown below is the lowest level to which authority is delegated.

Appendix 1 - Table A - Delegated Authority.

Appendix 2 - Table B - Delegated Financial Limits.

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate if the Chief Executive is absent powers delegated to them will automatically transfer to the Deputy Chief Executive.

Chair's Action of Committees of the Board

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

SCHEDULE OF DELEGATED MATTERS

DELEGATED MATTERS

Delegated Matter
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS

TABLE A (SEE APPENDIX 1)

Delegated Matter	Reference No.
AUDITARRANGEMENTS	1
AUTHORISATION OF CLINICAL TRIALS	2
AUTHORISATION OF NEW DRUGS	3
BANK/OPG ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
CAPITAL INVESTMENT	5
CLINICAL AUDIT	6
COMMERCIAL SPONSORSHIP	7
COMPLAINTS (PATIENTS & RELATIVES)	8
CONFIDENTIAL INFORMATION	9
DATAPROTECTIONACT	10
DECLARATION OF INTERESTS	11
DISPOSAL AND CONDEMNATIONS	12
ENVIRONMENTAL REGULATIONS	13
	14

External Borrowing	**15**
Financial Planning/Budgetary Responsibility	**16**
Financial Procedures	**17**
Fire Precautions	**18**
Fixed Assets	**19**
Fraud	**20**
Funds Held On Trust	**21**
Health & Safety	**22**
Hospitality/ Gifts	**23**
Infectious Diseases & Notifiable Outbreaks	**24**
IM&T	**25**
Legal Proceedings	**26**
Losses, Write-Offs & Compensation	**27**
Meetings	**28**
Medical	**29**
Non Pay Expenditure	**30**
Nursing	**31**
Patients Services Agreements	**32**
Patients' Property	**33**
Personnel & Pay	**34**
Quotations, Tendering & Contract Procedures	**35**
Records	**36**
	37
Reporting Incidents To The Police	**38**
Risk Management	**39**
Seal	**40**
Security Management	**41**
Setting Of Fees & Charges	
Stores And Receipt Of Goods	

Table B - Delegated Financial Limits (see appendix 2)

Delegated Limit	Reference No.
Charitable Funds	**1**
Gifts & Hospitality	**2**
Litigation Claims	**3**
Losses and Special Payments	**4**
Petty Cash Disbursements	**5**
Requisitioning Goods And Services	**6**
Non Pay Expenditure	6.1
Agency Staff	6.2

Capital expenditure	6.3
Removal Expenses	6.4
Quotations and Tenders	**7**
Business Case Approval	**8**
Budget Redesignation	**9**

Appendix one:

Table A - Delegated Authority

ℹIf the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	DELEGATED MATTER	DELEGATED TO ℹ	OPERATIONAL RESPONSIBILITY
1.	**Standing Orders/Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chair	Chair
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two Non-Executive Directors
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Audit Arrangements		
a) Recommendation to the Governors' Council for the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor.	Audit Committee (for recommendation to the Governors' Council for approval).	Chief Finance Officer
b) Monitor and review the effectiveness of the internal audit function.	Audit Committee	Chief Finance Officer
c) Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d) Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e) Ensure provision of a cost-effective internal audit service	Audit Committee	Chief Finance Officer
f) Implement internal audit recommendations	Chief Executive	Relevant Officers
2. Authorisation of Clinical Trials & Research Projects	Chief Executive	Medical Director
3. Authorisation of New Drugs	Chief Executive	Medical Director & Chief Pharmacist
4. Bank Accounts/Cash (Excluding Charitable Fund (Funds Held on Trust) Accounts**)**		
a) Operation:		
• Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Head of Financial Services
• Opening bank accounts	Chief Finance Officer	Head of Financial Services
• Authorisation of transfers between Foundation Trust bank accounts	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures
• Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• Authorisation of: - - BACS schedules - CHAPS schedules - RFT schedules - FASTER payments - Automated cheque schedules -	Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures
b)	Investments:		
	• Investment of surplus funds in accordance with the Foundation Trusts Treasury Management Policy	Chief Finance Officer	Head of Financial Services
	• Development of a Treasury Management Policy	Chief Finance Officer	Head of Financial Services
c)	Petty Cash	Chief Finance Officer	Refer To Table B Delegated Limits
5.	**Capital Investment**		
	• Formulation of a capital investment programme necessary to meet legislative, regulatory, health and safety and service requirements.	Chief Executive	Chief Finance Officer
	• Approval of emergency requests necessary to meet legislative, regulatory, health and service requirements and report on all capital expenditure including variance to plan.	Chief Executive	Chief Finance Officer
	• Responsiblility for the management of capital schemes to ensure they are delivered within the timescales and within the resources available.	Chief Executive	Chief Finance Officer
	• Ensure that capital investment is not undertaken without the approval of funding necessary to cover the cost.	Chief Executive	Chief Finance Officer
	• Ensure that there is funding available to cover the revenue consequences of any capital investment.	Chief Executive	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Preparation and dissemination of policies and procedures to ensure compliance and adherence to capital accounting and reporting standards and requirements.	Chief Finance Officer	Deputy Chief Finance Officer
• Authorisation of capital expenditure requests once the scheme has been approved and funding has been identified.	Chief Executive	Refer to Table B (Delegated Limits)
• Assess the requirements for the operation of the Construction Industry Taxation (CIS) scheme.	Chief Finance Officer	Head of Financial Services
• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the Standing Orders and Standing Financial Instructions	Chief Executive	Chief Finance Officer
•		
b) Private Finance:		
• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.	Chief Executive	Chief Finance Officer
Leases (property and equipment)		
• Granting and termination of leases with Annual rent < £250k	Chief Executive	Chief Finance Officer
• Granting and termination of leases of > £250k should be reported to the Board of Directors	Board of Directors	Chief Executive
6. Clinical Audit	Chief Executive	Medical Director
7. Commercial Sponsorship		
• Agreement to proposal	Chief Executive	Executive Directors / Assocate Directors of Operations / Clinical Business Unit Managers / Heads of Department. Approval and registration in line with the Policy on Business Conduct, Hospitality and Sponsorship.
•		
8. Complaints (Patients & Relatives)		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a)	Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Chief Nurse/Deputy Chief Executive
b)	Responsibility for ensuring complaints relating to a Clinical Business Unit/ department is investigated thoroughly.	Chief Executive	Clinical Business Unit Manager/Lead Nurse/Clinical Director
c)	Medico - Legal Complaints Coordination of their management.	Chief Executive	Chief Nurse/Deputy Chief Executive
9.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Medical Director.
	Freedom of Information Act compliance code	Chief Executive	Chief Information Officer
10.	**Data Protection Act**		
a)	Review of Foundation Trust's compliance	Chief Executive	Chief Information Officer
11.	**Declaration of Interest**		
	• Maintaining a register of interests	Chief Executive	Head of Corporate Affairs
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Senior Managers / Consultants
12.	**Disposal and Condemnations**		
	•		
	• Develop and maintain a Disposal and Condemnations Policy	Chief Finance Officer	Head of Financial Services
	• Disposal of Protected Property (as defined in the Terms of Authorisation	Chief Executive (with authorisation of the Independent Regulator)	
	•		
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Associate Director of Estates and Facilities

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
14.	**External Borrowing**		
a)	Advise Trust Board of the requirements to repay and draw down Public Dividend Capital.	Chief Finance Officer	Head of Financial Services
b)	Approve a list of employees authorised to request short term borrowings on behalf of the Foundation Trust.	Board	Chief Executive
c)	Application for draw down of Public Dividend Capital (PDC)m working capital and capital loans and other forms of external borrowing.	Chief Executive	Chief Finance Officer
d)	Preparation of procedural instructions concerning applications for PDC, working capital and capital loans and overdrafts.	Chief Finance Officer	Head of Financial Services
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting: • Submit annual capital and revenue budgets to the Trust Board • o Delegate budgets to budget holders	Chief Executive Chief Finance Officer	Chief Finance Officer Deputy Chief Finance Officer
b)	Monitor: o Developand maintain systems of budgetary control. o Monitor performance against budget o o o Submit returns in accordance with the Independent Regulator's requirements.	Chief Finance Officer Chief Finance Officer Chief Finance Officer	Deputy Chief Finance Officer Deputy Chief Finance Officer Deputy Chief Finance Officer

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	○ Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Finance Officer	All budget holders
	Preparation of:		
	• Annual Accounts	Chief Finance Officer	Deputy Chief Finance Officer
	• Annual Report	Chief Executive	Deputy Chief Executive
c)	Budget Responsibilities	Chief Finance Officer	Budget Holders
	Ensure that.		
	• no overspend or reduction of income that cannot be met from redesignation is incurred without prior consent of Board. • approved budget is not used for any other than specified purpose subject to rules of redesignation. • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.		
	• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Finance Officer	Deputy Chief Finance Officer
d)	Authorisation of Redesignation: Redesignation between different budget holders requires the agreement of both parties.	Chief Executive	Refer To Table B Delegated Limits
16.	**Financial Procedures and Systems**		
a)	Maintenance & update on NHS Foundation Trust Financial Procedures	Chief Finance Officer	Head of Financial Services
b)	Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action. • Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors, Committees, Sub Committees and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems	Chief Finance Officer	Deputy Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
17. Fire precautions • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Associate Director of Estates and Facilities
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Finance Officer	Head of Financial Services
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Chief Finance Officer	Chief Operating Officer
c) Calculate, account and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Finance Officer	Head of Financial Services
d)Responsibility for security of Foundation Trust's assets.	Chief Executive	Associate Director of Estates and Facilities .
19. Fraud (See also 26, 36)		
a) Monitor compliance with Secretary of State directions on anti fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.	Audit Committee	Chief Finance Officer.
b) Notify NHS Counter Fraud Authority (NHSCFA). and External Audit of all suspected Frauds	Chief Finance Officer	Anti Fraud Specialist
20. Funds Held on Trust (Charitable and Non Charitable Funds)		
a) Management of funds:: •	Charitable Funds Committee	Head of Financial Planning
b) Maintenance of authorised signatory list of nominated fund holders.	Chief Finance Officer	Head of Financial Planning
c) Compliance with expenditure Limits	Chief Finance Officer	Refer To Table B Delegated Limits
d) Development of procedures for receiving	Chief Finance Officer	Head of Financial Planning

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
donations		
e) Dealing with legacies	Director of Community Engagement + Fundraising	Charity Fundraising Manager
f) Fundraising Appeals	Director of Community Engagement +Fundraising	Charity Fundraising Manager
▪ Preparation of budget.	Director of Community Engagement & Fundraising	Fund raising manager for the appeal with advice from Finance. .
▪ Reporting progress and performance against budget.	Chief Finance Officer	Head of Financial Planning
g) Operation and management of Bank Accounts: •	Chief Finance Officer	Head of Financial Planning
h) Operation and management of Investments in line with the policy •	Charitable Funds Committee	Chief Finance Officer
i) Regulation of funds in accordance with Charities Commission	Chief Finance Officer	Head of Financial Planning
21. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse/Deputy Chief Executive
22. Hospitality/Gifts		
a) Keeping of hospitality register	Chief Executive	Deputy Chief Executive
b) Applies to both individual and collective hospitality receipt items. See Appendix B for limits.		All staff declaration required in Foundation Trust's Hospitality Register

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
23.	**Infectious Diseases & Notifiable Outbreaks**	Chief Executive	Chief Nurse/Deputy Chief Executive
24.	**Information Management & Technology**		
	Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T Strategy. • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested. • Seeking third party assurances regarding financial systems operated externally.	Chief Finance Officer	Deputy Chief Finance Officer
	• Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Chief Finance Officer	Chief Information Officer
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Chief Finance Officer	Chief Information Officer
25.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors	Chief Executive	Executive Directors
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Executive Directors
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Director
26.	**Losses, Write-off & Compensation**		
a)	<u>Losses</u> Losses of cash due to (a) Theft, Fraud etc (b) Overpayment of salaries (c) Other causes	Chief Executive	Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
(2) Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Chief Finance Officer
(3) Bad debts and claims abandoned in relation to:		Chief Finance Officer
(a)Private Patients	Chief Executive	
(b) Overseas visitors		
(c) Other		Chief Finance Officer
(4) Damage to buildings, and property including stores losses) due to:		
(a) Theft, fraud, arson etc		
(b) Store losses		
(c) Other		
	Chief Executive	
Reviewing appropriate requirement for insurance claims	Chief Finance Officer	Head of Financial Services
d) A register of all losses and special payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Head of Financial Services
e) A report of all of the above payments should be presented to the Audit Committee	Chief Finance Officer	Head of Financial Services
(e) Special Payments	Chief Executive	Chief Finance Officer
Compensation payments by Court Order		
5) Compensation payments by Court Order		Chief Finance Officer
6) Extra contractual to contractors	Chief Executive	
(7) Ex gratia Payments in respect of :-		Chief Finance Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) To patients/staff for loss of personal effects		
b) For clinical negligence with legal advice c) For personal injury with legal advice		
• Other clinical negligence and personal injury		
• Other employment payments (not including special severance payments which are disclosed below inheading No. 8 – Special Severance Payments.		
• Patient referrals outside the UK and EEA Guidelines		
• Other ex-gratia payments • (h) Maladministration, no financial loss loss		
(8) Special Severance Payments		
• Redundancy <£50,000 – approval	Chief Executive	Chief People Officer / Chief Finance Officer
Assurance on Value for Money	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer
• Redundancy >£50,000 – approval and Value for Money	Nomination and Remuneration Committee Chief Executive	Chief Executive / Chief People Officer / Chief Finance Officer
• Mutually Agreed Severance Scheme <£50,000 – approval	Nomination and Remuneration Committee	Chief People Officer / Chief Finance Officer Chief Executive / Chief People Officer /

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Assurance on Value for Money	Nomination and Remuneration Committee	Chief Finance Officer
	Chief Executive	Chief Executive / Chief People Officer / Chief Finance Officer
• Mutually Agreed Severance Scheme <£50,000 – approval and Value for Money	Nomination and Remuneration Committee	Chief People Officer / Chief Finance Officer
	Chief Executive	
• Legal Costs related to non contractual employment dispute / or negotiated agreement, with no payment to individual	Nomination and Remuneration Committee	Chief Executive / Chief People Officer / Chief Finance Officer
Assurance on Value for Money	Nomination and Remuneration Committee	Chief People Officer / Chief Finance Officer
• Non Contractual payment and Legal costs related to employment dispute / or negotiated agreement <£50,000 – approval		Chief Executive / Chief People Officer / Chief Finance Officer
Assurance on Value for Money		Chief Executive / Chief People Officer / Chief Finance Officer
• Non Contractual payment and Legal costs related to employment dispute / or negotiated agreement >£50,000 – approval and value for money		
(9) Extra statutory and regulatory		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
27.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board	Chair	Chair
b)	Chair all Foundation Trust Board meetings and associated responsibilities	Chair	Chair
28.	**Medical**		
	• Clinical Governance arrangements	Medical Director / Chief Nurse/Deputy Chief Executive	Medical Director / Chief Nurse/Deputy Chief Executive
	• Medical Leadership	Medical Director	Medical Director
	• Programmes of Medical Education	Medical Director	Medical Director/Director of Medical Education
	• Medical Staffing Plans	Medical Director	Medical Director
	• Medical Research	Medical Director	Medical Director /
29.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Chief Finance Officer
b)	Maximise value for money when requisitioning goods and or/ services.	Chief Executive	Chief Finance Officer
c)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)	Chief Executive	Chief Finance Officer
d)	Develop systems for the payment of accounts	Chief Finance Officer	Head of Financial Services
e)	Prompt payment of accounts	Chief Finance Officer	Head of Financial Services
f)	Financial Limits for ordering / requisitioning goods and services	Chief Finance Officer	Refer To Table B Delegated Limits
g)	Approve prepayment arrangements	Chief Finance Officer	Deputy Chief Finance Officer
30.	**Nursing**		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	▪ Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Matters involving individual professional competence of nursing staff.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Compliance with professional training a development of nursing staff.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
	▪ Quality assurance of nursing processes.	Chief Nurse/Deputy Chief Executive	Deputy Chief Nurse/Deputy Chief Executive
31.	**Patient Services Agreements**		
a)	Negotiation of Foundation Trust Contract and Non-Commercial Contracts	Chief Executive	Chief Finance Officer
b)	Identifyingand monitoring noncontract activity (NCA)	Chief Finance Officer	Deputy Chief Finance Officer
c)	Reporting actual and forecast income	Chief Executive	Deputy Chief Finance Officer
d)	Costing Foundation Trust Contract and Non-Commercial Contracts	Chief Finance Officer	Deputy Chief Finance Officer
e)	Reference costing / Payment by Results	Chief Finance Officer	Deputy Chief Finance Officer
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Deputy Chief Finance Officer
32.	**Patients' Property** (in conjunction with financial advice)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Nurse/Deputy Chief Executive	Deputy Director Nursing and Patient Experience Lead Nurse
b)	Prepare detailed written instructions for the administration of patients' property	Chief Nurse/Deputy Chief Executive	Deputy Director Nursing and Patient Experience
c)	Informing staff of their duties in respect of patients' property	Chief Nurse/Deputy Chief Executive	Associate Director of Operations Clinical Business Unit Managers and / Heads of Department

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d)	Issuing property of deceased patients. ▪ <£4,999 in accordance with agreed Foundation Trust policies. ▪ >£5,000 only on production of a probate letter of administration	Chief Nurse/Deputy Chief Executive	General Office Halton / Cash Office Warrington
33.	**Workforce**		
a)	Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive / Executive Directors	Chief People Officer / Deputy Directors / Associate Directors of Operations / Clinical Business Unit Managers / Heads of Department
b)	Develop Human Resource policies and strategies for approval by the board including training, industrial relations.	Chief People Officer	Deputy Chief People Officer
c)	Authority to fill funded post on the establishment with permanent staff.	Chief People Officer	Executive Directors / Deputy Director / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department in accordance with Trust policy
d)	The granting of additional increments to staff within budget	Chief Executive	Chief People Officer
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Chief People Officer	Deputy Chief People Officer / Head of HR
f)	Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance.	Chief Finance Officer	Deputy Chief Finance Officer / Head of Management Accounts
	• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Chief Finance Officer
	• Self financing changes to an establishment	Chief Finance Officer	Deputy Chief Finance Officer / Head of Management Accounts
g)	Pay		
	• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration and Terms of Employment Committee.	Chief Executive	Chief Executive
	• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Chief People Officer	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Service/Dept

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Authority to complete and authorise positive reporting forms (SVLs)	Chief Finance Officer	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Service/Dept
• Authority to authorise overtime	Chief People Officer / Chief Finance Officer	Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department or Service / Lead Nurse / Matron / Lead AHP
• Authority to authorise travel & subsistence expenses.	Chief People Officer / Chief Finance Officer	Line Managers
• Authority to authorise travel & subsistence expenses over three months old.	Chief People Officer/Chief Finance Officer Chief People Officer	
• Authority to approve excess travel expenses as a result of organisational change.		Deputy Directors / Associate Director of Operations / Clinical Business Unit Managers / Heads of Department or Service
h) Leave *(Note entitlement may be taken in hours)*		Deputy Directors / Associate Director of Operations / Clinical Business Unit Managers / Heads of Department or Service (with advice from HR)

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Chief People Officer	*Refer to Annual Leave Policy*
Annual Leave		
- Approval of annual leave		Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of 5 days	Chief Executive	Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers
- Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only)	Chief Executive	Executive Directors / Deputy Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department Medical Staff – Medical Director
Special Leave	Chief People Officer	Refer to Special Leave Policy
• Special leave (as detailed in the Trust Policy)		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Managers
• Leave without pay		Executive Directors / Associate Directors of Operation / Clinical Business Unit Managers / Heads of Department / Line Manager
• Authority to grant Special Leave over one week		Executive Directors / Deputy Directors / Associate Directors of Operations
• Medical Staff Leave of Absence – paid and unpaid	Medical Director	Medical Director / Divisional Medical Directors
• Time off in lieu		Departmental / Line Managers Line Managers
• Maternity Leave - paid and unpaid	Chief People Officer	Automatic approval with guidance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Sick Leave		
	i) Extension or re-instatement of sick leave on pay	Chief People Officer	Chief People Officer
			Chief People Officer
	ii) Return to work part-time on full pay to assist recovery recovery over four weeks		Chief People Officer
	iii) Award Injury Allowance		
	Study Leave		
	• Study leave outside the UK	Chief Executive	Executive Director
	• Medical staff study leave (UK) - Consultant / Non Career Grade - Career Grade	Medical Director	Medical Director Post Graduate Tutor
	• All other study leave (UK)	Chief People Officer	Executive Directors / Deputy Directors / Associate Director of Operations / Heads of Department/Service (in accordance with agreed Foundation Trust policy)
i)	Removal Expenses, Excess Rent and House Purchases All staff (agreed at interview) Maximum £6,000 Senior Medical Staff Maximum £8,000 Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Chief People Officer	Executive Directors/Deputy Directors/Associate Director of Operations/Head of Department/Service Refer to Table B Delegated Limits

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
j)	Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Director of Organisational Development & Governance must be sought when the grievance reaches the level of Divisional Director of Operations / Heads of Department	Chief People Officer	As per procedure
k)	Authorised Car Grievance Procedure Users • Leased cars (Business and personal) • Regular user allowance	Chief Executive Chief Finance Officer	Chief Finance Officer Executive Director / Associate Director of Operations / Clinical Business Unit Managers / Heads of Department
l)	Mobile Phone / Messaging Services	Chief Finance Officer	Chief Finance Officer / Associate Director of Estates and Facilities
m)	Renewal of Fixed Term Contract	Chief People Officer	Heads of Department /Service on advice from Human Resources and Divisional Accountants
n)	Staff Retirement Policy		
	▪ Authorisation of a retire and return application	Chief People Officer	Heads of Department/Service on advice from Human Resources and Divisional Accountants

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
o)	Redundancy		
	• Approval to proceed	Chief Executive	Executive Team Chief People Officer / Chief Finance Officer Commercial Development
	• Payments (including legal fees) fees payable to employees' solicitors as part of settlement agreement below £50,000	Chief Executive	Chief People Officer / Chief Finance Officer Commercial Development
	• Payments (including legal fees) (including legal fees payable to employee's solicitors as part of settlement agreement)) over £50,000	Nominations and Remuneration Committee	Chief People Officer Chief Finance Officer
	• Mutually Agreed Redundancy Scheme		
	○ Agreement to run scheme.	Trust Board / Exec team	
	Approval of payments		
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Executive	Chief People Officer
q)	Disciplinary Procedure (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
r)	Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Chief People Officer	Deputy Chief People Officer
s)	Engagement of staff not on the establishment		
	• Management Consultants		Refer to Table B
	▪ Booking of bank staff		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Nursing and AHPs • Medical	Chief Nurse/Deputy Chief Executive	Associate Directors of Operation / Divisional Heads of Nursing /Ward Managers
• other	Executive Directors	Deputy Director / Associate Directors of Operation / Heads of Department / Line Managers
▪ Booking of agency staff		
• Nursing • Medical	Chief Nurse/Deputy Chief Executive	Deputy Directors / Associate Directors of Operation / Divisional Heads of Nursing
• other	Executive Directors	Deputy Directors / Associate Directors of Operation / Heads of Department / Line Managers
34. Quotation, Tendering & Contract Procedures		
a) Services: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Clinical Business Unit Managers Head of Department Associate Director of Procurement Deputy Head of Procurement Senior Procurement Manager
b) Competitive Tenders: • Authorisation Limits	Chief Executive	Refer To Table B Delegated Limits
• Maintain a register to show each set of	Chief Executive	Associate Director of Procurement

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	competitive tender invitations dispatched.		
	• Receipt and custody of tenders prior to opening	Chief Executive	Associate Director Procurement
	• Opening Tenders	Chief Executive	Release of electronic tenders on eTendering portal by a designated officer (procurement project lead and deputy procurement project lead)
	• Decide if late tenders should be considered	Chief Executive	Chief Finance Officer
	• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Associate Director Procurement
c)	Quotations	Chief Executive	Associate Director Procurement
d)	Waiving the requirement to obtain tenders or quotations subject to Standing Orders (reporting to Audit Committee)	Chief Executive	Refer To Table B Delegated Limits
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice	Chief Executive	Executive Directors / Associate Directors of Operation / Heads of Department
b)	Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer	Deputy Chief Finance Officer
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Executive	/Local Security management Specialist (if relating to an employee this should be done with advice from HR)
b)	Where a fraud is involved (reporting to the Directorate of Counter Fraud Services) Fraud Services)	Chief Finance Officer	Head of Internal Audit / Local Counter Fraud Officer (if relating to an employee this should be done with advice from HR)
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Finance Officer	Chief Finance Officer (if relating to an employee this should be done with advice

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		from HR)
37. Risk Management		
• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Nurse/Deputy Chief Executive
• Developing systems for the management of risk.	Chief Nurse/Deputy Chief Executive	Deputy Director of Integrated Governance + Quality
• Developing incident and accident reporting systems	Chief Nurse/Deputy Chief Executive	Deputy Director of Integrated Governance + Quality
• Compliance with the reporting of incidents and accidents	Chief Nurse/Deputy Chief Executive	All staff
38. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Head of Corporate Affairs
b) Attestation of seal in accordance with Standing Orders	Chair / Chief Executive	Chair / Chief Executive (report to Board of Directors)
c) Property transactions and any other legal requirement for the use of the seal.	Chair / Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Director
39. Security Management		
a) Monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Executive	Chief Operating Officer / Local Security Management Specialist.
40. Setting and Recovery of Fees and Charges (Income)		
a) Setting and recovery of fees and charges for Private Patient, Overseas Visitors, Income Generation – patient related and non-patient related services.	Chief Finance Officer	Deputy Chief Finance Officer -

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
c)	Recovery of fees and charges on private Patient Overseas Visitors, Income Generation, and other patient related and non-patient related services.	Chief Finance Officer	Head of Financial Services
e)	Security of cash and other negotiable instruments	Chief Finance Officer	Head of Financial Services
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over the receipt and distribution of goods, issues and returns	Chief Finance Officer	Associate Director of Procurement/Chief Pharmacist
b)	Stocktaking arrangements	Chief Finance Officer	Deputy Chief Finance Officer
stock.			

42. Contract Award Recommendation Reports and Signing of Commercial Contracts

	Delegated To	Delegated Limit	Operational Responsibility
Completion of Contract Award Recommendation Reports	Chief Finance Officer / Deputy Chief Executive	All values	Associate Director of Procurement
Approval of Contract Award Recommendation Reports and the signing of Commercial Contract	Chief Executive	Up to £100,000	Deputy Chief Finance Officer
		Up to £250,000	Chief Finance Officer & Deputy Chief Executive
		Over £250,000	Chief Executive

43. Change Control Notices against approved Commercial Contracts

	Delegated To	Delegated Limit	Operational Responsibility
*Ratification of the Change Control Notice	Chief Finance Officer /	All values	Associate Director of

	Deputy Chief Executive		Procurement Deputy Associate Director of Procurement Head of Procurement and Performance Senior Contract Manager
Identification of Budget	Chief Finance Officer / Deputy Chief Executive	All values	Budget Holder
Verification of Budget	Chief Finance Officer / Deputy Chief Executive	All values	CBU Senior Business Accountant
Approval of Change Control Notice	Chief Finance Officer / Deputy Chief Executive	In accordance with the values detailed int the Scheme of Reservation and Delegation 'Requisitioning Good and Services and Approving Payments'	In accordance with the values detailed int the Scheme of Reservation and Delegation 'Requisitioning Good and Services and Approving Payments'

*This will be to confirm that the CCN is permissible within the existing contract.

44. Business Cases		
Completion of business cases	Chief Executive	Chief Finance Officer Chief Finance Officer
Approval of business cases	Chief Executive	

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend – Bids (designated, restricted and unrestricted)	Up to £1,000	Director of Communications & Engagement and Financial Planning Manager
	£1,001 - £5,000	Executive Management Team and Financial Planning Manager
	Over £,5000	Charitable Funds Committee
Charitable Spend – Grants *Following successful grant applications, funds received can only be spent on the intended purpose in line with the original application.	Up to £5000	Director of Communications & Engagement and Financial Planning Manager
	£5,001 - £50,000	Executive Management Team and Financial Planning Manager
	Over £50,000	Charitable Funds Committee
2. GIFTS AND HOSPITALITY		
2.1 Cash & Vouchers		
Cash and vouchers Should always be declined.	any value	All Staff
2.2 Gifts		
Gifts do not need to be declared	up to £50 (Single)	All Staff
Gifts Multiple gifts from the same source over a 12 month period should be treated the same as single gifts **over £50 (see below)**	up to £50 (Multiple)	
Gifts should be accepted on behalf of the Trust (not in a personal capacity) They should be recorded on the register and delivered to the WHH Charity as 'Gifts in Kind' to be used for the benefit of patients	Over £50	
2.3 Hospitality		
Meal and refreshments May be accepted and need not be declared	up to £25	All Staff
Meal and refreshments May be accepted and must be declared	£25 - £75	
Meal and refreshments		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix two:

Table B – Delegated Financial Limits

All thresholds are inclusive of VAT irrespective of recovery arrangements.

Details of procurement thresholds will be provided by the Head of Procurement

If the Chief Executive is absent, powers delegated to them will automatically transfer to the Deputy Chief Executive.

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
3. LITIGATION CLAIMS		
Clinical Negligence scheme for the Trust (CNST) and Clinical Risk Pooling Scheme (LTPS & PES - above excess only) for the Trust		NHS Resolution (NHSR) on behalf of the Trust
Employers Liability (EL) claims within excess	up to £3,000	Litigation & Risk Manager
Public Liability (PL) claims within excess	up to £10,000	
4. LOSSES AND SPECIAL PAYMENTS		
Losses:		
1. Losses of cash due to:		
a. theft, fraud etc. b. overpayment of salaries etc. c. other causes	up to £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
2. Fruitless payments and constructive losses	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors

3. Bad debts and claims abandoned in relation to:		
a. private patients b. overseas visitors c. other	up to £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
4. Damage to buildings, property etc. (including stores losses) due to:		
a. theft, fraud etc. b. stores losses c. other	up to £500	Ward Manager or Department Manager
	£500 - £1,500	Head of Service/CBU Manager
	£1,501 - £2,500	Head of Financial Services
	£2,501 - £5,000	Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors

4. LOSSES AND SPECIAL PAYMENTS		
Special payments: From 2020/21 all Special Payment over £95k must be sent to HM Treasury for		

Approval		
5. Compensation under court order or legally binding arbitration award	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
6. Extra contractual to contractors	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
7. Ex gratia payments in respect of:		
a. loss of personal effects b. clinical negligence with advice c. personal injury with advice d. other negligence and injury e. other employment payments (not including special severance payments which are disclosed below) f. patient referrals outside the UK and EEA Guidelines g. other h. maladministration, no financial loss	up to £500	Ward Manager or Department Manager
	£500 - £1,500	Lead Nurse & Matron/Head of Service/CBU Manager
	£1,501 - £2,500	Lead Nurse & Matron/Head of Financial Services
	£2,501 - £5,000	Deputy Chief Nurse/Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors

8. Special severance payments Special severance payments when staff leave a public sector employer should only rarely be considered. They will always require HM Treasury approval because they are usually novel, contentious and potentially repercussive: NHS bodies have no delegated authority to make such payments unless so approved. NHS Bodies must complete a template for submission to HMT for approval.	up to £10,000	HM Treasury
	£10,001 - £250,000	
	Over £250,000	

4. LOSSES AND SPECIAL PAYMENTS (see Appendix for further detail)		
Special payments: From 2020/21 all Special Payment over £95k must be sent to HM Treasury for Approval		
9. Extra statutory and regulatory Extra statutory and regulatory are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms.	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive and Chief Finance Officer
	Over £250,000	Board of Directors
5. PETTY CASH DISBURSEMENTS & PATIENT MONIES (authority to pay cash)		
Petty Cash	up to £50	Budget Holder

	Over £50	Chief Finance Officer OR Nominated Deputy (Head of Financial Services)
Patients Monies	up to £100	Cash & General Office Manager
	£101 - £5,000	Deputy Chief Finance Officer or Head of Financial Services
	Over £5,000	Chief Finance Officer
6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS (see Appendix 3 for addition details)		
6.1 Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses)	~~up to £10,000~~	~~Department Manager~~ ~~Lead Nurse~~ ~~Matron~~
	up to £25,000	Assistant Clinical Business Manager Associate Directors (not named elsewhere) Deputy Chief Pharmacist Head of Service
	up to £50,000	Chief Pharmacist Clinical Business Unit Manager Deputy Chief Information Officer
	up to £75,000	Deputy Directors Associate Director Clinical Support Services Associate Director of Estates & Facilities Associate Director Planned Care & Halton Associate Director Unplanned

	Care Chief Information Officer
up to £100,000	Deputy Chief Finance Officer Director of Operations and Performance & Deputy Chief Operating Officer
up to £250,000	Executive Directors
over £250,000	Chief Executive (delegated to Deputy Chief Executive in absence of CE)

6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
6.2 Consultancy Services	up to £50,000	Chief Executive / Executive Directors
	over £50,000	NHS Improvement
6.3 Capital Expenditure	n/a	Board of Directors following recommendation by Capital Planning Group supported by Finance and Sustainability Committee
Annual capital programme and amendments to the capital programme		
Orders for schemes within the approved capital programme	up to £5,000,000	Finance & Sustainability Committee
	over £5,000,000	Trust Board
Emergency schemes approved by	up to £250,000	Chief Finance Officer or Deputy Chief Finance Officer

	£250,000 - £500,000	Chief Executive
	over £500,000	Board of Directors
6.4 Removal Expenses	up to £8,000	Chief People Officer
7. QUOTATIONS AND TENDERS		
~~**Quotations:** inviting minimum of 3 written quotations for goods/services~~ Quotations; inviting a minimum of 3 written quotations for goods/services. Where requirements are clear and sufficient to obtain a price, this will be a written quotation based on price alone.	~~£10,000 - £60,000~~ £12,000 - £59,999 inclusive of VAT	Associate Director of Procurement (except drugs) Chief Pharmacist (drugs only)* *only these two people can invite tenders or obtain quotes
~~**Competitive Tenders:** inviting a minimum of 3 written competitive tenders for goods/services (incompliance with EC directives as appropriate) EU limits and subsequent changes to be provided under separate correspondence by Associate Director of Procurement~~ Competitive Tenders; inviting a	~~over £60,000~~ Over £60,000 inclusive of VAT	

minimum of 3 written competitive tenders for goods/services (in compliance with Public Contract Regulations 2015 or the Procurement Act 2023 or the Provider Selection Regime 2024). Public Contract Regulations 2015 or the Procurement Act 2023 or the Provider Selection Regime 2024 and subsequent changes to be provided under separate correspondence by the Associate Director of Procurement		
8. WAIVERS		
Waiving the requirement to obtain tenders or quotations subject to Standing Orders (reporting to Audit Committee)	£120,000 – £100,000	Deputy Chief Finance Officer
	~~Over £100,000 to Public Contracts Regulations Thresholds~~ Over £100,000 to Public	Chief Finance Officer

	Contracts Regulations 2015 / Procurement Act 2023	

9. BUSINESS CASE APPROVAL (TRUST FUNDED)		
Revenue only	All	Executive Team (once approved delegated authority limits apply)
Revenue including capital		
Revenue only	over £500,000	Board of Directors (once approved delegated authority limits apply)
Revenue including capital		
10. REDESIGNATION		
Trust must still meet Financial Targets. Total trust budget remains under spent. Total divisional /departmental budget remains under spent	up to £25,000	Deputy Chief Finance Officer
	up to £100,000	Chief Finance Officer
	up to £250,000	Chief Executive
	over £250,000	Trust Board

Appendix three

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8
10k	**25k**	**50k**	**75k**	**100k**	**250k**	**£250k - £ 499,999**	**£500k+**
Department Manager	Assistant Clinical Business Manager	Associate Chief of Nursing	Associate Director Clinical Support Services	Deputy Chief Finance Officer	Executive Director	Chief Executive	Trust Board
Head of Service	Associate Directors (Not Named Elsewhere)	Business Manager	Associate Director of Estates & Facilities	Deputy Directors			
Lead Nurse	Chief Pharmacy Technician	Chief Pharmacist	Associate Director Planned Care	Director of Governance and Quality			
Matron	Deputy Chief Pharmacist	Clinical Business Unit Manager	Associate Director Unplanned Care	Director of Operations & Performance & Deputy Chief Operating Officer			

Senior Executive Secretary	Head of Service	Deputy Chief Information Officer	Chief Information Officer				
		Director of Medical Education	Company Secretary & Associate Director of Corporate Governance				
Audiology Service Manager	Assistant CBU Manager	Associate Chief of Nursing	Associate Director Clinical Support Services	Deputy Chief Finance Officer	Chief Finance Officer / Deputy Chief Executive	Chief Execut ive	Trus t Boa rd
Cancer Nurse Transformation Manager	Associate Director of Finance	Business Manager - Medical Cabinet	Associate Director of Estates & Facilities	Deputy Chief Nurse	Chief Nurse / Deputy Chief Executive		
Cathether Lab Manager	Associate Director of Infection Control	Chief Pharmacist	Associate Director Planned Care	Deputy Chief People Officer	Chief Operating Officer		
Clinical Modality Lead	Associate Director of Nursing	Clinical Business Unit Manager	Associate Director Unplanned Care	Deputy Medical Director	Chief People Officer		

CT Principal Radiographer	Associate Director of Procurement	Deputy Chief Information Officer	Chief Information Officer	Director of Governance and Quality	Director of Communications and Engagement		
Deputy Head Orthoptist	Chief Pharmacy Technician	Director of Medical Education	Company Secretary & Associate Director of Corporate Governance	Director of Operations & Performance & Deputy Chief Operating Officer	Director of Strategy & Partnerships		
Diabetes Service Manager	Deputy Chief Pharmacist				Medical Director		
Facilities Manager	Halton Healthy New Town Project Manager						
Head of Clinical Coding	Head of Capital Estates						
Head of Communications & Engagement	Head of Estates						

Head of Complaints, PALS & Legal Services	Head of Learning & OD						
Head of Continued Professional Development	Head of Therapies						
Head of Contracting	Medical Engineering Manager						
Head of Employee Engagement & Wellbeing	Radiology Manager						
Head of Management Accounts							
Head of Resuscitation & Stimulation							

Head of Security and LSMS							
Knowledge and Evidence Service Manager							
Lead Nurse							
Matron							
North West Skills Development Manager							
OPD Access Manager							

OPD Service Manager							
Organisational Development Manager							
Pathology Service Manager							
Principle Clinical Physiotherapist							
Senior Estates Officer							
Senior Executive Secretary							

Senior Orthoptist							
Sup 3 Radiographer							
Theatre Service Development Manager							
Therapy Manager							

Equality impact assessment

1. **This section asks you to consider a few questions relating to your policy, process, procedure or decision.**

Initial screening	Yes	No
1.1. Does your policy affect people (Patients/Workforce/Public)?	☒	☐
1.2. Does the policy affect one or more group of people in a different way to another?	☐	☒
1.3. Does the policy offer opportunity to promote equality?	☒	☐

1.4. Does your policy impact positively, negatively or neutrally on any of the below characteristics/groups?
If yes, please indicate how and which type (positive or negative) in the 'Barriers/Impact' section:
Neutral impact is where there will be no change in actual/potential impact on this protected group.

Initial assessment	Scale	Barriers/impact
Age	neutral	
Disability - learning disabilities/difficulties, physical/hidden disability, sensory impairment and mental health problems	neutral	
Gender reassignment	neutral	
Race	neutral	
Religion or belief	neutral	
Sex	neutral	
Sexual orientation including lesbian, gay and bisexual people	neutral	
Marriage and civil partnership – including same sex relationships	neutral	
Pregnancy and maternity/paternity	neutral	
Carers	neutral	
Social factors - deprivation, homelessness, education etc.	neutral	

Armed forces and military veterans	neutral	

1.5.	Is the impact of the policy likely to be negative?	☐ **Yes**	☒ **No**

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

1.7.	Does your policy support positive action for underrepresented groups.	☐ **Yes** ☐ **No** ☒ **N/A**

If you have answered no and neutral to all of the questions in section 1 then a full Equality Impact Assessment is not required. Where you have answered yes, please move to section 3.

2. Does your policy support the general aims of the Public Sector Equality Duty (Equality Act 2010)?

Yes ☒ **No** ☐	**1.** Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010 **2.** Advance equality of opportunity and remove disadvantages between those who share a protected characteristic and those who do not **3.** Foster good relations between people who share a protected characteristic and those who do not

3. Please assess your proposals analysis equality reference scale:

☐	**High –** This policy shows a **high degree of negative or positive** impact to one or more protected characteristics or one or more general aims of the Equality Act 2010 or Armed Forces Act 2021 (where rationale cannot be justified)
☐	**Medium –** This policy shows a **medium degree of impact** (positive or negative) to one or more protected characteristic.
☐	**Low –** This policy **does not have any impact to any protected characteristic** or general aim of the Equality Act 2010 or Armed Forces Act 2021.

If your analysis has scored **high**, then a full Equality Impact Assessment should be completed (Stage 2). This can be found here. If your analysis has scored **low or medium** when considering the evidence detailed above, then a full Equality Impact Assessment may not be required.

If you require any support, please contact the Equality, Diversity and Inclusion Team at whh.equalityimpactassessments@nhs.net

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS POLICY

Lead executive	Director of Finance		
Author's details	Karen Spencer Head of Financial Services		
Type of document	Policy		
Target audience	All Executive Directors, budget holders and managers		
Document purpose	Standing Financial Instructions Policy		
Ratification meeting	Audit Committee		
Approval meeting	Trust Board		
Implementation date	~~Friday, 01 December 2023~~Monday, 01 December 2025	Review date	~~30 November 2025~~30 November 2027
WHH documents to be read in conjunction with			
Document change history			
Version	4.2~~1~~		
What is different?	~~Changed Chief Finance Officer & Deputy Chief Executive to Chief Finance Officer.~~ ~~Changed NHS England & Improvement to NHS England.~~ ~~Change NHSE/I to NHSE.~~ Change to the threshold obtaining 3 quotations is increased from £10,000 to £12,000 inclusive of VAT. Change to the starting value for obtaining 3 quotes from £10,000 to £12,000 Changes to procurement narrative as a result of new procurement regulation introduced on 24 February 2024 known at the Procurement Act. All approved at the April 2025 Audit Committee.		
Appendices/electronic forms	n/a		
What is the impact of change?	No impact, only a change to names.		
Training requirements	n/a		
Keywords	n/a		

Taxonomy	**Type**	**Policy category non-clinical**	**Policy category clinical**

	Non-Clinical	Finance & Procurement	Choose an item.

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1. Executive summary

NHS England (NHSE) sets the Terms of Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector with any relevant code of practice and guidance issued by NHSE /I.

The Code of Conduct and Accountability in the NHS issued by the Department of Health requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer or Deputy Chief Finance Officer & Trust Freedom to Speak Up Guardian **MUST BE SOUGHT BEFORE ACTING.** The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

If for any reason these Standing Financial Instructions (SFIs) are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these (SFIs) to the Chief Finance Officer as soon as possible.

2. Purpose and scope

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and

effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Foundation Trust.

These SFIs identify the financial responsibilities, which apply to everyone working for the Foundation Trust and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes.

