North Cheshire and Mersey
NHS Foundation Trust

Trust Board – Part 1 (public)

Date and time:	5 August 2026, 10:00am – 12:30pm
Location:	WELL Runcorn Hub, Granville Street, Runcorn, WA7 1NE

9 - 9:30am	WELL Runcorn Hub – tour			**Esme Polshaw** General manager- WELL Runcorn Hub,	
Agenda item	**Time**	**Agenda item**	**Objective/ desired outcome**	**Process**	**Lead**
BM/26/08/ 042	**10:00**	Engagement Story – Halton Adult Services	***To note***	***Presentation***	Julie Griffiths, Head of Adult Services, Halton and David Hines, Patient
BM/26/08/ 043	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/26/08/ 044	**10:17**	Minutes and Action Log of the previous Trust Board meeting held on: **3 June 2026**	***For approval***	***Minutes***	Chair
BM/26/08/ 045	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/26/08/ 046	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/26/08/ 047	**10:35**	Chair's Report	***For info/update***	***Verbal***	Chair
Trust Board matters					
BM/26/08/ 048	**10:40**	Board Assurance Framework	***For assurance***	***Report***	Company Secretary
BM/26/08/ 049	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports	***For assurance***	***Report***	All Executive Directors

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

a)		**Quality Dashboard Including** Assurance Reports Quality Safety and Assurance Committee 09.06.2026, 14.07.2026, 28.07.2026	***For assurance***	***Report***	Exec Medical Director Chief Nurse, Cliff Richards, Committee Chair
b)		**People Dashboard Including** Assurance Reports Strategic People Committee 17.06.2026, 15.07.2026	***For assurance***	***Report***	Chief People Officer, Julie Jarman, Committee Chair
c)		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Performance Committee 22.06.2026, 29.07.2026	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
d)		**Audit Committee Including** Assurance Reports 22.06.2026	***For assurance***	***Report & Presentation***	Senior Independent Director Mike O'Connor Committee Chair
Quality					
BM/26/08/050	**11:00**	Fragile Clinical Services Update	***To note for assurance***	***Report***	Executive Medical Director
BM/26/08/051	**11:10**	**Maternity & Neonatal Summary Update** • Maternity & Neonatal Quality Review Report (includes TC Audit as appendix) • Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	***To note for assurance***	***Reports***	Interim Director of Midwifery

		• Avoiding Term Admission into Neonatal Unit (ATAIN) Q4 ***Update regarding Ockenden and Amos review***		***Verbal***	Chief Nurse
People					
BM/26/08/052	**11:25**	Communications and Engagement Report	***For info/update***	***Report***	Director of Comms and Engagement
BM/26/08/053	**11:35**	Gender Pay Gap: Combined Report	***To note for assurance***	***Report***	Chief People Officer
BM/26/08/054	**11:40**	Living Well Hub – 2-year Review	***To note for assurance***	***Report***	Chief Strategy and Partnerships Officer
Finance, Sustainability and Productivity					
BM/26/08/055	**11:45**	Emergency Preparedness Report	***To note for assurance***	***Report***	Chief Operating Officer
Governance					
BM/26/08/056	**12:05**	Committee Chairs Annual Reports • Quality and Safety Assurance Committee • Strategic People Committee • Finance, Sustainability and Productivity Committee	***For approval***	***Report***	Company Secretary
BM/26/08/057	**12:10**	• Code of Governance Compliance • Provider Licence Annual Report (for Year End / Audit Committee)	***For approval***	***Report***	Company Secretary
BM/26/08/058	**12:15**	Fit and Proper Persons Test - Annual Report on Board Members	***For info/update***	***Report***	Company Secretary

Closing					
BM/26/08/059	**12:20**	Review of Meeting	***For info/update***	***Verbal***	Chair
BM/26/08/060		Any Other Business	***For info/update***	***Verbal***	Chair

Supplementary Papers for Noting

Agenda item	Report Title	Assurance Committee	Objective/ desired outcome	Process	Lead
BM/26/08/061	Compliance Update Q4 (CQC)	Ref: QSAC/26/06/060 Date: 09.06.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/062	Learning from Deaths Q4	Ref: QSAC/26/06/065 Date: 09.06.2026 Outcome: noted	To note	report	Exec Medical Director
BM/26/08/063	Learning From Experience Summary Report Q4	Ref: QSAC/26/06/067 Date: 09.06.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/064	Mortuary Licensed Activity Report	Ref: QSAC/26/07/095 Date: 14.07.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/065	Infection Prevention and Control Board Assurance Framework Compliance	Ref: QSAC/26/07/097 Date: 14.07.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/066	Medicines Management	Ref: QSAC/26/07/108 Date:28.07.2026 Outcome: noted	To note	report	Exec Medical Director
BM/26/08/067	Controlled Drugs Annual Report	Ref: QSAC/26/07/109 Date: 28.07.2026 Outcome: noted	To note	report	Exec Medical Director
BM/26/08/068	Director of Infection Prevention & Control Annual Report (DIPC)	Ref: QSAC/26/07/113 Date: 28.07.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/069	Safeguarding Report	Ref: QSAC/26/07/115 Date: 28.07.2026 Outcome: noted	To note	report	Chief Nurse

BM/26/08/070	Health and Wellbeing Report	Ref: SPC/26/06/050 Date:17.06.2026 Outcome: noted	To note	report	Chief People Officer
BM/26/08/071	Safe Nurse Staffing	Ref: SPC/26/06/052 Date: 17.06.2026 Outcome: noted	To note	report	Chief Nurse
BM/26/08/072	Guardian of Safe working Annual Report	Ref: SPC/26/07/073 Date: 15.07.2026 Outcome: noted	To note	report	Exec Medical Director

Date and time of next meeting:
7 October 2026, starting at 10am. Halton Education Centre, Halton Hospital

North Cheshire and Mersey
NHS Foundation Trust

Wellbeing Service

David's story

Trust Board August 2026

Home
Community
Hospital

Background

The service complete health checks for patients with severe mental illness within Halton

The patient's name is David

David's initial assessment was in March 2025 with follow up in January 2026

He was supported with stress and anxiety, ADHD assessment and signposting to other services

What prompted David to seek support?

• Home • Community • Hospital

Caring for you

First appointment

March 2025

- David was supported to access the mental health practitioner at the GP practice, Wellbeing Enterprises and social activities, and the Health Improvement Team for exercise therapy.

Second appointment

January 2026

- David had seen the mental health practitioner, been assessed and diagnosed with ADHD, participated in talking therapies and received CBT, linked in with Wellbeing Enterprises and the Health Improvement Team, and enrolled for a counselling course at University.

David’s overall thoughts about the service

- Positive impact of the CBT counselling – better understanding of my mental health condition, healthier overall outlook on life, goals in sight
- Meeting new people and making new friends
- Local activities i.e. walking groups and litter picks
- Diagnosis of ADHD
- Service has processes in place – organised and timely
- Nice and patient staff, which put me at ease.
- Positive signposting to other services.

“Overall, I thought the treatment was right and was presented in a way I could understand, which is important. One of the most important things for me was the continuity of the process. It was because of this I started to trust this specific service - follow-up letters and phone calls where also on time. This service worked for me.”

What we aim to do

We tailor our interventions to meet everyone's specific needs.

Consideration of mental health, physical health, sexual health, social circumstances and any other factors that may affect wellbeing.

Reinforces the value of continuing to provide flexible, personalised care that recognises the whole person rather than applying a one-size-fits-all approach.

SMI Health Assessment Team Learning

Presenting treatment in a way patients can understand is important.

Continuity of process helps people to trust the service; this is crucial for the service to maintain.

Importance of treating each person as an individual and considering their unique circumstances rather than making assumptions based on where they live or other general factors.

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.

North Cheshire and Mersey NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 3 June 2026 Trust Conference Room, Warrington Hospital/Via MS Teams	
Present	
Andy Carter (AC)	Chair
Nikhil Khashu (NK)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Jayne Downey (JD)	Non-Executive Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Paul Fitzsimmons (PF)	Executive Medical Director
Ali Kennah (AK)	Chief Nurse
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Jane Hurst (JH)	Chief Finance Officer
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
In Attendance	
Kate Henry (KH)	Director of Communications & Engagement
Paula Woods (PW)	Chief People Officer
John Culshaw (JC)	Company Secretary
Emily Kelso (EK)	Head of Corporate Governance **(minutes)**
Mark Slater (MS)	Patient **BM/26/06/023**
Claudine Reynolds (CR)	Lead Nurse Medical Care and ICU **BM/26/06/023**
Alex Ingram (AI)	Ward Manager **BM/26/06/023**
Tina Moors (TM)	Interim Director of Midwifery
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Stephen Walton	Public Governor, Warrington and Halton
Catherine Ardern	Public Governor, Warrington and Halton
Dorcas Akeju	Public Governor, Rest of England

Agenda Ref	Agenda Item
BM/26/06/023	**Engagement Story – My ICU experience** The Board received a detailed patient experience story from MS regarding two admissions involving A&E and ICU care. MS advised that his first admission followed a farm accident in which he sustained several broken ribs. He was assessed promptly in A&E and transferred to ICU for pain management, which he described as excellent.

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	MS highlighted some issues from this admission. Due to sleep apnoea, he had been encouraged to use a mask; however, no suitable mask was available and the one provided was uncomfortable despite repeated adjustments. He also referred to frequent night-time disturbances for medication, which affected rest. Notwithstanding this, he observed strong teamworking across ICU. He noted he had been discharged home due to lack of ward capacity and, in retrospect, felt a longer stay may have been beneficial. Follow-up had been directed to his GP despite his punctured lung. The second admission was more serious, during which MS was placed in a medically induced coma for around four weeks. While his family described staff as caring and skilled, communication was inconsistent, including a distressing late-night call regarding prognosis without sufficient opportunity to remain at the bedside. MS highlighted the importance of clearer communication and basic care on recovery, alongside challenges of immobility, poor sleep and boredom due to lack of stimulation, with staff interaction providing key support. Despite these issues, MS spoke positively about ICU care overall, attributing his recovery to staff professionalism and teamwork. The Board identified family communication, consistency of messaging and patient experience during prolonged stays as key learning points. It was confirmed the story would be shared with the ICU team and governance meeting, with AI agreeing to explore improvements, including charitable support and enhanced patient resources to address boredom, and to report back. Assurance was sought on improving communication with patients families; it was acknowledged that this was an area for strengthening. AC thanked MS for his contribution, noting the value of patient insight in informing improvement. **The Trust Board noted the story and associated learning**
BM/26/06/024	**Welcome, Apologies and Declarations of Interest** AC formally opened the meeting and welcomed those present. He drew attention to the observers joining the meeting and welcomed the observing governors. AC advised the Board that apologies had been received from LG and JH who had been called on to prepare for a national meeting taking place tomorrow and noted that LG was expected to join the second part of the meeting later in the day. No declarations of interest were made. **The Trust Board noted the apologies and declarations of interest.**
BM/26/06/025	**Minutes and Action Log of the previous meeting held on 1 April 2026.**

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	The minutes of the meeting held on 1 April 2026 were taken as read. AC invited observations and amendments and, as no substantive amendments were proposed, the Board agreed the minutes as an accurate record of the meeting. In considering the action log, the Board noted that the actions had largely been completed. PW pointed out a typing correction required in section 2 of the action log. **The Trust Board approved the minutes of the meeting held on 1 April 2026 and noted the action log, subject to the minor amendment above.**
BM/26/06/026	**Matters Arising** AC advised that the matters arising from the previous meeting were either complete or would be covered under items elsewhere on the agenda. No additional matters were raised by members. **The Trust Board noted that there were no matters arising.**
BM/26/06/027	**Chief Executive's Report** NK presented his report and highlighted key developments, noting the formal establishment of the enlarged trust North Cheshire and Mersey NHS FT and the appointment of AC as Chair. He paid tribute to current Chief Nurse AK acknowledging her upcoming retirement after more than 30 years' NHS service, recognising her leadership since 2017, her commitment to staff and patients, and her significant contribution to the organisation. NK confirmed that, following an earlier unsuccessful recruitment process, recruitment to the Chief Nurse role would recommence. NK updated the Board on the second tranche of the MARS scheme, confirming it had concluded and applications were being processed. He also highlighted recent achievements, including continued recognition as a Veteran Aware organisation and success of the "Your Future, Your Way" programme, which had achieved regional champion status and received a national shortlist nomination. In relation to service transformation, NK noted the success of the gynaecology one-stop clinic, with over 600 patients seen and high satisfaction levels. He also referenced recognition of the clinical workforce during May and the third shared learning forum, which brought staff, governors and experts by experience together to share improvement learning. The Thank You Awards and start of year conference were also highlighted as important milestones in bringing together the newly integrated organisation and engaging staff in priorities and longer-term strategy under "NCM 2030".

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	NK advised of national developments, including the appointment of the Rt Hon James Murray MP as Secretary of State for Health and Social Care, and confirmed impending industrial action by resident doctors from 15–19 June, with possible further action in July. He noted the Trust was more adversely affected than some peers due to higher participation rates. He also referenced ongoing engagement within the Cheshire and Merseyside Provider Collaborative and confirmed that oversight of enforcement undertakings would now be managed through a single PwC framework. JS sought assurance on whether the Trust was sufficiently aligned with primary care in developing neighbourhood models to reduce A&E demand. NK confirmed that c.£5 million of community-based bids had been submitted via the ICB aligned to the "left shift" agenda but noted that development of an integrated health organisation model remained at an early stage. He acknowledged variability in primary care engagement and organisational maturity. PF added that progress differed across areas, with greater alignment in Halton compared to Warrington, where multiple PCNs and inconsistent boundaries created challenges. He confirmed the Trust was working with partners to develop a coherent neighbourhood model but noted the need for a more consistent primary care voice. CR observed that this reflected longstanding challenges and that maturity varied across the system. CR also sought clarification on alignment between identified start of year conference priorities and the Board-approved operating plan. NK confirmed these were consistent, with the conference focused on translating agreed priorities into operational delivery. AC noted the conference had supported staff understanding of organisational priorities. **The Trust Board noted and discussed the Chief Executive's Report including national updates.**
BM/26/06/028	**Chair's Report** AC introduced his report and reflected on recent meetings and visits, many undertaken alongside NK to support his induction and understanding of the organisation. He highlighted several visits. AC described a visit to the medical engineering team at Warrington, where he was impressed by both technical expertise and the team's focus on innovation and cost efficiency. He also visited St Helens Dental Clinic, noting the welcoming environment for patients but raising concern regarding limited parking. At the Joint CANTreat Cancer Centre in Halton, he observed high-quality facilities and care provision prior to its temporary closure for refurbishment. Additional visits to Drive Safe and the Runcorn Well Hub provided further insight into the breadth of community services. Within acute services, AC spent time in paediatrics, the Emergency Department and SDEC, focusing on patient experience. He highlighted the positive impact of senior nurse triage at reception in improving prioritisation and flow, noting that activity levels during his visit had been unusually low. He

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	also visited Grappenhall Clinic and met the South Warrington District Nurse Team, which he described as delivering exceptional care. A visit to St Rocco's Hospice highlighted financial challenges, and AC emphasised the importance of exploring how the Trust might support the service. AC reflected that a consistent theme across visits was the extent to which staff went above and beyond for patients, particularly within community services, often under significant pressure. AC also reported on system engagement, including meetings with local authority leaders and discussion of the ongoing challenges associated with no criteria to reside (NCTR). He noted that recent system discussions had been constructive but required sustained focus. He confirmed that he and NK had met with local MPs to provide updates on the new organisation, with all MPs now engaged. In relation to the national context, AC highlighted the recent progression of the Health Bill, including proposals relating to a single patient record, abolition of NHS England, and changes affecting ICBs, Healthwatch and governors, noting that implementation would be phased. AC paid tribute to the Thank You Awards, describing the event as highly successful and recognising the significant effort involved in its delivery. He also noted a recent charity fundraising event as part of the Charity's 30th anniversary. Finally, he reflected positively on his first Council of Governors meeting, welcoming the constructive challenge provided, particularly in relation to smoking on hospital sites, which he noted remained an ongoing issue. **The Trust Board noted the updates provided by the Chair.**
BM/26/06/029	**Integrated Performance Reports and Assurance Committee Report** The Board received the Integrated Performance Report and committee assurance reports and undertook a detailed discussion on quality, people, performance and finance, alongside the broader question of how quality assurance is understood and described across the organisation. **Quality** AK and PF introduced the quality section. AK highlighted MRSA bacteraemia as an exception, with three attributable cases and one non-attributable case. She advised that one case was expected to fall out of the next reporting cycle, leading to an improved trajectory. Sepsis performance remained a challenge, with improvement in inpatient settings but continued difficulty within ED. PF outlined additional measures introduced in May, including sepsis grab bags, revised ED medical cover on corridors and a dedicated sepsis bleep. These changes were supported by work to create additional space, including use of surgical SDEC. He advised that May data would be a critical review point and that, if improvement was not demonstrated, more radical options would need to be considered. These could include a dedicated sepsis team, though PF and AK cautioned against risks such as disengagement from core

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responsibilities and unintended consequences, including over-treatment. A formal deep dive was scheduled for the QSAC in July.

AC queried whether learning could be drawn from higher-performing providers. PF advised that ED performance was generally weaker nationally and that improved process measures did not always correlate with better outcomes. JD supported improvement but emphasised the importance of retaining clinical ownership of patient care. CR highlighted that multiple handovers in sepsis care may be contributing to delays, particularly in ED.

Positive assurance was noted, including 13 months without MRSA, alongside improvements in VTE and medicines reconciliation. JD raised concern regarding grade 3 and 4 pressure ulcers.

JJ challenged the clarity of SPC charts and trend presentation, citing inconsistencies between narrative and reported direction of travel. AK acknowledged that reporting required refinement. AK further noted that overall infection rates were lower than the previous year despite current threshold breaches and highlighted emerging staffing pressures, with reduced fill rates and lower bank usage potentially impacting care delivery. While no widespread harm was evident, some localised impact had been reported and continued monitoring was in place.

People

PW presented the workforce position, highlighting supporting attendance, workforce plan compliance, training compliance and PDRs. Sickness absence was reported at 5.72% against a 5.0% target, with continued improvement driven by reductions in long-term absence, while short-term absence remained a focus. Targeted interventions, including enhanced HR and Occupational Health support and structured performance reviews, were in place.

A new supporting attendance policy had been agreed across the region, with a shared ambition to reduce absence by 1%. PW noted the current rate was the lowest since September 2024 and had been positively recognised by PwC and the ICB.

Workforce plan compliance was reported at 98.98%, with the organisation at 62 WTE below plan. Vacancy controls had been strengthened through more robust triangulation at vacancy panels. JJ queried the calculation methodology, and PW agreed further clarification was required. It was agreed PW would provide a clearer explanation of workforce plan compliance metrics.

NK requested reporting on annual leave utilisation to support staff wellbeing and avoid concentration of leave later in the year. It was agreed PW would report to the SPC on annual leave patterns and associated risks.

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Concerns were raised regarding vacancy data. PW advised that substantive vacancies were estimated at c.100, with higher figures reflecting temporary staffing, and confirmed that further validation was underway with JH. The Board requested further clarification. It was agreed PW and JH would triangulate and confirm vacancy and temporary staffing positions.

DM noted that, while sickness trends were improving overall, operational hotspots such as theatres continued to require attention.

Performance

DM reported a strong year-end position, with all elective, cancer and diagnostic targets achieved and confirmation that the Trust had been stood down from Tier 2 for electives. A temporary dip in diagnostics in April was attributed to national year-end activity and was already recovering.

Urgent and emergency care remained the principal concern. Four-hour performance had improved significantly, supported by ED improvement workstreams, including SDEC and UTC developments. However, 12-hour performance remained a key risk. DM outlined a comprehensive improvement programme focused on flow, ambulance handovers, corridor care and reducing bed occupancy, supported by system-wide action. Progress would continue to be monitored through FSPC.

An increase in 52-week waits in community services, particularly paediatric neurodevelopment, was noted as a national capacity issue. An options appraisal was underway.

JJ sought assurance on fracture clinic performance. PF confirmed significant improvement over recent years and reassured the Board that patient safety was maintained, with ED managing pain and stabilisation. Additional consultant capacity was expected to support further improvement.

Finance

JS summarised committee assurance, noting strong oversight of workforce, emerging improvement in ED performance and a more mature CIP approach, although risks remained in later delivery. Month 1 financial performance was £0.9m adverse due to industrial action, with recovery anticipated.

Capital programme oversight was confirmed as robust, with schemes on track. AC requested further assurance following a historic estates rental issue. It was agreed FSPC would review estate lease and rental controls.

CR raised broader assurance concerns regarding quality, noting that while financial assurance was well developed, the organisation lacked a clearly articulated and integrated quality framework. NK acknowledged this and confirmed alignment with emerging national approaches, but agreed a clearer local articulation was required.

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	CR also raised assurance on the typing backlog, which had reduced significantly and remained on track for clearance ahead of the historical system (Big Hand) switch-off, and highlighted risks relating to Section 136 capacity, it was noted that progress would continue to be monitored through the QSAC. JJ raised a workforce risk linked to the Agenda for Change review, noting potential impact on morale where expectations of regrading were not met. PW confirmed regional alignment on approach and ongoing oversight through EMT and the SPC. JS concluded that committees remained sighted on key risks, with improving performance in some areas and continued focus required on delivery and assurance. AC sought assurance on workforce reduction tracking, with PW confirming service-level plans were in place and being progressed. CR raised a local operational issue regarding audiology reception cover, with PW agreeing to review. **The Board discussed the IPR and Committee assurance, including areas of underperformance, underlying drivers and actions in place**
QUALITY	
BM/26/06/030	**Fragile Clinical Services Update** PF introduced the update and advised that four services remained under fragile services oversight, with some encouraging progress. In relation to neck of femur (NOF), PF reported improved performance with time to theatre better than the national average. Prompt surgery rates had increased to 55% against a national comparator of 57.3%, and 30-day mortality had been zero for January to March. PF advised that, alongside previously noted data quality issues, this should return quarter 4 mortality to the expected range. However, further work was required, particularly in relation to weekend operating and flexible theatre capacity, with increased Saturday capacity planned. PF also addressed previous inconsistencies between local and national NOF data, confirming that future Board reporting would use only validated national data, accepting a one-to-two-month time lag. Internal monitoring would continue to support operational management. In rheumatology, PF reported some improvement, although the service remained a concern. The biologics backlog had reduced to one patient, and progress had been made on the DMARD backlog, though further validation was required. DMARD monitoring remained a risk, with a fail-safe process in place. An emergency capital bid was being progressed for a monitoring system

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	integrated with Trust IT. The service continued to be overseen through twice-weekly improvement meetings and would return to committee as a hot topic. PF advised that chronic pain services had improved and were now NICE compliant, with SOPs implemented with primary care for opioid management. Focus had shifted to developing a community-based model, with a recent workshop involving system partners providing clarity on the future model. Work would now progress with commissioners to agree delivery timescales. In urology, PF reported an improved position, although demand pressures remained. Recruitment to consultant vacancies was ongoing, and work was underway to determine a sustainable staffing model. The service would also be considered within the wider Cheshire system blueprint. AC sought assurance on consultant capacity. PF confirmed recruitment had reached establishment but noted that the key issue remained whether the establishment itself was sufficient. JJ asked about alignment between the Trust's definition of fragile services and wider system definitions. PF clarified that the Trust's definition was focused on quality and patient safety risk, whereas system definitions were more aligned to operational and financial sustainability. JJ emphasised the importance of ensuring the Board remained sighted on services presenting direct quality or safety risks. **The Board discussed the fragile services update and noted current risks and progress, agreeing that continued focus and oversight are required.**
BM/26/06/031	**Maternity Update** TM presented the maternity update, noting that the detailed report had been reviewed by the Quality Committee and focusing on key issues. The principal areas of improvement remained neonatal admissions, particularly term admissions, and postpartum haemorrhage (PPH). TM reported that neonatal admissions remained above the 6% threshold, although there had been improvement from 9.18% to 8.0%. Actions included implementation of respiratory distress guidance, changes to oxygen use at delivery and learning from neighbouring trusts, including Whiston. External review of the Trust's ATAIN process was also planned. A perinatal improvement tool was in development to strengthen oversight, with an action tracker and executive scrutiny to improve assurance. In relation to PPH, TM advised that the service remained a national outlier, although some improvement had been seen. Work was underway through a test of change and re-audit against regional guidelines. Instrumental deliveries had been identified as a key driver, with challenges in measuring blood loss

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accurately. New equipment had been introduced to support improved measurement, and a further deep dive was scheduled for the QSAC.

TM also highlighted that stillbirth and neonatal mortality rates remained below national averages. The Trust remained compliant with the Maternity Incentive Scheme (year 7), with year 8 now commenced and assurance shifting more directly to the Board following removal of LMNS sign-off.

AK reported recent discussions with LMNS, confirming continued focus on ATAIN and PPH, alongside emerging cultural themes. She noted significant national attention on maternity services, including recent incidents and forthcoming reviews, and emphasised the need for strengthened internal assurance arrangements.

PF highlighted the need to consider neonatal admission rates alongside the Trust's strong safety and mortality outcomes, noting that a lower threshold for admission and available capacity may contribute. He stressed the need to balance avoidance of unnecessary separation with maintaining safety. PPH remained a clear concern, with further clinical engagement planned.

JD supported this approach, noting the importance of understanding length of neonatal stay and the distinction between precautionary and longer admissions. She also reflected positively on team culture, which she considered supportive of improvement.

JS sought assurance on any additional internal concerns. TM advised that the primary issue under review was the admission threshold and confirmed confidence in the accuracy and transparency of Trust reporting, although benchmarking remained challenging across providers.

The Board discussed the opportunity for greater peer review through the Provider Collaborative. AK also highlighted ongoing coronial cases and emerging themes, including CTG interpretation and training assurance, noting that these remained under close review. Work was underway to improve dashboard reporting to board to provide clearer oversight and to strengthen Board assurance, including clearer visibility of ATAIN, PPH and key risk themes.

NK reflected on potential future external scrutiny of neonatal admissions and the implications of declining birth rates for service configuration and workforce capability. JD and PF noted that case complexity was increasing and would need to inform future planning.

AC sought assurance on wider obstetrics and gynaecology services. PF confirmed that gynaecology services had improved significantly and no longer presented the same concerns, with the one-stop model operating effectively and no current safety issues identified.

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	The Board discussed maternity quality and safety performance, noting the overall position, areas of improvement and ongoing risks.
BM/26/06/032	**Complaints Annual Report** AK presented the annual report, noting increased activity across complaints (up 64) and PALS (up over 600), with no new trends beyond established high-volume areas. Of the complaints received, 29 were upheld; 14 remained dissatisfied and 28 were reopened, largely for clarification. As executive signatory, AK confirmed that most complaints contained legitimate concerns. Pressures within PALS were highlighted, including staff safety concerns and inconsistent use of the office due to limited staffing. Temporary resource had been deployed, a charitable bid submitted for refurbishment, and organisational changes were impacting staffing. Immediate priorities were the safe reopening of the office and completion of the transition, with AK confirming that an update on plans and timescales for reopening would be circulated once arrangements were confirmed. Although PALS activity had increased without a corresponding rise in formal complaints, suggesting earlier resolution. AK noted the need to confirm whether this reflected genuine resolution or unmet need. The importance of consistent capture of all complaints was emphasised, alongside improved communication where alternative routes (e.g. incidents) were used. Training was to be strengthened accordingly. Complaints were acknowledged within three days and responded to within 25 days, with extensions applied where required. PALS aimed to resolve issues within 48–72 hours. JJ supported strengthening feedback mechanisms, cautioning that fewer formal complaints did not necessarily indicate resolution, and emphasised that response quality was more important than timeliness. AK agreed. AC raised concerns about rising PALS demand and sought clarity on reopening timescales; AK advised that delays were due to staff safety considerations. Volunteer support had been introduced. CR noted that many complaints related to clinical treatment and suggested further analysis to distinguish between care and communication issues. **The Board noted the report and the need to improve response quality, feedback mechanisms, PALS visibility, and consistency of communication with complainants.**
PEOPLE	
BM/26/06/033	**Communications and Engagement Report** KH introduced the report as the first integrated communications and engagement report for the newly combined organisation, explaining that it aimed to provide enhanced data and insight to support operational management and Board assurance, and invited feedback to inform further development.

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	KH highlighted website analytics, noting high demand for urgent and emergency care information, which informed how content should be presented to improve accessibility. She also reported improved internal communications analytics, including newsletter open and read rates, enabling more targeted staff engagement. The report covered April activity due to reporting timelines. Communications had focused primarily on integration, including day one activity, branding, intranet and website updates, and development of microsites, alongside business-as-usual work such as the Thank You Awards and service-level communications, including endoscopy. KH highlighted expanded social media reporting and advised that the team intended to strengthen its approach with specialist digital support. She also outlined progress in integrating patient information processes and implementing a new database to improve document control and reduce outdated materials. In relation to engagement, KH referenced activity including the Staying Connected Disability Forum and involvement of experts by experience. Charity activity included the ICU balcony opening and planning for the Charity's 30th anniversary events, with KH confirming that further details and reminders, including opportunities for Board member involvement, would be circulated. **The Trust Board noted the content of the report.**
BM/26/06/034	**Freedom to Speak Up Guardian Report** The Freedom to Speak Up Guardian report was received and noted. AC highlighted key points from the committee discussion, including that a half-year review was scheduled for early July and would be the first undertaken on a fully integrated basis. He also noted reduced capacity following the retirement of the former Bridgewater lead. AC observed that the report appeared somewhat optimistic when considered alongside wider evidence, particularly staff survey feedback indicating that some staff lacked confidence that concerns would be acted upon. He emphasised the need to strengthen a "you said, we did" approach to demonstrate organisational responsiveness, while recognising confidentiality constraints, and to improve how this was communicated. PF added that most speaking up cases now related to personal or workforce matters rather than safety-critical issues, highlighting the importance of ensuring that formal HR and management processes were trusted and effective, with Freedom to Speak Up remaining an escalation route rather than the default. NK commented on report presentation, advising that percentage changes should be supported by absolute numbers where volumes were small to

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	ensure accurate interpretation, and it was agreed that future reports would include both. AC also reflected feedback from community visits, where staff had raised concerns about issues remaining unresolved over extended periods, including parking and banding, emphasising that clear communication and feedback were essential to maintain trust, even where resolution was not possible. **The Board discussed and noted the report**
GOVERNANCE	
BM/26/06/035	**Terms of Reference – Audit Committee; Cycles of Business – Quality and Safety Assurance Committee, Strategic People Committee, Finance, Sustainability and Performance Committee, Audit Committee** JC introduced the suite of governance papers seeking approval. He advised that the revised Terms of Reference for the Audit Committee and the updated Cycles of Business for the Board committees had already been through the relevant committees and had their support. **The Board approved the revised Committee Terms of Reference and Cycles of Business as presented.**
BM/26/06/036	**Council of Governors Terms of Reference and Cycle of Business** JC then presented the revised Council of Governors Terms of Reference and Cycle of Business. He confirmed that these had already been considered and supported by the governors. No additional comments were raised. **The Board approved the revised Council of Governors Terms of Reference and Cycle of Business.**
Closing	
BM/26/06/037	**Review of the Meeting** In reviewing the meeting, AC thanked governors for their attendance and noted the breadth of discussion. He referred to PALS and invited SF to comment on governor involvement; SF confirmed that governors and experts by experience were working with the team, with further meetings planned to shape the future model, and emphasised the importance of restoring face-to-face access. AC also marked National Volunteers Week, thanking volunteers, including governors, for their contribution. AK reported positive recent engagement activity, with increased volunteer numbers and improved support arrangements, and noted ongoing work to strengthen oversight, alongside minor feedback regarding the need for additional uniforms.
BM/26/06/038	**Any Other Business**

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	AC invited any further business. No additional items were raised. **The meeting ended at 12.27pm**, with Part 2 to reconvene after lunch at 1.30pm.
Supplementary papers for noting	
BM/26/06/039	**Infection Prevention & Control Update Q4**
BM/26/06/040	**Patient Experience 6 Monthly Report – Patient Experience Sub-committee**
BM/26/06/041	**Guardian of Safe Working Report Q4**
Date and time of next meeting – 10am, Wednesday 5 August, Conference Room, Ground Floor, Spencer House, Birchwood.	

Signed:
Position: Chair
Date:

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North Cheshire and Mersey
NHS Foundation Trust

Trust Board - Action Log

Agenda reference:	BM/26/08/044ii	Subject:	Action Log Trust Board	Date of meeting:	5 August 2026

1. Actions on agenda

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

2. Actions completed and closed off since last meeting

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

3. Rolling tracker of outstanding actions

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/26/06/023	3 June 2026	ICU Engagement Story	to explore improvements to patient experience (including communication, patient resources and support) and report back to Board/QSAC	AK/AI	August Board			

BM/26/06/029	3 June 2026	Workforce / People (IPR)	Provide a clearer explanation of workforce plan compliance metrics - Requested by Board following challenge on methodology	PW	July			
			Report on annual leave utilisation patterns and associated risks to SPC .to support staff wellbeing and planning	PW	July			
			Triangulate and confirm vacancy and temporary staffing position. Further validation required following Board concern	PW	July			
BM/26/06/029	3 June 2026	IPR Finance / Estates Assurance	To review estate lease and rental controls to provide further assurance. Requested following historic estates issue.	FSPC/JH	July FSPC			
BM/26/06/032	3 June 2026	Complaints / PALS	To circulate update on plans and timescales for safe reopening of the PALS office.	AK	Once arrangements are confirmed		Dependent on staffing and safety arrangements	

RAG Key

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/046**			
Subject:	**Chief Executive's Report**			
Date of meeting:	5 August 2026			
Action required:	**Noting**			
Author(s):	Nikhil Khashu, Chief Executive			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This report provides the Board with an update on key Trust, national, regional and system developments since the last meeting. It highlights continued work to develop the culture of North Cheshire and Mersey NHS Foundation Trust, improve patient flow, reduce corridor care, strengthen inclusion and staff experience, support strategy development and maintain focus on information governance and patient confidentiality. The report also summarises national and regional updates, including NHS England's expectations on cyber security assurance, minimum standards for patient experience in elective care, resident doctor arrangements, regional leadership changes, and system priorities across Cheshire and Merseyside. Overall, the report reflects continued progress during a period of organisational development, with sustained focus on quality, performance, partnership working, patient experience and delivery of the Trust's strategic priorities			

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Board is asked to note the content of the Chief Executive's report.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 3 June 2026, some of which are not covered elsewhere on the agenda for this meeting.

2. Key elements

2.1 Trust News

Developing the culture of North Cheshire and Mersey

Since the establishment of North Cheshire and Mersey NHS Foundation Trust (NCM), work has continued to support the development of a shared organisational culture. The Trust's values, kind, open, fair and one team, provide the basis for this work and are now being supported through a new behavioural framework, which sets out how colleagues can bring those values to life in day to day practice.

The development of the framework reflects the opportunity created by integration to bring together the strongest elements of both predecessor organisations and shape a culture that staff can recognise and feel proud of. Colleagues have been invited to contribute their views on what it currently feels like to work at the Trust and what they would like it to feel like in the future, supporting the development of a culture statement that is grounded in staff experience.

Alongside this, the Trust has introduced the NCM Champion role, bringing together the previous Culture Champion and People Promise Champion arrangements. NCM Champions will act as local points of contact within teams, helping to share information, signpost colleagues to support, encourage feedback and identify gaps in staff experience. The ambition is for every ward, department and team to have access to an NCM Champion, helping colleagues feel informed, supported and heard wherever they work.

The national NHS staff standards have also been introduced across the organisation. These standards focus on line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism and flexible working. They align closely with the Trust's emphasis on doing the basics brilliantly and will provide a framework for continuing to improve staff experience, drawing on local staff feedback and wider People Promise priorities.

Improving patient flow and reducing corridor care

The Trust has maintained a strong focus on reducing corridor care and improving patient flow. A Corridor Care Summit brought together clinical and senior colleagues from across the Trust, alongside partners from North West Ambulance Service, local

authority partners and Healthwatch, to consider the experience of patients and staff and identify practical actions to support improvement.

The summit reinforced that corridor care is not solely an Emergency Department issue but reflects whole system flow. Delays in discharge decisions, limited early senior review and capacity that does not flex with demand were identified as areas requiring continued focus. The discussion concluded with clear actions, including improving criteria led discharge, making better use of the discharge lounge and strengthening pathways between hospital and community care.

Linked to this work, the Trust has launched a new Board Round Improvement Toolkit as part of its Home First approach. The toolkit is designed to support more consistent, efficient and focused board rounds, with clearer roles and responsibilities for multidisciplinary teams. It promotes use of the nationally recognised S.H.O.P. model, sick, home, other and plan, and encourages teams to ask, why not home today, as part of discharge planning.

Inclusive, person centred care for people with learning disabilities and autism

During Learning Disability Awareness Week, the Trust shared an example of person centred care for a patient with complex needs who required reasonable adjustments to support access to planned investigations and treatment. Colleagues from a range of services worked with the patient, family and partners to develop an individualised approach, demonstrating the importance of listening, adapting care and working across organisational boundaries to reduce health inequalities and improve experience.

Inclusion, belonging and staff experience

The Trust has continued its programme of work to strengthen inclusion and improve staff experience. Following publication of the annual Staff Survey results, a Race Inclusion Summit was held to explore the experience of staff through the lens of race. The discussion recognised areas of positive experience, while also highlighting areas where further work is required to improve consistency, fairness and inclusion for colleagues across the organisation.

The inclusion summit programme has continued with further sessions focused on disability and LGBTQ+ inclusion. These sessions provide an opportunity for colleagues and allies to examine workforce data, share experiences and identify actions to address disparities. The themes emerging from this work highlight the importance of psychological safety, fairness, wellbeing and trust across all protected characteristics.

The Trust has also marked South Asian Heritage Month, with colleagues reflecting on the theme of unity in diversity and the value of listening, understanding and empathy in creating a workplace where everyone feels they belong. This work is being

supported by staff networks, including the Multiethnic Staff Network, and contributes to the wider ambition of building a genuinely inclusive organisation.

In addition, the Trust continues to support inclusive employment through its supported internship programme, delivered with Warrington and Vale Royal College, Warrington Borough Council and DFN Project SEARCH. The programme supports young people aged 17 to 24 with additional needs through structured workplace placements that help build skills, confidence and independence. The positive experience of interns and host teams demonstrates the value of creating more inclusive pathways into employment.

Learning from national maternity and neonatal reviews

The Trust has reflected on the findings of the Independent Review of Maternity Services at Nottingham University Hospitals, led by Donna Ockenden. The report describes serious and repeated failings in care, leadership, culture, accountability, discrimination and listening to women and families. The findings provide important learning for all healthcare organisations, including services beyond maternity and neonatal care.

The Trust's current focus is on ensuring that the learning is considered carefully and openly. The report reinforces the need to listen to patients, families and colleagues, act early when concerns are raised, remain open and honest when things go wrong and create an environment where people feel safe to speak up and challenge. Learning from both this report and the national maternity and neonatal investigation will be reviewed through Trust Board and relevant governance routes.

Developing the Trust strategy and NCM 2030

The Trust has begun the next phase of engagement to support development of a new organisational strategy for the next three to five years. The strategy will set out the Trust's shared vision, priorities and ambition for improving the health and wellbeing of the communities it serves, and for delivering outstanding care into the future.

Colleagues have been invited to contribute through a Trust wide survey, which remains open until 30 September 2026. The engagement process is intended to capture the experience, ideas and expertise of staff, patients, carers, partners and wider stakeholders, ensuring that the strategy is shaped by those who deliver, receive and work alongside Trust services.

Supporting the Armed Forces community

The Armed Forces and Veterans Network continues to support colleagues and patients connected to the Armed Forces community. The network is open to veterans, reservists, military spouses and family members, cadet force volunteers and allies, and provides a forum for connection, awareness and mutual support.

The network highlights the skills and experience that members of the Armed Forces community bring to the organisation, including teamwork, resilience, leadership and adaptability. It also supports the Trust's wider commitment as an inclusive employer and as a supporter of the Armed Forces Covenant Employer Recognition Scheme Silver Award.

Through the network, the Trust is helping to raise awareness of the needs of veterans and their families within both the workforce and patient population, ensuring that members of the Armed Forces community can feel recognised, understood and supported.

Protecting patient information and confidentiality

The Trust has reinforced the importance of protecting patient information and ensuring that records are accessed only where there is a clear and legitimate work related reason. This followed national attention on unlawful access to patient records and provided an opportunity to remind colleagues of their professional, legal and ethical responsibilities.

Accessing patient records out of curiosity or for personal reasons is unlawful and unacceptable. This includes accessing records relating to family members, friends, colleagues, people of local or national interest or previous patients where there is no current and valid work related reason. Such access can result in disciplinary action, dismissal, referral to professional regulators and, in some cases, criminal prosecution.

Colleagues have been reminded to access records only where necessary for their role, to keep patient information secure, and to report immediately if a record is accessed in error.

NHS England tiering update

The Trust has received confirmation from NHS England North West of its Quarter 1 2026/27 tiering status. The Trust has moved out of tiering for elective care, reflecting sustained progress and improvement over recent months, supported by strengthened governance, performance recovery and delivery against agreed trajectories.

Tiering is the national oversight process used by NHS England where services facing delivery challenges receive additional support, scrutiny and oversight. The Trust will remain in tiering for Urgent and Emergency Care, reflecting the need for continued focus on improvement in that area.

2.2 National, Regional & ICB News

Resident doctors offer and implementation

NHS England wrote to chief executives in June advising that the Government had made a comprehensive offer to the BMA Resident Doctors Committee on pay and job conditions.

The offer has since been accepted by resident doctors. The focus has therefore moved from managing immediate industrial action risk to implementation. The Trust will continue to review the operational, workforce and financial implications as national guidance is issued.

Cyber security risk and Board assurance

NHS England has written to NHS trust and integrated care board chairs and chief executives asking boards and executive teams to assure themselves that cyber security risks are being managed effectively, with clear and sustained improvement programmes.

NHS England has set out key areas for Board and executive assurance on cyber security, including oversight of core controls, resilience arrangements and incident response. The Trust will continue to review these expectations through its established digital, information governance and risk assurance routes, including oversight of preparedness, recovery arrangements for critical systems and progress against cyber improvement plans.

Minimum standards of patient experience for elective care

NHS England has issued new minimum standards setting out what patients should expect following referral for planned care, including clear communication on whether a referral has been accepted, regular updates while waiting, information to support patients during their wait, timely appointment information, rebooking following cancellations, and confirmation when care is complete and what happens next. Trust Boards are expected to assess current performance against each standard, identify areas for improvement and publish a statement in 2026/27 setting out their approach to compliance, with an annual statement on progress thereafter.

An initial assessment has been undertaken against the eight standards. This indicates that the Trust is already meeting some requirements, including the provision of clear appointment information, but that further work is required to strengthen consistency in other areas. Improvement actions have been identified, with a number of target timescales currently set for January 2027 and March 2027, with progress overseen through the Trust's established operational and governance routes.

NHS England North West regional leadership

NHS England North West has shared changes to its Regional Executive Team following publication of the consultation outcome report on the new regional operating model. Michael Gregory, Regional Medical Director, will retire in the autumn, having remained in post to support transition to new structures. Clare Duggan, Regional Director of Strategy and Transformation, and James McLean, Regional Chief Nurse, are also leaving NHS England.

Bridget Lees will act up as Regional Chief Nurse while permanent recruitment takes place. Scott McLean has joined on secondment from University Hospitals of Morecambe Bay NHS Foundation Trust as Regional Director of Delivery and Transformation. Sam James will return to his substantive Director of Performance role following a period acting up as Regional Chief Operating Officer.

NHS England North West strategic priorities

NHS England North West has also set out expectations for systems and providers to move from medium term planning into clear delivery plans for longer term strategic objectives. The regional focus remains on delivering agreed access improvements across primary, community and secondary care, including physical and mental health.

The region has asked systems to develop detailed plans for the next phase of medium term delivery, including transformation of outpatient, urgent and emergency care and mental health access, alongside delivery of the three national shifts of neighbourhood, digital and prevention. Quarterly Executive Strategic Review discussions with integrated care boards and provider collaboratives are expected to focus on outcomes, barriers and regional support required, helping define success for the North West towards 2030.

CMPC Provider Strategy

The Provider Strategy programme continues to progress across partnership, transformation and service redesign workstreams. This briefing provides a summary of key developments discussed at the CMPC Blueprint Delivery Group meeting held on 10th July 2026. The programme remains focused on strengthening provider collaboration, supporting service sustainability and delivering the ambitions set out within the CMPC Provider Strategy.

- **National Policy and System Developments:** An update was provided on several significant national developments, including the expected appointment of a new Prime Minister on 16th July 2026; and the ongoing progression of the Health Amendment Bill. The Bill includes proposals relating to NHS England, NHS Governors, Healthwatch and Trust Chair appointments. It was noted that this is being discussed through the CMPC CoSec professional group to share intelligence and local action.
  The Baroness Amos Review and Ockenden Report into maternity services publications have been released. There has been communication about the launch of the NHS College of Management, increasing national focus on digital transformation and artificial intelligence, and the establishment of the NHS Online Trust, which is expected to become operational in 2027.

- **Alliance Models and Collaborative Governance:** The alliance and collaborative models for CMPC are being explored to ensure that the operating and governance framework will enable Cheshire and Merseyside providers to make collective decisions and deliver transformation programmes collaboratively whilst retaining

sovereignty and statutory accountability within individual organisations. The recent Chairs and Chief Executives workshop was designed to test how these arrangements would work in practice when faced with complex, system-wide decisions**.** Briefings and communications with Boards to keep them informed of priorities, workstreams and programmes is key to supporting this.

- **Service Chain Model:** Progress on the Service Chain Model was presented recognising different models can be implemented. The proposed model has been shared with The Clatterbridge Cancer Centre and The Walton Centre for initial feedback, given their existing service chain arrangements. Following receipt of feedback, the model will be refined and shared more widely with Chief Executives for consideration.

- **Community Services Mapping:** Cheshire & Merseyside providers are in the process of submitting their Community Services Mapping submissions. Once all returns are received, a system-wide analysis phase will commence to establish a comprehensive view of community services across Cheshire and Merseyside. The work aims to identify variation in service provision, opportunities for standardisation, areas of duplication and potential opportunities for collaboration to drive service improvement.

- **Future Service Transformation Opportunities:** Discussion highlighted the importance of linking the Community Services Mapping work with wider Provider Strategy programmes, including the Single Point of Access and Fragile Services workstreams. Members recognised the need for further modelling to understand the scale of activity transfer required from acute to community settings to deliver meaningful operational and financial benefits across the system, and to understand the scale required to enable cost to be taken out.

Halton Borough Council leadership changes

Halton Borough Council has advised system partners that Cllr Mike Wharton has stepped down as Leader of the Council and that Cllr Dave Thompson has stepped down as Deputy Leader. Both will continue as ward councillors. The Labour Group is expected to identify successors, with appointments due to be considered by Full Council.

The Trust will continue to maintain close partnership working with Halton Borough Council and other local authority partners as leadership arrangements are confirmed, particularly in relation to shared priorities across place, integration, prevention and community based care.

2.3 Overview of Trust Performance

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

Appendix 2 provides an update on the latest published NHS Oversight Framework metrics and highlights trend against the previous quarter publication.

2.4 Special Days/Weeks for professional groups

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

June 2026

- Volunteers' Week
- Bike Week
- Men's Health Week
- Carers Week
- Diabetes Awareness Week
- Learning Disability Week
- Loneliness Awareness Week
- National Clean Air Day
- Uk Windrush Day

July 2026

- South Asian Heritage Month
- Disability Pride Month
- Alcohol Awareness Week

2.5 Signed under Seal

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

2.6 Meetings Attended

Since the last Board meeting, I have continued to engage extensively with national, regional and system partners, representing the Trust and influencing wider discussions on NHS performance, finance, leadership and service transformation. This has included participation in national discussions with the Department of Health and Social Care and NHS England, Cheshire and Merseyside Provider Collaborative leadership and delivery forums, NHS England leadership and talent development events, CEO and Chair workshops, and engagement with senior NHS leaders including Sir Jim Mackey, Elizabeth O'Mahoney, Sally Senior, Sheena Cumiskey and Liz Bishop.

I have also attended sessions held by NHS Confederation and PwC, providing opportunities to share learning, strengthen strategic partnerships and ensure that the

Trust's perspective informs regional and national policy development and decision making.

3. Recommendations

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

Appendix 1: CEO Dashboard – Month 11 (February 2026)
Appendix 2: National Oversight Framework Q4

Appendix 2 - CEO Dashboard Month 3 – June 2026

North Cheshire and Mersey NHS Foundation Trust

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	17	
Sepsis Screening Emergency	above 90%	78.00%	
Sepsis Screening Inpatients	above 90%	80.00%	
Sepsis Antibiotics Emergency	above 90%	60.00%	
Sepsis Antibiotics Inpatient	above 90%	72.00%	
Inpatient Falls	below YTD 119	133 YTD	
VTE	above 95%	95.28%	
Acute Pressure Ulcers (Category 2)	below YTD 27	36 YTD	
Acute Pressure Ulcers (Category 3 and Category 4)	below YTD 2	4 YTD	
Community Pressure Ulcers (Category 2)	below YTD 47	61 YTD	
Community Pressure Ulcers (Category 3 and Category 4)	below YTD 13	11 YTD	
Medication Reconciliation (within 24 hrs)	above 80%	44.99%	
Complaints over 6 months	0	0	
Healthcare Infections - MRSA	below YTD 0	0 YTD	
Healthcare Infections - MSSA	below YTD 8	6 YTD	
Healthcare Infections – CDI (cumulative)	below YTD 16	21 YTD	
Healthcare Infections - E. coli (cumulative)	below YTD 19	22 YTD	
Healthcare Infections – Klebsiella (cumulative)	below YTD 7	3 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	below YTD 2	3 YTD	
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	3.60%	
MUST nutritional assessment completion	above 85%	77.13%	
Duty of Candor	100%	100.00%	

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	5.72%	
Workforce FTE Plan Compliance	100% or below	98.99%	
Core/Mandatory Training	above 85%	91.50%	
PDR Compliance	above 85%	84.02%	

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	95.62%	
RTT 18 Weeks	above 92%	65.08%	
RTT - patients waiting 52+ Weeks	0	308	
RTT - patients waiting 65+ Weeks	0	0	
Elective Outpatient activity	104%	104%	
A&E % patients seen within 4 hours	Below 78.00%	67.92%	
A&E % waiting longer than 12 hours	Below 2.00%	23.48%	
% Patients referred to ED from UTC	Below 3.00%	15.14%	
Cancer 28 Day Faster Diagnostic Standard	above 75%	81.91%	
Cancer 62 Day Wait	above 85%	79.17%	
Ambulance Vehicle Handovers within 45 mins	100%	72.76%	
Cancelled Operations – not rearranged within 28 days	0	0	
Capped Theatre Utilisation	above 85%	75.68%	
Average days from discharge-ready to actual discharge	1 day or below	1.6 days	
Urgent Community Response (UCR)	70.00%	95.90%	
% Of Community Waiters over 52 weeks (exc. Derm and Dental)	0.00%	20.28%	
Number of patients waiting over 52 weeks (inc. Derm & Dental)	0	2049	
Number of patients waiting over 65 weeks (inc. Derm & Dental)	0	1549	
Number of patients waiting over 104 weeks (inc. Derm & Dental)	0	431	

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£13.4	-£14.3	
Capital Spend (£m)	£6.5	£1.9	
Cash Balance (£m)	£13.5	£22.2	
Better Practice Payment Code (£m)	above 95%	51%	
Agency Reduction (£m)	£0.6 (30% reduction from 2025/65 plan)	£0.3	
Bank Reduction (£m)	£6.8 (10% reduction from 2025/26 plan)	£8.2	
CIP In Year Delivered in relation to plan	90% of plan	100%	
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	65%	

Strategy

The WELL Runcorn Hub opened its doors to the public in late June 2026. This is the latest project in our programme of work leading the development of multi-agency collaborative health and wellbeing facilities across Warrington and Halton, in line with the national direction set out in the Government's 10-year plan for the NHS.

The Trust received confirmation of funding support from NHS England to allow us to develop the initial phases of a proposal to build a new Urgent Treatment Centre close to the ED on the Warrington hospital site. The work will involve the development of detailed plans for the location, scale and future costs of the facility, and will form the basis of the full business case for the development that will go back to NHS England in early 2027 for formal review.

Partners from across Warrington Place came together for a Living Well LIVE! event to showcase the work done to date in Warrington on the Living Well programme and discuss future ideas and opportunities. To accompany the event, the teams involved in the Living Well programme produced a report to highlight the achievements of the various Living Well projects over the last two years and some case studies of success.

Work is now progressing to start to integrate a number of the early priority clinical pathways between the acute and community teams as part of phase 2 of the Better Care Together integration programme.

Work has also now commenced around the development of the new Trust strategy and clinical strategy. These documents will set out the strategic direction for NCM to 2030 and start to detail what the organisation will focus on over the coming years as part of a wider transformation and improvement programme. Staff are encouraged to get involved in the development of the strategies and all feedback and suggestions are welcome.

Appendix 1

NHS Oversight Framework - NCM June 2026 Update

Trust Rank
102 out of 134
Previous quarter rank: **106** out of 134
Improvement of 4 places

NHS
North Cheshire and Mersey
NHS Foundation Trust

Access to services			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q4 2025/26	2.28	**61** out of 117	▼		Q3 2025/26	2.81	**72** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q4 2025/26	1.00	**14** out of 118	▶		Q3 2025/26	1.00	**10** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Mar-26	1.00	**52** out of 130	▼		Dec-25	3.58	**111** out of 131
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Mar-26	2.42	**62** out of 130	▼		Dec-25	2.43	**63** out of 131
Elective care	Difference between planned and actual 18 week performance	Quarterly	Mar-26	1.00	**71** out of 130	▼		Dec-25	2.65	**69** out of 131
Elective Care	Percentage of patients waiting over 52 weeks for community services	Quarterly	Mar-26	3.55	**37** out of 42	▲	Within exception slides	Dec-25	3.56	**36** out of 41
Urgent and emergency care	A&E within 4 hours	Quarterly	Q4 2025/26	3.50	**101** out of 123	▼		Q3 2025/26	3.60	**105** out of 123
Urgent and emergency care	A&E within 12 hours	Quarterly	Q4 2025/26	3.90	**118** out of 119	▲	Within exception slides	Q3 2025/26	3.90	**104** out of 123

Effectiveness and experience			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quarterly	Mar-26	3.91	**124** out of 128	▲	Within exception slides	Dec-25	3.45	**104** out of 126
Effective out of hospital care	Urgent Community Response 2-hour performance	Quarterly	Q4 2025/26	1.17	**3** out of 38	▶		Q3 2025/26	1.15	**3** out of 50
Patient experience	Summary Hospital-level mortality indicator	Annually	Jan 24 - Dec 25	2.00	Not Ranked	▶		Oct-24 - Sep 25	2.00	Not Ranked
Patient experience	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked	▶		2024	2.00	Not Ranked

Finance and productivity			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Finance	Planned surplus/deficit	Quarterly	Q4 2025/26	4.00	**126** out of 134	▶		Q3 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Month 12 2025/26	4.00	**132** out of 134	▲	Within exception slides	Month 9 2025	4.00	**121** out of 134

Patient Safety			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Patient Safety	Number of MRSA bacteraemia cases	Quarterly	Jan 25 - Dec 25	1.00	Not Ranked	▼		Jan 25 - Dec 25	2.66	Not Ranked
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Apr 25 - Mar 26	2.07	Not Ranked	▲	Within exception slides	Jan 25 - Dec 25	1.00	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	2024	1.81	**37** out of 134	▶		2024	1.81	**37** out of 134
Patient Safety	Proportion of C. difficile infections	Quarterly	Apr 25 - Mar 26	3.33	Not Ranked	▲	Within exception slides	Jan 25 - Dec 25	3.20	Not Ranked

People and Workforce			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric score**	**Rank**
Retention and culture	Sickness absence rate	Quarterly	Q3 2025/26	3.19	**114** out of 134	▼		Q2 2025/26	3.38	**120** out of 134
Retention and culture	NHS Staff survey engagement theme sub-score	Annually	2024	2.29	**58** out of 134	▶		2024	2.29	**58** out of 134

Key
▶ No Change
▼ Improvement
▲ Concern

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/048**			
Subject:	**Board Assurance Framework Q1**			
Date of meeting:	5 August 2026			
Action required:	**for approval**			
Author(s):	Emily Kelso, Head of corporate governance			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations:	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	This report presents the Quarter 1 review of the Trust's nine strategic Board Assurance Framework (BAF) risks. Following review through the relevant Board Committees, no changes are proposed to risk ratings, risk descriptions, target ratings or risk appetite statements. No strategic risks have been added, closed or de-escalated during the quarter. All nine strategic risks remain above target and continue to require ongoing monitoring. The highest-rated risks remain **BAF 2 – Urgent and Emergency Care Flow and BAF 6 – Financial Sustainability, both rated 20**. Committees concluded that current ratings remain appropriate and accurately reflect the Trust's strategic risk profile. Implementation of the consolidated BAF for the enlarged Trust and combined Corporate Risk Register has strengthened strategic risk oversight across the organisation, with all corporate risks mapped to a strategic			

<table>
<tr><td></td><td colspan="3">BAF risk and allocated to a designated Board Committee. Work to improve risk management arrangements continues through the Corporate Risk Register Improvement Programme.

Appendix 1 contains the detailed Quarter 1 reports for each strategic BAF risk. Appendix 2 provides the Trust Risk Appetite Statement approved by the Trust Board on 1 April 2026.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to:
Note the Quarter 1 position for all nine Board Assurance Framework risks detailed in Appendix 1.
Note that no strategic risks have been added, amended, de-escalated or closed during Quarter 1.
Take assurance from the oversight and scrutiny provided by the Quality and Safety Assurance Committee, Strategic People Committee and Finance, Sustainability and Performance Committee.
Take assurance that appropriate controls, mitigations and assurance arrangements remain in place for the effective management of strategic risks across the Trust.
Note progress against the Corporate Risk Register Improvement Programme and the work of the Risk Review Group to strengthen the Trust's risk management framework.
Approve the Quarter 1 Board Assurance Framework position for North Cheshire and Mersey NHS Foundation Trust, as recommended by the assigned Committees.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td colspan="2">Committee</td><td>All</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td>QSAC/26/07/085, SPC/26/07/066, FSPC/26/07/063</td></tr>
<tr><td colspan="2">Date of meeting</td><td>14.07.2026, 15.07.2026, 29.07.2026</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td>Approved</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

A Board Assurance Framework (BAF) is the principal mechanism through which NHS Boards gain visibility of the strategic risks that could compromise delivery of their statutory duties, including quality of care, patient safety, finance, workforce, performance and regulatory compliance. It provides a clear line of sight between organisational objectives, the risks that threaten their delivery, the controls in place, and the strength of assurance available to the Board, enabling informed, evidence-based decision-making and effective resource allocation.

This report provides the Quarter 1 position for the nine strategic risks within the North Cheshire and Mersey NHS Foundation Trust Board Assurance Framework (BAF). The consolidated BAF for the enlarged Trust was approved by the Trust Board in April 2026 and provides a single framework for the oversight of strategic risks across the organisation. The framework ensures that the Trust Board retains oversight of risks that could compromise delivery of organisational objectives, whilst high rated (15 and above) operational risks are managed through the Corporate Risk Register, divisional governance arrangements and Board Committees.

Quarter 1 assurance has been provided through the Quality and Safety Assurance Committee (QSAC), Strategic People Committee (SPC) and Finance, Sustainability and Performance Committee (FSPC), which have reviewed the strategic risks within their respective remits and supported the Quarter 1 position for recommendation to the Trust Board.

1.1 Strategic Risk Overview, (Full reports are attached as **Appendix 1**).

BAF Risk	Executive Lead	Current Rating	Target Rating	Risk Appetite
BAF 1 – Quality of Care and Patient Safety	Executive Medical Director / Chief Nurse	**16 ⇔ (L4xC4)**	4	Minimal
BAF 2 – Urgent and Emergency Care Flow	Chief Operating Officer	**20 ⇔ (L5xC4)**	4	Minimal
BAF 3 – Planned Care Access and Elective Recovery	Chief Operating Officer	**12 ⇔ (L3xC4)**	6	Cautious
BAF 4 – Embedded Health Equity	Chief Nurse / Chief Strategy and Partnerships Officer	**9 ⇔ (L3xC3)**	4	Cautious
BAF 5 – Workforce Capacity, Capability and Wellbeing	Chief People Officer	**12 ⇔ (L4xC3)**	6	Cautious

BAF 6 – Financial Sustainability	Chief Finance Officer	**20 ⇔ (L5xC4)**	9	Open
BAF 7 – Digital Resilience, Cyber Security and EPR	Executive Medical Director	**16 ⇔ (L4xC4)**	6	Cautious
BAF 8 – Estates, Infrastructure and Capital Planning	Chief Operating Officer	**16 ⇔ (L4xC4)**	9	Seek
BAF 9 – Partnership, Integration and System Working	Chief Strategy and Partnerships Officer	**9 ⇔ (L3xC3)**	4	Open

2. Strategic Risk Updates

2.1 New Risks

Since implementation of the consolidated Board Assurance Framework in April 2026, no new strategic risks have been identified or added to the Board Assurance Framework. The current nine-risk structure remains appropriate and continues to provide comprehensive coverage of the Trust's principal strategic risks.

2.2 Amendments to Risk Ratings

There have been no changes to strategic risk ratings during Quarter 1. Following review by the relevant Board Committees, all nine strategic risks remain above their target ratings and remain unchanged. Committee discussions concluded that the existing controls and mitigating actions remain appropriate, based on the quarterly updates provided by Executive Leads and risk owners.

2.3 Amendments to Risk Descriptions

There have been no amendments to strategic risk descriptions during Quarter 1. The existing risk descriptions continue to reflect the principal threats to the achievement of organisational objectives and remain aligned to the Trust Strategic Plan and Risk Appetite Statement.

2.4 De-escalation of Risks

No strategic BAF risks have been closed or de-escalated during Quarter 1. All strategic risks remain active and subject to ongoing monitoring through the Committee governance structure and quarterly review process.

2.5 Existing Risks – Updates

Detailed reports are attached as **Appendix 1**. Key updates are summarised below:

Strategic Risk	Key Update	Current Rating	Impact on Rating
BAF 1 – Quality of Care and Patient Safety	Key areas of exposure continue to relate to fragile services, specialist workforce resilience, patient safety, clinical documentation, diagnostic capacity and service sustainability. Linked risks demonstrate ongoing challenges across rheumatology, maternity diabetes pathways, fracture neck of femur performance and specialist workforce capacity.	**16 (L4xC4)**	None ⇔
BAF 2 – Urgent and Emergency Care Flow	Continues to represent the highest-rated quality and operational risk. Significant focus remains on emergency department demand, patient flow, discharge pathways, system capacity, escalation areas and corridor care.	**20 (L5xC4)**	None ⇔
BAF 3 – Planned Care Access and Elective Recovery	Progress continues through elective recovery programmes, Community Diagnostic Centres and infrastructure developments. Challenges remain in diagnostics, workforce capacity, outpatient backlogs and some elective waiting times.	**12 (L3xC4)**	None ⇔
BAF 4 – Embedded Health Equity	Work continues to embed health equity through targeted programmes, partnership working and access initiatives. Further work is required to strengthen reporting arrangements and measurement of outcomes across protected and vulnerable groups.	**9 (L3xC3)**	None ⇔
BAF 5 – Workforce Capacity, Capability and Wellbeing	Workforce challenges continue across vacancies, sickness absence, workforce supply and safe staffing. Recruitment, retention, leadership development and wellbeing initiatives continue to support workforce resilience. Whilst Resident Doctors have accepted the national pay offer, Consultant and SAS industrial action mandates continue to create uncertainty.	**12 (L4xC3)**	None ⇔
BAF 6 – Financial Sustainability	Financial sustainability remains dependent on the delivery of recurrent efficiencies, productivity improvements and planned activity levels. The Financial Recovery Plan, together with established governance, forecasting and	**20 (L5xC4)**	None ⇔

	Delivery Unit arrangements, continues to provide oversight and assurance.		
BAF 7 – Digital Resilience, Cyber Security and EPR	Cyber resilience, digital infrastructure and EPR risks continue to be managed through DSPT compliance, penetration testing, patch management and EPR programme governance. Key gaps remain around Privileged Access Management (PAM), Multi-Factor Authentication (MFA) coverage, unsupported systems and technical debt.	**16 (L4xC4)**	None ⇔
BAF 8 – Estates, Infrastructure and Capital Planning	Risks continue to be managed through capital planning, statutory compliance arrangements, Six Facet Surveys and redevelopment planning. Challenges remain around backlog maintenance, ageing infrastructure, capital constraints and estate resilience.	**16 (L4xC4)**	None ⇔
BAF 9 – Partnership, Integration and System Working	Integration and partnership risks continue to be managed through post-transaction governance, Better Care Together workstreams, clinical integration programmes and system leadership arrangements. Further work is required around pathway standardisation, benefits realisation and workforce productivity.	**9 (L3xC3)**	None ⇔

3. Corporate Risk Register

The establishment of a consolidated Board Assurance Framework and aligned Corporate Risk Register represents a significant step forward in strengthening risk management arrangements across the Trust. The Quarter 1 review has, however, identified a number of areas where further improvement is required. A Corporate Risk Register Improvement Programme is therefore in place, with a focus on:

- Strengthening the quality and consistency of risk descriptions, ratings, controls, assurances and action plans.
- Reducing the number of overdue reviews and overdue actions.
- Improving alignment between operational, corporate and strategic risks.
- Embedding the Three Lines of Defence model across strategic risk management arrangements.
- Improving Datix data quality and reporting.
- Enhancing organisational capability through risk management training and development.

The Risk Review Group continues to oversee delivery of this improvement programme and provides assurance that actions are being progressed to further strengthen the maturity and effectiveness of risk management arrangements across the Trust. Committee reports recognised that the introduction of the consolidated BAF and aligned Corporate Risk Register has strengthened governance arrangements through improved transparency, accountability, escalation pathways and Board-level visibility of strategic risks.

As part of the development of the consolidated Board Assurance Framework (BAF), all risks within the Corporate Risk Register have been mapped to a strategic BAF risk and assigned to a designated Board Committee. **Appendix 1** (Individual Risk Reports) provides a high-level summary of the corporate risks aligned to each strategic BAF risk.

These risks are reviewed in detail on a quarterly basis by the relevant Board Committee, where challenge and scrutiny are provided by members. The corporate risks provide the operational evidence and assurance underpinning the strategic risk assessments presented within the Board Assurance Framework.

4. Recommendations

The Trust Board is asked to:

- Note the Quarter 1 position for all nine Board Assurance Framework risks detailed in **Appendix 1.**
- Note that no strategic risks have been added, amended, de-escalated or closed during Quarter 1.
- Take assurance from the oversight and scrutiny provided by the Quality and Safety Assurance Committee, Strategic People Committee and Finance, Sustainability and Performance Committee.
- Take assurance that appropriate controls, mitigations and assurance arrangements remain in place for the effective management of strategic risks across the Trust.
- Note progress against the Corporate Risk Register Improvement Programme and the work of the Risk Review Group to strengthen the Trust's risk management framework.
- Approve the Quarter 1 Board Assurance Framework position for North Cheshire and Mersey NHS Foundation Trust, as recommended by the assigned Committees.

Appendix 1 –NCM Board Assurance Framework Q1 2026/27

North Cheshire and Mersey NHS Foundation Trust

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

BAF 7	EMD	**Digital Resilience, Cyber Security & EPR** If our digital infrastructure, cyber defences and EPR programme are not mature or resilient, then we may face operational disruption, cyber attack, data loss and reduced productivity, resulting in risks to patient safety, data compliance and efficiency.	3	16 (L4xC4)	6 (L3 xC2)	Well-Led Safe Effective	Cautious	Finance, Sustainability and Performance Committee
BAF 8	COO	**Estates, Infrastructure & Capital Planning** If we cannot maintain, modernise or safely operate our estate, then we may fail to provide safe facilities, meet statutory requirements or support service transformation, resulting in increased safety risk and delayed improvement.	3	16 (L4xC4)	9 (L3xC3)	Well-Led Responsive	Open	Finance, Sustainability and Performance Committee
BAF 9	CSPO	**Partnership, Integration & System Working** If we do not integrate services effectively and fail to collaborate successfully with system partners, then fragmentation of pathways will continue, and outcomes diminish resulting in failure to meet increased demands and reduced long-term sustainability	3	9 (L3xC3)	4 (L2xC2)	Responsive , Safe, Well-Led	Open	Finance, Sustainability and Performance Committee

Strategic Aims:

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

Abbreviation	Position Title
CN	Chief Nurse
EMD	Executive Medical Director
COO	Chief Operating Officer
CSPO	Chief Strategy and Partnerships Officer
COO	Chief Operation Officer
CPO	Chief People Officer

BAF1: Quality of Care & Patient Safety (Risk 2458 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
16			

Controls

Clinical Governance & Safety Controls

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

Fragile Services Oversight

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

Quality Improvement & Service Transformation

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

Patient Experience

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

Assurances

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

Gaps

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

Action Description	Responsible Officer	Deadline	Completion Date
Standardise safety bundles with monthly audit & feedback loops including cross-divisional peer review and hotspot escalation.	Chief Nurse	Q1–Q2	
Implement fragile specialty sustainability programme covering workforce, diagnostics, job planning, escalation triggers and networked support.	Executive Medical Director	Ongoing	
Strengthen PSIRF learning adoption including thematic reviews, human factors training, learning briefs, and cross-site learning huddles.	Executive Medical Director / Chief Nurse	Q1–Q4	
Improve documentation compliance via digital optimisation, audits, coaching, standard templates and AMaT integration.	Executive Medical Director / Chief Nurse	Q2–Q4	

Linked High Scoring Corporate Risks (15 and above)

Risk ID	Risk Description	Scoring
2299	Maternity Diabetes Pathway Effectiveness	15
2436	Colposcopy/Hysteroscopy Equipment Replacement	16
2361	Rheumatology Monitoring (DMARD) Pathway	↓ 16
2257	Rheumatology Nurse Response Delays	16
1725	Fractured Neck of Femur Best Practice Tariff Performance	16
2001	Fragile Services Sustainability	20
2258	Misfiled Clinical Documents and Data Integrity	20
2573	Obstetric Diabetes Consultant Capacity	20

BAF2: Urgent & Emergency Care Flow (Risk 224 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
20			

Controls

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

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

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

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

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

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

Gaps

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

Action Description	Responsible Officer	Deadline	Completion Date
Optimise SDEC and UTC/minors streaming to reduce front-door pressure	Chief Operating Officer	Q1–Q2	
Deliver system-wide UEC improvement programme (5 workstreams)	UEC Programme Lead	Ongoing	
Maintain escalation of 4-hour and 12-hr DTA standards via command structure	Chief Operating Officer	Continuous	
GIRFT Corridor Care Plan Phase 1	Chief Operating Officer	Q1	
Improvement in paediatric pathway to be >90%	Chief Operating Officer	Q1–Q2	
SDEC – test separation of medical and surgical pathways to increase capacity	Chief Operating Officer	Q1	**April 2026**
Minors to continue >95%	Chief Operating Officer	Ongoing	
Continue to implement Ambulance Handover 45 (H45) recommendations	Chief Operating Officer	Q1	
To incorporate pharmacy first into the triage streaming pathways in order to increase patient deflection from ED	Lead Pharmacist	Q1	

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Headline**	**Scoring**
2113	Delirium Screening Compliance and Patient Flow Standards	15
2392	Enhanced Care Demand Exceeding ED Capacity	15
2400	Accessibility and Reasonable Adjustments in ED	15
2431	Delayed Medicines Administration in ED	16
2044	Corridor Care and Escalation Space Safety	16
2249	Emergency Department Alarm System Reliability	16
1905	SDEC Capacity and Delayed Assessment	16

BAF3: Planned Care Access & Elective Recovery (Risk 1215 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4

Controls

Elective Site & Theatre Capacity Controls

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

Diagnostics & CDC Controls

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

Waiting List & PTL Controls

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

Workforce Controls

- Continuous review of ward and theatre staffing.
- WLI review used to inform pay incentives and overtime capacity.
- Workforce planning for elective centre expansion.

System & Flow Controls Supporting Elective Care

- Daily Bed Meetings to ensure adequate elective capacity.
- Bioquell pods in ICU and ED to support IPC and reduce escalations into Main Theatre.