3. Duties and responsibilities

Role	Responsibilities
Board of Directors	It is the responsibility of the Board of Directors to ensure systems and processes are in place to monitor and implement this policy.
Chief Executive	In line with the requirements of Governance, the Chief Executive carries ultimate responsibility for assuring the quality of the services provided by the Trust that is included within this policy.
Executive Directors	All Executive Directors are the authorised Leads to sign off corporate policies within their areas of responsibility.
Delegated Executive Lead	The Chief Finance Officer has been delegated by the Chief Executive to take the Executive ownership for this policy.
Senior Clinicians and Managers	Senior Clinicians and Managers are responsible for the provision of managerial and professional advice to their teams in accordance with this policy.
All Staff	All staff are required to comply with this policy. If for any reason a deviation occurs this should be alerted to their manager/supervisor.

4. Policy details

TERMINOLOGY

Unless the contrary intention appears or the context otherwise requires, words or expressions contained in the Constitution bear the same meaning as in the NHS Act 2006. References in the

Constitution to legislation include all amendments, replacements, or re-enactments made.

In the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation the following definitions apply:

	Definition
the 2006 Act	Means the National Health Service Act 2006.
Accounting Officer	This Is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. They shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.
Appointing organisations	Means those organisations named in the Constitution who are entitled to appoint Governors.
Authorisation	This is the authorisation for the Trust to become an NHS Foundation Trust given by NHS Improvement, under Section 35 of the 2006 Act.
Board of Directors	Means the Board of Directors as constituted in accordance with the constitution.
Budget	Means a resource, expressed in financial or manpower terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust;
Budget Holder	The director or employee with delegated authority to manage finances for a specific area of the organisation.
The Chair	Means the Chairperson of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by

	Definition
	the Constitution..
Chief Executive	Means the Chief Officer (and Accounting Officer) of the Foundation Trust
Committee	Means a committee appointed by the Board of Directors or Council of Governors.
Constitution	Constitution of Warrington & Halton Hospitals NHS Foundation Trust. Describes the type of organisation, its primary purpose, governance arrangements and membership.
Contracting & Procuring	Means the systems for procuring goods and services.
Director	Means a person appointed to the Board of Directors in accordance with the Trust's constitution and includes the Chair.
Chief Finance Officer	Shall mean the Chief Finance Officer of the Foundation Trust.
Executive Director	Means an Executive Director of the Trust.
External Auditor	the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act;
Financial Year	a) The period beginning with the date on which the Foundation Trust is authorised under the 2006 Act and ending with the next 31 March; and b) each successive period of twelve months beginning with 1 April.
the Foundation Trust (or Trust)	Means Warrington & Halton Hospitals NHS Foundation Trust.

	Definition
Foundation Trust Contract	Agreement between the Foundation Trust and Commissioners for the provision and commissioning of health services.
Funds Held on Trust	those funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under 2003 Act. Such funds may or may not be charitable.
Member	Means a member of the Foundation Trust;
NHS England and Improvement	regulator of Foundation Trusts, NHS Trusts and Independent providers of NHS funder care.
Nominated Officer	Means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	Means an employee of the Foundation Trust.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters.
Scheme of Reservation and Delegation	(SoRD) details how the powers are reserved to the Board of Directors and delegated within the Foundation Trust.
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust.

Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust.

RESPONSIBILITIES AND DELEGATION

The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of income and expenditure and capital budgets, approval of the Annual Plan and monitoring returns to NHS Improvement;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and

d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Reservation and Delegation.

The Constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Scheme of Reservation and Delegation adopted by the Foundation Trust.

Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust's system of internal control.

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

It is a duty of the Chief Executive to ensure that Directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Foundation Trust.

The Chief Finance Officer is responsible for:

a) implementing the Foundation Trust's financial policies and procedures, and for co-ordinating any corrective action necessary to further these policies and procedures, (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time;

and, without prejudice to any other functions of directors and employees to the Foundation Trust, the duties of the Chief Finance Officer include:

d) the provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

e) the design, implementation and supervision of systems of internal financial control; and

f) the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

All directors and employees are responsible for:

a) the security of the property of the Foundation Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

AUDIT

Audit Committee

In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and Foundation Trust Governance requirements, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

Internal Audit

- Monitor and review the effectiveness of the internal audit service

External Audit

- To assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable.
- To undertake a market testing exercise for the appointment of the external auditor at least once every five years.
- To make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor.
- To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.

b) reviewing financial and information systems and monitor the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing of significant financial reporting judgements;

c) the monitoring of compliance with Standing Orders and Standing Financial Instructions;

d) reviewing schedules of losses and compensation and making recommendations to the Board of Directors as prescribed in the Scheme of Reservation and Delegation;

e) reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example

the Statement on Internal Control and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors.

f) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems), that supports the achievement of the organisation's objectives.

The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, The Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance).

It is the responsibility of the Chief Finance Officer to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the appointment

The appointment of the External Auditor is subject to the ratification by the Council of Governors.

Chief Finance Officer

The Chief Finance Officer is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function and the coordination of other assurance arrangements;

b) ensuring that the internal audit is adequate and meets the NHS Foundation Trust audit standards;

c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

The report must cover:

i) a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards,

ii) major internal financial control weaknesses discovered,

iii) progress on the implementation of internal audit recommendations,

iv) progress against plan over the previous year,

v) strategic audit plan,

vi) a detailed plan for the coming year.

The Chief Finance Officer or designated auditors is entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;

c) the production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and

d) explanations concerning any matter under investigation.

Internal Audit

The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

Role of Internal Audit

The role of internal audit have two key areas:

- The provision of an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives.
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) fraud and other offences,

ii) waste, extravagance, inefficient administration,

iii) poor value for money or other causes.

e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Chief Finance Officer must be notified immediately.

The Senior Audit Manager will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust.

The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Senior Audit Manager. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Senior Audit Manager shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee.

Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer. Changes implemented in response to audit recommendations must be maintained in the future and not viewed as merely satisfying immediate audit point.

External Audit

Duties

The Foundation Trust is to have an External Auditor and is to provide the External Auditor with every facility and all information which they may reasonably require for the purposes of their functions under the 2006 Act.

The External Auditor is to carry out their duties in accordance with the 2006 Act and in accordance with any directions given by NHSE on standards, procedures and techniques to be adopted.

In auditing the accounts, the External Auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Foundation Trust is required to include a statement on internal control within the financial statements. The External Auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements and other work.

Appointment of External Auditor

The External Auditor is appointed by the Council of Governors following recommendation from the Audit Committee.

Appointment of the External Auditor must comply with Paragraph 23 of Schedule 7 to the 2006 Act.

The Council of Governors shall appoint or remove the External Auditor. Council of Governors

The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Any such auditors are to be appointed by the Council of Governors.

Undertaking Work

NHSE may require auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between NHS Improvement, the External Auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators or Regulated Entities.

The auditor may provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor.

Liaison with Internal Audit

It is expected that the External Auditor will liaise with the internal audit service in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The External Auditor may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the Audit Code. In particular the External Auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

Access to Documents

The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions.

Public Interest Report

In the event of the External Auditor issuing a Public Interest Report the Foundation Trust shall:

- Send the public interest report to the Council of Governors the Board of Directors and NHS Improvement:
  - At once if it is an immediate report; or
  - Not later than 14 days after conclusion of the audit.
- forward a report to NHSE within 30 days (or such shorter period as NHSE may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest Report.

Fraud and Corruption

The Foundation Trust shall take all necessary steps to counter fraud relating to its functions and having regard to any reasonable guidance or advice issued by the NHS Counter Fraud Authority (NHSCFA). The Foundation Trust shall act in accordance with:

- the NHS Fraud and Corruption Manual;
- the policy statement "Applying appropriate sanctions consistently" published by NHSCFA;

The Foundation Trust shall nominate a suitable person to carry out the duties of the Anti-Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

The Anti-Fraud Specialist shall report to the Chief Finance Officer and shall work with the staff in the NHSCFA in accordance with the Department of Health Fraud and Corruption Manual.

The Anti-Fraud Specialist will provide a written plan and report, at least annually on counter fraud work within the Foundation Trust.

Security Management

The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by the NHSCFA

The Foundation Trust shall nominate an Executive Director to be responsible to the Board of Directors for security management.

The Foundation Trust shall nominate and appoint a Anti-Fraud Specialist as per the Foundation Trust Contract.

The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Chief Operating Officer (COO) and the appointed Anti-Fraud Specialist.

BUSINESS PLANNING, FINANICAL PLANNING AND PERFORMANCE MONITORING

Preparation and approval of Strategic and Operational Plans

The Chief Executive will compile and submit to the Board of Directors strategic and operational plans. The annual operational plan incorporates financial targets and forecast limits of available resources. The annual operational plan will contain:

a) a statement of the significant assumptions on which the plan is based; and

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit revenue and capital budgets for approval by the Board of Directors. Such budgets will:

a) be in accordance with the strategic aims and objectives of the foundation trust.

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds;

e) identify potential risks;

f) be based on reasonable and realistic assumptions; and

g) enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

The Chief Finance Officer shall monitor the financial performance against budgets on a monthly basis and report to the Board of Directors. Any significant variances should be reported by the Chief Finance Officer to the Board of Directors in an appropriate timeframe and the Board of Directors shall be advised of action to be taken in respect of such variances.

All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

All budget holders will sign up to their allocated budgets at the commencement of each financial year.

The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to all budget holders to help them manage successfully.

Budgetary delegation

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise budget re-designation;

e) achievement of planned levels of service; and

f) the provision of regular reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Board of Directors.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

Budgetary control and reporting

The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

a) regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

   i) income and expenditure to date showing trends and forecast year-end position;

   ii) statement of financial position, including movements in working capital;

   iii) statement of cash flow

   iii) capital project spend and projected out-turn against plan;

   iv) explanations of any material variances from plan/budget; and

   v) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial, and workload budgets;

d) the monitoring of management action to correct variances;

e) arrangements for the authorisation of budget transfers;

f) advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and

g) review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Finance Officer will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

Each budget holder is responsible for ensuring that:

a) any likely budget overspend or income under recovery which cannot be met by budget re-designation is not incurred without the prior consent of the Board of Directors;

b) officers shall not exceed the budget limit set;

c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of re-designation; and

d) no permanent employees are appointed without the approval of the Chief Executive or Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and Service Development Strategy.

Capital expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in capital investment, private financing, fixed assets registers and security of assets section) A Project Sponsor will be identified who will assume responsibility for the budget relating to the scheme.

NHSE return

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSE within the specified timescales.

ANNUAL ACCOUNTS AND REPORTS

Annual Accounts

The Foundation Trust shall keep accounts in such form as the NHSE may, with the approval of HM Treasury direct. The accounts are to be audited by the Foundation Trust's External Auditor.

The following documents will be made available to the Comptroller and Auditor General for examination at their request:

- the accounts;
- any records relating to them; and
- any report of the External Auditor on them.

The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer. The Accounting Officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts, in such form as NHSE may, with the approval of the Treasury direct. In preparing its annual accounts, the Accounting Officer shall cause the Foundation Trust to comply with any directions given by NHSE with the approval of the Treasury as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts;

and shall be responsible for the functions of the Foundation Trust as set out in the 2006 Act.

The annual accounts and statement of audit opinion are presented to the Audit Committee and Board of Directors.

The Accounting Officer shall cause the Foundation Trust to:

- lay a copy of the annual accounts, and any report of the External Auditor on them, before Parliament; and
- once it has done so, send copies of those documents to NHS Improvement.

Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

Annual Reports

The Foundation Trust shall prepare an annual report and send to NHSE and lay before Parliament. The reports are to give:

- information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and

- any other information NHSE requires.

The Foundation Trust is to comply with any decision NHSE makes as to:

- the form of the reports;
- when the reports are to be sent to them; and
- the periods to which the reports are to relate.

The External Auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

BANK ACCOUNTS

General

The Chief Finance Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by NHS Improvement.

The Board of Directors shall approve the banking arrangements.

Bank Accounts

The Chief Finance Officer is responsible for:

a) all bank accounts operated under the Government Banking Services initiative and other forms of working capital financing that may be available from the Department of Health;

b) establishing separate bank accounts for the Foundation Trust's charitable funds;

c) ensuring payments made from all bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken);

e) establishing an appropriate committed working capital facility which comply with DH/NHSI guidance on the level of cleared funds.

f) ensuring that committed working capital facility proposals are reviewed and agreed in line with the Scheme of Reservation and Delegation and the Trust's Treasury Management Policy.

All bank accounts should be held in the name of the Foundation Trust. No officer other than the Chief Finance Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

Banking procedures

The Chief Finance Officer will prepare detailed instructions (including bank mandates) on the operation of all bank accounts, which must include:

a) the conditions under which each bank account is to be operated;

b) the limit to be applied to any overdraft; and

c) those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

The Chief Finance Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

The Chief Finance Officer shall approve security procedures, including those arrangements with third party organisations, for any cheques issued without a hand-written signature e.g. electronic signature lithographed. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Income systems

The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

The Chief Finance Officer is also responsible for the prompt banking of all monies received.

Fees and charges other than Foundation Trust Contract.

The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health (such as Payment by Results

National Tariffs), HM Treasury or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's 'Commercial Sponsorship – Ethical Standards for the NHS' shall be followed. See Standing Orders for details.

All employees must ensure that procedures for the charging of income are adhered to.

Private Health Care

The Foundation Trust shall ensure that the proportion of total income of the Trust in any financial year derived from private charges shall not be greater than the percentage set out in Schedule 4 of the Terms of Authorisation.

If the percentage is exceeded, or is expected to be exceeded, NHSE will be notified and an appropriate action plan developed to correct the non-compliance.

Debt recovery

The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

Income not received should be dealt with in accordance with losses procedures.

Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

The Chief Finance Officer is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable. (No form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

Official money shall not under any circumstances be used for the encashment of private cheques, nor for temporary loans.

Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

All cheques, postal orders and cash shall be banked promptly intact under arrangements approved by the Chief Finance Officer.

The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Finance Officer and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this should follow the form of the Foundation Trust's Fraud and

Corruption Response Plan and the guidance provided by the NHSCFA. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Foundation Trust's Losses and Special Payments Procedures.

FOUNDATION TRUST CONTRACTS

Provision of Services

The Board of Directors of the Foundation Trust shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide the mandatory goods and services referred to in the Terms of Authorisation and related Schedules.

Foundation Trust Contracts (see overlap with Foundation Trust Contracts/Healthcare Services arrangements)

The Chief Executive, as the accounting officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTC) with commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and

wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the Performance Assessment Framework contained within the FTC; and
- that FTC builds where appropriate on existing partnership arrangements.

A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the FTC.

Non-Commercial Contract – Including SLAs with other NHS Bodies

Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible officer should ensure that an appropriate non-commercial contract is present and signed by both parties. This legally binding contract shall as a minimum incorporate:

- a description of the service and indicative activity levels;
- the terms, commencement date and length of the agreement;
- the value of service provided and price;
- the payment terms and payment mechanism;
- contract variation procedures;
- the lead officers;
- compliance with Trust policies, procedures and protocols (including employment) as deemed appropriate;
- compliance with applicable standards, regulations and legislation;
- monitoring arrangements and performance review process;
- dispute resolution procedures and processes;
- remedies;
- information sharing and confidentiality;
- risk management and clinical governance agreements;
- liabilities and indemnities;
- legal ownership for any delivered product or material; and
- contract cancellation and termination arrangements.

Non-commercial contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

The Nomination and Remuneration Committee

In accordance with Standing Orders the Board of Directors shall establish the above Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will:

a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other senior employees), including:

   i) all aspects of salary (including any performance-related elements/bonuses);

   ii) provisions for other benefits, including pensions and cars;

   iii) arrangements for termination of employment and other contractual terms;

b) make such recommendations to the Board of Directors on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust - having proper regard to the Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

c) monitor and evaluate the performance of individual Executive Directors (and other senior employees); and

d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

e) scrutiny and approval of all payments that fall outside normal salary remuneration when ceasing employment e.g. MARS schemes, severance payments, redundancy payments, and any related compromise agreements.

The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board of Directors meetings should record such decisions.

The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

The Council of Governors, at the General Meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors.

Funded establishment

The manpower plans incorporated within the operational plan will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive.

The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Chief Finance Officer is responsible for verifying that funding is available.

Staff appointments

No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration; unless

a) authorised to do so by the Chief Executive; and

b) within the limit of their approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

The Board of Directors will approve procedures presented by the Chief Executive for the determination of salary and contractual terms and conditions of all employees.

Processing of the payroll

The Chief People Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances; including verification that the rates of pay and relevant conditions of service are in accordance with current agreements;

c) making payment on agreed dates; and

d) agreeing method of payment.

The Chief People Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee;

h) procedures for payment by cheque, bank credit, or cash to employees;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash; and

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

Appropriately nominated managers have delegated responsibility for:

a) processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;

b) submitting time records, and other notifications in accordance with the agreed timetables;

c) completing time records and other notifications in accordance with the Chief People Officer instructions and in the form prescribed by the Chief People Officer; and

d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Finance Officer.

Regardless of the arrangements for providing the payroll service, the Chief People Officer in conjunction with the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

Contracts of employment

The Board of Directors shall delegate responsibility to a manager for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health & Safety legislation; and

b) dealing with variations to, or termination of, contracts of employment.

NON-PAY EXPENDITURE

Delegation of authority

The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services should be updated and reviewed regularly by Procurement. An annual verification will be undertaken by the Procurement Department

b) where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

c) the maximum level of each requisition and the system for authorisation above that level.

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

The Scheme of Reservation and Delegation contains the delegated financial limits for each manager within the Trust. These financial limits are approved by the Board

Choice, requisitioning, ordering, receipt and payment for goods and services

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust. In so doing, the advice of the Trust's advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer hall be consulted.

The Chief Finance Officer shall be responsible for the payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. and the requirements of the Public Contracts Regulations 2015 or the Procurement Act 2023.

The Chief Finance Officer will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Scheme of Reservation and Delegation and regularly reviewed;

b) prepare procedural instructions where not already provided in the Scheme of Reservation and Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Authorised signatures will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

ii) verification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

iii) a procedure and system for submission of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and

iv) instructions to employees regarding the handling and payment of accounts within the Finance Department; and

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except per section below in relation to prepayments).

It is expected that prepayments are sometimes required for fully comprehensive maintenance contracts, rental and insurance. However, prepayment arrangements for other goods and services are only permitted where exceptional circumstances apply. In such instances:

a) prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate;

b) the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c) the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

d) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Finance Officer;

c) state the Foundation Trust terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a) all contracts other than for a simple purchase permitted within the Scheme of Reservation and Delegation or delegated budget, and other commitments which may result in a liability are notified to the Chief Finance Officer in the form of a written report in advance of any commitment being made that will be approved by the Chief Finance Officer

b) ~~are advertised and awarded in accordance with EU rules on public procurement and subsequent tenders make reference to compliance with all relevant industry quality~~

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHSI, the Chief Executive and Chief Finance Officer; where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; and

   ii) conventional hospitality, such as lunches in the course of working visits (see Gifts and Hospitality Policy); no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

e) all goods, services, or works are ordered on an official order with the exception of purchases from petty cash or on purchasing cards;

f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

h) goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future un-competitive purchase;

i) purchases from petty cash are restricted in value and by type of purchase in accordance with the Scheme of Reservation and Delegation; and

j) petty cash records are maintained in a form as determined by the Chief Finance Officer.

k) Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

Every contract entered into using Procure 21 (P21) tender for building or engineering works will abide by the rules and regulations regarding this procurement route. If the Trust deems appropriate and or in

the best interests of the Trust these documents may be modified and/or amplified to accord with Department of Health Guidance and, in minor respects, to cover special features of individual projects.

Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under the powers of the 2006 Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

EXTERNAL BORROWING AND INVESTMENTS

External Borrowing

The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

The total amount of the Trust's borrowing must be affordable within the use of Resources Rating included within NHSE's Single Oversight Framework.

Any application for a loan or overdraft facility must be approved by the Board and will only be made by the Chief Finance Officer or a person with specific delegated powers from the Chief Finance Officer.

All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

Public Dividend Capital

On authorisation as a Foundation Trust the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team and is subject to approval by the Secretary of State.

The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

Investment

The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

The Foundation Trust may also give financial assistance (whether by way of loan, Guarantee or otherwise) to any person for the purposes of or in connection with its functions.

Investment of Temporary Cash Surpluses

Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors through the Foundation Trust's Treasury Management Policy.

The Audit Committee will review and approve the Treasury Management Policy on a regular basis and seek regular assurances that the policy is being adhered to and remains effective.

The Board of Directors is responsible for establishing and monitoring an appropriate investment strategy.

The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will incorporate guidance from NHSE as appropriate.

CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Capital investment

Chief Finance Officer

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

For capital expenditure proposals the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Reservation and Delegation):

a) that a business case is produced setting out:

   i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

   ii) appropriate project management and control arrangements; and

   iii) the involvement of appropriate Foundation Trust personnel and external agencies; and

b) that the Chief Finance Officer has certified professionally to the capital costs and revenue consequences detailed in the business case.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "CONCODE" and any advice from NHS Improvement.

The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender; and

c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "CONCODE" and guidance in the Foundation Trust's Standing Orders.

The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

Private Finance (see overlap with Private Finance for Capital procurement)

The Foundation Trust should normally test for Private Finance Initiative when considering capital procurement. When the Board of Directors propose, or is required, to use finance provided by the private sector the following should apply.

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) A business case must be referred to the appropriate DOH for approval or treated as per current guidelines (refer to NHSE guidance 'Roles and Responsibilities in the Approval of NHS Foundation Trust PFI Schemes').

(c) The proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to ultra vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Asset registers

Director of Finance and Commercial Development is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the Asset Register to be conducted once a year.

The Foundation Trust shall maintain a Fixed Asset Register recording fixed assets and containing all the details required to account correctly for its fixed assets.

Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

The value of each asset shall be adjusted to current values in accordance with the relevant standards and guidance.

The value of each asset shall be depreciated using methods in accordance with the relevant standards and guidance.

The Chief Finance Officer shall calculate and account for capital charges in accordance with the Foundation Trust Financial Reporting Manual, and other applicable guidance issued by NHSE and HM Treasury.

Protected Property

A register of Protected Property is required to be maintained in accordance with requirements issued by NHS Improvement. The property referred to in Condition 9(1) of the Terms of Authorisation, which is to be protected, is limited to land and buildings owned or leased by the Foundation Trust (assets such as equipment, financial assets, cash or intellectual property will not be regarded as protected assets).

No Protected Property may be disposed of (including disposing of part of it or granting an interest in it) without the approval of NHS Improvement.

This will be achieved through the annual planning process. The annual plan will include proposed changes in the treatment of assets that are protected and proposed disposals and acquisitions.

The Foundation Trust is required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

During the year when the proposed changes are made the Fixed Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

As required by Condition 9 (4) of the Terms of Authorisation the Foundation Trust must make the Fixed Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

Security of assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All significant discrepancies revealed by verification of physical assets to the Fixed Asset Register shall be notified to the Chief Finance Officer.

Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

Where practical, assets should be marked as Foundation Trust property.

STOCK, STORES AND RECEIPT OF GOODS

Stocks

Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store: -

a) controlled stores - specific areas designated for the holding and control of goods;

b) wards & departments - goods required for immediate usage to support operational services; and

c) manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

Such stocks should be kept to a minimum and for;

a) controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stocktake or perpetual inventory procedures; and

b) valued at the lower of cost or net realisable value.

Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee in accordance with the SORD by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel, oil and coal stocks shall be the responsibility of a designated Associate Director of Estates and Facilities.

The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Associate Director of Procurement.

Wherever practicable, stocks should be marked as NHS Foundation Trust property.

The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses. Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

The Head of Financial shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Head of Financial Services shall report to the Chief Finance Officer any

evidence of significant overstocking and of any negligence or malpractice (see also Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Receipt of Goods

A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

For goods supplied via third party distributors, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy them that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for low-value high volume items such as stationery.

Issue of Stocks

The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variations.

All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

ESTATES EMERGENCY ORDERS

To maintain a fully operational site, Estates will, on occasion, be required to undertake emergency repairs which can be within normal operational hours (Monday to Thursday 08:30 – 17:00 and Friday 08:30 – 16:30) or out of hours.

On occasion these will be considered an extraordinary emergency request defined as a requirement to meet an **immediate** need to avoid a regulatory breach and ensure patient, staff and visitor safety. The SFIs determine that orders must be generated for all goods and services (*all goods, services or works are ordered on an official order with the exception of purchases from petty cash or on purchasing cards*). To meet this immediate and urgent need and ensure compliance with SFIs, a change to the SFIs is **proposed** to permit the generation of emergency order numbers that can be provided to the supplier with the requisition raised retrospectively. Use of this process will vary depending upon whether the need arises within normal working hours or out of hours as described below. The financial threshold for emergency requests will be below he capital threshold of £5,000 where the Emergency Capital process will be used.

In-Hours Emergency Requests

- The need is escalated to the Associate Director of Estates and Facilities (or delegated deputy in their absence) to confirm that requirement meets the definition of an extraordinary emergency request that would result in a regulatory breach or risk the health and safety of patients, staff and visitors.
- The Associate Director of Estates and Facilities contacts Procurement confirming that requirement who will then determine if any existing frameworks or current contracts can be utilised to meet the need. It must be noted however, that time would be of the essences and the very nature of the emergency may preclude this.
- In the absence of any contract or framework, Procurement would issue Estates with an emergency order number to provide to the supplier to undertake the work.
- Estates appoint the supplier obtaining an indicative quote for the work and provide the pre-assigned order number to the supplier.
- Supplier completes the work and provides a comprehensive quote within five days of completed of the works.
- Estates submit a retrospective requisition providing full details inclusive of costs of the work undertaken.
- Procurement updates the order and issue a hard copy order to the supplier as a follow-up and against the which the supplier will invoice the Trust within five days of estates providing updated details of works undertaken.

Out of Hours Emergency Requests

Procurement will allocate a maximum of five emergency order numbers to Estates to be used in an out of hour emergency that meets the definition previously described. The process for out of hours is as follows:

- The need is escalated to the Associate Director of Estates and Facilities (or delegated deputy in their absence) to confirm that this meets the definition of an extraordinary emergency request that would result in a regulatory breach or risk the health and safety of patients, staff and visitors.
- The Associate Director of Estates and Facilities assigns a previously allocated emergency order number to the Estates Officer
- Estates liaise directly with known suppliers obtaining an indicative cost for the work to be undertaken.
- Estates appoint the supplier and provide the pre-assigned order number to the supplier.
- Supplier completes the work and provides a compressive quote.
- Estates request an amendment to the order providing full details inclusive of costs of the work undertaken within five days of completed of the works.
- Procurement updates the order and sends the amended order to the supplier within five days of estates providing updated details of works undertaken.

In all circumstances the emergency requests are only for expenditure that fall below the Public Contracts Regulations that the Trust is legally required to comply with. Where the cost exceeds the financial thresholds stated in the SFIs for formal tendering to be undertaken, a retrospective Waiver will be completed and reported to the Audit Committee.

The use of emergency orders will be monitored by the Procurement Team to ensure that they remain within the parameters specified and will be reported to the Finance and Sustainability Committee on a monthly basis.

DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

The Chief Finance Officer must prepare detailed procedures and a Disposals Policy for the disposal of assets including condemnations and ensure that these are notified to managers.

When it is decided to dispose of a Foundation Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate. For protected assets see 'Protected Property' page 36 of these SFIs.

All other material items of unwanted equipment shall be dealt with in accordance with the Disposals and Condemnation of Assets Policy.

All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

b) recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

Losses and special payments

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Finance Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Finance Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially.

Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform their Local Counter Fraud Officer who will inform the relevant CFSMS regional team before any action is taken and reach agreement how the case is to be handled.

For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Chief Finance Officer must immediately notify:

a) the Board of Directors;

b) the External Auditor; and

c) Counter Fraud and Security Management Service (through the Anti-Fraud specialist).

The notifying and approval of losses and special payments is in accordance with the Scheme of Reservation and Delegation. The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

Compensation Claims

The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and the NHS Resolution (NHSR) in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by: -

a) adopting prudent risk management strategies including continuous review;

b) implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants;

c) adopting a systematic approach to claims handling in line with the best current and cost-effective practice;

d) following guidance issued by the NHSR relating to clinical negligence;

e) achieving the Standards for Better Health; and

f) implementing an effective system of Clinical Governance.

The Medical Director and Director of Nursing are responsible for clinical negligence: for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

INFORMATION TECHNOLOGY

Responsibilities and duties of the Chief Finance Officer

The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which they is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990.

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks.

e) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

The Chief Finance Officer shall satisfy them self those new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

The Director of Integrated Governance & Quality shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the region wishes to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Requirement for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall satisfy himself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Chief Finance Officer staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

Risk Assessment

The Chief Finance Officer shall ensure that risks to the Trust arising from the use of Information Technology are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

Disclosure

The Foundation Trust shall disclose to NHSE and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the Terms of Authorisation, Schedule 6. Other information, as requested, shall be provided to NHS Improvement.

PATIENTS' PROPERTY

The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions.

The Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

The Director of Nursing must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money.

A patient's property record, in a form determined by the Chief Nurse shall be completed in respect of the following:

a) property handed in for safe custody by any patient (or guardian as appropriate);

b) property taken into safe custody having been found in the possessions of:

- mentally disordered patients;
- confused and/or disorientated patients;
- unconscious patients;
- patients dying in hospital; and
- patients found dead on arrival at hospital (property removed by police); and

c) A record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

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Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions instructions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions instructions. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Chief Nurse , in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Nursing or delegated finance officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the

property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, in which case the property shall be placed in the secure care of the most senior member of nursing staff on duty.

In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing. (see Patient Property Policy)

FUNDS HELD ON TRUST

General

The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust, the trustee responsibilities must be discharged separately, and full recognition must be given to its dual accountabilities to the Charity Commission.

The reserved powers of the Board of Directors and the Scheme of Reservation and Delegation make clear where decisions for which discretion must be exercised are to be taken and by whom.

As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

The over-riding principle is that the integrity of each Trust must be maintained, and statutory and Trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board of Directors acting as Trustees.

The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds, including an Investment Register.

Existing Charitable Funds

The Chief Finance Officer shall arrange for the administration of all existing funds. A "Deed of Establishment" must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

The Chief Finance Officer shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

The Chief Finance Officer shall ensure that all funds are currently registered with the Charity Commission in accordance with the Charities Acts and the Charity Commission's latest guidance and best practice.

New Charitable Funds

The Chief Finance Officer shall, recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund.

All new funds must be formally approved by the Charitable Funds Committee.

The Deed of Establishment for any new fund shall clearly identify, among other things , the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

Sources of New Funds

All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund-raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

All gifts, donations and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Cash Office (Warrington) / General Office (Halton) to be banked directly to the Charitable Funds Bank Account.

In respect of Donations, the Chief Finance Officer shall: -

a) provide guidelines to officers of the Foundation Trust as to how to proceed when offered funds. These will include: -

   i) the identification of the donor's intentions;

   ii) where possible, the avoidance of creating excessive numbers of funds;

   iii) the avoidance of impossible, undesirable or administratively difficult objects;

   iv) sources of immediate further advice; and

   v) treatment of offers for personal gifts; and

b) provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

In respect of Legacies, the Director of Community Engagement & Fundraising shall be kept informed of and record all enquiries regarding legacies. Where required, the Chief Finance Officer shall: -

a) provide advice covering any approach regarding: -

   i) the wording of wills; and

   ii) the receipt of funds/other assets from executors;

b) after the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Finance Officer who alone shall be empowered to give an executor a good discharge;

c) where necessary, obtain grant of probate, or make application for grant of letters of administration;

d) be empowered to negotiate arrangements regarding the administration of a Will with executors and to discharge them from their duty; and

e) be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies.

The Charitable Funds Committee approve all fund-raising appeals. The Chief Finance Officer shall: -

a) advise on the financial implications of any proposal for fund-raising activities;

b) deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations;

c) be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge;

d) be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and

e) be responsible for the appropriate treatment of all funds received from this source.

In respect of Trading Income the Chief Finance Officer shall: -

a) be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and

b) be primarily responsible for the appropriate treatment of all funds received from this source.

In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

Investment Management

The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Funds Committee shall include: -

a) the formulation of investment policy which meets statutory requirements with regard to income generation and the enhancement of capital value;

b) the appointment of advisers, brokers and, where appropriate, investment fund managers and: -

   i) the Chief Finance Officer shall recommend the terms of such appointments; and for which

   ii) written agreements shall be signed by the Chief Executive;

c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

d) the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;

e) that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;

f) the review of the performance of brokers and fund managers; and

g) the reporting of investment performance.

The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

Expenditure from Charitable Funds

Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee on behalf of the Board of Directors. In so doing the committee shall be aware of the following: -

a) the objects of various funds and the designated objectives;

b) the availability of liquid funds within each Trust;

c) the powers of delegation available to commit resources;

d) the avoidance of the use of trust funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the trust shall be discharged by trust funds at the earliest possible time;

e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and

f) the definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Reservation and Delegation; exceptions are as follows: -

a) any staff salaries/wages costs require Charitable Funds Committee approval; and

b) no funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

Banking Services

The Chief Finance Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each Trust where this is deemed necessary by the Charity Commission.

Asset Management

Assets in the ownership of or used by the Foundation Trust, shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Finance Officer shall ensure: -

a) that appropriate records of all donated assets owned by the Foundation Trust are maintained, and that all assets, at agreed valuations are brought to account;

b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

c) that donated assets received on trust shall be accounted for appropriately; and

d) that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

Reporting

The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, among other things, the receipt of funds, investments and expenditure.

The Chief Finance Officer shall prepare annual accounts in the required manner, which shall be submitted, to the Charitable Funds Committee within agreed timescales.

The Chief Finance Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for review by the Charitable Funds Committee and adoption by the Board of Directors.

Accounting and Audit of Funds held on Trust

The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of the independent reviewer.

Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by the independent reviewer during the year.

The Charitable Funds Committee shall be advised by the Chief Finance Officer on the outcome of the annual independent review.

Taxation and Excise Duty

The Chief Finance Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

TENDERING AND CONTRACT PROCEDURES

Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied).

~~**EU Directives Governing Public Procurement**~~ **Public Procurement Regulations Governing Public Procurement**

~~Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust.~~

The Public Contract Regulation 2015, the Procurement Act 2023 and Provider Selection Regime Regulations, shall have effect as if incorporated in the Standing Orders and Standing Financial

Instructions. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained with the Foundation Trust.

Formal Competitive Tendering

The foundation trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles and

- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the department of health);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

~~where the foundation trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.~~ Where the foundation trust elects to invite tenders for the supply of healthcare the requirements of the Provider Selection Regime shall apply.

Formal tendering procedures are defined as a procurement exercise undertaken within clearly defined timescales, a clear and detailed specification and a pre-determined set of evaluation criteria with all bids submitted on time, fully evaluated by key stakeholders in accordance with these Standing Financial Instructions and The Public Contract Regulations 2015 or the Procurement Act 2023 as applicable and will apply to all expenditure as detailed in the Scheme of Reservation and Delegation.

Formal tendering procedures are not required where:

a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation, (this figure to be reviewed annually); or

b) the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with; or

c) it relates to disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

d) where the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS).

e) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

Formal tendering procedures may be waived in the following circumstances:

f) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Foundation Trust record;

g) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

h) where specialist expertise is required and is available from only one source;

i) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

j) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

k) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Foundation Trust record and reported to the Audit Committee at each meeting.

Fair and Adequate Competition

Where the exceptions set out above apply, the Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three ~~two~~ firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Contracts and Commissions for the NHS Estate

Concode) without prior approval in accordance with the Scheme of Reservation and Delegation.

Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Finance Officer and be recorded in an appropriate Foundation Trust record.

Contracting and Tendering Procedure

Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) it is received electronically by the due date and time specified in the Invitation to Tender (ITT) printed label supplied by the Foundation Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) All tenders will be issued electronically via the eTendering system. All tenders will be locked until the due date at which point, they will be unlocked by a designated officer.-

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Receipt and safe custody of tenders

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall recorded electronically on the eTenering system.

Opening tenders and Register of tenders

(i)As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked via the eTendering system by a designated officer. The date will be recorded electronically recorded on the eTendering system.

(iii) The 'originating' Department will be taken to mean the department sponsoring or commissioning the tender.

(iv) The e contract management system will automatically record and store all the above information for competitive tender invitations despatched electronically.

(v) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order below).

Admissibility

i) If for any reason the option is that tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) the Procurement department will investigate as part of the procurement process and in compliance with EU Regulations. In the event that this cannot be resolved the Procurement Department would make a recommendation to either cancel the process or remove a particular supplier from the process.

(ii) Where only one tender is sought and/or received, the Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer

decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) Contracts will be awarded based on the Most Economically Advantageous Tender (MEAT) that takes into account technical and service capability as well as cost, or the highest, if payment is to be received by the Foundation Trust unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. The % applied to price will vary based upon the goods or services being procured.

~~A standard tender evaluation criterion based on 70% technical and service capability and 30% related to cost (70/30). A requirement that any request to deviate from this 70/30 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change.~~

A standard tender evaluation criterion based on 60% technical and service capability and 40% related to cost (60/40). Where a collaborative procurement is to be undertaken the Trust will comply with the consensus of all Trusts participating in the collaboration. For Trust specific contracts, there is a requirement that any request to deviate from this 60/40 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; and

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

Quotations: Competitive and non-competitive

~~General Position on quotations~~

~~Quotations are required as per the values contained within the Scheme of Reservation and Delegation.~~

~~Competitive Quotations~~

~~(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust.~~

~~(ii) Quotations should be in writing.~~

~~(iii) All quotations should be treated as confidential and should be retained for inspection.~~

~~(iv) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Foundation Trust, or the highest if payment is to be received by the Foundation Trust, then the choice made and the reasons why should be recorded in a permanent record~~

For quotations at a value detailed in the Scheme of Reservation and Delegation a 'light touch' can be applied whereby three written quotations can be obtained based on price where the requirement can be clearly articulated. Where the requirement cannot be clearly articulated sufficient for a price to be provided or that requires other factors to be taken into consideration, a formal tendering process will be undertaken. Quotations should be obtained from at least 3 firms/individuals and

(i) should be in writing and issued and received via the Trusts etendering portal

(ii) should be treated as confidential and retained for inspection.

(iii) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation

(iv) the outcome should be set out in a report and approved in line with the requirements of the Standing Financial Instructions and Scheme of Reservation and Delegation

Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals; and

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii) of this SFI) apply.

Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of the Chief Finance Officer.

Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, any commitments which may result in a liability are notified to the Chief Finance Officer in the form of a written report in advance of any commitment being made that will be approved by the Chief Finance Officer. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives.

(a) The Foundation Trust shall use other external agencies for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

(b) If the Foundation Trust does not use other external agencies where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

Private Finance for capital procurement (see overlap with Capital Investment, Private Finance, Fixed Assets Register, Security of Assets – Private Finance)

The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply.

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate body for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of Directors.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Compliance requirements for all contracts

The Board of Directors may only enter into contracts on behalf of the Foundation Trust within the statutory powers and shall comply with:

(a) The Foundation Trust's Standing Orders and Standing Financial Instructions;

~~(b) EU Directives and other statutory provisions;~~ b) The Public Contract Regulations 2015 or the Procurement Act 2023 or the Provider Selection Regime 2024 as appropriate;

(c) any available guidance on capital investment and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable;

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

(g) In all contracts made by the Foundation Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

Foundation Trust Contracts / Healthcare Services Agreements (see overlap Foundation Trust contracts)

All agreements entered into by the Trust for the receipt of services from, or the provision of services to, NHS and Foundation Trusts shall be reflected in a Contract Agreement. The Contract is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission Service Contracts with Providers of Healthcare.

Disposals (See overlap with Disposal and Condemnations, Insurance, Losses and Special Payments)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) obsolete or condemned articles and stores must be disposed of in accordance with the Disposal Policy

(b) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Reservation and Delegation, this figure to be reviewed on a periodic basis;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(d) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

All groups should work independently of each other and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board of Directors.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

Applicability of SFIs on Tendering and Contracting to funds held in trust

These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's trust funds and private resources.

Business Case Approval

The Chief Finance Officer is responsible for defining the process for how business cases (revenue and capital) are generated, prioritised and approved)

All Officers are required to comply with the policies, procedures and processes established.

ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

The Chief Finance Officer shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is also deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

Refer also to Standing Orders, Standards of Business Conduct and Gifts and Hospitality Policy.

RETENTION OF DOCUMENTS

context

All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

Accountability

The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and / or obsolete services. Under the Public Records Act all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in Department of Health guidance, Records Management Code of Practice.

Types of Record Covered by The Code of Practice

The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held.

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises
- Accident and emergency, birth and all other registers
- Theatre registers and minor operations (and other related) registers
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint-handling)
- X-ray and imaging reports, output and other images
- Photographs, slides and other images
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails
- Computerised records
- Scanned records

- Text messages (both out-going from the NHS and in-coming responses from the patient)

The documents held in archives shall be capable of retrieval by authorised persons.

Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

RISK MANAGEMENT

Programme of Risk Management

The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, which must be approved and monitored by the Board of Directors.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured; and

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

Insurance arrangements

The Board of Directors shall decide if the Foundation Trust will insure through the risk pooling schemes administered by the NHSR or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decide not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

Arrangements to be followed by the Board of Directors in agreeing Insurance cover

(1) Where the Board of Directors decide to use the risk pooling schemes administered by the NHSR the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board of Directors decide not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Standard Areas for Commercial Insurance Cover

(1) Foundation Trusts may enter commercial arrangements for insuring motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use.
(2) Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into.
(3) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Foundation Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHSR. In any case of doubt concerning a Foundation

Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health.

Consideration for Other Areas of Insurance Cover

As a Foundation Trust the Board of Directors need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

(1) Directors' and Officers' Liability – although recognising the cover available through the NHSR, due regard is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover;

(2) property damage – due regard for the provision for underwriting claims;

(3) business interruption resulting from property damage – due regard for the provision to cover for loss of income;

(4) personal accident and travel cover – for those individuals who travel in healthcare vehicles in the course of their business; and

(5) engineering cover – due regard for the provision for the continued use of the assets.

(Use of Standard Operating Procedures recommended giving clear and unambiguous guidance to staff)

Equality impact assessment

1. **This section asks you to consider a few questions relating to your policy, process, procedure or decision.**

Initial screening	Yes	No
1.1. Does your policy affect people (Patients/Workforce/Public)?	☒	☐
1.2. Does the policy affect one or more group of people in a different way to another?	☐	☒
1.3. Does the policy offer opportunity to promote equality?	☒	☐

1.4. Does your policy impact positively, negatively or neutrally on any of the below characteristics/groups?
If yes, please indicate how and which type (positive or negative) in the 'Barriers/Impact' section:
Neutral impact is where there will be no change in actual/potential impact on this protected group.

Initial assessment	Scale	Barriers/impact
Age	neutral	
Disability - learning disabilities/difficulties, physical/hidden disability, sensory impairment and mental health problems	neutral	
Gender reassignment	neutral	
Race	neutral	
Religion or belief	neutral	
Sex	neutral	
Sexual orientation including lesbian, gay and bisexual people	neutral	
Marriage and civil partnership – including same sex relationships	neutral	
Pregnancy and maternity/paternity	neutral	
Carers	neutral	
Social factors - deprivation, homelessness, education etc.	neutral	
Armed forces and military veterans	neutral	

1.5.	Is the impact of the policy likely to be negative?	☐ **Yes**	☒ **No**

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

1.7.	Does your policy support positive action for underrepresented groups.	☐ **Yes** ☐ **No** ☒ **N/A**

If you have answered no and neutral to all of the questions in section 1 then a full Equality Impact Assessment is not required. Where you have answered yes, please move to section 3.