- Ongoing independent sector and insourcing/outsourcing arrangements.

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

Gaps

Capacity Gaps

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

Estate & Infrastructure Gaps

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

Quality & Safety Gaps

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

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

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Headline**	**Scoring**
1634	Ophthalmology Follow-Up Capacity Constraints	15
2187	Radiology Reporting Capacity Constraints	15
2208	Delayed Gynaecological Cancer Diagnosis Pathway	15
2586	Mother and Baby Separation Rates (ATAIN)	15
2427	Gastroenterology Outpatient Backlog	16
2360	Hand Therapy Capacity and Treatment Delays	16
2295	Urology Cancer Pathway Delays	16
1048	Specialty Doctor and Consultant Workforce Capacity	16
2465	Neurodevelopmental Assessment Waiting Times	20

North Cheshire and Mersey NHS Foundation Trust

BAF 4 – Embedded Health Equity (Risk 2459 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
16			

Controls

Health Inequalities, Access & Population Health Controls

- Health Inequalities & Prevention Pledge with Trust Board oversight.
- Embedding health equity expectations into governance (Board, QSAC, QIA panels).
- Exec leadership within ICS, Provider Collaborative and Children's Services development.
- Understanding access variation through activity, referral and cohort data (e.g., deprivation, ethnicity, LD/SMI).
- Integrated Care Partnership involvement: Warrington Together, One Halton, Dental Networks.
- Improved access to health and wellbeing services for residents of Warrington and Runcorn through the Living Well Hub and WELL Runcorn initiatives, focusing on preventative health and condition management, as well as providing holistic support for the wider determinants of health outcomes.

Safeguarding, Inclusion & Accessible Care Controls

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

Partnership & System Controls

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

Assurances

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

	• Programme oversight of the Prevention & Health Inequalities Pledge	• External audits (Risk Management, PSIRF, Quality Spot Checks, Dermatology etc.). • Anchor Institution assessment framework.

Gaps

System & Data Gaps

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

Operational Gaps

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

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

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Headline**	**Scoring**
2387	Hospital-Associated Deconditioning in Inpatients	**16**

BAF 5 – Workforce Capacity, Capability & Wellbeing (Risk 1134 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
16			

Controls

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

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

Recruitment, Attraction & Retention Controls
- VCP vacancy panel scrutiny
- TRAC recruitment improvements
- Apprenticeship & widening participation programmes
- Student nurse recruitment/engagement; STEPP; CSWD pipeline
- Internal transfer process to reduce turnover and improve retention
- Social media attraction strategy; improved benefits package; flexible retirement options

EDI, Culture & Leadership Controls
- "See it. Report it. Stop it" campaign aligning sexual safety, bullying and harassment and violence and aggression
- Talent management and succession planning ("Scope for Growth")
- Leadership development, coaching and resilience training
- Bi-monthly Staff Side meetings; FTSU; POD Council; JLNC/JNCC
- Cultural review implementation programme

Workforce Planning & System Controls

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

Workforce Design and Transformation

- Implementation of the Target Operating Model
- Implementation of 'small scale change' programme to improve productivity
- Implementation of workforce design principles

Industrial Action

- Updated IA policies and clear Trust-wide approach.
- Early workforce planning through advance rostering and standardised templates.
- Established IA governance: tactical meetings, escalation routes, EMD-led oversight and sign-off.
- Staff communications maintained; national guidance followed.
- Rate card used to secure medical staffing and maintain service continuity.
- Resident doctor pay dispute resolved June 2026.

Assurances

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

Gaps

Workforce Gaps & Safer Staffing

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

Attendance, Sickness & Wellbeing Gaps

- Sickness absence above target with 6 month absence reduction
- High temporary staffing reliance and increased unplanned bed capacity requiring escalation areas
- Exit interview completion rates remain low

Culture, EDI & Engagement Gaps

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

Industrial Action

- Ongoing and potential new industrial action across multiple staff groups, with several ballots active or pending.

- Risk of further cancellation of elective and outpatient activity to maintain safe staffing.
- Financial and recovery impacts expected from cancelled activity and IA-related staffing costs.
- Limited visibility on timing of consultation industrial action likely overlap with school summer holidays when rota's are lighter due to high annual usage.
- Requirement to respond to system information requests via EPRR and ensure alignment with ICB planning.

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

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Description**	**Scoring**
200	High Staff Sickness Impacting Workforce Capacity	**15**
1324	Junior Doctor Workforce Shortfall	**15**
1907	Acute Medical Unit Staffing Resilience	**15**
2160	Resident Doctor Capacity and Staffing Resilience	**15**
2437	Resident Doctor Availability and Service Capacity	**15**
2438	Nursing Workforce Gaps Affecting Enhanced Care	**16**
2412	Paediatric ED Nursing Workforce Capacity	**16**
2429	Out-of-Hours Retinal Laser Cover	**16**
115	Minimum Nurse Staffing Capacity	**16**
1611	Acute Consultant Workforce Shortages	**16**
2300	Clinical Coding Capacity and Backlog Growth	**20**

North Cheshire and Mersey
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BAF 6 – Financial Sustainability (Risk 134 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
20⇔			

Controls

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

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

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

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External
• Monthly I&E, cashflow, capital, workforce and CIP reporting • OPS, non-pay expenditure controls, bank/agency reporting • Capital Planning Group	• Finance, Performance & Sustainability Committee, • Quality Committee – QIAs for CIP schemes • Strategic People Committee – CIP delivery of workforce	• Internal Audit: high assurance ratings for AR, AP, GL, treasury (BW & WHH) • External Audit: unqualified accounts opinion (BW & WHH) • • PWC and NHSE/ICB monitoring and assurance of financial plans

• Financial Resources Group (FRG) o Activity and income delivery monitoring; dynamic plans for RTT, cancer & diagnostics o Staff sickness, variable pay, and vacancy tracking (linked to financial impact)	• Delivery Unit – CIP assurance and benefits realisation, productivity review – use of NHSE productivity packs to target key areas	

Gaps

Recurrent Financial Gaps

- Further work is required to increase the recurrent nature of the financial improvement programme and to fully identify supporting schemes
- Structural deficit requiring ongoing cash support
- Insufficient external funding for key strategic developments (e.g., estates programmes)

Activity & Income Risks

- Risk of under-delivery of activity impacting PbR income
- Potential loss of income due to contract caps, over-performance limits or industrial action
- Deconstruction of block – potential risk from 2027/28
- Unplanned escalation capacity driving cost pressures
- Waiting list pressures – RTT waits, dental theatre capacity

Capacity & System Risks

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

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

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Description**	**Scoring**
2099	Target Variable Activity Income Achievement	**16↑**
2100	Delivery of Cost Improvement Programme Targets	**16↑**

BAF 7 – Digital Resilience, Cyber Security & EPR (Risk 2457 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
16⇔			

Controls

Cyber Security Controls

- DSPT approach standard met and ongoing cyber assurance improvements.
- Monthly penetration testing through NHS England VMS service.
- SOC monitoring, phishing simulations, regional/national threat intelligence feeds (National Cyber Security Centre, NHSE Cyber Security Opertions Centre, Cyber Assoicates Network and C&M ICB Cyber Group).
- Patch management automation, strong boundary firewall controls, antivirus monitoring.
- Local firewalls enabled on devices; remote devices routed through a secured connection.
- Segmented network architecture; MFA in place for NHSMail.
- Secondary secure backup at Halton Data Centre.
- Some systems hosted on cloud (Offsite)
- Device upgrades: Windows 11 programme (93.7% complete); Server 2016 migrations (80% complete).
- Cyber training for Board and key digital leaders.
- Phishing exercise completed yearly
- Cyber BCP documentation / communication tested yearly at local and regionally

Digital Infrastructure & Technical Debt Controls

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

EPR Programme Controls

- Contract extension for incumbent EPR to cover procurement window.
- EPR Programme Board, Digital Strategy Group, PMO oversight, PEB governance.
- Clinical safety case development and data migration plans.
- Collaborative single-instance EPR procurement with partner Trusts.
- Legal guidance confirming requirement for single-host contract.
- Joint development of OBC/FBC with NHSE and FD.

- Standardisation of clinical pathways for single-instance design.

System & Partnership Controls

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

Assurances

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

Gaps

Cyber Security Gaps

- Lack of real-time zero-day detection due to incomplete logging tool.
- No Privileged Access Management (PAM) implemented for admin accounts.
- Limited MFA coverage beyond NHSMail and a few new systems
- Absence of centralised SIEM/log aggregation and actionable alerting in the Acute setting.
- Limited 24/7 cyber cover.
- Unsupported systems in use
- Weak 3rd-party vendor cyber controls.
- Bluetooth control gaps and unsupported IoT/medical device scanning capability.

Infrastructure & Technical Debt Gaps

- All Windows 10 end-of-life devices requiring replacement.
- Server 2016 support ending in 2026 with migration backlog.
- CISCO network hardware requiring refresh.

EPR Programme Gaps

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

Action Description	Responsible Officer	Deadline	Completion Date
Implement Privilege Access Management (PAM) / MFA across the NHSE approved Trust essential functions and their associated 3rd party vendors and system admin	Head of Digital Compliance & DSD Lead / Head of IT, Deputy Digital Services	31/03/2027	
Complete Server 2016 migration/decommissioning programme	Head of Digital Compliance & DSD Lead	31/10/2026	
Decommission legacy systems aligned to EPR roadmap	SIRO / EPR Programme Director	Q2–Q4 2026	
Deliver single OBC/FBC for EPR procurement	Medical Director/ EPR Programme Director	Nov 2025–Mar 2026	

Develop consolidated SIEM/logging solution with real-time alerting across NCM Digital servers/systems	Head of Digital Compliance & DSD Lead / / Head of IT, Deputy Digital Services	Q2–Q3 2026	
Replace non-Windows-11-compliant hardware	Head of Digital Compliance & DSD Lead	Q1–Q4 2026	
Strengthen readiness assessment and clinical safety case for EPR deployment	Clinical Safety Officer / EPR Programme Director	Ongoing	

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
1372	Electronic Patient Record Replacement Programme	**16**
1114	Cyber Security and Digital Infrastructure Resilience	**16**

North Cheshire and Mersey NHS Foundation Trust

BAF 8. Estates, Infrastructure & Capital Planning (Risk 2273 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
16⇔			

Controls

Core Estates & Compliance Controls

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

Strategic Capital & Redevelopment Controls

- Estates strategy for hospital redevelopment plans completed.
- Town Deal infrastructure schemes: Living Well Hub, WELL Runcorn Hub
- One Public Estate funding in place for Halton redevelopment and Warrington estate review.
- Strategic planning alignment with ICS Infrastructure Plan & CMAST priorities.
- Working on integrated estates strategy following integration with community and dental services.
- UTC business case in development supported by the ICB.
- External funding obtained to install renewable energy technology to support net zero carbon targets.

Operational Estate Controls

- Critical infrastructure upgrades aligned to Digital Disaster Recovery
- Capacity and layout improvements supporting UEC flow and elective expansion
- Ward and operating theatre refurbishment is underway
- Works completed from national maternity safety survey.
- PLACE, H&S and compliance reporting to operational governance.

System & Partnership Controls

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

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External

• PPM completion dashboards & compliance reporting. • Incident logs linked to estate failures. • PLACE assessments; H&S audits. • Monitoring of reactive maintenance demand. • Estates safety groups (e.g. water, fire, electrical, ventilation)	• Capital Planning Group (CPG), Tactical Estates Group (TEG), Health & Safety Sub-Committee. • Reporting to Finance, Performance & Sustainability Committee (FPSC). • Oversight of capital bids, decant plans, and statutory compliance.	• External compliance audits (HTM/HBN, Fire Authority, environmental health). • NHSE oversight of Town Deal, RAAC funding and CDC compliance. • External estate condition surveys, RAAC verification, financial due diligence. • CQC inspections.

Gaps

Capital & Funding Gaps

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

Operational Estate Constraints

- Ageing buildings and plant affecting reliability and patient environment.
- High reactive maintenance burden from ageing infrastructure.
- Equipment difficult to maintain due to location/age.
- Phase 2 community integration programme.
- Infrastructure unable to cope with adverse weather conditions and extremes of heat/cold due to aging estate.

Infrastructure Resilience

- Estates constraints limiting UEC flow
- Estate condition limits full deployment of digital DR and EPR-ready infrastructure
- Non-clinical workforce constraints affecting estates delivery

System & Governance Gaps

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

Action Description	Responsible Officer	Deadline	Completion Date
Develop multi-phase redevelopment plan with architects and cost advisors	Chief Strategy and Partnerships Officer / Chief Operating Officer	31/12/2026	
Reallocate capital via CPG/FSC to support phased works	Chief Operating Officer / Chief Finance Officer	Q1–Q4	
Strengthen decant strategy and prioritised refurbishment plan	Associate Director of Estates and Facilities	Q2–Q3	
Continue partner advocacy for new hospitals plan	Chief Strategy and Partnerships Officer	Ongoing	
Enhance assurance on statutory compliance (H&S, Fire, HTM)	Associate Director of Estates / Chief Operating Officer	Q1–Q4	
Align estate infrastructure upgrades with EPR & digital roadmap	Associate Director of Estates and Facilities / Chief Information Officer	Q1–Q4	
Progress works and funding bids to decarbonise the estate in line with net zero carbon targets.	Associate Director of Estates / Chief Operating Officer	Q1-Q4 2026-27	
Compete programmes of work to address critical infrastructure risk and maternity survey findings.	Associate Director of Estates / Chief Operating Officer	Q1-Q4 2026-27	

Linked High Scoring Corporate Risks (15 and above)

Risk ID	Risk Title	Scoring
125	Estate Sustainability and Backlog Maintenance Pressures	20
2384	Theatre Infrastructure and Water Ingress	16
2414	Catering Transport Equipment Failure	16
2358	Ophthalmology Estate and Clinical Environment Suitability	20
1701	Pathology Facilities Infrastructure Failure	16
423	Lift Reliability and Infrastructure Resilience	16

North Cheshire and Mersey
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BAF 9 - Partnership, Integration & System Working (Risk 2253 DATIX)

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

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

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

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4
9⇔			

Controls

Governance

- successful transaction for the enlarged organisation North Cheshire and Mersey NHS FT from 1st April 2026, shared priorities with ICB/place; clinical networks for fragile/specialist services.
- NCM2030 governance agreed, reporting to EMT and Committees of the Board.

Partnership & System Working Controls

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

Clinical & Operational Alignment Controls

- developing NCM strategy – aligned to local regional and national priorities
- Clinical services integration programme Influencing neighbourhood health development **System Leadership & Strategic Controls**
- participation in Cheshire & Mersey Provider Collaborative (CMPC) CEO Group and Blueprint Delivery Groups

Assurances

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

Gaps

Governance & Integration Gaps

- Variability in pathway standards across organisations.

System & Partnership Gaps

- risk of lack of capability and capacity at Place
- Pressures in system partners (e.g., finance, UEC demand)
- Need for shared benefits tracking across organisational boundaries.

Cultural & Workforce Gaps

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

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

Linked High Scoring Corporate Risks (15 and above)		
Risk ID	**Risk Description**	**Scoring**
2351	Research Capacity and Protected Clinical Time	**20**

North Cheshire and Mersey NHS Foundation Trust

Risk Appetite Statement for North Cheshire and Mersey NHS Foundation Trust

Introduction

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

Our Mission

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

Our Vision

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

Our Aims

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

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

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

Defining Our Risk Appetite

Approved by: Trust Board
Date: 1 April 2026

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

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

Risk Appetite by Category

Quality

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

General Principles

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

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

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

Risk Appetite Levels

The Trust adopts the Good Governance Institute's definitions:

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/049**			
Subject:	Integrated Performance Report			
Date of meeting:	5th August 2026			
Action required:	The KPIs that are underperforming are managed in line with the Trust's Performance Assurance Framework.			
Author(s):	Janet Parker – Deputy Chief Finance Officer Andrew Hatfield – Performance and Systems Development Lead			
Executive director sponsor:	Jane Hurst, Chief Finance Officer Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Paula Woods – Chief People Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 2: Urgent and Emergency Care Flow BAF 3: Planned Care Access & Elective Recovery BAF 5: Workforce Capacity, Capability & Wellbeing BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and	**Yes**	**No**	**N/A**
				✓

	Armed Forces Act 2021:			
	Further Information / Comments:			
Executive summary:	The Trust has 81 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>three indicators that are both failing and have special cause variation of a concerning nature</u>**, these are: • **65. Percentage of patients waiting over 52 weeks for community services (excluding dental and dermatology)** – Target 0% • **66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology) -** Target zero • **69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology) -** Target zero There are **<u>no indicators that have special cause variation of a concerning nature and do not have a target.</u>** There are **<u>2 indicators that consistently fail and cannot be measured for variation,</u>** these are: • **79. CIP (recurrent) –** % delivered against plan • **81. Bank Reduction** – delivery against 15% reduction of 2025/26 plan There is **<u>2 Indicators that has been requested via the Action Log to be monitored going forward,</u>** They are: • **37. A&E Waiting Times** - Under 4 hour wait (% excluding WUTC) • **39. A&E Waiting Times** – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge – Target 2% or less There are **<u>4 Indicators that has been highlighted via the latest published NHS Oversight Framework metrics table that are also not reported as exceptions,</u>** They are:			

	• **4. Healthcare Acquired Infections (CDI)** • **5. Healthcare Acquired Infections (E.coli)** • **59. Average number of days from discharge ready date to actual discharge date** • **74. Trust Financial Position** There are **no indicators with new recalculation points applied** to improve the accuracy of the SPC charts in identifying significant shifts in process variation. **Financial Position** At Month 3 the Trust has recorded a deficit position of £14.3m which is £0.9m worse than plan. The difference of £0.9m is due to the impact of industrial action in April.		
Purpose: (please select as appropriate)	**Approval** ✓	**To note** ✓	**Decision**
Recommendation:	The Trust Board is asked to: 1. Approve cash support of up to £7.177m from NHSE for Quarter 3 2026/27. 2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee. Note the contents of this report.		
Previously considered by:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSPC/26/07/065 (iii) FSPC/26/07/065 (vii)	
	Date of meeting	29/07/2026	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Changes to the capital contingency supported and approved.	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

1.1 IPR Indicators

All 81 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 provides an update on the latest published NHS Oversight Framework metrics and highlights trend against the previous quarter publication.

Appendix 2 Provides an overview of SPC assurance and highlights variation across the current and previous month’s data.

The Integrated Performance Dashboard (**Appendix 3**) 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.

North Cheshire and Mersey NHS Foundation Trust

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** **Access & Performance** 65. Percentage of patients over 52 weeks for community services (excluding dental and dermatology) 66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology) 69. Number of patients waiting over 104 weeks to access community services (including dental and dermatology)	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 1.Incidents 16. Medication Safety - Reconciliation within 24 hours 23. Complaints over 6 months 25. Friends and Family (ED and UCC) 27. Mixed Sex Accommodation Breaches (Non ITU) 28. Sepsis - % screening for all emergency patients 30. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 31. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 35. MUST nutritional assessment completion **Access & Performance** 39. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 45 minutes 45. Percentage referred onto A&E from UTC 46. Patients seen in the Fracture Clinic within 72 hours 52. Cancer 62 Days First Treatment 59. Average number of days from discharge ready date to actual discharge date 62. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 64. Capped Theatre Utilisation 67. Number of patients waiting over 52 weeks to access community services (including dental and dermatology) 68. Number of patients waiting over 65 weeks to access community services (including dental and dermatology) **Workforce** 70. Supporting Attendance	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Access & Performance** 37. A&E Wait Times - % patients waiting under 4 hours (including WUTC) ⬆ 38. A&E Wait Times - % patients waiting under 4 hours (excluding WUTC) ⬆ 37. Referral to treatment Open Pathways 38. RTT - Number of patients waiting 52+ weeks 48. Referral to Treatment Open Pathways 49. Referral to treatment – Number of patients waiting 52+ weeks **Workforce** 73. PDR compliance ⬆	**CONSISTENTLY FAILING TARGET & NO SPC** **Finance** 81. Bank Reduction

		Finance 76. Capital Programme **(£1.9m - *£6.5m target*)** 77. Better Payment Practice Code **(51% - *95% target*)**		
	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** 56. Elective Outpatient Activity ↓	**Quality** 3. Healthcare Acquired Infections (MSSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 8. VTE Assessment 9. Inpatient Falls & harm levels 10. Acute Pressure Ulcers (Category 2) 11. Acute Pressure Ulcers (Category 3 & 4) 12. Community Acquired Pressure Ulcers (Cat 2) 13. Community Acquired Pressure Ulcers (Cat 3 & 4) 19. Average Fill Rate – Day registered nurses / midwives ↑ 21. Average Fill Rate – Night registered nurses / midwives 29. Sepsis - % screening for all inpatients 32. Acute Kidney Injury 34. Maternity Postpartum Haemorrhage ↑ 36. Duty of Candor **Access & Performance** 47. Diagnostic Waiting Times 6 Weeks ↑ **Workforce** 71. Workforce FTE Plan Compliance	**Access & Performance** 50. 28 Day Faster Cancer Diagnosis Standard	**Finance** 80. 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)	**Workforce** 72. Core/Mandatory Training	**Quality** 2.Healthcare Acquired Infections (MRSA) ⬆ 20. Average Fill Rate – Day care staff 22. Average Fill Rate – Night care staff 24. Friends and Family (Inpatients & Day cases) 26. Friends and Family (Community) **Access & Performance** 51. Cancer 31 Days First Treatment 61. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 65. Urgent Community Response (UCR) 2 hour compliance %	**Finance** 78. Cost Improvement Programme – In year performance to date (£m)	**Finance** 79. Cost Improvement Programme - (recurrent) - In year (£m)
	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** 14. Mortality ratio – HSMR 15. Mortality ratio - SHMI	**Quality** 17. Acute Medication Incidents 18. Community Medication Incidents 34. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 40. Average time in department ED 53. Reduction in Outpatient Follow Ups 57. Super Stranded Patients 58. No Criteria to Reside (NCTR) 60. % Patients discharged to their usual place of residence	**Access & Performance** 44. Type 5 attendances ⬆	**Access & Performance** 54. Elective Recovery Activity (Grouped SPCs) 55. Elective Recovery Diagnostic Activity **Finance** 74. Trust Financial Position (£m) 75. 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**

Descriptions of each KPI are available in **Appendix 4**. Further detail around interpretation of Statistical Process Control (SPC) charts and "Making Data Count" icons can be found in **Appendix 5**.

The Income Statement for June 2026 is attached in **Appendix 6**.

The Trust submitted a deficit plan of £30.5m. The Trust was not allocated any deficit support funding (DSF) this year. Following national escalation, the Trust has negotiated an improved income position of £5m with C&M ICB which will reduce the deficit to £25.5m. NHSE have also indicated that the Trust's Control Total will move from £16.7m deficit to £25.5m deficit. The Trust will then be able to access DSF of £25.5m to reach a breakeven position. Accessing DSF each quarter (£6.4m each quarter) is based on the following criteria:

- Q1 – Acceptance of compliant plan – We now have a compliant plan, therefore DSF is expected to flow.
- Q2 – All material contracts signed and 100% of the value of planned CIP is fully developed or implemented – Contracts signed and planned CIP is fully developed or implemented in line with PwC deadline therefore Q2 DSF should flow.
- Q3 – Most likely case risk adjusted forecast demonstrates delivery of forecast outturn – DSF will be dependent on the risk adjusted forecast for M5 (submitted mid September) demonstrating delivery of plan.
- Q4 – Most likely case risk adjusted forecast demonstrates delivery of planned exit run rate – DSF will be dependent on the risk adjusted forecast for M8 (submitted mid December) demonstrating delivery of exit run rate.

There are several risks to the achievement of the planned deficit and future sustainability. The key risks are as follows:

- Ability to deliver challenging CIP target of circa 7% through productivity and workforce transformation (risk if funding for MARS not received).
- Funding for Industrial Action in month 1 is not received and further unfunded Industrial Action takes place in the year.
- Whilst national guidance was to assume pay awards and rebandings are offset by income, this has not been the case in previous years.
- Achieving the income plan through core capacity (improved productivity).
- Achieving the Endoscopy Hub activity plan through mutual aid referrals as demand from external providers was not seen in 2025/26.
- Cost of support from PwC via the FPRM process continues.
- Cash level and ability to access revenue cash support.

Cash

The cash balance at the end of June is £22.2m of which £7.8m relates to capital creditors. Given the current cash position and the planned deficit for 2026/27 the Trust is in receipt of cash support. The Finance, Sustainability and Performance Committee discussed and supported the application for cash support for Quarter 3 2026/27 from NHSE. The Trust Board is asked to approve up to £7.177m cash support for Quarter 3 2026/27. If DSF flows and the cash is no longer 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 (51% against a target of 95%, 65% cumulative position in March 2026). Cash days are at 16 days which is the same as last month (16 days). June's cash operating days have stayed the same due to continuing to hold capital cash from year end.

CIP

At 30 June 2026, the Trust has delivered a CIP of £4m which is in line with plan. However, it should be noted that £1.4m has been achieved from non-recurrent vacancies and central items.

All the £36.8m CIP plan has been identified with £24.2m implemented / in delivery and £12.6m fully developed but not yet in delivery. There is a significant risk to the Trust if it cannot deliver recurrent CIP in 2026/27, therefore further work is required to turn current non-recurrent schemes recurrent or identify additional recurrent schemes. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.

Capital Programme

The Trust total capital funding consists of £17.1m Capital Departmental Expenditure Limit (CDEL) and £4.6m external funding, a total of £21.7m. The Trust also has £1.6m DHSC funded IFRS16.

The Trust capital spend for month 3 is £1.9m which is £4.6m below the plan of £6.5m. £3.8m relates to the timing of leases (IFRS16) and the remainder is mainly due to capital schemes originally planned for 2026/27 being brought forward to 2025/26. The plan is expected to be fully delivered by year end.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

	Acute Contingency		C&D Contingency		Sub Total	Surgical Robot	Total Contingency fund
DETAIL	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Contingency balance start of month 3		**1,349**		**150**	**1,499**		**1,499**
Proposed changes in month							
VAT Recovered		**19**			**19**		**19**
Requests supported at CPG							
Woolston refurb			- 20				
Aseptic Unity final addendum	- 23						
Airvo 3 machines	- 20						
Mortuary security	- 8						
Heat Wave Response	- 21						
Sub Total		**- 72**		**- 20**	**- 92**		**- 92**
Funding prioritised for Surgical Robot		**- 900**			**- 900**	**900**	**-**
Contingency as at end of month 3		**396**		**130**	**526**	**900**	**1,426**

The Trust Board is asked to:

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

3. Actions required/responsible officer

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

4. Measurements/evaluations

The following committees provide assurance to the Trust Board:

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

5. Recommendations

The Trust Board is asked to:

1. Note the contents of this report.
2. Approve cash support of up to £7.177m from NHSE for Quarter 3 2026/27.
3. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee.

Appendix 1

NHS Oversight Framework - NCM June 2026 Update

Trust Rank
102 out of 134
Previous quarter rank: **106** out of 134
Improvement of 4 places

NHS
North Cheshire and Mersey
NHS Foundation Trust

Access to services			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q4 2025/26	2.28	**61** out of 117	▼		Q3 2025/26	2.81	**72** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q4 2025/26	1.00	**14** out of 118	▶		Q3 2025/26	1.00	**10** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Mar-26	1.00	**52** out of 130	▼		Dec-25	3.58	**111** out of 131
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Mar-26	2.42	**62** out of 130	▼		Dec-25	2.43	**63** out of 131
Elective care	Difference between planned and actual 18 week performance	Quarterly	Mar-26	1.00	**71** out of 130	▼		Dec-25	2.65	**69** out of 131
Elective Care	Percentage of patients waiting over 52 weeks for community services	Quarterly	Mar-26	3.55	**37** out of 42	▲	Within exception slides	Dec-25	3.56	**36** out of 41
Urgent and emergency care	A&E within 4 hours	Quarterly	Q4 2025/26	3.50	**101** out of 123	▼		Q3 2025/26	3.60	**105** out of 123
Urgent and emergency care	A&E within 12 hours	Quarterly	Q4 2025/26	3.90	**118** out of 119	▲	Within exception slides	Q3 2025/26	3.90	**104** out of 123

Effectiveness and experience			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quarterly	Mar-26	3.91	**124** out of 128	▲	Within exception slides	Dec-25	3.45	**104** out of 126
Effective out of hospital care	Urgent Community Response 2-hour performance	Quarterly	Q4 2025/26	1.17	**3** out of 38	▶		Q3 2025/26	1.15	**3** out of 50
Patient experience	Summary Hospital-level mortality indicator	Annually	Jan 24 - Dec 25	2.00	Not Ranked	▶		Oct-24 - Sep 25	2.00	Not Ranked
Patient experience	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked	▶		2024	2.00	Not Ranked

Finance and productivity			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Finance	Planned surplus/deficit	Quarterly	Q4 2025/26	4.00	**126** out of 134	▶		Q3 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Month 12 2025/26	4.00	**132** out of 134	▲	Within exception slides	Month 9 2025	4.00	**121** out of 134

Patient Safety			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Patient Safety	Number of MRSA bacteraemia cases	Quarterly	Jan 25 - Dec 25	1.00	Not Ranked	▼		Jan 25 - Dec 25	2.66	Not Ranked
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Apr 25 - Mar 26	2.07	Not Ranked	▲	Within exception slides	Jan 25 - Dec 25	1.00	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	2024	1.81	**37** out of 134	▶		2024	1.81	**37** out of 134
Patient Safety	Proportion of C. difficile infections	Quarterly	Apr 25 - Mar 26	3.33	Not Ranked	▲	Within exception slides	Jan 25 - Dec 25	3.20	Not Ranked

People and Workforce			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric score**	**Rank**
Retention and culture	Sickness absence rate	Quarterly	Q3 2025/26	3.19	**114** out of 134	▼		Q2 2025/26	3.38	**120** out of 134
Retention and culture	NHS Staff survey engagement theme sub-score	Annually	2024	2.29	**58** out of 134	▶		2024	2.29	**58** out of 134

Key
▶ No Change
▼ Improvement
▲ Concern

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

Appendix 2

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		Latest				Previous		
	QUALITY	Target/Threshold	Actual	Period	Variation	Actual	Period	Assurance
1	Incidents	0	17	Jun-26		41	May-26	
2	Healthcare Acquired Infections (MRSA)	0 (for 2026/27)	0	Jun-26		0	May-26	
3	Healthcare Acquired Infections (MSSA)	32 (for 2026/27	2	Jun-26		1	May-26	
4	Healthcare Acquired Infections (CDI)	65 (for 2026/27)	7	Jun-26		4	May-26	
5	Healthcare Acquired Infections (Ecoli)	75 (for 2026/27)	7	Jun-26		7	May-26	
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2026/27)	2	Jun-26		1	May-26	
7	Healthcare Acquired Infections (PA)	8 (for 2026/27)	2	Jun-26		1	May-26	
8	VTE Assessment	95.00%	95.28%	Jun-26		95.32%	May-26	
9	Inpatient Falls	10% reduction from 2025/26	45	Jun-26		39	May-26	
10	Acute - Total Pressure Ulcers (Category 2)	20% reduction from 2025/26	18	Jun-26		9	May-26	
11	Acute - Total Pressure Ulcers (Category 3 & 4)	20% reduction from 2025/26	1	Jun-26		0	May-26	
12	Community Acquired Pressure Ulcers (Category 2)	20% reduction from 2025/26	22	Jun-26		22	May-26	
13	Community Acquired Pressure Ulcers (Category 3 and above)	20% reduction from 2025/26	6	Jun-26		2	May-26	

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14	Mortality ratio - HSMR	No target set	92.57	Jun-26		92.04	May-26	No SPC
15	Mortality ratio - SHMI	No target set	103.35	Jun-26		102.29	May-26	No SPC
16	Medication Safety Reconciliation within 24 hours	80.00%	44.99%	Jun-26		38.70%	May-26	F
17	Acute Medication Incidents	No target set	126	Jun-26		114	May-26	No SPC
18	Community Medication Incidents	No target set	15	Jun-26		14	May-26	No SPC
19	Average Fill Rate - Day registered nurses / midwives	90%	89.83%	Jun-26		91.72%	May-26	?
20	Average Fill Rate - Day care staff	90%	94.48%	Jun-26		94.74%	May-26	P
21	Average Fill Rate - Night registered nurses / midwives	90%	93.85%	Jun-26		94.48%	May-26	?
22	Average Fill Rate - Night care staff	90%	103.98%	Jun-26		106.67%	May-26	P
23	Complaints	Zero complaints open over 6 months old/in the backlog	0	Jun-26		0	May-26	?
24	Friends and Family (Inpatients & Day cases)	95%	96.85%	Jun-26		96.07%	May-26	P
25	Friends and Family (ED and UCC)	87%	72.83%	Jun-26		74.57%	May-26	F
26	Friends and Family (Community)	90%	94.44%	Jun-26		94.25%	May-26	P
27	Mixed Sex Accommodation Breaches (ITU)	0	17	Jun-26		26	May-26	F

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28	Sepsis - % screening for all emergency patients.	90.00%	78.00%	Jun-26		82.00%	May-26	F
29	Sepsis - % screening for all inpatients	90.00%	80.00%	Jun-26		76.00%	May-26	?
30	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	60.00%	Jun-26		66.00%	May-26	F
31	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	72.00%	Jun-26		60.00%	May-26	F
32	Acute Kidney Injury	Less than previous month	145	Jun-26		138	May-26	?
33	Maternity Postpartum Haemorrhage	3.70%	3.60%	Jun-26		6.28%	May-26	?
34	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	46%	Jun-26		52%	May-26	No SPC
35	MUST nutritional assessment completion	above > 85%	77.13%	Jun-26		75%	May-26	F
36	Duty of Candor	100%	100.00%	Jun-26		91%	May-26	?

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
37	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	67.92%	Jun-26	H	68%	May-26	F
38	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	75.31%	Jun-26	H	75%	May-26	F
39	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	23.48%	Jun-26		21.9%	May-26	F
40	Average time in department ED	No Target	385	Jun-26		367	May-26	No SPC
41	Ambulance Handovers within 15 minutes	65%	31.35%	Jun-26		42.37%	May-26	F
42	Ambulance Handovers within 30 minutes	95%	61.76%	Jun-26		74.45%	May-26	F
43	Ambulance Handovers within 45 minutes	100%	72.76%	Jun-26		83.76%	May-26	F
44	Type 5 attendances	No Target set	3053	Jun-26	H	2795	May-26	No SPC
45	Percentage referred onto A&E from UTC	3% or below	10.51%	Jun-26		9.47%	May-26	F
46	Patients seen in the Fracture Clinic within 72 hours	95%	71.60%	Jun-26		74%	May-26	?
47	Diagnostic Waiting Times 6 Weeks	95.00%	95.62%	Jun-26		94.79%	May-26	?
48	Referral to treatment Open Pathways	92.00%	65.08%	Jun-26	H	65.13%	May-26	F
49	Referral to treatment - Number of patients waiting 52+ weeks	0	308	Jun-26	L	311	May-26	F

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50	28 Day Faster Cancer Diagnosis Standard	75%	81.91%	May-26		77.46%	Apr-26	
51	Cancer 31 Day Wait	96%	98.65%	May-26		97.80%	Apr-26	
52	Cancer 62 Day Wait	85%	79.17%	May-26		78.28%	Apr-26	
53	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	76%	Jun-26		79%	May-26	No SPC
54	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
55	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
56	Elective Outpatient Activity	104%	89%	Jun-26		91%	May-26	
57	Super Stranded Patients	Trajectory	142	Jun-26		121	May-26	No SPC
58	No Criteria to Reside (NCTR)	No Target set	202	Jun-26		156	May-26	No SPC
59	Average number of days from discharge ready date to actual discharge date	1 Day or less	1.60	Jun-26		1.37	May-26	
60	% Patients discharged to their usual place of residence	No Current Threshold	97%	Jun-26		97%	May-26	No SPC
61	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%	0.83%	Jun-26		0.62%	May-26	
62	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	0	Jun-26		0	May-26	

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63	Capped Theatre Utilisation	85%	75.68%	Jun-26			74.90%	May-26	
64	Urgent Community Response (UCR) 2 hour compliance %	70%	95.90%	Jun-26			96.40%	May-26	
65	Percentage of patients over 52 weeks for community services (**excluding** dental and dermatology)	0%	20.28%	Jun-26			20%	May-26	
66	Number of patients waiting over 104+ weeks to access community services (**excluding** dental and dermatology)	0	427	Jun-26			286	May-26	
67	Number of patients waiting over 52 weeks to access community services (**including** dental and dermatology)	0	2049	Jun-26			1896	May-26	
68	Number of patients waiting over 65 weeks to access community services (**including** dental and dermatology)	0	1549	Jun-26			1413	May-26	
69	Number of patients waiting over 104 weeks to access community services (**including** dental and dermatology)	0	431	Jun-26			293	May-26	

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Consistently fails the target

		Latest				Previous		Assurance
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
70	Supporting Attendance	5.00%	5.72%	Jun-26		5.66%	May-26	
71	Workforce FTE Plan Compliance	100% Plan	101.02%	Jun-26		101%	May-26	
72	Core/Mandatory Training	85.00%	91.50%	Jun-26		91.38%	May-26	
73	PDR compliance	85.00%	84.02%	Jun-26		82.87%	May-26	

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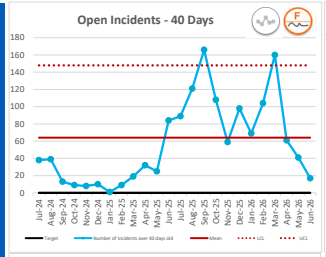
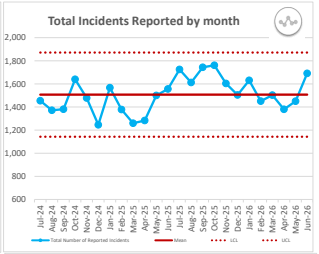
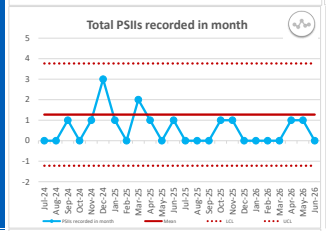
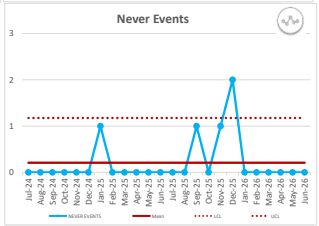
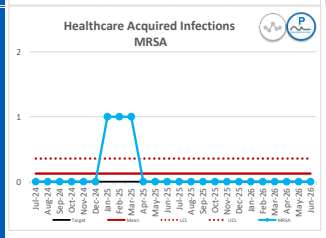
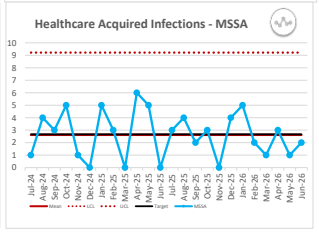
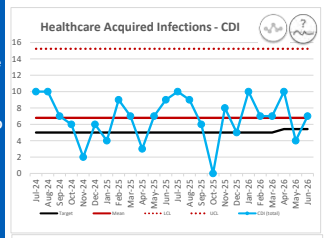
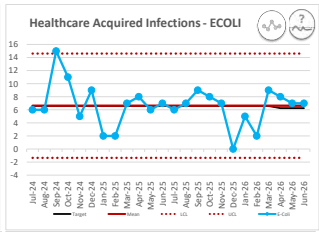
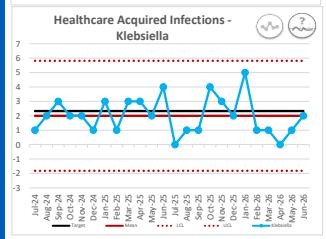
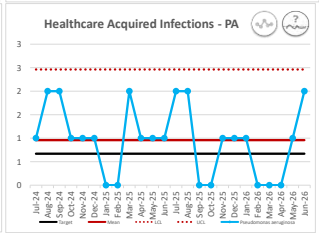


Inconsistently passes and fail the target

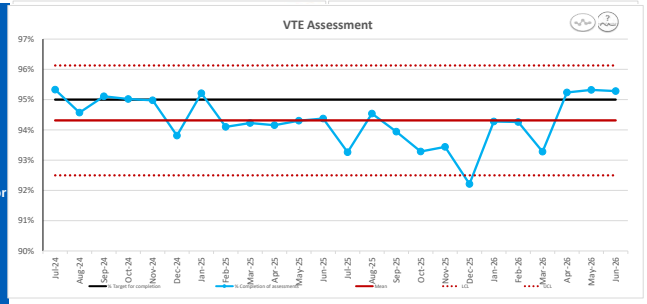
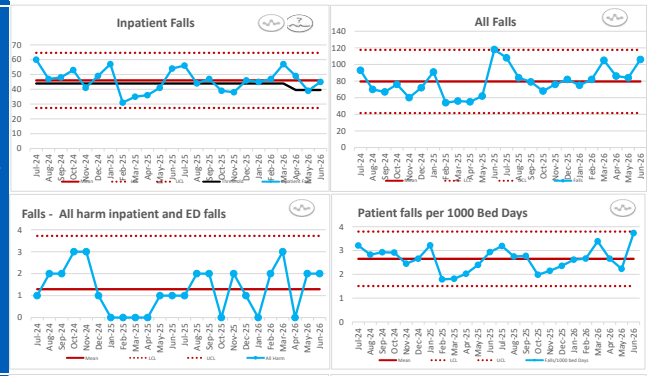
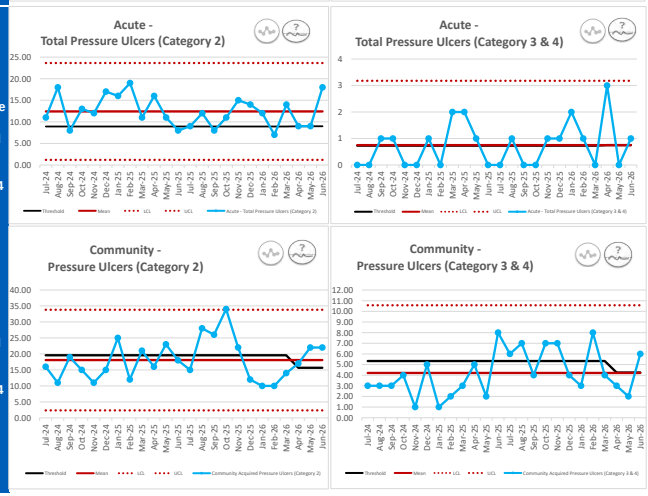


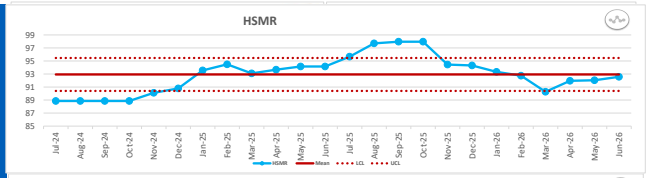
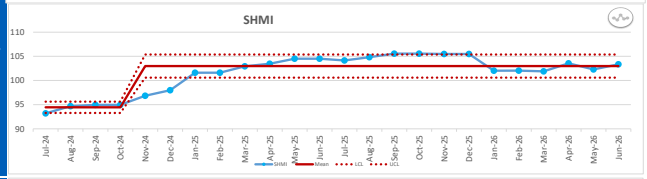
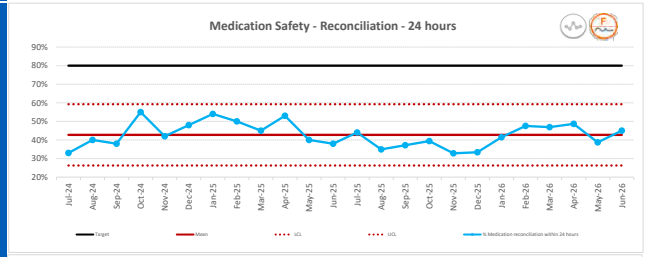
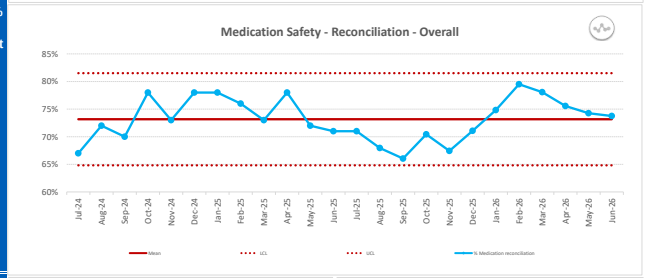
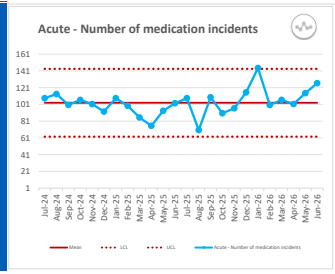
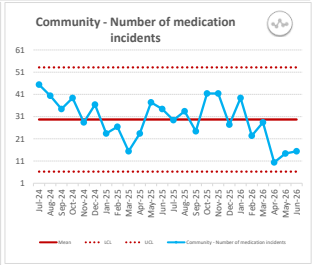
Consistently fails the target

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
74	Trust Financial Position (£m)	-£13.37	-£14.29	Jun-26	No SPC	-£10.52	May-26	No SPC
75	Cash Balance (£m)	£13.46	£22.22	Jun-26	No SPC	£22.73	May-26	No SPC
76	Capital Programme (£m)	£6.51	£1.89	Jun-26		£0.21	May-26	F
77	Better Payment Practice Code (Cumulative)	95%	51%	Jun-26		56%	May-26	F
78	Cost Improvement Programme - In year (£m)	90% of plan	100%	Jun-26	H	100%	May-26	P
79	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	65%	Jun-26	No SPC	60%	May-26	P
80	Agency Reduction (£m)	£0.58	£0.33	Jun-26	No SPC	£0.26	May-26	?
81	Bank Reduction (£m)	£6.83	£8.19	Jun-26	No SPC	£5.69	May-26	F

Appendix 3	Trust Performance			Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events	There was 17 incident/s over 40 days old.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause Variation.	No PSIIs were declared in June 2026. At the time of reporting, there were 46 open learning responses underway, excluding cluster reviews. No never events were reported during June 2026. There were 17 incidents open over 40-days at the time of reporting on 01 June 2026, which was a reduction from the previous month when 41 incidents were noted to have been open for over 40 days. Note as of 01/06/2026 - there are 3 open incidents on Ulysses, all over 40 days old. These have since been closed.	A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each Clinical Business Unit (CBU) has a designated Governance Team member to provide support and promote consistency. Incidents overdue 40 days- The incident position is escalated daily to the triumvirates for the relevant areas, and this work is being prioritised. There is evidence of improvement in the June 2026 data. Datix system alerts at an additional lower threshold (30 days) to enable further support to be provided and this will be monitored closely. A daily report of learning response and action positions for Care Group Triumvirates oversight is in place. Weekly Governance recovery data sets that are prepared by the Governance Department to support care groups and PSII's & other learning responses are monitored weekly by the Executive Led Safety Oversight Meeting (SOM) with appropriate escalation to the CBU leads. Extraordinary meetings arranged with senior Care Group staff and the Governance team for progress reviews and to improve position for services.
2. Healthcare Acquired Infections (MRSA) 3. Healthcare Acquired Infections (MSSA) Threshold for 2025/26: 32 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	MRSA 0 cases YTD is equal to Threshold 0 YTD MSSA 6 cases YTD is under Threshold 8.01 YTD CDI 21 cases YTD is above Threshold 16.26 YTD ECOLI 22 cases YTD is above Threshold 18.75 YTD Klebsiella 3 cases YTD is under Threshold 6.99 YTD PA 3 cases YTD is above Threshold 2.49 YTD	     	(MRSA) Assurance: The Trust consistently passes 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.	Overall, HCAI rates decreased in 2025/26 compared with the previous financial year. The Trust is not currently identified as a high outlier for HCAI case numbers or rates. There have been no MRSA bacteraemia cases reported over the rolling 15-month period. Changing population demographics, including an increasing proportion of older people, may be contributing to the rise in Gram-negative bloodstream infection cases. Increases in Clostridioides difficile infection and MSSA bacteraemia cases are also being seen nationally. NHSE HCAI thresholds for 2026/27 are awaited	An MRSA/MSSA Prevention Action Plan is in place and includes a review of peripheral cannula dwell times in line with EPIC3 guidance, alongside revision of the Trust cannulation policy. Training for peer ANTT assessors is progressing, with further improvement in ANTT competency assessment compliance being supported through the Clinical Business Units (CBUs). A CDI Prevention Action Plan is in place. Ribotyping of toxin-positive cases continues, supported by ongoing surveillance to identify any periods of increased incidence. Antimicrobial stewardship ward round activity remains ongoing. Further work is planned to review the potential expansion of probiotic use for CDI prevention. Cleaning frequencies are also being reviewed in areas where domestic assistant staffing concerns have been identified. For E. coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections, CAUTI surveillance continues. The UTI prevention toolkit is being reinforced in wards where UTI-associated Gram-negative bloodstream infection cases have been identified, supporting targeted improvement and prevention activity.

Home Community Hospital

Appendix 3	Trust Performance		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%	The Trust achieved the required target at 95.3% for VTE assessments in the month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	VTE risk assessment (RA) performance target in June 2026 met the mandatory threshold with 95% compliance.	A number of actions have already been taken to strengthen assurance and improve VTE risk assessment compliance. Ward-based teams have been encouraged to use real-time data from the Getting it Right First Time (GIRFT) Inpatient Ward Productivity Dashboard to identify and complete outstanding VTE risk assessments. Feedback mechanisms are in place with Clinical Business Units (CBUs) to support a clearer understanding of areas of non-compliance, with oversight provided through the VTE Risk Assessment Dashboard as part of monthly CBU Clinical Governance agendas. Clinical Leads, Clinical Directors, CBUs and Care Groups are informed monthly of performance, enabling targeted action within individual clinical areas. The dashboard also identifies the five wards with the highest levels of non-compliance, supporting focused improvement and local accountability. Further improvement actions are planned to support sustained compliance above the mandatory 95% VTE risk assessment target. CBUs are working with Ward Managers and Ward Clerks to use real-time Ward Productivity Dashboard data during daily morning board rounds on working days, ensuring outstanding VTE risk assessments are reviewed and addressed in a timely way. A visual guide has been shared with CBUs for dissemination to ward clerks and ward managers. In March 2026, a pop-up information box was implemented on the GIRFT Inpatient Dashboard to clearly signpost the underlying data source. The Patient Safety Nursing Team will also reinforce the mandatory contractual requirement for VTE risk assessment completion through the Nursing Forum and a Trust-wide Safety Brief. Compliance trends will continue to be monitored through the Thrombosis Group, with further improvement actions agreed where required.
9. Inpatient Falls & harm levels Target: 10% reduction from 2024/25	106 total falls were reported in month. 45 of these were inpatient falls. YTD inpatient falls: 133 (above threshold 118.5)		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	In June there were 38 acute site inpatient falls and 9 within the Emergency Department (ED). Of the acute site inpatient falls, 24 were catagorised as no harm with 12 as low harm. There were 2 incidents that have been catagorised as moderate harm (1 patient sustained a # NOF and the other patient sustained a wedge compression #), these were both reported to National Audit of Inpatient falls (NAIF). The falls in the ED had 7 catagorised as no harm and the remaining 2 as low harm to the patient. Communications this month have been sent out via trust wide safety brief to include use of glide and locks to prevent patients slipping from chairs and encouraging the use of the patient falls prevention leaflet so that patients can make informed decisions about falls prevention strategies.	Assurance is provided that targeted actions were completed to strengthen falls prevention, post-fall review and staff education across the Trust. The Patient Safety Improvement Nurses (PSIN) arranged for the Trust falls alarm representative to deliver a dedicated falls alarm training session for therapy staff, supported by the Therapy Manager. The updated falls review process within both Datix and the digital SWARM was approved by the Governance Manager and launched Trust-wide in June 2026. The PSIN also shared information on bone protection for patients who had experienced a fall or were at risk of fragility fractures, in line with NICE recommendations. This was further supported by the Clinical Education Team through inclusion within the Trust-wide falls induction programme.
10. Acute - Total Pressure Ulcers (Category 2) Target: 20% reduction from 2024/25 11. Acute Total Pressure Ulcers (Category 3 and above) Target: 20% reduction from 2025/26 12. Community Acquired Pressure Ulcers (Category 2) Target: 20% reduction from 13. Community Acquired Pressure Ulcers (Category 3 or above) Target: 20% reduction from	Acute In month: 18 category 2 hospital-acquired pressure ulcers YTD: 36 (above threshold 26.76) In month: 1 category 3 & 4 pressure ulcers YTD: 4 (above threshold 2.25) Community In month: 22 category 2 community-acquired pressure ulcers YTD: 61 (above threshold 47.01) In month: 6 category 3 & 4 pressure ulcers YTD: 11 (under threshold 12.75)		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In June 2026, 18 category 2 pressure ulcers were reported across the acute inpatient areas. Three device-related pressure ulcers were reported during the same period, associated with glasses, a catheter strap and catheter tubing. Targeted improvement work has been undertaken with areas experiencing higher incidence and will continue until sustained improvement is demonstrated. A key learning theme relates to the impact of heatwave conditions, with increased emphasis on hydration, skin inspection, repositioning, moisture management and timely escalation for patients at increased risk of skin damage	Assurance is provided that a range of targeted actions are in place to improve pressure ulcer prevention and strengthen learning across acute services. SWARM investigations are completed by ward managers or matrons, with learning shared with ward teams and through the Operational Patient Safety Group. All pressure ulcers are subject to SWARM review with governance involvement, and improvement plans are in place across Unplanned Care and Planned Care Groups, with oversight from the Associate Chief Nurses. Compliance and review meetings are also taking place to support ongoing monitoring and the sharing of lessons learned. Additional preventative actions have been implemented to reduce harm associated with equipment and devices. The pressure-relieving mattress provider has increased on-site technical support to check mattress pumps and replace any faulty equipment. Film dressings are being applied to patients' heels in the Emergency Department to reduce friction and shear damage, and a Trust-wide safety brief has been issued regarding TED stockings, supported by a Single Point Lesson. Staff have been asked to retain any stockings associated with pressure damage to enable tissue viability review and audit. Silicone tape is also being implemented to reduce the risk of device-related pressure ulcers to the ears and face.

Appendix 3	Trust Performance		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)?
14. Mortality ratio - HSMR Target: Plan 15. Mortality ratio - SHMI Target: Plan	The Hospital Standard Mortality Ratio (HSMR) in month was 92.57. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 103.35.	 	(HSMR) Assurance: NA - no target Variation: Common Cause (Normal) variation. (SHMI) Assurance: NA - no target Variation: Common Cause (Normal) variation.	NHS England have advised they are to change the reporting approach to Same Day Emergency Care (SDEC) activity. SDEC type care provided in Emergency Departments known as Extended Emergency Medicine Ambulatory Care (EEMAC) will be recorded in ECDS.	"Non-EEMAC SDEC-type activity is planned to remain within the Inpatient dataset. There have been workshops with acute trusts looking at the details for the inpatient element of SDEC activity and further clarification is expected in the near future. We will update on this as more information becomes available, as this will impact the SHMI."
16. Medication Safety Reconciliation within 24 hours Target: 80%	Medicines reconciliation was completed within 24 hours of admission for 44.99% of patients. 73.75% of patients had MR completed during inpatient stay.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Current pharmacy staffing levels do not allow full coverage across all inpatient areas. Available resource is therefore deployed according to patient activity and acuity, with variation in performance between Clinical Business Units (CBUs) reflecting this risk-based approach. Higher-acuity and critical areas, including the Emergency Department, Acute Medical Unit, Intensive Care Unit and Acute Cardiac Care Unit, are prioritised, while areas such as elective surgery and maternity are considered lower priority for pharmacy resource. Assurance is provided that, for patients prescribed high-risk medicines, 74% had medicines reconciliation completed within 24 hours and 96% had this completed at some point during their inpatient episode, indicating that available pharmacy resource is being directed towards the most clinically appropriate patient cohort. Deployment is supported by audit data and prioritises patients known to be prescribed high-risk medicines. Of the patients who did not receive medicines reconciliation, 62% were within the Women and Children's and Surgical Specialties CBUs, primarily maternity patients in the birth suite and Midwifery-Led Unit. Previous analysis of this cohort identified that 90% of women were not prescribed regular medication and fewer than 5% were prescribed a critical medicine. Analysis of surgical specialties has also shown that, on average each month, 60–70% of patients who did not receive medicines reconciliation were discharged by day two of admission. In this context, full medicines reconciliation for this cohort would not represent the most appropriate use of limited pharmacy resource, and medicines are reconciled by pharmacy as part of the TTO clinical check process.	"Midwife recording of medicines reconciliation commenced in November 2025, and the number of medicines reconciliations recorded within maternity areas is beginning to increase. Ongoing training and support are being provided by the Medication Safety Nurse to strengthen midwife documentation and support sustained improvement. Deployment of pharmacy prioritisation tool to all pharmacy teams to provide pharmacy staff with a method of identifying and prioritising highest risk patients across the organisation, rather than by area. Tool being piloted in IMC pharmacy team and work is progressing with IT and Digital Analytics team to support the further development and rollout of this tool. Plan to undertake a Quality Improvement Project in Q2 2026/27 to assess the impact of completing and recording medicines reconciliation the day prior to planned admission for an elective surgical procedure associated with a planned inpatient episode.
17. Acute Medication Incidents Target: No target set 18. Acute Medication Incidents Target: No target set	In month there were 126 acute medication incidents, and 15 community medication incidents	 	(Acute) Assurance: No Target Set Variation: Common Cause (Normal) variation. (Community) Assurance: No Target Set Variation: Common Cause (Normal) variation.	Medication incidents within Acute services remain broadly stable overall, although an increase in reporting was observed during late 2025 and early 2026, with a single month exceeding the upper control limit. Incident numbers have subsequently returned within expected variation, although remain above the historical mean and continue to be monitored. Community services have demonstrated a sustained reduction in medication incidents over the reporting period, with recent months reporting levels consistently below the historical average. This suggests improving performance, with ongoing oversight to ensure reporting culture remains robust and learning from incidents continues to be embedded	Medication incidents are managed through the Trust's incident reporting and governance framework, with all incidents reviewed to identify themes, contributory factors and opportunities for learning. Regular oversight is provided through divisional and corporate quality governance structures, with targeted action plans implemented where trends, hotspots or areas of concern are identified. Current reporting levels provide assurance that incidents continue to be reported, investigated and used to drive quality improvement, with no emerging themes indicating a significant deterioration in safety

19. Average Fill Rate - Day registered nurses/ midwives

Target: 90%

20. Average Fill Rate - Day - care staff

Target: 90%

21. Average Fill Rate - Night registered nurses/ midwives

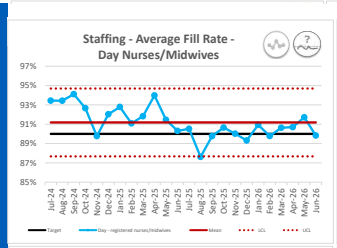
Target: 90%

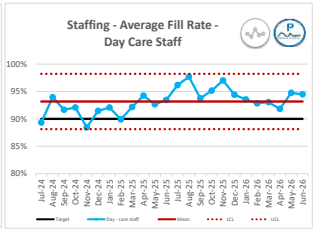
22. Average Fill Rate - Night care staff

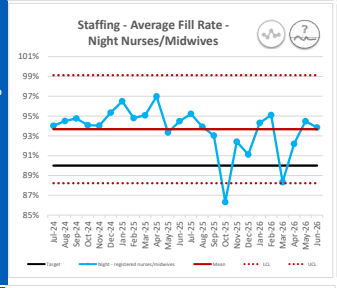
Target: 90%

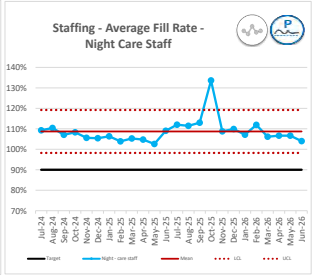
In month, the staffing fill rates were:

Day (Nurses/Midwife) 89.83%
Day (Care Staff) 94.48%
Night (Nurses/Midwife) 93.85%
Night (Care Staff) 103.98%









(Day Nurses/Midwives) Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

(Day Care Staff) Assurance: The Trust consistently passes the target.

Variation: Common Cause (Normal) variation.

(Night Nurses/Midwives) Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

(Night Care Staff) Assurance: The Trust consistently passes the target.

Variation: Common Cause (Normal) variation.

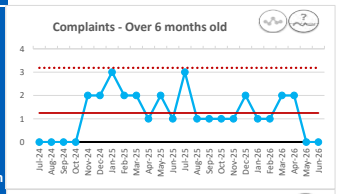
Fill rates continue to be impacted by sustained operational pressures across the Trust, including increased demand within the Emergency Department, higher patient acuity, additional escalation beds, and a growing number of patients with no criteria to reside. These factors require staff to provide cover across expanded clinical areas and temporary capacity, creating additional workforce demands that influence roster fill rates despite ongoing staffing mitigation measures

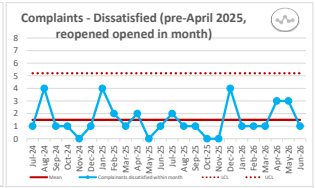
Acuity, patient activity and staffing levels continue to be actively monitored through established safe staffing processes, with oversight provided by Ward Managers, Matrons and Lead Nurses to ensure safe and effective patient care is maintained. The implementation of an enhanced Ward Vacancy Tracker in March 2026 has strengthened workforce oversight, providing improved visibility of substantive vacancies, recruitment pipeline activity and anticipated workforce supply.
Registered Nurse (RN) vacancy rates increased marginally from 6.64% in April 2026 to 7.21% in May 2026, remaining below the Trust benchmark of 9%. Whilst Band 5 RN vacancies represent the largest proportion of nursing vacancies, local workforce tracking demonstrates continued improvement in the net vacancy position, reducing from 49.39 WTE in April 2026 to 46.81 WTE in May 2026, reflecting the positive impact of ongoing recruitment activity. Health Care Support Worker (HCSW) vacancies increased from 11.74% to 13.23%, remaining above the Trust benchmark; however, vacancy levels within the largest area of pressure, Integrated Medicine and Community Services, reduced slightly during the reporting period.
The Trust continues to maintain a proactive recruitment strategy through regular centralised recruitment campaigns, targeted specialty recruitment events and engagement with the future workforce pipeline. Recent recruitment activity has secured a number of appointments across both registered nursing and support worker roles, including successful recruitment from final-year student nurse cohorts and the Care Support Worker Development Programme. These initiatives are expected to provide further improvements in vacancy levels over coming months as candidates progress through pre-employment checks and commence in post.
Community Services have demonstrated a positive trajectory, with RN vacancy rates reducing from 9.25% to 7.66% and HCSW vacancies reducing from 8.96% to 8.78%, both now below or approaching Trust benchmarks. Further work is underway to strengthen workforce assurance arrangements within Community Services through extension of the vacancy tracker and inclusion of additional services within daily staffing oversight processes. Overall, the Committee can be assured that robust governance, workforce monitoring and recruitment initiatives remain in place, with ongoing actions focused on reducing vacancy levels and sustaining safe staffing across all clinical services.

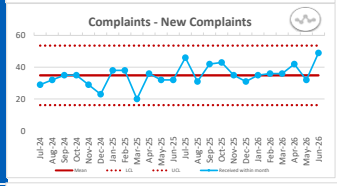
23. Complaints

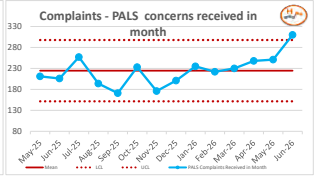
Target: Zero complaints open over 6 months old/in the backlog

In month there were 49 complaints received within month and 0 cases over 6 months old









Assurance: The Trust inconsistently passes/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 management and resolution of complaints. In June 2026, one dissatisfied complaint was received, and there were no complaints open for longer than six months, providing assurance regarding the effectiveness of complaint handling processes.
PALS activity continues to increase, with 310 concerns received during June 2026. Review of complaints and PALS feedback has identified no new or emerging themes, and no specific areas of concern requiring escalation. Feedback continues to be monitored through established governance arrangements to ensure opportunities for learning and service improvement are identified and acted upon appropriately

There were 111 open complaints at the time of reporting. All complaints continue to be actively monitored through established governance processes to support timely investigation and response. Where appropriate, concerns are resolved at the earliest opportunity through the Patient Advice and Liaison Service (PALS), and complainants are routinely offered engagement with clinical teams to support resolution and ensure their experience informs learning and improvement. Dedicated complaints case handlers within each Clinical Business Unit provide oversight and consistency in complaint management.

Weekly review of complaint themes and associated actions continues to support organisational learning and identify areas requiring additional support or intervention. Work is ongoing to redesign the PALS service, with the aim of creating a more streamlined and responsive process for managing concerns, improving the patient experience and reducing unnecessary escalation to formal complaints

24. Friends and Family (Inpatients & Day cases)

Target: 95%

25. Friends and Family (ED and UCC)

Target: 87%

26. Friends and Family (Community)

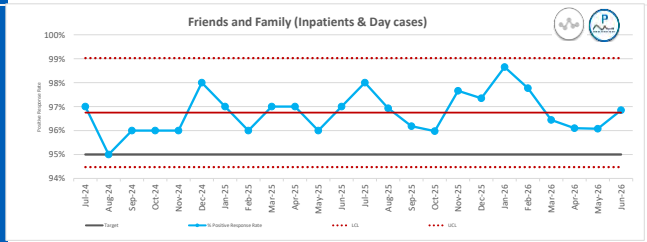
Target: 90%

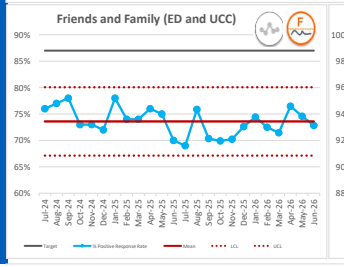
The Trust achieved:

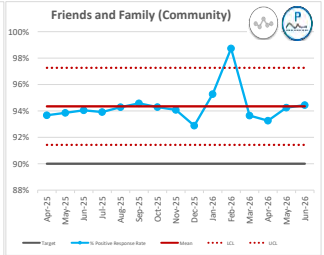
96.85% in month for Inpatient & Day Case FFT

72.83% for ED/UCC FFT.

94.44% for Community 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.

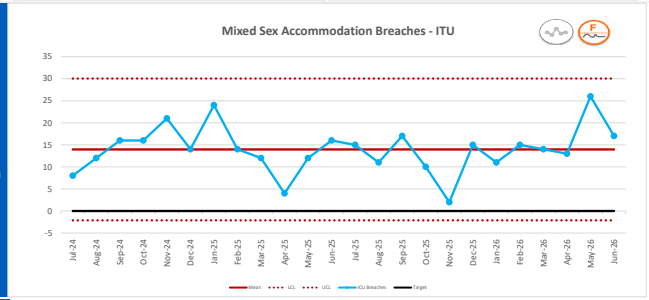
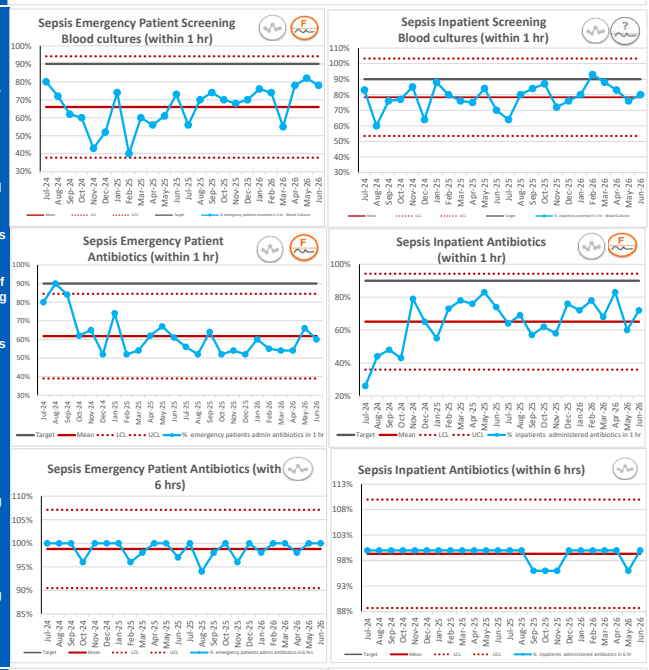
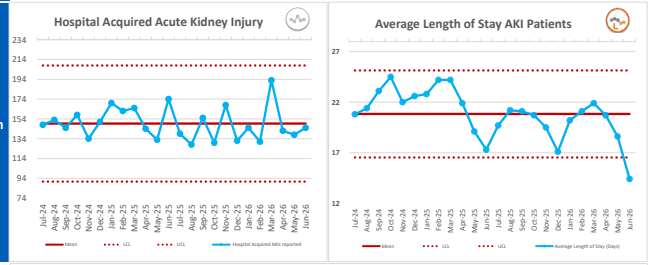
(Community) Assurance: The Trust consistently fails the target.

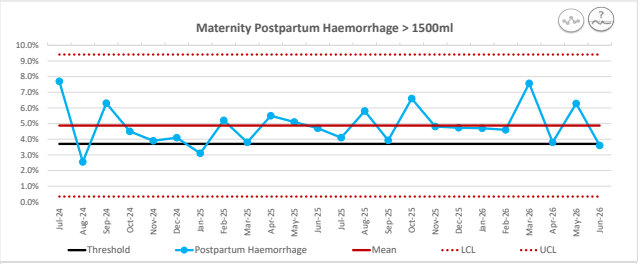
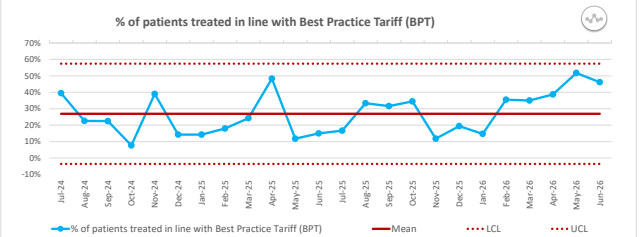
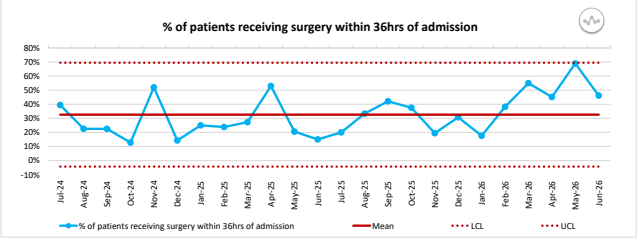
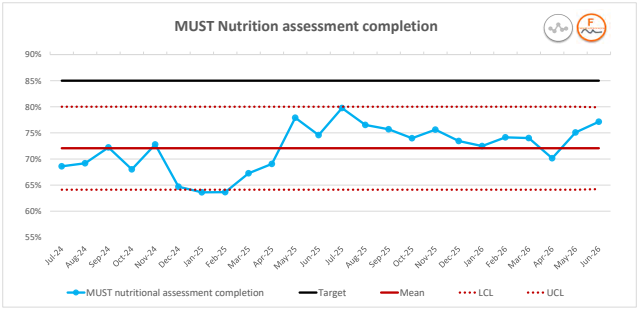
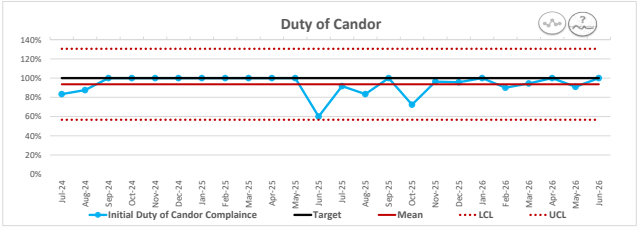
(Community) Variation: Common Cause (Normal) variation.