2. Does your policy support the general aims of the Public Sector Equality Duty (Equality Act 2010)?

Yes ☒ **No** ☐	**1.** Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010 **2.** Advance equality of opportunity and remove disadvantages between those who share a protected characteristic and those who do not **3.** Foster good relations between people who share a protected characteristic and those who do not

3. Please assess your proposals analysis equality reference scale:

☐	**High –** This policy shows a **high degree of negative or positive** impact to one or more protected characteristics or one or more general aims of the Equality Act 2010 or Armed Forces Act 2021 (where rationale cannot be justified)
☐	**Medium –** This policy shows a **medium degree of impact** (positive or negative) to one or more protected characteristic.
☐	**Low –** This policy **does not have any impact to any protected characteristic** or general aim of the Equality Act 2010 or Armed Forces Act 2021.

If your analysis has scored **high**, then a full Equality Impact Assessment should be completed (Stage 2). This can be found here. If your analysis has scored **low or medium** when considering the evidence detailed above, then a full Equality Impact Assessment may not be required.

If you require any support, please contact the Equality, Diversity and Inclusion Team at whh.equalityimpactassessments@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/138**			
SUBJECT:	**WHH Membership Strategy 2023-25 proposed extension to 2026**			
DATE OF MEETING:	3 December 2025			
AUTHOR(S):	Emily Kelso, Corporate Governance and Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No** ✓	***N/A*** ✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The WHH Membership Strategy has built on the success of our Working with People and Communities Strategy 2022–2025 and seeks to help us progress as a Foundation Trust that better supports its members and actively recruits new members. The strategy addresses how we plan to communicate and engage with our members and aligns with the overarching Trust Strategy. **Extension to 2026: Rationale and Benefits** In light of the planned integration, it is proposed that this Membership Strategy be extended to cover the period up			

to 2026. There are several key reasons for this extension:

- **Continuity and Stability:** Extending the current strategy will ensure there is no gap in our approach to membership engagement and recruitment during a period of significant organisational change. This is vital to maintain momentum and avoid disruption as the Trust moves through the integration process.
- **Alignment with Integration Timeline:** The integration process is expected to conclude in 2026. Extending the strategy ensures our membership activities remain aligned with the Trust's operational and strategic priorities right up to the point of integration.
- **Consistency for Members:** Our members will benefit from a consistent approach to engagement, communication, and support, which is particularly important during times of change and uncertainty.
- **Evidence of Progress:** Quarterly updates to the Governor Engagement Group (GEG) and Council of Governors have demonstrated steady progress against the three strategic objectives. Maintaining the current objectives into 2026 allows us to build on this progress and continue to deliver meaningful outcomes for our members.
- **Preparation for the Future:** By extending the current strategy, we can focus on delivering our existing commitments while also preparing for the development of a new membership strategy tailored to the needs and ambitions of the newly integrated Trust.

At the point of integration, a new Membership Strategy will be developed and proposed for the integrated organisation, ensuring alignment with the overarching mission, vision, aims and values.

Progress and Objectives

The GEG and Council of Governors continue to receive quarterly updates on the membership strategy, which have shown steady progress against achieving the three objectives. It is proposed that these objectives remain unchanged into 2026:

- **Objective 1: High Quality Information**
  Provision of high-quality information to WHH Members, equipping them with the knowledge they need to understand the offer of membership at WHH and to act as ambassadors for the Trust.
- **Objective 2: Inclusivity**
  Ensuring our membership is reflective of the diverse people and communities we serve, with a particular focus on attracting younger members and those from currently underrepresented groups.
- **Objective 3: Sustainability**
  Taking meaningful steps to promote sustainability in all membership communications and activities.

It is anticipated that extending the WHH Membership

	Strategy to 2026 will provide the necessary continuity and stability as we move towards integration, ensuring our members and governors remain engaged and supported throughout this period of change. We ask the Trust Board to ratify this extension as recommended by the Council of Governors, recognising the value it will bring in maintaining momentum, preparing the ground for a refreshed membership strategy for the new integrated organisation, and ensuring a smooth transition for both governors and members.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to ratify the extension of the membership strategy. This extension aims to ensure continuity and stability as the Trust progresses towards integration and has been recommended by the Council of Governors.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	**COG/25/11/54**	
	Date of meeting	13 November 2025	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Membership strategy

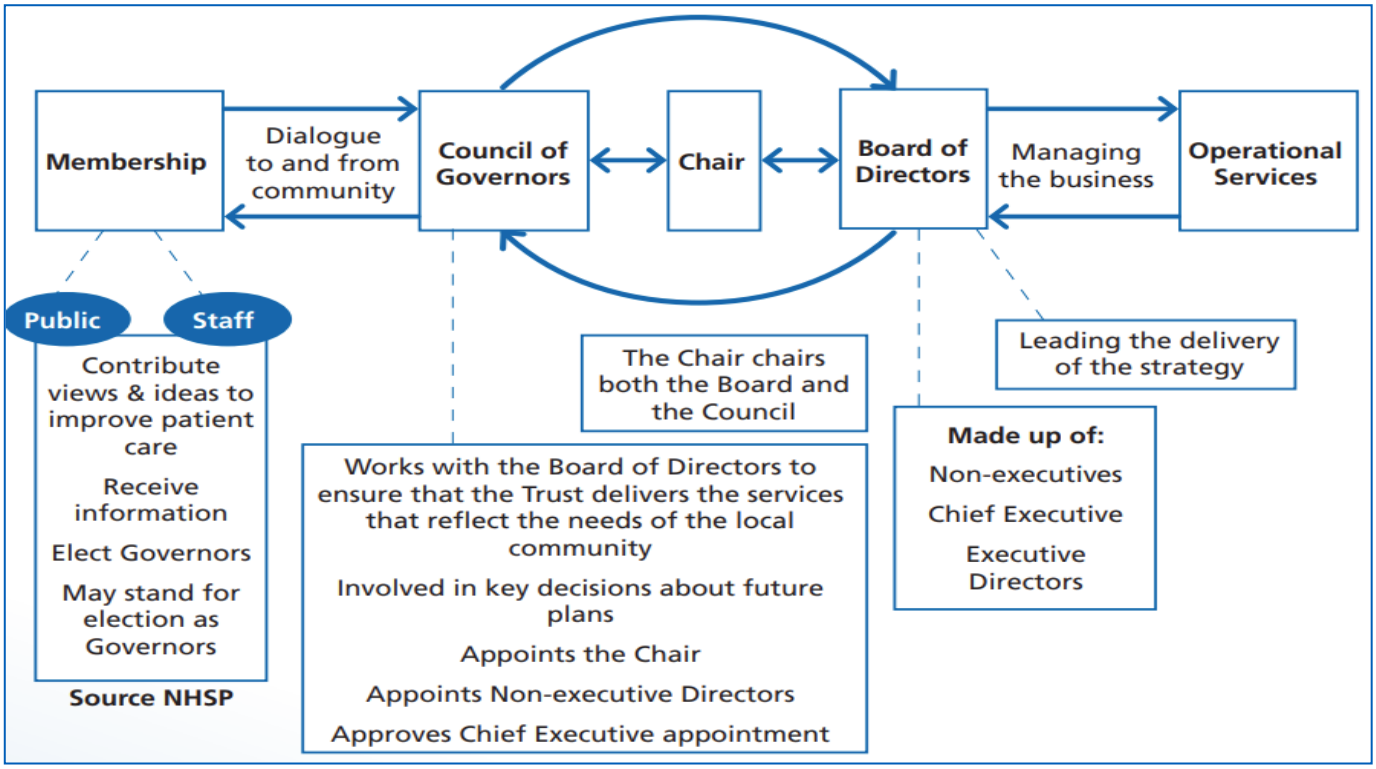
2023 - 2026



Hello and welcome

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) achieved Foundation Trust status in 2008. A Foundation Trust is an NHS organisation which gives greater opportunities for people, patients and staff who have an interest in the Trust to have more of a say about the way in which services are provided. Foundation Trust status is only awarded to hospitals who have shown they demonstrate the highest clinical standards, quality leadership and a great record of patient responsiveness and safety.

As a Foundation Trust WHH is accountable to the local community, the patients it cares for and the people it employs through its membership. By becoming members, local people and our staff can have a say in how services will be designed and delivered, and vote for governors. Our governors perform a vital role in holding non-executive Board members to account for the performance of the Trust. As such an involved, informed, representative and vibrant membership is integral to the anchoring of the Trust to our Integrated Care System (ICS) of Cheshire and Merseyside and delivering the WHH mission to be outstanding for our patients, our communities and each other. This vital link between membership and the Trust is illustrated through the diagram below.



We strive for our membership to reflect the broad and diverse public communities we serve as well as patients, their families and carers, and our staff. CIVICA Engagement Services (CES) is our membership database provider. CIVICA securely hold and manage our public membership data. Members of the public can become a member of WHH by completing an online form https://secure.membra.co.uk/join/warringtonhalton. Staff automatically become a member of the Trust when they are employed.
Members are grouped into the following constituencies:

Public

- Warrington

- Halton
- Rest of England

Staff

- Medical
- Nursing and Midwifery
- Support
- Clinical Scientists or Allied Health Professional
- Estates, Administration & Managerial

This Membership Strategy builds on the success of our 'Working with People and Communities Strategy and seeks to help us progress as a Foundation Trust that better supports its members and actively recruits new members. The strategy will address how we plan to communicate and engage with our members. The strategy also ties in with the overarching Trust strategy, which articulates our Vision to be a great place to receive healthcare, work and learn.

The strategy will seek to address ways to retain active members and recruit new members particularly from underrepresented groups. Most importantly, it aims to show members that their contributions towards the development of the Trust are valued. The Membership Strategy run will from 2023 until 2026 with the following key themes:

- High Quality information
- Inclusivity
- Sustainability

Definitions

NHS – National Health Service
GEG – Governor Engagement Group
CoG – Council of Governors
Constitution – a document that sets out the rules for how the organisation is governed.
Integrated Care System (ICS) – WHH is part of The Cheshire and Merseyside Integrated Care System. Integrated care systems (ICSs) are partnerships that bring together the health and care organisations in a particular local area, to improve population health and healthcare, tackle unequal outcomes and access, enhance productivity and value for money and help the NHS to support broader social and economic development.

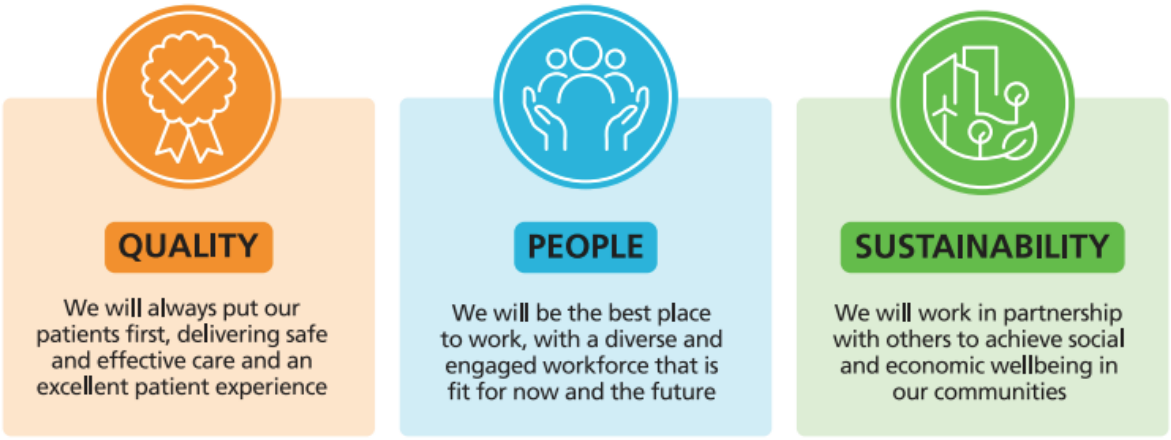
Engagement

The Governor Engagement Group (GEG) is a subcommittee of the Council of Governors at WHH and is chaired by a public governor. It has delegated authority from the Council of Governors to make decisions on behalf of and be accountable to the Council of Governors with regards to ensuring WHH is effectively recruiting and engaging with its membership, reviewing the membership priorities as well as representing the interests of the patients, carers, families and the general public in the areas served by the Trust. The Governor Engagement Group will be consulted on the content of the Membership Strategy, they will be responsible for reviewing it and recommending the strategy for approval by the Council of Governors.

A key element in achieving success is to build on the partnerships we have as well as developing new ones. This includes relationships with internal and external stakeholders, some examples of these stakeholders are: patients and their families; carers; public; staff; Multi-Ethnic Staff Network; PROGRESS Staff Network – supporting the LGBTQIA+ Community; Disability Awareness Staff Network; Armed Forces and Military Veterans Community Staff Network; WHH Charity; Experts by Experience, Warrington & Vale Royal College; Warrington Council; Halton Council; Chester University; volunteers and Warrington Sikh Gurdwara amongst others.

Our partners will help us steer the membership direction so that the priorities can be achieved, it is important that we get people involved and embed the themes into the organisation through the wider Strategic Aims and the 12 Strategic Objectives that sit within 'Our Strategy 2023-26'.

WHH Strategic Aims:



Strategic Objectives

The Membership Strategy will seek to address ways to increase the recruitment and retention of active members ensuring we are not just attracting people to become members but also keeping our current members informed and engaged. Most importantly, it aims to show members that their contributions towards the development of the Trust are valued. The new strategy will run from 2023 until 2026 with the following objectives:

1. **High Quality Information**
   Provision of high-quality Information to WHH Members to provide them with the knowledge they need to understand the offer of membership at WHH and to be ambassadors for the Trust.
2. **Inclusivity**
   Ensure our membership is reflective of the different people and communities, we serve, with a focus on attracting younger members and those from groups that are currently underrepresented.
3. **Sustainability**
   Taking meaningful steps so we can make sure that we are promoting sustainability in all membership communications and activities.

Strategic Objective 1 – High Quality Information				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Educate current and prospective members on the membership offer at WHH. Reinforcing the various ways members can contribute their views, thoughts and ideas to help shape WHH and showcasing what the Trust is doing in response to the feedback received. Keep members and partners updated on developments at WHH plus the activity of the Council of Governors so that we can promote engagement and also attract new members. Retention of active members and recruitment of new members. Development of suitable induction training for newly elected governors & development training for current governors.	Intentional and consistent use of social media channels as well as traditional methods like email to communicate messages. Refining the membership offer and the role of the governors by breaking down the benefits through infographics and videos. Online/hybrid surveys or polls and questionnaires to understand how members feel about the membership. Hosting information events on topics that members tell us are important to them. Performing a database cleanse – to retain active members and identify underrepresented groups, which will then be a target for recruitment activities. The Governor Engagement Group to be involved in the development of agendas for governor induction and development training	Events will be better attended by members. WHH newsletter circulated at least three times per year to those members we have email addresses for. Meaningful and targeted induction and development training programmes for governors.	Number of public and staff members attending Trust events.	Governor Engagement Group All governors Corporate Governance & Membership Manager Head of Communications & Engagement

Strategic Objective 2 – Inclusivity				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Focusing on reaching out to the target groups which are underrepresented such as under 35's, public male members as well as those in ethnic minority groups. Simplifying our communications so that the message is clear and accessible.	Introduce a Member Welcome letter, explaining the benefits of FT Membership at WHH. Refresh the Trust Member Newsletter with a focus on Membership. Partnering with internal stakeholders such as staff networks, patient experience colleagues and so on for joint collaborative work that promotes the membership across teams. Partnering with external stakeholders such as schools, youth groups, colleges, universities, religious centres, and other health related forums to explore areas of joint working. Making communications accessible such as videos and in alternative languages and formats. Target our staff members by ensuring our staff governors are more visible across the Trust.	Increase the understanding of the benefits of FT membership. More frequent circulation of a Trust Member Newsletter – at least three times per year. Posters of governors printed and visible across Trust sites.	An increase in members from the underrepresented groups, this will be measured using the analytic tools available on Civica Engage. Increased governor attendance at community events particularly those with a target audience of underrepresented groups.	Governor Engagement Group All governors Corporate Governance & Membership Manager Head of Communications & Engagement Director of Communications & Engagement

Strategic Objective 3 – Sustainability				
Priorities	**Actions**	**Outcomes**	**Measurements**	**Owner**
Being environmentally conscious in production of our marketing material. Playing an active role in contributions to the sustainability agenda at WHH. Carrying out a database cleanse to Improve the quality of the data we hold for public members, retaining active members only and recruit new members particularly from underrepresented groups.	Cutting back on the use of non-renewable materials and/ or opting for recyclable alternatives in all our print (posters, newsletter, handbooks, leaflets, etc). Using digital communications rather that paper/printed communications materials. Asking members (who we hold postal addresses for only) to opt in to being a member of the Trust and to provide their email addresses, this will be included as part of the governor elections mail outs.	Develop creative and engaging membership communications using email, and social media. Increasing the number of email address we have for public members.	An analysis of email circulations will show that members are reading emails/newsletters for a longer period of time showing increased engagement with our revised communication methods. We will increase the number of email addresses we have for public members.	Governors Engagement Group All governors Corporate Governance & Membership Manager Head of Communications & Engagement

Governance

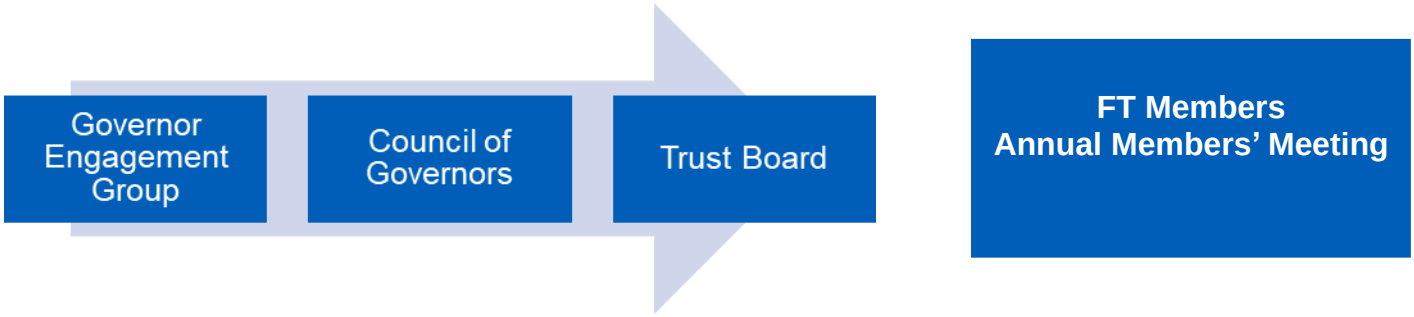
The Governor Engagement Group (GEG) will be responsible for reviewing and supporting the implementation of this strategy to ensure that the objectives are achieved.

The GEG meets on a quarterly basis to review the membership numbers and demographics as well as level of engagement with membership communication materials and events. Through ongoing evaluation of the objectives as set out in the strategy, the GEG is responsible for fulfilling the priorities and reporting on progress into the Council of Governors quarterly at a formal meeting.

As stated within the Trust Constitution, The Council of Governors shall present to the members (at the Annual Members' Meeting):

- a report on steps taken to secure that (taken as a whole) the actual membership of its Public Constituency and of the classes of the Staff Constituency are representative of those eligible for such membership.
- The progress of the Membership Strategy

In addition, the Council of Governors will present:
- a report on steps taken to ensure that the Trust's membership is representative of those eligible for membership.
- any changes to the Membership Strategy



Duties and Responsibilities

Governor Engagement Group – Responsible for reviewing and implementing this strategy to ensure that the priorities are achieved. They are responsible for fulfilling the priorities and reporting on progress into the council quarterly and recommending approval of the Membership Strategy top the Council of Governors.

Council of Governors – Receiving quarterly progress reports against the priorities detailed within the strategy and approving the Membership Strategy.

Governors – Ensuring they are familiar with the Membership Strategy and use the strategy to guide them in their communications with members.

Trust Board – Receiving and ratifying the Membership Strategy.

Lead Governor/Chair of the Governor Engagement Group – Reporting on steps taken to ensure that the Trust's membership is representative of those eligible for membershipand any changes to the Membership Strategy in the Annual Report and at the Annual Members' Meeting.

APPENDIX – Matrix of Enabling Strategies aligned to Trust Quality, People and Sustainability Aims

	Trust Strategic Objectives 2023 - 2026	Objective 1	Objective 2	Objective 3
Quality	**1. Patient safety** We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	☑		
	2. Clinical effectiveness We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	☑		
	3. Patient experience We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	☑		
	4. Research, Development and innovation We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	☑		
People	**5. Looking after our people** We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.		☑	
	6. Innovating the way we work We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.		☑	
	7. Growing our workforce for the future We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.		☑	
	8. Belonging in WHH We will enable staff to have a voice through the development of a just and learning culture.		☑	
Sustainability	**9. Working in partnership** We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.			☑
	10. Working responsibly We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.			☑
	11. Sustainable estate and digitally enabled We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.			☑
	12. Financial sustainability We will develop and deliver financial sustainability plans with our staff, system partners and stakeholders.			☑

Assurance & Monitoring

Approvals Log					
Stage 1		**Stage 2**		**Stage 3**	
Governor Engagement Group (1st Draft)	1 August 2022				
Governor Engagement Group (final)	1 November 2023	Council of Governors	9 November 2023	Trust Board	6 December 2023

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact the Communications Team on 01925 662710

Polish: Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie

Punjabi: ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ

Urdu: یہاشاعتدرخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے

Bengali: এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ

Gujurati: આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મેટમાં ઉપલબ્ધ છે

Arabic: هذا المنشور متاح بلغات أو تنسيقات بديلة عند الطلب

French: Cette publication est disponible dans d'autres langues ou formats sur demande

Cantonese: 本出版物可應要求以其他語言或格式提供

Portugese: Esta publicação está disponível em idiomas ou formatos alternativos a pedido

Spanish: Esta publicación está disponible enidiomas o formatos alternativos bajo petició

Working Together

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Embracing Change

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/139**	
SUBJECT:	**Amendments to the Constitution – Partner Governor Composition**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	**To approve**	
EXECUTIVE DIRECTOR SPONSOR:	Emily Kelso, Corporate Governance and Membership Manager	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*

The Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:

45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and

45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

This report sets out a recommendation to amend the Warrington and Halton Hospitals NHS Foundation Trust Constitution in accordance with Clause 45, which permits

<table>
<tr><td></td><td colspan="3">changes subject to approval by both the Board of Directors and the Council of Governors.

The proposed amendment concerns the reconfiguration of the Trust's Partnership Governor representation. Following the resignation of Rachael Bagshaw, Founder of Walking Mums Cheshire, as a Partnership Governor.

To ensure continued representation from the voluntary sector and to align with the governance structure of Bridgewater Community Healthcare NHS Foundation Trust (BCH), it is recommended that the Walking Mums Cheshire Partnership Governor position be replaced with a Voluntary and Community Sector Representative partner governor. This adjustment will maintain the number of Partnership Governors at five and strengthen collaboration between WHH and BCH, recognising the vital role of the third sector in supporting community health and wellbeing.

The Council of Governors reviewed the amendment at their formal meeting on the 13th November 2025 and are recommending for ratification by the Trust Board.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">As recommended by the council of Governro the Trust Board are asked ratify the amendment to the Trust's Constitution to:
Reallocate the Partnership Governor position currently held by Walking Mums Cheshire to a Voluntary and Community Services Representative.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Council of Governors</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">COG/25/11/61</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">13.11.2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Recommended for approval by the Trust Board, subject to confirmation that the voluntary sector governor role remains independent from the Trust</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Amendments to the Constitution – Partner Governor Composition	AGENDA REF:	BM/25/12/139

1. Background/Context

In regard to amendments to the Trust's Constitution, the current WHH Constitution states:

> *45. Amendment of the constitution*
> *45.1. The Trust may make amendments to its constitution if:*
> *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and*
> *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.*

Once approved the Trust must ensure that the amended Constitution is properly published and made available to the public.

This report outlines the process and justification for the recommendation being made to reallocate the Partnership Governor position currently held by Walking Mums Cheshire to a **Voluntary & Community Sector Representative.**

2. KEY ELEMENTS

2.1 Background

Partnership Governors play a vital role in NHS Foundation Trusts by enhancing governance, accountability, and community engagement. They are typically appointed from key stakeholder organisations—such as local authorities, universities, and community groups—and bring diverse perspectives and expertise to the Trust's Council of Governors.
Their responsibilities include:

- Holding the Trust's Board of Directors to account by scrutinising performance and ensuring decisions reflect the interests of the wider community.
- Acting as a bridge between the Trust and the communities it serves, ensuring local needs and priorities are considered in decision-making.

The Trust's current Partnership Governors represent:

- Warrington Borough Council
- Halton Borough Council
- Warrington & Weaver Vale Colleges
- Warrington Sikh Gurdwara
- Walking Mums Cheshire

In May 2025, the Governor Engagement Group proposed the appointment of **Rachael Bagshaw**, Founder of *Walking Mums Cheshire*, as an additional Partnership Governor. The group, launched in September 2024, connects mothers across Warrington and Cheshire through regular walks and events, promoting mental wellbeing and community support.

3.2 Update on Appointment

Following her appointment, **Rachael Bagshaw** has made the decision to step down from the Partnership Governor role after reflecting on its fit with her group's aims. While the position offered valuable insight, time constraints made it difficult to continue while simultaneously focusing on the rapid growth of Walking Mums Cheshire

3.3 Revised Partner Governor Composition Proposal

Recognising the vital role of the third sector in supporting community health and wellbeing, it is proposed that the number of Partnership Governors remains at five. However, the current representation from *Walking Mums Cheshire* will be replaced with a:
• **Voluntary & Community Sector Representative**

This representative will be appointed from a recognised third-sector organisation operating within the Trust's catchment area. The purpose of this role is to strengthen links between the Trust and local community groups, charities, and voluntary organisations, ensuring that the voice of the wider community is reflected in governance discussions. Importantly, this is **not** a hospital volunteer position; it is a strategic partnership role focused on community engagement and advocacy.

This adjustment aligns the membership structure of the WHH Council of Governors with that of Bridgewater Community Healthcare NHS Foundation Trust (BCH) and creates an opportunity for BCH's Voluntary Services Representative Partnership Governor to join the WHH Council of Governors. This alignment will enhance collaboration between the two organisations both in the lead-up to and following the transaction.

BCH Parter Governor Composition:

Appointed and Partnership Governors	
Partnership organisation	**Number of Appointed Governors**
Two representatives from statutory borough-based partner organisations (such as councils, Healthwatch or other statutory organisations). This will be reviewed and confirmed on an annual basis by the Chair and Lead Governor.	2
Voluntary Services Representative	1
Higher Education Institution	1
Total	**4**

4 Recommendation

As recommended by the council of Governro the Trust Board are asked to ratify the amendment to the Trust's Constitution to:

- Reallocate the Partnership Governor position currently held by Walking Mums Cheshire to a **Voluntary and Community Services Representative**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/140 – BM/25/12/143**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	3 December 2025	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive	
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			
Further Information: ***Each paper is individually marked from September 2023***			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			
3. Foster good relations between people who share a protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			

EXECUTIVE SUMMARY *(KEY ISSUES):*	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 3 December 2025. No actions are required from the Trust Board they are provided for information only. The papers provided are: • **BM/25/12/140 -** Patient Experience 6 Monthly Report – Patient Experience Sub-committee (PESC) - Includes In-Patient Survey • **BM/25/12/141 -** Learning From Experience Summary

	Report Q2 • **BM/25/12/142** - DIPC Q2 Report • **BM/25/12/143** - Guardian of Safe Working Report Q2		
PURPOSE: ***(please select as appropriate)***	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees as detailed ion papers	
	Agenda Ref.	As detailed on papers	
	Date of meeting	As noted on papers	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/12/141**
SUBJECT:	**Learning from Experience (LFE) Quarter 2 2025/26**
DATE OF MEETING:	Tuesday 11 November 2025
ACTION REQUIRED:	The members of the Trust Board are asked to note the contents of this paper.
AUTHOR(S):	Nicola Edmondson, Associate Director of Governance, with input from Care Group and Corporate Leads.
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse
LINK TO STRATEGIC OBJECTIVE	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience ✓ **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future ✓ **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(Please DELETE as appropriate)**	• 224 If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department. • 1215 If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. • 134 If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton • 2001 If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. • 1114 If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption

	of clinical and non-clinical services and a potential failure to meet statutory obligations. • 1372 If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety • 2273 If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances • 115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care • 1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff • 1757 If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care. • 2253 If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful	**Yes**	**No**	**N/A**

	discrimination, harassment and victimisation, and other prohibited conduct	✓	✓	✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓	✓	✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓	✓	✓
	Further Information:			
EXECUTIVE SUMMARY:	The Learning from Experience Report Quarter 2 2025/26 provides assurance that effective learning from experience is taking place across the organisation. The content of this report reflects data available at the time of reporting from the Datix Risk Management System and other relevant governance sources. The report covers the period from 01 July 2025 to 30 September 2025, with reference to the previous quarter where appropriate. It includes both quantitative and qualitative analysis, with triangulation of data to demonstrate how learning is being embedded across the organisation. This supports the ongoing development of knowledge, skills and behaviours that contribute to improved patient care and a capable, responsive workforce. Areas covered will include: • Incidents • Complaints • Claims • Health and Safety • Clinical Audit • Inquests • Quality Improvement • Research • Compliance and Patient Experience The report identifies key highlights including **Incident Reporting**: • 3,552 incidents reported in Q2 (↑19.3% from Q1: 2,977). • Harm Profile: 63 moderate harm, 8 severe harm, and 1 fatal incident across all CBUs. **Learning Themes**:			

- **Urgent & Emergency Care**: delayed paediatric treatment, missed diagnosis post-discharge, and oxygen transfer safety. Actions implemented include SOP reinforcement, staff training, and escalation protocols.
- **Women's & Children's**: 21 moderate harm incidents; focus on Obstetric Anal Sphincter Injury (OASI) prevention, Post partum Haemorrhage (PPH) management, and reducing term neonatal admissions. Mandatory training and QI initiatives underway.
- **Clinical Support Services**: Delay in imaging and reporting addressed through escalation guidance, SOP development, and capacity management.
- **Medical Care & IMC**: Mixed-sex accommodation breaches, falls prevention, and IPC compliance remain priorities with targeted training and monitoring.
- **Surgical Specialties**: Issues with continuity of care and appointment management addressed through governance reviews and process improvements.

Complaints & PALS:

- **Complaints**: 109 received (↑23.9%); clinical treatment remains the top theme.
- **PALS**: 534 concerns received (↓5.1%); top themes include clinical treatment and appointment delays.

I**nquests**

At the time of reporting on 06 October 2025, there were 33 Coroners Inquests open. Of these, 1 has a linked complaint and 1 has a linked PALS concern, a meeting has been agreed with the ED Matron to avoid it being formalised as a complaint. There are no inquests linked to a PSII

Examples of Improvements noted

- Improvements in CD audits following assigned a named Pharmacist or Pharmacy Technician responsible for conducting monthly expiry date checks at the end of each month
- A 21.95% (N=9) decrease in medication incidents noted in Surgical Specialties compared to Q1
- Antisocial, Abusive and Violent Behaviour incidents reduced by 11 incidents (11.96%) compared to the previous quarter.
- There were 100 complaints closed in Q2 which is an increase of 35 complaints (53.85%) compared to Q1 where 65 complaints were closed.
- No Clostridium Difficille incidents were reported in October 2025.

<table>
<tr><td></td><td colspan="3">The paper also notes the release of Learning from Patient Safety Events (LFPSE) Taxonomy Version 6 was originally scheduled for summer 2025. However, implementation nationally has been delayed due to system-related issues. A confirmed upgrade date is currently awaited from Datix.
The report demonstrates that learning is being captured, acted upon, and embedded across the organisation</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 members of the Board of Directors are asked to note the contents of this paper.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QAC/25/11/190</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11 November 2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">noted</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>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Section 41 – confidentiality</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Learning from Experience, Quarter 2 2025/26	AGENDA REF:	BM/25/12/141

1. LEARNING OVERVIEW

The purpose of this report is to provide assurance to the Trust Board that Warrington and Halton Hospitals NHS Foundation Trust (WHH) is effectively managing key governance areas including incidents, complaints, claims, health and safety, clinical audit, inquests, quality improvement, research, compliance and patient experience. It also aims to demonstrate the Trusts ongoing commitment to learning and improvement in order to minimise risks to patients, staff and the organisation.

The Learning from Experience Report Quarter 2 (Q2) 2025/26 presents findings from data reviewed between 01 July 2025 and 30 September 2025, with comparisons to Quarter 1 (Q1) 2025/26 where relevant. The report includes both quantitative and qualitative data analysis, drawing on data from the Datix Risk Management System and other relevant governance sources. This triangulated approach supports the identification of learning across the key workstreams listed above.

The report summarises emerging themes, trends and key findings, and outlines the actions taken to support sustained improvement across WHH.

Key Highlights

- **Incident Reporting**:
    - 3,552 incidents reported in Q2 (↑19.3% from Q1: 2,977).
    - Harm Profile: 63 moderate harm, 8 severe harm, and 1 fatal incident across all CBUs.
    - Increase reflects strengthened reporting culture and proactive risk identification.

- **Significant Learning Themes**:
    - **Urgent & Emergency Care**: Cases included delayed paediatric treatment, missed diagnosis post-discharge, and oxygen transfer safety. Actions implemented include SOP reinforcement, staff training, and escalation protocols.
    - **Women's & Children's**: 21 moderate harm incidents; focus on OASI prevention, PPH management, and reducing term neonatal admissions. Mandatory training and QI initiatives underway.
    - **Clinical Support Services**: Delay in imaging and reporting addressed through escalation guidance, SOP development, and capacity management.
    - **Medical Care & IMC**: Mixed-sex accommodation breaches, falls prevention, and IPC compliance remain priorities with targeted training and monitoring.

- **Surgical Specialties**: Issues with continuity of care and appointment management addressed through governance reviews and process improvements.

- **Complaints & PALS**:
  - **Complaints**: 109 received (↑23.9%); clinical treatment remains the top theme.
  - **PALS**: 534 concerns received (↓5.1%); top themes include clinical treatment and appointment delays.
  - Learning disseminated via Single Point Lessons and governance forums.

- **Claims & Inquests**:
  - **Clinical Claims**: 39 received (↑34.5%); damages paid £432,961.80 across three cases.
  - **Inquests**: 14 opened (↓22.2%); learning focused on palliative care, oxygen transfer safety, and documentation standards.

- **Quality Improvement & Compliance**:
  - Two QI projects completed with measurable impact (frailty screening and pulmonary rehab risk management).
  - 100% completion of initial self-assessments under the CQC Single Assessment Framework; compliance oversight strengthened through weekly summits and QCOG monitoring.

- **Training & Culture**:
  - Patient Safety training compliance >98%; PSIRF policy endorsed subject to minor amendments.
  - Enhanced engagement with patients and families in learning processes; Datix improvements implemented to support thematic analysis.

Assurance Position
The report demonstrates that learning is being captured, acted upon, and embedded across the organisation. Key risks remain linked to capacity pressures, documentation standards, and timely escalation, all of which are subject to active monitoring and improvement plans.

2. RECOMMENDATIONS

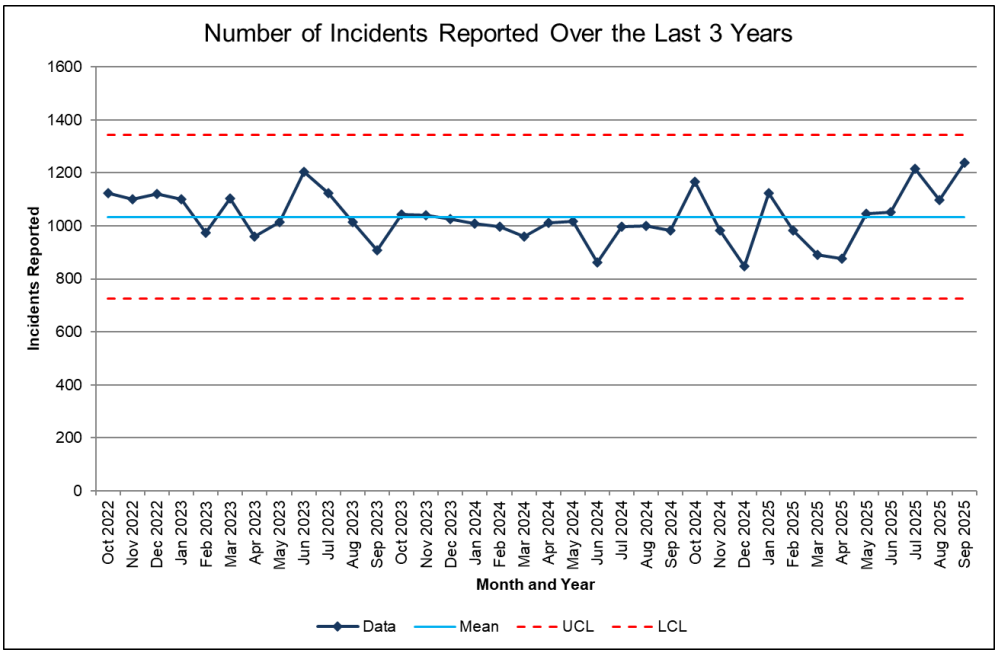
The members of Trust Board of Directors are asked to note the contents of the report.

1. APPENDIX 1 LEARNING FROM INCIDENTS

2.1 Incident Reporting Position

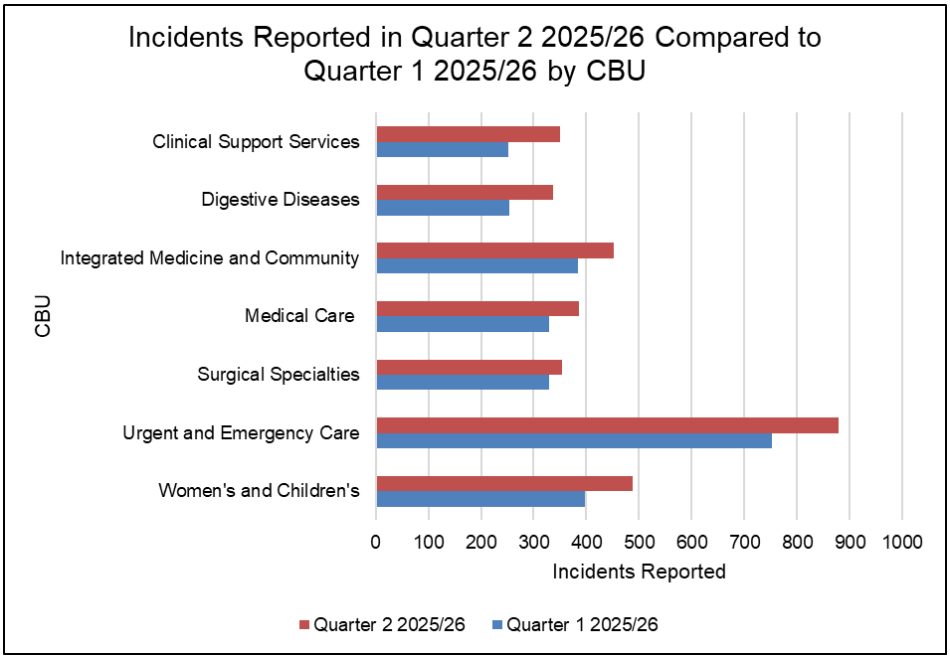
Incident reporting across WHH remains within expected normal variation, with a shift above the mean in incidents reported observed in Q2 compared to the previous 12 months. In Q2, a total of 3552 incidents were reported. This is an increase of 575 incidents (19.31%) compared to Q1 where 2977 incidents were reported. This upward shift will continue to be monitored to determine whether if reflects an emerging trend.

Graph 1



In Q2, 3242 incidents were reported across the CBUs and the Care Group, Clinical Support Services. The remaining 310 incidents were reported under Corporate Support Services (197), External Site/Organisation (111) and Trustwide (2). Estates and Facilities made up the majority of the Corporate Support Services incidents with 161 (81.73%) incidents reported. This was followed by Digital Services (15, 7.61%).

Graph 2



All CBUs had an increase in incidents reported during Q2 compared to Q1. The most significant percentage increase was observed within Clinical Support Services Care Group, which recorded a 38.89% increase (98 incidents). It is important to note that Clinical Support Services is categorised as a Care Group rather than a CBU; therefore, its increase cannot be directly compared to the CBUs. Digestive Diseases had a 32.81% increase (83 incidents) and Women's and Children's with a 22.67% increase (90 incidents). The below table shows a breakdown of incidents reported under Clinical Support Services between Q2 and Q1 by severity.

Severity	Q2	Q1
No Harm	264	184
Low Harm	76	66
Moderate Harm	9	2
Severe Harm	1	0
Fatal	0	0

2.1.1 Clinical Support Services Learning

There were 350 incidents reported in Q2 compared to 252 in Q1. This is an increase of 98 incidents (38.89%). All areas of incidents, patients, staff, organisation and contractor/visitor, had an increase in incidents reported with patient incidents increasing by 72 incidents (35.29%). There was 1 severe harm incident and 9 moderate harm incidents reported in Q2. The top 3 reported themes in Q2 were the same as Q1: Diagnostic Imaging Issues (63, 18%), Medication (60, 17.14%) and Treatment and Procedure (44, 12.57%).

The severe harm incident related to an 83-year-old patient who presented with a sudden onset of back pain radiating to the groin, unrelieved by IV morphine. Given the clinical presentation, there was a concern for potential abdominal aortic aneurysm, ischaemic bowel, or renal stones.

An urgent CT scan was requested by the ED clinician to exclude these conditions. However, the Radiology Hub advised that the scan was not required overnight, as the patient's

observations were within normal limits, and requested that the team await blood results before proceeding. The CT scan was performed the following morning at 10:15, after which the patient was taken directly to emergency theatre for bowel surgery.

The incident has been discussed at the Executive Led Safety Oversight meeting (SOM) – for initial overview and a multidisciplinary review has been undertaken.

Issues identified:

- Delay in imaging due to differing clinical opinions between the referring team and the Radiology Hub.
- Lack of real-time monitoring and overnight reassessment of patient observations, which may have provided further clinical evidence to expedite imaging.
- Inadequate documentation of escalation discussions, including the timing and details of reviews.
- Missed opportunity for direct consultant-to-consultant discussion when disagreement arose about the need for urgent imaging.

Learning

- **Escalation:** If a referrer disagrees with a Radiology decision, they should escalate by contacting the Consultant Radiologist on call for direct discussion.
- **Documentation standards:** Accurate and timely documentation of all escalation discussions and clinical reviews is essential.
- **Ongoing patient assessment** is critical; any change or persistence of severe pain should trigger re-evaluation and escalation regardless of initial findings.
- **Interdepartmental communication**: Clear, timely communication between ED, Radiology, and Surgical teams is essential to avoid delays.

Actions Taken

- **Incident Shared:** The ED Matron has shared the incident and learning points with the wider Emergency Department (ED) team, highlighting missed opportunities for real-time observation and reassessment.
- **Governance presentation:** The Surgical Governance Lead will present the case summary at the next Surgical Governance Meeting to reinforce the importance of documenting escalation decisions and accurate review timings.
- **Spot checks:** Ad hoc reviews of surgical team documentation to monitor compliance with documentation standards.
- **Communication:** The ED Clinical Lead has communicated the learning via governance email and daily safety huddles to promote shared understanding amongst ED clinicians.
- The finalised MDT report will be added to the agenda for the next ED Governance Meeting to support cross-departmental learning.

Learning Example – Delay in Diagnosis of Cancer

An incident was reported due to a delay in issuing a radiology report for a patient who was subsequently diagnosed with pancreatic cancer. The patient attended for a CT scan of the chest, abdomen and pelvis (CAP) on 18 June 2025, following a routine request from their GP. The scan was allocated for reporting on 31 July 2025 as part of a waiting list initiative (WLI) and the report was verified on 12 August 2025, following a patient enquiry regarding the results. The expected reported turnaround time for reporting examinations of this type is four weeks. In this case, the report was delayed by approximately 4-5 weeks.

The delay in this case was attributed to two key factors:

- Ongoing capacity challenges within the Radiology Department, which continue to impact on timely reporting capacity and results issuance.
- A further delay post -allocation, where the examination was not reported promptly after being assigned to a Radiologist, resulting in an additional delay of approximately two weeks.

Learning and Actions identified:

- The Trust acknowledges the current reporting capacity challenges within Radiology. These are being actively managed using Waiting List Initiative (WLI) sessions and 'outsourcing' of selected reporting tasks.
- Key learning from this incident is the need to ensure that scans allocated under WLI are reported within 3 working days.
- If a Radiologist is unable to complete the report within this timeframe, they must notify the Radiology Clerical Services Manager to facilitate reallocation of the examination.
- This learning will be shared at the next Radiology Specialty Governance meeting, to reinforce expectations and improve compliance with reporting timelines.
- If a Radiologist is unable to complete the report within this timeframe, they must notify the Radiology Clerical Services Manager to facilitate reallocation of the examination.
- This learning is scheduled to be shared at the Radiology Specialty Governance Meeting in November, to reinforce expectations and improve compliance with reporting timelines.
- The outstanding examinations and associated improvement actions will be subject to weekly review and monitoring.
- A review of the current process for ensuring all applicable examinations receive a report will be undertaken. As part of this, a Standard Operating Procedure (SOP) will be developed to ensure a robust safety netting mechanism. This SOP is scheduled for completion by the end of Q3.

Medication Error learning.

The Q1 LFE report outlined actions taken in response to multiple incidents and findings from controlled drug audits, which highlighted delays in the removal of expired controlled drugs (CDs) from ward and department-controlled drug cupboards. In response, all wards and departments have now been assigned a named Pharmacist or Pharmacy Technician responsible for conducting monthly expiry date checks at the end of each month. Expired or expiring stock is removed as part of this process. Compliance is monitored by the Pharmacy Leadership Team. In Q2 only one incident involving CDs was reported. The CD audit conducted at the end of Q1 identified just one area with expired stock, indicating early signs of improvement, when compared to audit results from Q1 24/25 which found eight areas had expired stock in the CD cupboard. The next round of CD audits is scheduled for the coming month and will provide further insight into whether this improvement has been sustained.

In Q2, an incident was reported involving the supply of phenobarbital mixture to Ward B11 with only one day remaining before its expiry. Phenobarbital, primarily used in the paediatric unit as an anticonvulsant, is classified as a critical medicine.

Upon investigation, it was identified that all available stock of this medicine within Pharmacy had the same expiry date, resulting in a temporary period during which the medicine was unavailable. No patients required dosing during this time, and no patient harm occurred.

Learning and actions taken to mitigate recurrence:

- The automated stock ordering system has been amended to trigger a reorder from wholesalers upon issue of a bottle. This aims to reduce the likelihood of holding stock from a single batch with the same expiry date.
- Due to the 10-day lead time for this product, a monthly expiry date check has been implemented to check Pharmacy stock. If stock is due to expire within the month, a new order will be placed manually to ensure continuity of supply.
- As a controlled drug, phenobarbital is covered by the monthly ward stock checks introduced following the Q1 incident described above. This process enables the Pharmacy Team to identify short-dated stock on wards and ensure that ward staff place timely orders for replacement stock.

Learning Example – Information Governance in Radiology

An incident was reported in which a carer opened a breast screening appointment letter for and discovered an additional letter intended for a different patient enclosed in the same envelope.

Standard breast screening appointments are issued via Synertec. However, for patients with additional needs, two letters are sent manually 'in house'. This process involves printing a standard appointment letter from the NHS Breast Screening System (NBSS), alongside an easy read letter and information leaflet produced as word documents. These are then assembled and dispatched by the screening clerks.

In this case, one staff member inserted the standard letter and the information leaflets into the envelopes, while a second member of staff subsequently added the easy read letters. This manual process led to the inclusion of an incorrect letter for another patient.

The error was identified promptly, and neither patient's appointment was affected.

Learning and action taken:

- To mitigate the risk of recurrence, the process has been revised. A single staff member will now be responsible for placing both letters into the envelope, with a second member conducting a verification check. It is anticipated that these changes will eliminate similar incidents going forward.

2.1.2 Digestive Diseases Learning

There were 337 incidents reported in Q2 compared to 253 in Q1. This is an increase of 84 incidents (33.2%). The top 3 reported themes in Q2 were Access, Transfer and Discharge (40, 11.87%), Medication (37, 10.98%) and Equipment/Medical Devices (25, 7.42%). Most incidents reported in Q2 were no harm (269, 79.82%), with 43 (12.76%) low harm and 4 (1.19%) moderate harm incidents reported. There were no Patient Safety Incident Investigations (PSIIs) declared.

Access, Transfer and Discharge was the most frequently reported incident theme in Q2. Most of these incident reports reflect positively on staff and departmental responsiveness, highlighting effective recognition and escalation of patients who presented to outpatient

facilities, while clinically unwell or deteriorating. In such cases, appropriate transfers from Halton or CSTM to Warrington Hospital were initiated, with timely interventions implemented.

Key Learning and Service Improvements:

A recurring theme involved Urology patients being listed at CSTM or patients listed for B4, where overnight stays were required. This issue has now been addressed: Ward B4 is equipped to provide overnight care, and plans are in place to relocate Urology lists to Halton following the opening of the new Theatre in October 2025. Improvements will be monitored through an expected reduction in overnight stays for none Post Anaesthesia Care Unit (PACU) patients at CSTM.

Several patients required unplanned admission to the Post-Anaesthetic Care Unit (PACU). This facility, serves as a contingency to support slightly more complex patients to be listed, enabling safe postoperative care when needed.

The Programmed Investigation Unit (PIU), Preoperative Treatment Centre and Endoscopy Centre at Halton have all reported instances of patients attending while unwell. In each case, staff identified the clinical concerns promptly, escalated appropriately, and followed the relevant policies to ensure safe transfer to the acute site at Warrington.

Two incidents were reported within Same Day Emergency Care (SDEC) relating to delays in surgical review and SDEC coding. In response, the Digestive Diseases have has revised the allocation of roles and responsibilities within the junior surgical team, ensuring that a designated team member is now assigned to SDEC in an aim to mitigate future delays. It is anticipated that there will now be a reduction in delays relating to coding being flagged during bed meetings. Additionally, a decrease in incidents being reported through Datix is expected.

Medication was the second most frequently reported incident theme in Q2, with a total of 37 incidents recorded. A review of the data identified a consistent pattern of inaccurate prescribing, involving three key drug types:

- Paracetamol
- Opiates
- Thrombolytic prophylaxis.

While each incident was investigated at the time of occurrence, these prescribing trends have highlighted the need for targeted learning. To support this, the themes were discussed at the Digestive Diseases Speciality Governance Meetings in October, with an aim of facilitating education and improvement.

Learning Example

In Q2 a complaint was received and subsequently escalated to an incident following clinical review. This incident involved a patient who presented with abdominal pain after undergoing a colonoscopy. A CT scan revealed a splenic haematoma and concern regarding bleeding from splenic vessels. The patient required surgical intervention and underwent a laparotomy.

Multi-Disciplinary Team Review (MDT) and Learning:

A key area of learning identified during the MDT review was related to the consent process. Specifically, the consent form used did not include the potential risk of injury to internal organs. This prompted a wider discussion with the Consultant Respiratory Physician, Trust

wide Cancer and Lung Cancer Lead, and the Associate Medical Director for Clinical Effectiveness regarding the legal and ethical standards for informed consent.

The discussion referenced the Montgomery v Lanarkshire Health Board (2015) ruling, which established a patient-centred standard for informed consent. Under the Montgomery law, clinicians are required to inform patients of all risks that a reasonable person would consider significant, and to provide clear, understandable information to support shared decision-making.
In this case, the patient was deemed to have full capacity throughout. The issue was not the patient's ability to consent, but whether the rare but significant risk of internal organ injury should have been explicitly communicated during the consent process.

Action Taken:

- An action has been agreed to assess the feasibility of introducing pre-printed consent forms that include all relevant and significant risks associated with procedures. This would support consistency and completeness in the consent process across the Trust

2.1.3 Surgical Specialties Learning

There were 353 incidents reported in Q2 compared to 329 in Q1. This is an increase of 24 incidents (7.29%). The incidents were categorised into 25 themes, with 13 themes showing an increase in the number of incidents reported compared to Q1. This indicates that the increase in incident reporting within Surgical Specialties was distributed across multiple themes, not subject to one theme. There were 22 moderate harm, 1 severe harm and 1 fatal incident reported in Q2.

The fatal harm incident was reported retrospectively in Q2 by the Medical Examiner following a review of a patient's death. The review raised concerns regarding the management of an Ear, Nose and Throat (ENT) patient who presented with a neck lump abscess. While the abscess was appropriately drained and sent for histological analysis, there was a significant delay in both the receipt of the histology result, and its communication to the patient. This delay contributed to a postponed escalation through appropriate clinical channels, which adversely impacted the timeliness of further investigation and management.

A multidisciplinary meeting has been scheduled to review the incident. The meeting will involve relevant stakeholders to review the circumstances surrounding the event, discuss contributing factors, learning and agree on actions to improve patient safety and service delivery. An update on learning and improvement will be provided in the Q3 report.

The severe harm incident was reported in Q2 involving a potential delay in post operative wound management. The patient underwent surgery performed by a Locum Consultant, who was not retained to complete post-operative ward rounds. This resulted in a disruption to continuity of care, and a delay in timely wound assessment, which ultimately contributed to patient harm.

This incident highlights the critical importance of ensuring continuity of post-operative care, particularly when Locum staff are involved. Clear handover protocols and robust staffing arrangements are essential to safeguard patient outcomes and prevent avoidable harm. A business case is in development to enable allocation of additional hours to existing Consultants.

Access, Transfer and Discharge incidents was the most frequently reported incident theme in Q2, accounting for 59 incidents reported (16.71%). These incidents reflect the complexities associated with managing patient flow across multiple sites and services.

A recurring theme identified relates to the transfer of deteriorating patients from Ward B2 at Halton Hospital to Warrington Hospital. These transfers are typically necessitated by the need for:

- Higher acuity care
- Specialist clinical input
- Access to advanced diagnostics and treatment options not available at the originating site.

In Q2, there were 40 (11.33%) incidents reported under the theme appointment issues. Of these:

- 2 incidents were reported as moderate harm
- 5 incidents as low harm
- 33 as incidents as no harm.

The moderate harm incidents were associated with patients presenting to the Virtual Fracture Clinic who subsequently required follow-up appointments in the Face-to-Face Fracture Clinic. Delays or omissions in arranging these follow-ups contributed to the harm classification, highlighting the need for robust tracking and escalation processes within the virtual care pathway.

The low harm incidents primarily involved:

- Appointment cancellations
- Incorrect appointment details being sent to patients
- Patients being lost to follow ups or experiencing delays in receiving appointments.

While these incidents did not result in significant clinical impact, they may have contributed to delays in care and patient experience.
These incidents were reviewed during CBU Governance Meetings, where key themes were identified. Discussions emphasised the importance of:

- Implementing robust appointment management systems
- Ensuring clear and consistent communication with patients
- Strengthening timely follow-up processes to support safe and effective care delivery

Capacity is a contributory cause and is currently under review by the Clinical Director (CD).

There were 32 (9.07%) Medication incidents reported in Q2, a decrease of 9 incidents (21.95%) compared to Q1. Of the Q2 incidents, there were 2 low harm incidents reported and the remaining 30 were all no harm incidents.

Learning Example-Medication:

A low harm incident was reported in Q2 involving a patient who was transferred between wards while receiving a potentially unsafe dosage of opiates. Although no significant harm occurred, the situation posed a risk to patient safety and required prompt clinical intervention.

This incident highlights the importance of thorough medication reconciliation during patient transfers, particularly with high-risk medications such as opiates. Ensuring accurate prescribing and continuity of analgesia is critical to preventing avoidable harm.

Actions and Learning:

- Following identification of the safety concern, the clinical team liaised promptly with the Pain Team to review the patient's analgesia regime
- A safe and appropriate management plan was agreed to ensure effective pain control while mitigating further risk.
- A review of the handover processes has been undertaken, with a change in practice implemented involving prescription checking. There have been no further incidents reported since the change was implemented.

2.1.4 Women's and Children's Learning

In Q2, there was an increase in patient safety incidents reported in Women's and Children's, following a reduction in reporting during Q1. This trend was also reflected in Maternity specific incidents. Importantly no severe or fatal incidents were reported in Q2. However, 21 moderate harm incidents were reported. The moderate harm incidents were as follows:

- 4 cooling babies. All have had Initial Safety Reviews completed to identify any immediate safety concerns.
  - 1 baby born in poor condition (shoulder dystocia following forceps birth). The incident was reported to and accepted for investigation by Maternity and Newborn Safety Investigations (MNSI).
  - 1 baby born in poor condition (shoulder dystocia following normal birth). The incident was reported to and accepted for investigation by MNSI.
  - 1 baby born in poor condition in the birthing pool on the NEST. The incident was reported to and accepted for investigation by MNSI.
  - 1 baby born in poor condition following emergency caesarean section. The incident did not meet the criteria for MNSI (<37/40). Initial Safety Review completed, progressing to an MDT Review.

- 2 women were admitted to the Intensive Care Unit (ICU). Both of these incidents had Initial Safety Reviews completed to identify any immediate safety concerns.
  - 1 (28/40) patient with preeclampsia requiring inotropic support following a category 2 caesarean section. Good care event reported and documented; the case was well managed.
  - 1 (27/40) The patient experienced a varicella pneumonia intrauterine death (IUD) and emergency caesarean section. The case was reported to Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) for Perinatal Mortality Review Tool (PMRT). Good care well managed.

- 1 hospital associated/preventable deep vein thrombosis (DVT).

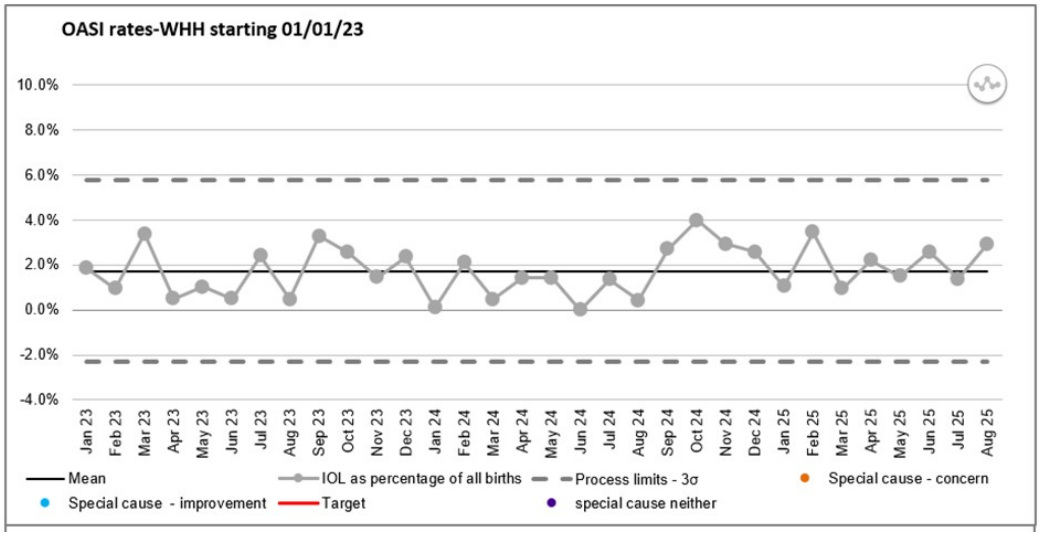
  - A patient was correctly risk assessed as requiring postnatal thromboprophylaxis, but the medication was not prescribed on discharge, resulting in a 10-day gap in treatment. The patient was subsequently diagnosed with a DVT 12 days post discharge home. The incident was reviewed by the Venous Thromboembolism (VTE) Steering Group, which recommended reflection on why the medication was not prescribed and improvements to the risk assessment process to ensure medication is prescribed for the complete period required. Learning was disseminated to all Maternity Teams via a Single Point Lesson issued by the Associate Clinical Director.

- 14 obstetric anal sphincter injuries (OASI).

OASI Incidents

All cases of OASI are reviewed by the Maternity MDT through the Intrapartum Review Group (IRG) and work continues to reduce rates. The below graph shows common cause variation.

Graph 3



- No themes in mode of birth (vaginal birth, instrumental birth).
- No themes in relation to the individual practitioner supporting the birth.
- The OASI Care Bundle was not always documented as having been discussed with women at the time of booking.
- Manual perineal protection (part of the care bundle) is documented in the birth summary as being offered in 100% of cases.

Learning and Actions

- OASI Care Bundle and reducing the risk of perineal tears is now being discussed during booking and documented. During Q3 the service will explore making this a mandatory field in BadgerNet.
- Learning to be shared with the teams during Q3 in relation to providing additional narrative regarding the measures adopted during birth, in particular whether manual perineal protection has been offered and implemented.
- To continue to include teaching about OASI and manual perineal protection as part of Maternity Mandatory Training via Prompt and Obstetric led departmental teaching.

Other Patient Safety Themes within Maternity Services in Q2 include:

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

Avoiding Term Admissions into Neonatal Units (ATAIN)

59 cases of term admission to the NNU were reported in Q2. This is an increase from Q1 when there were 51 cases of term admission reported.

Review Process:

- All term admissions are reviewed through the ATAIN process, which reports quarterly to the QAC.
- An action plan remains in place to address emerging themes.

Learning and next steps:

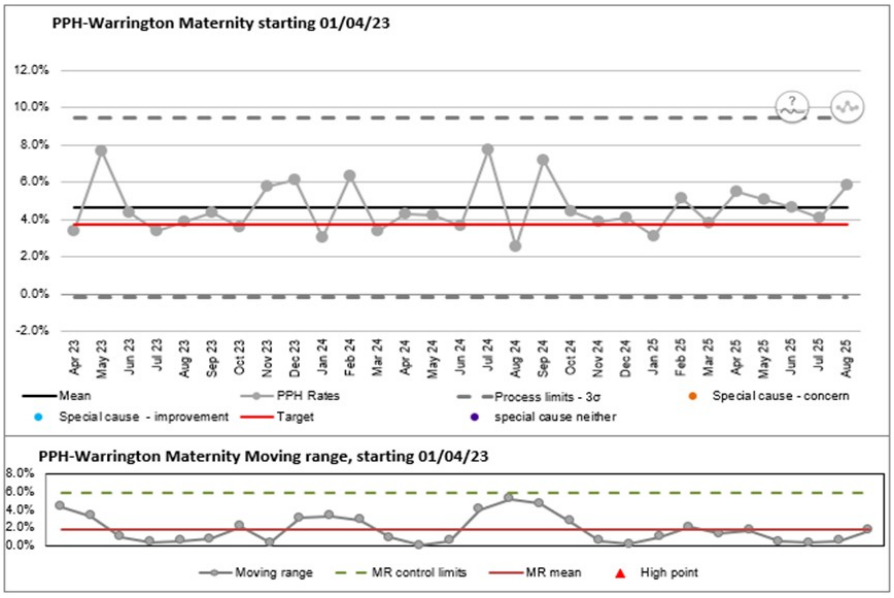
Respiratory distress continues to be the predominant reason for admission. In response, clinical teams are maintaining positive end-expiratory pressure (PEEP) at 30, actively researching the use of Continuous Positive Airway Pressure (CPAP) a non-invasive respiratory support method used in neonatal care to help babies breathe more effectively. In addition, Opioid use during labour is currently under review to identify opportunities for improvement in maternal and neonatal outcomes. A key concern is the respiratory impact on neonates, as opioids can depress neonatal respiration and have been linked to increased admissions for respiratory distress

PPH Combined total for Q2 105

There were 31 PPH ≥1500ml incidents in Q2. This is an increase from Q1 when there were when there were 26 cases. All cases of PPH ≥1500ml are reviewed via the MDT Intrapartum Review Group (IRG), to ensure any urgent learning is enacted. Rates of PPH ≥1500ml are also reported via the Maternity Dashboard to CBU Governance Meetings, Patient Safety Clinical Effectiveness Sub-Committee (PSCESC), QAC, and the Board of Directors.

There were 74 PPH 1000-1500ml in Q2, an increase from Q3 when there were 51. These cases have all been reviewed locally using a standardised proforma. Learning identified as part of the local review of PPH 1000-1500ml reflects the learning identified through the more formal IRG process.

Graph 4



Action Plan for PPH

- **Regional Guideline Implementation:** The Northwest Regional PPH guideline V1 was ratified in September and has been disseminated to clinical teams ahead of its publication on the hub. It introduces revised recommendations for third stage management, which are anticipated to contribute to a reduction in postpartum haemorrhage (PPH) rates and enhance overall maternal outcomes.
- **August Data Trends:** continues to demonstrate common cause variation, with a noted increase compared to previous months. This remains under close surveillance to ensure appropriate escalation if required
- **Postpartum Haemorrhage (PPH) Quality Improvement:** The PPH QI initiative has temporarily reverted to a working group status. It will be reinstated as a formal QI project following the implementation of the newly ratified regional guideline
- **Ongoing Data Collection:** Data collection remains active and robust, supporting continuous monitoring and analysis of outcomes
- **Case Review and Learning:** Individual cases are consistently reviewed within the Intrapartum Review Group to extract learning and inform practice improvements.
- **Audit –** Re Audit 6 months (Nov-May) post Guideline Implementation.

2.1.5 Integrated Medicine and Community (IMC) Learning

There were 452 incidents reported in Q2 compared to 384 reported in Q1. This is an increase of 68 incidents (17.71%). There were 5 moderate harm incidents and no severe harm or fatal incidents reported in Q2.

The top reporting theme in Q2 was Antisocial, Abusive and Violent Behaviour with 81 incidents reported, a decrease of 11 incidents (11.96%) from Q1. 30 (37.04%) of these incidents were patient on staff physical assaults and 29 (35.8%) were patient antisocial behaviour incidents. Most cases involved a patient's lacking capacity, therefore limiting the use of the Trusts Unacceptable Behaviour Policy.

All staff are required to complete Conflict Resolution Training and compliance for IMC is 93.17%. Staff are also supported to complete their De-escalation Training to facilitate the management of these situations. Current compliance for this training in IMC is 62.95%, an increase from Q1 where training compliance was at 57.93%. The Trust's target for compliance is 85%.

Learning and actions implemented:

- Additional de-escalation training scheduled with clear trajectories developed.
- Bespoke training sessions for underperforming wards.
- Staff affected by incidents are supported by their line manager and CBU Team, with input from Health and Safety, Occupational Health and/or the Wellbeing Hub as required.
- Trauma-informed approach (to support violence and abuse prevention and reduction) commenced.
- Post-incident debriefs and wellbeing support implemented.
- Risk-Taking Behaviours Risk Assessment introduced; evaluation due in Q3.

During Q2, a total of 78 (17.26%) Slips, Trips and Falls incidents were reported in IMC, with one resulting in moderate harm.

Learning and actions implemented:

- Ward Manager to collaborate with the Patient Safety Nurses to deliver additional Falls Prevention Training, reinforcing understanding of enhanced care levels and requirements.
- Lessons learned disseminated across teams to strengthen awareness and improve practice around enhanced care.
- Individualised falls action plans are in in place within all ward areas to support continuous improvement
- Weekly review of falls incidents undertaken at the Harm Free Care Meeting, led by the Patient Safety Nurses, ensuring proactive monitoring and risk mitigation.

There were 59 (13.05%) Infection Prevention and Control (IPC) incidents reported in Q2. 23 of these incidents related to hospital onset Covid-19 cases; 12 cases classified as hospital onset after 15 days of admission and 11 cases classified between days 8 and 14 of admission. 3 incidents were reported as Covid-19 ward outbreaks.

Learning and actions implemented:

- Stringent IPC walkarounds have been conducted in affected areas to monitor and reinforce compliance with infection prevention standards.
- Action plans to address deficiencies in hand hygiene and clinical waste disposal; implementation underway.
- Ongoing monitoring by Associate Chief Nurse and the IPC Team through ad hoc reviews to sustain compliance and embed best practice.

In Q2, there were 11 reported cases of hospital onset Clostridium Difficile (CDT) in IMC. No CDT incidences were reported in October 2025.
Key learning themes:

- Timely collection of stool samples and prompt isolation of suspected cases.
- Daily review of patients receiving intravenous antibiotics to support early recognition and intervention.

Learning and actions implemented:

- Trust wide CDT Prevention Action Plan remains in place and continues to be actively monitored.
- Brilliant Basics Action Plan coproduced with the Senior Nursing Team with a detailed project implementation plan developed by the IPC Team.
- Productive Ward Initiative is being implemented to promote consistency and alignment across all wards, supporting sustained improvements in IPC practices.
- The IPC Team will continue to monitor compliance with these actions and review trends in CDT incidents to inform ongoing quality improvement activity.
- Monthly updates are being provided by the IPC Team and the Associate Chief Nurse to the Chief Nurse. Information is also cascaded via monthly Ward Managers Meeting and Housekeepers Meetings, with education for all staff groups remaining a key component of the implemented communication strategy.

During Q2, all incidents reported in relation to the Trusts I-Bleep System were assessed as no harm. A triangulation review of previous incidents identified that the underlying issues are complex and relate to several factors including the electronic systems design, the current operational procedures and the processes for inputting and evaluating tasks within the I-Bleep System. These issues are multifactorial and have a Trustwide impact. The I-Bleep System is currently subject to a comprehensive review to ensure that all operational and technical aspects are fully evaluated. Any issues identified through this process are discussed at the

Deteriorating Patient Group, escalated through the appropriate governance routes and managed in line with established procedures.

2.1.6 Medical Care Learning

There were 386 incidents reported in Q2 compared to 330 in Q1. This is an increase of 56 incidents (16.97%). There were 7 moderate harm incidents and no severe harm or fatal incidents reported in Q2. Access, Transfer and Discharge was the top reported theme in Q2 with 83 incidents (21.5%) reported. 43 (51.81%) of theses incidents were reported as mixed sex accommodation breaches.

Context:

Breaches predominantly occurred in ICU due to extended patient stays and capacity constraints. In line with the Trust's policy *Eliminating Mixed Sex Accommodation in Critical Care and ICU*, clinically justified breaches may occur in exceptional circumstances such as bed shortages or predictable fluctuations in demand**.**

Learning and actions implemented:

- ICU teams continue to cohort Level 1 patients by sex wherever practicable.
- Daily escalation to the Patient Flow Team and senior managers to address delays in transfers and mitigate capacity pressures.
- Ongoing compliance monitoring against Single Sex Accommodation Guidelines

Antisocial, Abusive and Violent Behaviour (43, 11.14%) and IPC (40, 10.36%) were within the top 3 reported themes of Q2. Within the IPC incidents, there were 18 incidents relating to hospital onset Covid 19 cases: 13 cases classified as hospital onset after 15 days of admission and 5 cases classified between days 8 and 14 of admission.

Learning and actions implemented:

- Action plans are in place and being implemented.
- Regular walkarounds by the Associate Chief Nurse and the IPC Team are being carried out to monitor progress and promote sustained best practice across all clinical areas.

There were 14 incidents reported as Slips, Trips and Falls in Q2.

Learning and actions implemented:

- The Trust continues to make progress in reducing falls through ongoing quality improvement initiatives.
- Launch of Think Yellow campaign to raise awareness of falls risk.
- Falls risk assessment must be completed within six hours of admission; at-risk patients provided with yellow socks and wristbands.
- Assessments are reviewed weekly or sooner if a patient's condition changes. Compliance is monitored via the LION dashboard and overseen by the Chief Nurse at Quality Summits.
- Adherence to best practice reinforced during morning Safety Briefs and at patient handovers.
- All falls' incidents are reviewed at the Weekly Harm Free Meeting, supported by the Patient Safety Improvement Nurses, who monitor emerging themes and ensure appropriate actions are taken. Recent learning has highlighted an increase in falls occurring in toilets and from bedside chairs. In response, greater emphasis has been placed on prevention measures, including ensuring staff remain outside the toilet for

patients identified at risk of falls and verifying that patients are wearing appropriate footwear.

2.1.7 Urgent and Emergency Care (UEC) Learning

There were 877 incidents reported in Q2, compared to 753 in Q1. This is an increase of 124 incidents (16.47%). There were 21 moderate harm and 4 severe harm incidents reported in Q2 with no fatal incidents identified.

Severe harm incidents:

Category 3 Necrotic Pressure Ulcer

- Identified on arrival to ED during body mapping.
- **Actions:** Safeguarding referral completed; Tissue Viability Nurse review and photographic documentation undertaken. Classified as an external response incident.

Delay in Paediatric Treatment

- 17-day delay due to omission of Virtual Fracture Clinic referral, resulting in surgical intervention.
- **Learning:** Reinforce timely and accurate completion of Virtual Fracture Clinic referrals prior to discharge to prevent avoidable harm

Isoprenaline Infusion Incident

- Cannula dislodged and unnoticed for 20–30 minutes, resulting in bradycardia (HR 20–30 bpm).
- **Learning and actions:** Reflective discussion arranged for Medical Registrar; refresher training on defibrillation equipment; feedback requested from nursing staff; Sims Form shared with Nursing Agency.

Missed Diagnosis Following Discharge

- Patient discharged after fall without imaging; later diagnosed with grade 3 knee fracture.
- **Learning:** Corridor Care SOP not followed; lack of collateral information and assumptions about chronic pain contributed to incomplete assessment. Emphasis on adherence to SOP and comprehensive assessment.

The top 2 reported themes in Q2 were Pressure Ulcer Present on Admission (129, 14.71%) and Moisture Associated Skin Damage (MASD) or Other Wound to Skin (85, 9.69%). Within the MASD theme, the number of patients admitted with MASD or another skin wound increased from 42 in Q1 to 78 in Q2.

Learning and actions implemented:

- ED staff are completing body maps as part of initial risk assessments for arriving patients, which has helped identify this as a significant issue. When necessary, a referral to the Tissue Viability Nurse is made.
- All occurrences are reported on Datix and disseminated as interface incidents within the community and to other healthcare providers. Additionally, referrals to the Trusts Safeguarding Team are completed where appropriate.
- In Q1, the Quality Improvement Project “Rock Around the Clock” was implemented. For each patient requiring pressure relief, a clock template is placed about their bed to

indicate the time and their last position. This system reduces the risk of patients remaining in one position for extended periods and helps staff to alternate patients between sitting and lying positions.

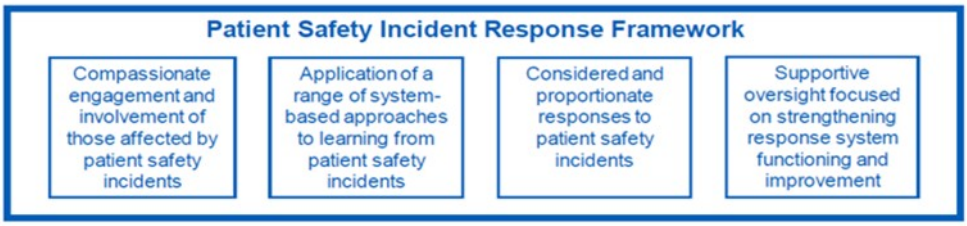
The third highest theme reported in Q2 was Access, Transfer and Discharge (77, 8.78%). Themes identified are delays in transferring to wards or other organisations and inappropriate referrals SDEC from general practitioners.

Learning and actions implemented:

- Interface incidents are raised for the inappropriate referrals and sent with a copy of the SDEC Admission Criteria.
- Delays escalated at NWAS monthly meetings.

2.2 Patient Safety Incident Response Framework (PSIRF) – Learning and Improving Patient Safety

Figure 1



Policy and Plan

The Patient Safety Incident Response Plan (PSIRP) Endorsement Review was held on 2 October 2025 and was successful, subject to minor amendments.

These included the correction of a typographical error, inclusion of a statement confirming continued compliance with national standards, supported by an update on:

- Review of investigation team composition
- Ongoing thematic analysis of learning

The updated Policy was submitted to the Integrated Care Board (ICB) on 3 November.

Investigation Summary Q2:

- **Initial Safety Reviews (ISR) – 140 completed, 11 currently ongoing**

The top 3 themes of completed ISRs were: Clinical Care Ongoing and Review (23), Assessment, Diagnosis and Investigation (20) and Treatment and Procedure (18).

- **After Action Reviews (AAR) – 6 identified, 5 completed, 3 currently ongoing**

The themes of completed AARs were Hospital Acquired Pressure Ulcer (2), Safeguarding Concern (1), Clinical Care Ongoing and Review (1) and Infrastructure, Environment and Resource (1).

- **Multi-Disciplinary Team (MDT) Reviews – 24 identified, 10 completed, 43 currently ongoing (15 of these are now being progressed by the CBUs)**

The top 2 (all other themes had 1 linked incident) themes of completed MDTs were: Treatment and Procedure (3) and Clinical Care Ongoing and Review (2).

- **Swarm Huddles – 2 identified, 1 completed, 1 currently ongoing**

The theme of the completed Swarm Huddle was Medication (1).

- **Cluster Reviews – 1 identified, 2 completed, 9 currently ongoing**

The themes of completed Cluster Reviews were Assessment, Diagnosis and Investigation (1) and Clinical Care Ongoing and Review (1).

- **Patient Safety Incident Investigations (PSII) – 0 identified, 2 completed, 6 currently ongoing**

The themes of completed PSIIs were Assessment, Diagnosis and Investigation (1) and Clinical Care Ongoing and Review (1).

Number and progression of open investigations, continue to be monitored via SOM.

Overview of WHH Training Position

- Essentials for patient safety for all staff - 98.14%
- Essentials for patient safety - Essentials of patient safety for boards and senior leadership teams - 100%
- Oversight of learning from patient safety incidents oversight - PSIRF Oversight Training has been scheduled for 05 November 2025. This session will be delivered by Gateway Training and Consultancy Ltd
- Engagement and involvement with those affected by a patient- 5 staff attended Ensuring Patient, Family and Staff Involvement in Learning from Patient Safety Incidents training (Gateway Training & Consultancy Ltd.) on 19 June 2025. Scoping of further training is currently being undertaken. A formal monitoring mechanism to ensure Engagement Leads contribute to two or more responses per year is currently in development and will be in place by the end of Q3. Implementation was initially planned for end of Q2 but required a comprehensive review of Datix investigation fields and subsequent system modifications.
- Patient Safety Syllabus level 3 and 4 - 3 Patient Safety Specialists have completed Level 3 and Level 4 Patient Safety Training Syllabus with Loughborough University.5 additional staff members are currently undertaking this training.

LFPSE

- LFPSE version 5 is currently used to report patient safety incidents, near misses, and good practice.
- It provides a standardised framework for categorising and reporting incidents, enabling data collection and analysis for learning and improvement.
- V5 will become non-compliant in 2026, meaning organisations will need to transition to V6 to continue reporting and contributing to LFPSE.
- The V6 taxonomy includes supporting questions for the Patient Safety Incident Response Framework (PSIRF). This ensures that the data collected within LFPSE directly facilitates the new national approach in responding to patient safety incidents.
- V6 will allow local organisations better management of LFPSE records without the Patient safety helpdesk intervention.

- The release of LFPSE Taxonomy Version 6 was originally scheduled for summer 2025. However, implementation has been delayed due to system-related issues, including the withdrawal of one release by the supplier and the presence of unresolved errors in the most recent version. A confirmed upgrade date is currently awaited from Datix.

Learning & Improvement

- Review of themes from completed PSIIs in progress, including gap analysis against QI workstreams and development of improvement workstreams. Findings to be presented at the Shared Learning Forum on 20 November 2025.
- All learning response templates revised to embed SEIPS checklist.
- MDT template updated to allow direct sharing of approved reports with individuals, eliminating separate learning response letters to:

    - Accelerate dissemination of learning
    - Improve transparency and reduce duplication

Education & Training

- Further training arranged in line with the Trust's Training Needs Analysis (TNA).
- Training proposal drafted and to be finalised in Q3.
- Development of Datix training videos underway; release planned by end of Q3.

Governance & Assurance

- MIAA PSIRF Audit Report presented June 2025: 4 of 5 actions complete; remaining action relates to compliance targets and monitoring mechanisms for Engagement and Learning Response Leads.
    - A training proposal has been drafted and is currently being finalised.
    - Formal monitoring mechanism under development; delayed from Q2 as required comprehensive review of Datix investigation fields and subsequent system modifications. These will be completed by the end of Q3.
- Draft Terms of Reference for new Patient Safety Specialist Group prepared to support culture and integrated safety improvement.
- A Duty of Candour audit is currently in progress and will be completed by 30 November.

Datix Enhancements

- Mandatory learning themes fields added to the incident module.
- PSII categories added to Datix supporting thematic analysis.
- Further Investigation" and Duty of Candour fields reviewed, new dashboards in development for improved oversight. Completion expected by end of Q3.

System and Process Updates

- Work ongoing with Datix on transition from LFPSE v5 to v6.
- Draft Interface Incident Standard Operating procedure (SOP) developed to standardise processes, clarify roles, ensure compliance with NHS England and LFPSE requirements
- Policy will be ratified at the Trust Policy Review Group in November 2025.

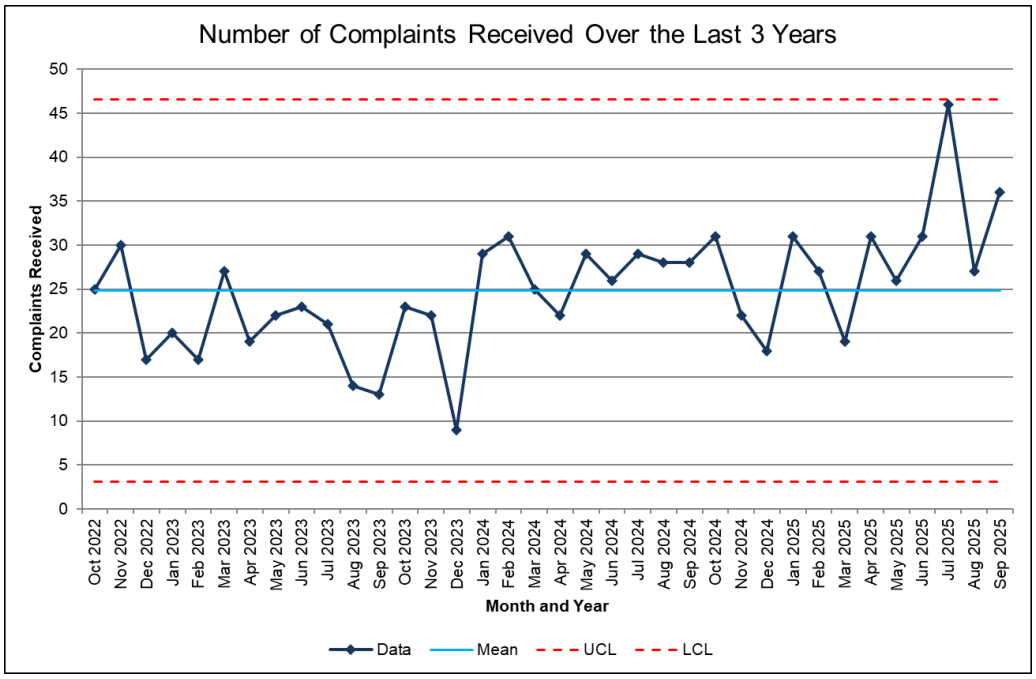
3. APPENDIX 2 LEARNING FROM COMPLAINTS AND PATIENT ADVICE AND LIAISON SERVICE

3.1 Complaints

3.1.1 Complaints Received

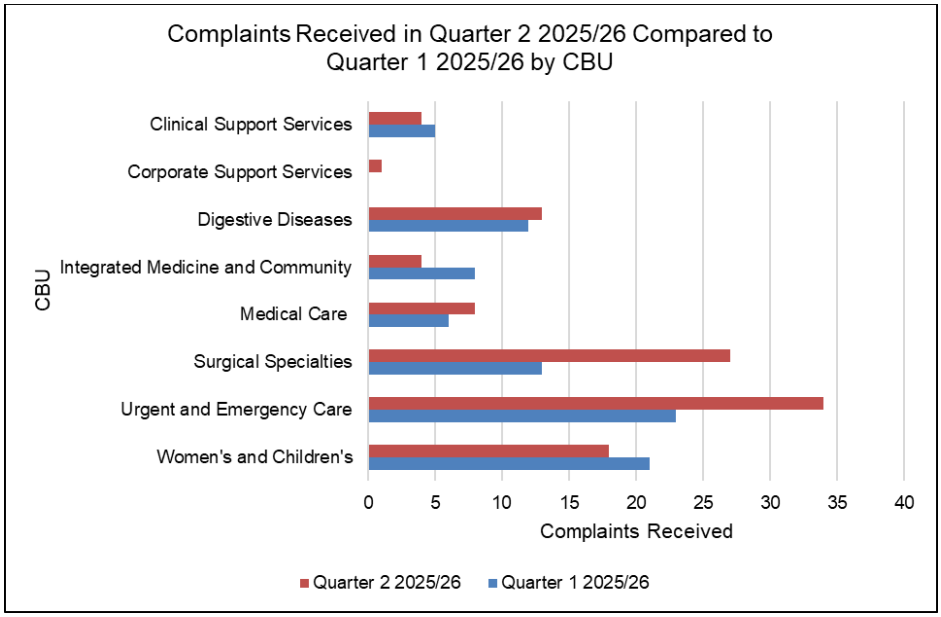
Complaints received across WHH has remained within expected normal variation with the exception of a significant increase observed in July 202. This spike will be monitored by the Complaints Team to determine whether this reflects a one-off event or whether this signals a broader trend. In Q2, a total of 109 complaints were received. This is an increase of 21 complaints (23.86%) compared to Q1 where 88 complaints were received.

Graph 5



The CBU with the largest percentage increase in complaints received in Q2 compared to Q1 was Surgical Specialties with a 107.69% increase (14 complaints). Integrated Medicine and Community had the largest percentage decrease in complaints received with a 50% decrease (4 complaints).