Inpatient and Day Case Services
The Trust achieved a positive Friends and Family Test (FFT) response rate of 96.85% in June 2026, maintaining performance above the Trust target of 95%. This represents a slight improvement compared to May 2026 and continues to outperform both regional and national benchmark averages, providing assurance regarding the quality of patient experience within inpatient and day case services.
Emergency Department/Urgent Care Centre (ED/UCC)
The Trust achieved a positive FFT response rate of 72.83%, representing a slight reduction compared to the previous month. Whilst performance remains below regional and national benchmark averages, patient feedback continues to identify both positive and negative experiences relating to staff attitude, waiting times, care delivery, communication and the care environment. Improvement activity remains focused on these areas to further enhance patient experience and satisfaction

The Trust continues to maintain robust oversight of patient experience through established governance arrangements, with Friends and Family Test (FFT) performance, key themes and associated improvement actions routinely reviewed at Clinical Business Unit level and through the Patient Experience and Inclusion Sub-Committee. FFT feedback is triangulated with intelligence from Trust Board, Governor, Senior Leader, PLACE and Patient Experience Team observational visits to provide a comprehensive understanding of patient experience and inform targeted improvement activity. Assurance is provided that arrangements are in place to maintain FFT service continuity following the appointment of a new provider through the Cheshire and Merseyside framework, with implementation plans progressing to support transition and future improvements in response rates and patient engagement.

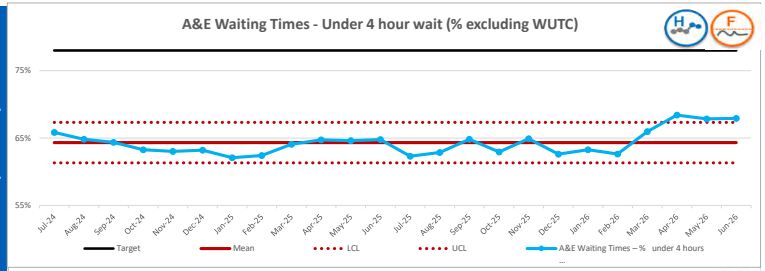
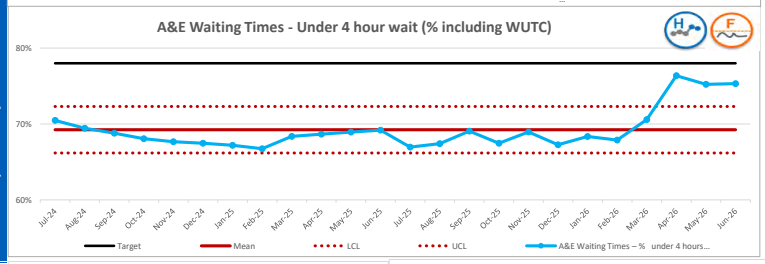
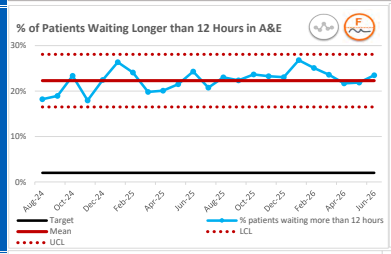
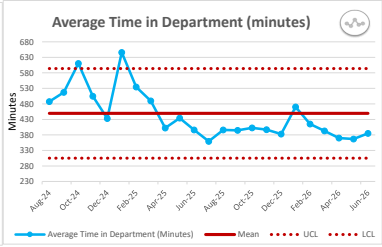
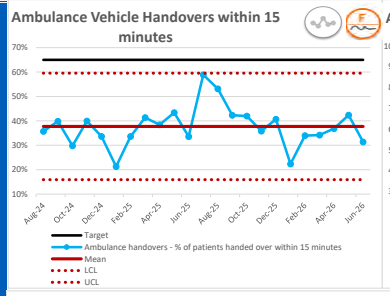
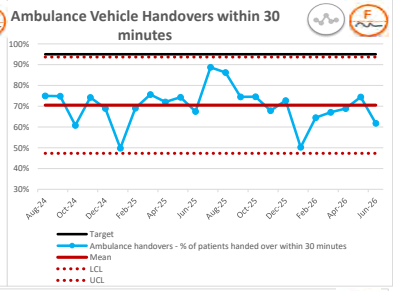
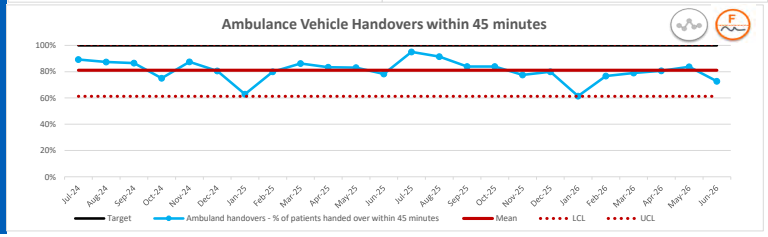
In response to FFT performance and patient feedback within Urgent and Emergency Care (UEC), a comprehensive programme of improvement work remains in place. Progress against the UEC patient experience action plan is monitored through the Patient Experience and Inclusion Sub-Committee, alongside recommendations arising from internal and external reviews, including Healthwatch and Governor visits. A range of initiatives have been implemented to enhance patient experience, including improved communication through digital information screens, ongoing environmental improvements, strengthened support for patients requiring reasonable adjustments, and the introduction of trauma-informed approaches through partnership working with Healthwatch. In addition, the Trust-wide executive-led Corridor Care Programme continues to focus on improving patient and staff experience throughout the emergency care pathway, recognising that patient flow is a whole-system responsibility. Volunteer support and real-time patient feedback mechanisms have also been enhanced, providing additional assurance that patient experience remains a key consideration within ongoing service improvement activity

Trust Performance		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. 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 17 MSA incident(s) within the ITU. 	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	There were 17 mixed-sex accommodation breaches reported in June 2026, a reduction of nine compared to May 2026. All breaches occurred within the Intensive Care Unit, with no breaches reported across any other inpatient ward areas, providing assurance that compliance with mixed-sex accommodation standards is being maintained elsewhere within the Trust. Patient flow and discharge delays continue to be actively managed through established escalation processes, with any delays reviewed by the Patient Flow Team and Tactical Manager and discussed within daily bed management meetings. Ongoing oversight supports timely decision-making and maximises opportunities to reduce delays, optimise capacity and maintain compliance with mixed-sex accommodation standards wherever possible.	Work continues across the Care Group and Patient Flow teams to prioritise the timely step-down of Level 1 patients from Intensive Care into the most appropriate clinical settings. A review of contributory factors associated with mixed-sex accommodation breaches has been undertaken, with targeted actions being developed to address identified causes and support sustained improvement. Ongoing challenges relating to patient flow, including a significant number of patients with no criteria to reside, continue to impact bed availability and flexibility across the Trust and are recognised as a contributing factor to breaches within the Intensive Care Unit. A review of the Trust's Mixed Sex Accommodation Policy is also underway to ensure arrangements remain aligned to current guidance and support consistent management, escalation and learning from breaches.
28. Sepsis - % screening for all emergency patients. **29. Sepsis - % screening for all inpatients** **Target: 90%** **30. Sepsis - % of emergency patients receive antibiotics within 1 hour of diagnosis** **31. Sepsis - % of inpatients patients receive antibiotics within 1 hour of diagnosis**	The Trust achieved: 78% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. 80% screening for all inpatients with suspected sepsis within 1 hour. 60% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. 72% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made. 100% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made. 100% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made. 	(Sepsis Emergency Screening) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation (Sepsis Inpatient Screening) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation (Sepsis Emergency Antibiotics <1hr) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation (Sepsis Inpatient Antibiotics <1hr) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	Sepsis compliance continues to show variation across both Emergency Department and inpatient areas, with some improvement noted in May 2026 for ED blood cultures, increasing to 82% from 78% in April. Inpatient blood culture compliance reduced to 76% in May from 83% in April, following previous improvements earlier in the year. Performance against key sepsis standards, including blood cultures, lactate within one hour and timely clinician review, has been impacted by operational pressures, including high patient attendances, occupancy pressures and staffing challenges. There is no single inpatient area identified as an outlier; however, continued monitoring remains in place to support improved compliance, timely escalation and consistent use of sepsis screening tools across ED and ward areas.	Sepsis performance continues to be closely monitored through the Deteriorating Patient Group, with recent audit data identifying variation in compliance with key standards, including blood cultures, lactate measurement, timely clinical review and use of the Sepsis Tool. A Trust-wide improvement programme is in place, supported by dedicated inpatient and Emergency Department workstreams, focused on strengthening early recognition and management of sepsis. Actions include staff education, expanded training for Health Care Support Workers, reintroduction of sepsis bags within ED, regular promotion of sepsis pathways through safety huddles and handovers, and ongoing review of compliance data. In addition, the Trust is reviewing local policies and performance indicators to align with the updated NICE sepsis guidance and support sustained improvement across all clinical areas.
32. Acute Kidney Injury **Target: Less than month in previous year**	There were 145 acute kidney injuries reported in month compared to 138 last month. 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	The number of hospital-acquired acute kidney injuries (HA-AKI) increased in June 2026. The increase should also be considered alongside the overall rise in AKI activity, including community-acquired AKI, which is likely to have been influenced by periods of warmer weather. As HA-AKI typically represents around one-third of all AKI cases, the increase is proportionate to the wider rise in AKI presentations. Length of stay for patients with AKI continues to reduce, providing assurance that the Acute Care Team (ACT), AKI clinics and discharge pathways are supporting timely care and discharge. Ongoing monitoring of 30-day readmission rates will be important to ensure that reductions in length of stay are being achieved without adversely impacting patient outcomes.	AKI performance remains under close review. Whilst the number of hospital-acquired AKIs increased in June 2026, this should be considered within the context of an overall rise in AKI cases, including community-acquired AKIs, which may have been influenced by periods of hot weather. Length of stay for patients with AKI continues to reduce, providing assurance that improvements in inpatient management, discharge pathways and utilisation of the AKI clinic are supporting timely care and discharge. Ongoing monitoring of 30-day readmissions will be important to ensure reduced length of stay is not associated with unintended consequences. A number of improvement initiatives are underway to reduce hospital-acquired AKI and strengthen patient outcomes. This includes the development of an integrated deteriorating patient bundle that combines sepsis and AKI pathways at the point of admission, enabling earlier identification and senior clinical review of patients at risk of deterioration. In addition, a Trust-wide AKI audit is underway to assess compliance with discharge processes, utilisation of the AKI clinic and adherence to established AKI discharge pathways, ensuring opportunities for further improvement are identified and acted upon.

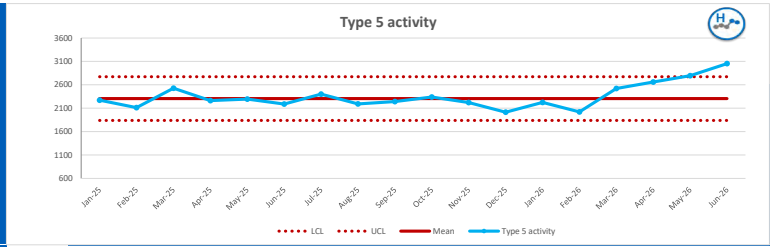
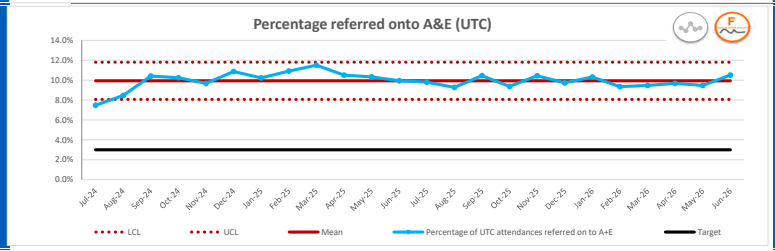
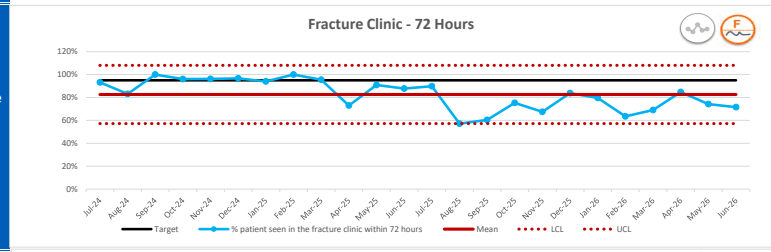
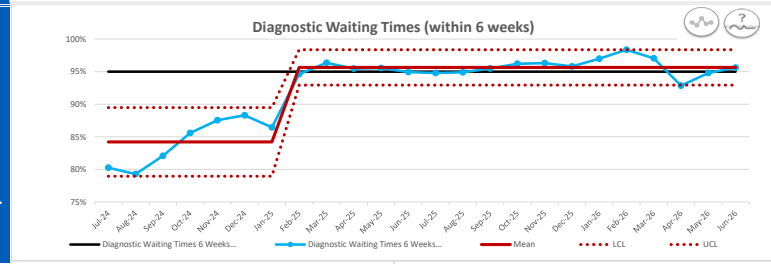
Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
33. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	Maternity Postpartum Haemorrhage was 3.60% in month compared to 6.28% last month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation	Postpartum haemorrhage (PPH) >1500ml rates continue to demonstrate common cause variation; however, comparator data from the Cheshire and Merseyside Local Maternity and Neonatal System indicates the Trust's rate of 66 cases per 1,000 births remains above the regional average of 32 cases per 1,000 births. The service continues to review contributory factors and monitor trends through established maternity governance arrangements to better understand this variation and identify opportunities for improvement .	Postpartum haemorrhage (PPH) >1500ml remains a key area of focus for the maternity service. Robust governance arrangements are in place, with all cases reviewed through the Intrapartum Review Group to identify learning opportunities and support continuous improvement. The Trust remains a consistent outlier when benchmarked against Cheshire and Merseyside peers, with a 12-month rolling mean of 5.13%, despite SPC data demonstrating common cause variation and relative stability over time. A comprehensive quality improvement programme is underway, focusing on standardised risk assessment, accurate quantification of blood loss, clear escalation processes aligned to regional guidance, multidisciplinary simulation training and strengthened real-time learning mechanisms. The impact of the revised guideline implementation will be evaluated through a planned re-audit, with findings and progress against the improvement programme reported to the Quality Assurance Committee to provide ongoing assurance regarding the effectiveness of actions taken.
34. Fractured Neck of Femur **Target: Best Practice Tariff**	46.15% of patients were treated in line with Best Practice Tariff (BPT) in Jun-26.	 	Variation: Common Cause (Normal) variation.	Performance against the National Hip Fracture Database (NHFD) Best Practice Tariff standards remains mixed. The Trust continues to achieve strong performance in key areas, including direct admission from the Emergency Department to the Orthopaedic Ward (93%) and timely orthogeriatric review, with 100% of patients reviewed and 82% assessed within the recommended 72-hour timeframe. These measures provide assurance that patients are receiving prompt specialist input and coordinated multidisciplinary care. Timely access to surgery remains the principal area for improvement, with 46% of eligible patients undergoing surgery within the recommended timeframe, although this represents an improvement on previous months. Progress is also being made through a multidisciplinary quality improvement programme focused on increasing day-one postoperative mobilisation, which achieved 64% in the most recent audit period. Ongoing work remains focused on improving surgical timeliness, early mobilisation and overall compliance with Best Practice Tariff standards to enhance patient outcomes and recovery	A comprehensive improvement programme is in place to enhance outcomes for patients with hip fracture. Key actions include ongoing work to improve timely access to surgery through strengthened theatre prioritisation and pathway optimisation, alongside a multidisciplinary quality improvement project focused on increasing day-one mobilisation rates. Strong performance in orthogeriatric review is being maintained, with continued emphasis on early comprehensive assessment and coordinated discharge planning. Performance against the National Hip Fracture Database (NHFD) Best Practice Tariff is reviewed regularly through governance forums, with targeted actions monitored to improve compliance and support delivery of best practice standards across the patient pathway.
35. MUST nutritional assessment completion **Target: above 85%**	MUST Nutrition assessment completion was 77.13% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	MUST compliance continues to demonstrate gradual improvement, with current performance now within 10% of the Trust target. Significant improvement has also been observed in compliance with completion of the seven-day nutritional reassessment metric, providing assurance that nutritional risk is being identified and monitored more effectively. Following integration with Community Services, the dataset now includes community assessment areas, providing a more comprehensive view of nutritional screening and monitoring across the organisation. Work is underway to incorporate community data within the Lion dashboard alongside acute performance data, which will strengthen real-time oversight, support local monitoring of compliance, and enable targeted improvement activity where required..	The monthly Nutrition, Food and Hydration Group continues to provide multidisciplinary oversight of nutritional care across the Trust, driving improvement through shared learning, quality improvement initiatives and targeted action plans developed by Clinical Business Units and key stakeholders. MUST compliance has been identified as a Trust quality priority for 2026/27, reflecting its importance in the early identification and management of malnutrition and its contribution to wider patient outcomes. Nutrition remains embedded within the Trust's patient safety approach, with MUST incorporated into reviews of harms such as falls and pressure ulcers to strengthen understanding of the relationship between nutritional status and patient deterioration. During 2026/27, a targeted programme of education and awareness will be implemented for the healthcare support worker workforce, focusing on the use of MUST and its role within holistic patient assessment and care. This work aims to further improve compliance, support earlier intervention and enhance the quality of nutritional care provided across the organisation
36. Duty of Candor **Target: 100%**	Duty of Candor Compliance was 100% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Duty of Candour performance continues to perform well, with all initial Duty of Candour actions completed within the Trust's required timescales in June 2026. Daily incident triage meetings ensure that all incidents meeting Duty of Candour requirements are identified promptly, providing assurance that statutory obligations are consistently met and that patients and families receive timely communication following patient safety events. Robust oversight and monitoring arrangements remain in place to sustain compliance and support a culture of openness, transparency and learning	Duty of Candour requirements are reviewed daily through the Trust-wide incident triage meeting, ensuring prompt identification, escalation and oversight of all incidents requiring Duty of Candour. This provides assurance that statutory requirements are consistently considered and actioned in a timely manner. Compliance is reported weekly to the Safety Oversight Meeting, providing ongoing organisational oversight and supporting sustained performance in meeting Duty of Candour obligations, alongside the promotion of openness, transparency and learning.

Access & Performance - Trust Position

Appendix 3

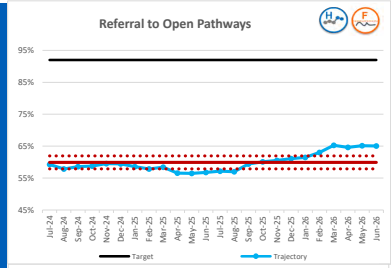
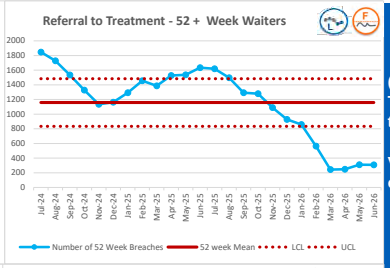
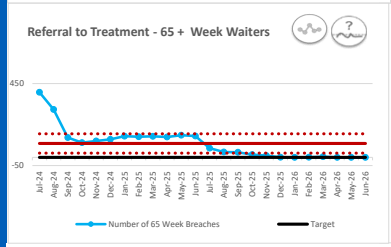
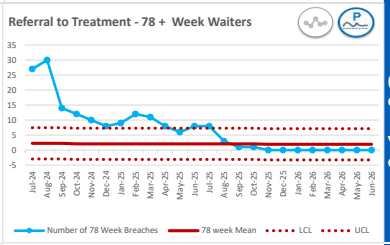
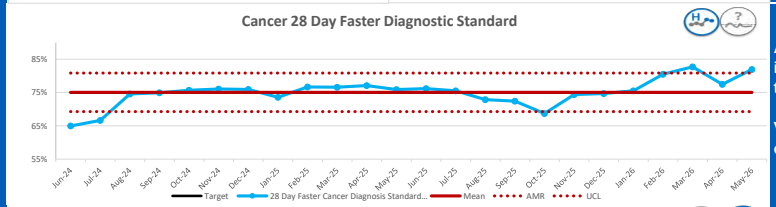
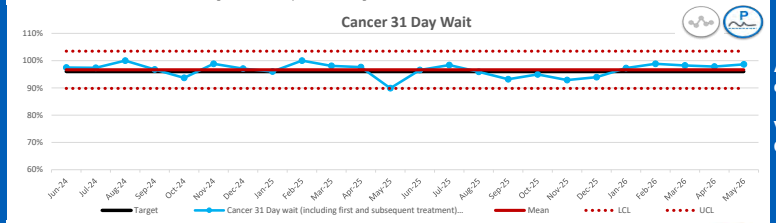
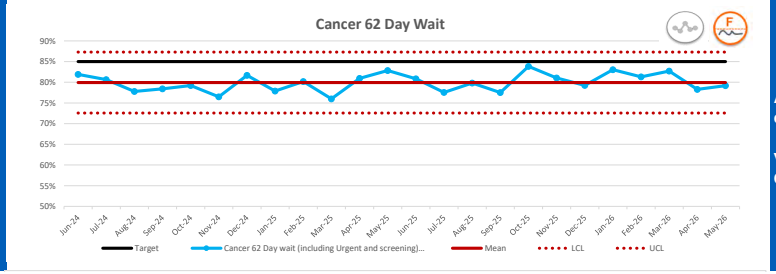
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
37. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC) **Target: 78%**	The Trust achieved 67.92% excluding Widnes UTC in month. The target is set at 78%, which is the national aspiration for 2026/27		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.	4 hour performance from April 26 includes 100% Widnes Type 3 activity. The Target to achieve by March 27 is 84% The National constitutional target remains 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. • More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance • Increased capacity through SDEC through separating Medical and Surgical SDEC has supported the improvement in 4 hour performance
38. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) **Target: 78%**	The Trust achieved 75.31% including Widnes UTC in month. The target is set at 78%, which is the national aspiration for 2026/27		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.		
39. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. **Target: 2% or**	23.48% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 385 minutes.	 	Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation. Assurance: No Target set Variation: There is Common Cause (normal) Variation.	12 hour performance continues to be negatively impacted by the wait to be seen in ED and overall high bed occupancy	• 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. • A reduction in non-admitted breaches has been supported through the ED improvement group, the next focus is on admitted breaches which has a direct correlation to flow out of ED
40. Average time in department ED No Target					
41. Ambulance Vehicle Handovers within 15 minutes **Target: 65%**	In month the Trust achieved: 31.4% Ambulance Handovers within 15 minutes (65% target) 61.8% Ambulance Handovers within 30 minutes (95% target) 72.8% Ambulance Handovers within 45 minutes (100% target)	  	(15) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation. (30) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation. (45) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.	The Trust continues to work with NWAS to support improving this metric. Main areas of concern are out of hours and at times of surge. Please note that ambulance handover metrics are now measured to the point of vehicle handover, rather than patient handover.	A QIA project with NWAS is planned to commence 20th July to support improving handover times
42. Ambulance Vehicle Handovers within 30 minutes **Target: 95%**					
43. Ambulance Handovers within 45 minutes **Target: 100%**					

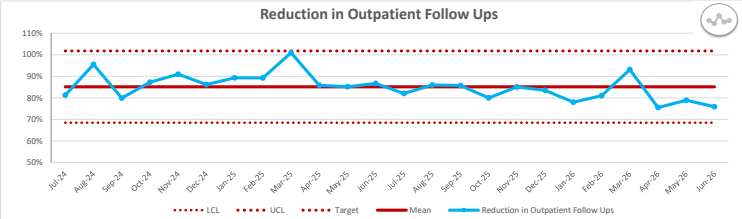
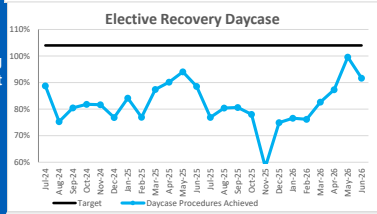
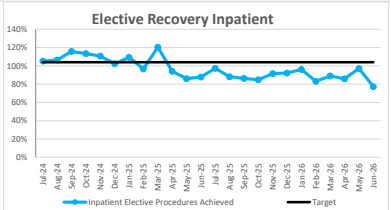
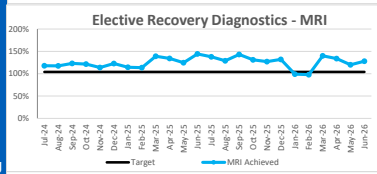
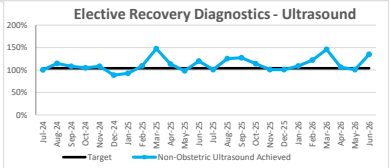
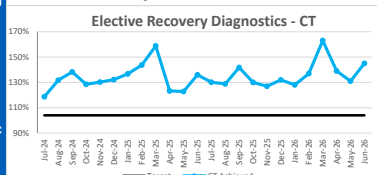
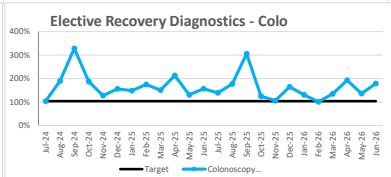
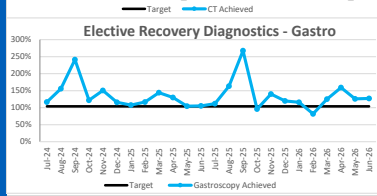
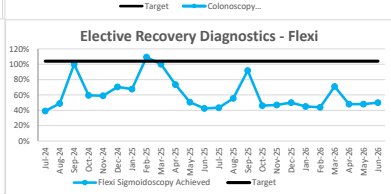
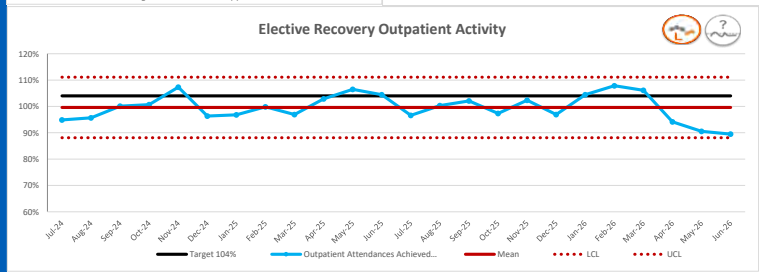
Appendix 3

	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)?
44. Type 5 activity No Target	In month there were 3053 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause variation of improving nature.	Type 5 activity includes SDEC (Medical and Surgical), FAU, PAU, GAU and Ed ambulatory The increase in activity can be seen due the separation of Medical and surgical SDEC	
45. Percentage of UTC attendances referred on to A+E	In month: 10.5% of UTC patients were referred to ED. Runcorn UTC: 16.5% Widnes UTC: 4.6%		Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.	There are no specific national guidance on expected levels of referrals the Trusts supports as right patient right place right time ethos	
46. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In month, the fracture clinic saw 71.6% of patients within 72 hours.		Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.	Workforce pressures continue to seen and accounts for fluctuations in performance	
47. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 95.6% in month. Acute in month was 95.5% in month. Community in month was 100.0% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is Common Cause (normal) Variation.	The Diagnostic performance has seen a decrease due to workforce challenges in Endoscopy, recovery is forecast for September if recruitment plans are realised	A recovery trajectory has been agreed for Endoscopy modalities, achievement of this is dependant on recruitment

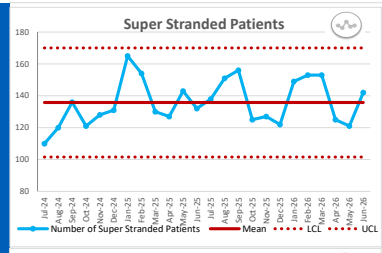
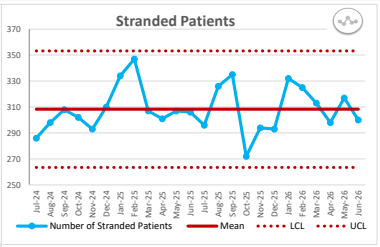
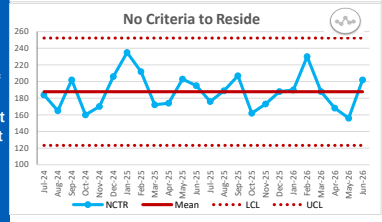
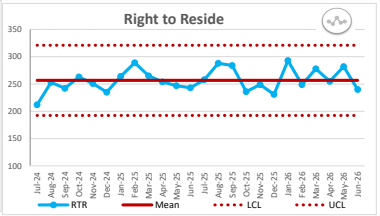
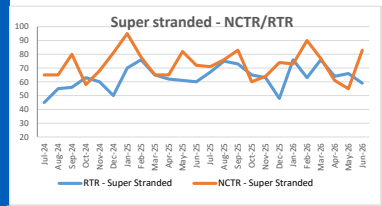
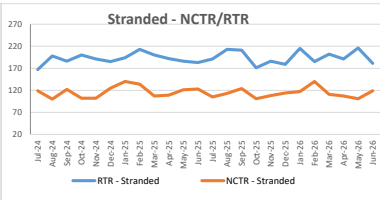
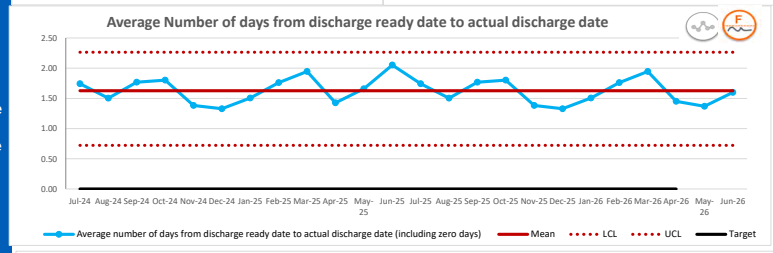
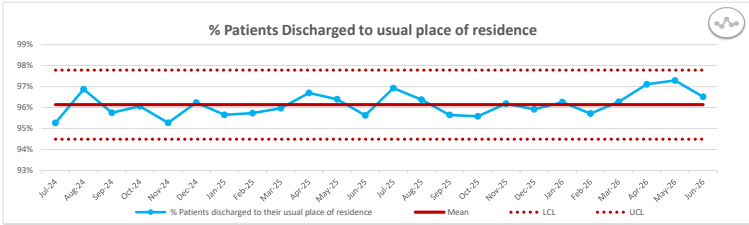
Access & Performance - Trust Position

Appendix 3

	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. Referral to treatment Open Pathways Target: 92%	The Trust achieved 65.08% in month. There were 308 52-week breaches, 0 78-week breaches and 0 65-week breaches.		(Open Pathways) Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.	The Trust has delivered in line with the annual planning submission	
49. RTT - Number of patients waiting 52+ weeks Target: 0					
			(52+) Assurance: The Trust consistently fails the target. Variation: There is special cause of improving nature.		
					
50. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 81.9% in month for 28 Day Faster Cancer Diagnosis Standard. Acute in month was 80.3% in month. Community in month was 86.6% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause variation of improving nature.	Under the changes to Cancer Waiting Times standards that came 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 has achieved the committed position for March 2026. In 2026/27 there will be a commitment to achieving 80% for the year as an aggregate.	The Trust has delivered the 28 Day FDS. There are improvement plans in place at tumour site level specifically, Urology, Colorectal and Gynae and agreed trajectories to support these are in place which are being monitored. The Cancer Alliance is also supporting this plan
51. Cancer 31 Day wait Target: 96%	The Trust achieved 98.6% in month for Cancer 31 Day Wait. Acute in month was 98.5% in month. Community in month was 100.0% in month.		Assurance: Target met consistently. Variation: There is Common Cause (normal) Variation.	Target is consistently achieved. All 31-day standards, first and subsequent will be combined from 1st October 2023	
52. Cancer 62 Day wait Target: 85%	The Trust achieved 79.17% in month for Cancer 62 Day Wait. Acute in month was 76.36% in month. Community in month was 96.30% in month.		Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.	From 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 75% by March 2026, moving to 80% by March 27. A trajectory has been developed with the Cancer Alliance to achieve this and the Trust continues to perform above this trajectory.	The 62-day referral to treatment target remains challenging but is seeing improvement due to the combined standards. The standard was met at 85.6% for the first time in several years in October.

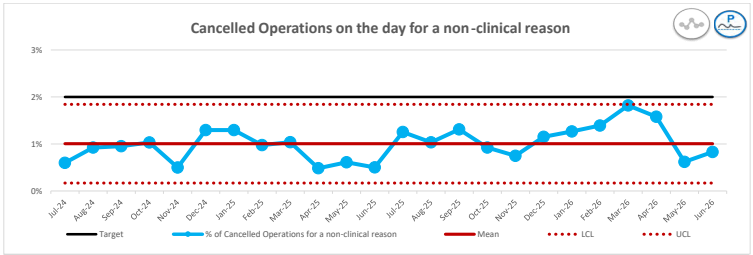
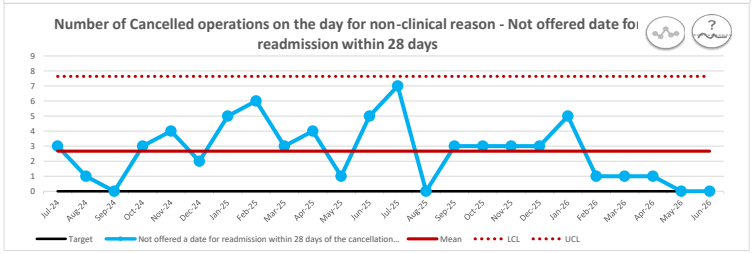
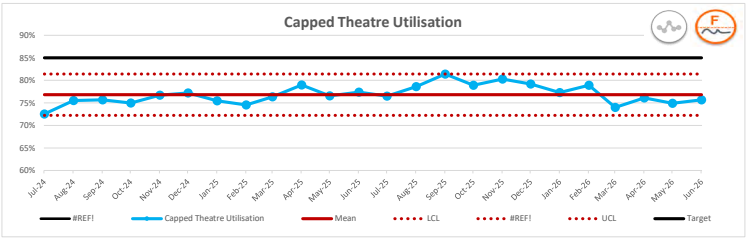
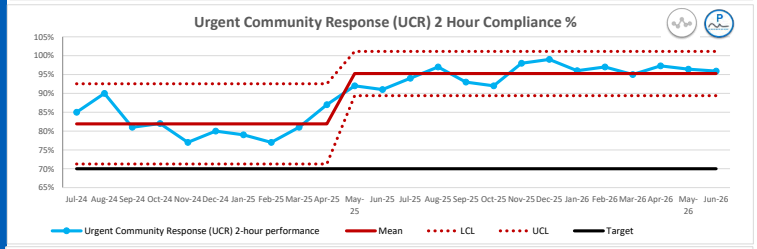
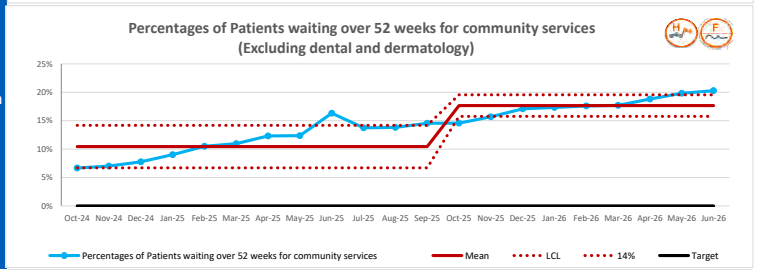
Appendix 3	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	Outpatient follow ups have reduced to 75.9% of 19/20 activity in month.		Assurance: N/A Trajectory Not Agreed. Variation: There is Common Cause (normal) Variation.	Outpatient follow ups is in line with the agreed trajectory as part of annual planning	
54. Elective Recovery Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following 90% of activity against 2019. This included 92% of Daycase Procedures and 77.33% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Activity is monitored inline with plan, underperformance has been due to workforce gaps and below plan referrals into Endoscopy Hub	
55. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following 130% of activity against 2019. This included: 104% of MRI 145% of CT 135% of Non-Obstetric Ultrasound 50% of Flexi Sigmoidoscopy 179% of Colonoscopy 127% of Gastroscopy	     	N/A - Grouped indicator.	Radiology modalities remain fully recovered, Challenges in Endoscopy and Echo seen in month	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
56. Elective Recovery Outpatient Activity Aggregate Target: 104%	In month, the Trust achieved 89.49% of Outpatient activity.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a concerning nature.	Workforce challenges across key specialties are the drivers behind the reduction in performance	Recovery plans are being monitored through Performance review Group and Delivery unit

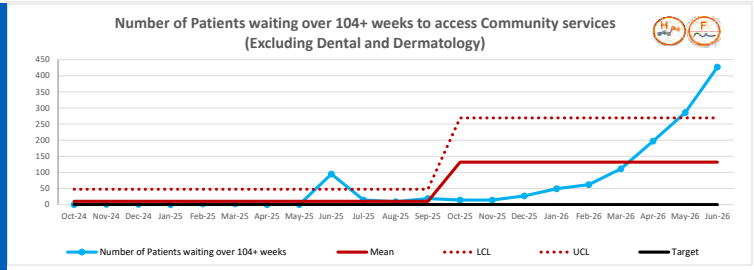
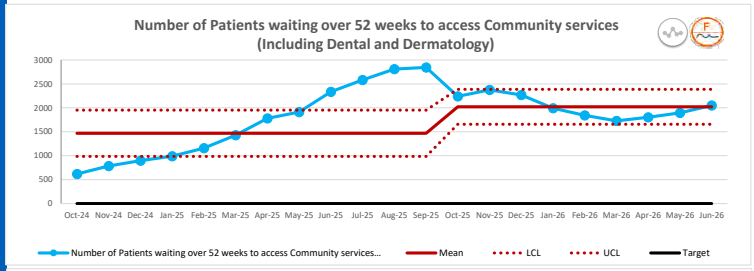
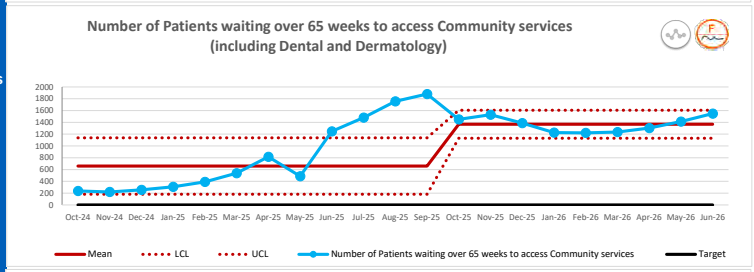
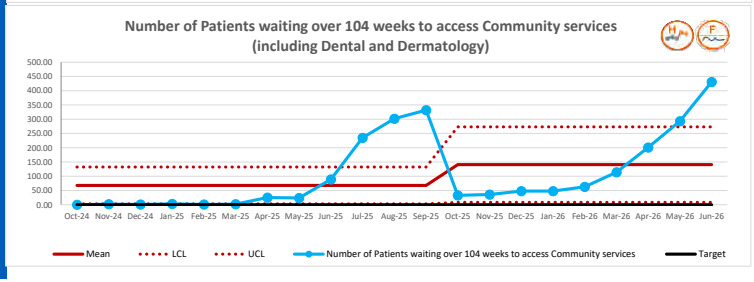
Appendix 3

	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)?
57. Super Stranded Patients **Target: No Target Set**	There were 300 stranded and 142 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2026/27.	 	(Super Stranded) 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.
58. No Criteria to Reside (NCTR) **Target: Trajectory**		 	(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.		
59. Average Number of days from discharge ready date to actual discharge date **Target: 1 day or less**	In month, the Trust achieved the average of 1.6 days from discharge ready date to discharge date.		Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.		The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available. Hospital delays are monitored through the daily bed meetings
60. % Patients discharged to their usual place of residence **Target: No Current Threshold**	96.51% patients in month were discharged to their usual place of residence.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.		

Access & Performance - Trust Position

Appendix 3

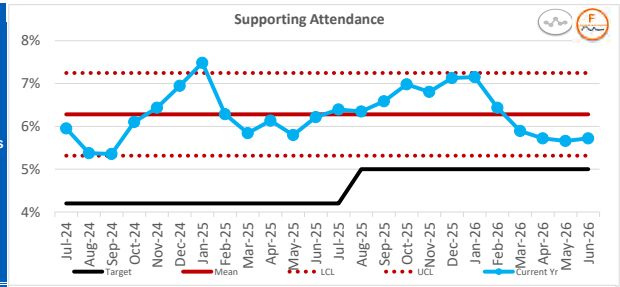
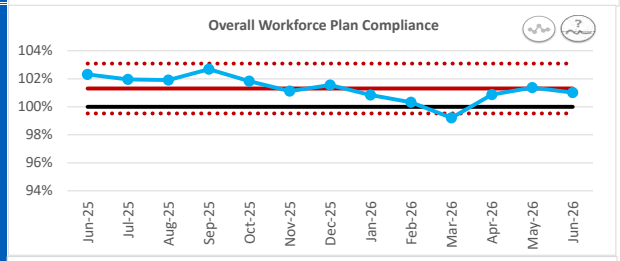
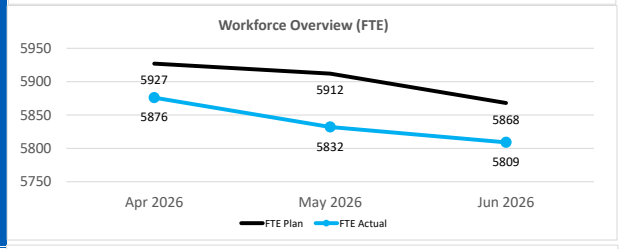
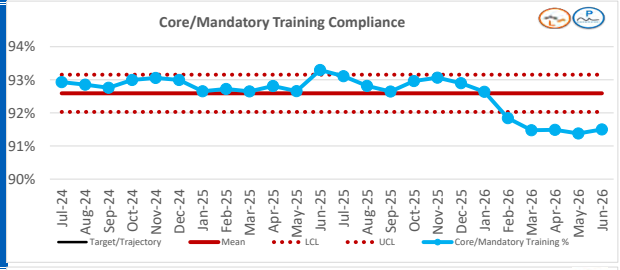
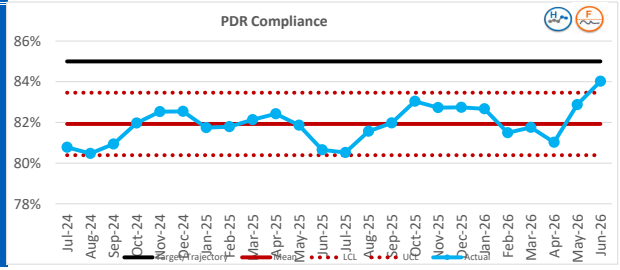
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
61. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 0.83% in month. 0 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.	The Trust continues to monitor this inline with the operational planning guidance	The planned care Transformation Group is monitoring this metric, any patient cancelled for non clinical reasons is being reviewed
62. 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.		
63. Capped Theatre Utilisation Target: 85%	Capped Theatre Utilisation was 75.68% in month		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	The Trust continues to monitor this inline with the operational planning guidance	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 Urology & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.
64. Urgent Community Response (UCR) 2-hour performance Target: 70%	2 Hour UCR Reponse rate was 95.9% in month		Assurance: Target met consistently. Variation: Common Cause (Normal) Variation.	The Trust continues to monitor this inline with the operational planning guidance	
65. Percentages of Patients waiting over 52 weeks for community services (Excluding dental and dermatology) Target: 0%	In month 20.28% of patients are waiting over 52 weeks for community services in month inline with the NHS Oversight Framework Indicator which does not include Dental or Dermatology community waits		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting longer than 52 weeks - 2 Podiatry patients (Halton), 1 has been seen, 1 has declined an appointment the service are working to try and convert a slot to bring them in. 2 in SMI Health Assessment Service. The service have concluded that these are data quality errors, the records will be corrected at source and are not expected to breach next month. The remaining patients are children awaiting an appointment for the Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton.	

	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)?
66. Number of Patients waiting over 104+ weeks to access Community services (Excluding Dental and Dermatology) **Target: 0**	In month 427 patients are waiting over 104 weeks for community services in month inline with the NHS Oversight Framework Indicator which does not include Dental or Dermatology community waits		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. There is one other patient in this category for the SMI Assessment service, the service have concluded that this is a data quality error, the record will be corrected at source and is not expected to breach next month.	Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue
67. Number of Patients waiting over 52 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 427 patients are waiting over 52 weeks for community services in month including Community Dental and Dermatology		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Over 52 weeks comprises: 1 in Dermatology, This patient has since received advice and guidance and will not be present in the next monthly snapshot. 2 in Halton Podiatry,1 has declined an appointment the service are working to try and convert a slot to bring them in. 2 in SMI Health Assessment Service, The SMI service have concluded that these are data quality errors, the records will be corrected at source and are not expected to breach next month. 144 in Community Paediatrics, 2060 Paediatric Neurodevelopment Pathway.	
68. Number of Patients waiting over 65 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 1549 patients are waiting over 65 weeks for community services in month including Community Dental and Dermatology		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	The patients waiting over 65 weeks comprises: 1 in Dermatology, This patient has since received advice and guidance and will not be present in the next monthly snapshot. There are 2 in Neurodevelopment nursing team, the service consider this to be a data error, the record will be corrected at source and will not be a breach in the next monthly snapshot. There are 93 in Community Paediatrics, 1502 Paediatric Neurodevelopment Pathway.	
69. Number of Patients waiting over 104 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 431 patients are waiting over 104 weeks for community services in month including Community Dental and Dermatology		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. There is one patient in Neurodevelopment Nursing Team. The service consider this to be a data error, the record will be corrected at source and will not be a breach in the next monthly snapshot.	

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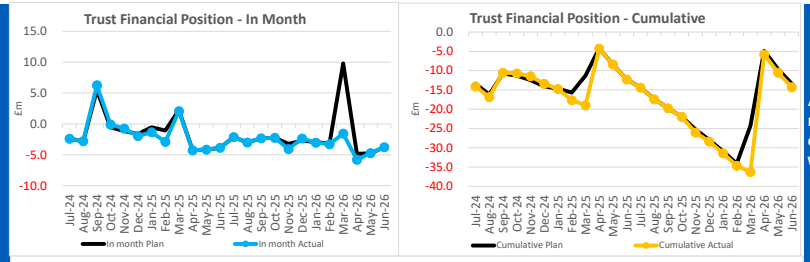
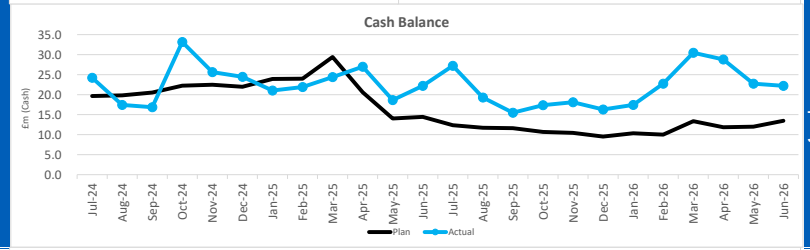
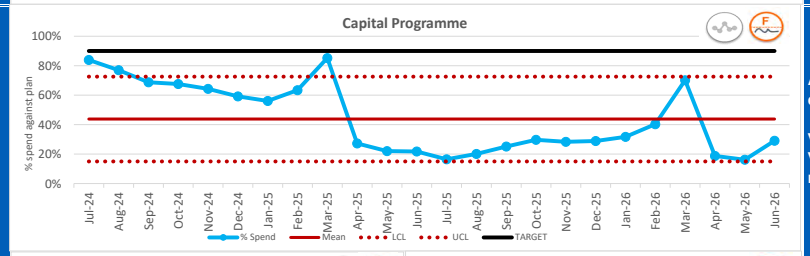
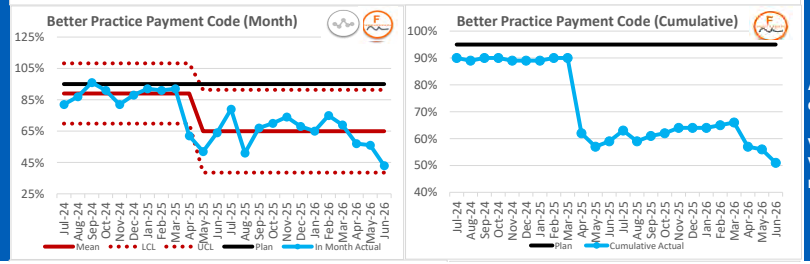
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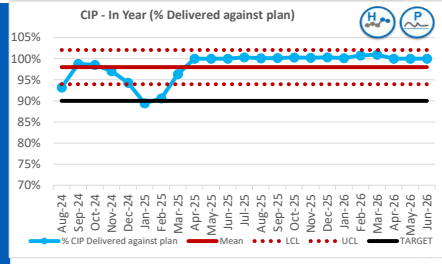
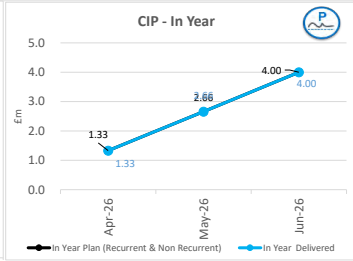
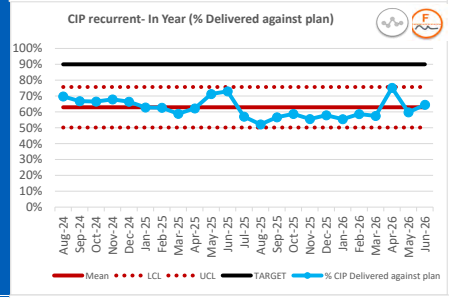
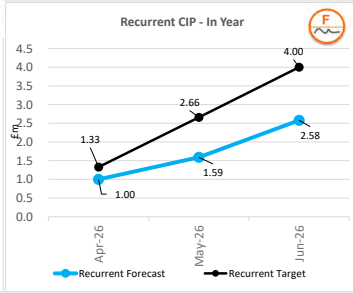
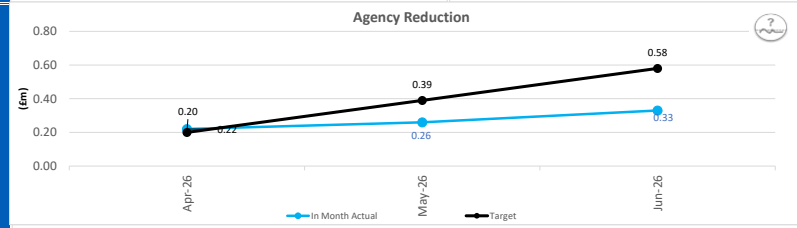
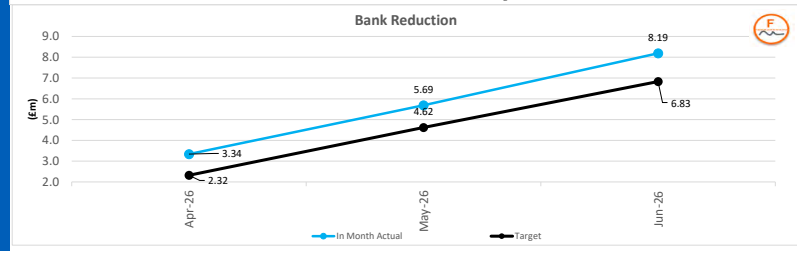
Appendix 3

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)?
70. Supporting Attendance **Target: Below 5%** The Trust's sickness rate was 5.72% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	The Trust has achieved a significant reduction in long-term sickness absence, decreasing from 4.8% in January 2025 to 3.3% in June 2026. Whilst long-term absence continues to improve, short-term sickness absence remains an area of focus at 2.5%. Sickness absence remains a key performance metric within the National Oversight Framework (NOF), underlining the importance of sustained improvement and effective attendance management.	The 24 areas with the highest absence-related temporary staffing costs (12 Acute and 12 Community) have received targeted HR and Occupational Health intervention, including detailed case management reviews, KPI monitoring, leadership support and executive-level oversight. Due to sustained improvements the list has been refreshed. The launch of the revised Supporting Attendance Policy, alongside Trust-wide manager briefings and training, has strengthened the consistency of attendance management practices. Digital solutions, including PowerApp notifications and enhanced reporting functionality, have further improved compliance, data quality and management oversight. These combined interventions are having a positive impact, evidenced by continued improvements in attendance and the achievement of the Trust's lowest sickness absence rate since September 2024.
71. Workforce FTE Plan Compliance **Target: 100% plan** The Trust's Workforce FTE Plan Compliance was 101% in month. The in-month plan was 5,868 FTE and the actual position was 5,809 FTE, which is 59 FTE below plan.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common cause (normal) variation.	The Trust is below plan in Month 3 (Jun-26), which means we are using less FTE than planned. To ensure the Trust remains on or below plan, substantive recruitment is subject to quality impact assessments (QIAs) through the vacancy control process and the use of temporary workers is scrutinised through weekly meetings with Executives and Staff Group leads.	Service leads continue to monitor delivery of their Workforce Plans and are required to demonstrate progress against agreed FTE reduction targets as part of the Vacancy Control Process (VCP). This ensures that recruitment decisions remain aligned to workforce plans and organisational priorities. A programme of service reviews has been agreed, with executive leads identified for each review. The outcomes will further inform workforce planning and establishment management, supported through ongoing oversight via the Vacancy Control Process and Delivery Unit governance arrangements.
72. Core/ Mandatory Training **Target: 85%** Core/Mandatory training compliance was 91.5% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a concerning nature.	CSTF Mandatory Training compliance remains above the Trust target. However, a gradual decline of 1.1% has been observed since December 2025 and will continue to be closely monitored to ensure compliance levels are maintained.	Mandatory training compliance is monitored through established governance arrangements, including the Education Governance Group and Mandatory Learning Oversight Group (MLOG), with Care Groups required to take corrective action where compliance falls below agreed standards. Training requirements are reviewed periodically to ensure they remain proportionate and minimise the time burden on staff. All requests for new mandatory training or changes to existing requirements are subject to approval through MLOG and sign-off by the Executive Management Team (EMT).
73. PDR **Target: 85%** Annualised PDR compliance was 84.02% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.	PDR compliance has continued to improve and now stands at 84%, representing a one percentage point increase from the previous month. A number of corporate areas and staff groups continue to achieve or exceed the 85% target following delivery of agreed improvement trajectories. Several CBUs have also demonstrated significant improvement over the last 12 months; however, overall performance remains just below the Trust target of 85%.	Significant work has been undertaken to improve both appraisal compliance and the quality of appraisal discussions across the Trust including appraisal roadshows. Comprehensive appraisal guidance has been developed to support managers and staff, and appraisal documentation is currently being reviewed and standardised as part of the integration programme. Digital solutions, including automated notifications and enhanced reporting tools, have also been introduced to improve compliance, provide greater oversight and support the timely completion of appraisals.

Finance and Sustainability - Trust Position

Appendix 3

	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)?
74. Trust Financial Position **Target: Plan**		At month 3 the Trust has recorded a deficit position of £14.3m which is £0.9m worse than plan.	At month 3, the deficit position is £0.9m worse than plan due to the impact of industrial action in April.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
75. Cash Balance **Target: On or better than plan**		The cash balance at 30 June 2026 is £22.2m.	The current cash balance is £22.2m which is £8.8m higher than the cash plan. This is predominantly due to having a larger than planned cash balance at the end of 2025/26, the implementation of cash management measures and having higher capital creditors than planned for 2025/26. Of the £22.2m cash, £7.8m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £10.346m is required for September 2026 (previously approved by board). A further £7.177m for Q3, approval is sought from the Trust Board. The finance team produces a daily cashflow and before payment runs are made a senior review is undertaken. Weekly reviews of non-NHS and NHS payments are being undertaken to determine whether payments can be deferred without incurring late payment interest charges.
76. 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 3 is £1.9m against a plan of £6.5m. This is mainly due to capital schemes originally planned for 2026/27 being brought forward to 2025/26 as well as the timing of leases (IFRS16). 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 2026/27 capital plan is monitored at CPG and reported to FSPC.
77. 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 51% 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.

	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)?
78. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date	 	**Assurance: The Trust consistently passes the target.** **Variation: Special Cause variation of improving nature.**	**At month 3, CIP is in line with plan.**	**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.**
79. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**£2.6m CIP has been delivered recurrently against the target of £4m.** **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 2027/28.** **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.**
80. Agency Reduction **Target: 30% reduction of 2025/26 plan**		**Agency expenditure is £0.3m at month 3 compared to a plan of £0.6m.**	**At month 3, agency expenditure is below plan.**	**Agency expenditure will continue to be reviewed throughout the year to ensure that it stays below the target set.**
81. Bank Reduction **Target: 10% reduction of 2025/26 plan**		**Bank expenditure is £8.2m at month 3 compared to a plan of £6.8m.**	**At month 3 bank expenditure is overspent by £1.4m. £1m is due to the impact of April Industrial Action and the remainder is mainly driven by UEC nursing and LTFT medical staff in surgery.**	**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.**

Appendix 4 – 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. Community services data is now included, and historical data has been refreshed to update the SPC charts.
	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, E. coli, Klebsiella, CDI and PA Gram Negative)	**2**	Methicillin-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.		Community services data is now included, and historical data has been refreshed to update the SPC charts.
		Falls per 1000 bed days in month.		Community services data is now included, and historical data has been refreshed to update the SPC charts.
	9	Total number of inpatient falls which have occurred in month.	10% decrease from	Community services data is now included, and historical data has

			previous year	been refreshed to update the SPC charts.
		Levels of harm reported as a result of a fall in month for inpatient and ED falls.		
Pressure Ulcers	**10**	Acute - Total Pressure Ulcers (Category 2)	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).
	11	Acute - Total Pressure Ulcers (Category 3 & 4)	20% reduction on previous year	
	12	Community Acquired Pressure Ulcers (Category 2)	20% reduction on previous year	
	13	Community Acquired Pressure Ulcers (Category 3 and above)	20% reduction on previous year	
HSMR Mortality Ratio	**14**	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.		
SHMI Mortality Ratio	**15**	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.		
Medication Safety	**16**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
Medication Incidents	**17**	Acute Medication Incidents		
	18	Community Medication Incidents		
Staffing Average Fill Levels	**19**	Staffing - Average Fill Rate - Day nurses/midwives	>=90%	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. Community services data is now included, and historical data has been refreshed to update the SPC charts.
	20	Staffing - Average Fill Rate - Day care staff		
	21	Staffing - Average Fill Rate - Night nurses/midwives		
	22	Staffing - Average Fill Rate - Night care staff		
Complaints		Number of new complaints.		Community services data is now included, and historical data has

				been refreshed to update the SPC charts.
	23	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)	**24**	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%	
Friends and Family (ED and UCC)	**25**	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%	
Friends and Family (Community)	**26**	Percentage of Community patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	90%	
Mixed Sex Accommodation Breaches (ITU)	**27**	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	**28**	Sepsis Emergency Patient Screening Blood cultures (within 1 hr)	>=90%	
	29	Sepsis Inpatient Screening Blood cultures (within 1 hr)	>=90%	
	30	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	
	31	Sepsis Inpatient Patient Antibiotics (within 1hr)	>=90%	
		Sepsis Emergency Patient Antibiotics (within 6hrs)	100%	
		Sepsis Inpatient Patient Antibiotics (within 6hrs)	100%	
Acute Kidney Injury	**32**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Average Length of Stay (LoS) of patients within an AKI.		
Postpartum Haemorrhage >1500ml	**33**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against Northwest Coast Regional Dashboard.	<3.7%	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against Northwest 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 Northwest Coast Maternity Dashboard.
Fractured Neck of Femur	**34**	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
		% of patients receiving surgery within 36hrs of admission		

				(nhfd.co.uk)). Shorter time to theatres significantly reduces risk of mortality and improves pain.
MUST nutritional assessment completion	**35**	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. Community services data is now included, and historical data has been refreshed to update the SPC charts.
Duty of Candor	**36**	Duty of Candor Compliance	100%	Initial Duty of Candor completed within 10 working days (by date letter sent). Community services data is now included, and historical data has been refreshed to update the SPC charts.
Access & Performance				
Under 4-hour A&E Wait time Target and ICS Trajectory (excluding WWIC)	**37**	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)	**38**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78%	Before integration with Bridgewater, 50% of Widnes UTC's 4-hour performance was included in WHH data. From 1st April, 100% of Widnes UTC performance will count toward NCM's 4-hour A&E metric.
Average Time in Department (ED)	**39**	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.	**40**	% 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	**41**	% 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
Ambulance Vehicle Handovers within 30 mins	**42**	% 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	**43**	% of ambulance handovers that took place within 45 minutes (based on the data recorded on the HAS system).	100%	vehicle handover (A2VH), replacing the previous arrival to patient handover (A2PH) metrics. These changes aim to improve consistency, operational clarity, and performance reporting.
Type 5 Activity	**44**	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.
Percentage of UTC attendances referred on to A&E	**45**	Percentage of UTC attendances referred on to A&E		Combined position from both Widnes and Runcorn UTC, using data that is already flowing via Emergency Care Data Set (ECDS) to NHS England.
Fracture Clinic	**46**	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	**47**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	Community Paediatric Audiology data is now included, and historical data has been refreshed to update the SPC charts.
RTT Open Pathways and 52 & 65 week waits	**48**	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.
	49	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	**50**	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. Community dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Cancer 31 Day wait	**51**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat. Community

				dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Cancer 62 Day wait	**52**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat. Community dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Reduction in Outpatient Follow Ups	**53**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
Elective Recovery Activity	**54**	% of Elective Activity (Inpatients)	104%	
		% of Elective Activity (Day cases)	104%	
Elective Recovery Diagnostics	**55**	% 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	**56**	% of Elective Recovery Outpatient Activity	104%	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	57	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)	**58**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Super stranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
	59	Average number of days from discharge ready date to actual discharge date		NHS Oversight Framework Indicator which benchmarks the average delay to discharge from when the patient is ready for

				discharge to the date of discharge.
% Patients discharged to their usual place of residence	**60**	% of patients who were discharged to their usual place of residence.		
Cancelled operations on the day for non-clinical reasons	**61**	% 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	**62**	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)	**63**	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.
Urgent Community Response (UCR) 2 Hour Compliance	**64**	Urgent Community Response (UCR) 2 Hour Compliance	>=70%	NHS Oversight Framework Indicator. Percentage of urgent community response referrals seen within 2 hours
Percentage of Patients Waiting over 52 weeks for community services (excluding dental and dermatology)	**65**	Percentage of Patients Waiting over 52 weeks for community services (excluding dental and dermatology)	0%	NHS Oversight Framework Indicator. Currently the Community services sitrep submission does not allow for dental or dermatology waiters to be submitted which impact the national position used on the NHS Oversight Framework.
Number of Patients waiting over 104+ weeks to access community services (excluding	**66**	Number of Patients waiting over 104+ weeks to access community services (excluding dental and dermatology)	0	Oversight on the number of patients submitted nationally via the Community services sitrep which does not allow for dental or dermatology waiters to be included.

dental and dermatology)				
Number of Patients waiting over 52 weeks to access community services (including dental and dermatology)	**67**	Number of Patients waiting over 52 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 52 weeks to access community services including dental and dermatology.
Number of Patients waiting over 65 weeks to access community services (including dental and dermatology)	**68**	Number of Patients waiting over 65 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 65 weeks to access community services including dental and dermatology.
Number of Patients waiting over 104 weeks to access community services (including dental and dermatology)	**69**	Number of Patients waiting over 104 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 104 weeks to access community services including dental and dermatology.
Workforce				
Supporting Attendance	**70**	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<5%	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Workforce FTE Plan Compliance	**71**	Workforce FTE Plan Compliance	100% plan	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Core / Mandatory Training	**72**	Percentage 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. Community services data is now included, and historical data has been refreshed to update the SPC charts.
Performance & Development Review (PDR)	**73**	Percentage of the PDR compliance.	>85%	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Finance				

Trust Financial Position	**74**	Cumulative operating surplus or deficit compared to plan.	Plan	
		In month operating surplus or deficit compared to plan.	Plan	
Cash Balance	**75**	The cash balance at month end compared to plan.	Plan	
Capital Programme	**76**	Capital expenditure compared to plan.	Plan	
Better Payment Practice Code	**77**	Payment of non-NHS trade invoices within 30 days of invoice date compared to target.	>95%	
Cost Improvement Programme – Plans in Progress in Year	**78**	Cost savings schemes in-year compared to plan.	>90% of annual target	
		CIP - In Year	plan	
Cost Improvement Programme – Recurrent	**79**	Cost savings schemes recurrent compared to plan.	>90% of annual target	
		Recurrent CIP - In Year	Plan	
Agency Reduction	**80**	Agency Reduction	30% reduction of 24/25 plan.	
Bank Reduction	**81**	Bank Reduction	10% reduction of 24/25 plan.	

Appendix 5 - Statistical Process Control

1.0 What is SPC?

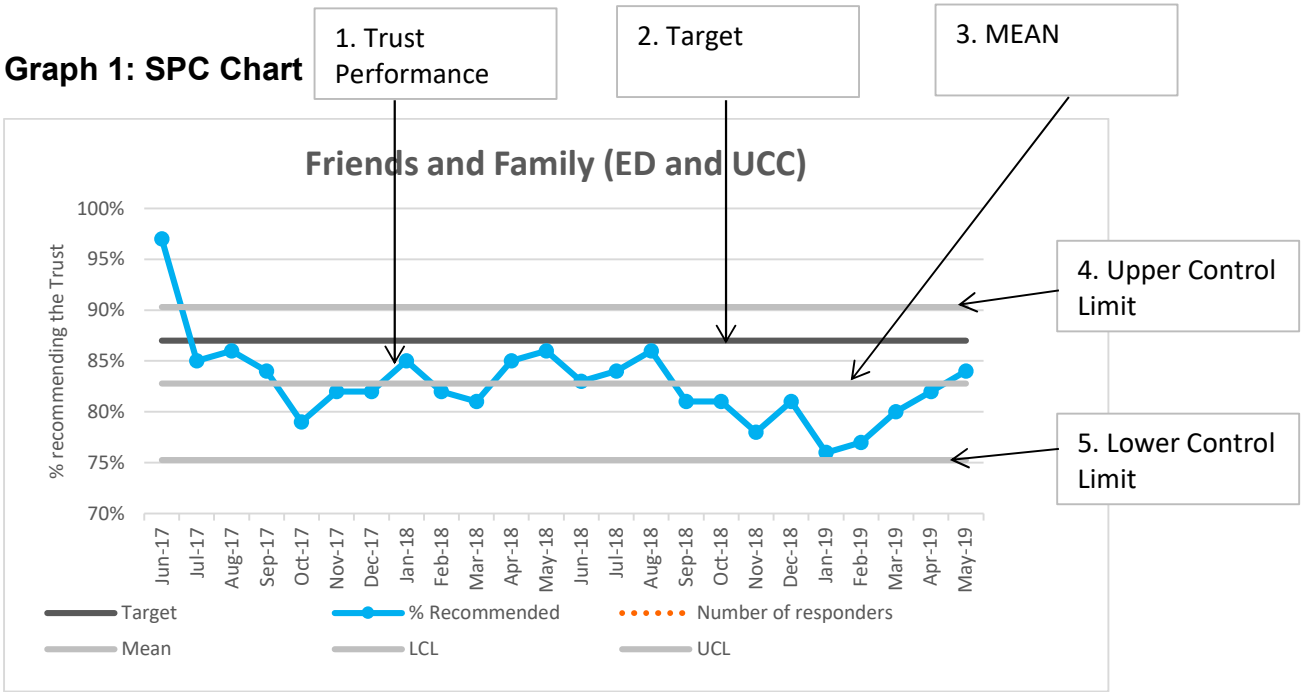
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

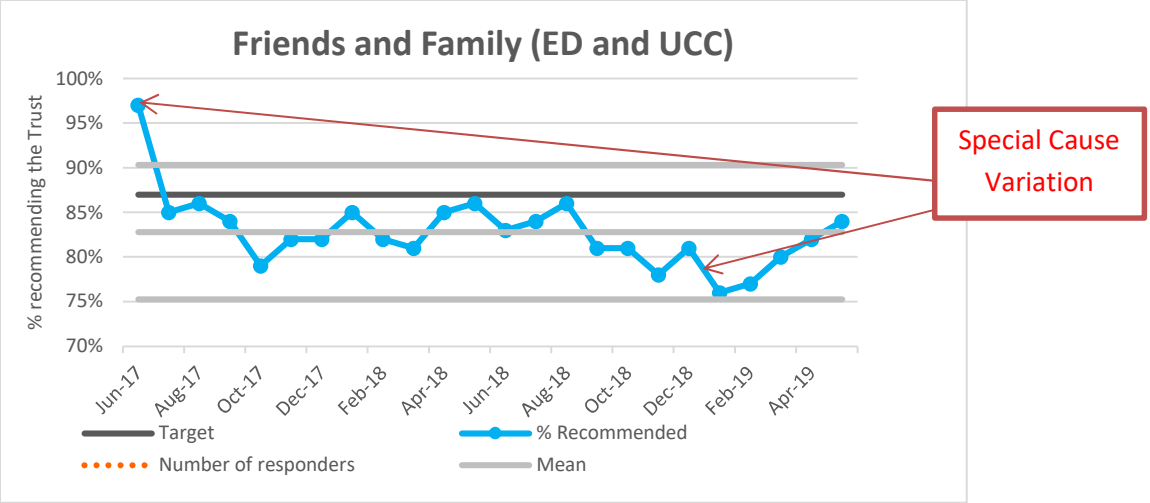


2.1 Interpreting a SPC Chart

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.

North Cheshire & Mersey NHS Foundation Trust **Appendix 6**

Income Statement at 30th June 2026

	Annual	Month			Year to date		
Income Statement	**Budget £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**
Operating Income							
NHS Clinical Income	**439,758**	**37,707**	**36,692**	**-1,015**	**109,252**	**107,382**	**-1,869**
Non NHS Clinical Income							
Private Patients	8	0	1	1	2	2	0
Non NHS Overseas Patients	72	6	19	13	18	37	19
Other non protected	818	68	85	17	205	146	-58
Community & Dental - Non NHS	16,084	1,401	1,513	111	4,165	4,111	-54
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**16,982**	**1,476**	**1,618**	**142**	**4,390**	**4,297**	**-93**
Other Operating Income							
Training & Education	13,646	1,077	1,059	-19	3,411	3,359	-53
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	18,387	1,709	1,382	-328	4,606	4,282	-325
Sub total	**32,033**	**2,787**	**2,440**	**-346**	**8,018**	**7,640**	**-377**
Total Operating Income	**488,773**	**41,969**	**40,750**	**-1,219**	**121,659**	**119,320**	**-2,339**
Operating Expenses							
Employee Benefit Expenses	-361,547	-31,857	-31,200	657	-93,309	-93,475	-166
Drugs	-24,238	-2,031	-1,823	208	-6,287	-5,605	682
Clinical Supplies and Services	-30,836	-2,691	-3,145	-454	-8,547	-8,327	221
Non Clinical Supplies	-71,579	-6,555	-5,868	687	-19,124	-18,759	365
Depreciation and Amortisation	-25,254	-2,137	-2,088	48	-6,314	-6,265	49
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	**-513,454**	**-45,271**	**-44,124**	**1,147**	**-133,581**	**-132,431**	**1,150**
Operating Surplus / (Deficit)	**-24,681**	**-3,302**	**-3,374**	**-72**	**-11,921**	**-13,111**	**-1,190**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0
Interest Income	842	70	152	82	210	471	261
Interest Expenses	-524	-44	-37	7	-132	-126	6
PDC Dividends	-6,777	-565	-565	0	-1,694	-1,694	0
Total Non Operating Income and Expenses	**-6,459**	**-539**	**-449**	**89**	**-1,616**	**-1,348**	**267**
Surplus / (Deficit) - as per Accounts	**-31,140**	**-3,841**	**-3,824**	**17**	**-13,537**	**-14,460**	**-922**
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	57	56	-2	167	167	0
Total Adjustments to Financial Performance	**669**	**58**	**56**	**-2**	**167**	**167**	**0**
Adjusted Surplus / (Deficit) as per NHSE Return	**-30,471**	**-3,783**	**-3,768**	**15**	**-13,370**	**-14,292**	**-922**

North Cheshire and Mersey
NHS Foundation Trust

IPR – June 2026 Detail

Home
Community
Hospital

Introduction

There are **2 Indicators that has been requested via the Action Log to be monitored going forward,** This is:

- **38. A&E Waiting Times** - Under 4 hour wait (% excluding WUTC)
- **39. A&E Waiting Times** – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge – Target 2% or less

There are **4 Indicators that has been highlighted via the latest published NHS Oversight Framework metrics table** that are also not reported as exceptions, They are:

- **4. Healthcare Acquired Infections (CDI)** - Threshold 65 (for 2026/27)
- **5. Healthcare Acquired Infections (E.coli)** - Threshold 75 (for 2026/27)
- **59. Average number of days from discharge ready date to actual discharge date** – Target 1 day or less
- **74. Trust Financial Position** – Plan

There are **3 indicators that are both failing and have special cause variation of a concerning nature**, these are:

- **65. Percentage of patients over 52 weeks for community services (excluding dental and dermatology)** – Target 0%
- **66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology)** – Target zero
- **69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology)** – Target zero

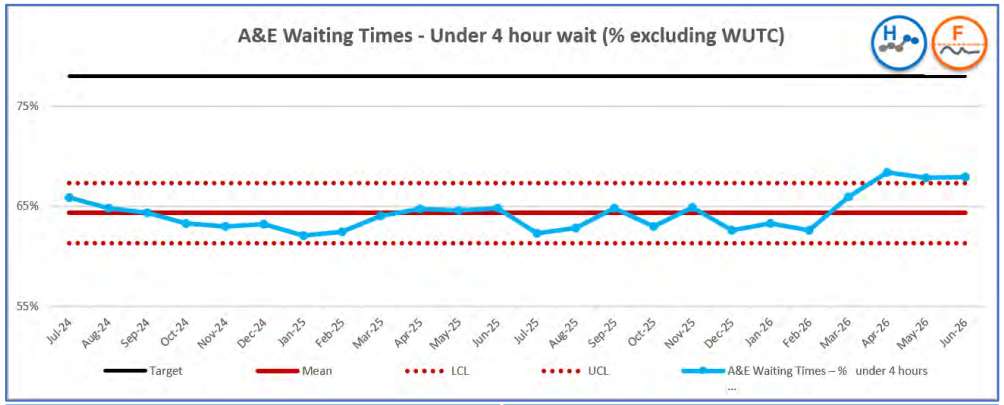
There are **2 indicators that consistently fail and cannot be measured for variation**, these are:

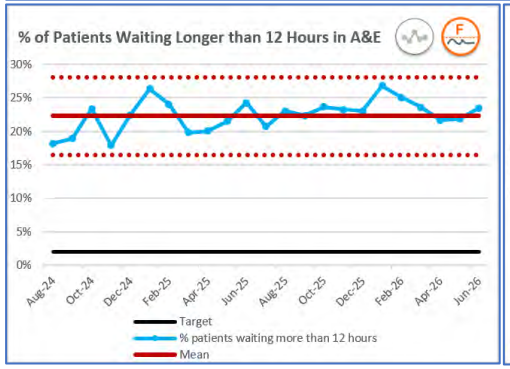
- **79. CIP (recurrent) –** % delivered against plan
- **81. Bank Reduction –** delivery against 10% reduction of 2025/26 plan

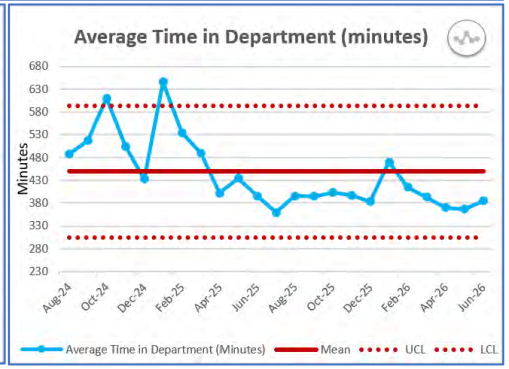
June 2026 IPR by Exception

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

39. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.