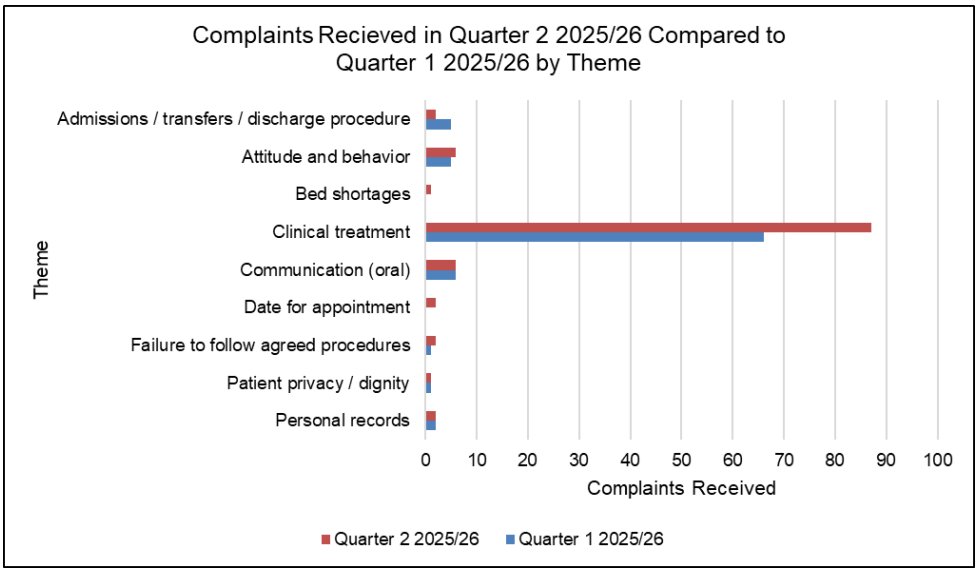
Graph 6



Due to the multifactorial nature of complaints, which may involve multiple linked subjects, the Complaints Team categorise complaint themes based on the primary subject identified.

Clinical Treatment consistently remains the most common theme of complaints received. In Q2, 87 Clinical Treatment complaints were received compared to 66 in Q1, an increase of 21 complaints (31.82%). The top 3 sub-themes within Clinical Treatment were Coordination of Medical Treatment (54), Wrong Diagnosis (11) and Poor Nursing Care (7). All of the CBUs, excluding Corporate Support Services, received complaints related to Clinical Treatment. Urgent and Emergency Care received the highest number of Clinical Treatment complaints with 26 received, followed by Surgical Specialties (24) and Women's and Children's (14). This distribution aligns with the number of overall complaints received across the CBUs.

Graph 7



3.1.2 Complaints Closed

There were 100 complaints closed in Q2 which is an increase of 35 complaints (53.85%) compared to Q1 where 65 complaints were closed. This increase is consistent with the increase in complaints received across the quarters.

The following table demonstrates the outcomes for the complaints closed in Q2 compared to Q1. Of note, partially upheld complaints are those where aspects of the complaint are upheld but the main issues are not.

Outcome	Q2	Q1
Not Upheld	34	29
Partially Upheld	56	31
Upheld	10	5
Total	**100**	**65**

3.1.3 Learning Examples from Complaint Investigations

You Said	We Did
Clinical Support Services	
Patient discharged from our care with the expected follow up care provided by Physiotherapy. Unfortunately, the referral was not made to the Community Team, leaving patient without adequate support.	Physiotherapist has undergone additional training to ensure that referral processes are correctly followed. This training will also be provided to all new staff members within the Therapy Team as part of their induction process.
Surgical Specialties	
Patients' dementia diagnosis was not known to staff following transfer to Ward B3.	It has been reiterated to all nursing staff on Ward B3, the importance of reviewing patient records and alerts immediately upon transfer of care. Matrons have also reinforced this requirement during staff briefings and handover training sessions. In addition, personal reflections have been undertaken by the individual member of staff involved in the handover of care.
Women's and Children's	
Concerns were raised for the lack of support shown to a new mother who wished to breast feed her baby. Mum was made to feel an inconvenience for asking for help by midwives.	The members of staff who were involved in the care have had individual reflective conversations with the Ward Manager, to ensure improvements in their communication and care. In addition, additional support has been sought from the Breast-Feeding Team to support staff in providing help to all mums, irrelevant of if they are feeding by bottle or by breast.
Integrated Medicine and Community	
Patient raised concerns for delays in pain relief medication being administered.	The Ward Manager and Shift Co-Ordinator for Ward B14 will go with the Nursing Team to check which patients are prescribed controlled drugs, to provide timely second checks, to ensure no delays with administrations of vital medications. It has been reiterated to all staff the expectation that patients who request pain relief must be managed as a priority.
Medical Care	

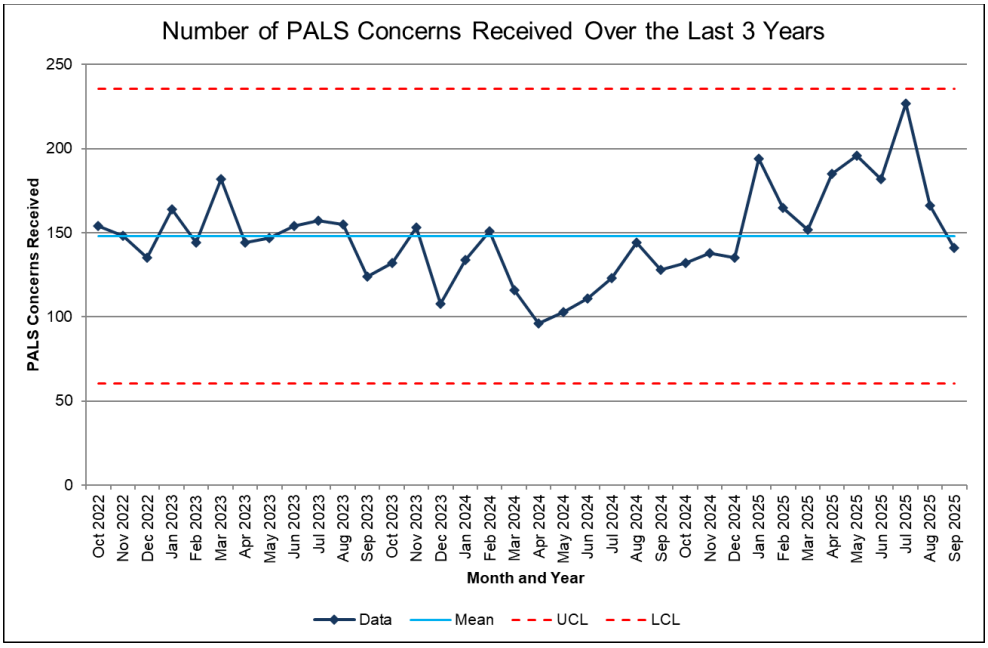
Patient experienced delays in Rheumatology treatment, due to pressures on the service currently.	The Rheumatology team have implemented a process for doctors to allow for pre-screening tests to be undertaken in clinic, to help streamline the service. An information booklet is being developed, which provides all information on when to contact the Rheumatology Service as well as guidance on managing a flare up. Current trial of a new prescription tracker, which will proactively issue prescriptions for patients. A new post has been agreed for an additional Rheumatology Nurse, with a senior nurse having nearly completed her Prescribing course.
Urgent and Emergency Care	
Doctor approached parents in the waiting room to inform them that there was a problem with their daughter's heart. This left their young daughter traumatised and thinking that she was going to die. Family asked that reflections take place to ensure these conversations are delivered with more empathy and sensitivity.	The doctor involved has reflected on the impact of language used during sensitive discussions, especially in the presence of children, and has committed to improving their approach. It was emphasised that families should leave the department with a clear understanding of the next steps in their child's care, wherever possible, and that all relevant concerns should be communicated transparently. This reminder has been shared across the Paediatric Emergency Department to reinforce best practices in patient and family communication.

3.2 Patient Advice and Liaison Service (PALS)

3.2.1 PALS Received

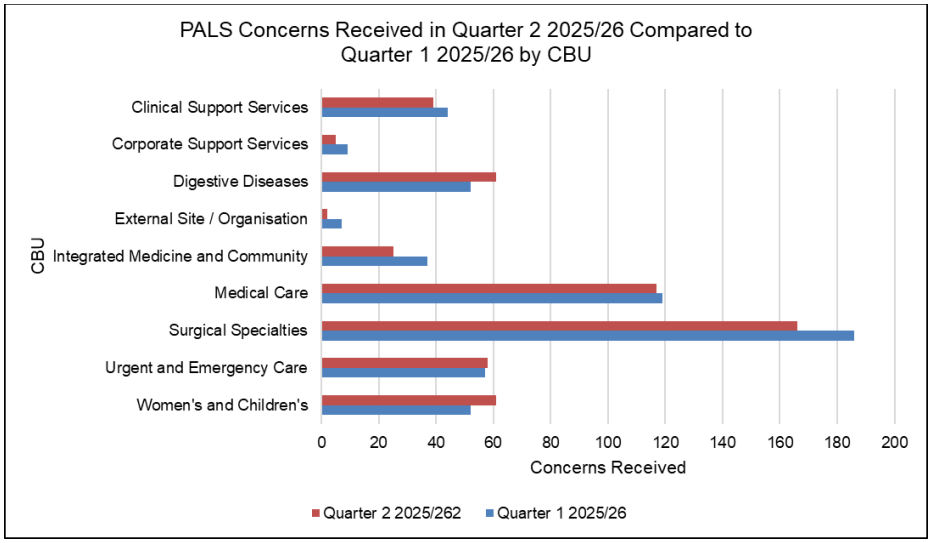
PALS concerns received across WHH remains within expected normal variation. There is a notable trend from January to August 2025 showing an increase in PALS concerns received. This trend is consistent with the initiation of a revised complaints process from December 2024 aimed to address concerns promptly and informally. In Q2, there were 534 PALS concerns received which is a decrease of 29 concerns (5.15%) compared to Q1 where 563 PALS concerns were received.

Graph 8



The CBUs with the largest percentage increase in PALS concerns received in Q2 compared to Q1 were Women's and Children's and Digestive Diseases with a 17.31% increase (9 concerns). External Site/Organisation had the largest percentage decrease in PALS concerns received with a 71.43% decrease (5 concerns), followed by Corporate Support Services with a 44.44% decrease (4 concerns).

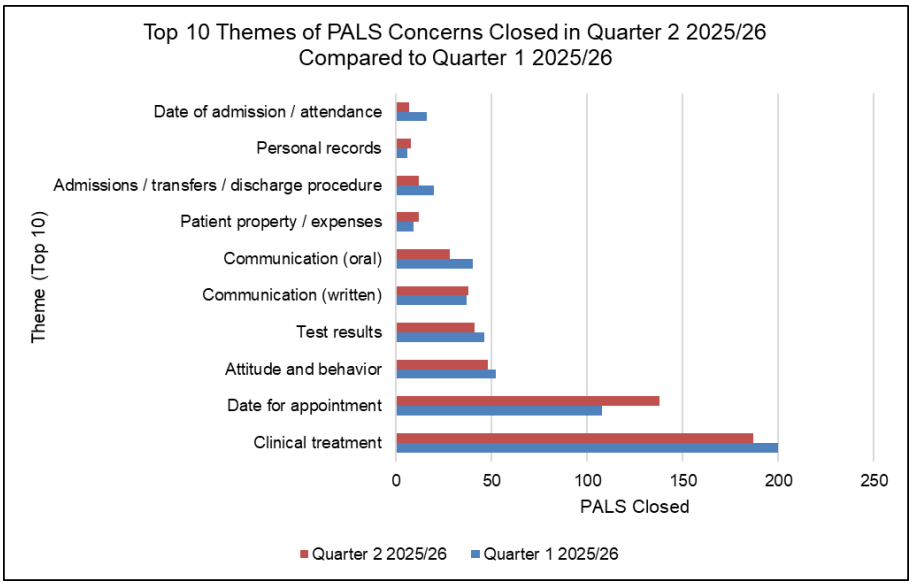
Graph 9



3.2.2 PALS Closed

There were 536 PALS concerns closed in Q2 which is a decrease of 26 concerns (4.63%) compared to Q1 where 562 PALS concerns were closed. This decrease is consistent with the decrease in PALS concerns received across the quarters. The top 3 themes for PALS concerns closed in Q2 were Clinical Treatment (200), Date for Appointment (108) and Attitude and Behaviour (52). These are the same top 3 themes for PALS concerns closed in Q1. The recurrence of these themes across the quarters, suggests that they are fixed areas of concern that require continual attention.

Graph 10



4. APPENDIX 3. LEARNING FROM COMPLIMENTS

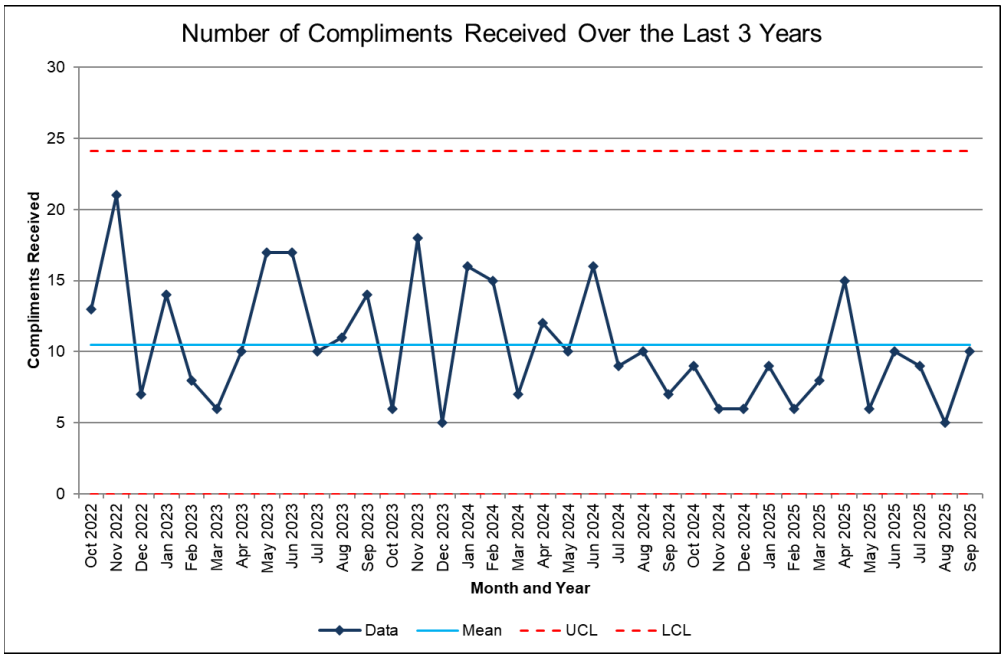
Compliments received across WHH is within expected normal variation. In Q2, there were 24 compliments received which is a decrease of 7 compliments (22.58%) compared to Q1 where

31 compliments were received. 12 of the compliments related to Excellent Care and Treatment, 10 related to Compassion and Kindness and the remaining 2 related to Supporting Patients and Good Communication.

A positive safety culture is one where compliments are fed back to staff in the same way as incident investigations. Compliments are a very useful tool for WHH to be able to identify what areas are working well. It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. However, compliments are likely to be underreported.

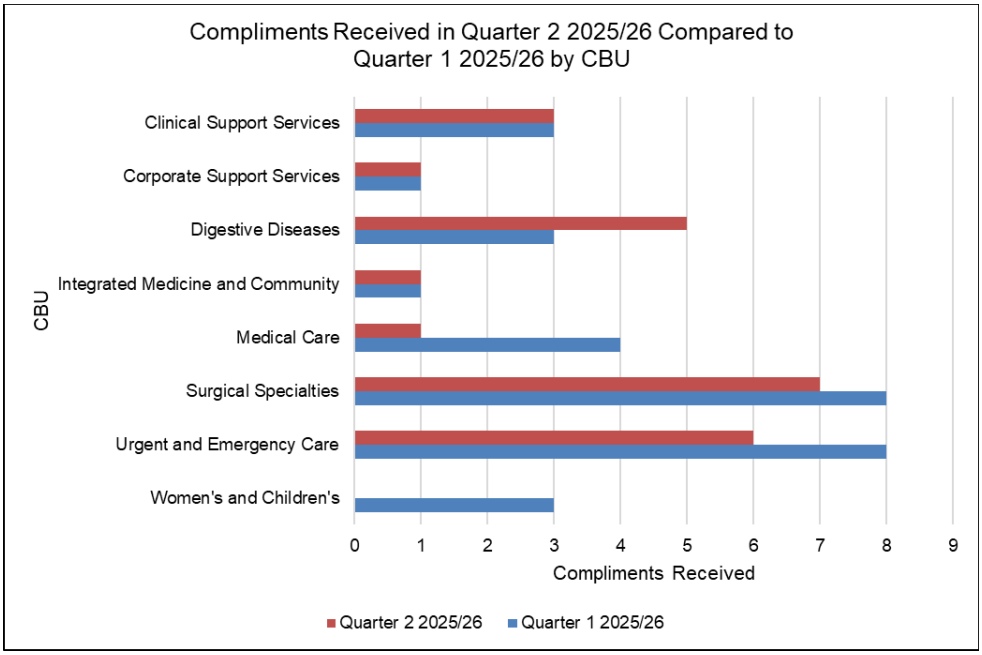
In Q1, improvements were made to the compliment's module on Datix to make it easier for staff to capture this data. A field within the compliment's module has been added to capture the themes of compliments and staff types that the compliment relates to. Work is underway with the Patient Experience Team to further improve this data. A centralised compliments inbox will be established in Q3.

Graph 11



Digestive Diseases was the only CBU to show an increase in compliments received between Q1 and Q2 with a percentage increase of 66.67% (2 compliments). Women's and Children's had the largest percentage decrease in compliments received in Q2 compared to Q1 with a 100% decrease (3 compliments).

Graph 12



5. APPENDIX 4. LEARNING FROM QUALITY IMPROVEMENT AND KNOWLEDGE AND EXPERIENCE

5.1 Learning from Registered Quality Improvement (QI) Projects Completed Q2

Two QI Projects were recorded as complete within Q2 and are highlighted in the table below together with their project progress score, based on the scoring method used by the Institute of Healthcare Improvement, and impact statement.

Project Aim	Project Lead(s)	Start Date	Completed Date	Project Outcome	Impact	QIP Certification Criteria Met?
To increase screening for the identification of Social Isolation for patients presenting with mid to moderate frailty on the FAU from 1% to 80% between January and June 2025.	Sophie Batty	12/02/2025	13/08/2025	4.0 Significant Improvement	Social Isolation (SI) is estimated to effect up to 27% of community dwelling older adults, with the Northwest region recording some of the highest rates. SI is associated with poor health outcomes including	Yes – Certificate of Excellence

					worsening of chronic health conditions, reduced function, cognitive decline, depression, anxiety, admission to long term care facilities and mortality. Baseline data showed just 1% of patients presenting to the FAU with mild to moderate frailty were screened for SI, with no onward referrals. This project tested the introduction of a standardised prompt within the Comprehensive Geriatric Assessment, a flow chart of local support services and educational information within staff induction resulting in a sustained increase in screening to 81% and an average of 6 referrals per month to local support services.	
To improve identificatio	Tina Joy	30/09/2024	20/09/2025	3.0 Modest Improveme	Pulmonary Rehabilitation	Yes

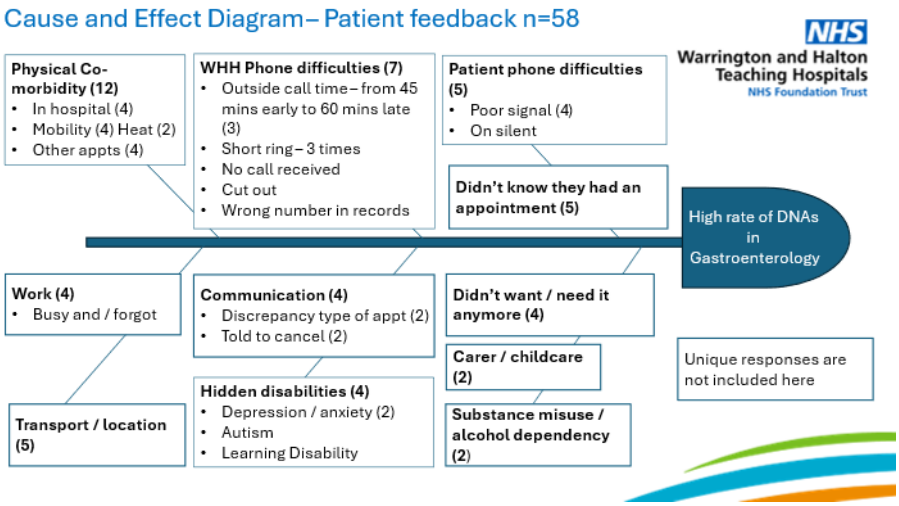
n of risks in Pulmonary Rehabilitation Classes and managing all high-risk patients in Pulmonary Rehabilitation Group sessions across all venues				nt	services conduct group exercises programmes, with a patient to staff ratio of 1:8 as per BT pulmonary Rehab guidelines. However, some high-risk patients may need more input than others to safely complete the programme and to maximise their treatment outcome. This project introduced a standardised risk assessment and documentation process, and patients stratified as high risk are now easily identified with a sticker on their name badge to facilitate enhanced support from staff.	

5.2 Learning from the Application of Knowledge and Evidence Service (KES)

5.2.1 Did Not Attend (DNA) Gastroenterology

The KES and QI Teams are working with a multidisciplinary team led by the Service Manager for Endoscopy and Gastroenterology to identify ways to reduce DNAs in Gastroenterology. To identify potential ways to increase attendance, the KES interviewed 58 patients who had DNA'd between May and July 2025 to gain insight into their understanding of the barriers to attending either their face to face or telephone appointment. Their responses were themed and presented as a fishbone diagram.

Figure 2



Proportionally, telephone clinics recorded a high number of DNAs, and this was duplicated in the findings above. It was agreed that the KES will investigate best practice in telephone consultations (such as the number of repeat call attempts and adhering to scheduled call times) and reach out to high performing Trusts to study their telephone consultation SOPs.

The KES or Public Health Specialty Registrar will also aim to explore DNA data areas of deprivation using the Population Health suite of tools.

5.2.2 Productivity Ideas – "Timewasters"

Coordinated by the Transformation Manager for Planned Care, the KES has carried out several focus groups with staff from Women's and Children's to gather their views on "timewasters"; what activities, processes, tasks or systems take far longer than they need to or get in the way of delivering patient care or performing their duties and what their solutions for this might be. Ideas are shared with the Teams and Senior Managers and added to the Women's and Children's Capital Improvement Plan to be assigned leads and followed up.

Teams interviewed included Maternity Matrons and Ward Managers, Ward B11 and Paediatric, Obstetrics and Gynaecology Administrators. Themes gathered to date include:

- Sub-optimal digital systems.
- Lack of digitalisation in notes.
- Lack of storage.
- Lengthy repetitive/duplicated meetings.
- Time consuming gathering and reporting of metrics that don't provide insight or have little value in informing improvements.
- Recent increase in lengthy wait for procurement approval and IT equipment.

- Recent complication of recruitment process causing severe delays in recruitment and higher spend with NHSP (NHS Professionals).
- Request for more administrative staff.

5.2.3 Volunteer Management System Implemented with Support of Evidence Review

The Patient Engagement Team identified that the Trust Volunteer Management System was unreliable, generated incorrect data and was difficult to use. On completion of an evidence review, the Patient Experience and Inclusion Assistant uncovered that a system called Better Impact was being used in the majority of other local Trusts. This was identified as a more robust system with greater functionality and available at a significantly reduced cost. The evidence review was used to build a successful business case, and the Trust migrated to the new system on 01 August 2025.

The Volunteers Manager and Patient Experience Manager stated that this achieved an initial saving of approximately £4,000 which is anticipated to be an annual saving for the Trust. The new system provides enhanced functionality to support both the management of the Volunteer Service and the volunteers themselves, drawing all functions, information and training that were previously accessed separately into one place saving time, increasing productivity and allowing a more user-friendly experience to staff and volunteers.

5.2.4 Embedding Evidence into Neurodiversity Support and Reasonable Adjustments

The Culture and Improvement Project Support Officer and Vice Chair of the Disability Awareness Staff Network (and previous Knowledge Services Assistant to the KES) requested an evidence review with a need to strengthen reasonable adjustments and neurodiversity awareness in the workplace. The aim was to ensure the organisation was aligned with best practice, to benchmark against what other Trusts and employers were doing and to identify approaches that could be adapted locally to improve policies and staff support.

The evidence was used to underpin rewriting of the Trusts Reasonable Adjustments Guidance. Toolkits identified in the evidence review provided practical examples and condition-specific considerations which have been integrated into the Trusts approach. This inspired the introduction of a dedicated neurodiversity section within the guidance, offering tailored examples of adjustments for common neurodivergent conditions.

Best practice highlighted in the review, shaped the development of neurodiversity sessions within the Disability Awareness Network. These are now held every other month, alternating with other disability awareness sessions.

Insights from other Trusts in framing reasonable adjustment discussions were applied to enhance the organisation's approach to language, phrasing and supportive conversations between managers and staff.

6. APPENDIX 5. LEARNING FROM SAFETY ALERTS

The Trust uses the Daily Safety Brief to share learning on a wider scale. There were 49 alerts issued in Q2: 14 in July 19 in August and 16 in September. When alerts are issued, some will be shared over several days giving staff an opportunity to see the alert. National Patient Safety Alerts are also shared widely and can provide learning from incidents that have occurred.

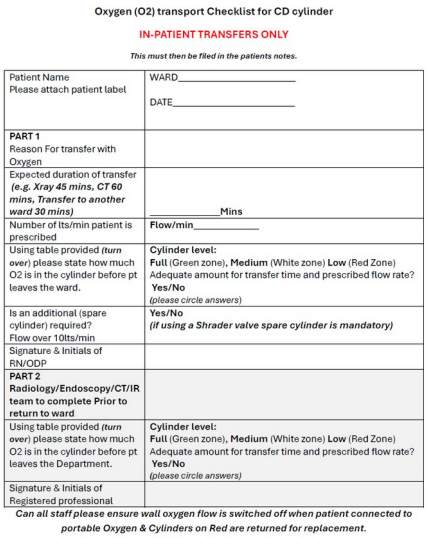
During Q2 an alert was raised following a clinical incident relating to the transfer of a patient with an oxygen cylinder. The review identified gaps in staff knowledge and training, including:

- Lack of a documented handover for hospital porters when transferring patients on an oxygen cylinder.
- Insufficient authorisation structures regarding oxygen being a prescribed medication
- Misalignment between policy and practice.

Improvement Actions Implemented:

- Development of an authorisation document for the transfer of a patient between hospital departments. An audit of this process was also undertaken.
- Improvement of staff knowledge through guidance, information and training.
- A Task and Finish Group was initiated on the basis of the Datix investigation that led to the identification and support for the necessary changes in the process and training to be taken. An outline of measures taken are included within section 8 of this report

Figure 3



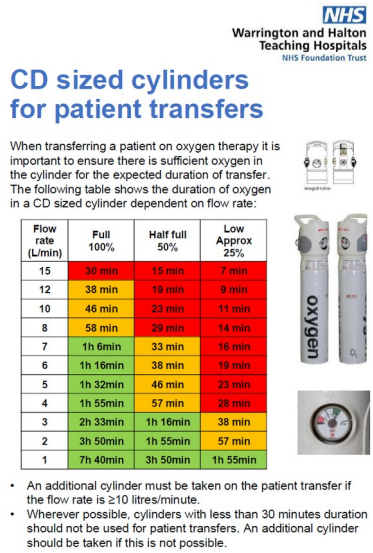
Oxygen (O2) transport Checklist for CD cylinder

IN-PATIENT TRANSFERS ONLY

This must then be filed in the patients notes.

Patient Name Please attach patient label	WARD_____ DATE_____
PART 1 Reason For transfer with Oxygen	
Expected duration of transfer ***(e.g. Xray 45 mins, CT 60 mins, Transfer to another ward 30 mins)***	_____Mins
Number of lts/min patient is prescribed	Flow/min_____
Using table provided ***(turn over)*** please state how much O2 is in the cylinder before pt leaves the ward.	**Cylinder level:** **Full** (Green zone), **Medium** (White zone) **Low** (Red Zone) Adequate amount for transfer time and prescribed flow rate? **Yes/No** *(please circle answers)*
Is an additional (spare cylinder) required? Flow over 10lts/min	**Yes/No** ***(if using a Shrader valve spare cylinder is mandatory)***
Signature & Initials of RN/ODP	
PART 2 **Radiology/Endoscopy/CT/IR team to complete Prior to return to ward**	
Using table provided ***(turn over)*** please state how much O2 is in the cylinder before pt leaves the Department.	**Cylinder level:** **Full** (Green zone), **Medium** (White zone) **Low** (Red Zone) Adequate amount for transfer time and prescribed flow rate? **Yes/No** *(please circle answers)*
Signature & Initials of Registered professional	

Can all staff please ensure wall oxygen flow is switched off when patient connected to portable Oxygen & Cylinders on Red are returned for replacement.



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

CD sized cylinders for patient transfers

When transferring a patient on oxygen therapy it is important to ensure there is sufficient oxygen in the cylinder for the expected duration of transfer. The following table shows the duration of oxygen in a CD sized cylinder dependent on flow rate:

Flow rate (L/min)	Full 100%	Half full 50%	Low Approx 25%
15	30 min	15 min	7 min
12	38 min	19 min	9 min
10	46 min	23 min	11 min
8	58 min	29 min	14 min
7	1h 6min	33 min	16 min
6	1h 16min	38 min	19 min
5	1h 32min	46 min	23 min
4	1h 55min	57 min	28 min
3	2h 33min	1h 16min	38 min
2	3h 50min	1h 55min	57 min
1	7h 40min	3h 50min	1h 55min

- An additional cylinder must be taken on the patient transfer if the flow rate is ≥10 litres/minute.
- Wherever possible, cylinders with less than 30 minutes duration should not be used for patient transfers. An additional cylinder should be taken if this is not possible.

7. APPENDIX 6. LEARNING FROM CLAIMS

7.1 Clinical Claims

7.1.1 Clinical Claims Received

There were 39 Clinical Claims received in Q2. This is an increase of 10 claims (34.48%) compared to Q1 where 29 claims were received.

7.1.2 Clinical Claims Closed

There were 38 ongoing Clinical Claims closed in Q2; 3 with damages totalling £432,961.80 (including costs of instructing Trust Solicitors), 2 successfully repudiated and 33 withdrawn including closed due to lack of further correspondence from the Claimant.

Specialty	Damages Paid	Number of Claims
Emergency Medicine	£380,489.80	2
Radiology	£52,472.00	1
Total	**£432,961.80**	**3**

7.2 Non-Clinical Claims (Employee Liability/Public Liability)

7.2.1 Non-Clinical Claims Received

There were no Public Lability Claims and 4 Employer Liability Claims received in Q2.

Public Liability	Number of Claims
Abusive, violent, disruptive or self-harming behaviour	2
Accident/incident that may result in injury/harm	2
Total	**4**

7.2.2 Non-Clinical Claims Closed

There were 2 ongoing Non-Clinical Claims closed in Q2; 1 with damages totalling £11,097.33 (including costs of instructing Trust Solicitors and 1 successfully repudiated.

Specialty	Damages Paid	Number of Claims
General Medicine	£11,097.33	1
Total	**£11,097.33**	**1**

7.3 Claims Learning and Actions

When a new claim is received, it is triangulated with the incidents and complaints reported on Datix and linked accordingly. Details of the learning identified from claims closed with damages is below.

Clinical Issues	
Incident Date: 09/02/2022 Patient did not receive follow up appointment for Aortic Aneurysms and later died.	
Lessons Learned	**Action Taken**
The patient was lost to follow up. A more robust process has replaced the Trusts Radiology booking process with the introduction of a follow up imaging alert on the Radiology Information System.	A more robust process has replaced the Trusts Radiology booking process.

Clinical Issues	
Incident Date: 19/02/2023 Failure to carry out risk assessment. Failure to place more staff on a one-to-one basis which would have reduced and prevented fall. Failure to assist patient to go to the bathroom. Patient sustained a fractured hip.	
Lessons Learned	**Action Taken**
There was no consideration of patient's new confusion, no capacity assessment completed or consideration for enhanced care. No falls risk assessment was completed on admission to the ED. Overcrowding in the ED caused the patient to be moved around the department.	All falls risk assessments to be completed on arrival to the department and as needs change. Falls walk rounds being completed daily. Daily falls risk assessments being trialled within the ED. All patients to be assessed for requiring enhanced care, the result should be

	available at the patient's bedside and on the ward Safety Brief. Falls prevention measures or equipment to be considered for all patients showing signs of confusion or at risk of falls.

Clinical Issues	
Incident Date: 01/12/2022 Delay in diagnosing a pulmonary embolism. Patient had a cardiac arrest and died.	
Lessons Learned	**Action Taken**
Delay in patient being seen by the ED Team due to capacity. Consistently elevated NEWS score which was not escalated. Low molecular weight Heparin was not prescribed as an urgent medication and was prescribed as a regular medication for administration at 6pm. This was therefore not administered. At the time of the patient's arrival, the department was short staffed and there were 6 calls from NWAS for patients who would need immediate attention from the doctors on their arrival to the ED. This would have increased the delay in the patient being seen. The department was full and there were patients on al corridors.	ED are to review the staffing figures for over weekend shifts and bank holidays to ensure the department is fully established to reduce waiting times. The staffing is reviewed several times during the day. The escalation process for medical staffing is currently being reviewed Education is to be provided to the whole ED Team to highlight the importance of completing Venous Thromboembolism (VTE) Assessments for all admitted patients. Patient Safety Team to complete an audit to ensure that VTE Assessments are being completed correctly and that if chemical prophylaxis is required, it is prescribed in a timely manner. The Clinician who did not prescribe Enoxaparin as an urgent medication is to complete a reflective statement and discuss this with their Medical Lead to ensure understanding. Staff are to undertake additional NEWS training and are to be reminded of the importance of documentation and escalation regarding an elevated NEWS score.

The Clinical Claims Review Group meets every quarter to assist in the management of claims and the risk arising from the claims.

8. APPENDIX 7. LEARNING FROM INQUESTS

At the time of reporting on 06 October 2025, there were 33 Coroners Inquests open. Of these, 1 has a linked complaint and 1 has a linked PALS concern, a meeting has been agreed with the ED Matron to avoid it being formalised as a complaint. There are no inquests linked to a PSII, and 5 inquests have legal representation. Here were 14 inquests opened in Q2, this is a decrease of 4 inquests (22.22%) compared to Q1 where 18 were opened.

Examples of learning from inquests in Q2

An inquest took place on 15 September 2025 and following a multi-disciplinary team investigation, a number of points of learning were identified. A significant amount of work was carried out in the months leading up to inquest to address the actions identified and to ensure

the Trust was in a position to provide assurance to Coroner that lessons have been learned and actions taken.

- National Palliative Care Guidance – Trust Key Performance Indicators emphasise that ward moves should be avoided unless there is a clear and justified reason specific to the patients needs. Whilst in this case the patient's condition was recognised as deteriorating, it was not formally acknowledged that they were in the dying phase of their life. It was identified that the Trusts High Flow Nasal Oxygen Policy is currently in line with the Palliative Care SOP but could be strengthened in order to assist in the decision making and prompt discussions that should occur and be clearly documented. The Trusts Palliative Care SOP has been drafted and is currently being reviewed by the wider team. When ratified, expected in December 2025, it will be shared across the Trust.
- Training on recognition of the dying person and how/when to seek Palliative Care Specialist advice has been delivered to the Trusts Acute Care Team in July 2025. Plans are being developed to deliver this training in Q3 to the Consultants within the IMC CBU. Palliative Care Teaching is delivered annually to the Foundation Doctors at the Trust.
- Observations were not recorded for periods of time. It is recognised that guidance for staff would be useful on the process to follow when it is not possible to obtain a physiological observation reading. The Trust's Adult Physiological Observation Policy including NEWS2 has been reviewed, and guidance has been added.
- The Trust identified that knowledge of the Clinical Transfer Policy generally should be strengthened. There is a patient transfer matrix, a decision-making tool to assist nursing colleagues to identify when medical review should be requested prior to patient transfer.
- The Clinical Transfer Policy sets out that where oxygen cylinders are required to support transfer, these should be checked and connected by a registered nurse or registered nursing associate. Measures taken to strengthen the checking of oxygen cylinders prior to transfer have been taken, namely:
    - An Oxygen Transfer Checklist has been developed to assist staff to prepare for safe transfer of patients. This checklist prompts Nursing Staff to identify the duration of transfer, the flow rate of oxygen required by the patient, and to check the cylinder to determine how much gas is within. Additional cylinders must be taken on patient transfers if the flow rate required by the patient is equal to or greater than 10 litres per minute. A chart is included in the checklist so that the team can determine whether the amount of gas is sufficient for transfer. Where cylinders are calculated to last less than 30 minutes, the checklist advises staff that a fresh cylinder should be used. If this not possible, a second cylinder should be taken. Completion of the checklist is now mandatory, and a copy will be placed in the patient record.
    - Awareness of the Oxygen Transfer Checklist and its correct use has been raised by; inclusion in the Clinical Transfer Policy which has been ratified and will be shared Trustwide via CBU and Care Group Governance Meetings, Chief Nurse Check In and the Trusts Nursing Midwifery and Allied Health Professionals Forum, communications to all clinical areas throughout the Trust, visits to clinical areas to gain assurance that the Checklist is in use, shared via Trustwide Safety Brief and spot check audits have been completed and feedback given to staff in real time.
    - A Self-Assessment Competency and associated documentation have been developed regarding the safe set up of oxygen cylinders for transportation. This includes watching a training video and a self-assessment competency against a number of items detailed in the video. This has been rolled out across Nursing and Midwifery during July 2025. Compliance with this across the Trust for Nurses and Midwives is 98.8%. In August 2025, this was rolled out to Allied Health

Professionals, and compliance for this staff group is 89.6%. Plans are in place to ensure that the remaining staff complete this training.

- Additionally, following approval from the Trusts Medical Gases Group and Education Governance, the Trust has rolled out an online training module called the 'Safe Use, Storage and Set Up of Medical Gases'. This is a national training package, and it has been added to the Trusts mandatory training on a role specific basis and will be completed every three years. This was opened up to staff in July 2025, but following approval through the Trusts governance processes it is currently being assigned to staffs mandatory training requirements according to their role. Compliance of this training will be monitored through the Trusts usual monitoring processes.

9. APPENDIX 8. LEARNING FROM PATIENT EXPERIENCE AND INCLUSION

9.1 Patient Stories

The Patient Experience and Inclusion Team continue to develop patient stories, utilising a combination of digital formats and face-to-face presentations, with either the patient or a representative in attendance. These stories are shared through multiple governance meetings, including but not limited to the Patient Experience and Inclusion Sub-Committee, the Quality Assurance Committee (QAC) and the Trust Board. The primary objective is to identify areas requiring improvement and to highlight best practices, thereby facilitating shared learning and enhancing the quality of care.

During Q2, patient stories that have been shared include:

- QAC July 2025
  - A face-to-face presentation from a surgical patient who had suffered a perforated bowel and required a laparotomy and colostomy. The patient shared their positive experience regarding their surgery and stay on ward A4. The patient reported that the MDT treated her as an individual throughout her care, reinforcing the importance of seeing the person behind the patient. The patient described that she was "demanding" at times during her stay and acknowledged that her mannerisms can sometimes be misinterpreted. However, the patient reflected that staff delivered high quality, person-centre and compassionate care, which included timely pain relief and clear communication throughout. She described that staff saw her as an individual, which made her feel respected.
  - The patient submitted a letter describing her positive experience and thanking staff, some of which were individually named, for their care and compassion during her stay. This has been recorded as a compliment via the Datix system.
  - The patient's feedback has been shared with the Ward Team and named individuals for their learning and reflections on the care they provided.
- Trust Board of Directors August 2025
  - A story was presented by a patient and her father following diagnosis and treatment of a tear of the anterior cruciate ligament (ACL) and meniscus at WHH. They shared their positive experience of their initial care in the Emergency Department but described their frustrations of WHH waiting list timescales. They reflected that they wish that they had been provided with timely and clear communication regarding the waiting list time, which may have resulted in them choosing to pursue private care to enable the patient to return to her football career at the earliest opportunity.
  - Positive feedback included:
    Good Communication with clinical staff.
    Consistency of care and engagement.

Compassion and reassurance provided.

- However, learning was identified, and shared with the Trust Board, relating to:
  Improved communications to patients on waiting lists with regular updates and/or reviews to enable patients to make informed decisions about their care.
  Emphasising the importance of seeing the person in the patient to improve their overall wellbeing.
  Recognising the importance of consistency of care in the post-operative phase.

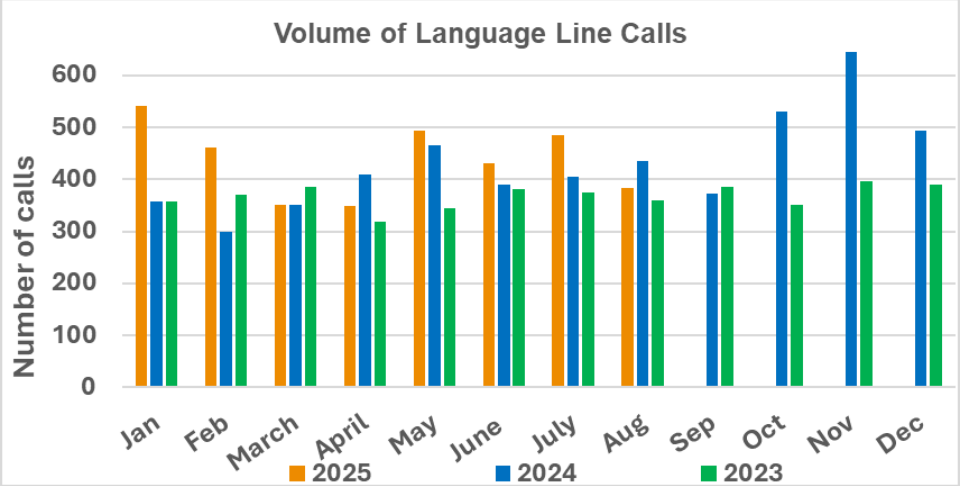
- QAC September 2025
  - A face-to-face presentation via Teams from a patient who had received care from the Pulmonary Rehabilitation Service and highly commended the service, with specific reference to:
    The group session retained personal care whilst allowing opportunity to share experience with our patients.
    They had previously been unable to walk, at times were bed bound and felt afraid to leave the home. However, the compassion and reassurance given after receiving diagnosis from the team have them confidence and now, they can go out shopping again with their partner.
    The support that they received from the staff had been invaluable in allowing them to continue with the things they enjoyed and improved quality of life.
  - Whilst overall a very positive experience, some lessons learnt were identified:
    Increased patient knowledge of the availability of Pulmonary Rehabilitation Services.
    Screening calls implemented to discuss rehabilitation with all patients, following referral.
    Working with Experts by Experience to review and improve how and when patients receive information about their diagnosis and the services available to them.

9.2 Patient Interpretation Services

Support provided for patients, where English is not there first language, is monitored through the Patient Experience and Inclusion Sub Committee (PEISC). The team monitor themes to look at where improvement or support is required. Data is supplied via an interpretation Dashboard to assure members that the quality and provision of Interpretation Services through contracted suppliers are fulfilling requests to support patients. Data is presented in a high-level dashboard bi-monthly.

Graph 13

Language Line Solutions – a comparison of the number of calls per month between 2023 to 2025 (September data not available at the time of writing).



The Big Word – face-to-face service requests made and the percentage fill rate 2024 to date.

b	*Service Requests*	*Services Fulfilled*	*% fill rate*
October 2024	42	41	96%
November 2024	47	43	95%
December 2024	41	38	96%
January 2025	54	32	68%
February 2025	53	34	55%
March 2025	34	32	94%
April 2025	21	19	90%
May 2025	18	18	100%
June 2025	25	21	84%
July 2025	22	19	86%
August 2025	27	24	89%
September 2025	Data not currently available		

British Sign Language Interpretation bookings comparisons 2023 to date. Data does not include September 2025.

Period	Deafness Resource Centre Active Booking Numbers			Language Line Video only Active Booking Numbers		
	2023/2024	2024/2025	2025/2026	2023/2024	2024/2025	2025/2026
Quarter 1 April – June	21	56	43	3	4	14
Quarter 2 July – September	30	69	33*	5	8	0*
Quarter 3 October – December	29	66		5	5	
Quarter 4 January - March	52	49		11	13	
Total	**92**	**240**	**76**	**24**	**30**	**14**

During Q2, inclusion progress has included:

- The Patient Experience and Inclusion Team were shortlisted as finalists at the Picker Experience Network Awards 2025 in the category Communicating Effectively with Patients and Families. This recognised their commitment to equality and improving

communication and interpretation access to support the needs of patients who are d/Deaf.

- The Trust and has been recognised within the National Adult Inpatient Survey 2024. Results published in mid-September highlighted that 4 of the top 5 Top WHH results compared with the national average, where patients experience is best, where for:
  - Individual needs: Staff considering patients' individual needs: Religious needs.
  - Individual needs: Staff considering patients' individual needs: Cultural needs.
  - Individual needs: Staff considering patients' individual needs: Language needs.
  - Individual needs: Staff considering patients' individual needs: Accessibility needs.
- Q1 and Q2 saw an increase in the number of Equality and Health Inequalities Assessments reviewed with a total for 168 completed in comparison to a total of 99 for the full financial year 2024/25. Evidencing that our workforce are paying 'due regard' to the general aims of the Public Sector Equaluty Duty and Armed Forces Act 2021; as well as working to reduce health inequalities.

10. APPENDIX 9. LEARNING FROM CLINICAL AUDIT

10.1 Learning from National Audits

National Paediatric Diabetes Audit (NPDA) 01 April 2023 – 31 March 2024

Summary

NPDA was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. A total of 169 children and young people with diabetes who received treatment at Warrington Hospital were included in the 2023/24 audit, with 23 diagnosed within the audit year.

Key Findings

The Paediatric Diabetes Unit is doing well and is not an outlier. The median HbA1C and percentage of patients with better glycaemic control (percentage patient < 58 mmol/mol) is improving year on year. The median HbA1c is better than national and regional average. Children and young people have better access to diabetes technology for Continuous Glucose Monitoring (CGM) and has improved the position with increased numbers of Hybrid Closed Loop (HCL) technology post audit submission. Currently the rate for HCL is better than the national average.

Learning

- Improvement required regarding annual care processes completion for urine albuminuria and diabetes retinal screening rates.
- To develop SMART goals and QI to ensure >90 % completion rates for Urine Albumin to Creatinine Ratio (ACR) and Diabetes Retinal screening.
- Increase the pace of full implementation of HCL technology to further improve the diabetes outcomes and patient experience.

Assurance rating (using Trust assurance rating matrix): HIGH Assurance

10.2 Learning from Local Audits

Re-Audit: Timely Multi-Disciplinaru Involvement in the Care of Antenatal, Intrapartum and Postnatal Women

Summary

The aim of this re-audit was to measure the participation and input of the multi-disciplinary team (MDT) in the handover and ward round for all obstetric patients including labour ward, ongoing inductions, antenatal and postnatal patients, as well as those requiring care on a non-maternity ward.

Key Findings

Compared to the initial audit in 2023:

MDT participation at AM handover, 89% vs 77% in initial audit.
MDT participation at PM handover, 43% vs 56% in initial audit.
Minimum twice daily ward round and must be all members of MDT present, 81% vs 67% in initial audit.
AM: all postnatal readmissions reviewed, 88% vs 70% in initial audit.

Learning

- To start an electronic data base of the staff members, present at the MDT hand over.
- Ensure all postnatal readmissions are marked on Ward C23 Board and inform C23 staff.
- Resident doctor staffing levels during the daytime to ensure sufficient coverage

Assurance rating (using Trust assurance rating matrix): MODERATE Assurance

11. APPENDIX 10. LEARNING FROM COMPLIANCE

11.1 Single Assessment Framework (SAF) Progress

The SAF replaces the Care Quality Commissions (CQC) former Key Lines of Enquiry (KLOE) model and represents the new regulatory approach for assessing quality across health and social care services. It is structured around the five key questions – Safe, Effective, Caring, Responsive, and Well-Led – and assesses how well services meet national quality standards through 34 Quality Statements supported by evidence.

Within the Trust, 100% of wards and departments have completed their initial self-assessments against the framework. An accompanying evidence directory is being compiled to validate submitted scores, identify areas requiring improvement, and ensure ongoing compliance. The process enables teams to understand their current level of compliance, celebrate strengths, and target areas for development.

The below figure presents the current breakdown of self-assessment scores for the *Safe* domain, illustrating how results are displayed across wards and departments and providing a visual reference for benchmarking performance.

Figure 4



The process is further strengthened by the introduction of a weekly Compliance Summits as part of the Trust's CQC preparedness programme. These meetings, chaired by the Chief Nurse or Deputy Chief Nurse and attended by Care Group Triumvirates, the Interim Head of Compliance, and Associate Chief of Nursing, are supported by detailed Care Group data packs covering HR, quality, safety, and governance metrics, including self-assessment progress and underpinning evidence.

Care Group performance data is also presented monthly to the Quality Compliance Oversight Group (QCOG) in line with the cycle of business. By sharing evidence portfolios aligned to the CQC Quality Statements, wards and departments can benchmark performance, share learning, and foster a culture of continuous improvement across the Trust.

Quality Compliance Oversight Group (QCOG)

Three QCOG meetings were held in Quarter 3 (July, August, and September 2025), providing continued oversight of quality, compliance, and regulatory preparedness as the Trust moves towards a CQC Well-Led inspection. Key areas of focus and learning included:

- **CQC Preparedness:** Ongoing development and monitoring of the CQC Well-Led Preparedness Action Plan, which includes the planned review of mobilisation plans and action cards key teams within the organisation, and strengthened engagement through weekly Compliance Summits.
- **Single Assessment Framework (SAF):** Confirmation that 100% of wards and departments have completed initial self-assessments. An evidence directory is being compiled to support the 34 Quality Statements, and learning from early submissions is being used to guide continuous improvement.
- **CQC Engagement:** A positive engagement meeting with CQC colleagues in July provided external assurance of progress and clarity on next steps for inspection readiness.
- **Inspection Outcomes:**
  - The **IR(ME)R inspection** (August 2025) highlighted strong compliance and leadership within Radiology.
  - An **unannounced Environmental Health Inspection** at Halton retained the Trusts 5-star rating, with further unannounced ward reviews expected.
- **CQC Must Do's and Should Do's:** Continued monitoring of actions from previous inspections.

- **Mock Inspections:** Reports detailing the outcomes of the Safeguarding and Medicines Management mock inspections have been completed, with an action plan developed and implemented for Safeguarding and a Medicines Management action plan in development following factual accuracy review. Both areas are being monitored and tracked through QCOG to ensure delivery of identified improvements
- **Policy Compliance (Regulation 17):** Compliance maintained at approximately 84%, supported by weekly policy review groups and continued focus on reducing out-of-date documents.
- **CQC Enquiries:** Marked improvement in timeliness of responses—reduced from 14 open enquiries in July to 4 by October 2025—reflecting improved governance processes and engagement from key colleagues.
- **Ward Accreditation:** Alignment of the accreditation process with the CQC Quality Statements and the Culture Plan to ensure consistent, evidence-based validation of care quality.
- **Risk and Assurance:** Integration of CQC domains within the Trust risk register, improving visibility of risks aligned to the five key questions (Safe, Effective, Caring, Responsive, Well-Led).

Learning from these meetings has reinforced the importance of proactive compliance management, consistent communication with Care Groups and CBUs, and the value of using assurance data to identify gaps early and support continuous improvement.

11.2 Learning from Mock Assessments

The Safeguarding Mock Inspection was undertaken on 03 June 2025. The review focused on the UEC CBU alongside selected cross-cutting areas across the Trust. The process mirrored that of a CQC inspection, incorporating document review, staff focus groups, and interviews with key leaders including the Chief Nurse and Associate Chief Nurse of Safeguarding and Complex Care. The final report has been completed, supported by a comprehensive action plan which is being monitored through QCOG and associated governance groups.

The Safeguarding mock inspection identified strong leadership, clear governance structures, and a well-established safeguarding framework across the Trust. Areas of good practice included visibility of the Safeguarding Team, robust escalation processes, and improved staff awareness of safeguarding responsibilities.

Key learning focused on strengthening documentation standards, improving consistency in training compliance, and enhancing feedback loops following safeguarding reviews.

The Medicines Management Mock Assessment was undertaken on 10 April and 16 May 2025, covering a representative sample of wards and departments. Assessment areas were selected based on medicines audit data, ward accreditation findings, previous CQC “Must Do” and “Should Do” actions, and a review of incidents, complaints, and risk registers. The assessment was supported by a Chief Pharmacist from a neighbouring Trust, who led staff focus groups, reviewed patient journeys, and undertook targeted documentation and ward reviews.

The Medicines Management mock inspection highlighted positive culture and engagement from clinical teams, with good examples of safe practice and strong pharmacy oversight. Learning centred on ensuring greater consistency in medicines storage checks, record-keeping, and controlled drug documentation across all areas.

The Medicines Management report was completed and presented at QCOG in September 2025 and is currently progressing through factual accuracy review and development of an

associated action plan, this will ensure learning is embedded and improvements are tracked through the relevant assurance forums.

Both mock inspections have strengthened the Trust's internal assurance processes and provided valuable insight into regulatory readiness, with clear mechanisms now in place to track completion and impact of resulting actions.

11.3 CQC Engagement Meetings

The most recent CQC Engagement Meeting took place on 17 July 2025 at Halton Hospital, attended by CQC representatives, Executive colleagues and senior leaders within the organisation. The meeting provided a comprehensive review of quality, safety, and governance developments across WHH. Key areas of discussion included.

- **CQC National Update**: Overview of CQC structural changes, including the introduction of four Chief Inspectors and the revised assessment model across networks.
- **Service Presentation:** A spotlight presentation on the Older Persons Short Stay Unit (OPSSU) highlighted positive early outcomes, reduced lengths of stay, and strong multidisciplinary working.
- **Quality Updates:**
  - **Maternity:** Review of staffing, recruitment, and culture improvement actions, supported by a Maternity Culture Action Plan.
  - **Nutrition** (MUST compliance): Significant improvement achieved through enhanced monitoring, ward walk-rounds, and staff training.
  - **Cancer Services:** Presentation of the Fragile Services work programme and improvement actions for urology and gastroenterology pathways.
  - **Paediatric Audiology:** Assurance provided that all affected cases had been reviewed in line with NHSE guidance, with no patient harm identified.
- **Responsive and Well-Led Updates:**
  - Overview of the Runcorn Health and Education "Living Well" Hub and associated registration requirements.
  - Progress in Freedom to Speak Up, with a significant increase in disclosures and strengthened Guardian capacity.
  - Advancements in health inequalities work, including implementation of the Equality and Health Inequalities Impact Assessment (EHIA) process and collaborative work with Bridgewater to embed health literacy and community engagement.
  - Dermatology AI Service recognised as an innovative example of integrated, technology-enabled care delivery.

The meeting also reviewed ongoing actions in relation to fragile services, ligature risk management, and infection prevention controls, with assurance provided that appropriate governance arrangements are in place.

The next CQC Engagement Meeting is scheduled for 04 November 2025.

11.4 CQC Enquiries

Significant progress has been made in the management of CQC enquiries over recent months, with the total number of open cases reducing from 14 to just 4. This improvement reflects strengthened internal governance, engagement with wards and departments, and continued coordination between the Compliance, Complaints, and Patient Safety teams.

The remaining four open enquiries relate to Emergency Department wait times and triage processes, diagnosis and treatment concerns, ligature-related patient safety incidents, and a wrong-site surgery Never Event. All are progressing to completion, subject to finalisation governance processes.

A further five enquiries have been submitted and are awaiting formal closure by the CQC, while the remainder have now been fully closed following satisfactory responses and assurance. This reduction demonstrates sustained improvement in the timeliness, quality, and consistency of responses, providing assurance that CQC enquiries are being managed proactively and transparently.

11.5 Planned Work for Q3 to Embrace Learning

- A programme of mock assessments will be scheduled on a bi-monthly basis.
- Continued work to reduce the number of outdated policies with oversight on improvement via the SOM.
- Full findings from the Medicines Management and Safeguarding mock assessment will be compiled and shared with relevant teams. Action plans will be initiated to address areas for improvement.
- Terms of reference and cycle of business documentation have been reviewed and updated accordingly to ensure the continued effectiveness of the Quality and Compliance Oversight Group.
- CQC Engagement took take place on 17 July 2025, a review of the meeting has taken place to support preparedness for well led inspection.
- Continue to process all CQC Enquiries.

12. APPENDIX 11. LEARNING FROM RESEARCH AND DEVELOPMENT ACTIVITY

12.1 Learning from Experience: Research Feasibility Process Improvement

In preparation for the introduction of a new national research funding model that will place greater emphasis on performance outcomes, the team is undertaking a review of our research study feasibility processes to ensure we are effectively meeting set-up and delivery targets. This exercise prompted focused reflection on current practices across both commercial and non-commercial studies.

Through this review, we identified that while feasibility processes for commercial studies are generally well established and efficient, there is scope for improvement in the management of non-commercial studies. To address this, a team meeting was held to explore current approaches, share learning, and identify barriers to timely and effective feasibility assessments.

The discussion enabled team members to reflect on what is working well, areas requiring improvement, and opportunities to enhance consistency. Key themes emerging from the session included the need for clearer role definitions, improved alignment of understanding, and the establishment of defined timelines for key stages of the process.

Although this work remains ongoing, there is already evidence of improved shared understanding within the team and enhanced collaboration. This learning from experience is supporting continuous improvement and helping to position the team to meet the expectations of the forthcoming performance-focused funding model.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/25/11/187**			
SUBJECT:	**Infection Prevention and Control Report Quarter 2**			
DATE OF MEETING:	11 November 2025			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention and Control			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah Chief Nurse/Director for Infection Prevention and Control			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments: Nil			
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 2 (Q2) of the 2025/26 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. Trust apportioned, mandatory reportable, healthcare associated infection (HCAI) cases to the end of Q2 are: • *E. coli* bacteraemia 43 cases (annual threshold 79 cases) • *Klebsiella Spp.* bacteraemia 11 cases (annual threshold 28 cases) • *P. aeruginosa* bacteraemia 7 cases (annual			

<table>
<tr><td></td><td colspan="3">threshold 8 cases)
• C. difficile 44 cases (annual threshold 60 cases)
• MRSA bacteraemia 0 cases
• MSSA bacteraemia 20 cases (no threshold)

A Well Organised Ward project has been launched with Clinical Business Units which focuses on decluttering and cleaning care environments using the 5S model. The project has experienced barriers to completion with the high operational pressures and requires revision, which will take place in Q3.

Inpatient Covid-19 cases to the end of Q2 were:
• 82 cases (0-2 days)
• 27 cases (3-7 days)
• 28 cases (8-14 days – probable healthcare associated)
• 49 cases (15+ days – definite healthcare associated)

Seven Covid-19 outbreaks affecting patients have been reported to the end of Q2.

A review of sharps injuries highlighted concerns with how injuries are reported, resulting in missed opportunities for investigation and learning. Actions are in place to address findings from the review.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note ✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="3">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">ICSC/25/10/174</td></tr>
<tr><td>Date of meeting</td><td colspan="2">30 October 2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit to Quality Assurance Committee</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 in Full</td></tr>
<tr><td>FOIA EXEMPTIONS</td><td colspan="3">Choose an item.</td></tr>
</table>

APPLIED: *(if relevant)*	

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 2	AGENDA REF:	QAC/25/11/187

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for Quarter 2 (Q2) of the 2025/26 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, continued response to Covid-19 cases and progress towards achieving the Infection Prevention Strategy.

Within the National Action Plan on confronting antimicrobial resistance (2024/29), an aim has been set to prevent any increase in Gram negative bloodstream infections (GNBSI) from the 2019/20 financial year baseline.

GNBSI include: -

- *Escherichia coli* (*E. coli)*
- *Klebsiella species (Klebsiella spp.)*
- *Pseudomonas aeruginosa (P. aeruginosa)*

This is a revision to the previous 50% reduction target, implemented following recognition of challenges linked to an aging population with comorbidities and anticipated increase in incidence of GNBSI. There is also a recognition that there is limited evidence in professional literature for interventions which work to prevent GNBSI.

Due to growing concern about the national increase in numbers of *Clostridioides difficile* (*C. difficile*) cases, the UK Health Security Agency (UKHSA), set up a national standard incident to review the situation. A technical report (May 2025) indicated the increase is not linked to changes in testing or hypervirulent ribotypes. The findings showed that whilst antibiotic consumption has increased, particularly in the access category of the UK Access, Watch, Reserve (AWaRe) classification, usage remains lower than pre-pandemic levels.

The report authors acknowledged gaps in the report and concluded further investigation into use of corridor care/boarding; infection prevention and control resources and staffing, cleaning, sampling and testing practices is required.

NHS England (NHSE) set annual thresholds to minimise rates of *C. difficile* and GNBSI. There is a zero-tolerance approach to avoidable *Meticillin-resistant Staphylococcus aureus* (MRSA) bloodstream infections (bacteraemia).

There are no set thresholds for *Meticillin-sensitive Staphylococcus aureus* (MSSA) bloodstream infections.

The thresholds set for WHH for 2025/26 are shown in table 1.

Table 1 WHH HCAI Thresholds for 2025/26

HCAI	WHH Thresholds 2025/26
C. difficile	≤60
E. coli	≤79
Klebsiella spp.	≤28
P. aeruginosa	≤8

Bacteraemia case apportionment is as detailed below:

- **Hospital-Onset Healthcare Associated** (HOHA) specimen date is ≥ 3 days after current admission date* (where day of admission is day 1)

- **Community-Onset Healthcare-Associated** (COHA) is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

- Community-Onset Community Associated (COCA) is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

***C. difficile* case apportionment** is as detailed below:

- **Hospital-Onset Healthcare Associated** (HOHA) specimen date is ≥3 days after the current admission date* (where day of admission is day 1)

- **Community-Onset Healthcare-Associated** (COHA) is not categorised HOHA, and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

- Community-Onset Indeterminate Association (COIA) is not categorised HOHA, and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the specimen date)

- Community-Onset Community Associated (COCA) is not categorised HOHA, and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)

HOHA and COHA cases are apportioned to acute Trusts.

*From April 2024, the UKHSA introduced use of 'decision to admit' date rather than admission date to calculate apportionment.

NHSE also set annual thresholds for all NHS Integrated Care Boards (ICB). These thresholds include all cases (comprising of the acute Trust and community cases).

The Cheshire and Merseyside ICB, HCAI thresholds are shown in table 2.

Table 2: NHS Cheshire and Merseyside (C&M) ICB Thresholds for 2025/26

C&M ICB	*C. difficile*	*E. coli*	*Klebsiella spp.*	*P. aeruginosa*
QYG	843	2,001	572	144

The zero-tolerance threshold for avoidable cases of MRSA bacteraemia cases remains in place.

There is currently no threshold for MSSA bacteraemia cases.

NHSE case definitions for Covid-19 cases, with date of admission equalling day 1, are as follows:

- **Hospital-Onset Definite Healthcare-Associated (HOdHA)** - First positive specimen date 15 or more days after admission to Trust
- **Hospital-Onset Probable Healthcare-Associated (HOpHA)** - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Indeterminate Healthcare-Associated (HOiHA) - First positive specimen date 3-7 days after admission to Trust

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

Red, Amber, Green (RAG) rating of Trust performance for HCAI by month is shown in Table 3, with more detailed information in appendix 1.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	Total	Status
C. difficile	≤60	3	7	9	10	9	6	44	Above in year trajectory by 14 cases

MRSA BSI	Zero	0	0	0	0	0	0	0	Zero tolerance to avoidable cases
MSSA BSI	No threshold	6	5	0	3	4	2	20	No threshold
E. coli BSI	≤79	8	6	7	6	7	9	43	Above in year trajectory by 4 cases
Klebsiella spp. BSI	≤28	3	2	4	0	1	1	11	Below in year trajectory by 3 cases
P. aeruginosa BSI	≤8	1	1	1	2	2	0	7	Above in year trajectory by 3 cases

***C. difficile*:** 25 Trust apportioned cases were reported in Q2. The Trust is above the in-year trajectory by 14 cases.

The *C. difficile* prevention action plan (appendix 2) was updated in September 2025 and includes:

- strengthening antimicrobial stewardship
- proton pump inhibitor guidance
- trialling probiotics
- improving environmental hygiene
- awareness raising on hand hygiene
- robust surveillance to detect periods of increased incidence
- promotion of the SIGHT mnemonic (suspect, isolate, gloves and aprons, handwashing and toxin test)
- timely isolation
- care of patients with C. difficile
- sharing learning from cases

***C. difficile* Outbreak ward B14**

Surveillance of hospital onset cases identified a period of increased incidence (2 toxin positive cases within 28 days on ward B14). Testing revealed both cases were ribotype 014 and additional DNA fingerprint (MLVA) testing confirmed the cases were indistinguishable (i.e. the cases were linked). An outbreak was declared and reported to UKHSA.

A programme of enhanced infection prevention and control support has been implemented and plans put in place for deep cleaning with hydrogen peroxide vapour (HPV).

Clusters of *C. difficile* cases were also identified on wards A9, and AMU (cases were not linked) and all bays on these wards have been decanted and deep cleaning undertaken using hydrogen peroxide vapour (HPV).

Progress with the Model/Well Organised Ward (WOW), has been slower than planned due to high bed occupancy and additional patient boarding. The WOW schedule is under review and will be revitalised and relaunched in Q3.

MRSA Bacteraemia:

- Nil cases in Q2 and nil cases at the mid-point of the year.

MSSA Bacteraemia:

- 9 cases were reported in Q2 making 20 cases at the mid-year point. There is no set threshold for MSSA cases.

There are a mixture of primary sources including skin and soft tissue infection, prosthetic joint infection and pneumonia. A review of peripheral cannula management is underway due to a number of IV device related likely sources.

The source of the infection was unknown for 10 of the hospital apportioned cases. Further review of the cases with unknown sources will take place to identify any areas for learning and improvement.

GNBSI:
GNBSI cases to the end of Q2

- *E. coli* (43 cases)
- *Klebsiella spp.* (11 cases) and
- *P. aeruginosa* (7 cases)

Urinary tract infections continue to be the main primary source. The GNBSI Prevention Action Group has been re-established and a request made to Clinical Business care groups to make data informed decisions on addressing case reductions within their areas. Once information on actions is received, the Driver Diagram will be revised to outline the Trust plan and will sit alongside the GNBSI prevention action plan with actions targeted at:

- Urinary catheters
    - catheter associated urinary tract infection surveillance
    - catheter prevalence survey
- Timely blood culture sampling in ED aligned to sepsis workstreams
- Oral hygiene to prevent hospital acquired pneumonia
- Hydration aligned to the Nutrition and Hydration Strategy
- Education on GNBSI prevention at Mandatory Training

Policy/Guideline/SOP Updates

The IPC Team annual workplan includes a schedule of documents for review in line with the National IPC manual for England. The following documents were updated and approved by the Infection Control Sub-Committee (ICSC) in Q2:

- Measles Policy
- IPC Team Organogram, Professional Reporting Structure and Framework of Assurance
- Training Planning Document for FFP3 Fit Testing
- Decontamination Policy
- Blood and Body Spillage Guidelines
- Deceased Patient Infection Control Guidelines
- Local Surveillance Guidelines
- Ward Closure Guidelines

- Specimen Guidelines
- Admission, Transfer and Discharge Guidelines

Audit

During Q2, 56 full Infection Prevention and Control (IPC) audits were completed. Scores are detailed in appendix 3. The IPC audit tool is aligned to the NHS England National Infection Prevention and Control Manual and includes standard precautions.

A summary of areas for improvement (list is not intended to be exhaustive) are included in table 4.

Table 4: Summary of Audit Findings

Element	Areas for improvement
General Environment	Dusty fans, dusty IT equipment and ventilation extraction vents
Clean Utility Rooms	Dusty stacker systems, ANT trays stored incorrectly and floor stains, poor estate impacting cleaning
Toilets and bathrooms	Personal items left in bathrooms
Linen	Build up of full linen bags in ward areas,

Concerns and issues requiring immediate action are reported to the nurse in charge at the time of the audit. Full audit findings are emailed to Ward Managers and an action plan to address findings is requested. Action plans are being followed up with a request for assurance on completion.

Clean Utility Rooms are the next focus area for the Well Organised Ward project.

The re-audit schedule is set according to findings. For areas with lower scoring results and areas with outbreaks or clusters of infections, re-audit is completed sooner and/or more frequently. All areas are monitored by an IPC and CBU Matron monthly visit and if concerns about IPC standards are identified, a repeat audit is completed.

Education and Training

Compliance with level 1 and level 2 IPC mandatory training has remained above 85% for substantive staff. Mandatory IPC training is available via eLearning, face to face training and at corporate induction.

Table 5 Mandatory Training Compliance

IPC Mandatory Training	A	M	J	J	A	S
Level 1 – Non-Clinical	94%	93%	96%	96%	95%	95%

Level 2 – Clinical	86%	87%	88%	86%	85%	84%

Awareness Raising Events

TB Seminar





In September, Dr Qazzafi Consultant Microbiologist Deputy DIPC and Infection Control Doctor presented a seminar on TB to the respiratory team, Occupational Health and Wellbeing, Community TB and Infection prevention and Control Teams.

The session highlighted the rising incidence of TB and provided information on the disease, treatment and updates to guidance on use of FFP3 masks in the National Infection Prevention and Control Manual. The session evaluated well by all attendees.

Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring. All areas are scoring 4-star or 5-star ratings (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories.

Efficacy audits, with representation from infection prevention and control, estates, facilities and nursing leaders are scheduled to take place weekly. The programme was paused over the holiday period.

The results from Q2 are displayed in table 6. Note the lower percentages may relate to lower numbers of factors in the element being reviewed.

Table 6 Efficacy Audit Results

Date	Ward/ Department	Cleanliness Assurance	IPC Assurance	Staff Appearance and Behaviour	Wate Segregation and Management	Consumables and Dispensers	Environment
2/7/25	Cardiac Catheter Lab	95%	91%	100%	67%	100%	80%
9/7/25	Ophthalmic OPD	95%	91%	100%	67%	100%	80%
16/7/25	Chapel, UIU, Mortuary	89%	91%	67%	67%	100%	60%
23/7/25	Antenatal clinic and Gynaecology Clinic	100%	64%	100%	100%	100%	60%
30/7/25	Internal corridors and Main entrances	95%	73%	100%	67%	100%	40%
3/9/25	PIU	95%	73%	100%	100%	100%	60%
10/9/25	B2, B4	84%	64%	100%	67%	100%	60%
17/9/25	Endoscopy	84%	73%	100%	100%	100%	60%

The audit findings show concerns with the cleanliness standards in main entrances and internal corridors. An out of hours inspection of corridors and stair wells has been scheduled for early in Q3 and recruitment is in progress to recruit domestic staff in this area. Concerns remain with the estates backlog maintenance and general tidiness.

The next steps include action planning to prioritise outstanding estate work and focus on improvements, where identified as required.

Incidents

Sharps Safety

In September 2025, a review of sharps injuries/exposure incidents was undertaken. A sharps injury is defined as ‘an incident, which causes a needle, blade (such as scalpel) or other medical instruments to penetrate the skin. This is sometimes called a percutaneous injury.’ Additional risks are associated with exposure via splashes to mucous membranes e.g. eyes/ oral cavity or areas of broken skin.

There are several policies and training programmes in place to support prevention of sharps injuries/exposure incidents and advice is provided on first aid actions required in the event these incidents arise.

The review period covered Jan – Jul 2025 inclusive. During this time 58 incidents were reported. Some of these incidents (n=29) were reported as patient rather than staff incidents. All incidents should undergo investigation and reports on findings added to the incident report. This occurred for 22 of the 58 incidents. Contaminated sharps were cited in 40 incidents. Harm rating were recorded as low/no harm however data from Occupational Health and Wellbeing (OH&W) was not readily available on numbers of staff requiring post exposure prophylaxis, follow-up bloods (up to 24 weeks) or staff absence.

Lower numbers of staff (n=44) attended OH&W, than incidents reported via Datix (n= 55 adjusted), 10 incidents were associated with clean splash/needle and would not require follow-up. Whilst this implies n=1, staff member did not attend for follow-up, it was not possible to confirm that the staff attending OH&W are the same as those who completed Datix reports (due to use of patient rather than staff details for reporting). A summary of review findings included:

- Inaccurate reporting on Datix (n=29)
- Majority of incidents involved contaminated sharps (n=40)
- Greater number of injuries reported by Emergency Medicine in UEC CBU
- Band-5 nurses = highest number of reported incidents (n=17)
- Higher numbers of incidents associated with:
    - Taking bloods (n=9)
    - Administering insulin (n=7)
    - Lower number of staff attending OH&W (44) than number of incidents reported on Datix (n=55* Corrected to remove 3 patient related incidents)
    - All incidents were reported as No harm (n=34) or Low harm (n=24), however, levels of harm could not be verified due to number of investigations not completed in line with the Trust policy and data unavailable for OH&W on post exposure prophylaxis, follow-up bloods and absence

The recommendations from this review include a requirement to contribute to improving staff safety and learning culture by:

- sharing sharps injury review findings at:
  - Infection Control Sub Committee
  - Health & Safety Sub-Committee
  - Medical Cabinet
  - NM&AHP Forum
  - Chief Nurse Check in
  - Trust-wide safety brief
  - UEC (ED) Study Day

- Target prevention activities in areas/staff groups with higher incidences
- Review risk assessment templates for prevention of sharps injury and splash/exposure
- Review Datix log-on screen to make clearer requirement to report staff injuries as non-clinical incidents
- Governance Team to identify and action any incorrectly reported incidents
- Continue programme of sharps safety training and audits
- Align Datix and OH&W data for ease of comparison and to support follow-up of staff/impact of injury
- Register an audit against the Needlestick Injury Prevention Policy
- Repeat the review of sharps injuries within 6 – 12 months of implementing actions

Covid-19

Covid-19 continues to have an impact on the Trust. Details of all cases from Q1 - Q2 are shown in Table 7.

Table 7 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	6	1	1	7	15
May	7	2	6	7	22
Jun	7	9	4	7	27
Jul	12	3	1	9	25
Aug	15	3	7	6	31
Sep	35	9	9	13	66
Total	**82**	**27**	**28**	**49**	**186**

Covid-19 Outbreaks

Three Covid-19 outbreaks were reported in Q2 (appendix 1). Additional oversight of infection prevention and control precautions was implemented to support ward teams.

Collaboration with Estates

The IPC Team continue to work closely with the Head of Estates Maintenance, Compliance and Risk on water safety and ventilation issues and the Head of Capital

Projects on all new builds and upgrade works. Work was completed to separate two rooms that can accommodate 2 patients into single occupancy rooms on wards B14 and B19.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Establish and deliver a workplan for 2025/26
- Provide expert infection prevention and control advice to colleagues
- Review escalations in infections, jointly with the associated Care Group
- Share learning from infection related incidents with relevant teams and external partners
- Align services with Bridgewater Community Healthcare Foundation Trust

4. IMPACT ON QPS?

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Attendance at training assists staff in their role and fulfils mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

5. MEASUREMENTS/EVALUATIONS

- UKHSA mandatory reportable HCAI
- Surveillance of nosocomial Covid-19 cases
- Local surveillance of HCAI and action implemented in response to increased incidences of HCAI and infection control related incidents
- Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI event aligned to SEIPS/PSIRF reports and audits with agree actions to support care improvements
- Cleanliness monitoring reports and multi-disciplinary efficacy audits

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy has been extended pending the integration with Bridgewater Community Healthcare Foundation Trust. The IPC Strategy objectives include:

- Prevention of healthcare associated infections

Table 8 HCAI Thresholds 2025/26

HCAI	WHH Thresholds 2025/26
C. difficile	≤60
E. coli	≤79
Klebsiella spp.	≤28
P. aeruginosa	≤8

- Antimicrobial Stewardship

- Prompt switching of intravenous to oral antibiotics (achieving 15% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria)

- Improving standards of environmental cleanliness
  - Deep cleaning programme

- Sustainability
  - Implementing actions in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Sub-Committee

Director of Infection Prevention and Control (DIPC) reports are submitted quarterly to:

- Infection Control Sub-Committee
- Quality Assurance Committee and onwards to Trust Board.

IPC Board Assurance Reports are submitted to the Quality Assurance Committee Biannually.

Verbal updates are provided by the Chief Nurse/DIPC to Trust Board monthly as part of the Integrated Performance Report.

The DIPC Annual Report is submitted to Trust Board and published on the Trust website.

Monitoring is in place at the Senior Executive Oversight Group.

8. TIMELINES

2025 – 2026 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

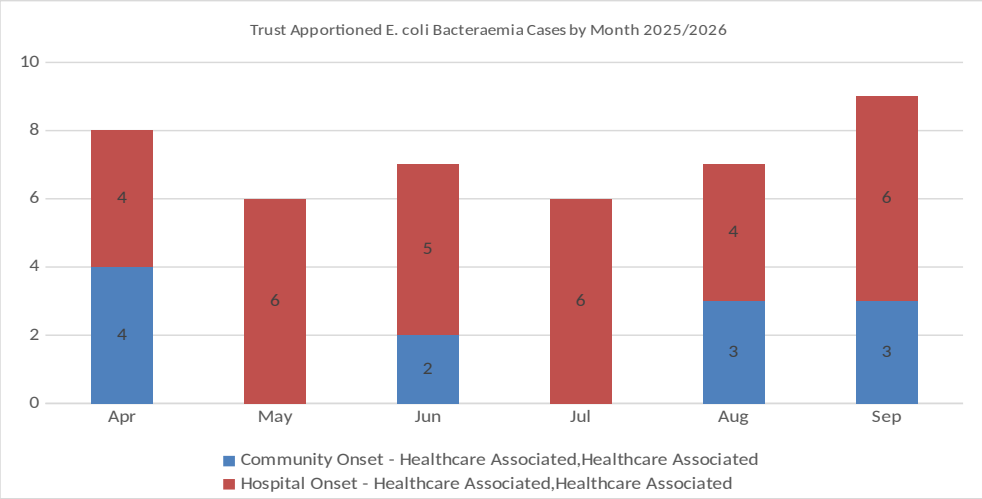
10. RECOMMENDATIONS

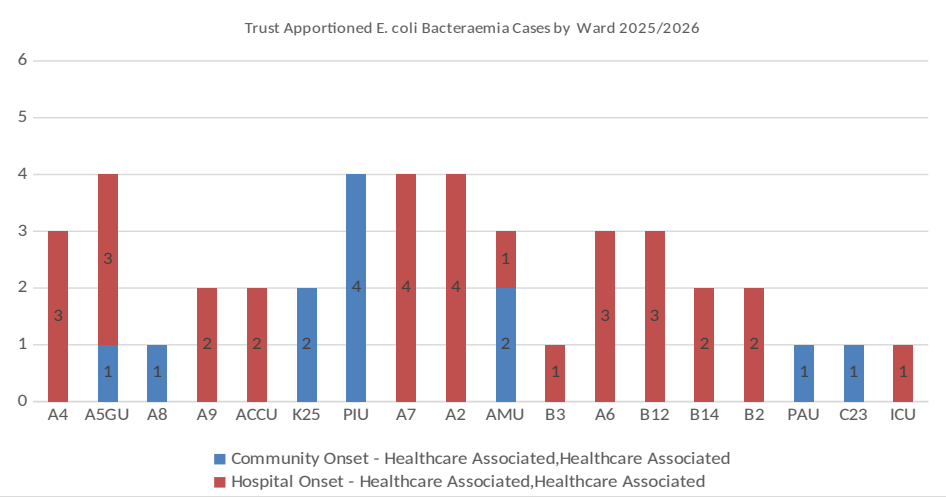
The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.

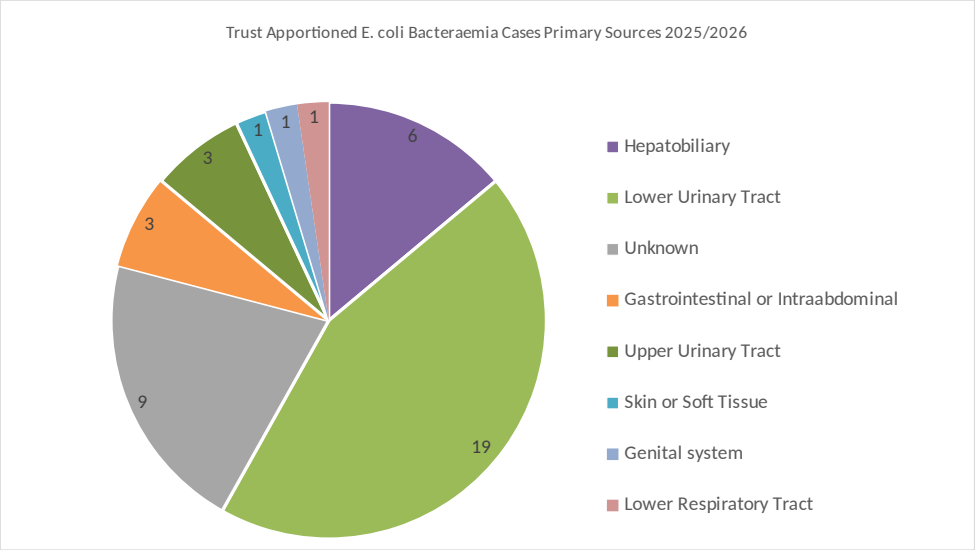
Appendix 1 Mandatory Healthcare Associated Infection Data

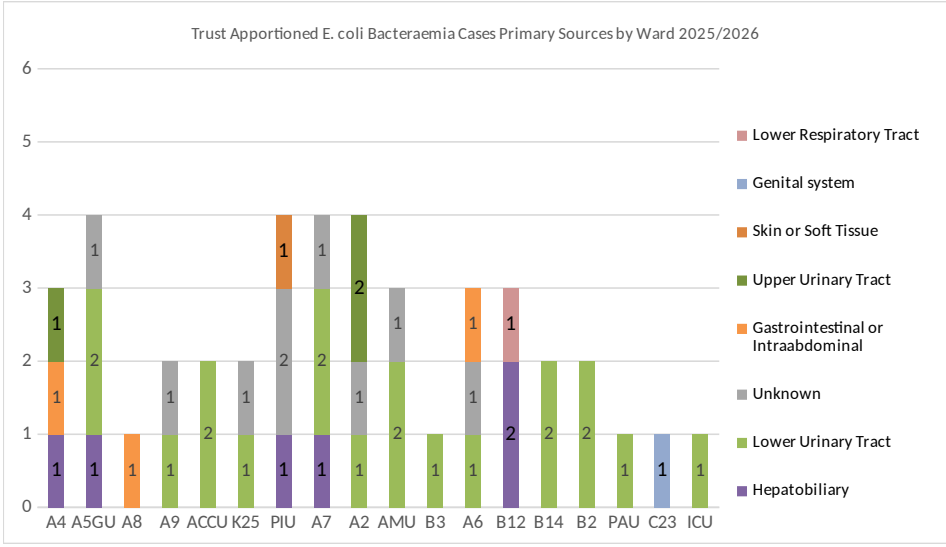
Gram Negative Bloodstream Infection: E. coli Apr – Sep 25