Acute Provider Table Update

A&E 4-hour performance
53 out of 118
Sourced: Acute Provider Table
June 26 data published July 26

A&E 12-hour performance
117 out of 118
Sourced: Acute Provider Table
June 26 data published July 26

Reasons for variation and what is the impact

Continued **high bed occupancy** (>96%) causing Admitted breaches across both pathways. This is driven by several factors including

- Average No Criteria To Reside levels at c23% (WBC accounts for c75% of the hospitals activity so has a bigger impact)
- Challenges in **maintaining wait to be seen** (WTBS) stemming from several internal workforce challenges and process delays. This is causing avoidable non admitted and paediatric breaches. Some of these reasons include:
- Miss alignment with demand and staffing capacity in the evening and overnight leading to long WTBS in the morning that isn't recovered – demonstrated through ECIST analysis.
- **ED footprint constraints**. WHH ED was last extended in the 1990's and built for c100 attendances per day. This is now closer to c250.
- Lack of a co-located **Urgent Treatment Centre** in Warrington to support deflection and alternatives pathways for patients to access non-Accident and Emergency care.
- The closest UTC is in Halton, which is a 10-mile, 20–30-minute drive.

How are we going to improve the position

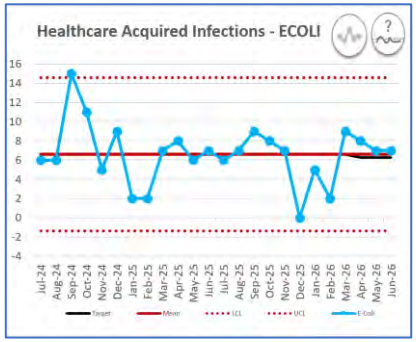
- Comprehensive improvement plan in place which covers both 4 hour and 12-hour impact- this is both internal improvements as well as system led external improvements to support reduction in NCTR
- Key interventions include:
- Focus on improving board rounds including setting a clear criteria for discharge
- Maximised use of discharge lounge to create earlier flow
- Maximised use of assessment areas
- Making 'Home first' the default position
- Adherence to clinical operational standards
- Continue to implement ICAHT and SW in-reach to support with timely discharge

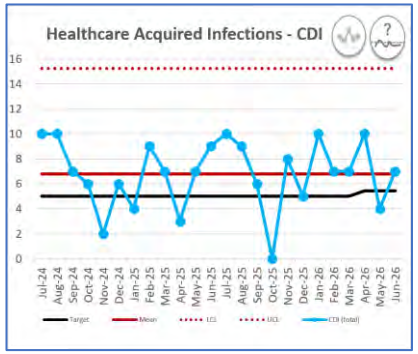
June 2026 IPR by Exception

4. Healthcare Acquired Infections (CDI) - Threshold 65 (for 2026/27) **&**
5. Healthcare Acquired Infections (E.coli) - Threshold 75 (for 2026/27)

Both quality indicators have been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for June 26.

Patient Safety			Current Qtr. Published				Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Reporting Date**	**Metric Score**	**Rank**
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Apr 25 - Mar 26	2.07	Not Ranked	▲	Jan 25 - Dec 25	1.00	Not Ranked
Patient Safety	Proportion of C. difficile infections	Quarterly	Apr 25 - Mar 26	3.33	Not Ranked	▲	Jan 25 - Dec 25	3.20	Not Ranked





Reasons for variation and what is the impact

- June 2026 NHS Oversight Framework data uses a rolling 12-month period Q4 2025/26 included April 25 to March 26
- The Trust is not currently identified as a high outlier for HCAI case numbers or rates.
- Changing population demographics, including an increasing proportion of older people, may be contributing to the rise in Gram-negative bloodstream infection cases.
- Increases in Clostridioides difficile infection and MSSA bacteraemia cases are also being seen nationally.
- NHSE HCAI thresholds for 2026/27 are awaited

How are we going to improve the position

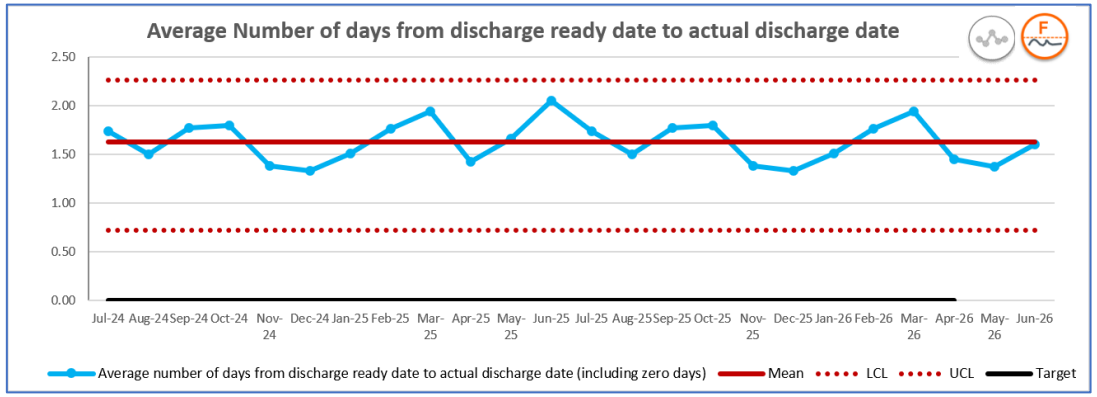
- A comprehensive CDI Prevention Action Plan remains in place, with ongoing ribotyping, enhanced surveillance and antimicrobial stewardship oversight. Opportunities to expand probiotic use and strengthen environmental cleaning controls continue to be reviewed.
- For *E. coli, Klebsiella* spp. and *Pseudomonas aeruginosa* bloodstream infections, CAUTI surveillance and targeted implementation of the UTI Prevention Toolkit continue to provide assurance and support the reduction of avoidable infections.

June 2026 IPR by Exception

59. Average number of days from discharge ready date to actual discharge date

This indicator has been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for June 26.

Effectiveness and experience			Current Qtr. Published				Previous Qtr. Published		
Sub-domain	Description	Refreshed	Reporting Date	Metric Score	Rank	Trend	Reporting Date	Metric Score	Rank
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quarterly	Mar-26	3.91	**124** out of 128	▲	Dec-25	3.45	**104** out of 126



Reasons for variation and what is the impact

- The Trust continues to monitor this inline with the operational planning guidance
- Delays in Warrington Place are driving this delay; this is largely as a result of workforce constraints in the Council

How are we going to improve the position

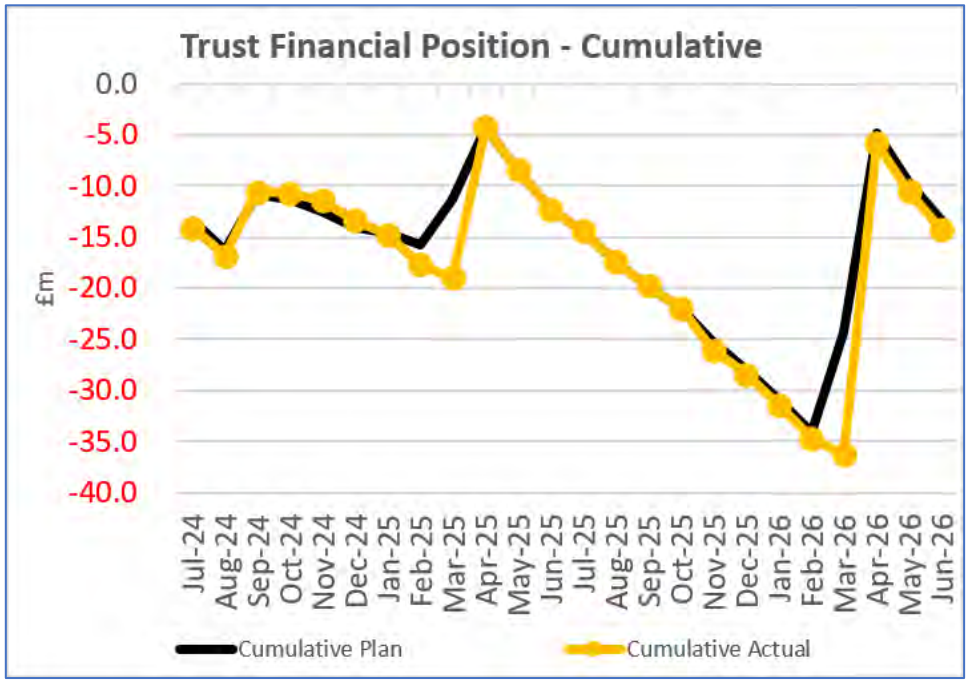
- The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available. Hospital delays are monitored through the daily bed meetings

June 2026 IPR by Exception

74. Trust Financial Position – Plan

This indicator has been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for June 26.

Finance and productivity			Current Qtr. Published				Previous Qtr. Published		
Sub-domain	Description	Refreshed	Reporting Date	Metric Score	Rank	Trend	Reporting Date	Metric Score	Rank
Finance	Planned surplus/deficit	Quarterly	Q4 2025/26	4.00	**126** out of 134	▶	Q3 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Month 12 2025/26	4.00	**132** out of 134	▲	Month 9 2025	4.00	**121** out of 134



Reasons for variation and what is the impact

At month 3 the Trust has recorded a deficit position of £14.3m which is £0.9m worse than plan.

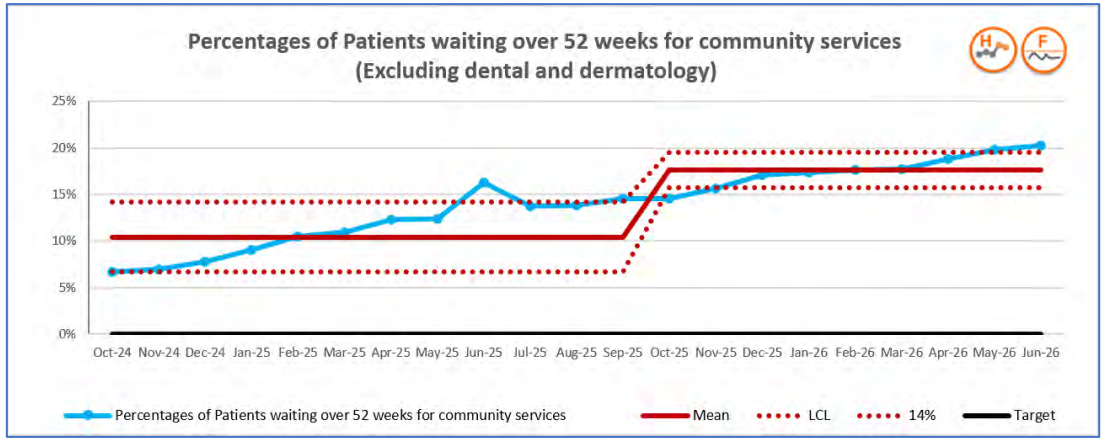
At month 3, the deficit position is £0.9m worse than plan due to the impact of industrial action in April.

How are we going to improve the position

Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.

June 2026 IPR by Exception

65. Percentage of patients over 52 weeks for community services (excluding dental and dermatology) – Target 0%



Reasons for variation and what is the impact

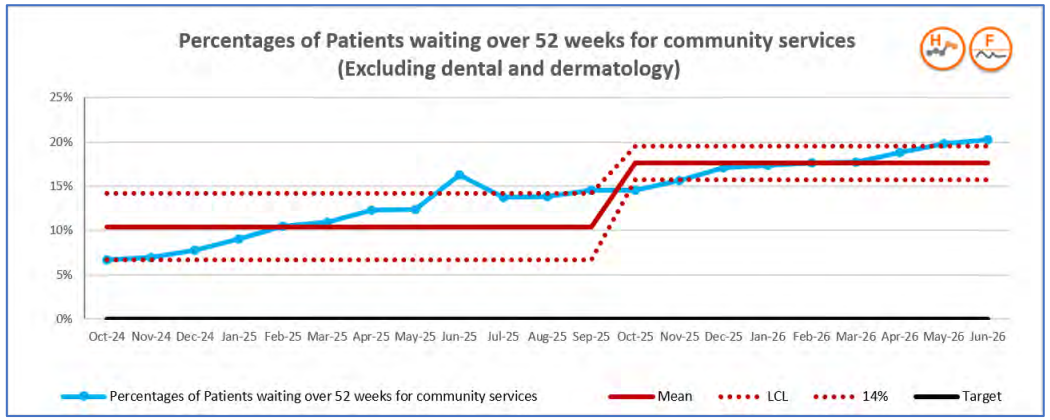
- Patients waiting longer than 52 weeks - 2 Podiatry patients (Halton), 1 has been seen, 1 has declined an appointment the service are working to try and convert a slot to bring them in. 2 in SMI Health Assessment Service. The service have concluded that these are data quality errors, the records will be corrected at source and are not expected to breach next month. The remaining patients are children awaiting an appointment for the Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton.

How are we going to improve the position

- Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue.

June 2026 IPR by Exception

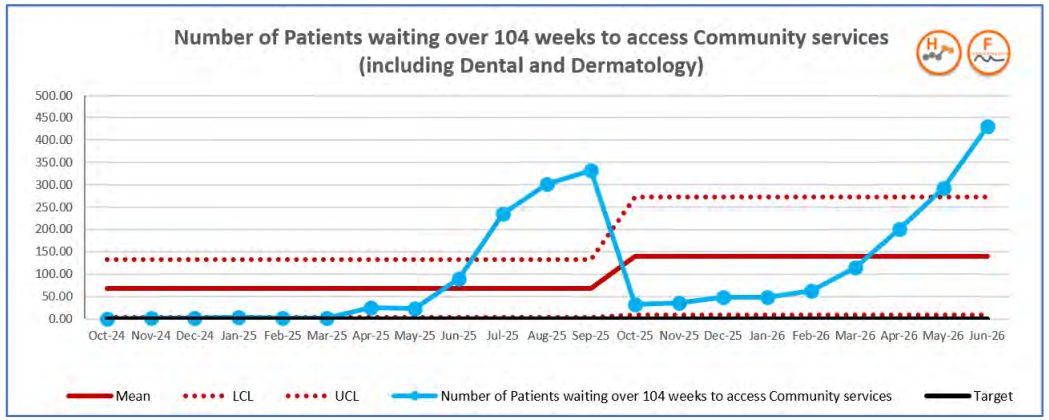
66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology)



Reasons for variation and what is the impact

- Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. There is one other patient in this category for the SMI Assessment service, the service have concluded that this is a data quality error, the record will be corrected at source and is not expected to breach next month.

69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology)

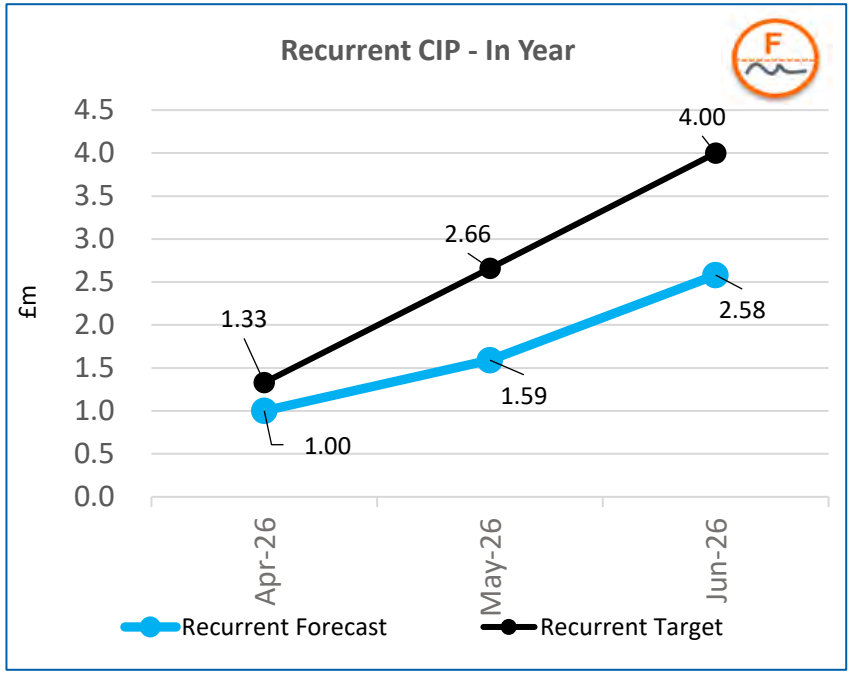


How are we going to improve the position

- Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue

June 2026 IPR by Exception

79. Cost Improvement Programme (recurrent) – In year performance to date



Reasons for variation and what is the impact

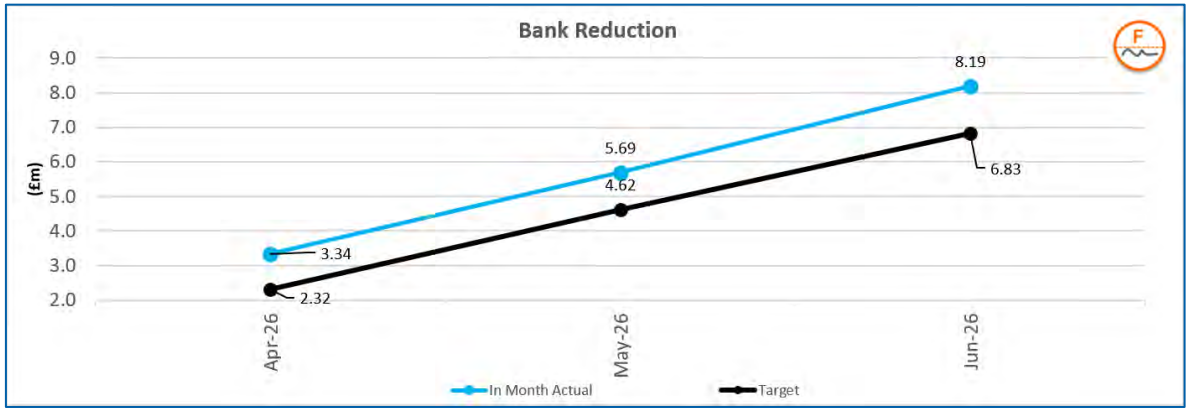
- £2.6m CIP has been delivered recurrently against the target of £4m.
- The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2027/28.
- 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.

How are we going to improve the position

- 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.

June 2026 IPR by Exception

81. Bank Reduction – delivery against 15% reduction of 2025/26 plan



Reasons for variation and what is the impact

- At month 3 bank expenditure is overspent by £1.4m. £1m is due to the impact of April Industrial Action and the remainder is mainly driven by UEC nursing and LTFT medical staff in surgery.

How are we going to improve the position

- 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.

Recalculations

There are **no indicators with new recalculation points applied** to improve the accuracy of the SPC charts in identifying significant shifts in process variation.

Recommendation

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049a(i)	**Date of Board meeting:**	5 August 2026

Date of meeting:	9 June 2026
Name of meeting and chair:	Quality and Safety 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 reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QSAC/26/06/056	**Deep Dive – Maternity: PPH, ATAIN, Coronial Reports**	The Committee received a maternity deep dive covering postpartum haemorrhage (PPH), avoiding term admissions into neonatal units (ATAIN), coronial referrals and neonatal safety intelligence. Assurance was received that improvement plans, multidisciplinary reviews and learning processes are in place. Whilst performance remains below the level expected in some areas, further work is underway to strengthen action planning, instrumental birth pathways and alignment with regional guidance.	**Moderate**	**Substantial**	Via standing reports to Committee.

QSAC/26/06/061	**ED Performance**	The Committee reviewed Emergency Department performance and quality indicators. Ongoing pressures relating to patient flow, long waits and capacity were noted, together with the impact on patient experience. Assurance was received regarding actions to improve discharge processes, reduce corridor care and strengthen system-wide working, alongside improvements in several patient safety metrics.	**Moderate**	**Substantial**	Via standing reports to Committee.
QSAC/26/06/062	**Typing Backlog**	The Committee noted significant progress in reducing the clinical correspondence backlog and received assurance that the remaining legacy backlog was expected to be cleared ahead of the transition to the Lyrebird system. The Committee was assured that arrangements were in place to support a safe transition and prevent recurrence, with ongoing monitoring to continue following implementation.	**Substantial**	**Substantial**	Any further issues to be presented back to the Committee by exception.

QSAC/26/06/063	**Fragile Services/ Patient Safety and Clinical Effectiveness Sub Committee Exception Report**	The Committee received assurance regarding a number of fragile services and patient safety priorities, including chronic pain, urology, outpatient follow-up management and sepsis. Progress was noted in developing sustainable service models and reducing clinical risk. Further work is underway to establish a Trust-wide approach to outpatient transformation and backlog reduction.	**Moderate**	**Substantial**	Via standing reports to Committee.

Further items discussed and received for assurance:
QSAC/26/06/057 Hot Topic – Lower limb immobilisation /VTE prophylaxis/prescribing responsibilities
QSAC/26/06/058 Hot Topic – Rheumatology
QSAC/26/06/059 Quality IPR Metrics
QSAC/26/06/060 Compliance Update – Quarter Four
QSAC/26/06/064 Fractured Neck of Femur Update
QSAC/26/06/065 Learning from Deaths Review – Quarter Four
QSAC/26/06/066 Quality Account – Final Version
QSAC/26/06/067 Learning from Experience Report – Quarter Four
QSAC/26/06/068 Six-month Chief Nurse Staffing Report – safer staffing report
QSAC/26/06/069(i) Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
QSAC/26/06/069i (ii) Avoiding Term Admission into Neonatal Unit (ATAIN) Quarter Four – item deferred to July
QSAC/26/06/069i (iii) Maternity and Neonatal Quality Review Report
QSAC/26/06/069i (iv) Transitional Care Audit – Quarter Four – item deferred

Items received for information:
QSAC/26/06/071 Quality Priorities Report
QSAC/26/06/072 BCH PSIRF Report
QSAC/26/06/073 BCH Complaints Report
QSAC/26/06/074 Enabling Strategy Alignment Progress Biannual Report
QSAC/26/06/075 Minutes from the Research Oversight Sub Committee – deferred to July

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 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 could/has resulted in failure to achieve the system objectives.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049a(ii)	**Date of Board meeting:**	5 August 2026

Date of meeting:	14 July 2026
Name of meeting and chair:	Quality and Safety 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 reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QSAC/26/07/082	**Patient Story - Experience as a patient with complex needs**	The Committee received a patient and carer story describing the experience of accessing urgent and emergency care for a young person with complex needs during the transition between children's and adult services. The account highlighted the importance of timely reasonable adjustments, clear transition planning, staff awareness and coordinated communication across pathways. Assurance was received on actions already taken, including targeted autism and learning disability training, improved patient alerts, learning disability care bags, patient	**N/a**	**N/a**	Progress on learning disability, autism and transition pathway improvements to be monitored through existing governance arrangements.

		and carer information, planned identification wristbands, senior clinical oversight at reception and work to develop a quiet or sensory space. The Committee noted that the learning extended beyond the Emergency Department and should inform wider improvements in person centred care for young people with complex needs.			
QSAC/26/07/083	**Deep Dive - Community Equipment Services**	The Committee received a deep dive on Community Equipment Services and noted progress in leadership, governance, workforce stability, training, incident reporting, equipment servicing and infection prevention and control. Assurance was received that improvement work was in place and that the servicing backlog remained on trajectory for clearance. The Committee noted that further assurance was required on the pace of backlog reduction, waiting times, vacancy levels, delivery performance and the impact of service pressures on patients. A further update was requested in three months to confirm that outstanding servicing, governance and improvement actions remain on track.	**Moderate**	**Moderate**	The Committee would receive a further update in 3 months time (October 2026).
QSAC/26/07/092	**Neurodevelopment Update**	The Committee received an update on the Neurodevelopmental Assessment Pathway and noted continued pressures from rising demand for autism and ADHD diagnostic assessments without a corresponding	**Moderate**	**Substantial**	A further progress update would be presented to the

		increase in commissioned capacity. Assurance was received that children on the waiting list had been risk stratified, with available capacity prioritised for those with greatest clinical need, and that clinical harm reviews and weekly monitoring arrangements were in place. The Committee recognised the significant work being undertaken to manage clinical risk but remained concerned about the underlying gap between demand and available resource. A strategic options paper is due to be considered by EMT, and a further update was requested for September 2026.			Committee in September 2026.
QSAC/26/07/093	**Mental Health Update**	The Committee received the Mental Health Update and noted that the wider improvement programme remained largely on track, with continued demand for mental health support and ongoing focus on violence and aggression. Assurance was received that incidents had reduced and that a revised Violence and Aggression Strategy would be presented in September 2026. The Committee considered the Section 136 pathway and supported the current safety based position, recognising the need for any future pathway change to be clinically safe, sustainable and supported by an appropriate care environment. Continued work with system partners will inform future	**Moderate**	**Substantial**	Committee to receive further update in September 2026.

		options for a co located mental health facility.			
QSAC/26/07/095	**Mortuary Report**	The Committee received the quarterly Human Tissue Authority and Mortuary Services update and was assured that mortuary services continued to operate in compliance with HTA standards, with no significant areas of concern or regulatory non compliance identified. The Committee noted that a formal Board level Statement of Assurance had been requested and that governance teams were coordinating the response. A small number of open actions from previous reviews and a recent UKAS visit remained subject to active monitoring through existing governance arrangements. Members also noted the importance of maintaining Board visibility of mortuary services and agreed that increased Board awareness of the service would be beneficial.	**Substantial**	**Substantial**	Action would be taken to progress the statement of assurance for sign off within submitted timescales (by 31 July 2026).

Further items discussed and received for assurance:
QSAC/26/07/084 Hot Topic - Sepsis
QSAC/26/07/085 Patient Safety and Clinical Effectiveness Sub Committee Exception Report Including Mortality Update
QSAC/26/07/088 Fractured Neck of Femur Update Including quarter by quarter mortality data
QSAC/26/07/089 Surgical Site Infection Update
QSAC/26/07/090 MIAA Theatre Safety Audit Update – deferred to September
QSAC/26/07/091 Radiology Update
QSAC/26/07/094 Maternity Reports
(i) Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
(ii) Avoiding Term Admission into Neonatal Unit (ATAIN) Q4
(iii) Maternity & Neonatal Quality Review Report
(iv) Transitional Care Audit Q4
QSAC/26/07/096 Impact of Incident Management Training on Classification and Duty of Candour for Community Services
QSAC/26/07/097 Infection, Prevention and Control BAF
QSAC/26/07/098 High Level Enquires and External Assessment/Inspections

Items received for information:
QSAC/26/07/099 BCT Integration and Due Diligence Update
QSAC/26/07/100 Committee Chair's Annual Report
QSAC/26/07/101 Quality Impact Assessment high level briefing paper
QSAC/26/07/102 Minutes from the Research Oversight Sub Committee

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 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 could/has resulted in failure to achieve the system objectives.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049a(iii)	**Date of Board meeting:**	5 August 2026

Date of meeting:	28 July 2026
Name of meeting and chair:	Extraordinary Quality and Safety 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 reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QSAC/26/07/109	**Controlled Drugs Annual Report**	The Committee received the annual Controlled Drugs Report and was assured that controlled drugs governance arrangements remained effective, with no severe harm incidents reported during the year. Increased incident reporting reflected an improving reporting culture, alongside strengthened arrangements to reduce diversion risk and enhance monitoring. The Committee also reviewed the position regarding the Home Office Controlled Drugs Licence and was assured that interim supply arrangements with East Cheshire remain in place pending regulatory resolution.	**Substantial**	**Moderate**	Further update on the licence position to be provided by exception.

QSAC/26/07/110	**Nursing and Midwifery Strategy Annual Report**	The Committee received the annual Nursing and Midwifery Strategy Report and noted continued progress across key priorities including Duty of Candour compliance, falls reduction, leadership development, PSIRF implementation and multidisciplinary working. Assurance was also received regarding the positive impact of integration and strengthened nursing leadership arrangements. The Committee was informed that the integrated nursing teams had received excellent feedback following a recent SEND inspection.	**Substantial**	**Substantial**	No further action required.
QSAC/26/07/113	**Director of Infection Prevention and Control (DIPC) Annual Report**	The Committee received the annual Director of Infection Prevention and Control Report. Whilst healthcare associated infection performance remained below the desired level in a number of areas, assurance was received regarding ongoing improvement work, audit compliance, environmental hygiene activity and antimicrobial stewardship arrangements. The Committee requested a future deep-dive review to further examine recurring infection themes and opportunities for improvement.	**Moderate**	**Substantial**	Committee to receive a dedicated deep dive review.
QSAC/26/07/116	**Board Assurance Statement in relation to Nottingham**	The Committee reviewed the proposed Board Assurance Statement in response to NHS England requirements arising from the Nottingham maternity review. The	**Substantial**	**Substantial**	Revised Board Assurance Statement to be considered

	Maternity and Neonatal Review findings on post-death care	Committee noted that the Trust was compliant with all but one assurance requirement relating to governance arrangements across bereavement and associated services. Assurance was received that improvement work was already underway and the Committee requested that the revised narrative clearly set out the remaining gap, actions and anticipated timescales for achieving full compliance. No immediate patient safety concerns were identified.			and approved prior to submission.

Further items discussed and received for assurance:
QSAC/26/07/108 Medicines Management Annual Report
QSAC/26/07/111 Dementia Strategy Annual Report
QSAC/26/07/112 Risk Management Strategy Annual Report – deferred to September
QSAC/26/07/114 Safeguarding Update Report (inc. Annual Report)
QSAC/26/07/115 Organ Donation Annual Report

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 controls are generally being applied consistently.
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049b(i)	Date of Board meeting:	5th August 2026

Date of meeting:	17 June 2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPC/26/06/045	**Deep Dive – staff survey – protected characteristics**	The Committee received a deep dive into the staff survey results with a focus on protected characteristics. Important to note the Lord Mann review and that all recommendations have been approved. Primary focus on 3 characteristics, race, disability and sexual orientation. The Committee noted the key findings of the deep dive and recommended actions. Further consideration of Board development in this area to be considered, including the completion of active bystander training.	**Moderate**	**Substantial**	Quarterly
SPC/26/06/046	**Hot Topic – AfC Job Evaluation (Annex 31)**	The Committee received a presentation following the publication of Job Evaluation standards for Agenda for Change staff (Annex 31 of T&Cs), and the national review of the Band 5 nursing competency profile.	**Moderate**	**Substantial**	August 2026

		The Committee noted and were assured by the progress to date with a request for the delivery plan to come to SPC in August 2026. There is an emerging risk being overseen by the Task and Finish group regarding any potential role reviews and changes to banding. This is also being monitored regionally via the Deputy and CPO networks.			
SPC/26/06/049	**Workforce Plan Update**	The Committee received a paper detailing the workforce plan as at month 2. The Committee were assured by the update and recognise the challenge to deliver with the actions being taken across the organisation to support delivery of the plan.	**Substantial**	**Substantial**	Monthly
SPC/26/06/050	**Health and Wellbeing Biannual Update**	The Committee received a paper in relation to the Health and Wellbeing Guardian biannual update. The Committee acknowledged that the Trust has a number of wellbeing offers to support staff. There was discussion regarding what impacts employee wellbeing as not just employee health, includes wider impacts such as corridor care, system pressures. Agreed to include wellbeing from a culture lens as well as intervention approach in future reports.	**Substantial**	**Substantial**	December 2026
SPC/26/06/051	**Gender Pay Gap Report**	The Committee received a paper in relation to the gender pay gap reports for WHH and BCH for approval. The committee approved the report and requested the detailed action plan come back for further discussion as a deep dive.	**Moderate**	**Substantial**	July 2026
SPC/26/06/055	**National Education and Training Survey (NETS) reporting**	The Committee received a paper in relation to the national education and training survey (NETS) reporting. The committee noted the survey's findings and that the findings from the survey were not at the standard	**Moderate**	**Substantial**	Within 4 months

		expected, with a particular discussion regarding student training in maternity. The committee received feedback that maternity was receiving significantly more students than comparators, impacting learning opportunities, and sickness of the practice education facilitator has also impacted access to learning opportunities. This is being addressed through an internal task and finish group. The Committee were made aware of the NETS score inclusion in the NOF from 26/27. The Committee requested for a deep dive update on the action plan with a particular focus on maternity.			

The Committee also received the following reports:
Reports for Assurance:
SPC/26/06/047 – Chief People Officer Report
SPC/26/06/048 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
SPC/26/06/052 – Safer Staffing Report – including red flag data
SPC/26/06/053 – Midwifery Staffing Report – Q4
SPC/26/06/054 – Annual Volunteer 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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North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049b(ii)	Date of Board meeting:	5th August 2026

Date of meeting:	15th July 2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPC/26/07/064	**Staff Story – Staff Networks (Women's and Disability Awareness Networks)**	The Committee received a Staff Story from the Women's and Disability Awareness Staff Networks. The Committee noted the significant levels of workforce engagement undertaken with staff who share specific characteristics, with programmes focused on neurodiversity awareness, menopause, period dignity and reasonable adjustments. The Committee discussed that due to operational capacity of services and teams, not all staff are able to frequently access the networks, however, work is underway to ensure this can be planned into rosters in advance to support both safe staffing and network engagement.	**Substantial**	**Substantial**	N/A

		The Committee positively noted the impact of staff networks aligned to the EDI strategic objectives as well as overall staff experience and wellbeing. Future staff stories will focus on other staff networks through 2026-27.			
SPC/26/07/065	**Hot Topic – Improving Attendance Update**	The Committee received a presentation focused on Improving Attendance. The Trust has strengthened attendance management through increased executive oversight, a new Supporting Attendance Policy and targeted interventions across hotspot areas. Early improvements are being seen in several services. Facilities, A&E and A9 remain areas of focus. The next phase will extend this approach across the top 12 absence hotspots	**Moderate**	**Substantial**	October 2026
SPC/26/07/067	**Workforce Integrated Performance Report**	The Committee received the Workforce Integrated Performance Report. It was noted DNA's in Occupational Health are increasing, which is being reviewed. Agency reliance remains low and Appraisals are improving, albeit below Trust target of 85%. PSIRF training is at 91% compliance, however reduced by 5% in month due to the large number of compliance expired following the launch of PSIRF training 3 years ago.	**Moderate**	**Substantial**	September 2026
SPC/26/07/068	**Chief People Officer Report**	The Committee noted the Chief People Officer report and specifically that the NHS Staff Standards that have been published. The Committee discussed that the standards would form part of the NHS Oversight Framework and therefore the Trust will be ranked against other organisations on their implementation and this can have an impact on the overall segment score for NCM.	**Moderate**	**Substantial**	August 2026

		Due to the fact the standards will be ranked based on the staff survey results and this being an annual metric, the Committee agreed that a review of the workforce IPR and cycle of business will be undertaken in August 2026 to ensure that there is appropriate governance and assurance of the standards at regular touchpoints.			
SPC/26/07/070	**Workforce Plan Update**	The Committee received a paper in relation to the workforce plan which provided assurance that the Trust is currently achieving the workforce plan reductions overall as an organisation. Data regarding the individual performance of each Care Group was also provided.	**Substantial**	**Substantial**	August 2026
SPC/26/07/071	**Staff Survey – Organisational Priorities Quarterly Update**	The Committee received a paper to provide the first quarterly update on delivery of the six organisational priorities agreed following analysis of the 2025 NHS Staff Survey. Key achievements include the launch of the NCM Behavioural Framework, implementation of executive site visit programmes, mobilisation of the NCM Champions network, development of the Cultural Review methodology, establishment of the People Performance Sub-Committee and implementation of the LEDS improvement methodology to support local ownership of staff survey actions.	**Substantial**	**Substantial**	Quarterly

The Committee also received the following reports:

Reports for Assurance:

SPC/26/07/069 - Workforce Brief on National, Regional, ICB, or Local Workforce Issues
SPC/26/07/072 - Safer Staffing Report
SPC/26/07/073 - Guardian of Safe Working – Annual Report
SPC/26/07/074 - Better Care Together - Post Integration Plan Update (PTIP) and Due Diligence Update
SPC/26/07/075 - Committee Chairs Annual Report

Matters to note for assurance:
SPC/26/07/076 - Workforce EDI Improvement Plan Sub Committee Chair's Log
SPC/26/07/077 - People Delivery Sub Committee

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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North Cheshire and Mersey NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/08/49c(i)	Meeting	Trust Board	Date Of Meeting	5 August 2026

Date of Meeting	22 June 2026
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
FSPC/26/06/042	**Deep Dive – Cost Pressures**	The Committee reviewed the key cost pressures reported at Month 2, with particular focus on urgent and emergency care medical staffing, theatres and general surgery. The Committee noted that these pressures were being driven by a combination of rota gaps, premium staffing, sickness, vacancies and consumable spend. Assurance was received that actions were being taken to strengthen rota alignment, recruitment, stock control, ordering processes and oversight of premium staffing. These areas remain subject to continued management focus given their impact on financial delivery.	The Committee received **limited** assurance given the overspending areas	The Committee **noted** and discussed the report and gave **moderate** assurance	**FSPC July 2026**
FSPC/26/06/043	**Hot Topic – Elective Recovery including revenue requests**	The Committee reviewed the elective recovery position and the revenue requirements associated with delivery of the RTT plan. The Committee noted that capacity and demand work had been completed and that productivity opportunities had been identified across outpatients and theatres. Assurance was received that further work was underway to	N/a as currently no delivery recorded	The Committee **noted** and discussed the report and gave **moderate** assurance	**Trust Board July 2026**

		determine the balance between additional investment and productivity driven efficiencies. The Committee supported the funding recommendation for Trust Board approval, recognising the continued risk to RTT delivery if additional capacity is not secured.			
FSPC/26/06/045	**Finance Update**	The Committee reviewed the Month 2 financial position, noting that the Trust was adverse to plan due to the impact of industrial action. The Committee also noted continuing risks relating to activity delivery, recurrent CIP, bank spend, future industrial action and unfunded national pressures. Assurance was received on the actions being taken to strengthen delivery, including continued focus on CIP, activity recovery, workforce controls, financial plan improvement and the National Cost Collection process	The Committee received **moderate** assurance due to the risk of overall plan delivery and level of non-recurrent CIP	The Committee **noted** the paper receiving **moderate** assurance and supported the NCC process for Trust Board approval	**FSPC July 2026** **Trust Board July 2026**
FSPC/26/06/046	**Workforce Plan Update**	The Committee reviewed progress against the 2026 to 2027 workforce plan and noted that the Trust was under plan at Month 2. Assurance was received on the actions being taken to develop detailed Care Group workforce reduction plans, strengthen vacancy control and temporary staffing arrangements, and align workforce plans with pay CIP delivery. The Committee noted that future delivery remained dependent on the progression of detailed plans, approved PIDs and associated service changes	The Committee received **moderate** assurance	The Committee **noted** and discussed the report and gave **moderate** assurance	**FSPC July 2026**
FSPC/26/06/048	**WHH Corporate Performance Report**	The Committee reviewed the Corporate Performance Report and noted positive performance across elective, cancer and diagnostics, alongside improvement in the Access and Performance NOF rating. Continued pressures were noted in urgent and emergency care, particularly 12 hour performance,	The Committee received **moderate** assurance given the balance between NOF	The Committee **noted** the paper receiving **substantial** assurance	**FSPC July 2026**

		ambulance handovers and corridor care. Assurance was received that improvement work continued through the ED Improvement Group, Performance Review Group and other established oversight routes.	improvements whilst some metrics are not achieving		

Items for noting

FSPC/26/06/044	*Delivery Unit Update*
FSPC/26/06/045 (ii)	*WHH Cost Pressures*
FSPC/26/06/045 (iii)	*WHH Cash Support Update*
FSPC/26/06/045 (iv)	*WHH Monthly CIP Update*
FSPC/26/06/045 (v)	*PwC Update*
FSPC/26/06/045 (vi)	*WHH Monthly Productivity Update*
FSPC/26/06/045 (vii)	*WHH Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPC/26/06/049	*Update on Delivery of 2026/27 Plan and Activity*
FSPC/26/06/050	*Pay Assurance Report*
FSPC/26/06/051	*Medical Workforce Review Group Quarterly Report (verbal update)*
FSPC/26/06/052	*EPRR Update and Annual Report*
FSPC/26/06/053	*Minutes/Action Log – EPR Procurement Oversight Group*
FSPC/26/06/054	*Digital Strategy Group update*

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/08/049c(ii)	Meeting	Trust Board	Date Of Meeting	5 August 2026

Date of Meeting	29 July 2026
Name of Meeting & Chair	Finance, Sustainability and Performance Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
FSPC/27/07/061	**Deep Dive – Run Rate**	The Committee reviewed the financial run rate position and the extent to which the current year to date position could impact delivery of the financial plan. Assurance was received that the forecast trajectory is expected to improve during the remainder of the year, supported by CIP phasing, planned activity delivery and continued executive oversight. The Committee noted the reduction in high risk CIP following focused review work, whilst recognising that delivery of efficiencies and activity levels remains critical to achievement of the plan	The Committee received **substantial** assurance	The Committee **noted** and discussed the report and gave **substantial** assurance	**Further update through monthly finance reporting**
FSPC/26/07/062	**Hot Topic – Bed Closures**	The Committee reviewed progress with planned bed reductions within the CIP programme and considered the financial, operational and quality impacts identified to date. Assurance was received that the initial closure had not shown a significant adverse impact on key indicators, although the Committee noted that continued monitoring would be required given the wider pressures on urgent and emergency care,	The Committee received **substantial** assurance	The Committee **noted** and discussed the report and gave **substantial** assurance	**Continued monitoring through FSPC, QASC and EMT.**

		patient flow and escalation capacity. Oversight will continue through FSPC, QASC and EMT.			
FSPC/26/07/065 (i)	**Finance Update**	The Committee reviewed the Month 3 financial position, noting that the Trust was adverse to plan, primarily due to the impact of industrial action. Assurance was received on the actions being taken to strengthen delivery, including continued focus on CIP, activity recovery, agency and bank controls, and management of national financial risks. The Committee noted that delivery of recurrent CIP and future forecast performance remain key areas of risk	The Committee received **moderate** assurance due to the risk of overall plan delivery and level of non-recurrent CIP	The Committee **noted** the paper receiving **moderate** assurance	**Further update through monthly finance reporting.**
FSPC/26/07/068	**WHH Corporate Performance Report**	The Committee reviewed the Corporate Performance Report and noted improvement in the Access and Performance NOF rating, alongside continuing pressures in urgent and emergency care, 12 hour performance, RTT waiting list growth and diagnostics. Assurance was received that performance is subject to routine oversight through established governance routes, with improvement work continuing across patient flow, elective recovery, diagnostics and ambulance handovers	The Committee received **moderate** assurance given the balance between NOF improvements whilst some metrics are not achieving	The Committee **noted** the paper receiving **substantial** assurance	**FSPC August 2026**

Items for noting

FSPC26//07/063	*Board Assurance Framework and Corporate Risk Register*
FSPC/26/07/064	*Delivery Unit Update*
FSPC/26/07/065 (ii)	*Cost Pressures*
FSPC/26/07/065 (iii)	*Cash Support Update – supported cash support of £7.177m for Trust Board approval*
FSPC/26/07/065 (iv)	*Monthly CIP Update*
FSPC/26/07/065 (v)	*PwC Update*
FSPC/26/07/065 (vi)	*Monthly Productivity Update*

FSPC/26/07/065 (vii)	*Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPC/26/07/066	*Workforce Plan Update*
FSPC/26/07/067	*Costing Update*
FSPC/26/07/069	*Elective Recovery*
FSPC/26/07/070	*Medical Workforce Review Group Quarterly Report*
FSPC/26/07/071	*Due Diligence Update*
FSPC/26/07/072	*Chair's Annual Report*
FSPC/26/07/073	*EPRR Group Minutes*
FSPC/26/07/074	*Digital Strategy Group*

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

Level of Assurance	Description
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North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/08/049d	Date of Board meeting:	5 August 2026

Date of meeting:	Monday 22 June 2026
Name of meeting and chair:	Audit Committee, Mike O'Connor (Non-Executive Director and SID)
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
AC/26/06/029	**Head of Final Audit Opinion – Final Reports (WHH and BCH)**	The Committee approved the final Head of Internal Audit Opinions for WHH and BCH. Both remained unchanged from draft and both organisations received substantial assurance, reflecting consistency with previous years.	**Substantial**	**High**	Approved at meeting.
AC/26/06/030	**Audit Findings Report and Auditor's Annual Report – WHH**	The Committee received and approved the Audit Findings Report and received the Auditor's Annual Report for note. The accounts audit was substantially complete with no matters requiring modification to the audit opinion and no material changes to the financial statements.	**Substantial**	**High**	NK and GW to review wording/detail outside the meeting. Management responses

		The Auditor's Annual Report identified two significant weaknesses: financial sustainability, including medium-term financial planning and CIP delivery, and performance, particularly urgent and emergency care. Governance arrangements were assessed as strong with no significant weaknesses in that domain.			accepted and subject to ongoing oversight.
AC/26/06/031	**Audit Findings Report and Auditor's Annual Report – BCH**	The Committee received the report for note. KPMG intended to issue an unqualified audit opinion and confirmed that no material issues required qualification. No significant weaknesses were identified for value for money. The Committee noted a positive final audit position, with one technical control observation on segregation of duties and one minor uncorrected misstatement, neither being material.	**High**	**High**	Final checks and completion of audit opinion documentation.
AC/26/06/032	**Final Audited Accounts and Financial Statements**	The Committee approved the final audited accounts for WHH and BCH. There were no changes to the overall financial position, with only minor classification, wording and disclosure amendments. The Committee authorised the relevant officers to sign the Letters of Representation, consolidation schedules and Trust certificates.	**High**	**High**	Relevant officers to sign final audit documentation.
AC/26/06/035	**MIAA Workforce CIP Governance Review**	The Committee received the MIAA Workforce CIP Governance Review for noting. The review confirmed that formal governance arrangements were in place during 2025/26 and that workforce CIP risks were visible through existing reporting routes. The Committee noted the development areas identified by MIAA and agreed that management actions should be developed and monitored through Audit Committee, with relevant	**Moderate**	**Moderate**	Management actions to be monitored via Audit Committee, with specific attention to QSAC triangulation and

		assurance also considered through the appropriate Board committees.			connected committee assurance.

Other agenda items:
AC/26/06/033 Annual Reports 2025/26 BCH and WHH
AC/26/06/034 Quality Accounts
AC/26/06/036 Code of Governance Compliance
AC/26/06/037 Compliance with Provider Licence
AC/26/06/038 Fit and Proper Persons Test Annual Report

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 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 could/has resulted in failure to achieve the system objectives.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/050**			
Subject:	**Fragile Clinical Services Update**			
Date of meeting:	5 August 2026			
Action required:	**Noting**			
Author(s):	Paul Fitzsimmons, Executive Medical Director			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
	BAF 3: Planned Care Access & Elective Recovery			
	BAF 5: Workforce Capacity, Capability & Wellbeing			
	BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This paper serves to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: • Orthopaedics – Fractured Neck of Femur • Urology • Chronic Pain Service • Rheumatology			

	Services de-escalated from Fragile Services oversight since last report: • None Services entering Fragile Services oversight since last report: • None		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	Trust board is asked to: • Note the current list of Fragile Services, associated clinical risk and high-level progress updates • Note significant progress and improvement within Planned Care Fragile Services (Fractured Neck of Femur and Chronic Pain) • Receive further Fragile Service Oversight reports		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

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 QASC and on to Trust Board since July 2023.

For the purposes of the Fragile Services Oversight program the Trust defines a Fragile Service as: ‘A service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm’.

This report aims to provide a high-level overview of services currently identified as being Fragile.

2. Key elements

Services de-escalated from Fragile Services oversight since last report:

- None

Services entering Fragile Services oversight since last report:

- None

Services remaining under Fragile Services oversight:

Orthopaedics – Fractured Neck of Femur and Chronic Pain services were escalated in January 2026 into a formal Planned Care Quality Recovery Plan. This has reported twice weekly to the Deputy Medical Director with a bi-weekly escalation report to the Medical Director, Chief Nurse and Chief Operating officer. Following progress on actions improvements in these services, this recovery plan has been completed and stood down.

These services will continue to remain under Fragile Services oversight, with Fractured Neck of Femur continuing to report directly to the Executive Management Team and QASC monthly.

Orthopaedics – Fractured Neck of Femur

Summary

Improvement has been seen in key performance indicators and outcome measures, with time to operation falling to below the national average in the last 2 months and crude mortality falling to be at or below the national average in the last reported quarter.

These improvements now require consolidation with measures to further decrease delays to surgery through a cost neutral increase in weekend operating in live consultation with Theatre staff.

As Case mix adjusted mortality is reported on an annualised basis, despite improvements in calendar Q1 2026 the Trust remains an alert outlier site for Q4 (Oct-Dec) 2025 and this is likely to persist into future quarters.

Figure 1 – Hip Fracture Crude 30-day Mortality

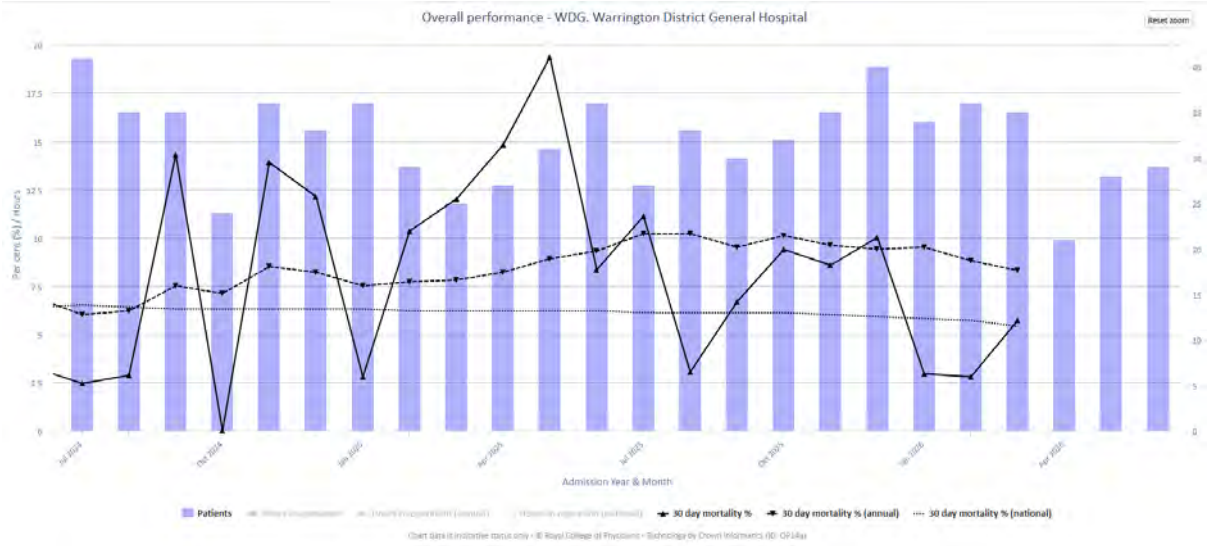


Figure 2 – Time to Operation



The service now needs to sustain and further improve this performance through implementing a sustainable and efficient theatres model to address the capacity gap at weekends. A sustainable cost neutral model to provide additional weekend capacity has been developed and is currently subject to theatre staff consultation.

The service will continue to report to PSCESC, EMT and QASC monthly.

Chronic Pain Service

Summary

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

Significant progress, all immediate safety actions completed. Confirmation that all new patient injection therapy is being given in line with NICE guidance. Opioid/gabapentoid prescribing SOP and standardised GP and patient letters have been approved and implemented.

Clinical Model Workshop with key stakeholders May 2026 has defined clinical recommendations for future – Lead commissioner identified to lead de-commissioning and recommissioning of service as a community based reablement focussed service.

Completed Actions

- Ongoing pharmacy review of all opioid recommendations
- Service Gap analysis against NICE guidelines
- No new patients commenced on facet joint or trigger point injections
- Review of injection activity and caseloads undertaken
- Meeting with East Chesire regarding their community model
- Finalised and operationalised SOPs and standardised letters
- Clinical Model Workshop (May 2026) has defined clinical recommendations for future service model with key stakeholders

Medium Term Actions

- Work with Lead commissioner to de-medicalise and transform service into a community-based therapist led reablement service – confirm timeline with Lead Commissioner

<u>Urology</u>

Summary

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

Emergent staffing risk from possible consultant staff retirements – mitigation now identified and being actioned

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

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand
- Significant volume of high-risk patients on waiting lists confirmed by AI list validation
- P2 – waiting list has deteriorated in last 2 months – plan for locum consultant recruitment to support recovery
- P3 waiting lists stable
- P4 waiting lists continue to improve following increases over summer 2025

- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance and diagnostic cystoscopy position very significantly improved – recent in month spike in undated surveillance patients – recovery will be supported by consultant and middle grade recruitment

Completed Actions

- Increased endoscopy cystoscopy capacity by 40/week
- Nurse delivered cystoscopy now live
- OP Clinic template standardisation completed
- Additional middle grades recruited
- Locum consultants commenced in post
- Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.
- Prostate triage nurse now in place supporting effective and timely management within the prostate pathway
- Surveillance waiting list processes for prostate and kidney cancer enhanced with dedicated surveillance access plans

Key Actions for Next Reporting Period

- WLI and outsourced sessions where required to support activity plan and safety
- Recruit to locum post
- Complete case for Urology substantive consultant expansion
- Recruit to middle grade vacancy

Medium Term Actions:

- Urology to be included in system work on developing sustainable models for fragile services

Rheumatology

Summary

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

Significant improvement in prescribing backlog, patient enquiry backlog, DMARD monitoring and prescription process though risk remains around monitoring during DMARD initiation. Significant outpatient backlogs persist.

Key areas of risk identified for improvement include:

- Prescribing capacity and responsiveness

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

Completed Actions

- Single email point of access introduced for all email patient queries
- DMARD prescription backlog now resolved
- Biologic prescription backlog now resolved
- DMARD processes amened – single register established and validated
- Basic DMARD fail safes in place
- Locum consultant in post and all substantive consultants now back in work
- Dedicated specialist pharmacist in post
- Medical and Nursing job plan changes made to support demand and capacity mismatch

3. Actions required/responsible officer

Key Actions for Next Reporting Period

- Complete capital case for introduction of proprietary DMARD monitoring system
- Continue to closely monitor timeliness of responses to patient queries
- Develop virtual DMARD education programme for patients
- Undertake demand capacity exercise and GIRFT pathway review to manage OP backlog

4. Recommendations

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates

- Note significant improvements delivered in Fractured Neck of Femur and Chronic Pain

- Receive further Fragile Service Oversight reports

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/051**			
Subject:	**Maternity & Neonatal Update April May 2026**			
Date of meeting:	5 August 2026			
Action required:	**To note**			
Author(s):	Tina Moors Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	The Board is asked to take assurance that maternity and neonatal services maintained a stable safety position during April and May 2026, with no maternal deaths, neonatal deaths or severe harm incidents reported during the reporting period. Workforce indicators remain positive, mandatory training compliance exceeds target, and maternity triage performance remains consistently high. Key areas requiring ongoing Board oversight are: Neonatal admissions to the Neonatal Unit (ATAIN), which remain above national and regional benchmarks despite improvement from 9.18% to 8.11%. Postpartum haemorrhage (PPH) rates, which remain above regional comparator rates. Induction of labour delays, although significant improvement was demonstrated during May 2026. Workforce and capacity pressures within the diabetes service.			

<table>
<tr><td></td><td colspan="3">Delivery of actions arising from the Perinatal Improvement Plan and the national Ockenden Nottingham Review.

The Board can take assurance that governance arrangements, audit programmes and quality improvement initiatives are in place to monitor these risks and support continued improvement. Residual risks remain in relation to neonatal admissions, PPH performance and diabetes workforce capacity and will continue to be monitored through established governance routes.
This paper provides the Board of Directors with oversight of the North Cheshire and Mersey NHS Foundation Trust position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 8 and local improvement actions.

The paper provides a summary in relation to the following reports for oversight and discussion:

Appendix 1a and 1b Maternity and Neonatal Quality Review Report
Appendix 2: Maternity Incentive Scheme MIS Year 8
Appendix 3: Maternity Self-Assessment
Appendix 4: Quarter 4 2025/26 Perinatal Mortality Review Tool (PMRT)
Appendix 5: Avoiding Term Admission into Neonatal Unit (ATAIN) Q4</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the contents of this report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QSAC/26/06/069i
QSAC/26/06/069iii
QSAC/26/07/094i
QSAC/26/07/094ii
QSAC/26/07/094iii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">June 2026 and July 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Noted and approved</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
</table>

Freedom of information exemptions applied: (if relevant)	None

1.Background/context

This paper provides an overview of activity, performance, and quality within the Maternity and Neonatal Services for the period April and May 2026.

The paper provides the Trust Board with oversight of the North Cheshire and Mersey NHS Foundation Trust position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 8 and local improvement actions.

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

Appendix 1a and 1b Maternity and Neonatal Quality Review Report
Appendix 2: Maternity Incentive Scheme MIS year 8
Appendix 3: Maternity Self-Assessment Tool
Appendix 4: Quarter 4 2025/26 Perinatal Mortality Review Tool (PMRT)
Appendix 5: Avoiding Term Admission into Neonatal Unit (ATAIN) Q4

All papers have been shared and discussed at the appropriate governance meetings.

2. Maternity and Neonatal Quality

See Appendix 1a and 1b Maternity Neonatal Quality

This paper provides an overview of activity, performance and quality within the Maternity and Neonatal Services for the period April and May 2026. It provides assurance to the Board of Directors on the Trust's position in relation to key national safety and quality standards and ongoing improvement activity.
The service continues to demonstrate a stable safety profile, with:

- No maternal or neonatal deaths reported across the period
- No severe harm events reported in either month
- Incidents primarily categorised as low or moderate harm

Key themes of outliers in LMNS remain consistent across both months:

- Admission of term babies to the Neonatal Unit (ATAIN)
- Postpartum haemorrhage (PPH ≥1500ml)

The Board can take assurance from sustained performance in workforce metrics, maternity triage compliance and induction of labour pathways; however, focused improvement and monitoring remain necessary in relation to term neonatal admissions, and PPH.

2.1 Key Quality & Safety Indicators

- April:
  - 0 severe harm events
  - 4 moderate harm events (OASI)

- May:
    - 0 severe harm events
    - 7 moderate harm events (OASI)

- Strong incident reporting levels maintained, supporting a positive safety culture

Position:

- There were 7 instances of a 3rd-degree tear in May 2026, an increase from the 4 reported in April 2026.
- Cluster review to be completed for Q1.
- No escalation in severe harm trends.

2.2 Areas of Focus & Improvement

Neonatal Admissions (ATAIN)

Appendix 5: Avoiding Term Admission into Neonatal Unit (ATAIN) Q4

- Remains above the national target of 6% and NWNODN target of 5.6%.
- Q4 rate improved to **8.11%** from **9.18%** in Q3.
- Respiratory symptoms remain the primary reason for admission, accounting for **71%** of term neonatal admissions.
- The proportion of admissions deemed avoidable reduced to **20%**, consistent with national expectations.

Actions and Improvements

- Development of a respiratory distress ("grunting baby") pathway, enabling babies to remain with their mothers while receiving enhanced monitoring.
- Continued use of the PEEP for 30 pathways to avoid early escalation to neonatal admission.
- Ongoing review of opioid prescribing to reduce potential neonatal respiratory depression.
- Provision of Transitional Care staffing from NNU to support care outside the unit.
- Introduction of NEWTT2 and routine neonatal oxygen saturation screening to support earlier identification of deterioration.
- Strengthened multidisciplinary ATAIN review processes to identify learning and improve decision-making.
- Collaboration with LMNS and peer organisations, including Whiston, to review best practice and identify further opportunities for improvement.
- Development of a neonatal admission proforma to support consistency in admission decision-making.
- Structured dissemination of learning from ATAIN reviews across maternity and neonatal services.

Position
The Board can take partial assurance that the actions implemented through the ATAIN improvement programme are resulting in sustained reductions in avoidable admissions and improved multidisciplinary oversight. However, residual risk remains as performance continues to exceed both national and regional targets. Progress is monitored through monthly ATAIN review meetings, governance committees and quarterly audit reporting.

Postpartum Haemorrhage (PPH)

- April rate (≥1500ml): **3.88%**
- May rate: **6.28%**
- PPH ≥1500ml, which remains higher than regional rates. **12-month rolling mean: 5.1%** (124/2432, 01/06/25-31/05/26) – 51 per 1000 births comparison to Cheshire and Mersey (C&M) 28 per 1000 births

Position
Although the May rate increased and remains above the Cheshire and Mersey comparator rate, monthly variation is recognised within maternity datasets. The sustained elevation above regional benchmarks has therefore been identified as an improvement priority.
The Board can take partial assurance that the Regional PPH Guideline has been embedded and that the PPH Quality Improvement Programme is providing ongoing oversight and learning. Residual risk remains while performance continues above regional comparator rates. Progress is monitored through the Intrapartum Review Group, maternity governance meetings and a six-month re-audit programme, with findings due to inform the next phase of improvement.

The Northwest Regional PPH Guideline is now fully embedded, with improvements observed through:

- Strengthened risk assessment
- More consistent escalation
- Improved third-stage management practices
- Reinforcement through safety huddles, case reviews and intrapartum governance

Key Actions and Improvements
The PPH Quality Improvement Programme continues in its Test of Change phase, focusing on:

- Standardised risk assessment at every contact
- Accurate quantification of blood loss
- Clear escalation triggers aligned to regional guidance
- Multidisciplinary simulation and emergency leadership training
- Real-time learning and feedback loops

All PPH cases are subject to structured review within the Intrapartum Review Group, ensuring:

- Rapid identification and sharing of learning
- Strong linkage between incident review, practice change and re-evaluation
- A 6-month re-audit (Nov 2025 – May 2026) is underway and will assess compliance with the regional guideline and impact of improvement actions
- Findings will inform the next phase of the improvement plan
- A deeper dive PPH audit identified 15 of the 35 major obstetric haemorrhage cases as being associated with instrumental birth.

OASI (3rd/4th Degree Tears)

- April: 1.94%
- May: 3.38%

Position

- Reduction following February increase
- Variation consistent with expected patterns

Induction of Labour (IOL)

- April: **21.6% total delays**
- May: **4.2% total delays**

Position

The Board can take assurance from the sustained reduction in induction delays during May 2026. Residual risk remains and continues to be reflected on the Care Business Unit Risk Register with a current risk rating of 16. Progress is monitored through maternity governance structures and monthly performance review.

Actions

- Implementation of balloon cervical ripening pathway
- Continued work to improve flow and pathway efficiency

2.3 Workforce Position

- Mandatory training compliance: 90% (above target)
- Safeguarding compliance: 92%
- Vacancy rate: 0.1%
- Turnover: below Trust target (8.8/7.7)

Improvement:

- PDR compliance improved from 83% (April 2026) to 84%(May 2026)

2.4 Performance & Activity

Maternity Triage

- April:
    - 96% seen within 15 minutes
    - 99.4% within 30 minutes

- May:
    - 96.7% seen within 15 minutes
    - 99.2% within 30 minutes
- Sustained high performance and compliance with national standards

Service User Experience
- April: 4 complaints
- May: 0 complaints

Position
- Low volume of complaints.

3. Governance and Assurance

- No Coroner Regulation 28 notices
- MNSI-Two Cases
  One case in progress - Referred April 2025 MI-041711 (HIE/NND) in progress – Draft report delayed until COD from PM. Inquest date deferred now until October 2026
- One new case referred in May MI-060160 Term Stillbirth during the IOL process
- Robust governance through:
    - Monthly quality and safety review
    - Audit and QI programmes
    - MDT learning processes

Key Risks identified
- Neonatal admissions remain above national target
- PPH increase.

The Trust Board is asked to:
- Note the contents of this report
- Acknowledge the continued stable safety position across April and May 2026
- Support continued focus on neonatal admissions, and PPH.

Risk Area	Current Position	Mitigation	Monitoring Route	Timescale
Neonatal Admissions (ATAIN)	8.11% and above target	Respiratory pathway, transitional care, ATAIN reviews	Maternity Governance, QSAC	Quarterly review
PPH	Above Cheshire & Mersey comparator rate	PPH QI Programme, guideline implementation, audit	Intrapartum Review Group	Q3 2026
Induction of Labour Delays	Improved but risk remains	Balloon ripening pathway and flow improvements	CBU Risk Register	Ongoing

Diabetes Capacity	Workforce pressure and rising demand	Dietitian recruitment and service redesign	Women's & Children's Governance	Q4 2026
Ockenden Response	National actions emerging	Gap analysis and PIP integration	QSAC and Board	Q3 2026

4. Maternity Incentive Scheme MIS Year 8

See Appendix 2

NHS Resolution has launched MIS Year 8, requiring Trusts to demonstrate compliance with six maternity safety actions by March 2027. Successful delivery enables recovery of 10% of CNST contributions and access to additional incentive funding.

The Trust remains on track to achieve MIS Year 8 requirements, with no current concerns regarding progress. Enhanced governance and reporting arrangements are being developed to support ongoing oversight and assurance.

Compliance with the Saving Babies' Lives Care Bundle continues to be monitored through routine audit activity, with the service prepared for external review.

Funding has been secured for a 0.6 WTE dietitian post to support the diabetes pathway and delivery of Saving Babies' Lives standards for women with pre-existing diabetes.

Progress against MIS Year 8 and the Saving Babies' Lives Care Bundle is monitored through established governance arrangements, providing continued oversight and assurance.

Delivery of MIS Year 8 remains on track, with robust governance arrangements in place and actions progressing to support ongoing compliance and improved maternity outcomes.

5. Maternity Self-Assessment Tool

Appendix 3a
Appendix 3b

We have completed the national Maternity Self-Assessment Tool, which benchmarks our maternity service against the standards and expectations arising from the Kirkup and Ockenden reports, CQC best practice, and the national maternity safety programme.

The tool contains 159 criteria across six key areas: leadership and infrastructure, MDT working, governance and ward-to-board accountability, application of national standards, safety culture, and understanding of business and quality impact.

As of 1 May 2026, we are compliant with **139 out of 159 criteria**, which is **87.4%**, showing a small but positive improvement from our previous position of 86.8%.

The remaining red and amber actions relate mainly to:

- Finalising our new Maternity Quality Improvement Plan
- Establishing a formal Maternity Safety Improvement Plan
- A Trust-wide communication strategy, which is paused pending the Bridgewater integration

All actions are progressing, and we expect further improvement by the end of Q2.

The self-assessment will be monitored through the Quinquevirate and Women's & Children's governance meetings, and we will report back to QAC every six months, with the next update due in November 2026.

6. Key Highlights: Quarter 4 2025/26 Perinatal Mortality Review Tool (PMRT)

Appendix 4

- No stillbirths or neonatal deaths recorded during Q4, with rates of 0.0 per 1,000 births/live births.
- Rolling 12-month stillbirth (**2.9/1,000**) and neonatal mortality (**0.83/1,000**) rates remain below national averages.
- Two PMRT reviews were completed, with parental feedback sought in both cases and external reviewer involvement in all reviews.
- No cases identified care issues likely to have affected outcomes; findings were either no concerns or issues that would not have changed outcomes.
- Good bereavement care was highlighted, with learning shared on growth surveillance and laboratory investigations following stillbirth.
- The Trust remains fully compliant with Maternity Incentive Scheme Year 8, Safety Action requirements.

Mortality rates remain below national benchmarks, review processes are robust, learning actions are in place, and full regulatory compliance has been maintained

7. Diabetes

Regional and local diabetes pathways are now established, supported by weekly multidisciplinary clinics for women with pre-existing and gestational diabetes. Referral processes have been strengthened, staff training completed, and additional administrative support introduced.

Workforce and capacity risks remain, particularly Diabetes Specialist Nurse availability and increasing service demand. Mitigating actions have been implemented, including a dedicated diabetes inbox, daily midwifery oversight, interim clinic cover, and progression of recruitment to a specialist dietitian post. These risks remain on the

service risk profile and are reviewed through women's services governance structures, with recruitment and service redesign actions monitored monthly.

A wider service review and business case development are underway to support sustainable future service delivery.

8 Perinatal Improvement Plan

Following the regional maternity assurance visit in March 2026, a Perinatal Improvement Plan (PIP) has been developed to address recommendations and required improvements.

The plan is jointly overseen by the Executive Team and regional maternity team, with monthly meetings now established. Early feedback has been positive, with additional support offered across key workstreams.

Progress is monitored through the Trust governance framework, Women and Children's Governance Meetings, Quality Assurance Committee and Quality Committee, providing a clear route of assurance to the Board. Delivery milestones are reviewed monthly, with progress against the plan reported through established governance arrangements.

9. Ockenden Nottingham Review 2026

The Ockenden Review identified significant failings in maternity and neonatal services at Nottingham University Hospitals and has resulted in 18 Immediate and Essential Actions for maternity services nationally.

North Cheshire and Mersey NHS Foundation Trust acknowledges the findings of the review and supports the national actions arising from it.

The Trust will undertake a detailed gap analysis against the national recommendations by Q3 2026, with identified actions incorporated into the Perinatal Improvement Plan. The Board can take assurance that established maternity governance, patient safety and assurance arrangements are already in place. However, residual risk remains until the full gap analysis has been completed and all actions have been assessed against local implementation requirements.
Progress will be monitored through the Perinatal Improvement Plan governance structure, Quality Assurance Committee and Board reporting cycle, with further updates provided as national guidance is released

10. Board Assurance Statement

The Board can take assurance that maternity and neonatal services continue to provide safe care and that appropriate governance arrangements are in place to monitor quality, safety and performance. No maternal deaths, neonatal deaths or

severe harm incidents were reported during the reporting period. Workforce, training compliance and triage performance remain positive.