Threshold	79
YTD Total	43



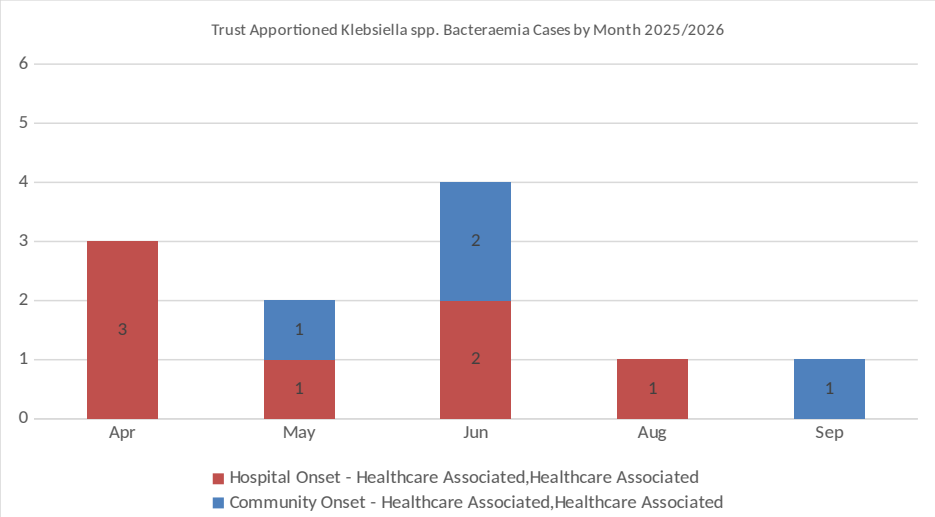


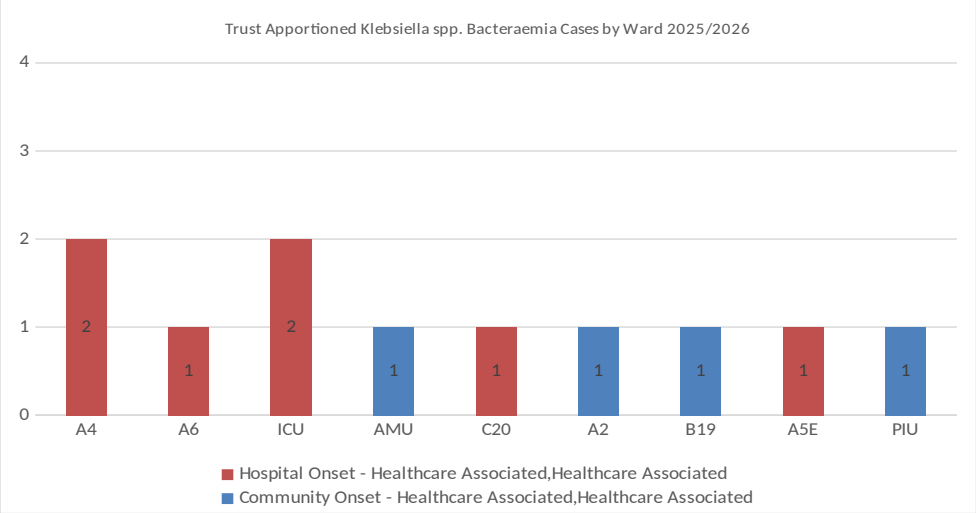


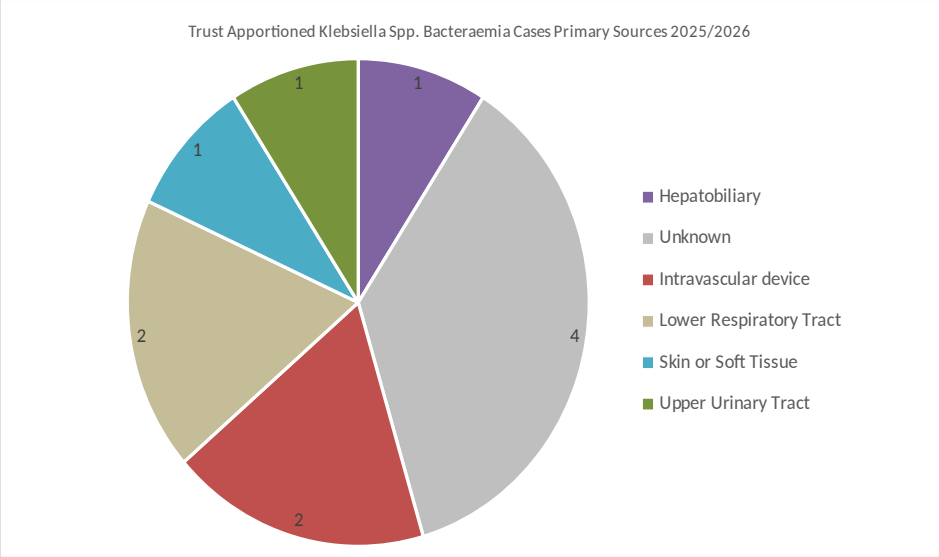


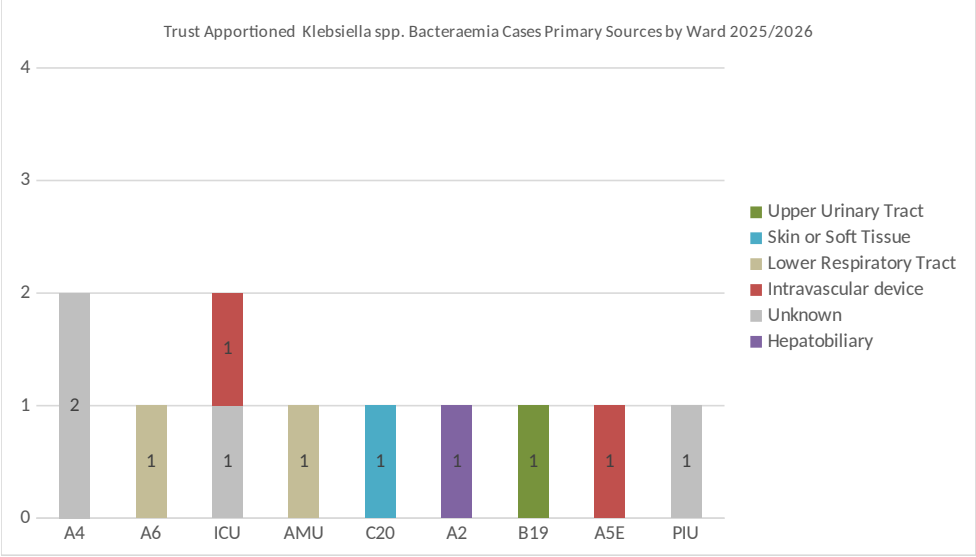
Gram Negative Bloodstream Infection: Klebsiella spp. Apr – Sep 25

Threshold	28
YTD Total	11



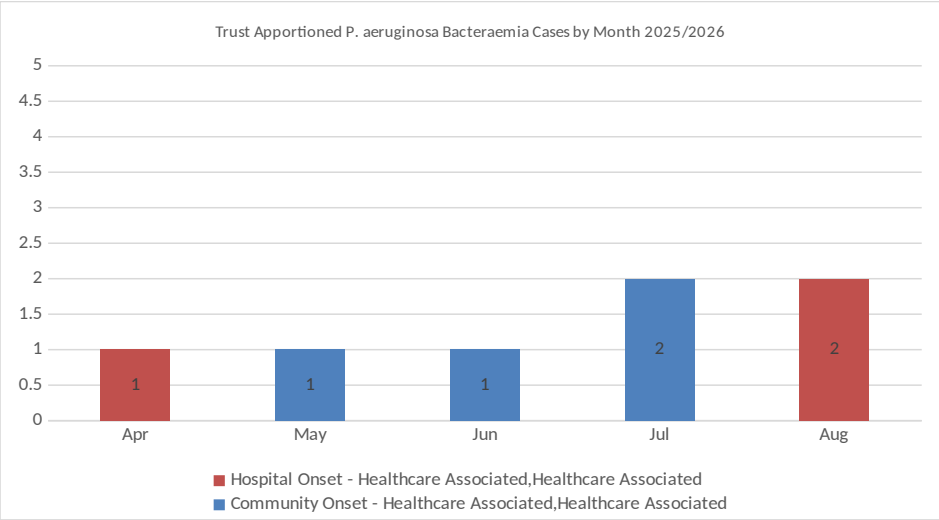


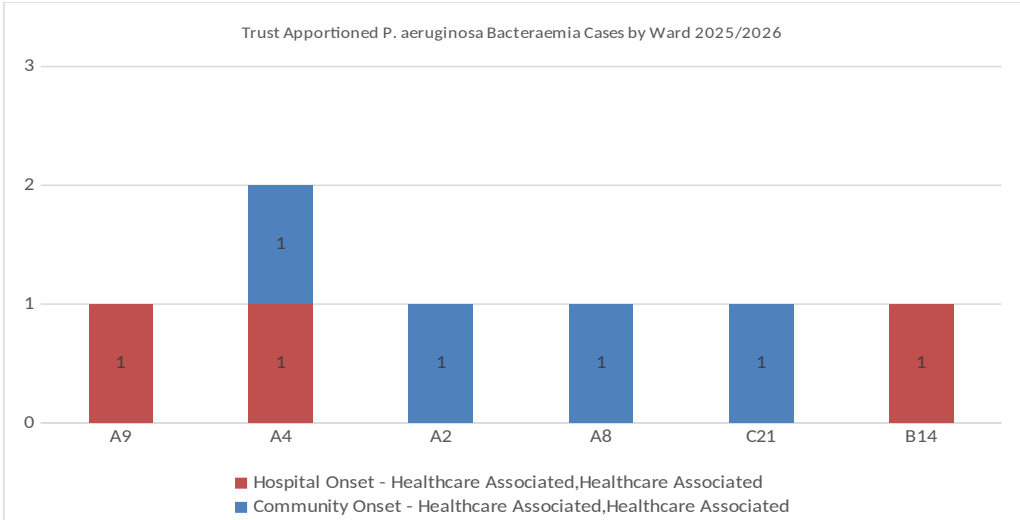


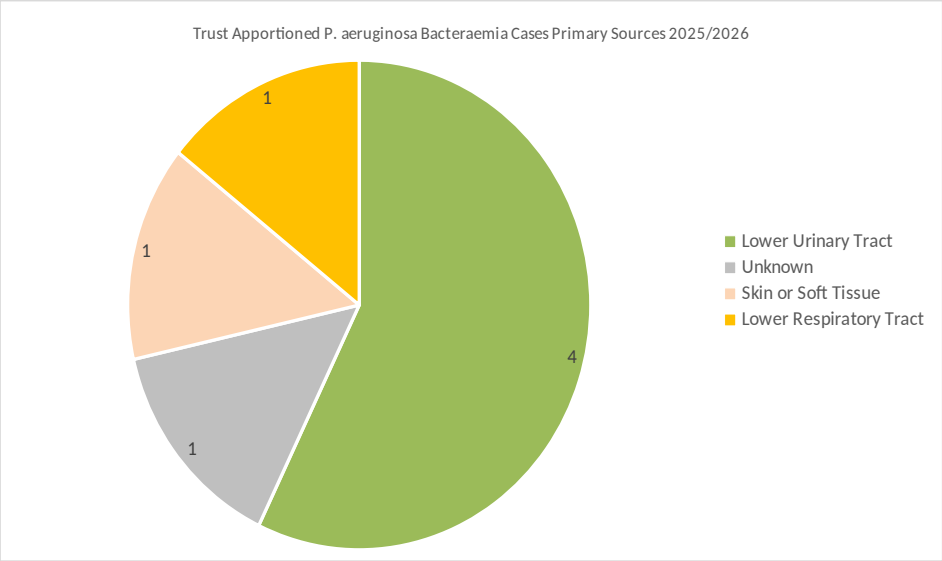


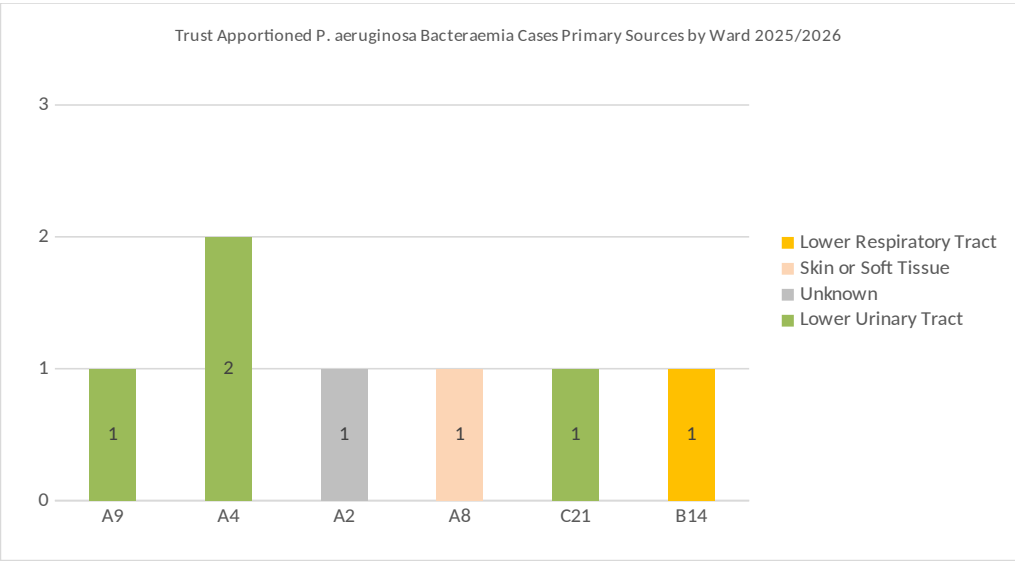
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr – Sep

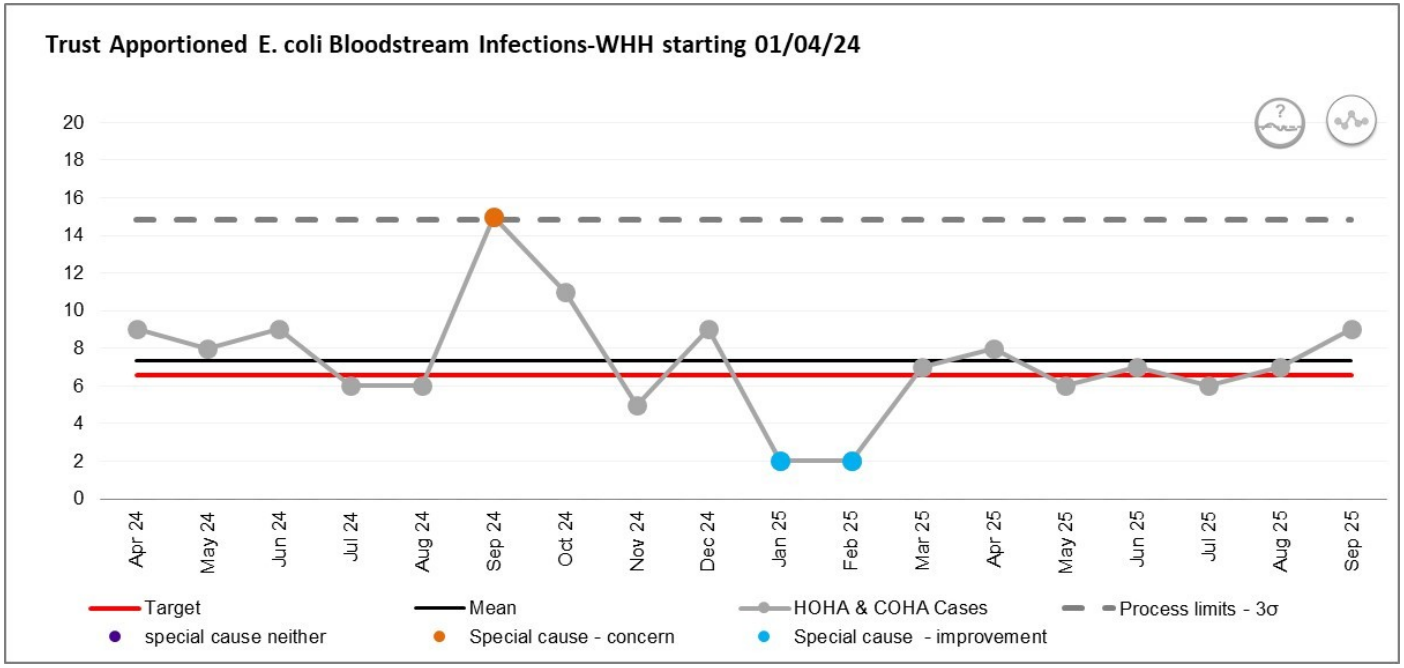
Threshold	8	25
YTD Total	7	

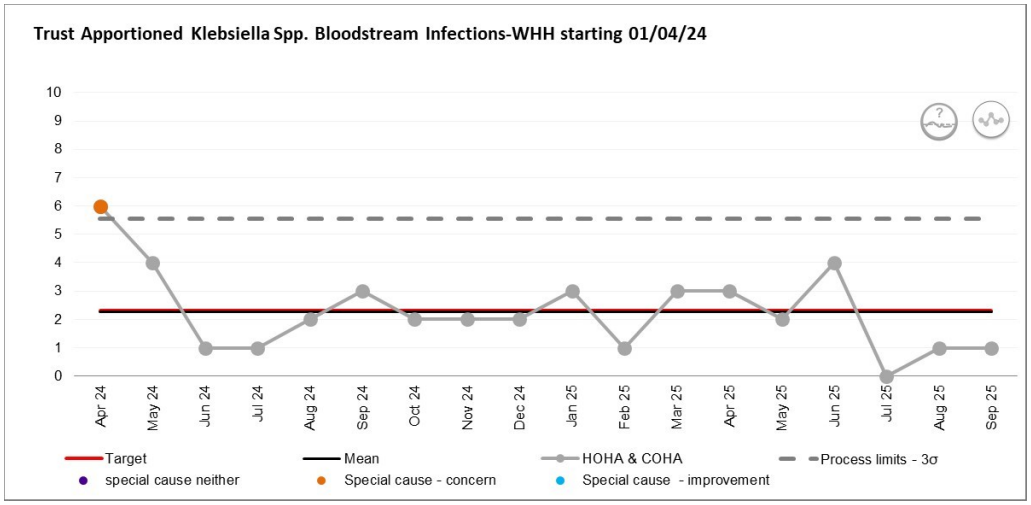


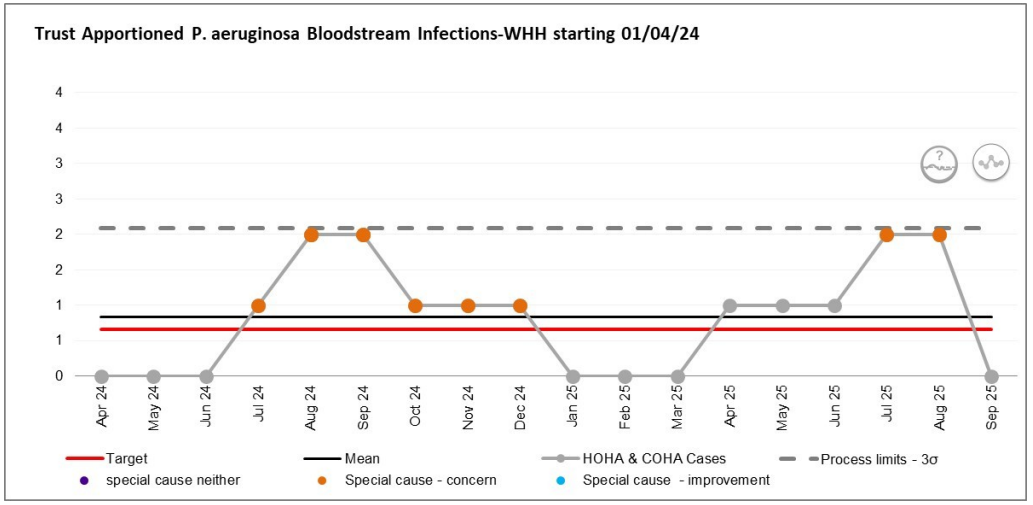







Trust Apportioned E. coli Bloodstream Infections-WHH starting 01/04/24
20
18
16
14
12
10
8
6
4
2
0
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Target
Mean
HOHA & COHA Cases
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement


Trust Apportioned Klebsiella Spp. Bloodstream Infections-WHH starting 01/04/24
10
9
8
7
6
5
4
3
2
1
0
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Target
Mean
HOHA & COHA
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement

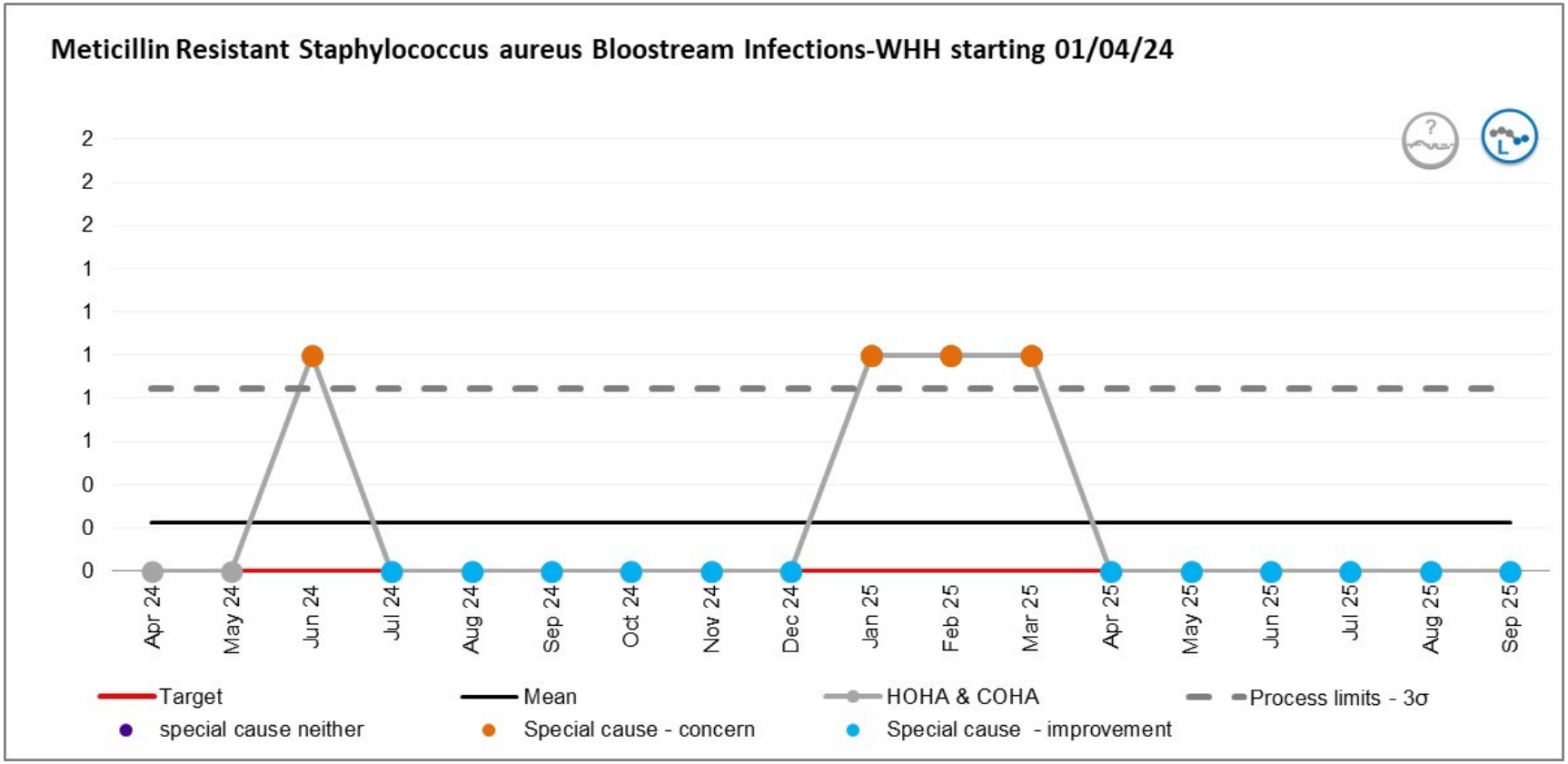

Trust Apportioned P. aeruginosa Bloodstream Infections-WHH starting 01/04/24
4
4
3
3
2
2
1
1
0
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Target
Mean
HOHA & COHA Cases
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement

Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr – Sep 25

Threshold	Zero
YTD Total	0

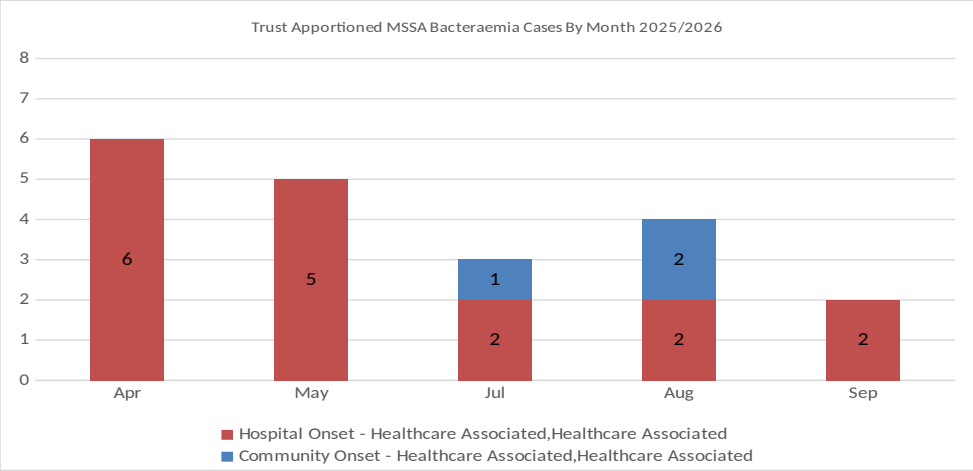
Nil MRSA Bacteraemia Cases Apr - Sep 2025

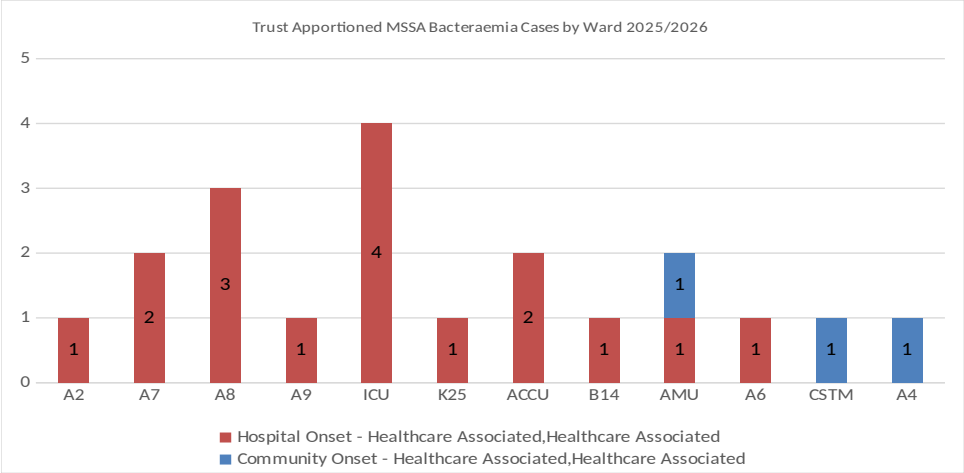
- Last Trust apportioned case – 14/03/2025

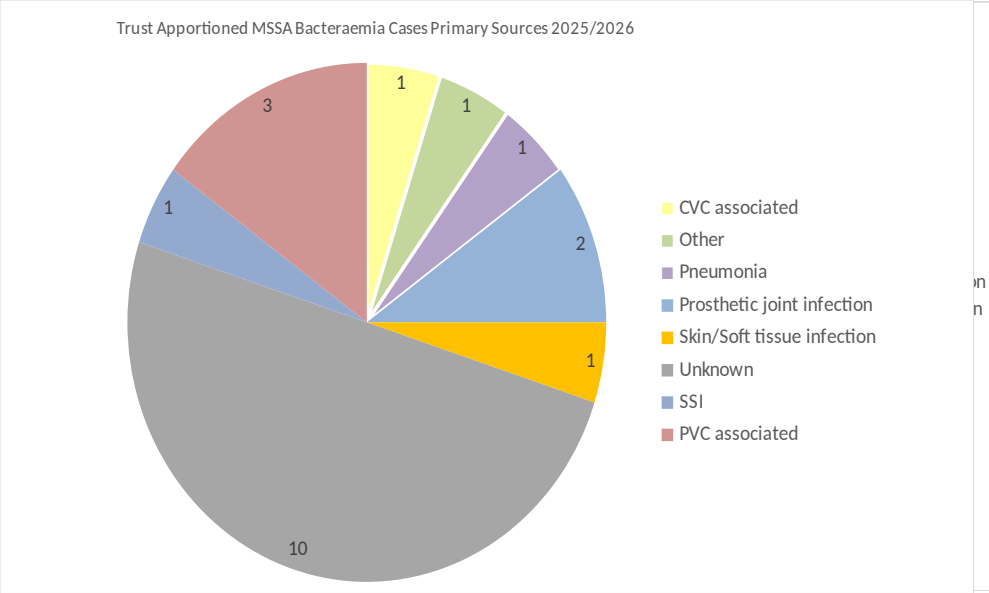


No Threshold	
YTD Total	20

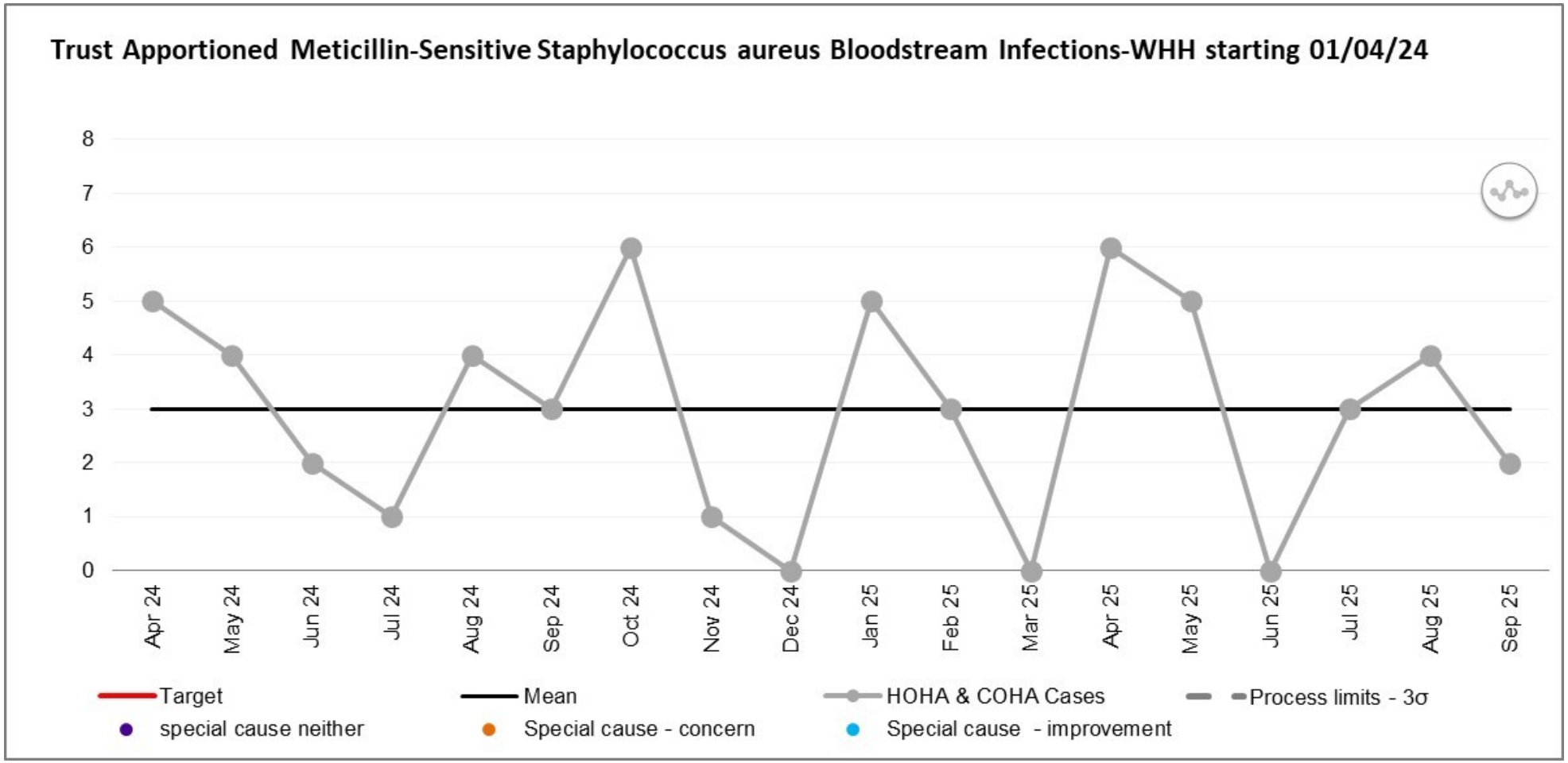
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr – Sep 25





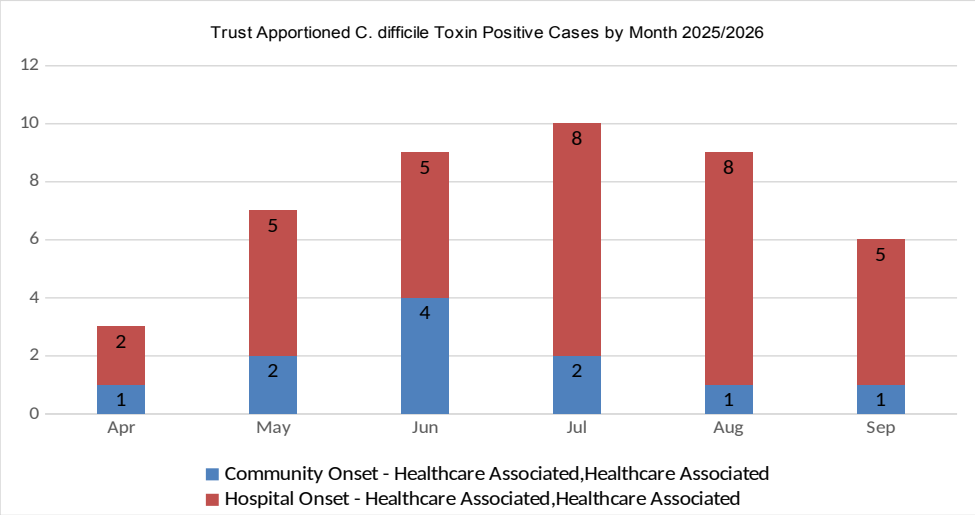


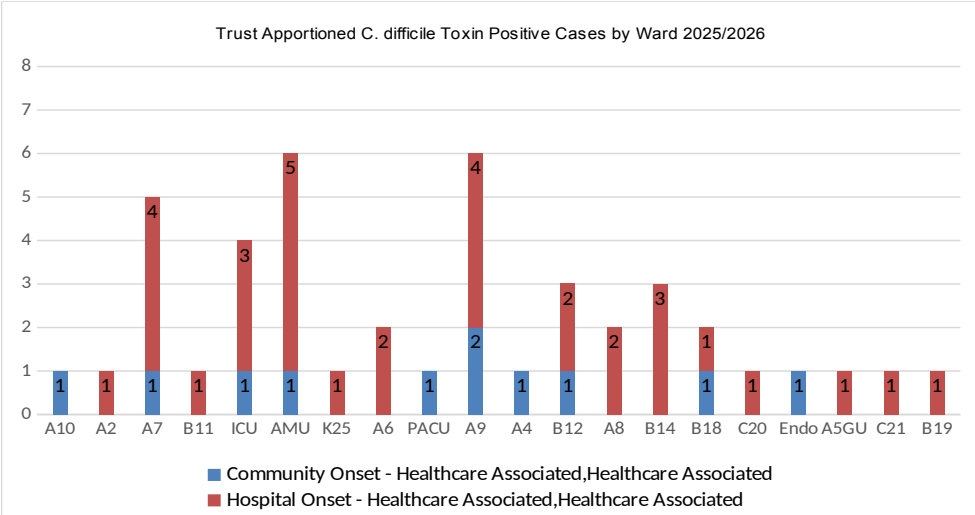
Meticillin Sensitive Staphylococcus aureus SPC Charts Apr 24 – Sep 25

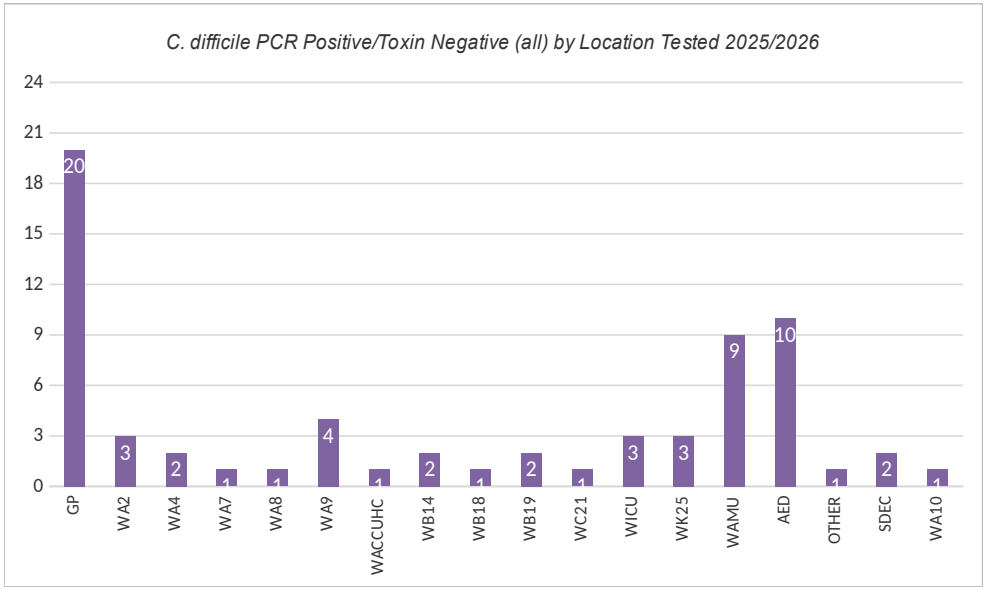


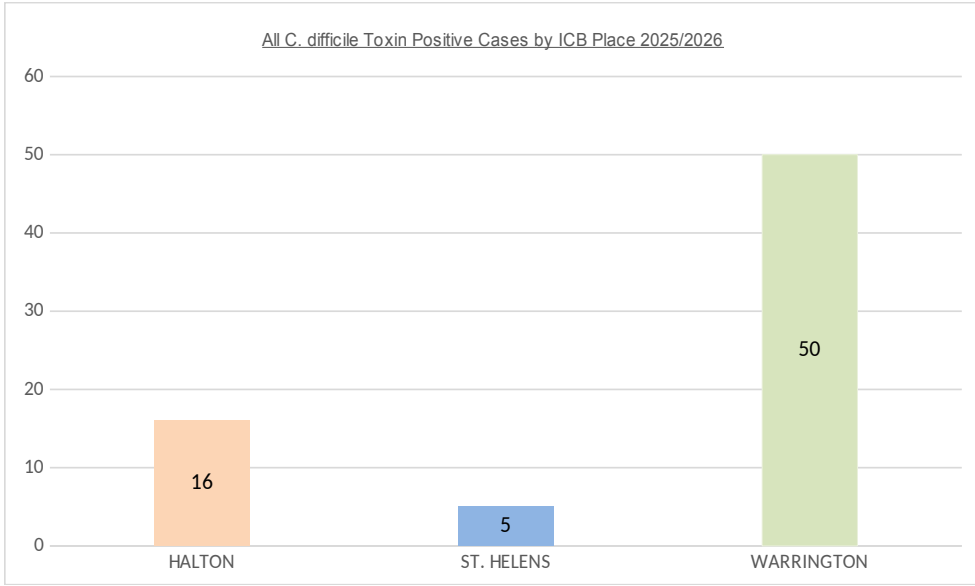
Threshold	**60**
YTD Total	**44**

Clostridioides difficile (C. difficile) Toxin Apr - Sep 25

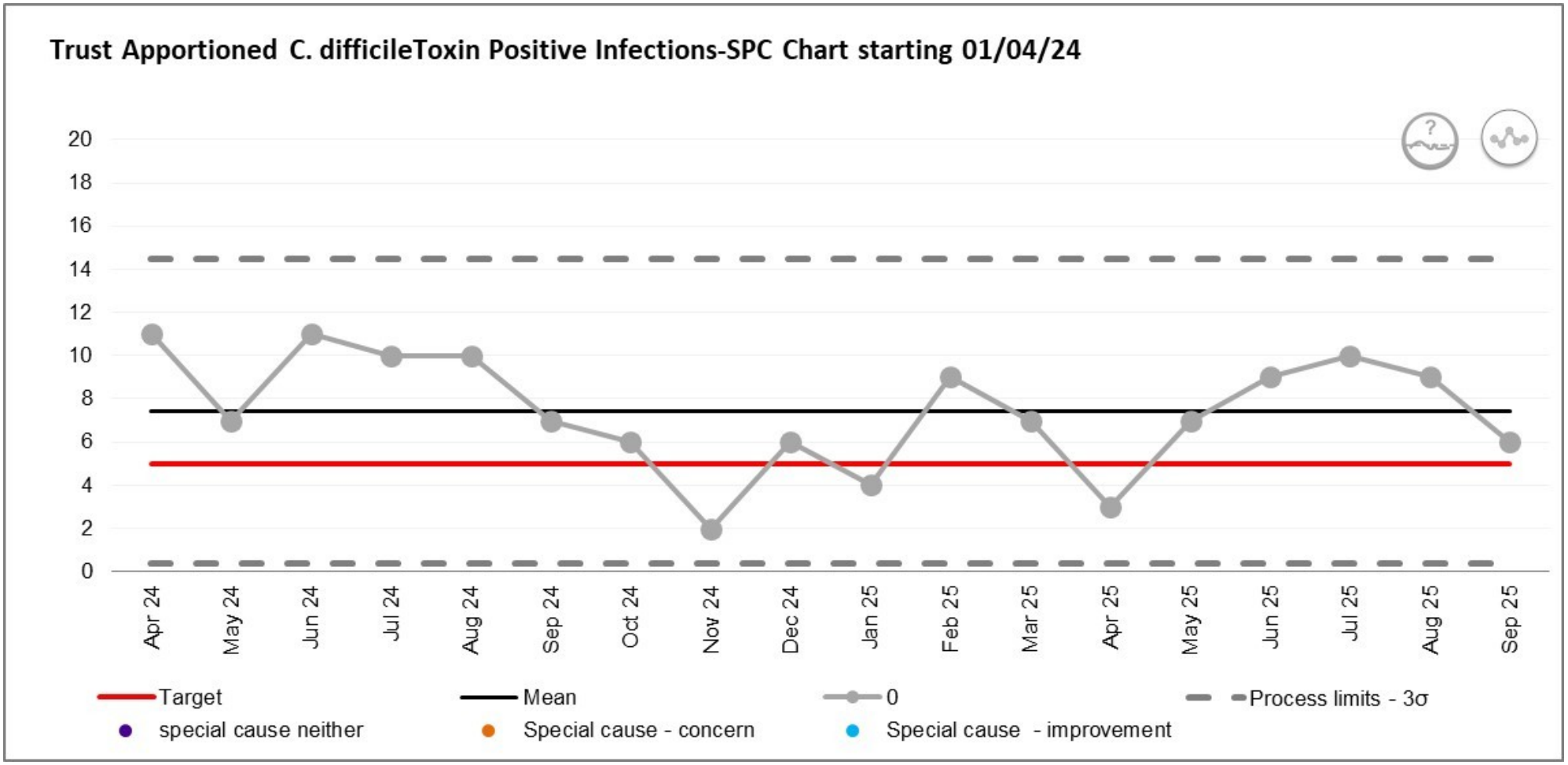




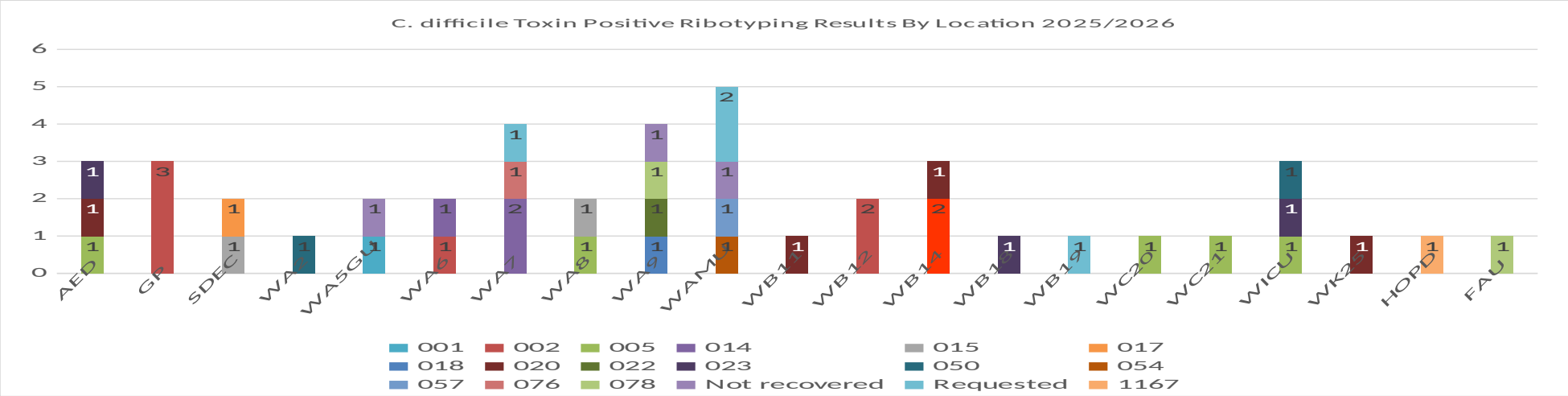




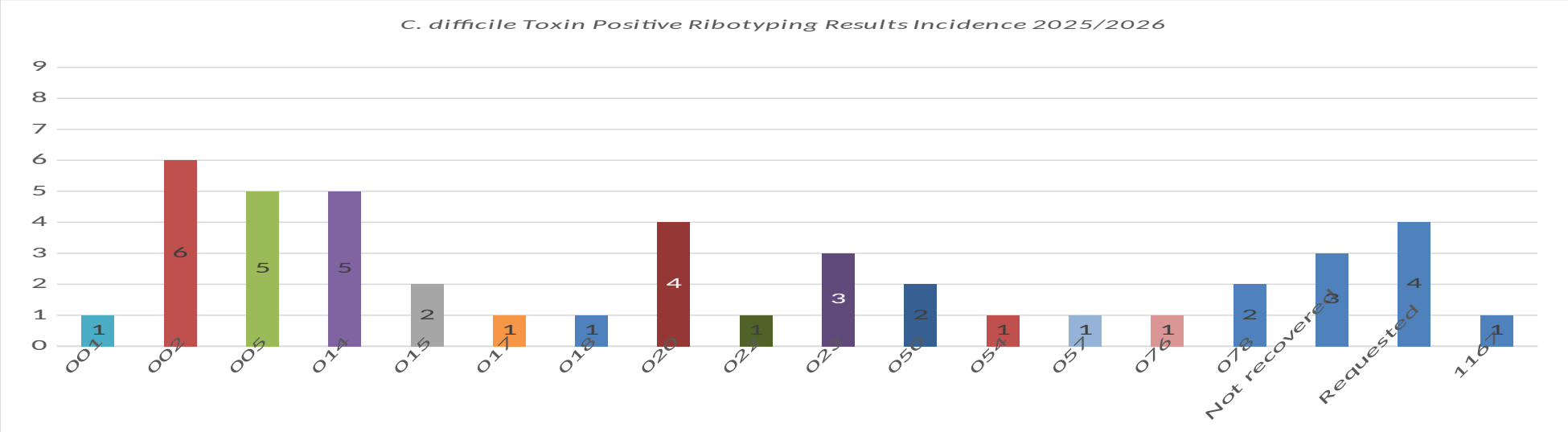
C. diffcile Toxin Positive Cases SPC Chart Apr 24 – Sep 25