Residual risks remain in relation to:

- Neonatal admissions above national and regional benchmarks.
- Postpartum haemorrhage rates above regional comparator performance.
- Workforce and capacity pressures within diabetes services.
- Ongoing implementation of the Perinatal Improvement Plan and Ockenden Review recommendations.

The Board can be assured that these risks are actively managed through established governance processes, quality improvement programmes, audit activity and committee oversight arrangements.

11. Assurance committee

The contents of this report have previously been noted and discussed at Quality Assurance Committee on 9th June 2026 and 7th July 2026.

12. Recommendations

The Trust Board of Directors is requested to note the content of this paper for information.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/051 – Appendix 1a**			
Subject:	**Maternity & Neonatal Quality Review – April 2026**			
Date of meeting:	5 August 2026			
Action required:	**To note**			
Author(s):	Tina Moors – Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.			
Executive summary:	This paper provides an update in relation to Maternity and Neonatal quality and provides Quality, Safety and Assurance Committee (QSAC) 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 QSAC 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 April 2026 there were 0 fatal, 0 severe harm events in the maternity or Neonatal Services. There were 4 moderate harm event (OASI) 3rd/4th degree tears Themes from Maternity/Neonatology patient safety events in April 2026 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 April mandatory training compliance and role specific training across maternity and child health colleagues is above 88%. Compliance with PDR completion is below Trust Target with a position of 83%. Work continues to achieve full compliance, and progress is being monitored on a weekly basis. Good compliance continues with maternity specific training standards can be noted with a continual improvement each month. Turnover for maternity and child health staff is 8.89% which is below the Trust target. The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 0.5% The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work continues with regard to induction of labour (IOL) particularly in reducing delays. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. An update regarding Maternity Workstreams • Diabetes • Regional Team Visit Two Complaints were received in the Maternity and Neonatal Services in April 2026

	No Regulation 28 enquiries have been received.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	For the Trust Board members to note the contents of this report.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QSAC/26/06/069iii**	
	Date of meeting	9 June 2026	
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

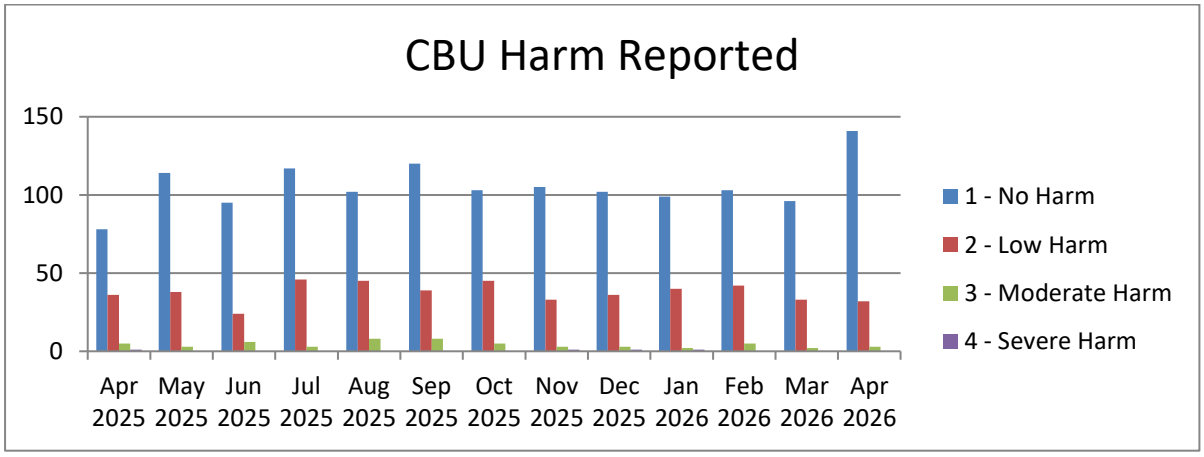
1. Background/context

This paper provides an update in relation to Maternity and Neonatal quality including relevant data and metrics for the month of April 2026.

The paper provides Trust Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action F within the Maternity Incentive Scheme Year 8 *Safety Action F requires the Trust Board to provide effective oversight of maternity safety through clear governance, regular scrutiny of risks and outcomes, and a culture that supports transparency and learning.*

2. Harm events

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU for the period April 2025 – April 2026



There were 121 patient safety events reported across the CBU in April 2026.

There were 0 fatal and 0 severe harm event in March 2025 in the Maternity or Neonatal services.

4 moderate harm event, 3rd/4th degree tears (OASI).

OASI – 4 Cases

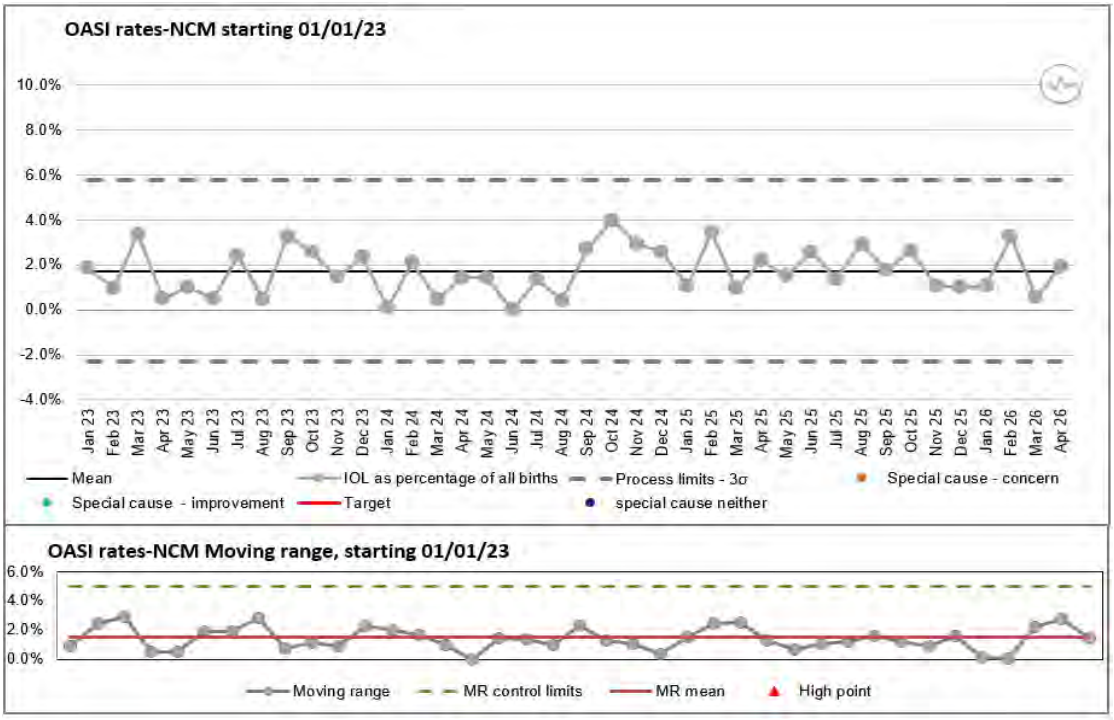
April rate: 1.94% (4/206) – 19.4 per 1000 births

12-month rolling mean: 1.82%

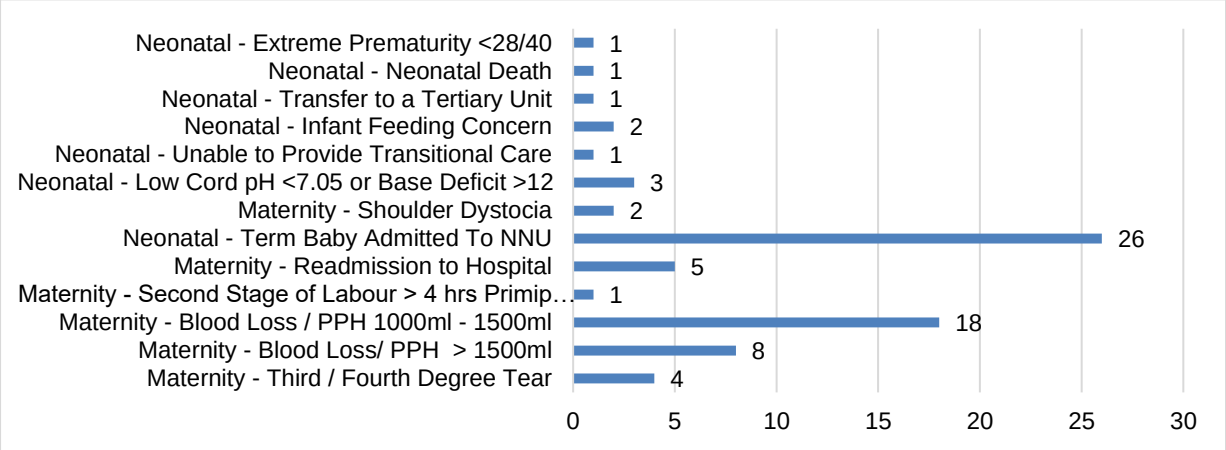
There were four instances of a 3rd degree tear in April 2026, which is an increase from the one reported in March. The SPC chart continues to show common cause variation.

Mode of birth:

- Two cases with spontaneous cephalic birth (3a tear, 3b tear)
- Two cases with forceps (both 3b tear)



Themes from Maternity/Neonatology patient safety events in April 2026 are detailed below:



*NND – extreme prematurity 22+1 born alive following PPROM at 21+4. Reported to MBRRACE for PMRT.

Top three themes from Maternity/Neonatology patient safety events in April 2026 were:

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

Admission of term babies admitted to Neonatal Unit (NNU)

Term admissions to the Neonatal Unit are reviewed each month by the ATAIN Team, consisting of colleagues from midwifery, obstetrics, neonatal and CBU management.

The national target for ATAIN is 6% (Percentage of live births admitted to the neonatal unit at term.) NCM remain an outlier for term admissions. The ATAIN rate for Q4 25/26 is 8.11% which demonstrates a decrease from the 9.18% reported for Q3 2025/2026.The team is committed to identifying areas of improvement and driving this improvement.

Current position

In April 2026, **26** term babies were admitted to the Neonatal Unit. The admissions followed previous months' trends where the majority of admissions were due to respiratory distress. As previously presented to Quality, Safety and Assurance Committee, the service completed a QI project last year and the 'PEEP for 30' pathway was implemented. This provides support for babies in respiratory distress for 30 minutes on Birth Suite or Maternity Theatre.

Action plan

Action	Notes/progress	Due date
Implementation of respiratory distress guideline to support babies remaining with their mothers wherever clinically appropriate.	The guideline has been presented and ratified at the Women's and Children's CBU Governance meeting and is pending upload onto the hub for implementation. Guideline has also been shared with the North West Neonatal Operational Delivery Network (NWNODN) and has received positive feedback.	30.06.26
NWNODN representative to attend an ATAIN MDT meeting to provide external scrutiny and support.	NWNODN representative attendance has been confirmed for 12.06.26.	12.06.26
Review Neonatal Admissions proforma to consider its impact on clinical decision-making and admission rates.	Proforma has been developed and will be in use from 01.06.26.	31.07.26
Deeper analysis of term neonatal admissions.	Deeper analysis is underway to support identification of trends and opportunities for reduction. This has commenced with a focussed review of infants born at 37 weeks gestation.	30.06.26
Structured process for disseminating learning from ATAIN reviews to be developed.	This is currently being developed. The ATAIN performance board within birth suite will continue to be updated on a monthly basis to inform staff of current performance and support ongoing improvement.	30.06.26
Planned collaborative learning from other ATAIN teams within LMNS to help identify new actions to improve condition of babies at birth	Initial meeting being scheduled with Arrowe Park Hospital ATAIN team, with further plans to meet with other units with similar term birth rates and neonatal level	30/6/26

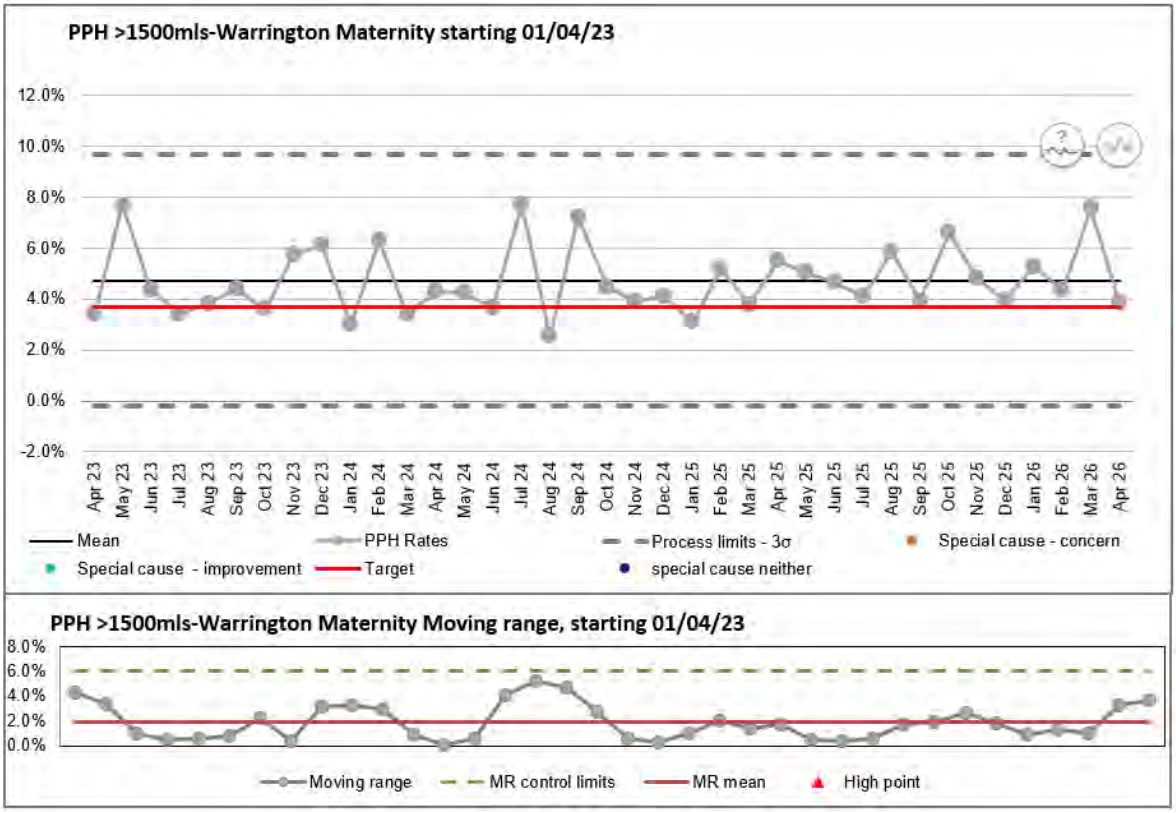
Post Partum Haemorrhage

There were **15** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and learning shared.
There were **8** cases of **PPH ≥1500mls**.

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

April rate: 3.88% (8/206) – 38.8 per 1000 births

12-month rolling mean: 4.99% (121/2423, 01/05/2025-30/04/2026)



April data shows a postpartum haemorrhage (PPH) rate of **3.88% (8/206 births)**, equating to **38.8 per 1000 births**. April data demonstrates common cause variation and a reduction compared to March data.

The implementation of the Northwest Regional PPH Guideline is now fully embedded, and we are beginning to see early behavioural and practice changes, even if this is not yet reflected rates. Strengthened risk assessment, improved escalation, and more consistent third-stage management are being observed through case reviews, safety huddles, and intrapartum governance.

The PPH Quality Improvement Project continues in its Test of Change phase, with focused workstreams addressing:

- Standardised risk assessment at every contact
- Accurate quantification of blood loss
- Clear escalation triggers aligned to the regional guideline
- Multidisciplinary simulation and emergency leadership training
- Real-time learning feedback loops

All PPH cases continue to undergo structured review within the Intrapartum Review Group, ensuring that learning is rapidly identified and shared. This is strengthening the link between incident review, practice change, and re-evaluation.

The six-month re-audit (Nov 2025 – May 2026) remains on track and will provide a robust assessment of compliance with the new guideline and the impact of the quality

improvement measures. This will inform the next phase of the improvement plan and allow us to refine our approach further.

We expect to see measurable improvement as the guideline becomes fully embedded and the Test of Change workstreams continue to drive consistency and cultural change across the service.

Action	Notes/progress	Due date
PPH audit to be conducted covering November 2025 to May 2026 – to be presented at the Joint Audit meeting with Anaesthetics on 23.09.26.	A formal PPH audit will be undertaken of PPH in the six months (November 2025 to May 2026) following implementation of the regional guideline. This will be presented at Clinical Audit on 23.09.26. This will inform further learning and improvement work.	23.09.26
Documentation of PPH Prevention	The BadgerNet PPH prevention assessment does not fully align with the regional guideline. This was escalated on 14.05.26, with all local updates completed and the remaining two criteria now with System C. Staff continue to assess PPH risk correctly in line with the regional guideline.	31.10.26
Procurement of Under Buttock Measuring Drapes for Instrumental Deliveries	Ordered and Expected imminent delivery	12.06.26

A reverse RAG rating is used in the action plan.

3. Workforce metrics and 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 April 2026 compliance for mandatory training across maternity and child health colleagues is 88% for Trust mandatory training and 90% for role specific training (both above the Trust target). Safeguarding Training 92%

This excludes staff who are currently absent from work on a long-term basis.

Compliance with PDR completion has shown improvement currently positioned at 83%. Action plan continues improve compliance includes allocated time for Line Managers to complete appraisals. Weekly monitoring with oversight from Matrons and escalation to CBU Senior Leadership Team where compliance is not achieved.

Good compliance with maternity specific training standards is being sustained.

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	Maternal AIMS
Midwives	98%	96%	95.4%	100%	91.4%
Obstetric Consultants	100%	91%	100%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	100%	n/a		n/a	n/a
Maternity Support Workers	97%	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 April 2026 is 8.89%, 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 0.5%. 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 April 2025-April 2026	
Month	**Attendances**
April	521
May	577
June	587
July	602
August	588
September	623
October	668
November	562
December	564
January	571
February	552
March	615
April	628

- In April 2026 628 triage attendances (403 Women) were recorded on the BadgerNet patient record system seeing an increase number of attendances per day of 20 to 30 over the year.
- The longest wait recorded for initial review was 46 minutes.
- 96% of all attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- 99.4% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 4 Women categorised as red on arrival.
- 23% of attendees were categorised orange on arrival, decrease to previous month of 29%

<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
- April 2026 Breaches. 23 Women Total Waited >15 minutes. No women categorised Red.

6. Induction of labour (IOL)

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

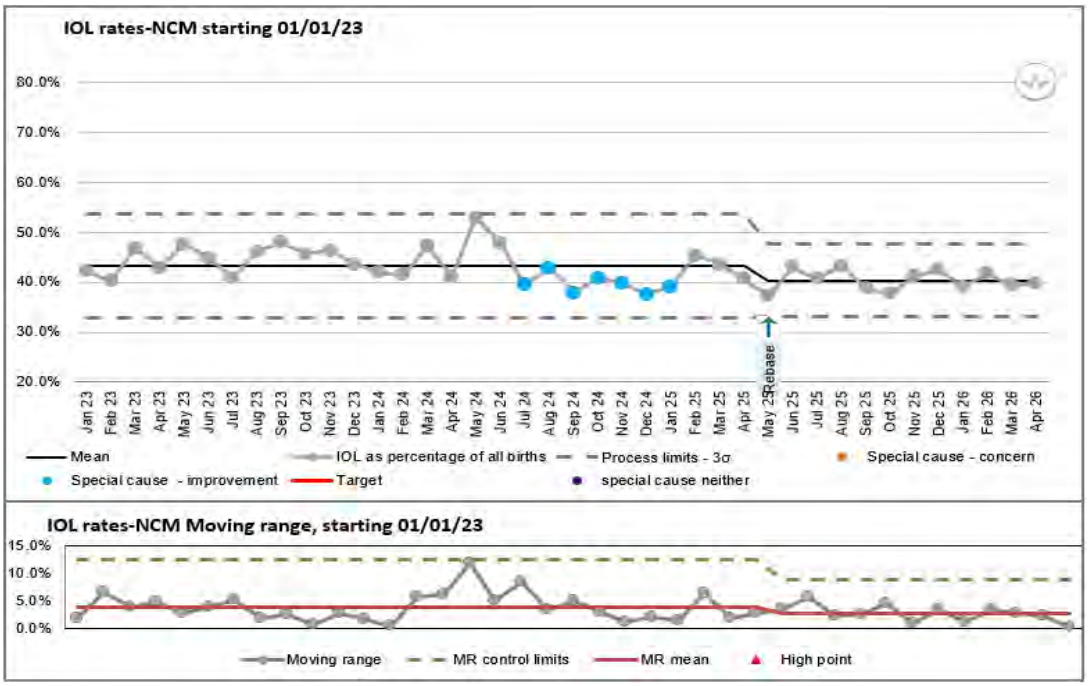
As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at WHH from January 2023 to April 2026, presented as a percentage of all births.

The SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated over the last 13 months

April rate: 39.81% - 398.1 per 1000 births

12-month rolling mean: 40.36%

The previous SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated over the last 14 months against the mean of 44.61%. Following a rebase being set at 01/05/2025, the process mean decreased from 44.61% (baseline of 12) to 40.39%, indicating an improvement in performance. The SPC chart shows common-cause variation relative to the updated mean.



Currently on BadgerNet NHS Choices leaflet is available and leaflets specific to NCM 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.

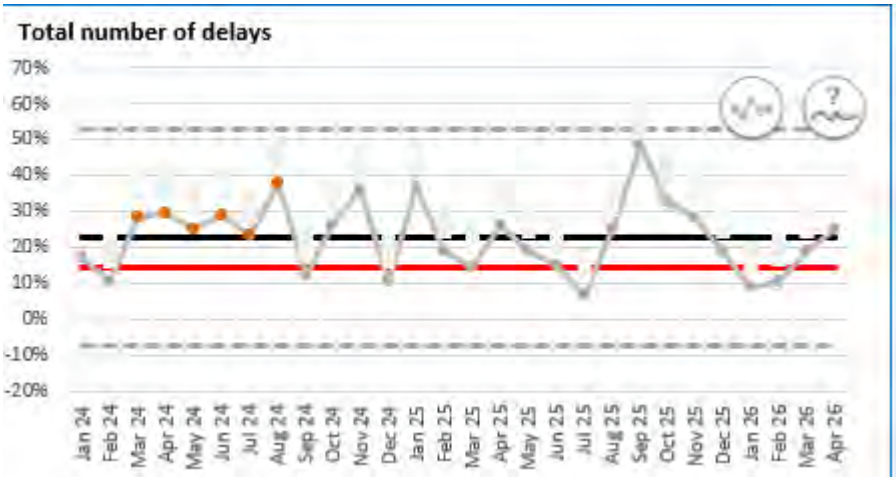
From 1st September, dedicated outpatient IOL slots were introduced on BadgerNotes. This ensures patients are aware of their outpatient pathway from the point of booking, supporting improved planning and communication.

IOL Delays

The IOL delays data for April demonstrates slight increase but a sustainable improvement following the increase we observed in September.

- In April, delays over 12 hours increased to 13.3%, and delays over 24 hours increased to 8.3%, bringing the overall **Total delay rate to 21.6%**
- In March, delays over 12 hours reduced to 10.6%, and delays over 24 hours dropped to 6.0%, bringing the overall **Total delay rate to 16.6%**

The SPC chart shows April remains below the long term average, although there has been a further increase this month.



- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 30th April 2026.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	43	129	51	29	87	60	48	447
Total Delayed	23	9	5	0	23	15	3	78
% of Total	53.49%	6.98%	9.80%	0.00%	26.44%	25.00%	6.25%	17.45%

- There has been a **14.9%** increase in the number of women undergoing IOL from **389** in March to **447** in April.
- There has been a **34.5%** increase in the total number of delays from **58 (14.91%)** in March to **78 (17.45%)** in April.
- The percentage of delays is highest at COC at **53.49%**, compared with **0%** at **MWL S&O**.

Action Plan

Following discussion with the Obstetric Lead, it has been agreed that cervical ripening balloons will be introduced into practice. Balloons will become the first-line method for multiparous women. Primiparous women will commence with 24 hours of Propess, followed by 12–18 hours of balloon ripening where clinically appropriate. This approach aims to reduce prolonged ripening phases, increase the proportion of women suitable for timely ARM, and support a more predictable and efficient progression through the induction pathway.

Work to introduce cervical ripening balloons is ongoing and has been shared with the obstetric team at our most recent obstetric audit, however progress is currently delayed due to lack of response from procurement, which is impacting implementation. This remains a priority as it is a cost improvement.

A separate Standard Operating Procedure (SOP) is not required, as a regional guideline is already in place. An appendix will be added to the existing local guidance to reflect the updated approach and ensure clarity around implementation.

Action	Notes/progress	Due date
Interim Theatre Co-ordinator role to be advertised by 30.06.26.	Role has been advertised, pending recruitment.	30.06.26
Induction of Labour (IOL) patient information videos to be finalised and published by 30.06.26.	Videos in development to support informed decision-making and improve women's understanding of the process. These will be voiced by NCM staff and made available in multiple languages to enhance accessibility.	30.06.26
Proposal to introduce the use of cervical ripening balloons to be submitted to the Product Evaluation Group (PEG) for approval by 31.07.26.	This will become the first line method of IOL for multiparous women and is expected to reduce the duration of the ripening phase, increase the number of women suitable for timely artificial rupture of membranes (ARM), and support improved patient flow through the pathway. The proposed change will be progressed through the appropriate governance process, Product Evaluation Group (PEG) due to the introduction of a new consumable.	31.07.26

A reverse RAG rating is used in the action plan.

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

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

7. MNSI position and reports received

7.1 Background

To ensure Trust Board has oversight of the sevice's position with

regard to cases being investigated by MNSI an update is provided each month.

7.2 Current position

One case in progress - Referred April 2025 MI-041711 (HIE/NND) in progress – Draft report delayed until COD from PM. Inquest date deferred now until October 2026

8. Assurance committee (if relevant)

8.1 Diabetes

The service has adopted the regional guideline for pre-existing diabetes and implemented a local guideline for gestational diabetes. A weekly multidisciplinary clinic is established for women with pre-existing diabetes, supported by a Diabetes Specialist Midwife, Consultant Diabetes Nurse, Consultant Obstetrician and a Diabetes Consultant with expertise in hybrid closed-loop insulin therapy. A separate weekly clinic for gestational diabetes is also in place, supported by the Diabetes Specialist Midwife. Referral criteria within BadgerNet have been updated to strengthen oversight and prioritisation, and Maternity Support Workers have completed training to deliver blood glucose monitoring education. Additional administrative support (0.2 WTE) has been implemented to assist the pathway.

Despite these developments, several risks remain.

- Challenges with Diabetes Specialist Nurse vacancies. If there is not sufficient Diabetes specialist Nurses to support the running of the joint medical and obstetric service for individuals with pre existing diabetes or gestational diabetes there may be poor outcomes for women. (Risk rating – 8)

- Short term absence of Medical Consultant being covered by consultant colleagues

- Pathway requires embedding with sufficient staffing and resources to support women. (Risk rating – 15)

- The new guideline has increased the number of women who are having HbA1c bloods completed which has increased the workload of the service.

Action	Notes/progress	Due date
Gap analysis has been completed and been sent to LMNS	Resilience within the Diabetes Specialist Midwife workforce is being strengthened, with recruitment to a Band 6 role (15 hours). A structured training plan is in place, with support from the Consultant Nurse to develop capability and expertise. Due to ongoing vacancies within the diabetes nursing team, support is currently being provided by the Consultant Nurse, with limited resilience. The CBU manager will meet with the team to agree sustainable arrangements for ongoing cover, including contingency planning for anticipated absences.	31.07.26
Dietician role to be agreed and progressed to advertisement	Permanent funding has been secured for a 0.6 WTE Dietitian. The Lead Dietitian is currently scoping the model of support required for the service. The post will be advertised by 30.06.26.	31.07.26
Guidelines re management of pre-existing and gestational diabetes to be implemented.	Local guideline for the management of gestational diabetes has been implemented and is in the process of being embedded within the service. This has resulted in increased workload. Awaiting to hear from NW Team and NICE regarding update on Guideline for Management of Diabetes	31.10.26
Group Starts for blood glucose monitoring and education at the Living Well Hub	Training plan agreed for MSW	30.6.26
Sustainable medical staffing solution with cross cover capacity to be developed	Short term plan is in place. Medical Director supporting with robust sustainable plan	31.7.26

A reverse RAG rating is used in the action plan.

8.2 Regional Maternity Team Annual Visit letter

A regional maternity team assurance visit was undertaken on 11th March 2026, and the Trust has now received the formal follow-up letter from the regional team. The visit and subsequent letter have resulted in a set of recommendations and required actions for the service.

These recommendations will form the basis of our new Perinatal Improvement Plan**,** which will be overseen jointly by the Executive Team and the regional maternity team. First Perinatal Improvement Plan Meeting is scheduled for 9th June 2026.

This Perinatal Improvement Plan will be structured into defined workstreams with clear accountability, and progress will be monitored through the Trust's governance framework.

The Perinatal Improvement Plan will be reported through the Quality Committee for oversight, and assurance. The formal regional letter will be presented at the next QSAC meeting to ensure full visibility and to support Board-level understanding of the required improvements and associated timelines.

9. Complaints

4 complaints were received relating to care in the maternity and neonatal services in April 2026

Description	Lead	Progress
Dissatisfied 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.	Chris Bentham	
Multiple concerns relating to patients' pregnancy, delays in assessments, scans and neglect. Also concerns regarding patient safety and transfer of care	Jo Richardson	

10. Coroner regulation 28 enquiries

10.1 No Regulation 28 enquiries have been received.

11. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM2608051 – Appendix 1b**			
Subject:	**Maternity & Neonatal Quality Review – May 2026**			
Date of meeting:	5 August 2026			
Action required:	**For information, discussion and to note**			
Author(s):	Tina Moors – Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.			
Executive summary:	This paper provides an update in relation to Maternity and Neonatal quality and provides Quality, Safety and Assurance Committee (QSAC) 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 QSAC 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			

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	No complaints were received in the Maternity and Neonatal Services in May 2026 No Regulation 28 enquiries have been received.		
Purpose: (please select as appropriate)	**Approval** ✓	**To note**	**Decision**
Recommendation:	To note		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QSAC/26/07/094iii**	
	Date of meeting	14 July 2026	
	Summary of Outcome	The Quality Assurance Committee received and reviewed the report and noted that the indicators continue to be monitored through the Perinatal Improvement Board and the Regional Team. The Committee was assured that appropriate oversight and governance arrangements are in place and agreed to recommend the report to the Board for information and assurance. No matters requiring escalation were identified	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

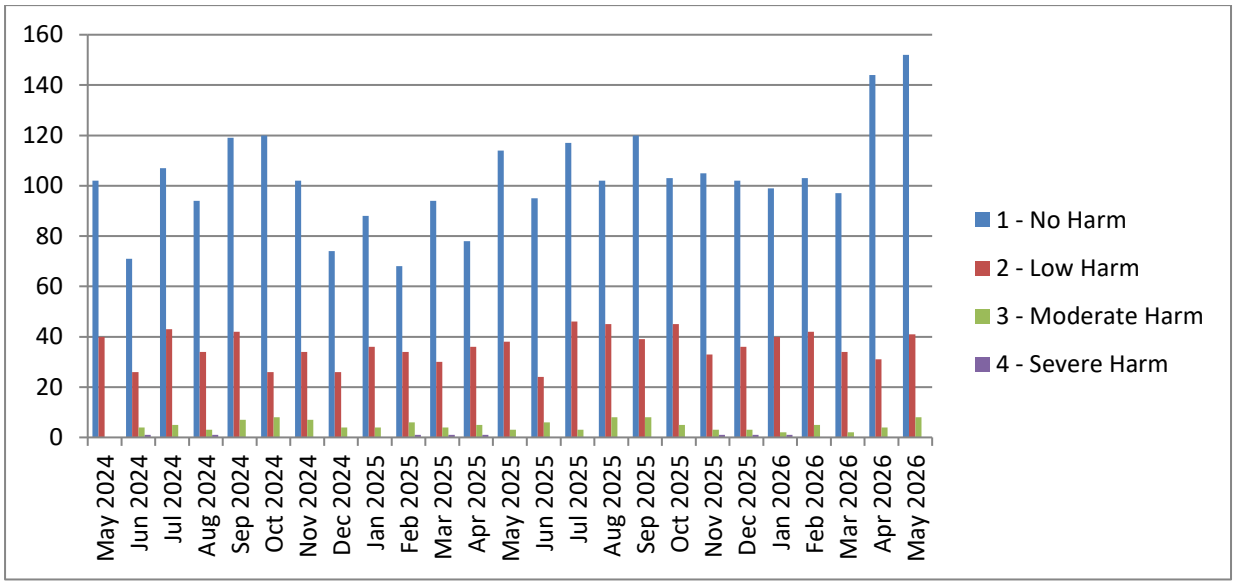
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The paper provides Quality, Safety and Assurance Committee (QSAC) with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action F within the Maternity Incentive Scheme Year 8 *Safety Action F requires the Trust Board to provide effective oversight of maternity safety through clear governance, regular scrutiny of risks and outcomes, and a culture that supports transparency and learning.*

2. Harm events

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU for the period May 2025 – May 2026



There were 202 patient safety events reported across the CBU in May 2026.

There were 0 fatal and 0 severe harm event in May 2026 in the Maternity or Neonatal services.

7 moderate harm event, 3rd/4th degree tears (OASI).

OASI – 7 Cases

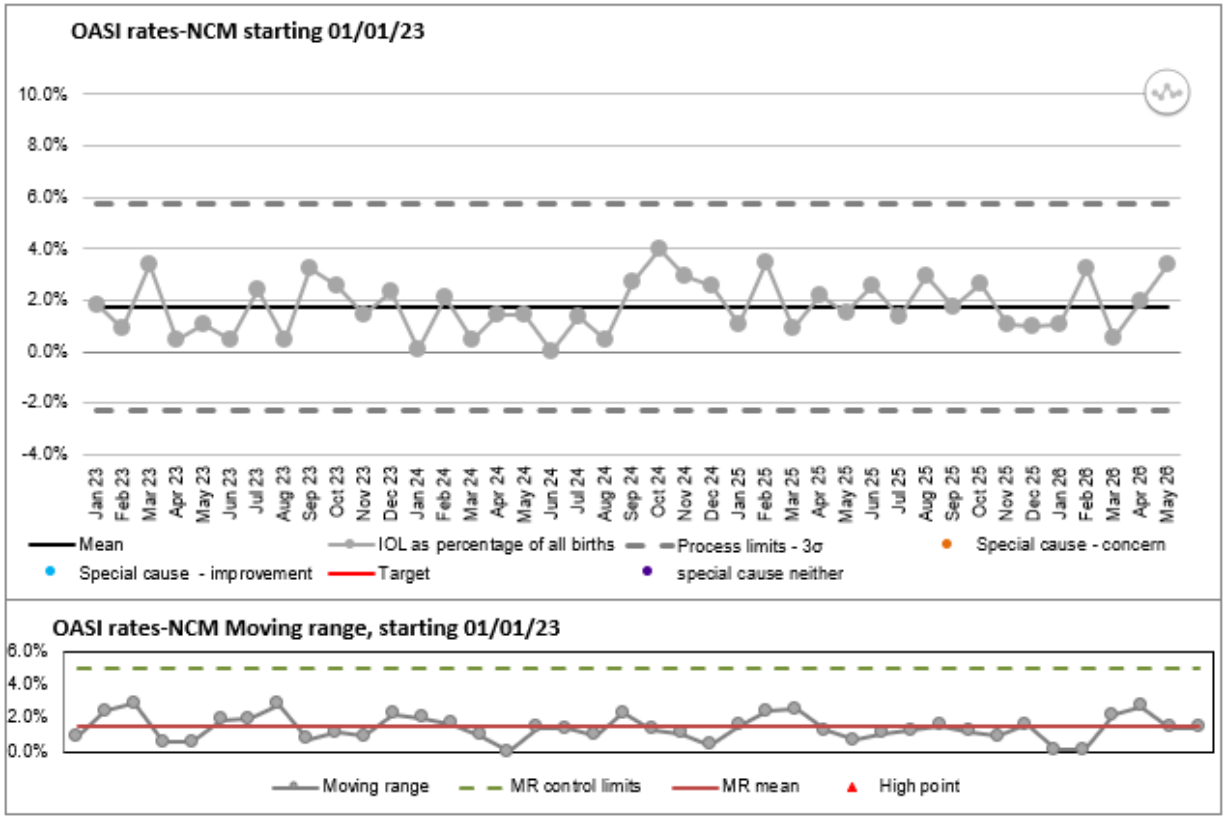
May rate: 3.38% (7/207) – 33.8 per 1000 births

12-month rolling mean: 1.97% (48/2432, 01/06/25-31/05/26) – 19.7 per 1000 births

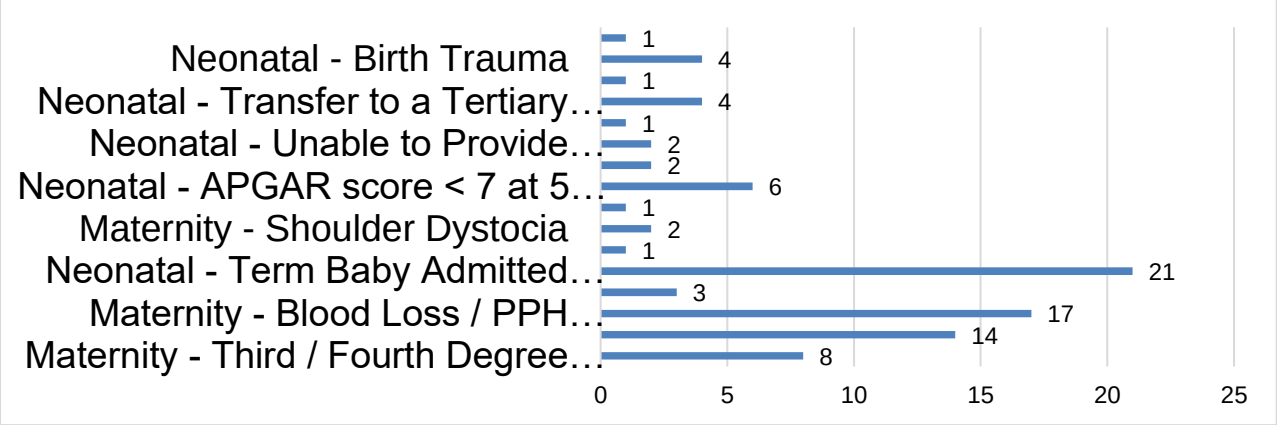
There were 7 instances of a 3rd-degree tear in May 2026, an increase from the 4 reported in April. Cluster review to be completed for Q1.

Mode of birth:

- Four cases with spontaneous cephalic birth (two cases 3a tear, 3b tear, 3c tear)
- Two cases with forceps (3a tear, 3b tear)
- One case with ventouse (3b tear)



Themes from Maternity/Neonatology patient safety events in May 2026 are detailed below:



Neonatal birth trauma – 4 in May no theme (3xC/S 1xForceps)

Top three themes from Maternity/Neonatology patient safety events in April 2026 were:

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

Admission of term babies admitted to Neonatal Unit (NNU)

Term admissions to the Neonatal Unit are reviewed each month by the ATAIN Team, consisting of colleagues from midwifery, obstetrics, neonatal and CBU management. The national target for ATAIN is 6% (Percentage of live births admitted to the neonatal unit at term.) NCM remain an outlier for term admissions. The ATAIN rate for Q4 25/26 is 8.11% which demonstrates a decrease from the 9.18% reported for Q3 2025/2026.The team is committed to identifying areas of improvement and driving this improvement.

Current position

In May 2026, **18** term babies were admitted to the Neonatal Unit. The admissions followed previous months' trends where the majority of admissions were due to respiratory distress. As previously presented to Quality, Safety and Assurance Committee, the service completed a QI project last year and the 'PEEP for 30' pathway was implemented. This provides support for babies in respiratory distress for 30 minutes on Birth Suite or Maternity Theatre.

Action plan

Action	Notes/progress	Due date
Implementation of respiratory distress guideline to support babies remaining with their mothers wherever clinically appropriate.	The guideline has been presented and ratified at the Women's and Children's CBU Governance meeting and is pending upload onto the hub for implementation. Guideline has also been shared with the North West Neonatal Operational Delivery Network (NWNODN) and has received positive feedback.	30.06.26
NWNODN representative to attend an ATAIN MDT meeting to provide external scrutiny and support.	NWNODN representative attendance has been confirmed for 12.06.26.	12.06.26
Review Neonatal Admissions proforma to consider its impact on clinical decision-making and admission rates.	Proforma has been developed and will be in use from 01.06.26.	31.07.26
Deeper analysis of term neonatal admissions.	Deeper analysis is underway to support identification of trends and opportunities for reduction. This has commenced with a focussed review of infants born at 37 weeks gestation.	30.06.26
Structured process for disseminating learning from ATAIN reviews to be developed.	This is currently being developed. The ATAIN performance board within birth suite will continue to be updated on a monthly basis to inform staff of current performance and support ongoing improvement.	30.06.26
Planned collaborative learning from other ATAIN teams within LMNS to help identify new actions to improve condition of babies at birth	Initial meeting being scheduled with Arrowe Park Hospital ATAIN team, with further plans to meet with other units with similar term birth rates and neonatal level	30/6/26

Work continues to be monitored through our Perinatal Improvement Board

Post Partum Haemorrhage

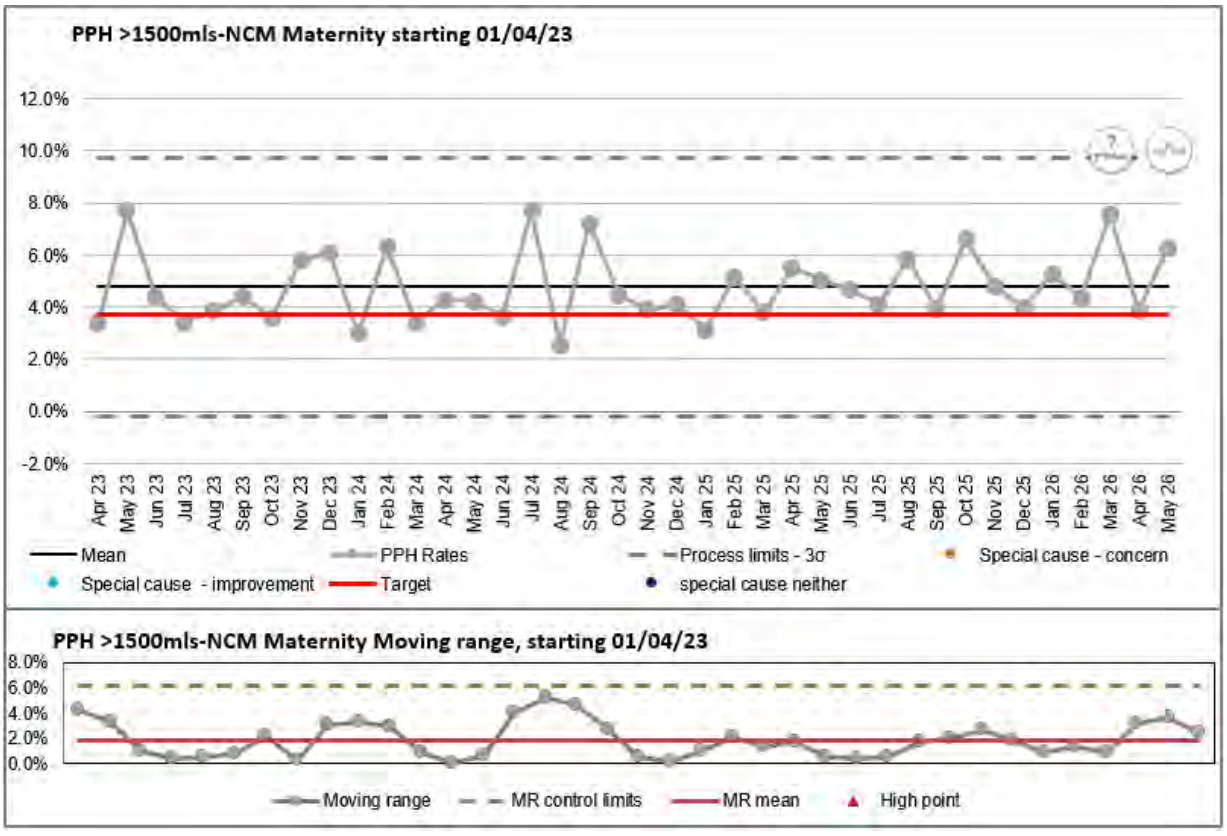
There were **18** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and learning shared.

There were **13** cases of **PPH ≥1500mls**.

- 6 x Caesarean Section
- 3 x Forceps
- 1 x Ventouse
- 3 x Normal Vaginal Delivery

May rate: 6.28% (13/207) – 62.8 per 1000 births

12-month rolling mean: 5.1% (124/2432, 01/06/25-31/05/26) – 51 per 1000 births



May data shows a postpartum haemorrhage (PPH) rate of **6.28% (13/207 births)**, equating to **62.8 per 1000 births**. May data demonstrates common cause variation and an increase compared to April data.

The implementation of the Northwest Regional PPH Guideline is now fully embedded, and we are beginning to see early behavioural and practice changes, even if this is not yet reflected rates. Strengthened risk assessment, improved escalation, and more consistent third-stage management are being observed through case reviews, safety huddles, and intrapartum governance.

The PPH Quality Improvement Project continues in its Test of Change phase, with focused workstreams addressing:

- Standardised risk assessment at every contact
- Accurate quantification of blood loss
- Clear escalation triggers aligned to the regional guideline
- Multidisciplinary simulation and emergency leadership training
- Real-time learning feedback loops

All PPH cases continue to undergo structured review within the Intrapartum Review Group, ensuring that learning is rapidly identified and shared. This is strengthening the link between incident review, practice change, and re-evaluation.

The six-month re-audit (Nov 2025 – May 2026) remains on track and will provide a robust assessment of compliance with the new guideline and the impact of the quality improvement measures. This will inform the next phase of the improvement plan and allow us to refine our approach further.

Deeper dive PPH Audit

Instrumental births (forceps and ventouse) only made up:

- 71 of 762 births **(9.3%)**

However, they accounted for:

- 15 of 35 MOH cases (**42.9%)**

MOH by delivery type:

Delivery Type	**Number of MOH Cases**	**% of all MOH cases**
Spontaneous vaginal birth (NVD)	8	22.9%
Forceps	10	28.6%
Ventouse	5	14.3%
Emergency caesarean section (EMCS)	9	25.7%

Elective caesarean section (ELCS)	3	8.6%

Grouped totals

Group	Number	%
Instrumental births (Forceps + Ventouse)	15	**42.9%**
Caesarean sections (EMCS + ELCS)	12	34.3%
Non operative vaginal births	8	22.9%

When reviewing the birth register, there was no theme regarding practitioners.

Action	Notes/progress	Due date
PPH audit to be conducted covering November 2025 to May 2026 – to be presented at the Joint Audit meeting with Anaesthetics on 23.09.26.	A formal PPH audit will be undertaken of PPH in the six months (November 2025 to May 2026) following implementation of the regional guideline. This will be presented at Clinical Audit on 23.09.26. This will inform further learning and improvement work.	23.09.26
Documentation of PPH Prevention	The BadgerNet PPH prevention assessment does not fully align with the regional guideline. This was escalated on 14.05.26, with all local updates completed and the remaining two criteria now with System C. Staff continue to assess PPH risk correctly in line with the regional guideline.	31.10.26
Procurement of Under Buttock Measuring Drapes for Instrumental Deliveries	Ordered and Expected imminent delivery	12.06.26

Work continues to be monitored through our Perinatal Improvement Board

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 May 2026 compliance for mandatory training across maternity and child health colleagues is 89% for Trust mandatory training and 90% for role specific training (both above the Trust target). Safeguarding Training 92%

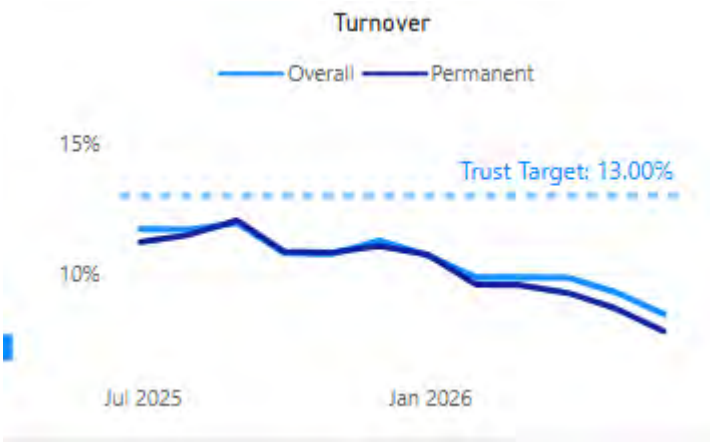
This excludes staff who are currently absent from work on a long-term basis.

Compliance with PDR completion has shown improvement currently positioned at 84%. Action plan continues improve compliance includes allocated time for Line Managers to complete appraisals. Weekly monitoring with oversight from Matrons and escalation to CBU Senior Leadership Team where compliance is not achieved.

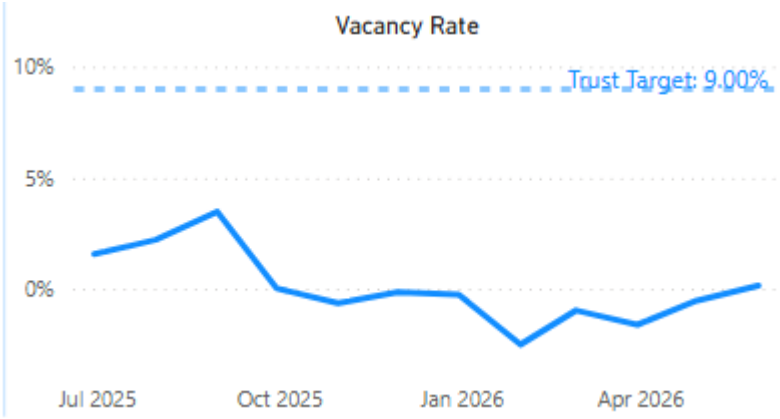
Good compliance with maternity specific training standards is being sustained.

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	Maternal AIMS
Midwives	98%	96%	95.4%	100%	91.4%
Obstetric Consultants	100%	91%	100%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	100%	n/a		n/a	n/a
Maternity Support Workers	97%	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 May 2026 is 7.7%, 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 0.1%. 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 May 2025-May 2026	
Month	**Attendances**
May	577
June	587
July	602
August	588
September	623
October	668
November	562
December	564
January	571
February	552
March	615
April	628
May	618

- In May 2026 618 triage attendances (391 Women) were recorded on the BadgerNet patient record system seeing an increase number of attendances per day of 20 to 30 over the year.
- The longest wait recorded for initial review was 51 minutes.
- ↑**96.7%** of all attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- ↓**99.2%** of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 0.6% Women categorised as red on arrival.
- 37.8% of attendees were categorised orange on arrival, increase to previous month of 23%

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
- May 2026 Breaches. 5 Women Total Waited >15 minutes. No women categorised Red.

6. Induction of labour (IOL)

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

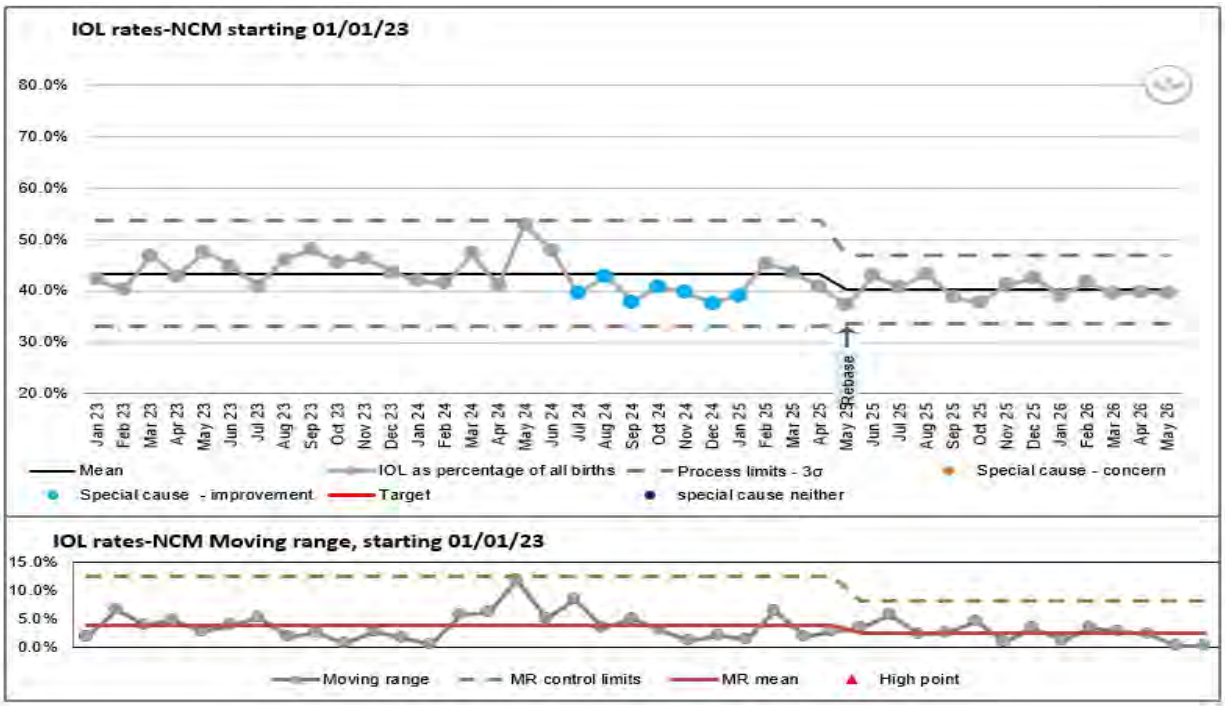
As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at WHH from April 23 to May 2026, presented as a percentage of all births.

The SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated over the last 13 months

May rate: 39.61% (82/207) - 396.1 per 1000 births

12-month rolling mean: 40.55% (980/2417, 01/06/25-31/05/26) - 405 per 1000 births

The previous SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated over the last 14 months against the mean of 44.61%. Following a rebase being set at 01/05/2025, the process mean decreased from 44.61% (baseline of 12) to 40.39%, indicating an improvement in performance. The SPC chart shows common-cause variation relative to the updated mean.

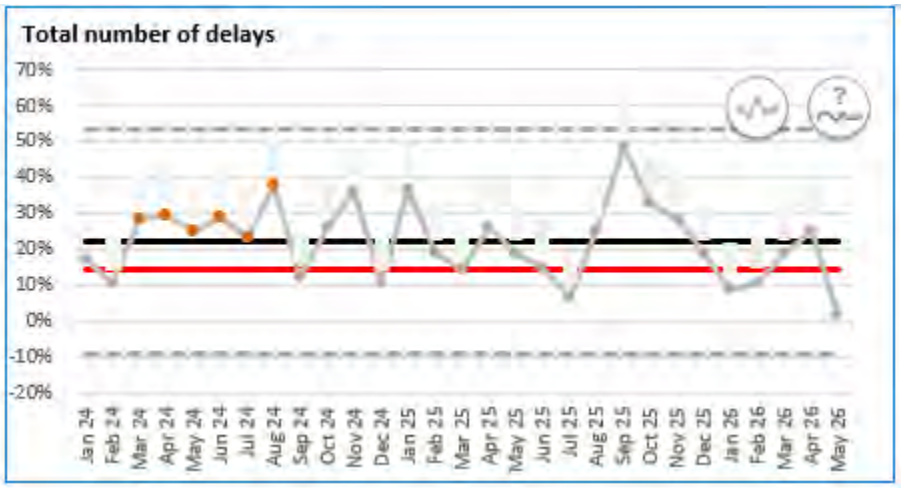


Currently on Badgernet NHS Choices leaflet is available and leaflets specific to NCM have also been developed and will be available via BadgerNet. These are designed to inform patients about the IOL process, associated risks and benefits, declining IOL, and induction prior to 39 weeks.

IOL Delays

The IOL delays data for April demonstrates slight increase but a sustainable improvement following the increase we observed in September.

- In May, delays over 12 hours significantly reduced to 2.78% and delays over 24 hours.1.5 **Total delay rate to 4.2%**
- In April, delays over 12 hours increased to 13.3%, and delays over 24 hours increased to 8.3%, bringing the overall **Total delay rate to 21.6%**



- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 31st May 2026.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	64	159	71	39	124	47	57	561
Total Delayed	46	23	15	0	55	2	11	152
% of Total	71.88%	14.47%	21.13%	0.00%	44.35%	4.26%	19.30%	27.09%

- There has been a **25.5%** increase in the number of women undergoing IOL from **447** in April to **561** in May.
- There has been a **94.9%** increase in the total number of delays from **78 (17.45%)** in April to **152 (27.09%)** in May.
- The percentage of delays is highest at COC at **71.88%**, compared with **0%** at **MWL S&O**.

Action Plan

Cervical ripening balloons will be introduced into practice. Balloons will become the first-line method for multiparous women. Primiparous women will commence with 24 hours of Propess, followed by 12–18 hours of balloon ripening where clinically appropriate. This approach aims to reduce prolonged ripening phases, increase the proportion of women suitable for timely ARM, and support a more predictable and efficient progression through the induction pathway.
Work to introduce cervical ripening balloons remains ongoing. Progress continues to be delayed due to ongoing procurement issues, despite support now being sought from the CBU Manager to help progress this. Implementation remains a priority as the balloons are cheaper than both Cook's and Propess, are expected to significantly reduce terbutaline use, and should support improved patient flow.

The IOL patient information leaflet has been approved by the Readers Panel and will now progress to CBU governance for final review.

Action	Notes/progress	Due date
Interim Theatre Co-ordinator role to be advertised by 30.06.26.	Role has been advertised, pending recruitment.	30.06.26
Induction of Labour (IOL) patient information videos to be finalised and published by 30.06.26.	Videos in development to support informed decision-making and improve women's understanding of the process. These will be voiced by NCM staff and made available in multiple languages to enhance accessibility.	30.06.26
Proposal to introduce the use of cervical ripening balloons to be submitted to the Product Evaluation Group (PEG) for approval by 31.07.26.	This will become the first line method of IOL for multiparous women and is expected to reduce the duration of the ripening phase, increase the number of women suitable for timely artificial rupture of membranes (ARM), and support improved patient flow through the pathway. The proposed change will be progressed through the appropriate governance process, Product Evaluation Group (PEG) due to the introduction of a new consumable.	31.07.26

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

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

7. MNSI position and reports received

7.1 Background

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

7.2 Current position

Two Cases

One case in progress - Referred April 2025 MI-041711 (HIE/NND) in progress – Draft report delayed until COD from PM. Inquest date deferred now until October 2026

One new case referred in May MI-060160 Term Stillbirth during the IOL process

8. Update on other workstreams

8.1 Diabetes

The maternity diabetes service has now adopted the regional guideline for pre-existing diabetes and implemented a local guideline for gestational diabetes. A weekly multidisciplinary clinic is established for women with pre-existing diabetes, supported by a Diabetes Specialist Midwife, Consultant Diabetes Nurse, Consultant Obstetrician and a Diabetes Consultant with expertise in hybrid closed-loop insulin therapy. A separate weekly clinic for gestational diabetes is also in place. Referral criteria within BadgerNet have been strengthened to improve oversight and prioritisation, and Maternity Support Workers have completed training to deliver blood glucose monitoring education. Additional administrative support (0.2 WTE) has been added to assist the pathway.

Despite these improvements, several risks remain. These include ongoing Diabetes Specialist Nurse vacancies, short-term consultant absence, increased workload due to expanded HbA1c testing, and the need for sufficient staffing and resources to fully embed the pathway. These issues have contributed to recent escalations regarding staffing shortfalls, process gaps and challenges in maintaining a safe service. In response, a series of immediate actions have been agreed and implemented.

Immediate Actions

- Centralised diabetes inbox established, monitored seven days a week, providing a dedicated escalation route for diabetes-related communications.
- Daily allocation of a midwife (09:00–17:00) to monitor the inbox, escalate concerns, undertake welfare calls and support referrals.
- Development of a clear pathway for the allocated midwife, including escalation and signposting processes.
- Additional administrative support from the Digital Team one day per week, with MSWs supporting referral management and fail-safe processes.
- Interim arrangements for Friday telephone clinic cover.
- Meeting arranged with the Lead Nurse to review current DSN allocation and explore opportunities to strengthen provision.
- Recruitment to the Dietitian post progressing, with advertisement due beginning July 2026.

Looking ahead, further service development work is underway. The LMNS gap analysis will inform a business case for a maternity-specific Diabetes Specialist Nurse. Options for securing full-time Band 6 support are being explored. External service models at East Lancashire and Stockport will be reviewed to identify learning and support ongoing redesign of the continuity of care model.

8.2 Perinatal Improvement Plan

A regional maternity team assurance visit was undertaken on 11th March 2026, and the Trust has now received the formal follow-up letter from the regional team. The visit and subsequent letter have resulted in a set of recommendations and required actions for the service.

Following the visit a Perinatal Improvement Plan (PIP) has now been developed**,** which will be overseen jointly by the Executive Team and the regional maternity team. First Perinatal Improvement Plan Meeting was on 9th June 2026 and will continue monthly thereafter. We received good feedback and further support relating to each workstream that will formulate the PIP

This Perinatal Improvement Plan will be structured into defined workstreams with clear accountability, and progress will be monitored through the Trust's governance framework.

The Perinatal Improvement Plan will be reported through the Quality Committee for oversight, and assurance. The formal regional letter will be presented at the next QSAC meeting to ensure full visibility and to support Board-level understanding of the required improvements and associated timelines.

8.3 Ockenden Nottingham Review 2026

Ockenden Report 2026 – Key Points and Next Steps for NCM

The Independent Review of Maternity Services at Nottingham University Hospitals (NUH), led by Donna Ockenden, has now been published on 24/06/26. It is the largest NHS maternity review undertaken within the NHS, examining over 2,500 family cases between **2012 and 2025**. The review identified significant and sustained failures in maternity and neonatal services, resulting in avoidable harm to mothers and babies.

Headline Findings

- Avoidable harm identified in 21% of maternity cases and 6% of neonatal cases.
- Failures sustained over more than a decade, including:
    - Unsafe staffing
    - Bullying and low psychological safety
    - Failure to listen to women and families
    - Escalation failures
    - Fragmented care
    - Weak governance and poor learning
- Significant psychological harm, with *1 in 3 women reporting traumatic birth experiences*.
- Clear evidence that culture, workforce pressures, and governance weaknesses directly contributed to avoidable harm.
- Serious failings in post death care, prompting national action and Human Tissue Authority requirements.

National actions announced include

- **18 Immediate and Essential Actions (IEAs)** across eight themes, including:
  - Listening to women and families
  - Workforce planning and safe staffing
  - Training and multi-professional learning
  - Risk assessment throughout pregnancy
  - Incident investigation and family involvement
  - Governance and board accountability
  - Culture, teamwork, and psychological safety
  - Mothers who have died and post-death care

- A National Maternity Taskforce will now consider the Ockenden findings alongside the upcoming **Amos Review (due 30 June 2026).**
- National guidance and expectations for providers will follow in September.

Immediate National Requirements

- Trusts will be asked to ensure robust oversight of mortuary services.
- The Human Tissue Authority will require a review of mortuary records from 2015–2026.
- Martha's Rule will be rolled out across all maternity and neonatal settings.
- Strengthened expectations around Duty of Candour and leadership understanding.
- All boards are expected to read the report and reflect on implications for their own services.

Assurance for NCM

1. Gap Analysis of IEAs

NCM will undertake a comprehensive gap analysis against all 18 Immediate and Essential Actions and their underpinning requirements.

- This work will be led by QUIN (CBU leadership) supported by Maternity Governance Team.
- Findings will be reported to the Board and incorporated into the local Perinatal Improvement Plan for ongoing monitoring.

2. Awaiting National Taskforce Guidance

While the gap analysis will begin immediately, we will await formal guidance from the National Maternity Taskforce before implementing major changes. This ensures:

- Alignment with national expectations
- Consistency across the NHS

- Avoidance of duplication or premature action
- A coordinated approach to improvement

Summary

The Ockenden Review highlights serious and sustained failings in maternity and neonatal care within Nottingham University Hospitals NHS Trust and reinforces the importance of maintaining a culture of safety, openness, learning and compassionate care. North Chesire and Mersey acknowledges the findings of the review and supports the national actions arising from it. An initial review has identified that existing governance, patient safety and maternity assurance arrangements are established within the trust

A detailed gap analysis will be completed against the national recommendations, with any required actions monitored through Trust's Governance framework. We will await guidance from the National Maternity Taskforce to support a coordinated and compliant response. Further updates will be provided to the Board once the detailed analysis has been completed.

10. Complaints

0 complaints were received relating to care in the maternity and neonatal services in May 2026

11. Coroner regulation 28 enquiries

11.1 No Regulation 28 enquiries have been received.

12. Recommendations

The members of the Quality, Safety and Assurance Committee is asked to receive and discuss the report. The report will be shared with Trust Board.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM2608051 – Appendix 2**			
Subject:	**Maternity Incentive Scheme Year 8**			
Date of meeting:	5 August 2026			
Action required:	**For information, discussion and to note**			
Author(s):	Helen Wall – Assurance & Improvement Manager (Women's and Children's) Tina Moors – Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum. 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 six 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			

<table>
<tr><td></td><td colspan="3">maternal deaths, and brain injuries by the end of 2025, compared to the 2010 baseline.

This paper provides an overview of current progress with the Saving Babies' Lives Care Bundle and incorporates feedback received from the Local Maternity and Neonatal System (LMNS).</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">For the report to be shared with the Trust Board as part of the quarterly maternity and neonatal overview.</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">QSAC/26/07/094i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">9th July 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

NHS Resolution has now commenced year eight of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 6 safety actions. Specifications and timelines were released on 31 March 2026. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 2 March 2027.

Trusts that can demonstrate compliance all 6 safety actions will recover 10% of their CNST contribution and receive a share of unallocated funds.

2. Current position

2.1 Current position against MIS Year 8

There are currently no concerns with the progress against MIS Year 8. Meetings with the leads and the assurance and improvement manager will commence in June to ensure oversight of the current position and progress is maintained. The process for reporting progress to the Quality and Safety Assurance Committee is currently being reviewed with the Trust informatics team. The aim is the current position will be presented within the internal obstetrics dashboard to clearly identify progress and areas for escalation and concerns. The team expect this to be available by July 2026.

2.2 Saving Babies' Lives Care Bundle

There have been no further reviews for the Saving Babies' Lives Care Bundle since the previous update.

With the launch of MIS Year 8, the reporting procedure has changed and there is no longer a requirement for this to be reviewed by the LMNS. The responsibility sits with the Trust to ensure accountability and oversight. However, the LMNS have informed the Trust that they will continue to monitor and support. The Trust are expected to receive clear guidance on the framework for monitoring this month.

The audit and assurance midwife has continued to audit the Trust's compliance against the requirements of SBL. The Trust are prepared for external review of these auditing processes.

Element 6 of SBL refers to the requirements for women with pre-existing diabetes. Women should be seen in a 'one-stop' clinic where there is a diabetes consultant, consultant obstetrician, diabetes specialist nurse, diabetes specialist midwife and a dietitian. A significant challenge has been identifying funding for a dietician to commence in post. On 28 May 2026 it was confirmed that a dietician 0.6wte will be joint funded by Women's and Children's CBU and the Therapies team. An expression of interest for this post will be advertised in June 2026. The introduction of this point will support clinics, one to one education and group education sessions to improve women's knowledge and management of diabetes in pregnancy.

3. Monitoring/reporting routes

Progress relating to the Saving Babies' Lives Care Bundle version 3.2 (SBLCBv3) and Maternity Incentive Scheme (MIS) Year 8 is reviewed and discussed at monthly Clinical Business Unit (CBU) Governance meetings. The content of this report will be formally presented at the Women's Health Governance meeting in June 2026 to ensure continued oversight and alignment with service improvement priorities.

4. Recommendations

The Quality, Safety and Assurance Committee in Common members are requested to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/051 – Appendix 3**			
Subject:	**Maternity Self-Assessment Tool**			
Date of meeting:	5 August 2026			
Action required:	**For information and to note**			
Author(s):	Helen Wall – Assurance & Improvement Manager (Women's and Children's)			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: This paper provides findings following completion of the NHS Maternity self-assessment tool, to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements to ensure a safe, effective maternity service. The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the self-assessment tool are to ensure safer care for this cohort. Achieving the principles within the tool will have a positive impact on this group.			
Executive summary:	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			

<table>
<tr><td></td><td colspan="3">also required as part of the North West Region Maternity Performance Oversight Panel assurance process.

The WHH benchmarking update in this report aligns to the key themes identified within the recommended tool:
• Directorate infrastructure and leadership
• Multidisciplinary team dynamics
• Governance infrastructure and ward-to-board accountability
• Application of national standards and guidance
• Safety culture across the Care Group and Trust
• Comprehension of business and impact on quality

The Maternity self-assessment tool identifies 159 criteria. As at 1st May 2026, WHH is fully compliant with 139/159 criteria. This equates to 87.4% of the criteria, an improvement from 86.8% when the last assessment was completed. Actions are ongoing to achieve full compliance. It is anticipated further progress will be made against all ongoing actions by the end of Q2 2026/27

The detail of the self-assessment is included in appendix one.

This paper is asked to be noted for information</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">For the Trust Board members to note the contents of this report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QSAC26/05/044iii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">12 May 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">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 Maternity self-assessment tool has been developed in response to national maternity review findings, including the Kirkup Report (2015) and recommendations for good safety principles within maternity services. The current tool has been further influenced by the findings of the Ockenden review (2020), 7 features of safety culture and the emerging themes from services on the safety support programme, and the trusts found to be outstanding following Care Quality Commissioner reviews in other maternity services across England.

The tool has been designed for NHS maternity service providers to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

The tool is underpinned with a philosophy of promoting a positive leadership and safety culture and to inform the Trust Board and Commissioners of the current maternity quality improvement and safety programme.

2. Key elements

The Maternity self-assessment tool has been structured according to the six key areas important for the leadership and quality of maternity services that emerged in the diagnostic phase (year 1) of the Maternity Safety Support Programme (2018). These were:

- Directorate infrastructure and leadership
- Multidisciplinary team dynamics
- Governance infrastructure and ward-to-board accountability
- Application of national standards and guidance
- Safety culture across the division and trust
- Comprehension of business and impact on quality

3. Measurements/evaluations

The Maternity self-assessment tool identifies 159 criteria to be evidenced against. As at 1st May 2026, WHH is fully compliant with 139, which equates to 87.4% of all actions. This is an improvement from the position when the assessment was last completed when compliance was noted against 86.8% of the criteria.

The 159 criteria have been RAG rated as follows: -

- Red 4 (3%)
- Amber 17(11%)
- Green 139 (87%)

Those criteria identified as amber and red can be themed within the following:

- Implementation of a Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation. This is in draft and will be in place by the end of May 2026.
- Establishment of a formal maternity safety improvement plan – this is underway as part the development of the Quality Improvement Plan for the maternity service.
- Well-developed and defined trust wide communication strategy to include maternity services – this action is on hold pending the Bridgewater integration.

Actions are ongoing to achieve full compliance. It is anticipated further progress will be made against all ongoing actions by the end of Q2 2026/27.

The detail of the self-assessment is included in appendix one.

4. Monitoring/reporting routes

Progress against the action plan will be monitored via the Quinumvirate and through the Women's and Children's monthly CBU governance meeting.

Best practice requires the self-assessment tool be completed every six months with a report to Quality Assurance Committee for discussion and for the report to then be shared with the Trust Board. Accordingly, a reviewed position will be brought to Quality Assurance Committee in November 2026.

5. Conclusion

The Maternity self-assessment tool has been undertaken, and the 159 criteria have been RAG rated. 139/159 of the criteria are compliant, which equates to 87% of all actions. Actions are in place to achieve full compliance. This has been developed in conjunction with the wider maternity strategy and transformation action plan, the North West Region Maternity Performance Oversight action plan, the workforce strategy and service equity and equality plans.