Trust Apportioned C. difficileToxin Positive Infections-SPC Chart starting 01/04/24
20
18
16
14
12
10
8
6
4
2
0
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Target
Mean
0
Process limits - 3σ
special cause neither
Special cause - concern
Special cause - improvement

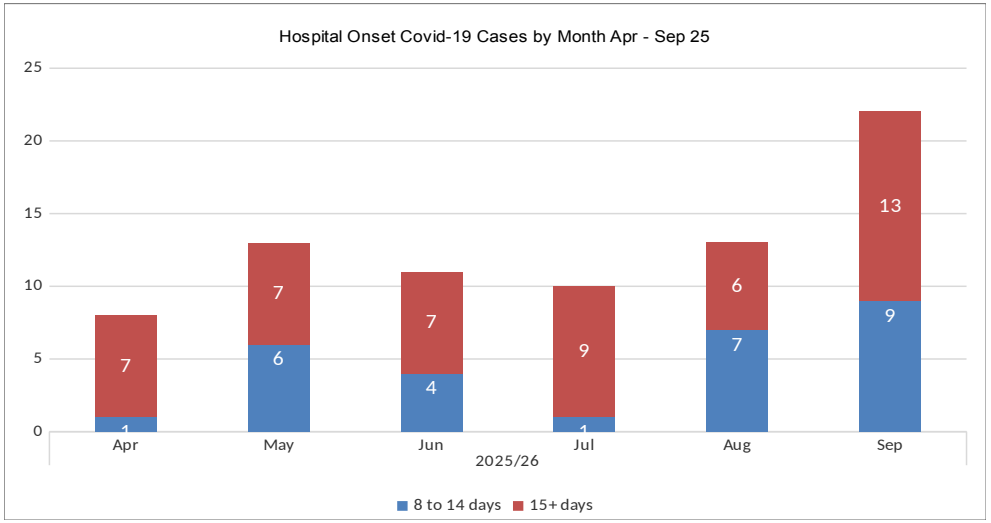
Trust Apportioned *Clostridioides difficile (C. difficile)* Ribotyping Results by Location when Tested Apr – Sep 25

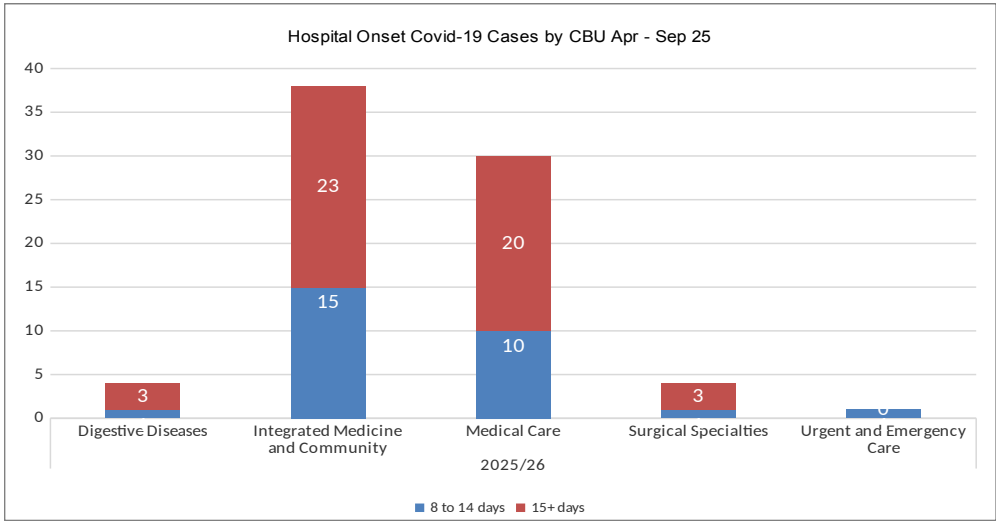


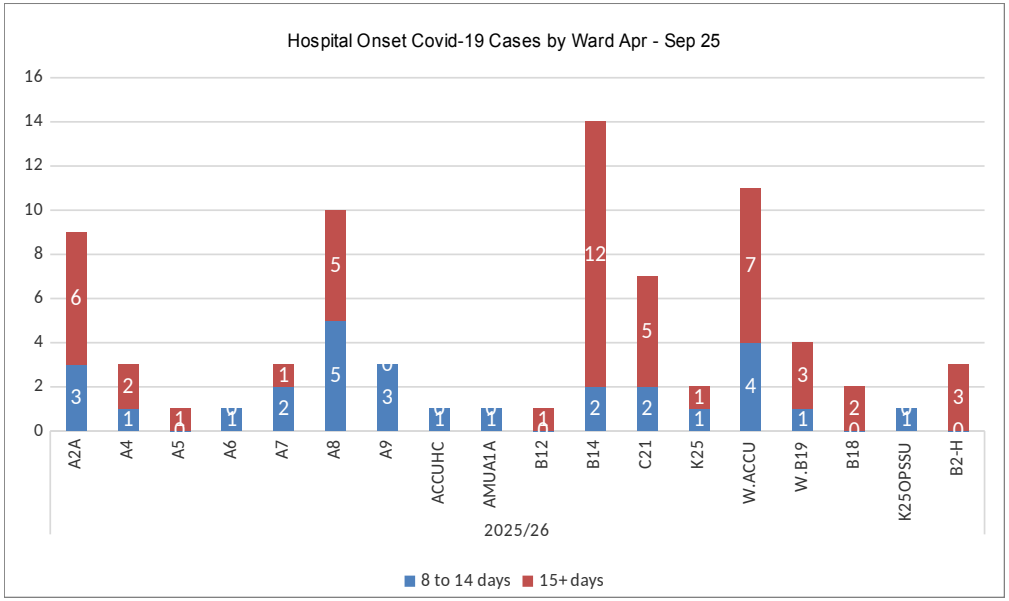
C. difficile Toxin Positive Ribotyping Results Incidence 2025/2026

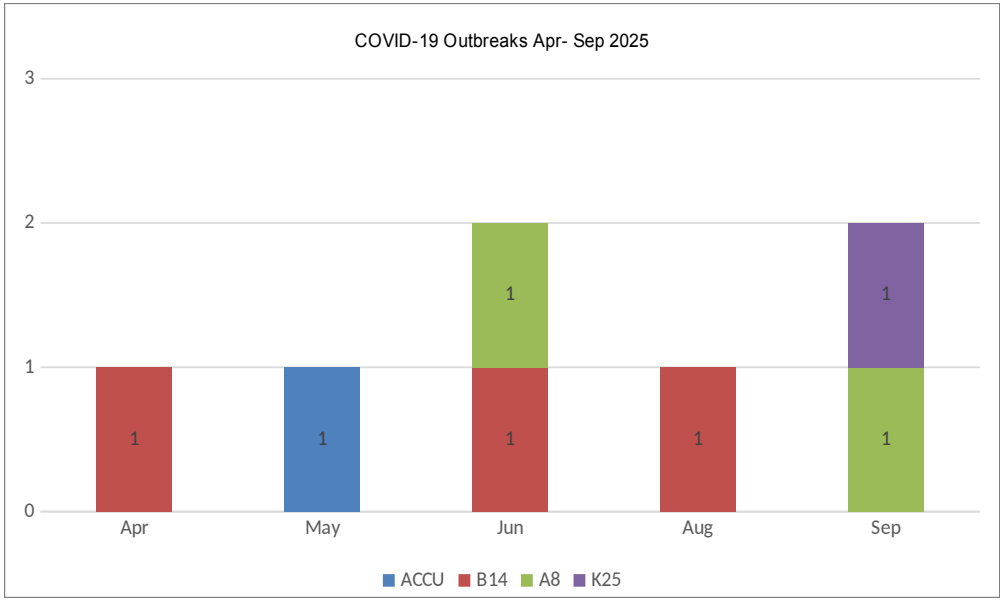


Covid-19 Cases Apr- Sep 2025

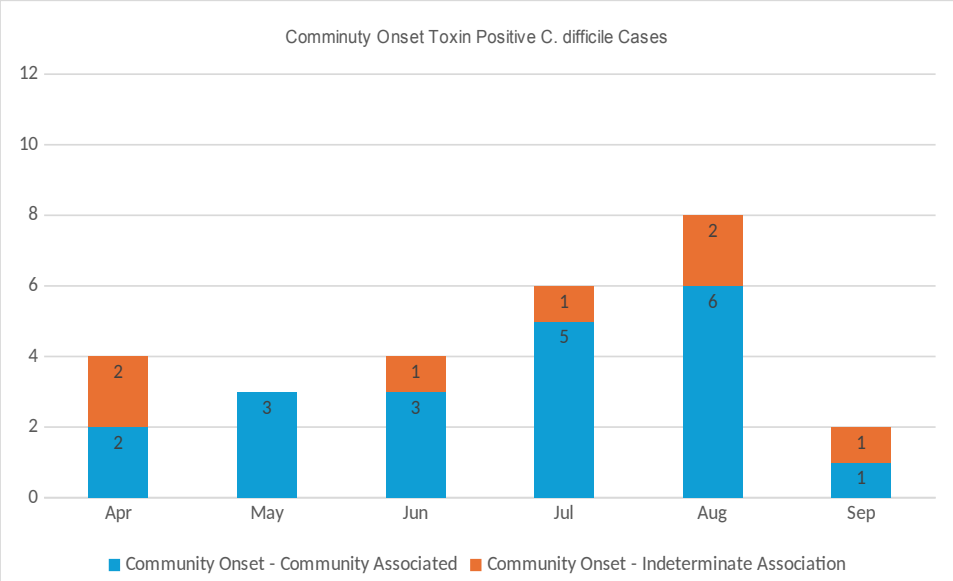


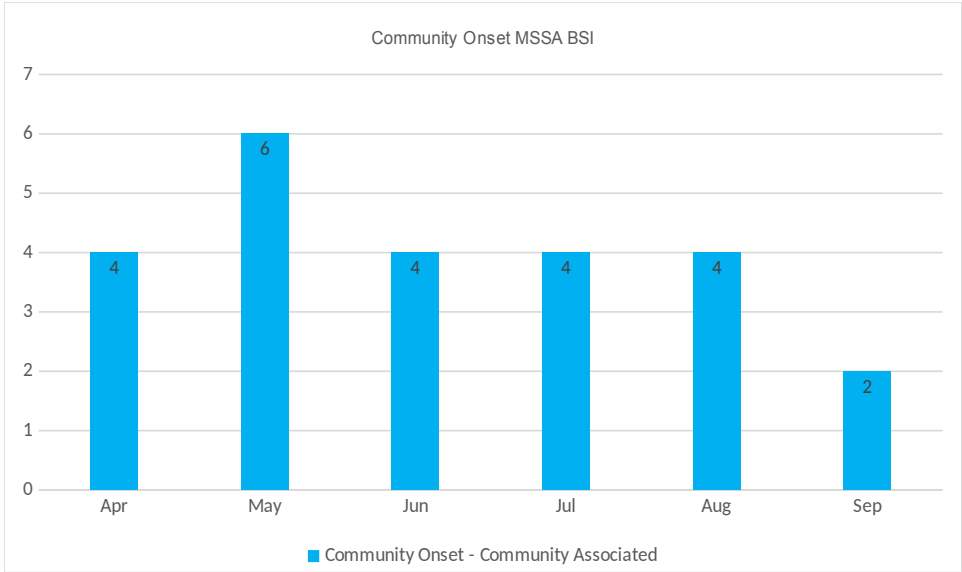


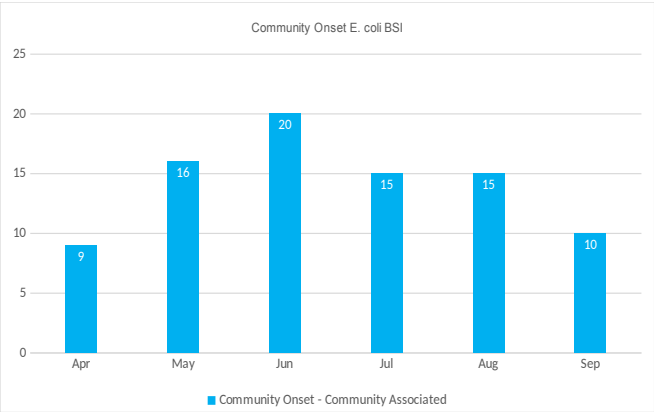


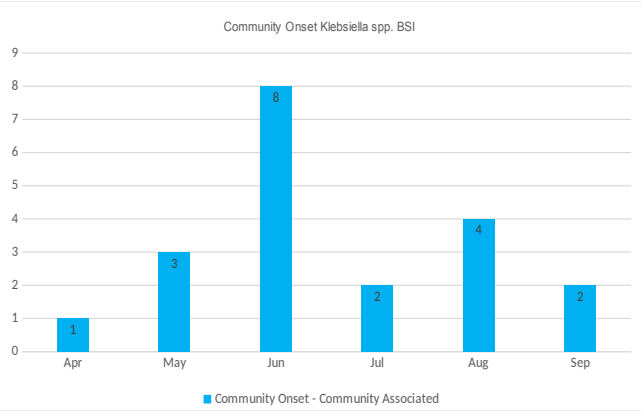


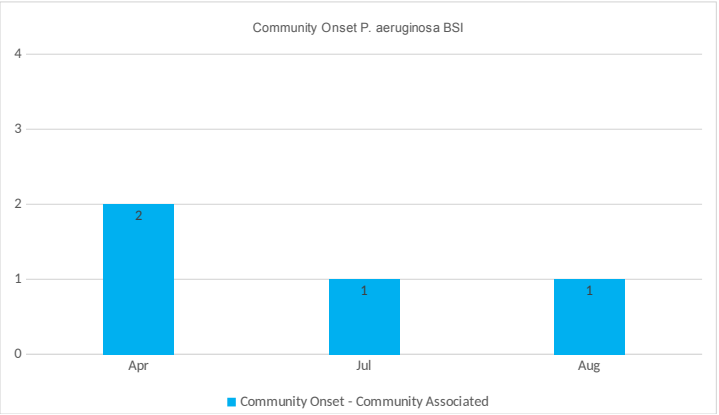
Mandatory Reported Community HCAI Cases Reported by WHH Apr – Sep 2025











Clostridioides (Clostridium) difficile

PREVENTION ACTION PLAN

2025 - 2026

Updated 05 2025
09 2025

C. difficile Prevention Action Plan 2025 - 2026

RAG

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance not received
Blue	Complete, assurance evidence received

No	Recommendation	Action Required	Lead	Review/ Target Date	Completion Date(s)	Progress	RAG
1	Antimicrobial Stewardship	Antibiotic prescribing teaching F1	CMM LPAMS	Oct 25		F1 Teaching scheduled for 25/09/25	
		Promotion of World Antibiotic Awareness Week	CMM LPAMS IPCN	Nov 25		Review of theme for 2025 under review	
		Biannual point prevalence prescribing audits	CMM LPAMS	Mar 25		PPA completed and reported Jun 25: 85% Compliance. Improved since Dec 24 but remains below internal 90% ambition. Recommendations under review	
		Participation in 2025/26 optional IVOS CQUIN quarterly (aim for ≤ 25%)	CMM LPAMS	Mar 26		Q1 completed 38% of patients (n=50) remained on IV antibiotics beyond the point at which switching criteria was met Activity refocussed to stewardship actions for review to participate in Q4	
		Antibiotic ward rounds	CMM LPAMS	Mar 26		Reduction in antibiotic ward round activity Apr – Aug due to temporary reduction in CMM staffing. Activity increased from Sep 25	
2	PPI Policy	Develop and launch a PPI policy	Gastro Pharmacy	Jun 25	Sep 25	PPI guidance produced awaiting Policy Review Group sign off (Aug 25)	
3	Probiotics	Trial use of probiotics on ward A8	Med Cons	Sep 25		Trial commenced, uptake unknown. Awaiting feedback from trial wards	

No	Recommendation	Action Required	Lead	Review/ Target Date	Completion Date(s)	Progress	RAG
4	Environmental Hygiene	Monitor standards of cleanliness and star ratings and take timely action on audit findings	HoF	Mar 26		Robust cleanliness monitoring programme. Data on timely action required.	
		Schedule of efficacy audits	HoF	Mar 26		Programme of efficacy audits in place	
		Complete PLACE assessment	HoF	Mar 26		Awaiting dates for PLACE assessments	
		Use of HPV after side room use for patients with C. difficile	HoF PFT	Mar 26		Programme in place for use of HPV following discharge of patients with C. difficile from side rooms	
		Decant of bay and use of HPV where more than one case of C. difficile occurs within the same bay within a 28-day period	HoF PFT	Mar 26		Loss of decant facility due to Trust-wide escalation, patient boarding and full capacity. Discussion in place with operational team and opportunities are sought to achieve	
		Develop Trust-wide deep clean programme	ACNs HoF	Mar 26		Loss of decant facility due to Trust-wide escalation, patient boarding and full capacity. Discussion in place with operational team and opportunities are sought to achieve	
		Implement Model Ward – Well Organised Ward	ADIPC ACN	Jan 26		Project plan devised and education commenced. Awaiting feedback from wards on progress. Project schedule is under review to support completion.	
5	Hand Hygiene	Peer hand hygiene audits	LNs Matrons	Mar 26		Awaiting feedback from CBUs on their peer audit programmes	
		Hand hygiene promotion Global Hand hygiene day	IPCNs	May 25	May 25	Hand hygiene promotional events Warrington 7/5/25 Halton 9/5/25	
		Hand hygiene training strategy UV light box	LNs Matrons	Mar 26		Strategy in place and UV light boxes are rotated monthly	
		Review Hand hygiene audit tool and provide training to auditors	IPCNs	Dec 25		Tool is aligned to the WHO 5 moments. Training provided to W&C CBU	

No	Recommendation	Action Required	Lead	Review/ Target Date	Completion Date(s)	Progress	RAG
6	Surveillance	Monitoring for Periods of Increased Incidence	IPCNs	Mar 26		In progress. Fortnightly circulation of period of increased incidence report at IPC Team meetings	
		Ribotyping of all CDT Trust apportioned cases	CMM MLSM	Mar 26		In progress – data included in monthly dashboard reports to Infection Control Sub-Committee	
		Case monitoring for recurrence and development of treatment plans including faecal microbiota transplant	CMMs IPCNs	Mar 26		Weekly MDT meetings ward B19	
7	Promote SIGHT Mnemonic	Social Media Campaign	IPCNs	Oct25		Increase in cases. Information on actions required circulated to	
8	Isolation and Cohorting	Timely isolation of patients with suspected CDI (≤ 4 hours) and where side room capacity is exceeded use of Bay C on ward B19 for cohorting cases	PFT	Mar 26		Scoping exercise in progress to identify data collection method	
		Where patients were not isolated prior to result, isolation is within 2 hours of receiving the result with escalation process to highlight anticipated delays	PFT	Mar 26		Scoping exercise in progress to identify data collection method	
9	Timely sampling of patients suspected to have C. difficile	Repeat Care Support Worker training days	IPCNs	Mar 26		Session delivered April 25 Additional dates to be advised	
		Display stool sampling signage in sluices	ADIPC	Oct 25		Signage ‘the stool rule’ in production, awaiting consumables to print. This is included in a wider plan to standardise signage in sluices as part of Model Ward plan	
10	Care of patients with CDI	Weekly MDT discussion of CDI cases on ward B19	CMMs IPCNs	Mar 26		Weekly MDT meetings in place	

No	Recommendation	Action Required	Lead	Review/ Target Date	Completion Date(s)	Progress	RAG
			B19 MDT				
		Enhanced review of patients with recurrent CDI	CMMs	Oct 25		Plan discussed with B19 consultants who are reviewing patients with recurrent C. difficile	
11	Learning from incidents	Revise approach to investigation of Trust apportioned CDI cases to align with PSIRF and system thinking	ADIPC	Mar 26		DIPC led review meetings-initiated Aug 25. C. difficile case review template revised. SEIPS used at review meetings.	
		System wide seminar on CDT	CMM ADIPC	Oct 25		Provisional date set for 22/10/25	
		GP learning event	CMM ADIPC	Nov 25		Provisional date set for 14/11/25	
		Revise approach to sharing learning from thematic analysis and audit findings adapted to different learning styles	IPCNs	Mar 25		Swarm huddles implemented 08/2024 analysis in progress to identify system factors	

ADIPC	Associate Director for IPC	Lesley McKay
CMMs	Consultant Microbiologists	Dr Zaman Qazzafi; Dr Toong Chin; Dr Janet Purcell
DCN	Deputy Chief Nurse	Tracy Fennell
HoF	Head of Facilities	Julie McGreal
HOPE	Head of Patient Experience	Interim Susan Dean
IPCNs	Infection Prevention & Control Nurses	Lesley McKay; Louise Bale; Jessica Ford; Soumya Zacharias,
LNs	Lead Nurses	All
LN IMC	Lead Nurse Integrated Medicine and Community	Janet Pye
LP AMS	Lead Pharmacist Antimicrobial Stewardship	Kate Rainbird
Matrons		All
Med Cons	Medical Consultant	
MLSM	Microbiology Laboratory Service Managers	Hannah Gill, David Green

Appendix 3 Infection Prevention and Control Audits by Care Group

Unplanned Care Group

Assessment	B18	ICU	ACCU/ HC	C21	A8	A8	B12	B14	B14	A7	B19	Dis. Suite	FAU	A9	AMU	AMU	Majors	Resus	Resp 1	EAU	Triage	Triage Area	PAED ED	ED MAJ ESC
Environment - General	95%	95%	95%	95%	90%	91%	91%	86%	95%	82%	95%	100%	100%	86%	91%	91%	100%	95%	86%	91%	62%	74%	73%	91%
Environment - Clean Utility	90%	90%	100%	100%	70%	90%	80%	80%	80%	100%	90%	100%	90%	80%	90%	90%	88%	88%	90%	90%	70%	70%	90%	80%
Environment - Dirty Utility	100%	100%	100%	92%	83%	92%	92%	100%	100%	100%	100%	92%	92%	92%	100%	92%	78%	78%	91%	92%	100%	100%	100%	92%
Environment - Cleaners Room	100%	100%	100%	100%	100%	91%	100%	100%	82%	100%	100%	100%	100%	100%	100%	100%	89%	89%	n/a	91%	100%	100%	91%	91%
Environment - Toilets & Bathrooms	93%	100%	86%	86%	79%	86%	86%	93%	100%	93%	93%	93%	93%	86%	100%	93%	100%	n/a	93%	85%	100%	83%	100%	93%
Ward Kitchens	96%	100%	100%	100%	100%	93%	81%	100%	100%	89%	96%	100%	100%	89%	93%	93%	96%	96%	n/a	100%	89%	89%	100%	85%
Handling/Disposal of Linen	100%	93%	86%	93%	100%	100%	93%	93%	93%	93%	100%	93%	100%	86%	86%	86%	100%	100%	78%	100%	71%	75%	100%	93%
Departmental Waste	92%	92%	100%	100%	100%	92%	100%	92%	92%	92%	83%	100%	100%	83%	92%	83%	92%	92%	100%	83%	92%	83%	100%	92%
Safe Handling Disposal of Sharps	100%	95%	95%	100%	89%	95%	95%	95%	95%	89%	100%	100%	100%	74%	89%	95%	100%	100%	94%	95%	95%	95%	100%	89%
Patient Equipment (General)	100%	100%	100%	96%	100%	96%	96%	92%	92%	96%	96%	100%	100%	92%	83%	92%	90%	86%	96%	86%	86%	79%	88%	96%
Personal Protective Equipment	93%	93%	100%	93%	93%	100%	100%	93%	93%	100%	100%	100%	100%	93%	100%	93%	100%	100%	100%	100%	90%	100%	100%	100%
Short Term Catheter Management	100%	94%	100%	94%	94%	94%	100%	100%	94%	88%	100%	100%	100%	94%	100%	94%	100%	100%	100%	100%	100%	100%	100%	94%
Care of peripheral intravenous lines	100%	100%	100%	91%	91%	91%	88%	91%	91%	91%	100%	100%	100%	100%	91%	91%	100%	100%	82%	100%	100%	100%	100%	100%
Isolation precautions	100%	85%	100%	92%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hand Hygiene	100%	96%	100%	96%	96%	96%	100%	88%	92%	96%	96%	100%	100%	96%	96%	84%	91%	90%	91%	100%	96%	96%	92%	84%
Enteral Feeding	N/A	100%	N/A	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A	100%	100%	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Central IV Devices	N/A	100%	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Overall Compliance	**97%**	**96%**	**97%**	**95%**	**92%**	**94%**	**93%**	**93%**	**94%**	**93%**	**97%**	**98%**	**98%**	**90%**	**94%**	**92%**	**95%**	**94%**	**92%**	**94%**	**90%**	**90%**	**96%**	**92%**
CBU	**MC**	**MC**	**MC**	**MC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**IMC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**	**UEC**

Planned Care Group

Assessment	PIU	A4	A4	Pre-op Halton	A5E	Endo (H)	Endo (W)	Ophth Clinic	A6	B2	Fracture clinic	Fracture Clinic	CSTM DCU	UIU	Maxilo facial (H)	Ophthalmic day surgery	B10/ PAU	B11	C23	BIRTH SUITE	IOL	ANC/ GYN CLINIC	COPD
Environment - General	73%	95%	91%	85%	91%	95%	95%	86%	77%	95%	100%	100%	100%	95%	100%	95%	91%	77%	82%	91%	100%	86%	95%
Environment - Clean Utility	70%	80%	80%	100%	100%	100%	100%	80%	80%	100%	100%	N/A	100%	90%	78%	89%	100%	100%	90%	90%	80%	100%	100%
Environment - Dirty Utility	92%	83%	100%	100%	83%	75%	100%	100%	92%	100%	N/A	N/A	100%	92%	N/A	100%	100%	100%	75%	67%	67%	100%	100%
Environment - Cleaners Room	91%	100%	91%	80%	100%	80%	91%	91%	91%	100%	100%	100%	91%	100%	N/A	100%	100%	100%	82%	91%	91%	100%	91%
Environment - Toilets & Bathrooms	100%	100%	100%	83%	93%	83%	100%	93%	86%	100%	100%	100%	100%	100%	N/A	100%	100%	71%	86%	86%	86%	93%	100%
Ward Kitchens	100%	100%	93%	81%	85%	81%	96%	93%	93%	85%	85%	100%	100%	96%	96%	100%	96%	96%	96%	81%	88%	93%	100%
Handling/Disposal of Linen	100%	93%	86%	100%	91%	100%	100%	86%	100%	100%	100%	100%	93%	100%	N/A	100%	100%	93%	86%	92%	92%	100%	100%
Departmental Waste	92%	83%	100%	91%	100%	92%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	92%	92%	92%	92%
Safe Handling Disposal of Sharps	100%	100%	95%	84%	95%	100%	100%	100%	95%	95%	100%	100%	100%	95%	100%	100%	100%	100%	100%	89%	95%	95%	100%
Patient Equipment (General)	100%	92%	92%	83%	92%	95%	92%	100%	96%	96%	100%	100%	100%	100%	100%	100%	100%	92%	94%	86%	83%	100%	100%
Personal Protective Equipment	100%	100%	93%	50%	78%	93%	93%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	0%	100%	100%
Short Term Catheter Management	N/A	100%	94%	100%	80%	100%	N/A	N/A	100%	90%	N/A	N/A	100%	100%	N/A	N/A	N/A	100%	94%	100%	100%	N/A	100%
Care of peripheral intravenous lines	100%	82%	91%	100%	71%	100%	100%	N/A	82%	100%	N/A	N/A	100%	100%	N/A	N/A	N/A	100%	91%	100%	100%	N/A	100%
Isolation precautions	N/A	100%	92%	100%	100%	100%	N/A	N/A	85%	100%	N/A	N/A	N/A	100%	100%	N/A	100%	100%	100%	100%	100%	N/A	100%
Hand Hygiene	96%	100%	88%	94%	100%	100%	100%	92%	76%	100%	100%	100%	100%	100%	93%	100%	94%	96%	96%	88%	84%	88%	100%
Enteral Feeding	N/A	N/A	N/A	n/a	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%
Central IV Devices	N/A	N/A	92%	n/a	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%
Overall Compliance	93%	94%	93%	89%	91%	93%	98%	93%	89%	97%	99%	100%	99%	98%	96%	99%	99%	94%	91%	90%	84%	96%	99%
CBU	DD	DD	DD	DD	DD	DD	DD	SS	SS	SS	SS	SS	SS	SS	SS	SS	W&C	W&C	W&C	W&C	W&C	W&C	W&C

Clinical Support Services Care Group

Assessment	Therapy outpatients GYM	Main OPD	Max Facial	Orthotics	Anti Coagulation clinic	Halton hub	Outpatient physio clinic	Physio gym	Phlebotomy Warrington
Environment - General	82%	100%	93%	87%	100%	93%	80%	82%	95%
Environment - Clean Utility	N/A	100%	100%	86%	90%	100%	N/A	N/A	**100%**
Environment - Dirty Utility	N/A	100%	N/A	N/A	N/A	82%	N/A	N/A	N/A
Environment - Cleaners Room	N/A	100%	100%	N/A	100%	90%	N/A	N/A	100%
Environment - Toilets & Bathrooms	80%	100%	N/A	N/A	100%	100%	**50%**	**92%**	**100%**
Ward Kitchens	83%	96%	100%	86%	N/A	100%	100%	83%	N/A
Handling/Disposal of Linen	92%	100%	N/A	N/A	N/A	100%	100%	100%	N/A
Departmental Waste	100%	92%	100%	100%	100%	100%	100%	100%	100%
Safe Handling Disposal of Sharps	100%	100%	100%	N/A	100%	95%	95%	n/a	95%
Patient Equipment (General)	86%	100%	100%	100%	100%	100%	83%	95%	100%
Personal Protective Equipment	87%	100%	93%	100%	100%	100%	87%	100%	100%
Short Term Catheter Management	N/A	N/A	N/A	N/A	N/A	N/A	N/A	n/a	N/A
Care of peripheral intravenous lines	N/A	N/A	N/A	N/A	N/A	N/A	N/A	n/a	N/A
Isolation precautions	N/A	100%	N/A	N/A	N/A	100%	N/A	n/a	N/A
Hand Hygiene	100%	100%	N/A	100%	100%	100%	100%	93%	100%
Enteral Feeding	N/A	N/A	N/A	N/A	N/A	N/A	N/A	n/a	N/A
Central IV Devices	N/A	N/A	N/A	N/A	N/A	N/A	N/A	n/a	N/A
Overall Compliance	**90%**	**99%**	**98%**	**94%**	**99%**	**97%**	**88%**	93%	**N/A**
CBU	**CSS**	**CSS**	**CSS**	**CSS**	**CSS**	**CSS**	**CSS**	**CSS**	**CSS**

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Strategic People Committee in Common

Agenda reference:	**SPCIC/25/11/161**			
Subject:	**Guardian of Safe Working Hours Q2 Report**			
Date of meeting:	19 November 2025			
Action required:	**To Note**			
Author(s):	Dr Rachel Wallis Guardian of Safe Working Hours			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
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 2016 Doctors in Training Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Resident Doctors in the form of exception reports via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 2 (1st July 2025 – 30th September 2025) 2025 -26, 45 exception reports were submitted of which 2 were highlighted as an immediate safety concern. These were immediately responded to and			

<table>
<tr><td></td><td colspan="3">action taken where appropriate.
The majority (39 individual reports, equating to 87%) of exception reports relate to hours of working. This is consistent across previous quarters. 1 exception report relates to patterns of work, 5 relate to missed educational opportunities and 0 exception reports were submitted in relation to service support available to the doctor. However, the narrative, where provided, often indicates an overlap between categories.

The introduction of exception reporting for trust employed or locally employed doctors whose working pattern mirrors that of residents has now been implemented and is starting to filter through to the Guardian with 2 reports submitted for additional hours worked.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
x</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.</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

The 2016 Junior Doctor (now Doctors in Training) Contract is well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Resident Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and chaired by the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers, participates in both regional and national Guardian of Safe Working networks and attended the National Guardian of Safe Working Conference in October. Additionally, through the national Guardian network, the GSW participates in consultation with national employers and BMA to negotiate changes as a consequence of the agreement following industrial action in 2024. These changes will now be implemented in February 2026.

Most resident doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of the monitoring of the 2016 Contract for Doctors in Training, the GSW is also required to submit data relating to the trainees hosted by WHH to the Lead Employer Guardian of Safe Working Hours, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. Key elements

Exception Reporting (July 25 – September 25)

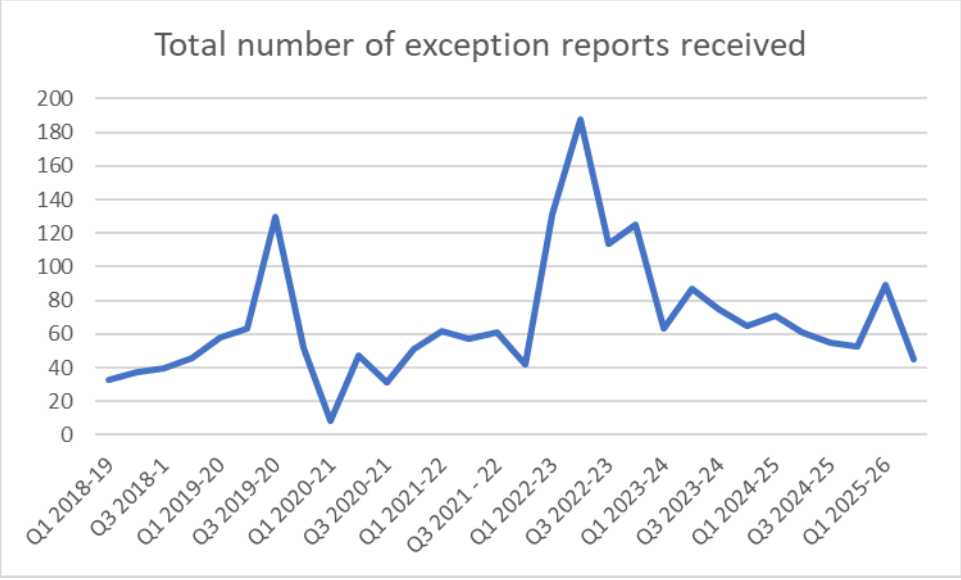
Exception Reports (ER) over past quarter	
Reference period of report	01/07/25 - 30/09/25
Total number of exception reports received	45
Number relating to immediate patient safety issues	2

Number relating to hours of working	39
Number relating to pattern of work	1
Number relating to educational opportunities	5
Number relating to service support available to the doctor	0

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

During Q2, 2025-2026, 45 exception reports (ERs) were submitted which is significantly less than received in Q1 2025-2026 (89). This number is consistent with usual reporting numbers at WHH; it is not clear why this is the case but a significant reduction in reports in O&G may have contributed. The GoSW will continue to monitor to see if this is maintained over the next quarters.
It is recognised that resident doctors are disproportionately impacted by service pressures with regard to attendances, flow and clinical complexity which reflects the issues currently being experienced throughout the NHS. Upcoming changes to the exception reporting process is anticipated to result in a significant increase in reports.

Please see Chart 1 for exception reporting trends over previous years.



Fines

The GSW has responsibly for protecting the safeguards contained in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

As per the TCS above any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

Fines: Q2 (July 2025-September 2025)

Grade	No of reports	reason	Fine to doctor (£)	Fine to GoSW (£)	Total (£)
F1	3	>13 hrs	81.60	136.10	217.70
F2	4	>13 hrs	226.76	377.92	604.68
Total	7		308.36	514.02	822.38

Fines were applied to exception reports where breaches in the terms and conditions of the 2016 contract had occurred. The F2 fines occurred in trauma and orthopaedics (4 fines) resulting from a weekend where sickness resulted in challenging shifts where doctors stayed beyond their rostered hours. This will be monitored but does not seem to be an ongoing issue. The F1 breaches are more widespread and may signal an issue with the F1s on the acute take resulting in additional hours being worked. The Guardian will monitor this and consider intervention if this persists through the next quarter. Fines are calculated as per the guidance set out by NHSE with regard to the contractual breaches. A portion of the fine is paid to the reporting doctor, and the rest sits in a fund ringfenced to improve the working lives and wellbeing of resident doctors under the remit of the Resident Doctors Forum (formerly Junior Doctors Forum)

Themes for Q2 (July 2025 – September 2025)
For this quarter there has been a significant reduction in exception reporting, with numbers returning to that experienced in previous quarters, suggesting Q1 was exceptional due to issues with O&G which appear to have been somewhat resolved. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this continues to be impacting junior doctors across the board.

General and Specialty Medicine – (18)
Q2 saw a small reduction in exception reporting in general and specialty medicine (Q1 21 ER). Exception reports in Medicine were mainly from the F1/F2 cohort of doctors and applied to extra hours being worked. There were no immediate safety concerns, and no fines were applicable in this quarter. This will continue to be monitored and continued improvement is anticipated

T&O (3)
There has continued to be a reduction in the number of exception reports submitted by foundation doctors in T&O. Work has continued with the T&O resident doctors to ensure senior support and the rota changes introduced following work schedule reviews appear to have had a beneficial impact, extra shifts have been put in at weekends and appear to be reducing the incidence of exception reporting in this area. There have been no further reports submitted by higher training grades with regard to NROC. Strong engagement from the medical management team within the specialty and with support from the AMD for Planned Care has seen considerable improvement in the medical ward cover being introduced imminently. The GSW is confident that the work done has reduced the risk in this area and we will remove T&O from the enhanced monitoring at present.

O&G (10)
Q2 has shown a significant reduction in the volume of exception reporting over the period with 1 further immediate safety concerns. This reflects the work done by the team to support the acute attendances. Additionally, there have been 2 educational opportunities reported by ST6, this relates to a period of sickness in the team and is not expected to be an ongoing issue. This will continue to be closely monitored.

General surgery/urology (11)
Reports were submitted by doctors in general surgery/urology on 11 occasions resulting from the pressures on the acute wards/on call. Due to the nature of the shift pattern in general surgery for the foundation doctors, this has resulted in the application of 3 fines for breaches of the maximum shift length and one work schedule review. The Guardian is concerned that this may continue to be an issue going forward and will ensure this is addressed in the Q3 report for information.

Locally Employed Doctors:
WHHFT have a number (50) of locally employed doctors (LEDs) who are employed mainly on fixed term contracts, most of which mirror those of resident doctors in training. As previously described, WHHFT introduced exception reporting to this group of doctors in September. To date there have been 2 exception reports submitted; 1 relating to a missed break and the second relating to additional hours worked. This will continue to be an area for oversight by the Guardian of Safe Working Hours.

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. The GSW will monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors.

The RDF meeting took place in September 2025 with good attendance from the majority of trainee groups and rota administrators.

Additionally, GSW has reported to the Lead Employer on the exception reports and activity for Q2 with regard to ST1/CT1 and above. In total 9 exception reports were submitted which is a significant reduction from This is felt to be a consequence of work carried out in Obstetrics and Gynaecology to address the pressures being felt in the

acute gynaecology/early pregnancy service as discussed earlier, 1 of which was identified as immediate patient safety issues and were addressed at the time of reporting. No fines were levied for exception reports in this quarter.

Rota Gaps:
As part of the overview of resident doctors' wellbeing and work pressures, the GSW is expected to provide an oversight of rota gaps in training programmes. In common with all trusts both regionally and nationally, WHH has noted an increase in the number of LTFT resident doctors as well as gaps in rotas with lead employer not allocating sufficient doctors to fill all training programme slots. LTFT posts compound the pressure on rotas as they are not backfilled by the lead employer and often leave 20-40% of hours uncovered in such posts. This in turn impacts upon the pressures on the FT doctors working those rotas. Although not within the remit of the GSW, it should be noted that this contributes to the need for locum expenditure and specialties look to mitigate this with the recruitment of locally employed doctors where possible, and consultants/SAS acting down, which has an increased cost pressure.

3. Actions required/responsible officer

- To continue to monitor areas of high exception reporting, in particular potential issues within general surgery/urology regarding intensity/support for foundation doctors.
- To monitor the effect of the medical workforce review with respect to exception reporting in General and Specialty Medicine and support to resident doctors in specialty
- To report rota gaps in resident doctors' rota to SPCiC.
- To encourage early resolution of exception reports and access to time off in lieu or payment as preferred by the reporting doctor.
- To consider and plan for changes to exception reporting to be implemented in February 2026.

4. Measurements/evaluations

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	6
Total number of overtime payments	2
Total number of work schedule reviews	1
Total number of reports resulting in no action	7
Total number of organisation changes	0
Compensation	0
Unresolved	1

	9
Total number of resolutions	**16**
Total resolved exceptions	**20**

Note:
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. Trajectories/objectives agreed

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Resident Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. Monitoring/reporting routes

Quarterly and Annual Guardian of Safe Working Hours’ Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust’s Annual Quality Account and signed off by the Chief Executive;

the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee in common) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issues raised by the Guardian of Safe Working and to provide relevant advice.

It is also good practice to share a copy of the report with the Resident Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

7. Timelines

SPCiC – Strategic People Committee in Common
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Resident Doctors and Locally Employed Doctors

- Q2 – (end of September 2025) – Submit November 2025
- Q3 – (end of December 2025) – Submit February 2026
- Q4 – (end of March 2026) – Submit April 2026
- Q1 – (end of June 2026) - Submitted August 2026

8. Assurance committee (if relevant)

N/A

9. Recommendations

The Committee are asked to consider the contents of the report and consider the assurances made accordingly. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Resident Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the resident doctors, and all doctors are in-line with safe working hours.