6. Recommendations

The Trust Board are asked to note this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/051 – Appendix 4**			
Subject:	**Quarter 4 2025-26 Perinatal Mortality Review/Audit**			
Date of meeting:	5 August 2026			
Action required:	**To note**			
Author(s):	Tina Moors, Interim Director of Midwifery, Lisa Davies Governance Quality Lead – Women's & Children's CBU			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and focusses attention on improving outcomes for this protected group.			
Executive summary:	The Perinatal Review Tool was 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 4 (Q4)			

	PMRT report for the period covering 01/01/2026 – 31/03/2026. During Q4, WHH did not report any babies for review to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): WHH stillbirth rate for Q4 2025/26 was 0.00 per 1000 births. WHH annual stillbirth rate (2024/25) was 1.6 per 1000 births. The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births. WHH Neonatal mortality rate during Q4 2025/2026 was 0.00 per 1000 live births. The MBRRACE-UK national neonatal rate is 3.0/1000 live births. During Q4, 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+6 weeks • One baby was born at 34+6 weeks In one case, there were no issues with care for the mother and baby up to the point that the baby was confirmed as having died. In one case, there were issues with care identified for the mother and baby up to the point that the baby was confirmed as having died that would have made no difference to the outcome for the baby. In one case, there were issues identified with the care of the mother following confirmation of the death of her baby that would have made no difference to the outcome for the mother. In one case, there were no issues identified with the care of the mother following confirmation of the death of her baby.

<table>
<tr><td></td><td colspan="3">Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is shared at Safety Oversight Meeting and monitored through Women's and Children's Governance Committee.

Full compliance is reported in relation to the Maternity Incentive Scheme; Safety Action 1 standards being met.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">For the Trust Board members to note the contents of this report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QSAC/26/05/044iv</td></tr>
<tr><td>Date of meeting</td><td colspan="2">12 May 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">The Quality Assurance Committee received and reviewed the Perinatal Mortality Review Tool (PMRT) report and noted the findings and associated learning. The Committee was assured that robust processes are in place for the review of perinatal deaths, with identified themes, actions, and learning being monitored through established governance arrangements. The Committee agreed to recommend the report to the Board for information and assurance.</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 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 4 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 4 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 no cases for review reported to MBRRACE-UK during Q4 reporting period.

2.1 Quarter 4. WHH Stillbirth Rate:

- WHH Q4 stillbirth rate for 2025/2026 is 0.00 per 1000 births.
- WHH rolling 12-month stillbirth rate is 2.90 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.

Table 1: WHH Mortality Data Over 12-month Period:

Metric	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	12-month total
Number of live births	571	652	610	555	2388
Total number of stillbirths >24 weeks	2	1(+*1)	2(+*2)	0(+*1)	5 (+4)
Total Stillbirth Rate >24 weeks (per 1000 births)	3.50	1.53	3.27	**0.00**	**3.80**
Number of intrapartum stillbirths	0	0	0	0	0
Number of term stillbirths (>37 weeks)	1	0	0	0	1
Neonatal deaths before 28 days (per 1000 births)	0.00	1.53	0.00	0.00	**2.1**
Neonatal deaths before 28 days	0 (+***1) (+**1)	1 (+**1)	0 (+***1)	0	3

*BadgerNet includes TOPFA (Termination of Pregnancy for Fetal Abnormality) stillbirth data that does not meet the criteria for PMRT.

**BadgerNet data includes neonatal deaths of babies born alive <24 weeks that do not meet the criteria for PMRT.

***BadgerNet data includes neonatal deaths of babies born at WHH who died elsewhere and not included in WHH PMRT data.

2.2 Q1. WHH Neonatal Mortality Rate:

- WHH neonatal mortality rate during Q4 2025/2026 is 0.00 per 1000 live births.
- WHH rolling 12-month neonatal mortality rate is 0.83 per 1000 live births.
- The MBRRACE-UK national rate is 3.0/1000 live births.

3. Quarter 4 2025/26 PMRT review findings

3.1 Quarter 4 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 24+6 weeks gestation was a stillbirth. This mother presented to a routine community midwife appointment and the fetal heart could not be detected - fetal death in utero was then confirmed. There were no issues with care identified in this case. The cause of death was agreed as possible placental abruption.

One baby born at 34+6 weeks gestation was a stillbirth. This mother presented to a routine community midwife appointment and the fetal heart could not be detected - fetal death in utero was then confirmed. There were issues identified with care related to the measurement and plotting of the symphysis fundal height on the customised growth chart that would have made no difference to the outcome for the baby. There were issues identified with care related to the request for Kleihauer test following the birth of the baby that would have made no difference to the outcome for the mother. The cause of death was identified as feto-maternal haemorrhage.

Surveillance Findings:

- Both babies were of a singleton pregnancy.
- The women were aged between 28-42 years.
- One woman was identified as Chinese

  One woman was identified as Indian.
- Neither woman had any communication problems because of learning difficulties/hearing problems.
- Both women had a BMI within normal range.
- Neither woman identified as a smoker.
- 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 Q4 two PMRT review panels took place. Parental perspective of the care received was sought.

In one case, there were no issues with care for the mother and baby up to the point that the baby was confirmed as having died.

In one case, there were issues with care identified for the mother and baby up to the point that the baby was confirmed as having died that would have made no difference to the outcome for the baby.

In one case, there were issues identified with the care of the mother following confirmation of the death of her baby that would have made no difference to the outcome for the mother.

In one case, there were no issues identified with the care of the mother following confirmation of the death of her baby.

Table 2: Q4 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
Grade A The review group concluded that there were no issues with care identified	**1**	**1**
Grade B The review group identified care issues which they considered would have made no difference to the outcome	**1**	**1**
Grade C The review group identified care issues which they considered may have made a difference to the outcome	**-**	**-**
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- Q4 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 Q4 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 Q4 which were attended by multidisciplinary internal and external panel members.

Table 4: Q4 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/01/2026 – 31/03/2026 = 2			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	1	1	2
Admin/Clerical	0	0	0
Bereavement Midwife	1	1	2
External Rep	1	1	2
Management Team	1	1	2
Midwife	1	1	2
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	/	/	/
Obstetrician	1	1	2
Other	0	0	0
Governance Manager	1	1	2
Safety Champion	0	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

- Parental involvement was sought in all cases as part of PMRT panel review.
- Both cases were notified to MBRRACE-UK and surveillance completed within the required timescale.
- In one case the baby was found to be measuring small for gestational age at the 20-week anomaly scan and was appropriately referred to the fetal medicine consultant for review.
- In one case the plotting of measurements on the customised growth chart during the antenatal appointment frequency was not as per NICE guidance.
- It was noted that bereavement care was good in both cases.

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

Q4 Action	Lead	Due Date	RAG rating
Appointment frequency for low-risk nulliparous woman and the requirement for measuring and plotting SFH on a customised growth chart to be shared as learning with the midwifery team.	Community Midwife Manager	31/03/2026	
Share learning and education for laboratory team on indication for blood tests for intra uterine death and stillbirth.	Specialist Transfusion Lead	31/03/2026	
In progress and outstanding actions	**Lead**	**Due Date**	**RAG rating**
Routine enquiry for domestic abuse required at every maternity contact where the woman is seen alone.	Antenatal & Postnatal Maternity Matron	30/04/2026	

4. Summary

WHH Q4 PMRT audit recorded two babies reported to MBRRACE born between 01/01/2026 and 31/03/2026.

- WHH stillbirth rate for Q4 2025/26 was 0.00 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 Q4 2025/2026 was 0.00 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- There were two babies requiring PMRT review panel in Q4.
- Full compliance reported in relation to Maternity Incentive Scheme; Safety Action 1 standards are being met.

5. Monitoring/reporting routes

This Report was shared at the Women's and Children's Clinical Business Unit Governance Meeting in April 2026.

6. Recommendations

The Trust Board are asked to note the findings of this paper as per MIS Year 7 recommendations.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM26/08/051 – Appendix 5**			
Subject:	**2025-2026 Quarter 4 Avoiding Term Admissions into Neonatal Unit (ATAIN) report**			
Date of meeting:	5th August 2026			
Action required:	**To Note**			
Author(s):	Kat Woodger – Consultant Paediatrician Delyth Webb – Consultant Paediatrician Annabel Grossmith – Consultant Obstetrician & Gynaecologist Emma Bentham – CBU Personal Assistant			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the principles within ATAIN will have a positive impact on this group.			
Executive summary:	• Q4 2025/26 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 8.11%, which does not meet the national target (6%) or the NWNODN target (5.6%). • All term admissions including those <6 hours have been included as this is the national and regional expectation. • All term admissions in Q4 were reviewed and learning from these cases informs the ATAIN action plan.			

	• An ATAIN action plan is in place to improve the service position against ATAIN standards. • The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	To note		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QSAC26/07/094	
	Date of meeting	14th July 2026	
	Summary of Outcome	The Committee received the ATAIN update and was assured that appropriate quality improvement activity is in place to reduce avoidable term admissions to neonatal care. Oversight of the ATAIN programme, including performance monitoring, delivery of improvement actions and review of outcomes, is provided through the Perinatal Improvement Board.	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***Submit to Trust Board***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

The ATAIN objective is to reduce the number of avoidable admissions of infants born at term (≥37+0 weeks gestation) to the Neonatal Unit (NNU). The national ambition is to ensure this rate is below 6% of live births. Northwest Neonatal Operational Delivery Network (NWNODN) has set a separate target of 5.6% for term admissions to neonatal units. This initiative is to reduce morbidity while keeping parents and babies together after birth.

The NHSE focus is to reduce the incidence of term admissions for breathing issues, hypoglycaemia, jaundice and/or poor condition at birth. NHSE estimate that at least 20% of term admissions in UK maternity units are potentially avoidable.

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

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

2. Key elements

2.1 WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies admitted to the Neonatal Unit (NNU) during the Q4 reporting period from 1 January 2026 to 31 March 2026.

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

Maternity Incentive Scheme (MIS) specification directs providers to report the ATAIN data to the Trust Board of Directors on a quarterly basis. It is also important to review the data over a longer time period to assess trends.

2.2 Summary of unexpected term admissions to NNU

The 25/26 Q4 ATAIN rate was 8.11%. This does not meet the national target of 6% or the NWNODN target of 5.6%. Warrington Hospital remains an outlier in the NWNODN for term admissions, although the rate of admissions this quarter has reduced from Q3.

WHH has remained an outlier for much of the last three years despite careful MDT analysis and understanding of our data and robust projects put in place to address recurring themes. For example, ‘PEEP for 30’ project (up to 30 minutes of respiratory support at delivery prior to considering NNU admission) has avoided significant numbers of admissions; our Transitional Care (TC) offering has been expanded to be

more consistent and there has been a change in training and guidance in fetal monitoring in low-risk settings.

Ongoing work targeting term admissions includes ongoing MDT CTG mandatory training and weekly MDT CTG workshops, ongoing work on the maternity diabetes pathway of care as a significant number of admissions are babies of mothers with diabetes whose babies have an increased risk of respiratory distress at birth.

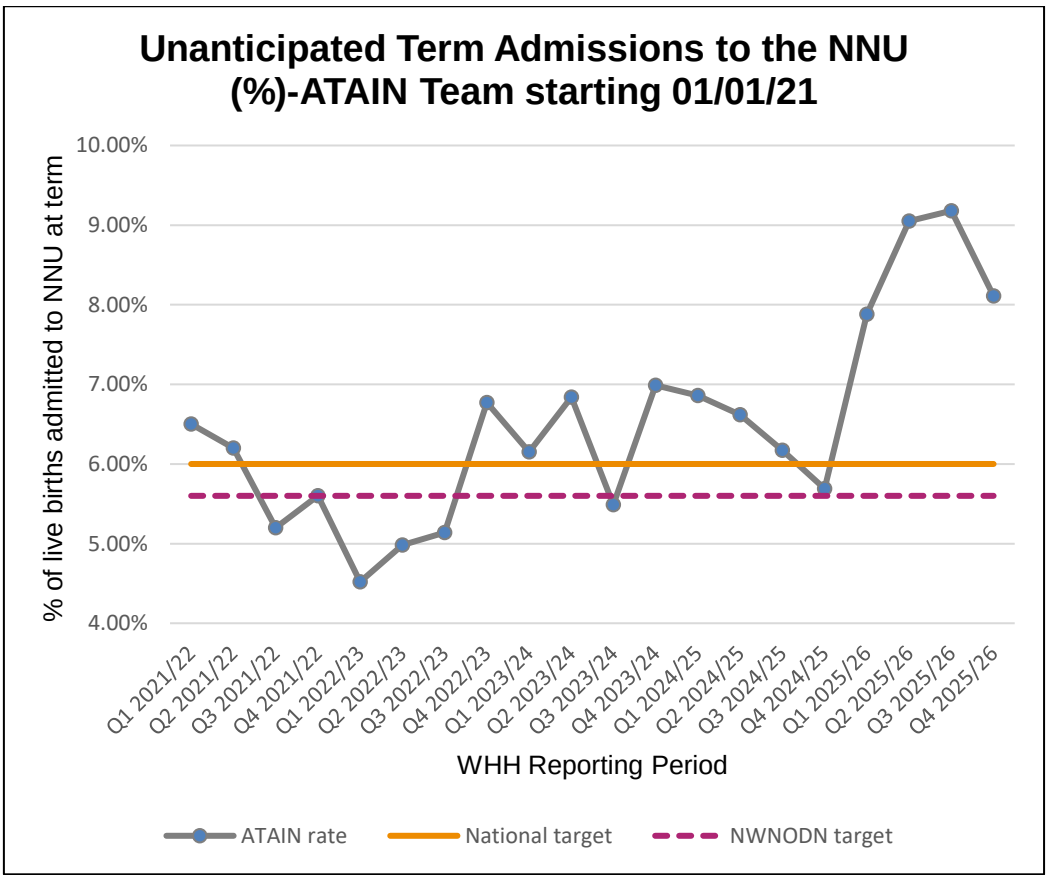
Opioid and opiate prescribing policy has changed since December 2025 to see if this may have been impacting on symptoms of respiratory distress at birth, but we have not seen a significant improvement as a result of this, this quarter.

In Q4 25/26 the NEWTT2 scoring system for newborns requiring extra observations was introduced (including assessment of oxygen saturations with each observation event) along with routine saturation screening for all babies at 6 hours of age. This enhanced tool has detected at least 4 babies at risk of early deterioration in the last quarter including one with serious congenital heart disease. There has not been an identified increase in avoidable admissions on introduction of this practice.

It is much more straightforward to generate actions when an admission is deemed avoidable. Our avoidable admission rate is not significantly higher than the NHS expectation of 20%. However, we continue to analyse the data of our unavoidable admissions (where care was optimal/according to current policy) to see if there is more we can understand about our specific demographic in Warrington Hospital, and whether we need to change policy in order to reduce the number of babies born requiring additional respiratory support, in particular.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	National target 6%	NWNODN Target 5.6%
Q1 Apr – Jun 2024	612	42	6.86%		
Q2 Jul – Sep 2024	680	45	6.62%		
Q3 Oct – Dec 2024	600	37	6.17%		
Q4 Jan – Mar 2025	580	33	5.69%		
Q1 Apr – Jun 2025	571	45	7.88%		
Q2 Jul – Sep 2025	652	59	9.05%		
Q3 Oct – Dec 2025	610	56	9.18%		
Q4 Jan – Mar 2026	555	45	8.11%		

Below is a summary of unanticipated term admissions to Neonatal Unit from January 2021 – March 2026.



As part of the ATAIN review, the team considers whether an admission to NNU was avoidable if care had been optimal. The table below shows the breakdown of these figures over the past year. The percentage of avoidable admissions has further reduced with again a significant number of unavoidable admissions (similar number to the previous quarter). The care in the unavoidable cases was subject to detailed MDT review and was found to be appropriate in all aspects, based on our current guidelines, suggesting that it may be difficult to reduce this figure.

However, ongoing QI projects including the further development of the maternal diabetic pathway and the implementation of a respiratory distress pathway, that will support more midwifery led observation without separation of mums and babies, may further reduce the incidence of admissions that are currently classed as unavoidable.

WHH Oct 2024 - Sep 2025	Number of Term Admissions	Outcome of ATAIN review		% avoidable
		Avoidable Admissions	Unavoidable Admissions	
Q3 Oct – Dec 2024	37	8	27	21.6%
Q4 Jan – Mar 2025	33	9	24	27.3%
Q1 Apr – Jun 2025	45	16	28	35.6%
Q2 Jul – Sep 2025	59	16	43	27.1%
Q3 Oct – Dec 2025	56	11	45	19.6%
Q4 Jan – Mar 2026	45	9	36	20.0%

1.3 Reasons for term admissions in Q4 (recorded on BadgerNet by ATAIN admission criteria)

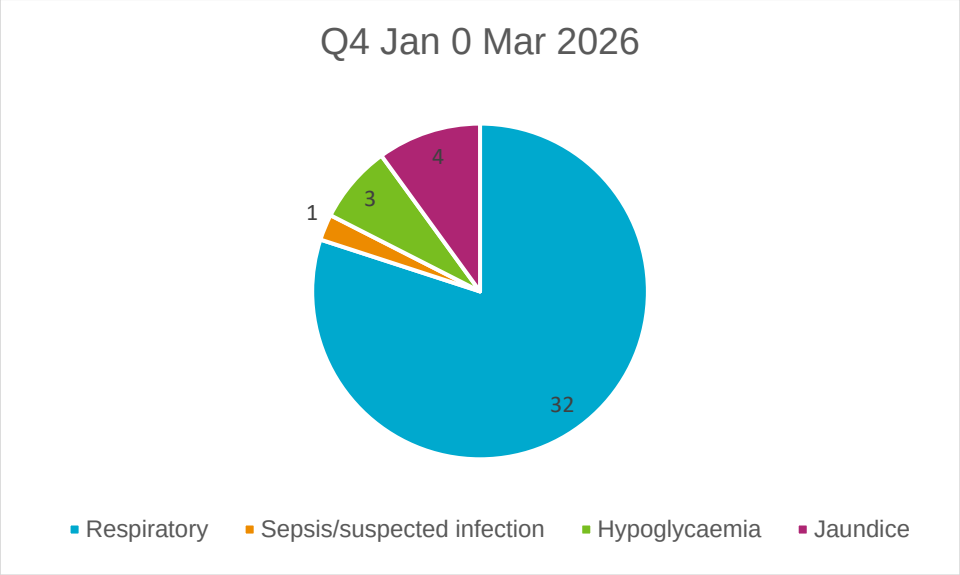
As in all quarters, the majority (71%) of term admissions were for management of a respiratory problem. This may include signs of respiratory distress (including grunting) and/or low oxygen saturations. These babies required a variable level of support on the neonatal unit from observation only to intubation and ventilation.

Nine cases were deemed avoidable as outlined below in section 2.4.

WHH Number Live Births		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions
Q4 Jan – Mar 2025	580	33	5.69%	19	58%	3	9.1%	3	9.1%	1	3%	2	6.1%
Q1 Apr – Jun 2025	571	45	7.88%	27	60%	1	2.2%	0	0%	3	6.7%	1	2.2%
Q2 Jul – Sep 2025	652	59	9.05%	36	61%	3	5.1%	2	3.4%	1	1.7%	0	0%
Q3 Oct – Dec 2025	610	56	9.18%	41	73%	0	0%	1	1.8%	3	5.4%	3	5.4%
Q4 Jan – Mar 2026	555	45	8.11%	32	71%	1	2.2%	3	6.7%	4	8.9%	0	0%

The table below details primary reasons for term admissions to NNU at WHH as per ATAIN groups (5 categorised as 'other'):

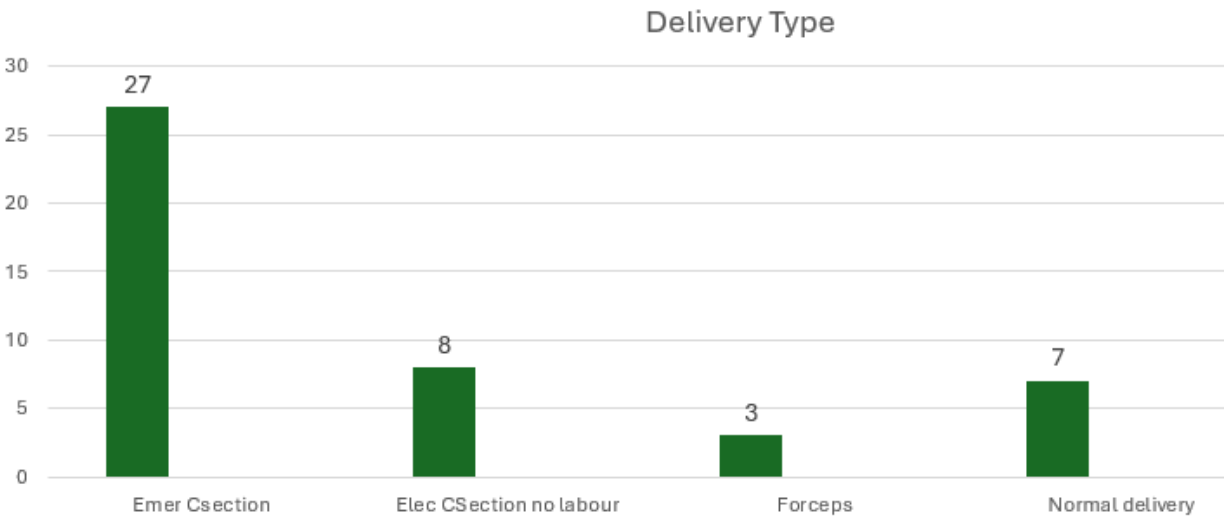
The majority of admissions are for respiratory distress.



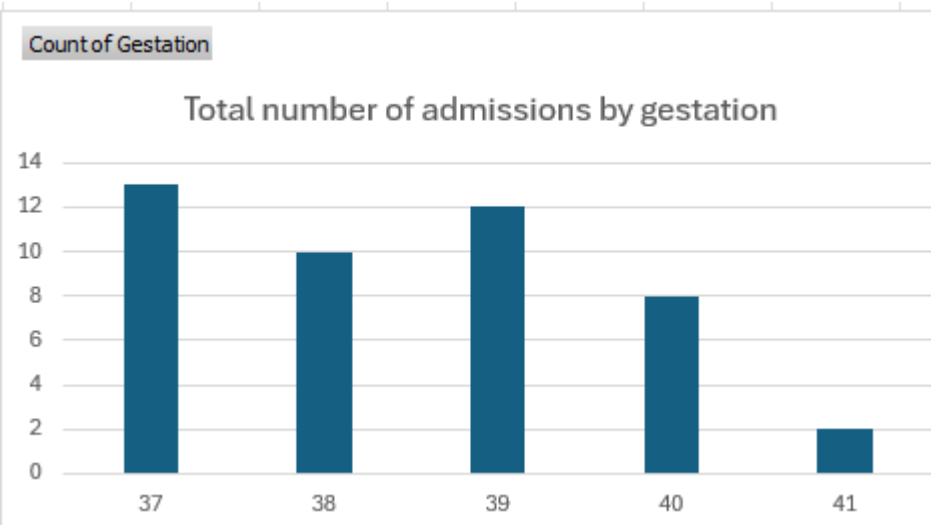
Mode of delivery
The rate of delivery by caesarean section has increased over recent years to 50%. This is reflected nationally.

Babies born by caesarean section are overrepresented in ATAIN figures, this may reflect a higher risk group due to fetal compromise, but babies born by elective caesarean section are also known to have a higher incidence of respiratory distress as they have not experienced the normal process of labour.

Indications for mode of delivery are reviewed in ATAIN and there were two avoidable events related to caesarean section identified as detailed below.



Gestation
Early term deliveries have an increased incidence of neonatal admission; this trend has been seen in previous quarters (over the last 12 months 57/128 or 44.5% of term admissions were 37 weeks gestation) but was less evident this quarter with an even spread of gestations. This is likely to reflect previous actions to reduce the incidence of early term induction of labour.



2.4 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- Baby 1: Baby could have stayed with mum and had bedside septic screen.
- Baby 2: No clinical reason for blood gas to be taken, which led to admission. Baby could have been supported as a reluctant feeder on Transitional Care.
- Baby 3: Baby was not unwell and could have been cared for by dad when mum was admitted to ICU.
- Baby 4: MDT felt that potentially earlier delivery was indicated on CTG review but it is uncertain whether delivering 30 minutes earlier would have avoided admission, given that acute hypoxia was likely related to the compound presentation and cord being tight around the neck twice. This situation would have occurred whatever the timing of delivery.
- Baby 5: Mother should have received antibiotics during labour as per management plan for PPROM. This may have affected the condition of the baby.
- Baby 6: Prolonged GA, also treatment for sepsis could have been started sooner.
- Baby 7: Documentation around counselling for decision for EMCS is inadequate. It is assumed that it is maternal request, in which case it is unavoidable from an obstetric point of view. PEEP for 30 pathway completed, longer period of observation following successful PEEP for 30 may have prevented admission.
- Baby 8: Baby could have been cared for on Transitional Care.

- Baby 9: Baby clinically improved while awaiting transfer to NNU, plan not changed to avoid admission. Baby observed on NNU for only 30 minutes and did not need any intervention. Was discharged to TC.

Themes are therefore:

1) **Overcautious admission to NNU** (6 cases) – safety brief shared to encourage senior neonatal nurses to challenge the decision to admit where not indicated. Whilst it is not dangerous to be overcautious, it often leads to overmedicalisation and separates parents and babies unnecessarily.
2) **Issues with escalation and communication during labour** – these have been dealt with using individual reflection and group CTG training.

2.4.1 Good Practice:

- Regular review of baby on postnatal ward overnight by paediatric ST1 and early recognition of deterioration requiring septic screen. Baby showed significant CRP rise.
- Recognition of need for escalation by night midwife leading to safe delivery
- Baby identified on routine saturation screening prior to symptoms of illness. Baby admitted and required escalation due to congenital heart disease
- No babies have presented with hypoxic-ischaemic encephalopathy requiring cooling in the last two quarters reflecting overall safe practice in our unit.

2.4.2 Ongoing actions to reduce admissions

Term respiratory pathway: Pathway is being implemented and will be in place by June 2026.

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

CTG training sessions for all maternity staff to occur weekly and ad hoc (CTG midwife will be full time from August 2026). Plans agreed to change the day and venue of CTG workshops to capture a wider MDT audience.

2.4.3 Recommendations:

- New project introducing CPAP in theatre recovery and in delivery rooms underway to reduce number of very short admissions to NNU.
- Respiratory pathway developed to allow closer monitoring of babies with some concerns but no indication for TC or NNU admission, without separation from parents.
- Opiate prescribing changes implemented in December which may help reduce the number of respiratory admissions further next quarter.
- Dissemination of learning and promotion of awareness of ATAIN processes: New ATAIN learning infographic devised to disseminate learning to MDT, facilitation of attendance at ATAIN meetings by trainees and midwifery colleagues in addition to the core MDT group, ATAIN findings presented at joint audit meetings and Mat/Neo quarterly forum.

- Continued review of ATAIN actions at the start of each ATAIN meeting to ensure timely completion.
- Ensure learning from ATAIN feeds into wider service workstream to improve pathways for those with diabetes in pregnancy – New JOS advice for Diabetes team is to seek advice from Public Health Consultant to identify if any actions can improve compliance in our NCM demographic.
- NEWTT2 now introduced which includes routine oxygen saturation monitoring on neonates and will allow earlier detection of deterioration.
- Recent ODN visit and Joint Oversight Support input have praised our processes of review, understanding of and scrutiny of our own data, and our actions to date, and have advised seeking advice from other units with favourable ATAIN rates, and those units that have implemented actions to bring them from out of target to within target, and of similar sized units. To date, we have taken advice from WUTH ATAIN team, who advised that no babies are admitted under 1 hour old, therefore they are giving babies a longer time to transition before admitting for respiratory support. Implementing this change would be expected to reduce the number of short admissions at NCM, but with a smaller NNU and therefore fewer staff, this cannot always be facilitated depending on acuity/staffing. However, since the end of quarter 4, at least 2 admissions have been avoiding by continuing PEEP for longer than our current pathway. Other units are to be contacted for similar sharing of their processes and previous actions.
- Admission proforma for term admissions is in development, to ensure babies fit the criteria for admission, and to try to reduce over-cautious admissions.
- Further data to be collected and analysed with the diabetic team on timing of delivery for diabetic patients and type of diabetes, to check whether delivery could be timed later to reduce early IOL/caesarean section rates.

3. Actions required/responsible officer

- CTG reviews for learning in C-shop forum – Emma Lucy
- Implementation of grunting baby pathway – Kat Woodger
- Proforma for term admissions to be trialled at time of admission – Kat Woodger
- Review data for multips who had induction of labour and mode of delivery – Maria Banks
- Individual reflective discussions – appropriate ATAIN member

4. Measurements/evaluations

Ongoing assessment of admissions figures and comparison with other units in the network.

5. Monitoring/reporting routes

Regular update to QAC for local executive oversight, review in NWNODN and LMNS meetings to compare with regional figures.

6. Timelines

Quarterly reports ongoing.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/052**			
Subject:	Communications and engagement activity report, May / June 2026			
Date of meeting:	5 August 2026			
Action required:	**N/A**			
Author(s):	Hayley Smith, deputy director of communications and engagement			
Executive director sponsor:	Kate Henry, director of communications and engagement			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 9: Partnership, Integration and System Working			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	This report provides an overview of communications and engagement activity across North Cheshire and Mersey NHS Foundation Trust during May and June 2026. Key activity focused on delivery of the inaugural North Cheshire and Mersey Thank You Awards, the continued rollout of the trust's brand and identity, support for organisational integration priorities, and the development of a new Brand and Reputation Plan.			

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

	The report highlights activity and performance across internal communications, external communications, media relations, social media, patient information, engagement and involvement, projects and campaigns, and charity communications. The reporting period also saw continued progress in embedding the North Cheshire and Mersey identity across the organisation.		
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 reporting period.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (FOIA):	Release document in full		
Freedom of information exemptions applied (if relevant):	None		

North Cheshire and Mersey
NHS Foundation Trust

May / June activity report

Communications and Engagement Team

Home
Community
Hospital

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Executive summary

This report has been produced to provide the Board of North Cheshire and Mersey NHS Foundation Trust with an overview of our corporate communications and engagement activity, featuring highlights and key achievements to show how we have connected with our staff, patients and communities during May / June 2026.

Reporting highlights:

- May activity largely focused on our flagship NCM Thank You Awards. The successful delivery of the event and extremely positive feedback demonstrated the impact of communications-led activity in driving engagement and organisational reputation.
- Campaign work continued to be weighted towards integration and the smooth rollout of the NCM name and brand to staff, patients and public. The team worked with departments across the trust to support initial phase 2 requests.
- The first full month of the new Smartsheet process for requesting communications and engagement support recorded 109 job requests in May and 69 in June (May was higher due to the transitional integration period). Requests focused on brand rollout, intranet development and awareness campaigns.
- June's key priority was the development of a new Brand and Reputation Plan to increase awareness of the new trust identity and strengthen its reputation with staff, patients and our communities.
- Filming also started on a 90-second launch film introducing North Cheshire and Mersey NHS Foundation Trust as one unified organisation. The video will represent a co-ordinated approach to home-based, community and hospital-based care, showing how services now work together to support patients at every stage of life.

Communications and engagement job requests

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May support requests

May saw the first full month of using the new process for recording support requests to the NCM Communications and Engagement Team.

Job request numbers remained steady, with a continued focus on requests for updating branded materials across the trust, updates to the intranet as teams increasingly work together, and support for annual awareness days.

- The majority (71%) of job requests were submitted by corporate services, reflecting continued demand for support with organisational integration
- The top job type requested in May was design and branding followed by social media
- Key job request examples for this month which the team supported included:
    - the development of NCM branding materials for phase two of rollout
    - multiple intranet workspace updates
    - communications to support awareness days across channels
    - design and proofreading support for annual report

Job requests at a glance

Total no of requests: 109

Approved: 99

More information needed: 7

Rejected (out of scope): 3

Jobs completed: 18

Month on month comparison: 102 (up 7)

June support requests

This month the team completed a significant number of jobs, from 18 in May to 52 in June (May impacted by the transitional integration period).

Overall job request numbers dropped slightly, but there was an increase in requests for internal communications and support for awareness days as we approach the summer months.

- The majority (66%) of June job requests were submitted by corporate services

- The top job type requested was intranet updates followed by design and branding and internal communications

- Key job request examples which the team supported included:

    - design support for the trust's new behavioural framework
    - communications to launch of a new infant feeding support group
    - adverse weather communications support and guidance
    - support to produce a 'Your Future, Your Way' video for a national conference

Job requests at a glance

Total no of requests: 69

Approved: 58

More information needed: 9

Rejected (out of scope): 2

Jobs completed: 52

Month on month comparison: 109 (down 40)

Key activity

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May at a glance: Internal communications

Intranet – top 5 viewed pages	Views
1. Staff Hub	1,930
2. NCM Brand Hub	2,320
3. Pharmacy	801
4. Clinical Hub	795
5. Communications Hub	788

Intranet – top 3 news stories	Views
1. The official TYA 2025-26 photo album has landed!	616
2. Introducing your 2025-26 Thank You Awards winners!	415
3. WHH Charity – Running up those hills to give something back	266

Intranet – key stats (no. of)	Total
Thank you messages	54
Approved message board posts	3
News articles	18
Announcements	12
Good morning messages*	9

Team Brief

Thursday 22 May, 11am

Live attendees: 240
Questions: 32
Total views incl. recording: 280

Month on month comparison
April 2026: 330 (down 90)

NCM news (staff bulletin)

Email views (number of times NCM news email accessed):

- 26 May: 7,545
- 18 May: 8,545
- 11 May: 7,596
- 5 May: 8312

Month average: 7,999 views

Top stories:

- Thank You #TeamNCM for a night to remember
- International Day of the Midwife celebrations
- Hospital parking update
- Rising star award success for Drive Ability North West's Simon Gregory

*Morning messages included: Halton gynaecology super clinic, staff recognition and reward, Shared Learning Forum, TYAs, International Clinical Trials Day and Nik's personal reflections

Examples:

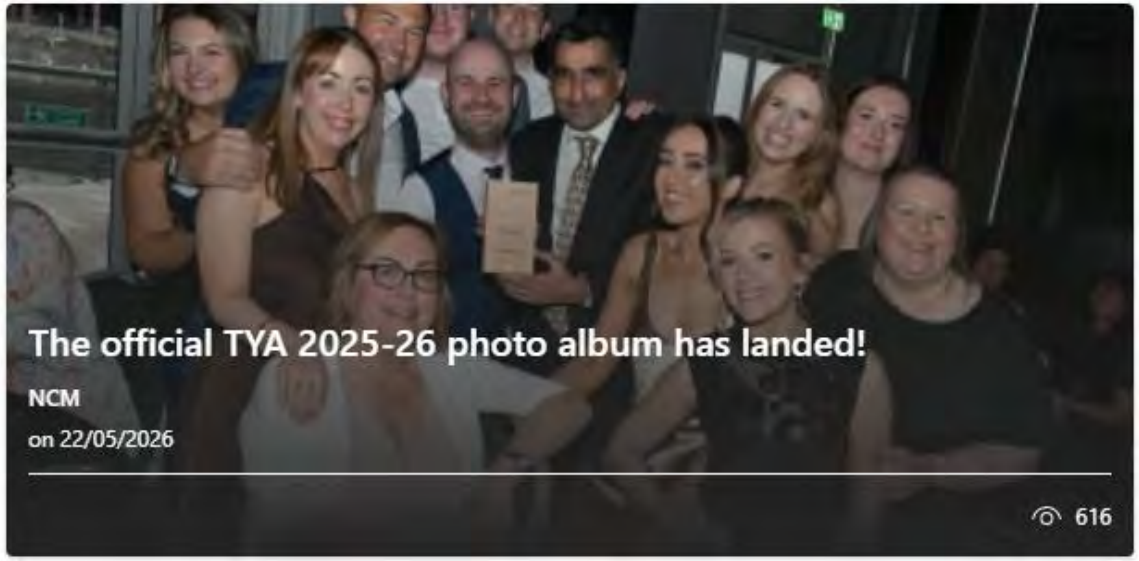


Julie Towse: Thanks Julie for the great care you gave to not just me but all of the patients in your bays. You truly are a great nurse with an amazing future ahead.

Tim Furfie: Thank you for always being so helpful and getting things done! Honestly have made my life so much easier having your support.

Molly Ellis: Showing excellent natural leadership skills, supporting the wider team especially in times of staff sickness.







Turn to page 37 for our latest charity update

June at a glance: Internal communications

Intranet – top 5 viewed pages	Views
1. Staff Hub	1,963
2. NCM Brand Hub	1,065
3. Clinical Hub	873
4. Pharmacy	845
5. Clinical quick reference	817

Intranet – top 3 news stories	Views
1. UPDATE: Raffle now closed!	282
2. Modular unit delivery at Warrington Hospital this weekend	275
3. WHH Charity – Which one will you take on?	230

Intranet – key stats (no. of)	Total
Thank you messages	116
Approved message board posts	9
News articles	19
Announcements	12
Good morning messages*	8

Team Brief

Tuesday 23 June, 3pm

Live attendees: 271
Questions: 35
Total views incl. recording: 308

Month on month comparison
May 2026: 240 (up 31)

NCM news (staff bulletin)

Email views (number of times NCM news email accessed):

- 29 June: 7,573
- 22 June: 7,441
- 15 June: 7,880
- 8 June: 7,493
- 1 June: 7,328

Month average: 7,543

Top stories:

- WELL Runcorn Hub opens to support joined-up care and wellbeing
- Watch back: Thank You Awards
- NCM colleagues join as Warrington Pride celebrated across the town
- You Made a Difference

*Morning messages included: Launching our new behaviour framework, Corridor Care Summit, an update from our June Board, inclusive care during Learning Disability Week and personal reflections from Nik.

Examples:



Faye Halpin: For believing and for making a difference to each and every child and family you meet. Never give up on what you want because you have a bright future

Lucy Singer: No matter what challenges you face you always have a smile on your face and deliver amazing care to your clients and colleagues.

Verity Bell: You are always super supportive and a font of knowledge on so much that make navigating systems to perform my clinical role so much easier. Thank you!







Turn to page 37 for our latest charity update

May at a glance: External communications

Trust website – top 5 viewed pages	Views
1. Work with us / job vacancies	18,958
2. Urgent and emergency care wait times	9,818
3. Our services – Urgent Treatment Centre (UTC) Runcorn	2,610
4. Locations – Warrington Hospital	2,560
5. Locations – Halton Hospital Nightingale Building	2,212

Trust website – top 3 news stories	Views
1. Meet the NHS champions shortlisted for annual Thank You Awards	710
2. Hospital parking update	356
3. Our name change to North Cheshire and Mersey NHS Foundation Trust	350

Media

Coverage / enquiries handled during the reporting period:

Proactive requests: 8

- Media releases written: 5
- News stories published: 4
- Charity articles published: 3

Reactive requests: 6

- Support (e.g. fact checking): 2
- Statements issued: 1
- No response provided: 2
- Interviews / visits: 1

Highlight of the month:

- BCC Radio Merseyside interview with Dr Paul Fitzsimmons
- Thank You Awards 2025-26 coverage across all local media outlets

Examples:



‘Don’t wait for the rash’: Mum urges parents to trust their instincts after son’s life-threatening meningitis case

Friday 01 May 2026



Annual trust award ceremony recognises extraordinary healthcare stars

Thursday 21 May 2026

Warrington Guardian

Warrington and Halton healthcare workers praised at top NHS awards

Healthcare professionals from Warrington and Halton were honoured at the North Cheshire and Mersey NHS Foundation Trust's annual Thank You...



Warrington Guardian

Finalists revealed for People's Choice Award at NHS ceremony

Cristobelle Federico, Dr Kate Hunter and Lucy Atlay shortlisted for NHS People's Choice Award celebrating care at Warrington and Halton...



Warrington Guardian

Warrington scheme hailed at NHS Excellence Awards

A LEADERSHIP programme focused on diversity has been named regional champion at a major NHS awards scheme. The 'Your Future Your Way' scheme...



June at a glance: External communications

Trust website – top 5 viewed pages	Views
1. Work with us / job vacancies	20,343
2. Urgent and emergency care wait times	8,986
3. Locations – Warrington Hospital	2,692
4. Our services – Blood test phlebotomy clinics	2,264
5. Our services – Urgent Treatment Centre Runcorn	2,249

Trust website – top 3 news stories	Views
1. Our name change to North Cheshire and Mersey NHS Foundation Trust	421
2. Hospital parking update	315
3. Willow Tree Hub appeal launched to support bereaved families at Warrington and Halton Teaching Hospitals	123

Media

Coverage / enquiries handled during the reporting period:

Proactive requests:

- Media releases written: 4
- News stories published: 9
- Charity articles published: 4

Reactive requests:

- Support (e.g. fact checking): 2
- Statements issued: 1
- No response provided: 3
- Interviews / visits: 0

Highlights of the month:

- Follow up People's Choice Award coverage in Warrington Guardian
- New infant feeding support group shared across local media outlets

Examples:



[Meet the NHS star named as your People's Choice Award winner]

Wednesday 24 June 2026



[Dedicated community matron attends prestigious Royal Garden Party at Buckingham Palace]

Monday 01 June 2026



[WELL Runcorn Hub opens to bring joined-up health, wellbeing and learning to the community]

Friday 26 June 2026

Social media

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Caring for you

May at a glance: Social media

Examples of the best performing posts (based on engagement rate):







Page engagement – the total number of interactions with content, including likes, comments, shares and clicks
Page reach – the number of unique users who have seen the content
Post impressions – the total number of times content has been displayed to users, including repeat views

Key stats

NCM May page followers: 14,671
Page engagement: 29,620
Page reach: 148,658

Month on month comparison: Followers increased by 32 while engagement nearly doubled (+96.8%), showing a strong improvement in audience interaction.

Maternity Facebook page statistics to be included from June 2026.

June at a glance: Social media

Examples of the best performing posts (based on interactions):







Post interactions - The number of times people engage with your content through actions such as likes, comments, shares and clicks.
Page engagement – the total number of interactions with content, including likes, comments, shares and clicks
Page reach – the number of unique users who have seen the content

Key stats

NCM June page followers:
14,700
Page engagement:
12,762
Page reach:
59,696

Month on month comparison:
Followers increased slightly by 29 while engagement fell by 56.9% and reach dropped by 59.8%, showing a smaller audience exposure and lower interaction in June compared with May due to last month's spike with the Thank You Awards posts.

Maternity Facebook page:
Followers:
11,888
Page engagement:
18,741
Page reach:
73,322

What worked well

Highlights from the reporting period included:

- building on our people-first approach to generate the highest levels of engagement by prioritising colleague, patient and service stories
- promoting teams and colleagues across NCM, celebrating awareness days and weeks and highlighting events led by services and staff
- key successes included celebrating International Nurses' Day, collaborating with Warrington Maternity Unit on International Day of the Midwife (one post received more than 1,000 comments), and thanking colleagues for their commitment and hard work during the recent heatwave
- live coverage of the first NCM Thank You Awards across all social media channels
- post TYA event marketing focused on individual winners e.g. People's Choice Award winner Cristobelle Federico, care support worker

Thank You Awards 2025-26



Day of the Midwife success



Next steps

Areas for development include:

- continuing to strengthen the trust's reputation through consistent messaging, storytelling and promotion across all channels
- increasing the volume and variety of impact stories and staff achievements
- considering the best methods of communicating essential national campaign updates and key messages to generate engagement, and refining our approach to awareness day communications
- focusing on locally branded, people-led content over generic campaign graphics that generate the lowest engagement
- increasing staff confidence and participation in short-form video content (current challenges in identifying colleagues willing to share their stories and experiences)
- proactively engaging with colleagues to build relationships via direct conversations and calls (current over reliance on email requests) to identify story opportunities earlier

Staff thank you for working in the heat



People's Choice Award winner



Projects and campaigns

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Caring for you

Key projects

Project	Progress / actions	Impact / outcomes
Cheshire and Merseyside Endoscopy Hub	Work commenced on developing a communications campaign to increase awareness and drive uptake of appointments at the Cheshire and Merseyside Endoscopy Hub.	Coordinated communications plan with internal and external stakeholders to ensure alignment of approach. Development of communication materials and paid social plan to drive awareness and understanding of the hub.
WELL Runcorn Hub	A soft opening took place on Monday 29 June. This was assisted by a communication suite of material for NCM and partners to promote the new facility (mainly internal audiences).	Plans are being finalised for the official launch, including stakeholders and media, on Thursday 10 September. Further communications work will continue behind the scenes, including building a social media community presence.





May integration update

Communications campaign work during May was once again weighted towards integration and the smooth rollout of the NCM name and brand to staff, patients and public.

Highlights this period	Status	Next steps
Further brand development rollout and continued staff communication / feedback to ensure correct implementation. New NCM style guide launched and introduced into the organisation.	Ongoing	Production of a North Cheshire and Mersey promotional video outlining who we are as an organisation and what we do.
The first NCM Thank You Awards event took place on Friday 15 May 2026 at the Titanic hotel in Liverpool.	Complete	Please see following slides for further details.
Progress around the Patient and Public Reference Group (PPRG) and the involvement of Healthwatch in the coming months around the planning of new feedback sessions.	Ongoing	PPRG event planned for 20 July to discuss the chronic pain priority pathway.
Development of communications and engagement priorities as part of the Better Care Together phase 2 delivery.	Complete	The first priority being worked on as part of the phase 2 delivery plan will be a focus on brand and reputation management.

June integration update

Although updates are included below, some communications activity previously classed as integration is now moving into business-as-usual work as daily and monthly requests embed within the wider organisation.

Highlights this period	Status	Next steps
Communications and engagement workstream highlight report for NHS England submission, covering the period of April to June.	Completed	Working through the plan and executing all proactive delivery.
Final filming stages of a bespoke NCM video outlining who we are as a single organisation.	Ongoing	Editing and sign off.
Preparation and planning for Patient and Public Reference Group (PPRG) meeting on 20 July. Meeting themed around chronic pain management and digital developments.	Ongoing	Facilitate 20 July meeting and prepare a feedback report.
Creation of a brand and reputation plan to support awareness of new trust name and increase proactive and positive communications to staff, patients and public	Approved by execs	Develop frontline ‘board to ward’ communications plan to support leadership visibility and staff engagement.

Thank You Awards 2025-26

- 268 colleagues and sponsors attended the first Thank You Awards as NCM on Friday 15 May at the Titanic hotel in Liverpool.
- 12 awards given on the night including the chief executive's Outstanding Achievement Award, presented to Dr Lalitha Chinnappan, consultant gastroenterologist and associate medical director for patient safety
- Individual nominations (more than 500) shared with staff members post event, along with a thank you message to those who nominated – significant time investment required but positive feedback received

Video recap of the event : https://youtu.be/7CFCguWEEe8?si=S8aGWo_p_PWTS6rn

Save the date: 2026-27 awards set to be held at the Titanic on 21 May 2027





Thank You Awards 2025-26

Feedback from the post event survey was exceptional:

- **100%** of respondents were very satisfied / satisfied
- **100%** of respondents felt the event provided value for money and were very satisfied or satisfied with the venue's facilities
- Quality of food was rated excellent or good by **89%**

Staff comments included:

- I loved the format of the evening, very well balanced and superbly organised!
- Overall it was a great night. It's always a lovely atmosphere and so positive to recognise people who go above and beyond
- Great atmosphere, a true celebration of staff and some fantastic dancing!
- A fabulous night from start to finish. Well organised and presented, great food service
- The event was fantastic and the staff worked extremely hard
- Everything was fabulous. An absolutely brilliant event
- Great effort by the organising team. It was an excellent event and value for money
- Fantastic night and we will be there for 2027
- I would highly recommend anyone to go next year
- I did not expect to win. The night was incredible, the people made it
- Very special. The room felt electric; full of buzz and excitement
- A wonderful evening and appreciated being recognised





Patient information (PINFO)

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May patient information (PINFO)

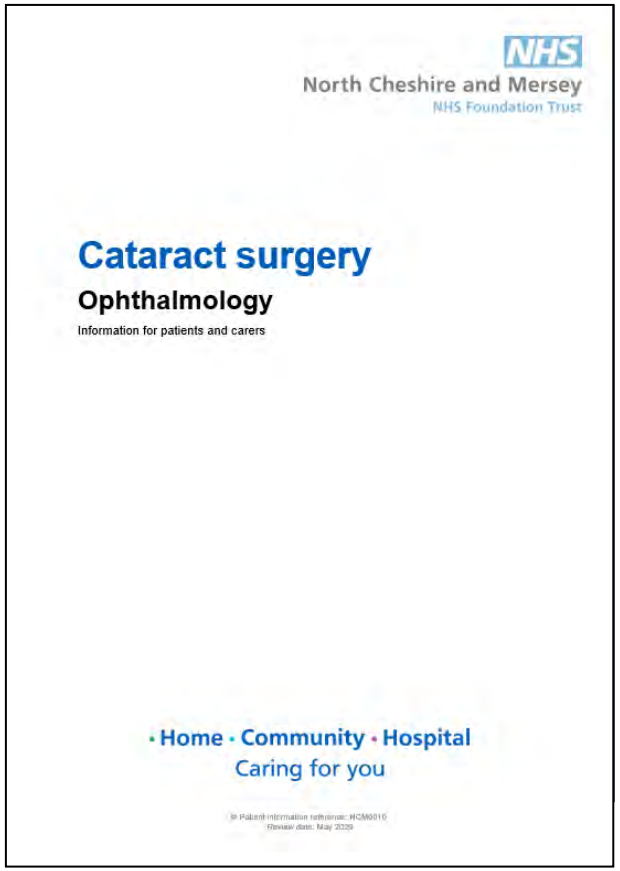
During the May reporting period the Communications and Engagement Team:

- supported clinical teams in putting **1** new leaflet through the PINFO process
- completed review / edit of **7** existing leaflets to meet review date and reflect NCM style guidelines
- completed a review date update on the database to align with the 3-yearly review period in the NCM Patient Information Policy to ensure consistency across all care groups

There were **604** trust-generated patient information leaflets across all care groups (including community and dental) of which **186 (31%)** were identified as beyond their review date.

Next steps:

- Design new reporting format to reflect care group and clinical business unit leaflets requiring review

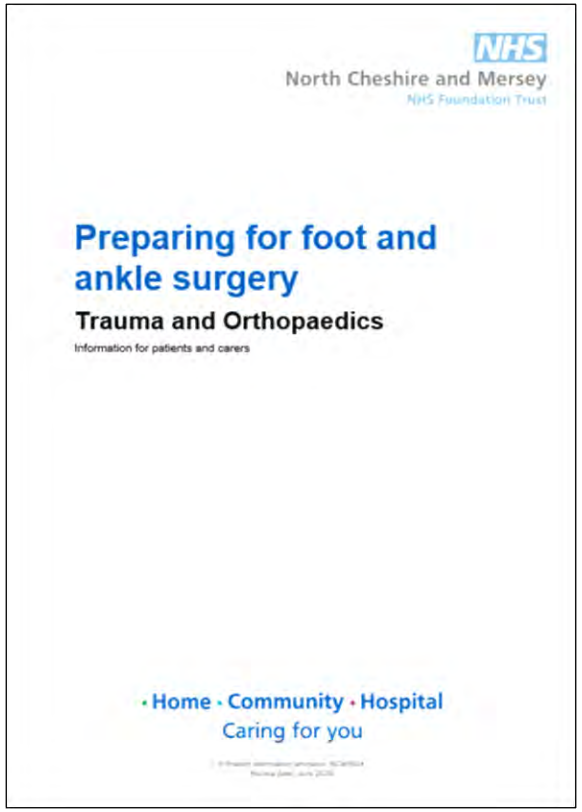


June patient information (PINFO)

During the June reporting period the Communications and Engagement Team:

- completed review / edit of **10** existing leaflets to meet review date and reflect NCM style guidelines and to achieve target reading age requirements
- no new leaflets were submitted to the PINFO process but there were **3** requests for PINFO in video format which are being progressed with teams
- completed a review date update on the database to align with the 3-yearly review period in the NCM Patient Information Policy to ensure consistency across all care groups

There were **604** trust-generated patient information leaflets across all care groups (including community and dental) of which **183** were identified as beyond their review date.



Next steps:

- initial user testing of the new Sharepoint database solution scheduled for 17 July 2026

Engagement and involvement report

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May key engagement activity

Halton Voluntary, Community, Faith and Social Enterprise (VCFSE) Forum

Halton VCFSE Forum is a local network supporting collaboration, consultation and information sharing within Halton and St Helens. Stephen Bennett, NCM head of strategy and partnerships, presented to network members (including the CEO of Halton Borough Council) on 6 May to introduce the trust and outline improvements, financial benefits and the next phases of the integration programme.



Key themes raised included:

- ensuring the voice of the community is meaningfully and reflected in any service redesign work
- how digital technology will be used to enable changes to clinical service delivery
- consideration of access and transport issues for residents as part of service redesign
- the need for inclusive engagement approaches, particularly for children and young people who may not use traditional methods of communication

The presentation generated positive conversations, with a clear emphasis placed by the network on the need for inclusive engagement, accessible services and ensuring that future changes reflect the needs of local communities.

International Clinical Trials Day 2026

Warrington Hospital

- Promotion and communications for the first International Clinical Trials Day as NCM was supported throughout May.
- The Research, Development and Innovation (RDI) Team hosted a stand at Warrington Hospital on 20 May to join the annual campaign, and celebrate everyone involved in delivering and participating in clinical research.
- The event was an opportunity for NCM to raise awareness of research within the trust, with both staff and patients, and to discuss research work and opportunities, including Pathway to Research (our secure database for patients who would like to be contacted about future research studies).
- The day was a great success, leading to 18 new registrations on the day, with a further six sign-ups online for Pathway to Research.



June key activity

Community engagement events

Warrington Pride, Saturday 13 June:

- More than 40,000 people attended the annual town centre event celebrating our LGBTQIA+ community, with trust staff taking part in the parade through Warrington town centre.
- An NCM stand was coordinated as part of the Pride Information Hub in Golden Square, with support from Lisa Welch, co-chair of Warrington and Halton Maternity and Neonatal Voices Partnership, Caitlin O'Brien, improving uptake officer in Breast Screening Services and Alan Davies, NCM governor.
- The team promoted trust services, listened to care experiences, recruited Experts by Experience and shared information: Watch the Warrington BID video.





Warrington Armed Forces Day, Saturday 27 June:

- NCM hosted a stand at Armed Forces Day – an annual family fun day at Crosfield's Rugby Club. Approximately 5,000 people attended the event, which included rugby league games and activities.
- Supported by deputy lead governor Diane Nield and governor Alan Davies, the event helped to raise awareness of NHS careers, volunteering and Experts by Experience.

Experts by Experience (EbyEs)

May at a glance

Total EbyEs May 2026	Total EbyEs May 2025	+ / - change yr on yr
226	194	32

New requests:

- PALS office redesign engagement
  - 11 x EbyEs recruited (plus 6 governors)
  - EbyEs requested to participate in a redesign of our PALS office, located in the main entrance of Warrington Hospital
  - Three engagement sessions scheduled: A face-to-face site visit on site, an online session to discuss proposed designs and an online session to discuss final design proposals. Next steps in the following reporting period.

Experts by Experience (EbyEs)

June at a glance

Total EbyEs June 2026	Total EbyEs June 2025	+ / - change yr on yr
231	197	34

New requests:

- Pre-operative assessment avatar testing – one-to-one testing for a web-based conversational tool that guides users through pre-operative questions and generates a structured summary to support the pre-op process (3 EbyEs).

Existing requests

- **WELL Runcorn soft opening** – event invitations for EbyEs involved in developing accessible facilities and furniture choices within Runcorn's new health and wellbeing hub (8 EbyEs).
- **Living Well Warrington website, Dementia Training Platform** – feedback requested to develop a central platform for dementia training, promoting best practice and supporting the Dementia Training Standards Framework (2 EbyEs).
- **PALS office redesign, site visits** – feedback requested from patients, relatives and carers to design a welcoming, accessible and confidential PALS office that meets the needs of PALS users (6 EbyEs).
- **Reducing DNAs in respiratory clinics** – request linked with Respiratory Therapy Team, who established a patient forum to improve services and increase access to pulmonary rehabilitation (6 EbyEs, recruited in April 2025).

Upcoming events

Date	Event	Time	Venue	Event purpose
6 September 2026	Warrington Mela	11am to 4pm	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within Warrington.
7 October 2026	Annual Members' Meeting	3.30pm to 4.30pm	Halton Education Centre, Halton Hospital, Palacefields, Runcorn, WA7 2DA	Annual meeting to present the annual report and accounts, provide performance feedback over the last year and the plan for the forthcoming year.

To join #TeamNCM at any of the events above, please email ncm.engagement@nhs.net

WHH Charity

Comms and engagement support

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Warrington and Halton Hospitals' Charity

May communications and engagement support



This month's highlights:

- Community rallies behind Tom as marathon challenge pauses through injury
- Running up them hills to give something back

Next steps / upcoming events:

- Paid social media campaigns and internal push to promote the Supporters' Club and upcoming fundraising events, including the Dragon Boat Race in August and the Warrington Running Festival in September.
- A Celebration of Hope concert on 7 July, bringing together 13 Catholic primary schools from across Warrington to raise funds for the Willow Tree Hub Appeal.
- Increased internal promotion through staff news stories and global communications, highlighting staff fundraising activities and raising awareness of how the charity can support teams and departments across the trust.

Warrington and Halton Hospitals' Charity

June communications and engagement support

This month's highlights:

- Push on charity events
- Karen Ross with be taking part in a 100-mile marathon to fundraise
- We crowned our charity champions
- Sensory toys making a big difference for young dental patients



Next steps / upcoming events:

- Final planning for A Celebration of Hope concert taking place at the Parr Hall on 7 July
- Inflatable course challenge (18 July), Dragon Boat Race (31 August), Warrington Running Festival (20 September)
- Fundraising support: Mike's wingwalk challenge, Moobs and Boobs park run
- Production of annual Impact Report

Newsletters: Latest newsletter released on 16 June 2026

Contact us

Email: ncm.communications@nhs.net

Website: northcheshireandmersey.nhs.uk

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Caring for you

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/053**			
Subject:	**Gender Pay Gap: Combined Report and Actions**			
Date of meeting:	5 August 2026			
Action required:	**To note for assurance**			
Author(s):	Adam Harrison-Moran, Associate chief people officer Ruth Besford, Equality and inclusion manager Adam Warburton, Culture and inclusion project support officer			
Executive director sponsor:	Paula Woods, Chief People Officer			
Link to strategic aim:	2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving.			
Link to risks on the board assurance framework:	BAF 5: Workforce Capacity, Capability & Wellbeing			
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: This report supports delivery of Public Sector Equality Duty through addressing gender pay disparities.			
Executive summary:	This report presents the combined Gender Pay Gap position for 2025/26 across Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare ahead of full organisational integration into North Cheshire and Mersey NHS Foundation Trust. Gender Pay Gap reporting is a statutory requirement under the Equality Act 2010 requiring annual reporting of pay differences between male and female staff.			

<table>
<tr><td></td><td colspan="3">Headline position:
Both organisations demonstrate persistent structural pay gaps driven by workforce composition, not unequal pay.
Acute pay gap remains higher and has seen a slight increase year-on-year (section 2.3.1 indicates when split by staff group the composition of the pay gap differs with Medical and Dental presenting a wider disparity).
Community and dental show a lower but increasing pay gap, influenced by workforce and leadership structure changes.
In both cases:
Workforce is predominantly female.
Males are overrepresented in higher pay quartiles when combined at an organisational level.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board are asked to receive the analysis and data included in this paper and appendices and note the contents for assurance, as previously approved by the Strategic People Committee.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Strategic People Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">SPC/26/06/052</td></tr>
<tr><td>Date of meeting</td><td colspan="2">17 June 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Approved</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

The Gender Pay Gap is defined as the difference between the average hourly earnings of men and women across the workforce and is distinct from equal pay.

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires all public sector organisations with over 250 employees to report and publish their Gender Pay Gap on their website on an annual basis.

Reporting is based on a snapshot date of 31 March 2026 and includes:

- Mean and median pay gaps
- Quartile distribution
- Bonus pay differentials

This report represents the final pre-integration position before reporting transitions to a single organisational submission from 2027 onwards. To support compliance, this report provides a summary of findings for both organisations with full reports available as Appendix One (Warrington and Halton Teaching Hospitals - WHH) and Appendix Two (Bridgewater Community Healthcare - BCH).

1.1 Definitions of the Gender Pay Gap

The Gender Pay Gap is a figure that shows the difference in the average pay between all men and women in a workforce. It is a measure of women's overall position in the paid workforce and does not compare like roles.

The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males and the total number of females employed in the workforce.

The median pay gap is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

1.2 Scope of analysis

The reports include all staff who were employed by WHH and BCH on full pay on the snapshot date of 31 March 2026.

Ordinary pay calculations include:

- Basic pay
- Paid leave including annual leave, sick, maternity, paternity, adoption, or parental leave (except where an employee is being paid statutory)
- Shift premium pay.

It does not include overtime pay, redundancy pay, or termination payments and expenses. Employees who are on half or nil pay for sickness absence or maternity leave, hosted staff and agency staff are not included in the results.

Bonus pay calculations include any pay related to performance, including Clinical Excellence Awards, made in the 12-month period directly before 31 March 2026.

Clinical Excellence Awards are financial incentives to Consultant Doctors, Consultant Dentists and Clinical Academics. Their purpose is to recognise senior clinicians' achievements beyond what is expected as part of their job plan.

Clinical Excellence Awards were previously split by national and local awards. Local Clinical Excellence Awards (LCEAs) in England, are no longer awarded annually, with the final award round being in 2023/24.

2. Key elements

2.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust

The full report can be found as Appendix One.

Workforce Profile

- Total workforce: 4,570
- Female: 3,592 (77%)
- Male: 978 (23%)

Pay Gap Position

- Mean pay gap: 21.91% (increase of 0.39%).
- Median pay gap: 5.06% (increase of 0.95%).
- Males earn:
    - £5.96 more per hour (mean).
    - £1.03 more per hour (median).

Quartile Analysis

- Male representation in highest quartile: 30.01%.
- Over-representation of males at highest pay levels persists.
- Females concentrated in lower and middle quartiles.

Bonus Pay

- Bonus recipients heavily skewed with 2.51% of male’s vs 0.20% of females.
- However, females receive higher bonus values when awarded:
    - Mean bonus gap: 55.72% higher for females.
    - Median bonus gap: 31.25% higher for females.

Interpretation

- Pay gap driven by senior role distribution and the medical and dental workforce structure although this is an improving baseline.
- Despite small increases, both mean and median shifts remain less than a 1% change, indicating relative stability but no improvement trajectory.

2.2 Bridgewater Community Healthcare NHS Foundation Trust

The full report can be found as Appendix Two.

Workforce Profile

- Total workforce: 1,435
- Female: 1,277 (89%)
- Male: 158 (11%)

Pay Gap Position

- Mean pay gap: 17.97% (increase of 5.82%).
- Median pay gap: 4.77% (increase of 2.49%).
- Males earn:
    - £4.77 more per hour (mean)
    - £0.99 more per hour (median)

Quartile Analysis

- Female representation strong in lower/middle quartiles but under-represented in upper quartile.
- Key driver is that there is higher male representation in senior and/or higher paid roles.

Bonus Pay

- No bonus payments recorded for 2025/26.

Interpretation

- Increase in pay gap primarily attributed to changes at executive level linked to integration.
- Workforce heavily female, but leadership and senior pay bands still male-influenced.

2.3 Key themes across both organisations

The Gender Pay Gap across both organisations is driven primarily by workforce and role distribution rather than equal pay concerns, with national terms and conditions and job evaluation arrangements continuing to provide assurance on equal pay.

The most significant contributing factor remains the over-representation of men in senior and higher-paid roles, while women make up the majority of the overall workforce but are less well represented in the highest pay quartile.

2.3.1 Analysis by Agenda for Change vs Medical and Dental (Acute)

A detailed review of the acute Trust Gender Pay Gap data has been completed to better understand the drivers behind the disparity identified within the upper pay quartiles. Whilst the acute workforce is comprised of 77% female and 23% male colleagues overall, analysis demonstrated that male colleagues account for 30.01% of staff within Quartile 4 (the highest earning quartile), significantly higher than their representation across the wider workforce. To better understand this position, a deeper analysis was undertaken excluding Medical and Dental staff.

This demonstrated that the disparity within Quartile 4 reduced substantially as noted in Table's One and Two, with male representation falling to 15.68%, closely aligned to the overall non-medical workforce profile of 16.24% male and 83.76% female.

Full Trust (Male = 23% of workforce / Female = 77% of workforce)					
	Total	**Female**	**Male**	**Female %**	**Male %**
Q1	1142	917	225	80.30%	19.70%
Q2	1097	896	201	81.68%	18.32%
Q3	1188	979	209	82.41%	17.59%
Q4	1143	800	343	69.99%	30.01%

Table One: Quartiles for the Trust including all staff groups

Trust excluding Medical and Dental (Male = 16.24% of workforce / Female = 83.76% of workforce)					
	Total	**Female**	**Male**	**Female %**	**Male %**
Q1	1141	917	224	80.37%	19.63%
Q2	1091	891	200	81.67%	18.33%
Q3	1119	942	177	84.18%	15.82%
Q4	797	672	125	84.32%	15.68%

Table Two: Quartiles for the Trust excluding medical and dental

The findings indicate that the composition of the Medical and Dental workforce, where 39.05% of the workforce are male and the majority of roles sit within the upper pay quartile, is a significant factor influencing the Trust's overall Gender Pay Gap position. Therefore, at a staff group analysis it is a challenge to report on the Trust Gender Pay Gap collectively for improvement due to the nature of the roles and subsequent pay.

This analysis provides assurance that the headline quartile disparity is largely influenced by workforce composition rather than being consistently replicated across the wider non-medical workforce. As a result, further analysis by staff group, profession and leadership level will now be undertaken to inform a targeted Gender Pay Gap engagement plan and support ongoing quarterly assurance through a dedicated governance process.

2.4 Next steps / action planning

From 1 April 2026 Warrington and Halton Teaching Hospitals NHS Foundation Trust acquired Bridgewater Community Healthcare NHS Foundation Trust and changed its name to North Cheshire and Mersey NHS Foundation Trust.

A combined action plan for improvement is in place from 2026-27 and can be found as Table Three.

Ref	Action	Rationale	Lead	Timescale	Success Measure
GPG01	Complete a detailed Gender Pay Gap deep dive by staff group, profession, pay band and leadership level to identify areas of over or under-representation and any workforce irregularities.	Initial analysis demonstrated that the acute upper quartile contains 30.01% male staff compared to 23% male representation across the workforce. Further analysis excluding Medical and Dental colleagues significantly reduced this disparity, indicating that workforce composition is a key driver and requires further investigation.	Adam Harrison-Moran / Ruth Besford	July 2026	Full analytical report completed and presented to SPC.
GPG02	Establish quarterly Gender Pay Gap Review Meetings aligned to WRES and WDES governance arrangements.	Enables routine scrutiny of workforce data, progression outcomes and improvement actions.	Adam Harrison-Moran	August 2026	Quarterly reporting established with agreed dashboard.
GPG03	Review representation within Agenda for Change Bands 8a - 9, Medical and Dental, VSM and Executive roles by gender.	Men remain disproportionately represented within higher paid quartiles and leadership positions.	Adam Harrison-Moran / Ruth Besford	September 2026	Baseline established and reported annually.
GPG04	Undertake recruitment and promotion equality	To understand whether there are gender disparities within promotion	Culture and Inclusion	October 2026	Annual recruitment and promotion

	analysis for Bands 8a and above.	and appointment processes.			equality report produced.
GPG05	Develop female leadership pipeline programme aligned to Leadership and Management Framework.	Improve progression opportunities into senior leadership and strategic roles.	Adam Harrison-Moran / Ruth Besford	March 2027	Increased participation of women in talent and leadership programmes.
GPG06	Develop clear career pathway maps for administrative, clerical and corporate services.	Analysis suggests a large proportion of female staff remain concentrated within lower and middle pay quartiles.	Adam Harrison-Moran / Ruth Besford	March 2027	Career pathways published and promoted trust wide.
GPG07	Strengthen appraisal quality focusing on career conversations and progression.	Improvement of career development opportunities already identified within the wider staff survey improvement programme.	Adam Harrison-Moran / Ruth Besford	March 2027	Improvement in NHS Staff Survey career progression indicators.
GPG08	Complete qualitative engagement sessions (Women's summit) with women working within Bands 7 - 9, VSM and Medical workforce roles.	To understand barriers to progression and identify improvement opportunities.	Ruth Besford	January 2027	Findings incorporated into action plan refresh.
GPG09	Establish integrated NCM Gender Pay Gap baseline following the first North	2026 represents the final pre-integration reporting position; a new integrated baseline is required.	Adam Harrison-Moran / Ruth Besford	June 2027	New baseline approved by SPC and Board.

	Cheshire and Mersey reporting cycle.				

Table Three: Combined Gender Pay Gap action plan (2026-27)

3. Actions required/responsible officer

- Delivery of combined NCM Gender Pay Gap action plan.
- Focus on:
    - Senior representation
    - Career progression pathways
    - Leadership pipeline diversity

4. Measurements/evaluations

Progress will be tracked through:

- Workforce equality datasets
- Staff survey indicators (experience, progression, fairness)
- KPI alignment within EDI and Culture Plan

5. Trajectories/objectives agreed

- Establish new integrated baseline (2026/27) to reduce mean pay gap trajectory over 3 to 5 years.
- Improve female representation in upper quartile.
- Improve equity of leadership pipeline.

6. Monitoring/reporting routes

Monitoring of the action plan for the Gender Pay Gap is completed by the People and Culture Sub-Committee through the workplan of the Workforce Equality, Diversity and Inclusion Strategy 2026-27.

7. Timelines

The Gender Pay Gap is analysed at a snapshot date of the 31 March 2026. Reporting of the data analysis and action plan is completed in May/June 2026 to support actions to be undertaken in the 2026/27 financial year.

The Gender Pay Gap must be published on the UK Government website by 30 March 2027.

8. Assurance committee (if relevant)

Reporting of progress and escalation for the Gender Pay Gap is completed through the Workforce Equality, Diversity and Inclusion Strategy updates to Strategic People Committee on a bi-annual basis.

9. Recommendations

The Trust Board are asked to receive the analysis and data included in this paper and appendices and note the contents for assurance, as previously approved by the Strategic People Committee.

North Cheshire and Mersey
NHS Foundation Trust

Gender Pay Gap

Warrington and Halton Teaching Hospitals NHS Foundation Trust

April 2025 to March 2026

Home Community Hospital

N.B. Warrington and Halton Teaching Hospitals NHS Foundation Trust was renamed North Cheshire and Mersey NHS Foundation Trust on 1 April 2026

Introduction

Background to the report

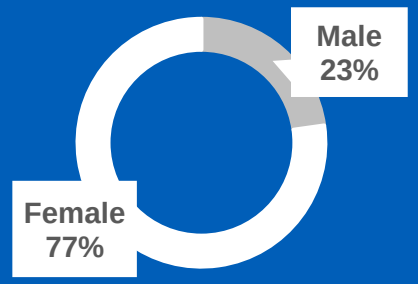
Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is committed to promoting, championing and advancing equality, diversity and human rights. We aim to make WHH the best place to work, creating a culture of belonging for all.

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, requires all public sector organisations with over 250 employees to report and publish their Gender Pay Gap annually.

The gender pay gap is defined in the Act as the difference between the average hourly earnings of males and that of females.

Gender pay reporting highlights any imbalance of average pay across the Trust. For example, if the Trust's workforce is predominantly female yet most senior positions are held by males, the average female salary would be lower than the average male salary.

WHH Gender Profile



What does this tell us?

Of the **4,570 workforce** included in the gender pay gap reporting, effective 31 March 2026, 3,592 were female compared to 978 males.

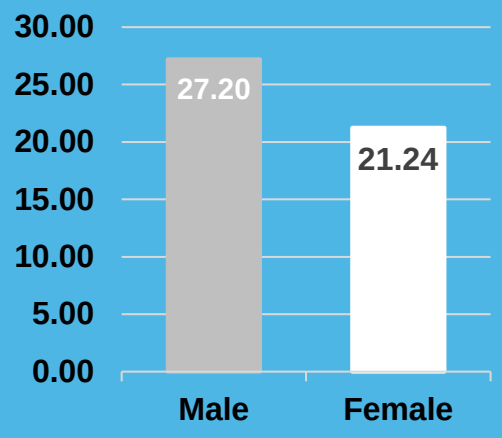
This shows an increase of 2% of males in the workforce in comparison to reporting in 2024/25. This is reflected nationally in NHS workforce profiles.

Gender Pay Gap 2025/26

Mean Pay Gap

Mean is the sum of the values divided by the number of values. In this context, the mean is the difference between the mean hourly rate for female and male employees.

Mean Hourly Rate



What does this tell us?

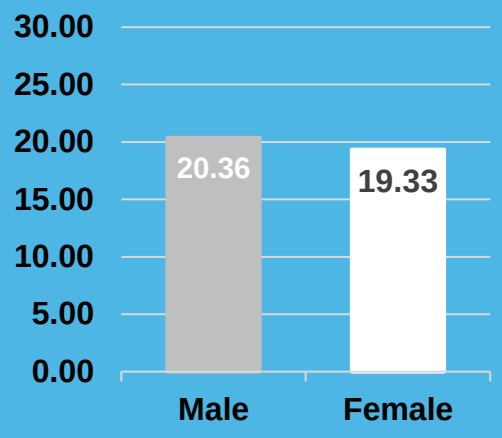
This highlights that the mean hourly pay for males is **£5.96 higher** than that of females, a gender **pay gap of 21.91%**.

This is an **increase of 0.39%** in the mean pay gap from 21.52% reported in 2024/25.

Median Pay Gap

Median is the middle value in a sorted list of values. It is the middle value of the pay distribution, such that 50% of people earn more than this and 50% earn less than the median.

Median Hourly Rate



What does this tell us?

This highlights that the median pay for males is **£1.03 higher** than females, a gender **pay gap of 5.06%**.

This is an **increase of 0.95%** in the median pay gap from 4.11% reported in 2024/25.

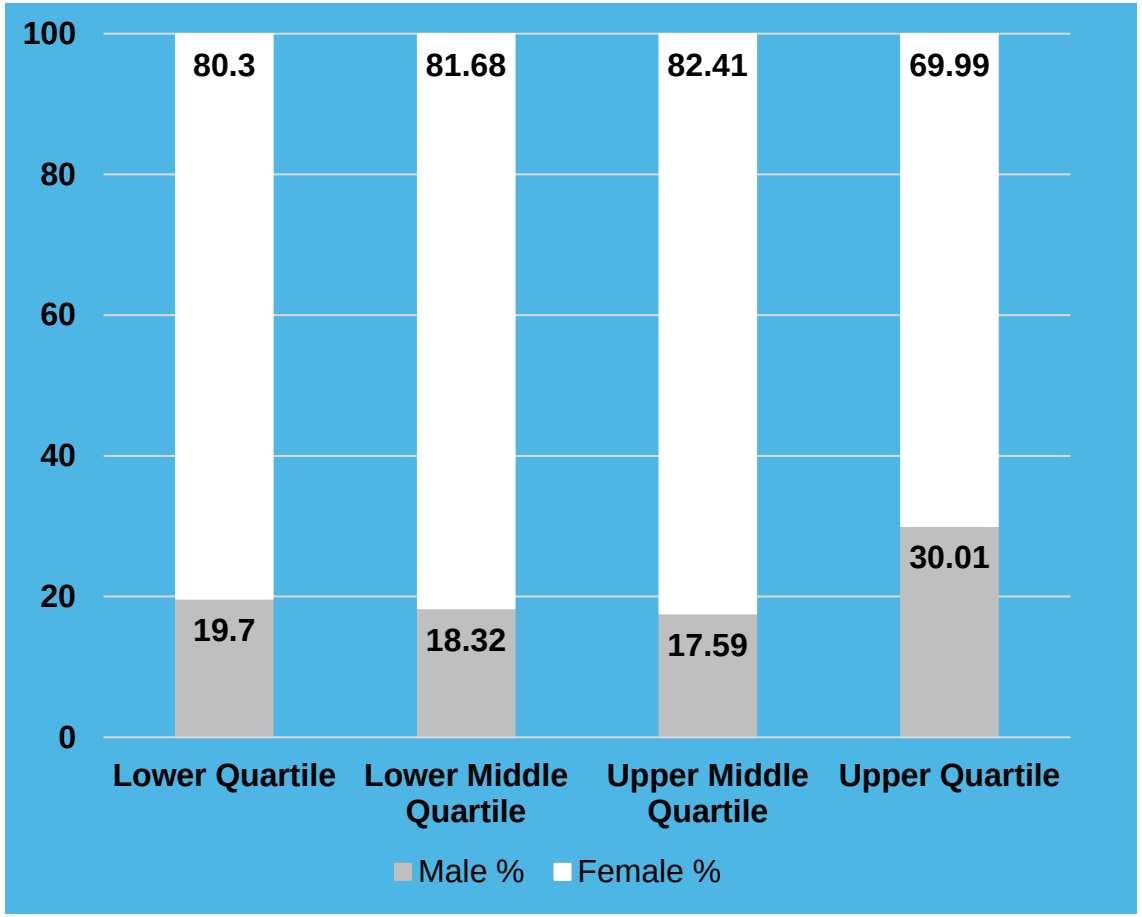
The median pay gap is the representative gender pay gap across the Trust. This does not take account of the highest paid employees which although a small number, may distort the data at the mean (average) level.

The data show that both the mean and median pay gaps have increased on last year's levels, however, both have been under 1% each. Despite this, work needs to be embedded to reverse this increase and close the pay gap.

Gender Pay Gap 2025/26

Quartile Split

The Trust is required to split the workforce into quartiles (blocks of 25%) split by pay, showing the proportion of males and females in each quartile.



Analysis

The quartile splits show that there is still an over-representation of the male workforce in the highest paid quartile. The upper quartile is made up of 30.01% male workforce which is approximately 7% greater than the male representation of the overall workforce.

Whilst the overall male representation has increased by 2%, this has not been a uniform increase across quartiles. The lower quartile increased by 0.98%, the lower middle decreased by 1.84%, the upper middle quartile increased by 0.64% and the upper quartile increased by 2.13% when compared to levels for financial year 2024/25.

On the flip side of this, females are over-represented in the lower, lower middle and upper middle quartiles and significantly under-represented in the upper quartile. The conclusion is that female staff are more likely to be in the upper middle and lower middle quartiles whilst male staff are more likely to be in the upper and lower quartiles, therefore the highest paid and lowest paid roles.

Enhanced work is required to in the upper quartile to reverse the increase seen in the pay gap but also in the middle quartiles to ensure fair representation across all areas.

Gender Pay Gap 2025/26

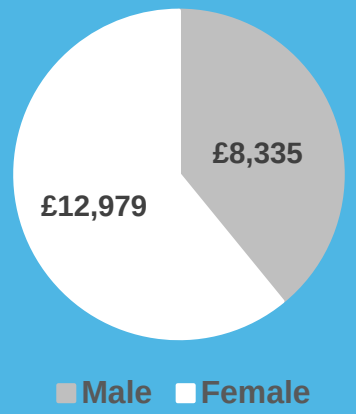
Bonus pay

Bonus pay for the Trust refers to Clinical Excellence Awards, a scheme that recognises and rewards consultants who contribute to the delivery of safe and high-quality care to patients, and to continuous improvement of NHS services.

Clinical Excellence Awards were previously split by national and local awards. Local Clinical Excellence Awards (LCEAs) in England, designed to reward consultants for outstanding clinical work, are no longer awarded annually, with the final award round being in 2023/24. This report provides an outline of national awards from 1 April 2025 to 31 March 2026, the data in this report provides a combined bonus 'mean' and 'median' calculation.

37 staff received a national award in this snapshot period; this equates to 0.20% of females and 2.51% of males in the workforce.

Mean Bonus Pay

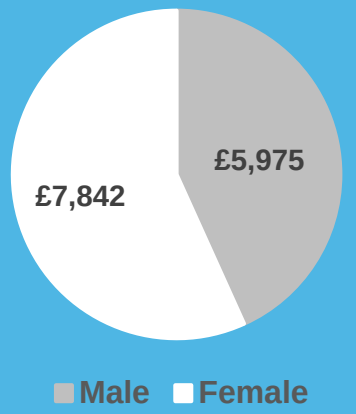


What does this tell us?

This highlights that females **received 55.72% higher** mean bonus pay compared to males.

This is a reduction in mean bonus pay gap of **11.7%** from 2024/25 data of 67.42% higher mean bonus pay for females.

Median Bonus Pay



What does this tell us?

This highlights that females **received 31.25% higher** median bonus pay compared to males.

This is a reduction in median bonus pay gap compared to 2024/25 where there was a gap of 50.00%.

This tells us that although less female staff received a bonus then male staff, when they did, female staff received a proportionately higher bonus payment. This is a continued trend from previous years of gender pay gap reporting.

Contact information:

ncm.inclusion@nhs.net

• Home • Community • Hospital

Caring for you

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Gender Pay Gap Report

31 March 2026

Date: May 2026



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Results for 31st March 2026 **Page 4**

Introduction

Since 2017 Gender Pay Gap legislation has required all employers with more than 250 staff to publish annual information on the pay gap between their male and female staff. For public sector organisations such as the NHS the snapshot date for data capture is 31st March every year.

The Gender Pay Gap regulations require six figures to be reported annually:

- Mean (average) gender pay gap in hourly ordinary pay
- Median (middle) gender pay gap in hourly ordinary pay
- Mean (average) gender pay gap in bonus pay
- Median (middle) gender pay gap in bonus pay
- Proportion of men and women in each pay quartile
- Proportion of men and women receiving bonus pay

Ordinary pay includes basic pay, allowances, and enhanced and special duties pay. It does not include any type of bonus pay. For this calculation just the snapshot date is used, so if staff were not paid for any reason (career break, or statutory sick or maternity pay for example) on 31st March 2026 they are not included.

Bonus pay in the Trust relates to Clinical Excellence Awards, a national scheme for medical consultants that recognises contribution to high quality care, and service improvement and innovation. The relevant dates for bonus pay are the full financial year, so in this report 1st April 2025 to 31st March 2026.

More information on gender pay gap and calculations can be found on the Government website at https://www.gov.uk/government/publications/gender-pay-gap-reporting-guidance-for-employers

Since 2024 – 2025 the Trust has been in a process that will see Bridgewater acquired by our local acute Trust, Warrington and Halton Teaching Hospitals NHS Foundation Trust. During this time there has been several joint executive roles to facilitate integration, these shared roles are reflected within calculations where appropriate.

It is important before we begin to highlight that while the national reporting mandate for the gender pay gap is for the binary norm of male and female, as a Trust we recognise that not all staff will identify within these confines. We are working to engage with these staff, to listen to their lived experience so that we can ensure that their employment experience is equitable, and that they feel supported, valued, and included within the team that is Bridgewater.

Results for 31st March 2026

Ordinary pay - profile

On 31st March 2026 we employed 1,435 staff who were relevant to gender pay gap reporting, including bank staff paid for work in the relevant period, and excluding substantive staff on statutory sick or maternity pay only on that date.

The female workforce total was 1,277 or 89.0% of the total relevant workforce, and the male workforce was 158 or 11.0% of the total relevant workforce.

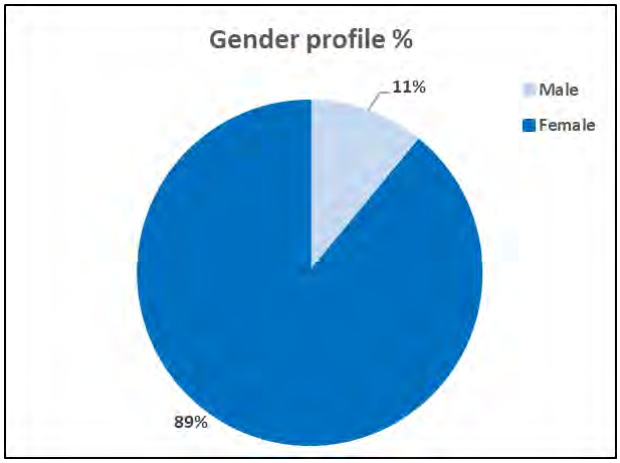


Table 1 shows the number of female and male staff in each pay quartile, the division of female and male staff into four roughly equal groups based on hourly pay.

Table 1: Showing the numbers and percentages of female and male staff in the four pay quartiles at 31st March 2026.

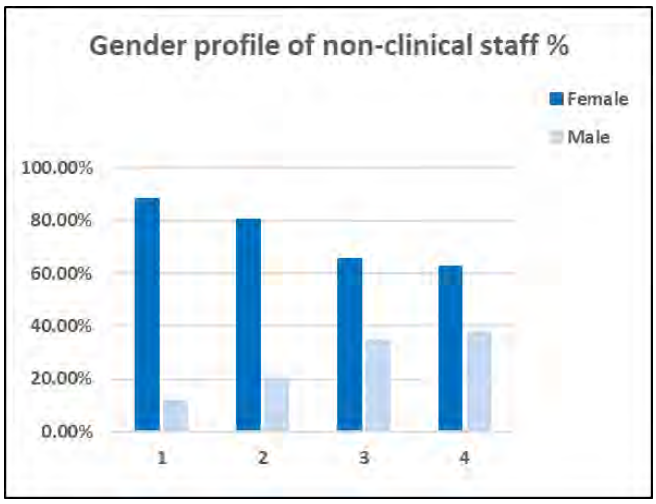
Female Workforce	Total	Percentage %	Male Workforce	Total	Percentage %
Lower quartile 1	309	86.1%	Lower quartile 1	50	13.9%
Lower middle quartile 2	336	93.3%	Lower middle quartile 2	24	6.7%
Upper middle quartile 3	329	92.2%	Upper middle quartile 3	28	7.8%
Upper quartile 4	303	84.4%	Upper quartile 4	56	15.6%

It will be observed that female staff are under-represented in quartile 4 when compared to quartiles 2 and 3, this influences particularly the mean, or average, gender pay gap figure – the greater number of male staff on higher Agenda for Change, Medical and Dental, and Very Senior Manager pay scheme bands increases the overall hourly rate for male staff. The median gender pay gap figure is balanced by the higher representation of female staff in the workforce overall, and the significant number of female staff in higher Agenda for Change, Medical and Dental, and Very Senior Manager pay scheme bands.

Further detail by staff group is provided on the following page.

Non-clinical staff

- The non-clinical workforce represents 25.0% of the overall Trust workforce.



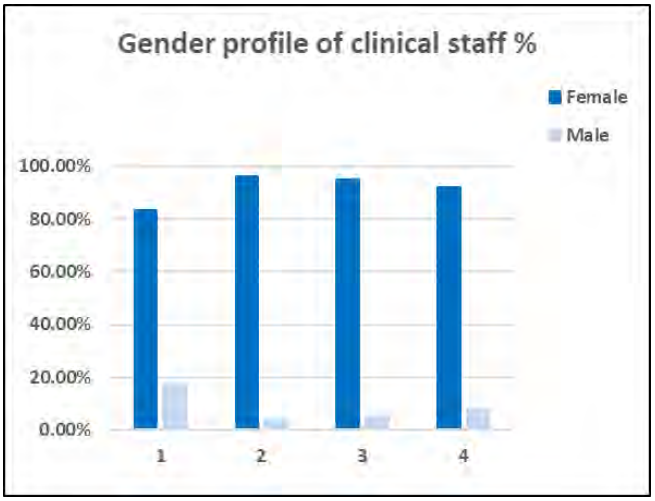
- The non-clinical workforce is paid through both Agenda for Change and Very Senior Manager pay schemes, reflective of the diversity of roles in this group.

- The non-clinical workforce is 80.2% female, with female staff significantly under-represented in quartiles 3 (65.6%) and 4 (62.5%).

- There is a large number of female staff in administrative and clerical roles at Agenda for Change pay band 3, represented in quartile 1; in higher quartiles and pay bands the ratio of female to male staff significantly reduces until pay bands ratios are broadly equal.

Clinical staff

- The clinical workforce represents 69.4% of the overall Trust workforce.



- The majority of the clinical workforce is paid through the Agenda for Change pay scheme.

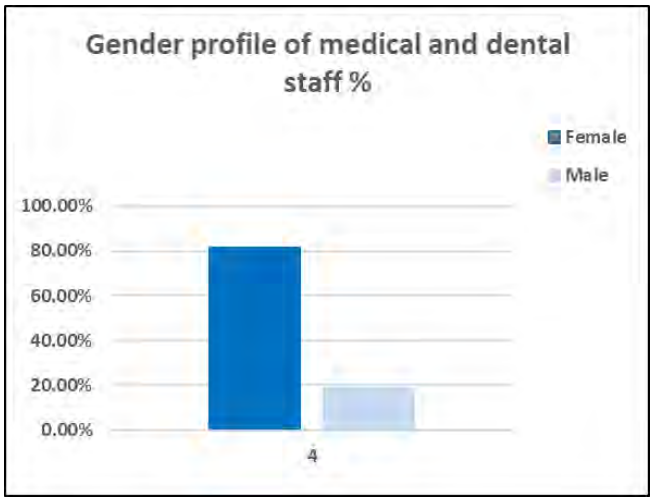
- The clinical workforce is 92.8% female, with female clinical staff under-represented in quartile 1 (83.3%).

- The clinical workforce shows particular representation, both female and male, in Agenda for Change pay bands 4 to 7, this includes community nurses, school nurses and health visitors, and many allied health professional therapist roles.

Medical and dental

- The medical and dental workforce is 81.3% female.

- Medical and dental staffing represent 5.6% of the overall Trust workforce, and 22.9% of quartile 4 – as a result of hourly rates all Medical and Dental staff are placed in this quartile.



- The influence of this group is the contribution of the staff to the hourly rate figures, and thereby to the gender pay gap calculations, and the greater representation of male staff (18.8%) in this group and the effect on overall Trust results.

Ordinary pay – gender pay gap results 31st March 2026

Table 2 tells us that the mean or average hourly rate for male staff at 31st March 2026 is £4.77 more than for female staff, a percentage pay gap of 17.97%. This is an increase in the pay gap by 5.82% from the previous year, and the actual monetary pay gap has increased by £1.94.

The median or middle hourly rate for male staff is £0.99 more than for female staff, a percentage pay gap of 4.77%. This is a increase in the pay gap by 2.49% from the previous year, the actual monetary pay gap has increased by £0.55 (55 pence).

Table 2: Showing the mean and median hourly rate of pay for female and male staff, and the gender pay gap shown as both a monetary value and as a percentage. At 31 March 2026.

	Mean hourly rate of pay	Median hourly rate of pay
Female	**£21.80**	**£19.78**
Male	**£26.57**	**£20.77**
Pay Gap monetary value £	**£4.77**	**£0.99**
Pay Gap percentage value %	**17.97%**	**4.77%**

Table 3 shows a comparison of gender pay gaps for ordinary pay from 2017 to 2026.

Table 3: Showing the mean and median gender pay gap results by percentage from 2017 to 2026.

	Mean Gender Pay Gap %	Mean Gender Pay Gap £	Median Gender Pay Gap %	Median Gender Pay Gap £
2017	23.52%	£4.55	8.48%	£1.27
2018	23.87%	£4.84	7.34%	£1.16
2019	22.38%	£4.53	1.54%	£0.24
2020	25.34%	£5.56	9.19%	£1.56
2021	16.24%	£3.28	4.13%	£0.67
2022	14.45%	£2.96	0.34%	£0.05
2023	15.97%	£3.48	3.16%	£0.55
2024	12.88%	£2.81	2.29%	£0.41
2025	12.15%	£2.83	2.28%	£0.44
2026	17.97%	£4.77	4.77%	£0.99

It will be observed from this table that the gender pay gap in the Trust has risen this reporting year, this is largely due to changes at executive level as a result of integration with our local hospital Trust.

Work is beginning to establish a new baseline for pay gap reporting as a new and larger workforce group from 1st April 2026, reporting as North Cheshire and Mersey NHS Foundation Trust will begin on 31st March 2027.

Bonus pay – results for year ending 31 March 2026

Bonus pay for the Trust historically has referred to Clinical Excellence Awards; this was a national scheme that recognised and rewarded consultants who contributed most to the delivery of safe and high-quality care to patients and to continuous improvement of NHS services.

Within Bridgewater there was no bonus pay in the year 1st April 2025 to 31st March 2026.

Contact details

Thank you for taking the time to read our gender pay gap report. Should you have any queries or questions or if you would prefer the contents of this report in another language or format, please contact our Equality & Inclusion Manager in the first instance, details below.

Paula Woods *(Director of People and Organisational Development)*

Ruth Besford *(Equality & Inclusion Manager)* *ruth.besford@nhs.net*

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/054**			
Subject:	Living Well Together: Two Years On			
Date of meeting:	5th August 2026			
Action required:	To note the progress, impact and learning from the Living Well programme over its first two years and support the proposed next phase of development.			
Author(s):	Rachel Moran, Strategic Programme Lead Steve Bennett, Head of Strategy and Partnerships			
Executive director sponsor:	Lucy Gardner, Chief Strategy & Partnership Officer			
Link to strategic aim:	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 9: If we do not integrate services effectively and fail to collaborate successfully with system partners, then fragmentation of pathways will continue, and outcomes diminish resulting in failure to meet increased demands and reduced long-term sustainability			
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 Living Well programme in Warrington has reached a significant two-year milestone. This report provides the Board with a summary of the Living Well Warrington programme two years on from the opening of the Living Well Hub in the Town Centre in March 2024. The programme has now developed into a connected offer across three elements: the town centre Living Well Hub, community-based Talking Points, and the Living Well Warrington digital platform. Together these support prevention, early intervention, improved access and more joined-up support for residents across Warrington.			

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Board is asked to: • Note the progress and impact of the Living Well programme over its first two years, as set out in the Two Years On report. • Recognise the programme's contribution to prevention, neighbourhood health, reducing inequalities and integrated community support. • Support the continued development of the model, including further evaluation, sustainable workforce planning and long-term funding arrangements. • Champion awareness and utilisation of the Living Well programme offers.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

Living Well is a Warrington place-based programme designed to make it easier for residents to access the right support earlier, closer to home and in ways that feel welcoming and accessible. It responds to increasing demand, widening inequalities and the needs of a growing and ageing population by shifting the emphasis towards prevention, early intervention, self-care and stronger community connections.

Since the Living Well Hub opened in March 2024, the programme has developed into a connected model comprising a central town-centre Hub, neighbourhood-based Talking Points and the Living Well Warrington digital platform. Together, these elements provide a single, recognisable approach for residents and professionals to

find local support, access advice, build confidence and connect with services across statutory and voluntary, community, faith and social enterprise partners.

The Trust Strategy and Partnerships Team has acted as an anchor for the programme's development, providing leadership, coordination and continuity as the model has evolved. This has included working in close partnership with the local authority, neighbouring NHS organisations and the VCFSE sector to shape the hub offer, support the development of the digital platform, strengthen shared priorities and ensure the programme remains connected to wider place-based, neighbourhood health and prevention agendas.

2. Key elements

The Living Well model brings together three linked elements: the Living Well Hub, a highly accessible town-centre space hosting a broad range of co-located services; Talking Points, which take personalised advice and support into neighbourhood settings; and Living Well Warrington, a digital platform that provides a trusted online gateway to local services, activities, events and volunteering opportunities.

- The Hub has welcomed more than 55,000 visits, with activity increasing from fewer than 200 visits per week to more than 3,500 visits per month by the end of year two.
- More than 170 different services have been delivered by over 40 partner organisations, with around 40% of people dropping in without an appointment.
- Talking Points have been delivered in 10 locations and generated more than 1,770 visits, with conversations supporting people to identify wider needs and take the next step before issues escalate.
- The digital platform has received more than 220,000 visits and includes over 120 VCFSE organisations, 100 public services and 190 local businesses.
- The offer has strong reach into more deprived communities, with around 88% of Hub visitors living in central areas of Warrington and nearly half of digital platform users coming from the most deprived areas.

3. Actions required/responsible officer

The Board is asked to note the report and support the next phase of the programme. Responsible officers will need to continue working with system partners to maintain the Living Well offer, strengthen evaluation, secure sustainable workforce and funding arrangements and develop the model as part of the wider shift towards prevention, neighbourhood health and community-based support.

4. Measurements/evaluations

Programme impact is measured through activity data, digital analytics, partner feedback, resident stories, service development and independent evaluation. The report demonstrates strong reach and growing use across the Hub, Talking Points and digital platform, including more than 55,000 Hub visits, more than 1,770 Talking Point visits and more than 220,000 digital platform visits. The programme has also secured national recognition, including highly commended entries at the HSJ Awards 2025, HFMA Awards 2025 and HSJ Digital Awards 2026, alongside finalist recognition for prevention and early intervention through digital.

Independent evaluation has identified evidence of increased uptake of health services, improved accessibility for people in deprived areas and potential to reduce health inequalities over the long term. Case studies also demonstrate preventative impact, including improved recovery support, reduced isolation, digital inclusion, dementia and carer support, family-centred early help and improved access to preventative health checks.

5. Trajectories/objectives agreed

The next phase of Living Well will focus on building on what works and strengthening the model as part of wider neighbourhood health, prevention and integration priorities.

- Develop shared tools, including Living Well conversations, to support guided access, early help and self-management.
- Expand neighbourhood-based hubs and community health worker models.
- Increase community involvement, ownership and co-production.
- Continue to evaluate impact and evidence long-term outcomes and system value.
- Secure long-term funding and workforce stability.

These objectives align with the ambition to establish Living Well as a sustainable, community-led model that supports people to live well for longer in their communities.

6. Monitoring/reporting routes

Progress with the Living Well programme will now be reported through the Trust NCM2030 governance arrangements. Updates will be periodically reported through:

- NCM2030 Programme governance
- Executive Management Team
- Trust Board and its Committees, where appropriate

7. Timelines

The Living Well Hub opened in March 2024. The Living Well Warrington digital platform launched in March 2025. The report provides a two-year review of progress and learning, with the next phase focused on consolidation, further development and long-term sustainability during 2026/27 and beyond.

8. Assurance committee (if relevant)

Programme governance will now report into the NCM2030 governance structure and onwards to Executive Management Team and committees of the Board and Trust Board as appropriate.

9. Recommendations

The Board is asked to:

- note the progress, reach and impact of Living Well over its first two years;
- recognise the programme's contribution to prevention, neighbourhood health, reducing health inequalities, digital inclusion and integrated community support;
- support continued development of the Living Well model as part of the wider shift towards community-based, preventative care;
- support further evaluation, outcome measurement and sustainability planning, including workforce and funding requirements.

LIVING WELL WARRINGTON

Living Well Together

Two years on



WARRINGTON Borough Council

NHS

Introduction

The Living Well programme in Warrington has reached an important milestone. Two years on from the opening of the Living Well Hub in March 2024, the programme has grown from a single, place-based wellbeing hub into a connected system of support across the borough.

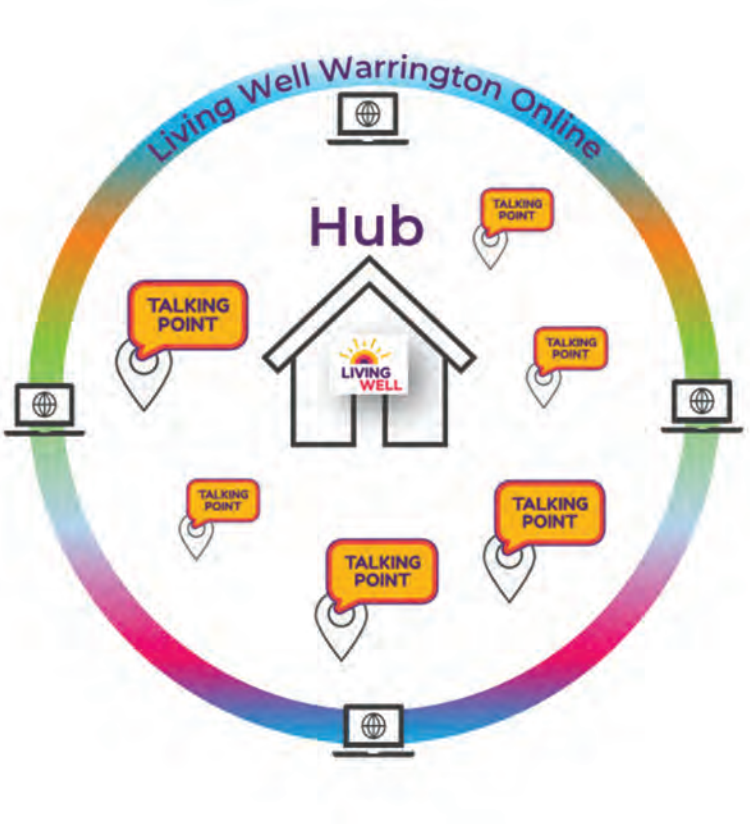
Living Well is about making it easier for people to access the support they need. Recognising that services can often feel complex and difficult to navigate, the programme focuses on simplifying access, strengthening connections between organisations, and making support more visible and accessible. Alongside this, there is a strong emphasis on prevention, early intervention and empowering people to manage their own wellbeing, helping to address the root causes of poor health and persistent inequalities.

Living Well now brings together three key elements:

- **The Living Well Hub** – a central, highly accessible, town centre space hosting a wide range of connected face-to-face services delivered by statutory and voluntary, community, faith and social enterprise (VCFSE) partners.
- **Talking Points** – a growing community-based outreach offer providing personalised, one-stop advice and support in neighbourhood settings across Warrington.
- **Living Well Warrington (digital platform)** – a trusted online gateway, launched in March 2025, helping residents and those supporting them to find and connect with local services more easily.

Together, these elements create a more joined-up system of support, linking services, places and communities. This approach reflects a shift towards prevention, early support and self-care in response to increasing demand, widening inequalities, and the needs of a growing and ageing population.

This Two Years On report brings these strands together for the first time. It tells the story of activity, impact and learning to date, and demonstrates how a community-led, neighbourhood approach is making a meaningful difference to residents, communities and the wider system.



Activity and reach

Living Well has become a trusted part of life for many people in Warrington over the past two years.

- 55,000+ visits to the Living Well Hub
- 1,770+ visits to Talking Points
- 220,000+ visits to Living Well Warrington online
- hundreds of services accessible across the system
- strong reach into more deprived communities

Living Well Hub

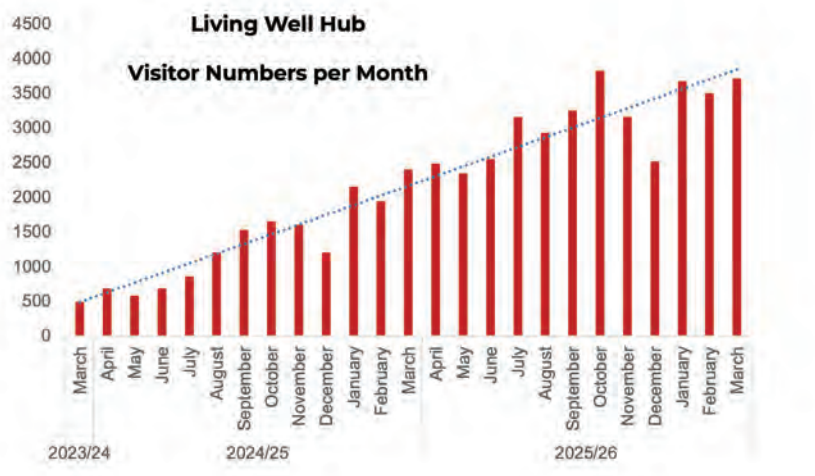
Since opening, the Living Well Hub has welcomed over 55,000 visits. Activity has grown steadily from fewer than 200 visits per week to more than 3,500 visits each month by the end of year two.

The hub is designed to be easy to access:

- 40% of people drop in without an appointment.
- Over 170 different services have been delivered by more than 40 different partner organisations.

It is particularly well used by people who may struggle to access traditional services.

- Around 88% of visitors live in central areas of Warrington. The areas that repeatedly record the poorest health outcomes.
- Around 10–15% of visitors access more than one service in a single visit.
- 1 in 10 say they would not have accessed any support at all without the hub.



Talking Points

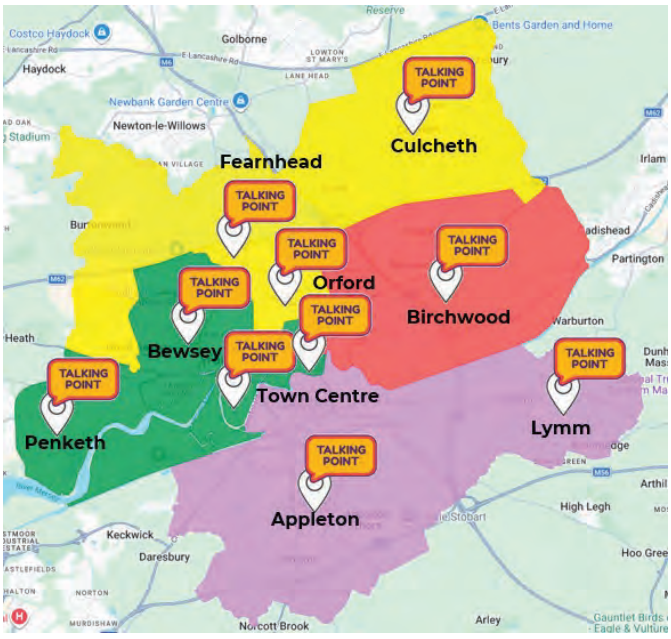
Talking Points takes the Living Well approach out into neighbourhoods and brings support closer to home.

Over two years:

- Delivered in 10 locations across Warrington
- Generated 1,770+ visits
- Conversations last between 15 and 30 minutes, enough time to listen, understand what's going on, and help someone take the next step.

The most common need is emergency food support, but 'good conversations' help uncover wider challenges, allowing for more holistic support to be offered.

For many, this is the first point of contact before things reach crisis point. It also helps us understand what people need, so we can adapt where services are delivered and what support is prioritised. Talking Points not only support individuals but also helps shape the wider Living Well offer.



LivingWellWarrington.org (online platform)

The Living Well Warrington website extends support beyond physical locations.

It provides:
- a simple and trusted gateway to find local help
- support and information available at any time
- clear pathways into services, explained in ways that people understand
- relevant and up to date activities, events and volunteering opportunities

The platform includes:
- 120+ voluntary, community and social enterprise organisations
- 100+ public services
- 190+ local businesses

Importantly:
- over half of users take action after viewing information
- nearly half of users are from the most deprived areas in Warrington

Features like AI natural language search, local neighbourhood pages and clear contact details help people navigate support more confidently, especially if they might otherwise struggle with digital tools.

NEW ACTIVITIES ADDED	NEW MEMBERS	TOTAL (UNIQUE) USERS	CONTACTS TO SERVICES	PAGE VIEWS
1274	625	41,872	3,778	220,000

Figure 1: An example of platform statistics

It is important to remember that these figures do not tell the whole story. Many people use the website to find information and then choose to make contact in person or by phone, meaning its true reach is likely to be even greater.

Services and delivery across the sytem

Living Well brings together a wide range of services in one place, helping residents to stay well, manage a condition, recover, or stay connected to their community.

Over time services have evolved, responding to what people are asking for and what staff and partners are seeing day to day. For example, feedback and insight from Talking Points has helped shape where outreach sessions take place and what support is prioritised.

In the same way, the Living Well Warrington website continues to grow and adapt. Members continually add more services, and working in partnership with Experts by Experience, the Living Well team add information on areas where people are actively looking for help, such as dementia support or local community centre activities. This means the offer reflects real need, not just what is available.

The data below brings this to life. It highlights some of the most viewed activities on the Living Well website, services that people are actively seeking out.

Behind these numbers are real stories: families accessing preloved school uniforms without stigma, older residents finding local memory cafés, or people discovering community activities they didn't know existed. It shows that people aren't just browsing, they're finding support that matters to them.



Figure 2: Activities listed on Living Well Warrington with over 1,000 views that support health inequalities.

In the Living Well Hub, the broad range of services offered continues to grow with these new services launched in the past 12 months:

Children and families
Warrington Autism Neuro Diverse (WANDS)
Special educational needs and disabilities (SEND) Stay and Play
Child adolescent mental health service (CAMHS)
Youth Service
Independent domestic violence advisor (IDVA) support
More than Men

Ageing well
Neuro Physiotherapy
Coffee morning
Adult Social Care assessments

Staying well
My health anxiety peer support (MY HAPS)
Read to Relax
TB Clinic



What difference has it made?

Over two years Living Well is making a real difference, both for individuals and for the wider system.

For residents

Living Well offers somewhere that feels welcoming and easy to use, whether that's a physical space in the Hub, a conversation in a community setting, or finding information online. People can drop in when they need to, build trusted relationships, and access support without having to navigate complicated systems.

People are:

- accessing support earlier
- finding services more easily
- feeling more confident and less isolated
- experiencing more joined up care

A key part of this is that residents and people working to support our health and wellbeing system actively shape activities, services and priorities, making Living Well a genuinely community led model grounded in co production and shared ownership.

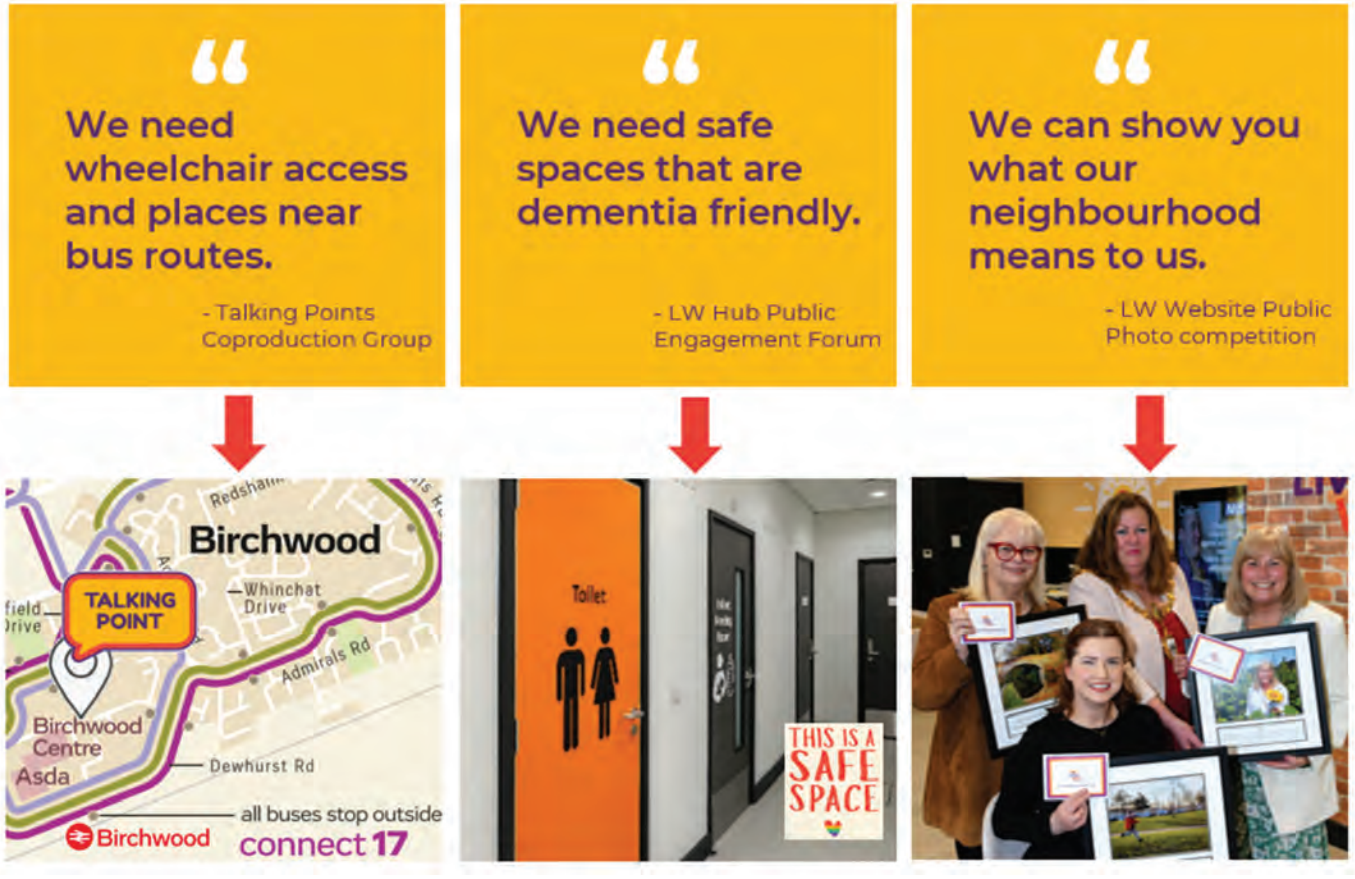


Figure 3: Example of co-production in Living Well

For the wider system

Independent evaluation found:

- increased uptake of health services
- improved accessibility, particularly in deprived areas
- potential to reduce health inequalities over time

For example, an independent Towns Fund evaluation conducted by the Ministry of Housing, Communities & Local Government found:

"There is strong evidence that the Living Well Hub has supported uptake of health services, and the accessibility of health and wellbeing services in Warrington."

"There is evidence that the Living Well Hub is overcoming key barriers to accessing health and wellbeing services, in particular for users from more deprived areas."

"...the evidence...suggests that the Living Well Hub may support a reduction in health inequalities over the long-term."

The programme is also gaining national recognition, featuring in:

- national guidance
- case studies

For example, the Hub has been included as a case study in national Best Start Family Hubs and Healthy Babies guidance for local authorities (April 2026 to March 2029), and the programme as a whole has attracted wider national recognition through awards and sector interest.

National award accolades include:

- Integrated Care Initiative of the Year (highly commended), HSJ Awards 2025
- Addressing Health Inequalities Through NHS Finance Action Award (highly commended), HFMA Awards 2025
- Reducing Health Inequalities Through Digital (highly commended), HSJ Digital Awards 2026
- Driving Prevention and Early Intervention Through Digital (finalist), HSJ Digital Awards 2026



Case studies

Mike's journey to recovery

Mike's story highlights how all three parts of the Living Well system can support individuals to transform their lives and live well.

Mike was homeless and living in temporary accommodation at James Lee House when he first accessed the Living Well Hub in June 2024. He describes having lived a chaotic lifestyle since his teenage years, beginning to use alcohol and substances at the age of 16, which later developed into addiction. As a result, Mike had been unable to sustain employment and experienced long periods of instability.

At the time he first visited the Hub, Mike had achieved 11 months of sobriety but recognised he needed structured support to maintain his recovery. Having heard about the Living Well Hub from peers, he called in seeking advice.

Mike first accessed the Living Well Hub through a Talking Point, where staff took time to have a good conversation, listen to his story and understand his needs without judgement. After years of living with instability linked to substance use and homelessness, Mike was looking for somewhere he could feel safe enough to start again.

During this visit, Mike recognised a practitioner from CGL – Pathways (Change Grow Live), which immediately helped build trust and reduce anxiety about engaging with services. Feeling reassured and supported, Mike chose to reconnect with the service and began attending weekly sessions with a recovery coordinator. This marked a turning point in his recovery journey.

As Mike moved towards the end of his structured treatment, he attended the Life After Pathways (LAP) group held at the Living Well Hub. The group helped prepare Mike for life beyond structured recovery support, supporting his transition towards independence and long-term stability.

The co-location of services within the Living Well Hub was instrumental in this engagement. Had Mike not accessed the Hub, it is unlikely he would have proactively re-engaged with recovery services. The welcoming, informal environment helped remove barriers that may otherwise have prevented him from seeking support.

From this point, Mike began building a consistent and healthy routine. He accessed:

- nutritional advice sessions
- smoking cessation support
- weekly recovery support through CGL Pathways
- weekly health monitoring using the KEITO body composition machine

This structured engagement became a protective factor in his recovery. Mike consciously focused on improving his physical health and fitness to support his sobriety and mental wellbeing.

Mike engaged consistently with services at the Hub for over a year. He has reflected that from the moment he walked through the doors of the Living Well Hub, he felt calm, relaxed and accepted. He describes staff as welcoming and non-judgemental, which he identifies as fundamental to maintaining his engagement.

Now, nearly two years since first attending the Hub, Mike is 2 years and 8 months substance-free.

During this time, he has:
• sustained his own tenancy
• become a volunteer at Pathways supporting peers on their varying recovery journeys
• enrolled on a course at Warrington & Vale Royal College
• taken on a strategic role with King's College London as a member of the NIHR Policy Research Unit in Addictions

As Mike has grown in confidence and independence, he has developed the skills to navigate support for himself. When he needs advice or guidance, he now uses the Living Well Warrington online platform as his first point of contact, enabling him to explore available services and access the right support at the right time.

Mike reports that Living Well has played a significant role in supporting him to remain substance-free and develop a renewed sense of purpose. He continues to prioritise his fitness, rebuild relationships, and describes himself as "finally loving life." He is now preparing to move into paid employment later this year.



Impact on health and acute services

Through sustained engagement at the Living Well Hub, Mike has maintained long-term sobriety, improved his physical health and developed structured routines that support his wellbeing. This preventative, relationship-based support has reduced his risk of relapse and the likelihood of emergency or crisis presentations to primary and acute services.
By providing early intervention, co-located recovery support, ongoing wellbeing monitoring and 24/7 access to the Living Well Warrington online platform the programme has helped prevent escalation to emergency care and supported sustained housing stability — enabling Michael to find and access the right support at the right time and reducing potential demand across the wider health and care system.

Case studies

Early support for the whole family

Emma first visited the Living Well Hub in summer 2024 while pregnant with her second child and working nearby. Emma describes herself as a very nervous and sensitive person and shared that if she had 'picked up the wrong vibe' when she first walked through the door, she would not have returned. First impressions truly mattered. She described how the Hub's calm, welcoming and non-clinical environment immediately made her feel safe. That first positive experience gave her the confidence to return.

Over time, Emma accessed a wide range of support through the Hub, including family hub sessions, health visitor drop-ins, welfare and benefits advice, early years funding support and postnatal services. Having multiple services available in one familiar building reduced her reliance on GP appointments for reassurance and helped her access the right advice at the right time, supporting early intervention for the whole family.

After her baby was born, Emma returned quickly to the Hub she trusted, accessing infant feeding, development reviews and peer support. She shared that the encouragement and reassurance she received enabled her to continue breastfeeding when she might otherwise have stopped. More recently, a routine visit for a blood test led to additional SEND support for her eldest child - demonstrating how the Hub routinely turns single contacts into broader family support without additional referrals.

Emma said:
"I am so glad I walked into the Living Well Hub when I did. I cannot tell you how much support I have received since coming here - and all under one roof... I am now pregnant again, and this time I want my maternity appointments to be at the Hub, so I only have to access one building."



Pictured: Living Well Hub general manager Emma Whaley with Emma and children Gabriel and Reuben

Emma's journey demonstrates the impact of the Living Well Hub as a family-centred, non-clinical, one-stop-shop environment. By bringing together antenatal care, early years support, welfare advice, clinical services and community provision in one accessible space, the Hub reduced anxiety, promoted early intervention and provided consistent, preventative support for the whole family.

Living Well Hub general manager Emma Whaley said:

"I have seen Emma transition from seeking reassurance through worry to engaging confidently and proactively - a clear indicator of successful early intervention"

Case studies

Mark and Sandra: Dementia and carer support

Sandra was diagnosed with vascular dementia in 2021, following several years of changes in memory, mood and daily functioning. As her condition progressed, Mark took on the role of primary carer and began to experience increasing emotional and practical strain. Both Mark and Sandra felt anxious about engaging with services and navigating the support available to them.

The couple first became aware of the Living Well Hub in September 2024 through a trusted, face to face introduction at a Lifetime Group session. This connection helped give them the confidence to attend the Still Me dementia group delivered at the Hub, providing a safe, familiar environment for peer support, social connection and access to professional advice.
As their engagement developed, Mark accessed tailored support through the Carers Hub, receiving emotional wellbeing support, practical guidance and advice on carer rights and entitlements. He also benefited from support from the hospital dementia team, helping him better understand dementia progression and advocate more confidently for Sandra across health and care appointments.

The group sessions also provided important education, including advice on scam awareness and safeguarding, supporting both Mark and Sandra to feel safer and more confident managing daily life. Regular visits from the Living Well bus further reduced barriers to accessing preventative health checks and vaccinations in a trusted, community setting.

Through continued involvement, Mark has grown in confidence and now actively contributes to the group, helping to welcome others and support sessions. This reflects the Hub's broader role in not only supporting carers but enabling people to build confidence, skills and a sense of purpose.

Mark describes the Living Well Hub as 'the best thing in Warrington'. He said:
"It has helped both me and Sandra. Receiving all of the advice in one place is so good. I feel so supported and if I have any issues, the first place I come to is the Living Well Hub."

This case study highlights the value of integrated, community based dementia and carer support. By bringing together voluntary, community and health services in one accessible location, the Living Well Hub has reduced isolation, improved wellbeing and strengthened resilience for both Sandra and Mark.



Case studies

Real People Digital Networks and Inclusion

Living Well has supported a local primary care network to connect residents with free, volunteer led digital drop in sessions, helping people build confidence managing their health online. Many residents attending these sessions initially felt anxious about using digital services, such as booking appointments, accessing test results or finding reliable health information. The drop ins provided a supportive, trusted environment where people could learn at their own pace.

A key strength of this approach is how it closes the loop between community need and community capacity. One volunteer, a retired IT manager, discovered a local IT buddy volunteering opportunity through the Living Well platform while looking for ways to share their skills. After signing up, they now regularly support residents at digital drop ins – helping others get online, access health services and build everyday digital confidence. In this way, Living Well turns residents with skills into community assets who directly support others.

After promoting its digital support offer through the Living Well platform, Westbrook Library and Community Centre reported record footfall and a significant increase in volunteer involvement. Increased visibility through Living Well helped re establish the centre as a valued local hub for learning, support and community connection.

For older residents, the digital network has also delivered preventative health benefits. By linking people to targeted strength and balance activities through the platform, Living Well has supported falls prevention, helping individuals build confidence, improve mobility and remain active for longer.



"I feel braver now. I understand things better...I can't believe I can see my family on the screen! It's wonderful to feel connected again." - Community centre partnership to improve digital literacy

"It used to take me hours to find local exercise classes for my older clients, now they are in all one place. " - Good Neighbours charity

Case studies

Coffee Morning Collaboration

Since August, the Living Well Hub has delivered a weekly Thursday coffee morning in response to quieter periods in the Hub and a growing need to address social isolation, particularly among older residents. Designed as a welcoming, non-clinical space, the session combines informal social connection with access to practical advice, prevention activity and trusted services.

The coffee morning is delivered through strong partnership working, bringing together the Living Well Hub team, Warrington Disability Partnership, Macmillan Cancer Support, Warrington Voluntary Action (social prescribing) and LiveWire, with additional partners attending as needed. This collaborative approach ensures attendees can access support for physical health, emotional wellbeing, financial concerns and community connection in a familiar and trusted environment.

Activities include informal conversation, quizzes and creative activities, chair based exercise and wellbeing sessions, alongside targeted input such as financial and scam prevention advice and singing sessions that support emotional wellbeing. Seasonal and intergenerational activities are embedded, including joint sessions with local childminders and pre school children.

Over time, the group has become a strong, self sustaining social network. Many attendees initially arrived alone and lacking confidence; regular attendance has supported new friendships, improved wellbeing and increased independence. Members now meet socially outside the Hub and organise their own activities, demonstrating a shift from supported engagement to long term social empowerment.

The trusted relationships built through the coffee morning have also improved access to preventative health services. For some, repeated informal contact has been a crucial step in overcoming anxiety and engaging with services such as vaccinations. A great example of this is when the Living Well bus was situated outside of the hub over 30 coffee morning attendees were able to have their flu jabs.



"The Living Well Hub and the Thursday coffee morning have genuinely changed my life. I love coming every week – I've met so many new friends and no longer feel on my own." – Lorraine

"The Living Well staff are very helpful... People who are lonely and suffering with their mental health are feeling less lonely and feel less anxious. The Hub is a god send in the community." – Mark

"The Thursday has done wonders for my self-confidence, enabling me to get out and meet new people. The staff are great and very willing to help."

Staff experience

"Meeting people at the Living Well Hub and Talking Point venues has been a fantastic opportunity to learn about the amazing work and services that anyone can access. Staff are so welcoming and we can all share our knowledge and expertise in our different roles.
It's not just about what adult social care can provide, but about connecting people to support close to home. Community venues host a wide range of groups, and community shops are a lifeline during ongoing financial pressures.

Many residents say they were unaware of what was available in their area, underlining the importance of sharing this knowledge more widely. I've met people from 18 to 96 years old who are happy to meet me here and we will offer a brew to put them at ease."

Angela, assistant practitioner at Warrington Borough Council

"The role of the social care advisor has proven to be highly effective at the Living Well Hub, delivering meaningful help to people with care and support needs.

"They have benefited from clearer pathways to access support, and a more responsive, person-centred approach, leading to increased confidence and wellbeing. I have also felt better supported, with enhanced communication, stronger collaboration, and reduced pressure in managing complex cases. Overall, the impact has been significantly positive."

Amy, social care advisor at Warrington Borough Council



Key learning

Key learning from the past two years includes:

- building this kind of model takes time, trust and strong relationships with partners working towards shared outcomes rather than organisational boundaries
- flexible, drop-in access is essential to reach people who may not engage with traditional services
- co-location of services is a key enabler of early intervention, improving access, reducing duplication and supporting more joined-up care
- embedding staff (such as social care advisors) in community settings strengthens multi-agency working, enables faster problem-solving, and reduces escalation to statutory services
- being co-located also supports better intelligence sharing, clearer pathways for residents, and more responsive, person-centred practice
- partnership working requires ongoing effort, supported by strong alignment, shared priorities and continuous collaboration
- programmes need to remain flexible and able to evolve, with delivery, learning and evaluation developing together over time
- digital access and capability are core enablers of inclusion, and should be embedded from the outset rather than added later
- effective delivery relies on sustainable workforce models, with stable roles and capacity planned early
- systems for capturing activity and impact must be designed to scale, as manual approaches quickly become unsustainable
- leadership is most effective when enabling rather than directing, creating space for local autonomy and innovation to emerge from practice
- delivering this kind of change often requires challenging traditional processes and ways of working
- the physical environment plays a significant role in engagement - welcoming, functional spaces and facilities can directly influence how people access and use services

Looking ahead

The next phase will focus on building on what works.

Priorities include:

- developing further shared tools (e.g. Living Well conversations) to support guided access, early help and self management
- expanding neighbourhood based hubs and community health worker models increasing community involvement and ownership
- continuing to evaluate and improve impact to evidence long term outcomes and system value
- securing long term funding and workforce stability

Living Well shows the difference it makes when services come together around people and communities. In doing so, it supports a wide range of local and national priorities, from prevention and neighbourhood health to reducing inequalities, improving digital inclusion, and building stronger, more resilient communities.

By bringing together a town centre hub, neighbourhood support and a single online front door, Living Well is making it easier for people to find and access the help they need, earlier and in the right place. It is also bringing services, skills and communities closer together, creating a more connected and responsive system across Warrington.

In its first two years, Living Well has shown that small changes in how we work together can make a big difference in people's lives. The next phase will build on this, helping more people live well for longer in their communities, while establishing Living Well as a national blueprint for excellence



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North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/055**			
Subject:	**Emergency Preparedness Annual Report (EPRR)**			
Date of meeting:	05 August 2026			
Action required:	**To note the EPRR annual report**			
Author(s):	Rachel Clint, Head of EPRR			
Executive director sponsor:	Daniel Moore, Chief Operating Officer and Deputy Chief Executive Officer			
Link to strategic aim:	3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 2: Urgent and Emergency Care Flow			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This report will:- •Provide an overview of the emergency preparedness arrangements that existed in Warrington and Halton teaching hospitals in 2025-2026 and within North Cheshire and Mersey NHS Foundation Trust from 1st April 2026. •Outline the work that has been undertaken in the area during the past 12 months. •Describe the trust response to incidents which have occurred during 2025-26. •Summarise the planned work streams and priorities for the year ahead. •Summarise the above based on experiences post integration.			
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
Recommendation:	The Board is asked to note the EPRR Annual Report			

Previously considered by:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSPC/26/XX/XXX
	Date of meeting	22/06/2026
	Summary of Outcome	Noted
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***	
Freedom of information status (foia):	Partial FOIA Exempt	
Freedom of information exemptions applied: ***(if relevant)***	Section 41 – confidentiality	

1. Background/context

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, the trust has a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans to maintain the continuity of our services in the event of a disruption.

The demands on the EPRR function in acute trusts have continued to experience both significant disruption and major change. The demands of Accountable Emergency Officers (AEOs), EPRR Professionals and Boards in ensuring robust, resilient systems for patients and communities continue to grow.

Like most NHS organisations, Warrington and Halton Teaching Hospitals (WHH) and North Cheshire and Mersey NHS Foundation Trust (NCM) has had our resilience tested on several occasions over the last year, most notably in the form of the operational pressures associated with winter, but also through the occurrences of business continuity incidents. The Trust continues to engage with the ICB and system partners to collaborate on the responses to significant events such as winter pressures and requests for mutual aid.

The trust plans and procedures, along with the commitment of staff, have enabled the Trust to manage incidents in a professional manner, helping to minimise disruption to patient care.

NHS England measure acute providers compliance with 62 core standards relating to emergency planning, response and resilience (EPRR). Community settings are measured against 58 core standards. In 2026 NCM will report as a single organisation against the compliance with 62 core standards. The ICB play a role in assessing the organisations self-assessments against the core standards.

2. Key elements

Purpose

The purpose of the annual report is to: -

- Provide an overview of the emergency preparedness arrangements that existed in WHH 2025/26 and within NCM from 1st April 2026
- Outline the work that has been undertaken in emergency planning during the past 12 months
- Describe the trust response to incidents which have occurred during 2025-26
- Summarise the planned work streams and priorities for the year ahead
- Outline the continuous improvement work streams to support NCM compliance with Core Standards for EPRR

3. Actions required/responsible officer

Emergency Preparedness Structure

The Trust has an Emergency Preparedness, Resilience and Response (EPRR) policy in place which outlines the approach to the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. In addition, key plans such as the Incident Response Plan, the overarching Trust Business Continuity Plan and Major Incident Plan underpin the plans outlining how critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Daniel Moore- Chief Operating Officer and Deputy Chief Executive is the designated Accountable Emergency Officer with responsibility for Emergency Planning within the Trust.
- Prior to integration, the lead director was supported by Rachel Clint, Head of Emergency Preparedness for EPRR at WHH.
- The lead director is currently supported by Rachel Clint, Head of Emergency Preparedness and John Morris, the Associate Director of Estates and EPRR.
- In the absence of the AEO, The Director of Operations and Performance, Zoe Harris, deputises and would fulfil the role of the Strategic Commander in their absence.
- John Somers is the Non-Executive Director with responsibility for Emergency Planning, all Non-Executive Directors have a responsibility for understanding and knowledge of the EPRR function.
- Trust Board are updated on significant matters associated with EPRR.

Committee Structure

To discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The EPRR Group, chaired by the Chief Operating Officer and Deputy Chief Executive, is charged with the responsibility of overseeing the development of emergency

preparedness arrangements within the Trust. The group meets bi-monthly and its membership includes senior managers from planned care, unplanned care and clinical support services, there is clinical attendance and appropriate representation from corporate services. The Community care group also attend the meeting as per the updated terms of reference following integration 1st April 2026.

In addition to emergency preparedness matters, the role of the EPRR Group is to anticipate and plan for forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans. Minutes of the Group's meetings are produced, and high-level briefing reports are provided to the Finance, Performance and Sustainability Committee and to the strategic executive group as and when it is appropriate. There are bi-annual updates shared with the Board.

EPRR External Structure:

The NHS England Area Team has lead responsibility for co-ordinating a local health response to an emergency. A Cheshire and Merseyside Local Health Resilience Partnership (LHRP) exist to deliver National EPRR strategy in the context of local risks, this partnership is coordinated by the Cheshire and Merseyside Integrated Care Board (ICB). The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The bi-annual Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Head of EPRR attends the Tactical LHRP meetings. There are also Local Resilience Forums in place for Cheshire, Merseyside and Greater Manchester. NCM obtain updates from these forums via the Cheshire and Merseyside ICB.

There is a memorandum of understanding in place that sets out the agreed contribution to Emergency Preparedness, Resilience and Response (EPRR) within Cheshire and Merseyside between NHS Cheshire and Merseyside who leads on EPRR, acting in its EPRR functions, on behalf of the NHS at Cheshire Resilience Forum (CRF); and NHS Cheshire and Merseyside who leads on EPRR, acting in its EPRR functions, on behalf of the NHS at Merseyside Resilience Forum (MRF); and commissioners and providers of NHS funded care within Cheshire and Merseyside Local Health Resilience Partnership area:

Integration

As part of the planning for integration, several core EPRR policies, plans and training were updated and provided prior to 1st April 2026. The Head of EPRR (previous lead for WHH) continues to collaborate with the Associate Director of Estates and EPRR (previous lead for BHCFT) continue to integrate all EPRR policies and workstreams through the transition period with the expectation that all are aligned by the end of Q2 2026/27.

4. Measurements/evaluations

Assurance Process

The Trust is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR.

In 2025, WHH self-assessment was finalised as 85% with a rating of partially compliant, compared to 68% in 2024 and a rating of non-compliant. This continued to demonstrate improvement on the assessment score of 5% in the 2023 cycle of assurance. Bridgewater self-assessment was finalised as 83% in 2025, showing an improvement from 81% in 2024 and 1% in 2023.

The Head of EPRR and Associate Director of Estates and EPRR have remained focused on addressing the standards that have been assessed as 'partial' and ensuring all trust plans are updated to reflect the requirements of the EPRR and Core Assurance Framework.

The main areas for priority focus identified from 2025 are within the domains of CBRN / Hazmat and Business Continuity. Several of the standards that were partial in the community setting have been addressed through integration including the availability of on-call structures. With targeted interventions and the establishment of sub-working groups, the gaps in the previous cycle should be addressed providing there is shared ownership beyond the EPRR function. There has been significant progress in CNRN/ Hazmat but buy in to business continuity review and updates has been slower. All compliant plans will also be refreshed as part of the work programme for EPRR.

The letter for the next cycle is expected to be received in early July 2026 and it is expected that there will be a submission of the self-assessment by the end of September 2026. FSPC and the Board will be appraised of any self-assessment and subsequently agreed scores.

Compared to other Trusts in Cheshire and Merseyside and beyond, NCM resource has been challenging and benchmarks less, however through integration this position has been improved. This will be reviewed as longer term integration and partnership plans continue to be established.

Incidents, Exercises & Learning

During 2025-26 the following significant incidents and exercises occurred, impacting WHH:

Creamfields (21st -25th August 2025)

The Creamfields Music Festival occurred in Daresbury in August 2025.

The August Bank Holiday weekend has historically been a busy period for the Trust. Fluctuations in demand associated with bank holiday periods exist, but the August Bank holiday weekend also coincides with the staging of the Creamfields Music Festival (CF) in Daresbury, of which Warrington Hospital is the primary receiving hospital for the event.

Creamfields 2025 was held between Thursday 21st August and Monday 25th August. A series of planning meetings with external organisations and partners took place, along with internal Bank Holiday weekend planning meetings.

Events Medical Service (EMS) was once again appointed as the main provider of healthcare on site and worked in partnership with NWAS. As far as possible, it was planned that patients would be treated on site or referred direct to admitting specialities.

Predictions for attendances, admissions, discharges and occupancy were shared based upon the past 6-week trends, alongside previous Bank Holiday and Creamfields Festival weekend activity. Historically most activity associated with the festival occurs on the Saturday and the Sunday when the festival reaches a peak of circa 70000 attendees.

As the local receiving Trust to the festival, it was imperative for robust plans to be in place in advance of the event to ensure the capacity for safe, patient-focused care across the Bank Holiday period and in the days that followed.

Representatives from clinical, nursing and operational teams met with the event organisers and medical team twice in advance of the festival weekend. There were monthly preparation updates through the EPRR Group and the Creamfields operational order and medical plans shared with senior operational and clinical colleagues. A bank holiday handover meeting took place on Friday 22nd August. The Creamfields Event Team invited the Trust to attend daily Silver Command meetings; the aim of these meeting was to coordinate any items to escalate or plans for mutual aid if required.

A full event debrief took place after the event. It was agreed that learning from previous years festivals had been embedded and there were minimal impacts on services at WHHFT during the festival weekend. There were in total 30 festival related hospital attends and 3 ITU admissions. There was slightly more pressure compared to the previous year, but the onsite medical offer continues to work well with fewer conveyances to the ED and UTC than historical trends have shown.

Communications Exercises

All NHS organisations are required to undertake a communication exercise every six months to test the ability to contact key staff 24 hours a day, seven days a week in the event of a Business Continuity, Critical, or Major Incident. This is applicable to NHS Cheshire and Merseyside and all Trusts within Cheshire and Merseyside.

There have been two tests of the Trust Major Incident communication cascade in the past 12 months. These occurred on Thursday 4th September 2025 and Wednesday 18th March 2026. The test on 18th March was an opportunity to ensure appropriate commanders at

the community setting were reached ahead of integration. NHS England planned to deliver communications Exercise Toucan during May 2026. These communications exercises have demonstrated improved efficiency and ensured the appropriate colleagues have been reached in preparation for any potential incident declaration. There will be another opportunity to test the communications system in the summer 2026.

Major Incident Exercise

The Trust has a plan that provides a framework to respond to a major incident declaration. There is a planned exercise scheduled for Tuesday 29th September (Exercise Capri). This will test the Trusts ability to receive multiple casualties using the live bed board and ED status. Participants will include Strategic Commanders, Tactical Commanders (acute and community), ED operational, clinical and nursing teams, Critical Care representatives, Theatre operational and clinical leads, communications and wider functions. Stakeholders from the ICB, NWAS and local acute providers have been invited to attend. Lessons identified from the exercise will be incorporated into the review of the trusts incident response plans.

ED Major Incident Live Exercise

On 17th September 2026, it is planned that there will be a live test of the trusts CBRN/ Hazmat plan. Senior clinical, operational and nursing colleagues in UEC will attended an exercise to test the CBRN / Hazmat Plan and the management of casualties in the event of an incident.

New and Emerging Pandemics Live Exercise

On 8th June 2026, there was a test of the New and Emerging Pandemics response plan, with consideration of a patient self-attending with Ebola. This exercise was used to revisit the plan and consider patient pathways through the ED and wider isolation and reporting requirements.

Mass Casualty Exercise

On 17th April 2026 the Head of EPRR attended a mass casualty exercise at Mersey and West Lancs NHS Foundation Trust. The Emergo system was used to facilitate this exercise. The Head of EPRR was able to learn from the format of the exercise and consider some of the interdependencies that coexist during mass casualty events.

A workshop based on a review of major incident and mass casualty plans was delivered by NHS England on 23rd April 2026. The Head of EPRR and clinical lead for mass casualties remain focused on keeping on top of any proposed changes to ensure these are included in trust plans and exercises.

National Power Outage Exercise

Exercise Kaus Australis was an NHS England led exercise based on a national power outage. This took place on 8th July 2025 and involved a tabletop exercise testing the Trusts fuel plans, business continuity plans and incident response plan. Both WHH and

BCHFT participated in this exercise and learning was identified and applied to the joint Trust fuel plan.

Cybersecurity Exercise
In July 2026, there will be a 3-day exercise conducted by NHS England based on a cyber security incident impacting upon a critical function across all providers. This is the theme for the north west of England, but also the national theme for 2026. Stakeholders have been engaged to ensure the Trust has appropriate representation at this exercise.

Winter Planning Exercise
A Winter Planning Exercise was conducted by the ICB on 2nd September 2025. The Chief Operating Officer and Deputy Chief Executive attended this, along with the Director of Operations and Performance. This was an opportunity to test local plans and consider the role of the wider system in the delivery of services and management of pressures over winter. Winter planning for 2026/27 will commence in August 2026.

Business Continuity
As part of the development of the trusts business continuity capabilities, all services have been asked to review their business continuity plans annually and test the plans in accordance with national guidelines. The Head of EPRR has created resources to support this process.

The Trust Business Continuity Plan is attached as Appendix 1.

Decontamination, CBRNe and HazMat
The Trust agreed to host NWAS training courses in June, August and September 2026, assisting the resilience of our responses to CBRNe incidents and supporting the development of the Trust's CBRNE and HAZMAT Plans.

On 16th December 2025, NWAS conducted an audit of the Trusts CBRN capabilities. The trust was able to provide some evidence to support the decontamination capabilities, meeting 23 of 28 standards. The action plan for addressing the gaps has been shared with UEC, with training and exercising identified as a priority along with the replenishment of suits to take the trust up to the expected compliance rating. The Head of EPRR has provided a risk assessment based on the outcomes and the Head of EPRR has requested increased ownership from the UEC CBU.

A CBRN Exercise has been planned and will take place as a live exercise in September 2026.

Industrial Action
There have been four instances of Resident Doctors industrial action over the past 12 months taking place July 2025, November 2025, December 2025, March 2026, April 2026 and June 2026. Resident Doctors have the mandate to continue to strike until July 2026

when there would be a re-ballot. The trust has a robust plan in place that supports the safe and sustainable delivery of patient care and activity during these periods of action.

Ballots are open for Consultants and SAS doctors and this closes on 6th July.

Other union groups have expressed disappointment with the pay announcements and have opened consultation with members of respective union groups. The situation is being monitored and the Trust Industrial Action Response Plan will be refreshed in preparation for any further action.

Adverse Weather business continuity incident

The Adverse Weather Plan is updated annually. Nationally, the heat health alert system is in place between 1st June and 30th September every year. This May, there was an extra-ordinary yellow heat health alert declared for the Northwest of England. As a result of limited notice using the traditional notifications, and the timing of the start of the event over a bank holiday weekend, the acute sites were less prepared for the weather between 22nd and 28th May. The Trust declared a business continuity incident and a response group was initiated, but not until 25th May. A full debrief has been conducted and the Trust plan was immediately reviewed incorporating the lessons identified ahead of any further periods of adverse weather.

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. In 2025-26 there have been more opportunities to engage teams in training exercises and this programme will continue. There have been several training sessions in place to support integrations with both Strategic and Tactical Commanders attending bespoke integration training. Routine bi-annual commander training has been along with standalone tabletop exercises.

Tactical Manager on-call training has been enhanced through the delivery of bi-annual events to on-call managers, with thematic focus areas based on the needs of trainees. Training this year has occurred on 19th September 2025 and 24th April 2026. The next session is scheduled to take place on 7th October 2026 (training has been scheduled 6 months in advance to ensure full attendance). This training also supports the portfolio and CPD of Tactical Commanders.

National Occupational Standards were introduced by NHSE in 2022 for Strategic and Tactical Managers. All Executive's and Tactical Managers have been invited to attend the rolling training programme and are required to maintain evidence of their training standards.

As part of the revised EPRR Framework in June 2022, the minimal occupational standards were introduced and all Strategic and Tactical managers are expected to attend Principles of Health Command every three years. Participation from NCM Strategic and Tactical managers has been very encouraging to date, with further

opportunities identified for 2026, ensuring new personnel have access to the training too. 100% of Tactical Commanders have attended the POHC course and refreshers, and all Strategic Commanders have attended or are booked on to refresher training within the coming months.

The Head of EPRR has also attended a range of training events and this year completed the Diploma in Health Emergency Planning (DipHEPRR) ensuring NCM has adequately trained and qualified EPRR Resource. In June 2026, the Head of EPRR will attend the Senior Emergo Instructor course and this will enhance the trust exercising capabilities.

A Training Needs Analysis and Exercise Schedule is in place to ensure appropriate training is available for all Tactical and Strategic Commanders. More consideration has been placed on wider training opportunities for operational commanders and for colleagues working in support services.

Wider Training Opportunities

Utilising contributions from acute and community providers, Cheshire and Merseyside ICB shared opportunities for, Legal awareness training and Media training 2025/26. These opportunities assist the Trust's Strategic Commanders in their compliance with the National and Minimal Occupational Standards for EPRR, and their skills as strategic commanders. Records of those who have attended the training are held by the Head of EPRR. Further opportunities for this training are likely to be extended to Tactical Commanders in 2026-27.

Wider events / disruptions

Several events with potential implications on the Trust have been monitored following guidelines in the Trust Business Continuity Plan or Incident Response Plan.
These have included:

- IPC outbreaks
- National cybersecurity issues
- Sterile services incident at WUFTH September – October 2025 – mutual aid provided
- BigHand Digital business continuity incident October – November 2025
- Telemetry business continuity incident February – March 2026
- Stryker cybersecurity incident January – February 2026
- May yellow/amber heatwave

Work undertaken in 2025/26

The following policies were refreshed for 1st April 2026 and updated to reflect local and national developments during 2025-26

- Major Incident Plan
- Incident Response Plan
- Incident Coordination Centre SOP
- Business Continuity Plan
- EPRR Policy

- Fuel Plan
- Adverse Weather Plan

The following policies and procedures are currently under review / awaiting approval

- Trust Escalation Plan
- Full Capacity Plan
- Tactical Commander Handbook
- Winter Plan
- Bank Holiday Plans
- CBRN/HazMat Plan
- Mass Casualty Plan
- Countermeasures Plan
- Lockdown Plan
- New and Emerging Pandemic Plan
- Trust Debrief Guidelines

Engagement has continued with the following external groups:

- Cheshire Health Resilience Partnership
- EPRR network
- System Partners (Cheshire and Merseyside ICB, Warrington Borough Council, Halton Borough Council)
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e., Creamfields festival. Member of Creamfields Safety Advisory Group and liaison with NWAS
- Merseyside LRF
- Greater Manchester LRF

Single Point of Contact

The Head of EPRR has continued to act as the trusts Single Point of Contact (SPOC) when required. This includes the monitoring, storing and cascading of national and local guidelines or incident related information. Since integration, the Associate Director of Estates and EPRR now acts as a second point of contact.

Learning and Lessons Identified

Learning from incidents and events is tracked through EPRR Group on a lessons identified tracker. Following on from an incident or exercise a debrief or exercise report details the learning, with an action plan to embed learning into policy reviews or to practice. Further information of this process is defined in the NCM Debrief Guidelines.

5. Trajectories/objectives agreed

NHS Core Assurance for EPRR

The Head of EPRR and Associate Director of Estates and EPRR continue to work towards achieving at least substantial compliance (89-99%) with the submission of the core standards self-assessment this year. There are some inter-dependencies with the requirement for additional input from departments to ensure this can be achieved. There are also some national guidelines requiring updates in areas such as Evacuation and

Shelter, Mass Casualties and Mass Countermeasures, the Head of EPRR will continue to refresh trust plans based on any updated guidance received.

Work programme for 2026/27

In 2025-26 the core focus has been to align policies appropriately as part of integration and to continue to refresh the emergency planning portfolio and embed lessons identified from the 2023/24 cycle of core assurance. Positive outcomes through the Core Assurance process and MIAA audit have been welcomed in recent years, however in EPRR the cycle of improvement is continuous.

For 2026-2027, the focus will include reviewing outcomes in line with the Core Assurance Framework and testing a number of NCM emergency plans. EPRR involves an ongoing cycle of planning, training, testing and improving.

With the changing requirements in EPRR it will be prudent to review the EPRR structure in the year ahead, especially through the integration process. The integration will require significant input with the need to complete another complete refresh of all EPRR documents and the requirement to increase the training programme to meet the requirements of the EPRR Framework 2022. Several priorities have been identified to address integration in the short, medium and long term, some of these are listed below:

- Develop a structure for the single delivery of EPRR and AEO functionality
- Refresh all policies and plans with consideration of different ways of working across acute and community settings
- Develop training and plans to amalgamate the on-call systems and processes
- Work in collaboration with Estates, Digital Services and Operational Managers to ensure resilience across acute and community functions
- Establish integrated on-call, business continuity and incident response arrangements.
- Planning for the Protection of Premises Act and the statutory components that will be assessed through the Security Industry Authority.

In addition to resource, EPRR has historically not had a non pay budget allocated. Despite this, annual servicing of PRPS Suits and the decontamination shelter takes place, utilising the UEC budget to cover costs incurred. There is the need to invest in additional training for instance for loggists and debrief trained personnel, as well as the requirement to offer training so commanders are up to date with the skills and education required as part of the minimal occupational standards. Furthermore, it is imperative that all incident control rooms are appropriately equipped with logbooks, tabards and such, this will require some funding to maintain the Trusts compliance with the EPRR Framework (2022).

In support of and in addition to the above, the following work plans will be undertaken:

- Continue to deliver training to key staff in Emergency Preparedness and Incident Management through Tactical Commander training, Strategic Commander training, Operational (Site) Manager training and ad-hoc events

- Continue to encourage and support opportunities for Strategic and Tactical on-call managers to attend the Public Health Commander training to ensure minimal occupational standards are met
- Test the Trust plans ensuring wider stakeholder input
- Embed learning from 2025-2026 to support planning for winter pressures
- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new national guidance
- EPRR education within care groups and the workforce to enhance resilience
- Review the Corporate Business Continuity Plan, embed the audit process and request all areas refresh and exercise their plans
- Monitor the lessons identified from other local, regional and national incidents.

6. Monitoring/reporting routes

The ICB led LHRP meets quarterly and is attended by the Trust Head of EPRR; the outcomes are fed into the Trusts EPRR Group meeting.

The Strategic LHRP meets bi-annually and is attended by the AEO.

Wider participation occurs with ICB exercise or task and finish groups, of which the Head of EPRR attends.

The EPRR Group meets bi-monthly and reports updates through the Finance, Performance and Sustainability Committee and Executive Management Group meetings as appropriate.

For any incidents or wide-scale events, Tactical Response meetings are established on an ad-hoc basis and follow the above reporting routes.

7. Timelines

This report is presented annually to the Finance, Performance and Sustainability Committee and subsequently to the to the Board. The Core Assurance submission will take place in September 2026. The Finance, Performance and Sustainability Committee and the Board will be appraised of the assessment and the outcomes of the core assurance self-assessment. EPRR updates occur bi-annual (and additionally following any significant incidents) as per the expectation from the EPRR Core Assurance Framework.

8. Assurance committee (if relevant)

The Head of EPRR regularly updates and escalates any prominent issues to the EPRR Group. This subgroup continues to report to the Finance, Performance and Sustainability Committee, and to the weekly Executive Management Group meetings when notable events are in place or incidents occur.

9. Recommendations

The FSPC is asked to note the significant work and achievements undertaken during 2025-26 and the planned work programme for 2026-27 in support of improvements in EPRR and the Trust's objectives.

Appendix 1 – Training records

Appendix 2 – Trust Business Continuity Plan

Business Continuity Plan NHS NCM.docx

Tactical Commander Training Register

Name	Initials	Tactical Commander Training 23/04/2024	Tactical Commander Training 15/11/2024	Tactical Commander Training 19/09/2025	Tactical Integration Training March 2026	Tactical Commander Training 24/04/2026	Portfolio	Principles of Health Command course	Legal Training
Carol McEvoy	CMc				11/03/2026			15/11/2023	
Ceri Rogers	CRo		Annual Leave		Strategic Rota	(Currently Strategic)		15/11/2023	
Chris Barlow	CB		Annual Leave					22/04/2024	
Claudine Reynolds	CRe	*1:1 session			11/03/2026			25/11/2022 Refresher 08/10/2025	
Daniel Coughlin	DC							14/06/2024	
Emma Blackwell	EB							15/03/2023	
Emma Hackett	EH		Maternity Leave		18/03/2026			15/05/2024	
Janet Pye	JP				18/03/2026			22/04/2024	
Kevin Sargeant	KS	New to rota			11/03/2026				
Laura James	LJ	*1:1 session 20/05/2024			11/03/2026			28/04/2023 Refresher 10/03/2026	
Lucy Parry	LP							18/10/2022 Refresher 08/10/2025	
Mark Rigby	MR							Attended a/w certificate	
Mel Alsop	MA							28/04/2023	
Neil Gregory	NG			Strategic Rota	11/03/2026				
Nic Milkins	NM	New to rota	New to rota		11/03/2026				
Rachel Clint	RC				Delivered training			20/02/2024	03/09/2024
Sharon Martlow	SM							29/07/2022 Refresher 08/10/2025	
Sheila Fields-Delaney	SFD							15/05/2024	
Katherine Watkins	KW	New to rota	New to rota	uction session Augus	18/03/2026			09/10/2025	

	Attended
	In progress
	Action required
	n/a

Name	Initials	Porftfolio	Principles of Health Command course	Media Training	MACA Training 10/07/2024	Legal Training	Strategic Integration Training March 2026		
Ali Kennah	AK		Attended 23/10/2024	2022		12/09/2024			Attended
Dan Moore	DM		Attended 23/01/2025	2022		02/10/2025	04/03/2026		In progress
Eshita Hasan	AH		Attended 16/07/2024			20/08/2024			Action required
Hilary Stennings	HS		Attended Tactical - Dates shared for 2025						n/a at time
Jane Hurst	JH		Attended 21/11/2023				04/03/2026		Limited numbers allocated for training
Kate Henry	KH		01/12/2022	2022		12/08/2024	04/03/2026		
Lucy Gardner	LG		Attended - awaiting certificate	2022			04/03/2026		
Ceri Rogers	NG		Attended Tactical - Dates shared for 2026						
Nikhil Khashu	SC		Dates shared for 2025						
Paul Fitzsimmons	PF		Attended 19/11/2024			19/08/2024	04/03/2026		
Sarah Haworth	SH		Attended Tactical - Dates shared for 2025						
Sharon Kilkenny	SK		Attended Tactical - Dates shared for 2025			02/09/2025			
Tracy Fennell	TF		Attended 13/06/2024						
Zoe Harris	ZH		Attended 16/08/2022 Refresher 04/08/2025	2025		20/08/2024			

Rachel Clint	Decision Loggist	Legal	Dip Health - award only	Debrief training	Introduction to Business Continuity	Dip HEPRR full	MACA
NHS /LHRP / ICB Training	04/09/2024	03/09/2024	2022	11/02/2025	20/03/2025	Jul-25	Jul-24

NHS /LHRP / ICB Training	EDI Considerations	JESIP awareness	JDM Awareness	LRF Awareness	JESIP for healthcare	Communications awareness	Specialist asset awareness
	26/02/2025	25/04/2025	25/04/2025	25/04/2025	23/07/2025	08/10/2025	08/10/2025

Media Training
22/09/2025

	Attended
	In progress
	Action required
	n/a

Loggists		04/09/2024	15/05/2019	06/12/2018	Contact number
Jennifer Caldwell	Administrator for Unplanned Care	Y			07772544903
Chloe McKeown	Executive Assistant	Y			07891181041
Emma Bentham	PA for W&C CBU	Y			07703738441
Kayleigh Barton	CBU administrator for Anaesthetics & Chronic Pain	Y			7380351281
Casey Bell	Project Support Officer - Digital Services	Y			7572759988
Charlotte Murphy	Project Support Officer - Digital Services	Y			
Kiera Hatton	IPC Secretary	Y			
Rachel Clint	Head of EPRR	Y			07809226601
Gill Kerr	ED Secretary				
Donna Hargreaves	Executive Assistant				
Jade Robinson	Assistant CBU Manager				7732348126
Jo Ditchfield	CBU admininstrator for Gastro & Endoscopy	Y			7990022779
Jackie Gifford	Senior Administrator				
Diane Taylor	A&E Supervisor				

	Attended
	In progress
	Action required
	n/a

		12th - 13th August 2024		
		1-day course in hospital decontamination procedures	PRPS Certification	12/08/2024
Debbie Cahill				12/08/2024
Jemma Colledge				12/08/2024
Jennifer Backmayor				12/08/2024
Chris Pak Him Khan				12/08/2024

Alistair Greenough		Train the trainer		
Melcolm Bell		Train the trainer		
Michael Sheffield		Train the trainer		

Rachel	Howard	370 ED - Use of the PRPS Decontamination Suit	Nurse Manager	23/11/2023
Mariya	Krasteva	370 ED - Use of the PRPS Decontamination Suit	Staff Nurse	23/11/2023
Niamh	McCullough	370 ED - Use of the PRPS Decontamination Suit	Sister or Charge Nurse	23/11/2023
Natalie	O'Connor	370 ED - Use of the PRPS Decontamination Suit	Sister or Charge Nurse	23/11/2023
Malcolm	Bell	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	01/06/2023
John	Connop	370 ED Deployment of the Chemical Decontamination Unit	Porter	01/06/2023
Jenny	Connor	370 ED Deployment of the Chemical Decontamination Unit	Healthcare Assistant	01/06/2023
Natalie	Gordon	370 ED Deployment of the Chemical Decontamination Unit	Healthcare Assistant	01/06/2023
Alistair	Greenough	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	01/06/2023
Daniel	Meredith	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	01/06/2023
Natalie	O'Connor	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	01/06/2023
Steven	Rose	370 ED Deployment of the Chemical Decontamination Unit	Porter	01/06/2023
Natalie	Whitehead	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	01/06/2023
Muhammad	Arif	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	05/05/2022
Rachel	Clint	370 ED Deployment of the Chemical Decontamination Unit	Senior Manager	05/05/2022
Iain	Mackenzie	370 ED Deployment of the Chemical Decontamination Unit		05/05/2022
Sharron	Owen	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	05/05/2022
Colin	Wong	370 ED Deployment of the Chemical Decontamination Unit	Consultant	05/05/2022
Beth	Youlton	370 ED Deployment of the Chemical Decontamination Unit	Specialist Nurse Practitioner	05/05/2022
Claire	Ashbrook	370 ED Deployment of the Chemical Decontamination Unit	Healthcare Assistant	08/06/2023
Jennifer	Bachmayer	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	08/06/2023
Aimee	Jamieson	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	08/06/2023
Paramjit	Saraon	370 ED Deployment of the Chemical Decontamination Unit	Assistant Practitioner Nursing	08/06/2023
Stephanie	Stocksborough	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	08/06/2023
Katherine	Zygadllo	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	08/06/2023

Katie	Dourley	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	19/05/2022
Leanne	Haigh	370 ED Deployment of the Chemical Decontamination Unit		19/05/2022
Alexander	McEaney	370 ED Deployment of the Chemical Decontamination Unit	Trust Grade Doctor or Dentist - Specialty Registrar	19/05/2022
Daniel	Meredith	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	19/05/2022
Caroline	Sheehan	370 ED Deployment of the Chemical Decontamination Unit	Assistant Practitioner Nursing	19/05/2022
Michael	Sheffield	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	19/05/2022
Rachel	Howard	370 ED Deployment of the Chemical Decontamination Unit	Nurse Manager	23/11/2023
Mariya	Krasteva	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	23/11/2023
Niamh	McCullough	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	23/11/2023
Natalie	O'Connor	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	23/11/2023
Anjella	Anthony	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	25/05/2023
Muhammad	Arif	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	25/05/2023
Katie	Daly	370 ED Deployment of the Chemical Decontamination Unit	Porter	25/05/2023
Claire	Jenkins	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	25/05/2023
Lynn	Yates	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	25/05/2023
Rakeha	Allan	370 ED Deployment of the Chemical Decontamination Unit		27/04/2023
Stacey	Appleby	370 ED Deployment of the Chemical Decontamination Unit	Assistant Practitioner Nursing	27/04/2023
Jasmine	Clay	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	27/04/2023
Lekshmi	Jayasankar	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	27/04/2023
Claire	Jenkins	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	27/04/2023
Nicola	McDonnell	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	27/04/2023
Clare	McHugh	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	27/04/2023
Lucy	Skidmore	370 ED Deployment of the Chemical Decontamination Unit	Staff Nurse	27/04/2023
Lynn	Yates	370 ED Deployment of the Chemical Decontamination Unit	Sister or Charge Nurse	27/04/2023

Wednesday 14th August 2024

BOWMAN, Karen	CBU Manager - UEC	
PATEL, Saagar	Lead Consultant - Acute Medicine	
HABIB, Yasmin	Lead Nurse - UEC	
ADEBOWALE, Adebola	Clinical Director - UEC	
ROBINSON, Jade	Assistant CBU Manager - UEC	
SHEFFIELD, Michael	Trauma Coordinator	
MEREDITH, Daniel	ED Manager (Nursing)	
MERRIMAN, David	Matron - UEC	
WONG, Colin	Consultant	
GREENOUGH, Alistair	Practice Educator	
FORREST, Mark	Associated Medical Director - Unplanned Care	
CLINT, Rachel	Head of EPRR	

Major Incident Tabletop
27th November 2024

BOWMAN, Karen	CBU Manager - UEC	
CLINT, Rachel	Head of EPRR	
FITZSIMMONS, Paul	Executive Medical Director	
FORREST, Mark	Associated Medical Director - Unplanned Care	
PATEL, Saagar	Lead Consultant - Acute Medicine	
ASPINALL, Alison	Head of Communications and Engagement	
BEECH, Kieran	Estates Manager	
BENTHAM, Emma	Administrator - W&C (Loggist)	
BUTLER, Jo	NHS Head of EPRR NW	
FIELDS-DELANEY, Sheila	CBU Manager - T&O	
HABIB, Yasmin	Lead Nurse - UEC	
HARRIS, Zoe	Director of Operations and Performance	
HERALD, Stephen	EPRR Lead - Cheshire	
JONES, Beth	EPRR Officer - Clatterbridge	
KENNAH, Alison	Chief Nurse	
McKay, Lesley	Deputy Director of IPC	
MEREDITH, Daniel	ED Manager (Nursing)	
MOORE, Daniel	Chief Operating Officer (AEO)	
ROBINSON, Jade	Assistant CBU Manager - UEC	
SARGEANT, Kevin	Service Manager - Respiratory and ITU	
WONG, Colin	Consultant	

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/056**
Subject:	**Committee Chairs Annual Reports** i. Quality and Safety Assurance Committee ii. Strategic People Committee iii. Finance, Sustainability and Productivity Committee
Date of meeting:	5th August 2026
Action required:	**For approval**
Author(s):	Cliff Richards, Non-Executive Director & Chair of QSAC Julie Jarman Non-Executive Director & Chair of SPC John Somers, Non-Executive Director & Chair of FSPC
Executive director sponsors:	Ali Kennah, Chief Nurse Paula Woods, Chief People Officer Jane Hurst, Chief Finance Officer
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience. 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 2: Urgent and Emergency Care Flow BAF 3: Planned Care Access & Elective Recovery BAF 4: Embedded Health Equity BAF 5: Workforce Capacity, Capability & Wellbeing BAF 6: Financial Sustainability BAF 7: Digital Resilience, Cyber Security & EPR BAF 8: Estates, Infrastructure & Capital Planning

<table>
<tr><td rowspan="3">Equality considerations:
(please select as appropriate)</td><td>Please indicate who is impacted by the equality considerations:</td><td>Patients</td><td>Workforce</td><td>Public</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information / Comments:</td></tr>
<tr><td>Executive summary:</td><td colspan="4">This report seeks to deliver assurance to the Trust Board that the:
• Quality and Safety Assurance Committee
• Strategic People Committee
• Finance, Sustainability and Productivity Committee
have met their Terms of Reference and have gained assurance throughout the reporting period of the Trust’s performance.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td colspan="2">Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="4">The Board is asked to review and note the reports which provide assurance that each of the Committees are meeting their purpose.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committees</td><td colspan="3">Quality and Safety Assurance Committee
Strategic People Committee
Finance, Sustainability and Productivity Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">QSAC26/07/100
SPC26/07/075
FSPC26/07/072</td></tr>
<tr><td>Date of meeting</td><td colspan="3">14 July 2026
15 July 2026
29 July 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Approved for reporting to Trust Board</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="4">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="4">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

Quality and Safety Assurance Committee

Agenda reference:	**QSAC/26/07/100**			
Subject:	**Committee Chair's Annual Report to the Trust Board**			
Date of meeting:	14 July 2026			
Action required:	**To note**			
Author(s):	Samantha Scholes, Head of Corporate Governance			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Executive director sponsor:	Ali Kennah, Chief Nurse			
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 Annual Chair's Report covers the period from 1 April 2025 to 31 March 2026 for: • Quality Assurance Committee (WHH) • Quality and Safety Committee (BCH) • Quality Assurance Committee in Common (WHH and BCH) and provides assurance to the Trust Board that the Committees have fulfilled their Terms of Reference and overseen the Trust's performance in alignment with Strategic Objective 1: QUALITY: *"We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience."* The report highlights the Committees activities and strategic oversight.			

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

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Committee is asked to note the report prior to submission for approval by the Trust Board.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***Submit to Trust Board***		
Freedom of information status (foia):	Partial FOIA exempt		
Freedom of information exemptions applied: ***(if relevant)***	Section 22 – information intended for future publication		

1. Background/context

Committees are required to report annually to the Board, outlining the work they have undertaken during the year, and where necessary, highlighting any areas of concern.

This report presents the activity of the following Committees, covering the reporting period 1 April 2025 to 31 March 2026:

- Quality Assurance Committee (QAC) (WHH) to January 2026
- Quality and Safety Committee (QSC) (BCH) to January 2026
- Quality, Safety and Assurance Committee in Common (QSACiC) from February 2026

The Committees were accountable to the Board of Directors for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety. This includes assurance around relevant Health and Safety matters.

The Committees of both WHH and BCH were also accountable to the Board for ensuring that the strategic objectives of both Trusts were delivered:

- WHH. Strategic Objective 1***: "*We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience"**
- BCH. Strategic Objective BAF 2: **Quality. Failure to deliver quality services and continually improve."** and BAF 3: **Health Equity. Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients."**

This report details the role of the Committees and the work that was undertaken during the 2025-26 financial year.

2. Key elements

2.1 Terms of Reference and Cycle of Business

The Committees' Terms of Reference were reviewed on the following dates, along with the cycle of business. This included a review of the membership, quoracy, duties and responsibilities of the Committees:

- Quality Assurance Committee: March 2025
- Quality and Safety Committee: June 2025
- Quality, Safety and Assurance Committee in Common: Board February 2026
- Quality Safety and Assurance Committee: March 2026

2.2 Frequency of Meetings

Meetings took place monthly throughout 2025-26 for QAC up to February 2026; bi-monthly for QSC up to February 2026 and monthly for QSACiC from February 2026 to March 2026. In addition there was an extraordinary meeting during July 2025 for QAC to help ensure all reports were appropriately scrutinised.

The Committees met 17 times in total during the year. Each of the meetings held during 2025-26 were quorate.

2.3 Summary of Committee Activities throughout 2025-26

2.3.1 Engagement Stories

Examples from 2025-26 were:

- Early Pregnancy Experience
- My Experience as a Surgical Inpatient on A4
- Pulmonary Rehabilitation Experience
- The Final Hours: Compassionate Communication

The 2026-27 Cycle of Business has engagement stories scheduled on a bi-monthly basis.

2.3.2 Deep Dives & Hot Topics

At each QAC and QSACiC meeting, the Committee received both a 'Hot Topic' and a 'Deep Dive' presentation to support focused scrutiny and assurance. Hot Topics provided high-level updates, often sharing a story, service development or improvement journey linked to national, local, partner or internal areas of focus. They also included new services, service accreditations, and matters escalated from sub-committees or other governance meetings. Deep Dives provided more detailed review and analysis of specific areas requiring closer oversight, including matters escalated from sub-committees, themes identified through wider reporting and triangulation, issues highlighted by the CQC, and items requested by the Trust Board.

Deep Dives received during the year included:

- Cancer Services
- Maternity CTG
- GIRFT Operational Gap Analysis
- Typing Backlog
- Theatre Safety – MIAA Update & Forward Plan
- Theatres specific update around prosthesis-related incidents – and update MIAA Theatre Safety Audi
- Antimicrobial Resistance
- Never Events

Hot Topics received during the year included:

- Chronic Pain Service External Review
- National Hip Fracture Mortality
- Patients with MH requirements in ED Section 136
- Cancer Escalation Dip Audit & Surveillance Pathway Survey
- Fragile Services Rheumatology; Big Hand EPRR Incident
- Sharps Incidents Q2
- Radiology Reporting

2.4 Risk Management (Quality)

In common with all other Committees of the Board, all new BAF risks for QSAC oversight in 2026-27 were supported by QSACiC in March 2026 and presented to Trust Board in April 2026 for approval.

2.5 Strategy Development

The committees received regular updates in relation to the Strategic Quality Priorities for both Trusts. In addition, updates of enabling quality strategies were provided, e.g. Mortality, Engagement, Dental, Violence Reduction, Risk Management, Quality, Dementia and Delirium, Nursing and Midwifery, Controlled Drugs Accountable Officer Framework and Patient Safety.

2.6 Quality Integrated Performance Report / Dashboard

The Committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored through the Integrated Quality and Performance Report (IQPR) for BCH and Integrated Performance Dashboard (IPR) for WHH. Reports were received bi-monthly to review performance and to determine assurance of mitigating actions as appropriate, in advance of presentation at Trust Board meetings.

The IQPR and IPR were reviewed at least annually to ensure all indicators remained relevant and up to date.

In February and March 2026, QSACiC received updates on the process to ensure consistent reporting, remove duplication and standardisation of the presentation of key metrics in preparation for the new Trust's IPR which included a new medication-incident metric.

2.7 Investigations and Learning from Experience

The Committee received a regular update to assure itself that investigations from patient safety incidents were being undertaken as per statutory and regulatory requirements. This also included monitoring Duty of Candour.

The Committees received a quarterly Learning from Experience Report containing both quantitative and qualitative data analysis using information obtained from the Datix and Ulysses risk management systems and other governance functions to triangulate the

data and learning from deaths, pressure ulcers, incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development. The reports provided a summary of themes, trends and key findings which have influenced learning and actions to support and sustain improvement.

2.8 Reports following Incidents/Concerns

The schedule of hot topics and deep dives described in section 2.3.1 highlights some specific incidents and concerns that have resulted in the committee taking a focussed view during the year. An update to the audit conducted by the WHH internal auditor, Mersey Internal Audit Agency (MIAA) in 2024-25 in relation to theatre safety was reviewed, including prioritisation and ongoing work.

2.9 Scheduled Quality Assurance Agenda Items

The Committees received several regular reports to provide assurance on quality and safety matters which were presented by members of both Trusts' Executive Teams, supported by subject matter experts, including:

- Quality Priorities – quarterly, providing progress against each of the annual priorities selected as part of the Quality Accounts.
- Infection prevention and control – quarterly
- Quality Improvement – biannual progress
- Learning from Deaths – quarterly
- Safe Staffing – quarterly

QAC and QSACiC also received an exception report at each meeting from the Patient Safety & Clinical Effectiveness Sub-Committee. The report included updates on the services classed as 'fragile' to demonstrate clarity and focus. For the purposes of the Fragile Services Oversight program, WHH defined 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'.

QSC also received reports on the quality and safety of patient care via the bi-monthly Quality Council Chair's report which included Dental, Dermatology, Padgate House, Neurodevelopment and Palliative Care.

2.10 Regulatory and Statutory monitoring

The Committees continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the Care Quality Commission Inspection Action plan via the Compliance Update agenda item) national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement.

All Committees supported and approved a number of annual reports including, Patient Experience, Health & Safety, Safeguarding, Mental Health, Risk Management, Violence

Prevention and Reduction Standards Palliative Care End of Life Care, Complaints, Infection Prevention & Control, Clinical Audit, Quality and Dementia and Delirium.

2.11 Maternity Oversight

Following increased scrutiny and the requirement for oversight at Board level on key national maternity safety and quality issues and in line with the requirements of the Maternity Incentive Scheme - Safety Action 9*, the Director of Midwifery presented a number of reports concerning quality & safety within the Maternity and Neonatal services as scheduled in the Cycle of Business, which have included:

- Maternity Incentive Scheme Year 7 update/sign off
- Cheshire & Merseyside Perinatal Mortality Report (PMRT)
- Avoiding Term Admission into Neonatal Unit (ATAIN)
- Perinatal Mortality Report
- Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
- Maternity Self-Assessment Tool
- Maternity & Neonatal Quality Review Report
- Review of Harm Events
- Transitional Care Audit (limited time)
- Post Partum Haemorrhage (Audit), now included in Maternity and Neonatal Quality Review
- CQC Maternity Survey
- Maternity and Neonatal Voices Partnerships (MNVP) biannual report
- Birth Trauma position (limited time)

Where required these reports were also presented at Trust Board meetings.

*****Maternity Incentive Scheme (MIS) - Safety action 9:*** *Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.*

2.12 Issues Carried Forward

There are a number of issues which the Committee will carry forward into 2026-27.

- Neurodevelopmental Pathways and Community Paediatrics
- Pressure Ulcer Prevention and Reduction
- Patient Safety Incident Management and PSIRF Maturity
- Paediatric Audiology
- Dental Services
- Dermatology Capacity and Cancer Pathway Management
- Emergency Department performance, flow and corridor care.
- Fractured Neck of Femur improvement programme.

- Theatre safety, never events and surgical culture.
- Cancer pathway governance and surveillance tracking.
- Fragile services (Rheumatology, Chronic Pain, Urology.
- Radiology reporting capacity and diagnostic resilience.
- Clinical typing backlog and AVT implementation.
- Pressure ulcer reduction and fundamental care reliability.
- Sepsis improvement programme.
- Mental health, ligature reduction and Section 136 arrangements.
- Safe staffing and workforce sustainability.
- Maternity safety priorities (PPH, ATAIN, IOL and Transitional Care).
- Infection prevention and antimicrobial resistance.
- Integration and due diligence quality risks.
- Ongoing monitoring of high-scoring risks through the Board Assurance Framework and Risk Review Group.

2.13 Summary

As Chair of QAC and QSAC and joint Chair of QSACiC, alongside Elaine Inglesby, BCH Non-Executive Director in February and March 2026 throughout 2025-26, I have sought to promote open and honest discussion, enabling areas of good practice to be recognised and matters requiring improvement to be escalated and addressed. The Committee regularly begins with a patient or staff story to ensure that the patient voice remains central to its work.

I would like to thank Committee members, directors, staff, and internal and external advisors for their support, engagement and contributions throughout the year.

Dr Cliff Richards, Chair of Quality Assurance Committee

3. Recommendations

The Committee is asked to note the report prior to submission for approval by the Trust Board.

North Cheshire and Mersey
NHS Foundation Trust

Strategic People Committee

Agenda reference:	**SPC/26/07/075**			
Subject:	**Committee Chairs Annual Report to the Trust Board**			
Date of meeting:	15 July 2026			
Action required:	**To note**			
Author(s):	Samantha Scholes, Head of corporate governance			
Link to strategic aim:	2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving.			
Executive director sponsor:	Paula Woods, Chief People Officer			
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: EIAs completed for all relevant projects.			
Executive summary:	This Annual Chair's Report covers the period from 1 April 2025 to 31 March 2026 for the Strategic People Committee in Common (WHH and BCH) and provides assurance to the Trust Board that the Committees have fulfilled their Terms of Reference and overseen the Trust's performance in alignment with Strategic Objective 2: PEOPLE: *"We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving"* The report highlights the Committee's activities and strategic oversight.			
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
Recommendation:	The committee is asked to note the report prior to submission for approval by the Trust Board.			
Previously considered by:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			

Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***Submit to Trust Board***
Freedom of information status (foia):	Partial FOIA exempt
Freedom of information exemptions applied: ***(if relevant)***	Section 22 – information intended for future publication

1. Background/context

Committees are required to report annually to the Board, outlining the work they have undertaken during the year, and where necessary, highlighting any areas of concern.

This report presents the activity of the Strategic People Committee in Common, covering the reporting period 1 April 2025 to 31 March 2026.

The Committee was accountable to the Boards for overseeing and assuring WHH and BCH's human resources and organisational development arrangements. It maintained strategic oversight of people systems and processes to support a positive working environment and the delivery of safe, high-quality care.

The Committee also oversaw inclusive workforce arrangements, delivery of the Workforce Equality, Diversity and Inclusion Strategy, alignment with the NHS People Promise, and relevant regulatory reporting.

It provided assurance that both Trusts' strategic objectives were being delivered and that arrangements supported staff voice, just and restorative culture, diversity, inclusion, oversight and assurance on organisational strategic workforce risks and ensured that these were appropriately managed, plus compassionate leadership and equity:

- BCH Strategic Objectives:
  - **BAF 4:** ***Staff – Failure to create an environment for staff to grow and thrive***
  - **BAF 5:** ***Resources – Failure to use our resources in a sustainable and effective way***
  - **BAF 6:** ***Equality, Diversity and Inclusion – Failure to build a culture that champions equality, diversity and inclusion for patients and staff***

WHH 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 with staff developing, growing and thriving***

This report details the membership and role of the Committee and the work that was undertaken during the 2025-26 financial year.

2. Key elements

2.1 Terms of Reference and Cycle of Business

The Terms of Reference were reviewed in August 2025 and March 2026, along with the cycle of business. This included a review of the membership, quoracy, duties, responsibilities and function of the Committee in Common.

2.2 Frequency of Meetings

Meetings continued to take place monthly in 2025-26. During the reporting period, there were 12 meetings.

During the reporting period, the Committee has been composed of four members: two from each Trust, including one Non-Executive Director per Trust and the Chief People Officer/ Director of People and Organisational Development (or nominated Deputy). If a Non-Executive Director was unavailable, a substitute Non-Executive Director from the respective Trust was permitted to attend and counted toward the quorum.

The Committee attendance record is attached at Appendix 3.

2.3 Summary of Committee Activities throughout 2025-26

2.3.1 Staff Stories

Examples from 2025-26 were:

- WHH International Recruitment Experience – 3 Years On
- BCH Degree Nurse Apprentices: Apprenticeship Journey
- BCH Children's Services (Flexible Working)
- WHH Newly Appointed Fellow

2.3.2 Deep Dives & Hot Topics

Deep Dives received by the Committee were:

- BCH Wellbeing and Sickness Absence Policy
- WHH National Staff Opinion Survey
- WHH Theatres: Response to Clinical Safety Reviews and Culture
- Corporate Services Workstream
- WEG
- PTIP Workforce and People Directorates
- Medical Rostering and System Change
- Staff Survey

Hot Topics received by the Committee were:

- Job Planning
- System Assurance: vacancies
- Job Planning
- WHH Leng Review
- Mental Health Hub – 10 Year Fit for the Future Plan
- TUPE Update
- Workforce Reduction Plans

2.4 Risk Management (Workforce)

In common with all other Committees of the Board, all new BAF risks for SPC oversight in 2026-27 were supported by SPCiC in March 2026 and presented to Trust Board in April 2026 for approval.

2.5 Strategy Updates

The Committee has been regularly updated on the Trusts' strategic workforce priorities, receiving biannual reports on the following strategies: People, Workforce Equality, Diversity, and Inclusion, Better Care Together Culture Plan. The Committee also approved the 2026-27 EDI strategies for both Trusts. Additionally, to align with the collaborative strategic direction, the Committee received monthly integration updates throughout the year.

2.6 Workforce Integrated Performance Report

The Committee has overseen an ongoing review of quality Key Performance Indicators, which were monitored through the Integrated Quality and Performance Report (IQPR) for BCH and Integrated Performance Dashboard (IPR) for WHH. Reports were received monthly to review performance and to determine assurance of mitigating actions as appropriate, in advance of presentation at Trust Board meetings.

The Workforce Integrated Performance Indicators for both Trusts were reviewed in February 2026 and approved at Trust Board for inclusion in the Trust Integrated Performance Report (IPR) dashboard from April 2025 – March 2026.

The table below lists the IPR reporting to Trust Board and SPCiC for 2025-26.

IPR 2025-26	**Reporting**	
	Board	**SPCiC**
Supporting Attendance		
Absence %	Bi-monthly	In month
Welcome Back Conversations		In month
Long term sickness absence		In month
Short term sickness absence		In month
Occupational Health and MH Wellbeing		
Management referrals received		In month
Number of OH DNAs (includes Physio)		In month
Number of referrals into Physio service		In month
Number of referrals into MH Wellbeing Hub		In month
Workforce Profile		
Workforce planning process		In month
Vacancy rate		In month
Turnover	Bi-monthly	In month
Retention		In month
Resourcing		
Bank and agency reliance		In month
Bank reliance		In month
Agency reliance		In month
Time to hire		In month
Training		
Core/Mandatory training compliance	Bi-monthly	In month
Role Specific training compliance		In month
PSIRF training compliance		In month
Corporate Induction		In month

Development		
PDR compliance	Bi-monthly	In month
Use of the Apprenticeship Levy		In month
Workforce carrying out Apprenticeships		In month
ED&I		
Non-disabled staff compared to disabled staff being appointed from shortlisting		In month
White staff being appointed from shortlisting compared to BME staff		In month
Representation of BME staff in Bands 7+ (Agenda for Change only)		In month
Improvement of disability declaration rates		In month

2.7 Regulatory and Statutory Reporting

The Committee continued to monitor the statutory and regulatory requirements relating to workforce, equality and diversity governance for both Trusts throughout the year which included:

Workforce Equality Reporting

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Equality Delivery System (EDS)
- EDI Annual Report
- Gender Pay Report
- Equality, Diversity and Inclusion reporting

Medical Workforce Compliance

- GMC National Trainee Survey
- GMC Revalidation Annual Reports
- Responsible Officer Annual Reports
- Guardian of Safe Working Reports
- Improving Working Lives compliance
- Resident Doctor compliance reporting

National Workforce Assurance Returns

- National Staff Opinion Survey
- National Education and Training Survey (NETS)
- Freedom to Speak Up reporting

The Committee received a bi-annual Freedom to Speak Up (FTSU) Report presented to by the Freedom to Speak Up Guardian, providing an overview of policy changes; the range of issues raised by our workforce; the number of FTSU Champions; promotional activities promoting access to the FTSU service and training compliance. The Chair of the Committee is the FTSU Non-Executive Lead.

The Committee receives bi-annual Health and Wellbeing (HWB) Guardian Reports. This report details benchmarking against national toolkits and HWB framework; the range of

HWB activities and offers available to our staff – bespoke, individual and team based; details of access of these services and the benefits to our staff. The report is presented to the Committee by the HWB Guardian.

2.8 Workforce Policies and Procedures Overview Report

The Committee received quarterly updates regarding policy development, review, and ratification workstreams managed through the HR Policy Group (BCH) and JNCC. The Committee through this report also received oversight of the Trust people policy and procedure framework, receiving assurance that the framework is being maintained, policies remain valid and in date.

2.9 Improving People Practices Report

The Committee in Common received an annual assurance report regarding employee relations case management activity across the Trusts. Employee relations in this context refers to the Disciplinary, Supporting Performance Improvement, Resolving Workplace Disputes and Supporting Attendance Policies.

The Committee in Common received an overview of the level of activity, areas of risks, and wider actions to improve employee relations case management performance.

2.10 Safe Staffing Reports

The Committee in Common received bi-monthly updates regarding the staffing of wards to support the delivery of safe levels of care. The reports provided assurance to that the Trust was safely staffed, staffing was closely monitored, and processes were in place to support appropriate escalation and to ensure risks were identified and mitigated appropriately.

Furthermore, the Committee received a Midwifery Safe Staffing report which provided assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents.

2.11 Topics Carried Forward

A number of topics would be carried forward into 2026-27 to maintain oversight including:

Workforce and Staffing

- Safer Staffing and workforce establishment reviews, including nurse vacancies, fill rates, sickness absence, and staffing pressures across clinical services. These were recurring reports throughout the year and remained active areas of oversight.
- Midwifery, neonatal and wider maternity staffing assurance, including recruitment and workforce sustainability.
- Workforce Integrated Performance Indicators (WIPI) and workforce metrics reporting.

Employee Relations and People Practices

- Improving People Practices / Employee Relations, including:

- Grievance and disciplinary case management
- Employment tribunal activity
- Just Culture approaches
- Workforce inequality monitoring within formal processes
- Long-running employee relations cases and monitoring of case duration.

Equality, Diversity and Inclusion

- Anti-Racist Framework implementation.
- Workforce Race Equality Standard (WRES) actions.
- Workforce Disability Equality Standard (WDES) actions.
- Monitoring of disparities in employee relations cases and workforce experience.

Organisational Development and Culture

- Freedom to Speak Up (FTSU) themes and organisational culture.
- Staff Survey improvement plans and workforce engagement actions.
- Leadership development and succession planning.
- Health and wellbeing initiatives aimed at reducing sickness absence and improving retention.

Recruitment and Retention

- Nursing and clinical workforce recruitment.
- International recruitment programmes.
- Retention initiatives and workforce supply challenges.
- Bank and temporary staffing utilisation.

Workforce Transformation

- Integration-related workforce programmes across both organisations.
- Development of future workforce strategies and workforce planning.
- Digital and operational workforce transformation initiatives.

Governance and Assurance

- Regular review of people-related risk register items.
- Workforce performance reporting to Trust Boards.
- Ongoing monitoring of People Strategy delivery and associated action plans.

2.12 Chair's Summary

As Chair of SPC and joint Chair of SPCiC, alongside Abdul Siddique, BCH Non-Executive Director throughout 2025-26, I encouraged honest and open discussion and challenge, so that areas of success could be celebrated, and areas of improvement identified, addressed and escalated as necessary.

I would like to thank all members of the Committee and the workforce for their responses, support and contributions throughout the year.

Julie Jarman
Chair of the Strategic People Committee

3. Recommendation

The committee is asked to note the report prior to submission for approval by the Trust Board.

North Cheshire and Mersey
NHS Foundation Trust

Finance, Sustainability and Performance Committee

Agenda reference:	**FSPC/26/07/072**			
Subject:	**Finance, Sustainability and Performance Committee Annual Chair's Report**			
Date of meeting:	29 July 2026			
Action required:	**To note**			
Author(s):	Samantha Scholes, Head of Corporate Governance			
Link to strategic aim:	3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Executive director sponsor:	Jane Hurst, Chief Finance Officer			
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 Annual Chair's Report covers the period from 1 April 2025 to 31 March 2026 for: • Finance and Sustainability Committee (WHH) • Finance and Performance Committee (BCH) • Finance, Sustainability and Performance Committee in Common (WHH and BCH) and provides assurance to the Trust Board that the Committees have fulfilled their Terms of Reference and overseen the Trusts' performance in alignment with; - WHH Strategic Aim 3*:* Sustainability, - BCH Strategic Objective, BAF 5: Resources. The report highlights the Committees' activities, risk management, and strategic oversight.			

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

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The committee is asked to note the report for onward reporting to the Trust Board – 5 August 2026.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***Submit to Trust Board***		
Freedom of information status (foia):	Partial FOIA exempt		
Freedom of information exemptions applied: ***(if relevant)***	Section 22 – information intended for future publication		

1. Background/context

Committees are required to report annually to the Board, outlining the work they have undertaken during the year, and where necessary, highlighting any areas of concern.

This report presents the activity of the following Committees, covering the reporting period 1 April 2025 to 31 March 2026:

- Finance and Sustainability Committee (FSC) (WHH) to June 2025
- Finance and Performance Committee (FPC) (BCH) to June 2025
- Finance, Sustainability and Performance Committees In Common (FSPCiC) from July 2025

The Committees were accountable to the Board of Directors for providing oversight and assurance on all aspects of financial and operational planning, digital, performance and strategic and business development.

The Committees of both Warrington and Halton Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) were also accountable to the Boards for ensuring that the strategic objectives of each Trust were delivered:

- WHH. Strategic Objective 3**: *'We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes"***
- BCH. Strategic Objective BAF 5: **Resources. Failure to use our resources in a sustainable and effective way; collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients."**

This report details the role of the Committees and the work that was undertaken during the 2025-26 financial year.

2. Key elements

2.1 Terms of Reference and Cycle of Business

The FSC and FPC Terms of Reference were reviewed in Q4 of 2024-25, along with the cycles of business. This included a review of the membership, quoracy, duties and responsibilities of the Committees for the year ahead.

The Finance, Sustainability and Performance Committees In Common (FSPCiC) which commenced in July 2025, reviewed the Terms of Reference and cycles of business at its inaugural meeting and in March 2026 for Finance, Sustainability and Performance Committee 2026-27.

2.2 Frequency of Meetings

Meetings took place monthly for FSC and FPC from April to June 2025 and monthly for FSPCiC from July 2025 to March 2026.

The Committees met 15 times in total during the year. Each of the meetings held during 2025-26 were quorate.

2.3 Summary of Committee Activities throughout 2025-26

2.3.1 Deep Dives & Hot Topics

At each FSC and FSPCiC meeting, the Committee received both a 'Hot Topic' and a 'Deep Dive'.

Hot Topics provided high level information about a current topic that needed focused attention and discussion by the Committee and relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from a sub-committees or other meetings.

Deep Dives provided an in-depth review of a topic that had been escalated from sub-committees or other meetings, areas noted from other reports and wider triangulation.

Deep Dives included during the year included:

- Delivery Unit
- Theatre Productivity / Length of Stay
- CBU CIPs
- Performance
- CIP Delivery Unit
- CIP L3
- Productivity, Speciality Level
- Tier 1 and Tier 2 Update
- Operational Planning
- Dental Contractual Responsibilities
- Productivity

Hot Topics received during the year included:

- CIP
- System Assurance
- UEC Improvement and Non-Elective Length of Stay
- Tier 1 and Dermatology
- PwC Update
- BCH Audiology
- L3 CIP (Long List/PwC List)
- Medium Term Plan
- Operational Planning
- Productivity: The Way Forward
- PwC Actions

2.4 Risk Management (Finance and Sustainability)

In common with all other Committees of the Board, all new BAF risks were considered in March 2026 and subsequently presented to the Board in April 2026.

2.5 Finance and Key Issues

The committees received regular updates in relation to the strategic priorities for both Trusts, particularly in relation to the anticipated integration of the two Trusts.. In addition, updates and reports of enabling strategies were provided, e.g. Sustainability and the Green Plan, Operational Planning, Strategic Planning, Digital and Estates.

Key financial headlines at 31 March 2026 WHH

The Trust reported a M12 deficit of £40.7m before deficit support funding. This was primarily due to the stretch CIP target not being delivered (£11.2m) and unfunded integration costs (£0.8m).

A total of £21.5m CIP had been delivered by year end, although only £14.4m was recurrent, with £7.1m delivered non-recurrently, which negatively impacts the underlying deficit. The Trust's underlying deficit stood at £45.5m, driven by the stretch target and recurrent CIP, partially offset by non-recurrent benefits in 2025/26.

Capital expenditure (including IFRS16) was £20.8m at M12. The Committee approved bringing forward £2.3m of 2026-27 capital to support delivery of the 2025-26 programme.

BCH

The Trust reported a M12 deficit position was £2.9m worse than plan at £4.4m due to stretch CIP not delivered.

£5.7m CIP delivered at month 12 with 94% being delivered recurrently. Non-pay expenditure was £1.7m above plan mainly due to unexpected rent reviews. This had mainly been offset by an underspend on agency expenditure.

There were no material breaches of financial governance arrangements identified during the year.

The three Committees reviewed and scrutinised the financial position and performance of the Trusts closely throughout the year and escalated any relevant items to the Board in the Chair's exception reports.

In addition, the Board has regularly reviewed the financial position, providing challenge to forecast outturns and the associated mitigations.

Capital expenditure has been closely monitored throughout the year by both the Capital Planning Group and the Committees, with particular attention given to schemes exceeding £0.5m.

Over the past 12 months, the Trusts have maintained regular engagement with the ICB and NHS England, during which the financial position, forecasts, plans and CIP have been reviewed and appropriately challenged.

2.5.2 PwC Report

PwC reports for WHH highlighted a need for stronger financial discipline, recurrent savings delivery and productivity management. By March 2026 the Trust had made significant progress in strengthening governance, workforce oversight and CIP management, however significant risks remained around delivery of a £30m+ savings programme (£21.5m BAU CIP and £13.1m stretch target), reducing the underlying deficit, and achieving a potential 7% efficiency requirement in 2026-27. Governance arrangements were viewed positively, but deliverability risks remained high.

2.5.3 Regular Scheduled Agenda Items

- Finance Reports
- Monthly CIP Update
- Corporate Performance Report
- IPR/IQPR
- Monthly Productivity Update
- Cost Pressures
- Capital Expenditure Reporting
- Integration Update
- Elective Recovery Update
- Pay Assurance Report
- Board Assurance Framework
- Delivery Unit Assurance Reporting

2.5.4 Revenue Requests/Approvals

- TIF Theatres (WHH April 2025)
- Elective Recovery (WHH June 2025)
- WLI and Winter Wards (26 August 2025)
- Elective Recovery Funding (September 2025)
- Planned Care Quality and Safety Waiting List Initiatives (November 2025)
- Elective Recovery Q4 (December 2025)
- ITU (March 2026)
- Virtual Wards (March 2026)

2.5.5 Theatre Productivity

The committee continued to receive regular reports and received assurance that productivity compared favourably with peer organisations with strong performance in specialities. In 2026-27, this would be a major contributor to the financial and productivity programme for the Trust.

Performance in year had improved from c.64% utilisation to c.80%, with a target of 83%, in line with the top-quartile performance nationally.

2.5.6 Issues Carried Forward/Escalated

- Integration Programme and Due Diligence.
- Financial Recovery (CIP, Level 3 CIP, Cost Pressures and Productivity).
- Operational Planning and Medium-Term Planning.
- Elective Recovery and Waiting List Management.
- Dermatology and Dental Performance Issues.
- Delivery Unit Assurance and Workforce/Productivity Oversight

2.6 Summary

As Chair of FSPC, FSC and joint Chair of FSPCiC, alongside Tina Wilkins, BCH Non-Executive Director from July 2025 to March 2026, I must acknowledge the significant financial challenges the Trust is currently facing in delivering recovery plans and improving productivity. The Committee's role is to provide oversight and assurance on the Trust's financial grip and control, and I can confirm that strong governance arrangements remain in place. However, there are ongoing challenges in meeting the financial plan for 2025-26, particularly given the recent risk of not receiving deficit support funding.

While the Committee is assured on the robustness of current controls, the financial position remains extremely constrained, requiring continued close scrutiny and a clear focus on delivering Cost Improvement Plans (CIPs) and productivity gains. It is anticipated that the proposed acceleration of the Trust's acquisition of Bridgewater, subject to ICB approval, will allow some benefits to be realised during the 2026/27 financial year to help ease these pressures.

The Committee will continue to monitor these challenges closely over the coming year, maintaining oversight of financial performance, recovery progress, CIPs and the timely delivery of planned productivity improvements.

John Somers, Chair of Finance, Sustainability and Performance Committee, July 2026

3. Recommendations

The committee is asked to note the report prior to submission for approval by the Trust Board.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/057(i)**			
Subject:	**Code of Governance Compliance**			
Date of meeting:	5 August 2026			
Action required:	**Approval**			
Author(s):	Jan McCartney – Deputy director of corporate governance			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	The Code of Governance for NHS Provider Trusts was most recently updated in April 2023 and sets out a common overarching framework for the corporate governance of trusts, reflecting developments in the UK corporate governance and the development of integrated care systems. Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code. The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence. The Annual Reporting Manual requires the Board of Directors to have considered the Trust's compliance/ non-			

<table>
<tr><td></td><td colspan="3">compliance with the Code and to include a statement to this effect in the Annual Report.

The Trust is declaring compliance with all elements of the code except:
• C.4.3 – Explanation provided
• D.2.1 – Explanation provided</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Board is asked to:

1. Review and note the Code of Governance Compliance assessment for 2026/27
2. Note the assurance provided by the Audit Committee regarding the robustness of the assessment
3. Endorse the proposed “comply or explain” positions and associated explanations.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Audit Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">AC/26/06/036</td></tr>
<tr><td>Date of meeting</td><td colspan="2">22 June 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">The committee agreed to provide the assurance to the Board</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 Code of Governance for NHS Provider Trusts was most recently updated in April 2023 and sets out a common overarching framework for the corporate governance of trusts, reflecting developments in the UK corporate governance and the development of integrated care systems.

Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence.

The Annual Reporting Manual requires the Board of Directors to have considered the Trust's compliance/ non-compliance with the Code and to include a statement to this effect in the Annual Report.

2. Key elements

The Code of Governance for NHS Provider Trusts comprises of the following sections:

Section A: Board leadership and purpose
Section B: Division of responsibilities
Section C: Composition, succession and evaluation
Section D: Audit, risk and internal control
Section E: Remuneration
Appendix B: Council of Governors

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. The purpose of the Code is to assist Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

The Code imposes some disclosure requirements on Foundation Trusts and Boards are expected to observe the Code or to explain where they do not comply. It includes a number of main and supporting principles and provisions and Foundation Trusts are required to publish a statement in the Annual Report confirming how these have been applied.

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is declaring compliance with all elements of the code except:

- C.4.3 – Explanation provided
- D.2.1 – Explanation provided

Details of compliance are described in **Appendix 1.**

3. Assurance

The self-assessment has been coordinated by the Corporate Governance function and informed by reviewing Board and Committee structures, terms or reference and governance documentation.

The findings are consistent and supports with the Trust's overall Well-Led position and governance maturity.

4. Recommendations

The Board is asked to:

1. **Review and note** the Code of Governance Compliance assessment for 2026/27
2. **Note the assurance provided by the Audit Committee** regarding the robustness of the assessment
3. **Endorse** the proposed "comply or explain" positions and associated explanations.

The NHS Foundation Trust Code of Governance – Compliance Checklist

A: Board Leadership and Purpose

A: Principles
1.1 - Every Trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members in the case of Foundation Trusts, and for all Trusts, patients, service users and the public. 1.2 – The Board of Directors should establish the Trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The Board of Directors must satisfy itself that the Trust's vision, values and culture are aligned. All Directors must act with integrity, lead by example and promote the desired culture. 1.3 - The Board of Directors should give particular attention to the Trust's role in reducing health inequalities in access, experience and outcomes. 1.4 - The Board of Directors should ensure that the necessary resources are in place for the Trust to meet its objectives, including the Trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The Board of Directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all Board members – and in particular Non-Executive Directors whose time may be constrained - should ensure they collectively have sufficient time and resource to carry out their functions. 1.5 – For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the Board of Directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners. 1.6 - The Board of Directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The Board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

Ref	Code Provisions	Trust Position	Evidence
A.2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB and place-based partnerships.	Compliant	Board Assurance Framework, Performance reporting and Quality Report. Oversight through Integrated Performance report presented to Board Committees and Trust Board.

			Confirmed through annual governance statement, and external audit opinion.
A.2.1	The Board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives.	Compliant	Active participant in the Cheshire & Merseyside Provider Collaborative. Active participant in both Warrington and Halton Place based arrangements. Community Diagnostic Centre provider, serving Cheshire and Merseyside. Endoscopy hub provider on behalf of Cheshire and Merseyside. Partnership with Alder Hey to provide paediatric services locally in partnership. Lead for delivery of Living Well Hub, incorporating 25 providers. Active participant in pathology collaboration across Cheshire and Merseyside.
A.2.1	The Trust should describe in its Annual Report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Compliant	Incorporated in Annual Governance Statement 2025/26.
A.2.2	The Board of Directors should develop, embody and articulate a clear vision and values for the Trust, with reference to the ICP's integrated care strategy and the Trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the Trust's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Compliant	The Trust's 2023-25 - extended Strategy (Our mission is to be outstanding for our patients, our communities and each other) correlates with the ICP strategy published in 2021
A.2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action.	Compliant	The Board receives assurance reports from the Strategic People Committee who are the delegated Committee to received: • EDI Annual Report

			• WRES Report • WDES Report The Trust Board receives details of the annual staff survey. The Trust Board receives bi-annual Freedom to Speak Up (FTSU) reports and has appointed an Non-Executive Freedom to Speak Up Champion who undertakes regular triangulation with the FTSU Guardian and FTSU Exec Lead. The Board undertake regular observation visits across the Trust. Updates on the Trust Culture Plan are presented to the Strategic people Committee biannually. The plan is aligned to the NW People and Culture Strategic Ambitions and the 10-year Health Plan for England.
A.2.3	The Board of Directors should assess and monitor culture. The Annual Report should explain the Board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Compliant	The National staff survey results provide assurance on the culture at NCM through a range of measures using the NHS People Promise, Staff Engagement and Morale themes. In addition, the results provide

			information on PSIRF (19a, 19b, 19c & 19d) and FTSU (Q 20a; 20b; 25e & 25f) Details included in the Annual Report 2025/26 NED Health & Wellbeing Champion appointed. Health and Wellbeing updates provided to Strategic People Committee biannually via the Health and Wellbeing Gurdian Report. The Board undertake regular observation visits across the Trust.
A.2.4	The Board of Directors should ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and that risk is managed effectively. The Board should regularly review the Trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Compliant	Oversight through Integrated Performance report presented to Board Committees and Trust Board. Financial and corporate performance reports received by the Finance, Sustainability and Performance Committee with escalation as appropriate to the Trust Board. We agree to consistent planning assumptions and CIP targets as part of annual planning, and this is outlined in the Annual Financial Plan submitted to the Board. BAF details risks in relation to quality, corporate and financial performance.

			Annual Governance Statement summaries arrangements.
A.2.5	The Board of Directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant.	Compliant	Integrated Performance Report reported bimonthly to the Board and Board Committees, the metrics are reviewed and agreed annually. Separate workforce and patient Equality, Diversity & Inclusion Groups in place reporting to Board Committees
A.2.5	Where appropriate, and in particular in high risk or complex areas, the Board of Directors should commission independent advice e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	Compliant	Risk-based Internal Audit annual work-plan with oversight by the Audit Committee.
A.2.6	The Board of Directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health & Social Care, NHS England and the CQC.	Compliant	Quality Strategy. Annual Quality Report.
A.2.7	The Chair and Board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the Trust's vision.	Compliant	The Chair and Board engage directly with the Council of Governors via the Council of Governors meeting and informal Q&A sessions. Publication of the Chair's written report in the Trust Board papers. Regular observation visits by the Trust Board Involvement in system and national professional networks.
A.2.7	Committee Chairs should engage with stakeholders on significant matters related to their areas of responsibility.	Compliant	Committee Chair Assurance Reports provided to the Trust Board and Council of Governors and published on Trust website.

			Audit Chair meets with External and Internal Audit representatives. Increased NED involvement in CMAST meetings Regular observation visits by the Trust Board. The NEDs have taken on specific roles such as Maternity champion Health and Wellbeing Champion Which enables them to engage with staff members on specific areas and bring back real time stories to trust board
A.2.7	The Chair should ensure that the Board of Directors as a whole has a clear understanding of the views of all stakeholders including system partners.	Compliant	The Chair is active within C&M through the ICB and CMPC meetings. Engagement is included in the Chair's briefings to the Trust Board and also the COG. External views also form part of the Trust's Quality Account.
A.2.7	NHS Foundation Trusts must hold a members' meeting at least annually.	Compliant	Annual Members Meeting held.
A.2.8	The Board of Directors should describe in the Annual Report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered.	Compliant	Annual report compliant with reporting guidance and includes some reference to stakeholders, system and place-based partners and key partnerships for collaboration.
A.2.8	The Board of Directors should keep engagement mechanisms under review so that they remain effective.	Compliant	Quarterly reporting to Board and CoG on communications and engagement activity, including Experts by Experience programme and engagement opportunities.

			Regular reporting on staff engagement, including NHS Staff Survey results to Board and SPC. Stakeholder engagement activity reported to Board as part of the Strategy highlight report.
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The Board of Directors should routinely review this and the reports arising from its operation.	Compliant	Substantive FTSU Guardian (and Deputy) in place. Freedom to Speak Up Policy. FTSU NED Champion FTSU Exec Lead Biannual FTSU Reports to Board
A.2.9	Raising Concerns – the Board should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Compliant	Substantive FTSU Guardian (and Deputy) in place. Freedom to Speak Up Policy. FTSU NED Champion FTSU Exec Lead Biannual FTSU Reports to Board
A.2.10	The Board of Directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	Compliant	Managing Conflicts of Interest Policy and reporting reviewed in year 2025/26 Internal audit provided substantial assurance on the process
A.2.11	Where Directors have concerns about the operation of the Board or the management of the trust that cannot be resolved, these should be recorded in the Board minutes.	Compliant	Comprehensive minutes are produced and agreed at Board meetings. Board members can request that concerns are recorded.
A.2.11	If on resignation a Non-Executive Director has any such concerns, they should provide a written statement to the Chair, for circulation to the Board.	Compliant	Situation has not arisen to date.

B: Division of Responsibilities

B: Principles
B.1.1 - The Chair leads the Board of Directors and, for Foundation Trusts, the Council of Governors, and is responsible for its overall effectiveness in leading and directing the Trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the Chair facilitates constructive Board relations and the effective contribution of all Non-Executive Directors, and ensures that Directors and, for Foundation Trusts, Governors, receive accurate, timely and clear information. B.1.2 - Responsibilities should be clearly divided between the leadership of the Board and the Executive leadership of the Trust's operations. No individual should have unfettered powers of decision. B.1.3 - Non-Executive Directors should have sufficient time to meet their Board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account. B.1.4 - The Board of Directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficient and economically. B.1.5 - The Board is collectively responsible for the performance of the Trust. B.1.6 - The Board of Directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the Trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies. B.1.7 - All members of the Board of Directors have joint responsibility for every Board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive as the Accounting Officer.

Ref	Code Provisions	Trust Position	Evidence
B.2.1	The Chair is responsible for leading on setting the agenda for the Board of Directors and, for Foundation Trusts, the Council of Governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Compliant	Board approved Cycle of Business in place for both Board and CoG meetings with agendas for individual meetings subject to approval by the Chair.
B.2.2	The Chair is responsible for ensuring that Directors and, for Foundation Trusts, Governors receive accurate, timely and clear information that enables them to perform their duties effectively.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly.

			Annual induction and development sessions. Governor attendance at local and national conferences The Chair, via the Foundation Trust Office, ensures CoG agendas and papers are appropriate and shared in a timely manner.
B.2.2	A Foundation Trust Chair should take steps to ensure that Governors have the necessary skills and knowledge to undertake their role.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly. Annual induction and development sessions. Governor attendance at local and national conferences
B.2.3	The Chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of Non-Executive Directors in particular, and ensuring a constructive relationship between Executive and Non-Executive Directors.	Compliant	Chair encourages appropriate debate and ensures that all member of the Board have the opportunity to contribute effectively. Monitored in Chair's appraisal process
B.2.4	A Foundation Trust Chair is responsible for ensuring that the Board and Council work together effectively.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly. Chair encourages Governor observation of Board and Board Committees Lead Governor observes Private Board

			Chair ensures Board member attendance and contribution at CoG meetings.
B.2.5	The Chair should be independent on appointment when assessed against the criteria set out in provision B.2.6 below.	Compliant	Independence is confirmed as part of the appointment process. Annual NED declarations of independence.
B.2.5	The roles of Chair and Chief Executive must not be exercised by the same individual.	Compliant	Chair and CEO roles held separately.
B.2.5	A Chief Executive should not become Chair of the same Trust.	Compliant	The Chair has not previously been the Chief Executive of the Trust.
B.2.5	The Board should identify a Deputy or Vice Chair who could be the Senior Independent Director.	Compliant	Deputy Chair appointed. SID appointed
B.2.5	The Chair should not sit on the Audit Committee. The Chair of Audit Committee, ideally, should not be the Vice chair or Senior Independent Director.	Compliant	The Chair does not sit on the Audit Committee
B.2.6	The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a Non-Executive Director's independence include, but are not limited to, whether a Director: ▪ Has been an employee of the Trust within the last two years; ▪ Has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the Trust; ▪ Has received or receives remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme; ▪ Has close family ties with any of the Trust's advisers, directors or senior employees ▪ Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;	Compliant	Annual confirmation of independence as part of governance reporting included in annual report. Rationale for appointment beyond 6 years detailed within proposal to the Governor Nomination & Remuneration Committee and CoG prior to approval.

	▪ Has served on the Trust Board for more than six years from the date of their first appointment; ▪ Is an appointed representative of the Trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the Board of Directors nonetheless considers that the Non-Executive Director is independent, it needs to be clearly explained why.		
B.2.7	At least half the Board of Directors, excluding the Chair, should be Non-Executive Directors whom the Board considers to be independent.	Complaint	Current composition is compliant. Six NEDs & 5 voting Execs
B.2.8	No individual should hold the positions of Director and Governor of any NHS Foundation Trust at the same time.	Compliant	No individuals breach this requirement.
B.2.9	The value of ensuring that Committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding Chairs and members of Committees.	Compliant	Committee Terms of Reference are reviewed annually.
B.2.9	For Foundation Trusts, the Council of Governors should take into account the value of appointing a Non-Executive Director with a clinical background to the Board of Directors, as well as the importance of appointing diverse Non-Executive Directors with a range of skill sets, backgrounds and lived experiences.	Compliant	Two Non-Executive Director has a clinical background. Diversity a key focus in NED recruitment process.
B.2.10	Only the Committee Chair and Committee members are entitled to be present at Nominations, Audit or Remuneration Committee meetings, but others may attend by invitation of the particular Committee.	Compliant	As per Terms of Reference.
B.2.11	In consultation with the Council of Governors, NHS Foundation Trust Boards should appoint one of the independent Non-Executive Directors to be the Senior Independent Director (SID); to provide a sounding board for the Chair and serve as an intermediary for the other Directors when necessary.	Compliant	SID appointed by Council of Governors
B.2.11	Led by the SID, the Non-Executive Directors should meet without the Chair present at least annually to appraise the Chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. The Chair Appraisal Framework published by NHS England refers.	Compliant	Chair appraisal process is led by the SID and is conducted in accordance with the Chair Appraisal Framework. Input provided by internal and external stakeholders.

B.2.12	Non-Executive Directors have a prime role in appointing and removing Executive Directors. They should scrutinise and hold to account the performance of management and individual Executive Directors against agreed performance objectives.	Compliant	Non-Executive Directors involved in all Executive Director appointments and provide input in Exec appraisals. Performance scrutinised via the IPR, Corporate Performance and Performance Assurance Frameworks in Trust Board and Committee meetings.
B.2.12	The Chair should hold meetings with the Non-Executive Directors without the Executive Directors present.	Compliant	NED only meetings held
B.2.13	The responsibilities of the Chair, Chief Executive, Senior Independent Director, Board and Committees should be clear, set out in writing, agreed by the Board of Directors and publicly available.	Compliant	Chair and CEO objectives and appraisal processes in place. Terms of Reference for Committees are published in Board meeting papers and are available on request. Board schedule of business in place. SID Role description in place.
B.2.13	The Annual Report should give the number of times the Board and Committees met, and individual Director attendance.	Compliant	Number of meetings and register of attendance included in Annual Report.
B.2.14	When appointing a Director, the Board of Directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the Board of Directors, with the reasons for permitting significant appointments explained in the Annual Report.	Compliant	All Directors are required to complete declarations of interest on appointment. This includes any other roles/ commitments and an indication of time involved. Any material appointments would be approved by the Board and explained in the Annual Report.
B.2.14	Full-time Executive Directors should not take on more than one Non-Executive Directorship of another Trust or organisation of comparable size and complexity, and not the Chair role of such an organisation.	Compliant	None of the Executive Directors currently hold Non-Executive roles.

B.2.15	All Directors should have access to the advice of the Company Secretary, who is responsible for advising the Board of Directors on all governance matters. Both the appointment and removal of the Company Secretary should be a matter for the whole Board.	Compliant	All Directors have access to the Company Secretary who advises the Board on all governance matters. Company Secretary appointed by the Board
B.2.16	All Directors, Executive and Non-Executive, have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.	Compliant	Chair encourages appropriate debate and ensures that all member of the Board have the opportunity to contribute effectively. Governor observation of the Board and Committees, with feedback to CoG & minutes of meetings demonstrate challenge.
B.2.16	Non-Executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Compliant	Non-Executive Directors satisfy this requirement through participation in Board and Committee meetings.
B.2.17	The Board of Directors should meet sufficiently regularly to discharge its duties effectively.	Compliant	The Board is scheduled to meet six times a year with 6 additional development sessions
B.2.17	The Board should have a schedule of matters reserved specifically for its decisions. This schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved.	Compliant	The Trust has a Scheme of Delegation in place, which is reviewed annually The Constitution describes how disputes between the COG and Board of Directors will be resolved.
B.2.17	The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by the Board, the Council of	Compliant	The narrative in the Annual Report reflects this requirement.

	Governors, Board Committees and the types of decisions that are delegated to the executive management of the Board of Directors.		

Section C: Composition, Succession and Evaluation

C: Principles
C.1.1a - Appointments to the Board of Directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for Board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. C1.1b - Appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability and cognitive and personal strengths. C1.1c - In particular, the Board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher. C.1.2 - The Board of Directors and its Committees should have a diversity of skills, experience and knowledge. The Board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the Board of Directors as a whole and membership regularly refreshed. C.1.3 - Annual evaluation of the Board of Directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each Director continues to contribute effectively.

C2 Provisions for NHS Foundation Trusts Board Appointments			
Ref	**Code Provisions**	**Trust Position**	**Evidence**
C.2.1	The Nominations Committee or Committees of Foundation Trusts, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors.	Compliant	Nominations and Remuneration Committee (NARC) for Executive Director appointments. Governor Nominations and Remuneration Committee (GNARC) for Non-Executive Director appointments.
C.2.1	The Nominations Committee(s) should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board of Directors to meet them.	Compliant	NARC Terms of reference include responsibilities for succession planning.
C.2.1	Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB,	Compliant	Interviews for Board position include ICB representation

	and the Foundation Trust should engage with NHS England to agree the approach.		
C.2.2	There may be one or two Nominations Committees. If there are two, one will be responsible for considering nominations for Executive Directors and the other for Non-Executive Directors (including the Chair).	Compliant	Nominations and Remuneration Committee (NARC) for Executive Director appointments. Governor Nominations and Remuneration Committee (GNARC) for Non-Executive Director appointments.
C.2.2	The Nominations Committees should regularly review the structure, size and composition of the Board of Directors and recommend changes where appropriate. In particular, the Nominations Committees should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the Board of Directors and, in light of this evaluation, describe the role and capabilities required for appointment of both Executive and Non-Executive Directors, including the Chair.	Compliant	Prior to any new appointment, an evaluation of the balance of skills, knowledge and experience on the Board is undertaken and then a description of the role and capabilities required for the particular appointment is prepared
C.2.3	The Chair or an independent Non-Executive Director should chair the Nominations Committees. At the discretion of the Committee, a Governor can chair the Committee in the case of appointments of Non-Executive Directors or the Chair.	Compliant	The Chair is the chair of both NARC and GNARC
C.2.4	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chair and Non-Executive Directors. Once suitable candidates have been identified, the Nominations Committee should make recommendations to the Council of Governors.	Compliant	As reflected in the GNARC Terms of Reference
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by Nominations Committees to support the Council of Governors in the appointment of the Chair and Non-Executive Directors.	Compliant	To be incorporated in the recruitment process for Non-Executive Directors as required.
C.2.5	If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement about any other connection it has with the Trust or individual directors.	Compliant	Use of external consultancy for NED appointments will be included in the Annual report as required.

C.2.6	The Nominations Committee responsible for the appointment of Non-Executive Directors should have Governors and/or independent members in the majority. Governors should also be in the majority on the interview panel.	Compliant	ToR confirms Governors should be in majority
C.2.7	When considering the appointment of Non-Executive Directors, the Council of Governors should take into account the views of the Board of Directors and the Nominations Committee on the qualifications, skills and experience required for each position.	Compliant	Governors are fully involved in NED appointments process including a specific Governor Focus Group. The interview panel includes both Governors and NED & Exec representation.
C.2.8	The Annual Report should describe the process followed by the Council of Governors to appoint the Chair and Non-Executive Directors.	Compliant	Included in Annual Report.
C.2.8	The main role and responsibilities of the Nominations Committee should be set out in publicly available written terms of reference.	Compliant	Nomination and Remuneration Committee TOR are available on request
C.2.9	Elected Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of Governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Compliant	Governors terms of office are 3 years and subject to re-election. Biographies are provided. 3 year tenure confirmed in constitution.
C.2.10	A requirement of the National Health Service Act 2006 is that the Chair, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive are responsible for deciding the appointment of Executive Directors. The Committee with responsibility for Executive Director nominations should identify suitable candidates to fill Executive Director vacancies as they arise and make recommendations to the Chair, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive.	Compliant	Appointments are made with Chair, CEO and NED involvement. The Nominations and Remuneration Committee oversee this process.
C.2.11	It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.	Compliant	This is set out in the Trust's Constitution.

C.2.12	The Governors are responsible at a general meeting for the appointment, re-appointment and removal of the Chair and other Non-Executive Directors.	Compliant	This is set out in the Trust's Constitution.
C.2.13	Non-Executive Directors, including the Chair, should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a Director.	Compliant	Chair and Non-Executive Directors appointed and/or re-appointed for terms not exceeding three years.
C.2.14	The terms and conditions of appointment of Non-Executive Directors should be made available to the Council of Governors. The letter of appointment should set out the expected time commitment.	Compliant	Terms and conditions of NEDs are provided to Governors as part of the NED appointment process. Time commitment/ T&Cs detailed in offer letter.
C.2.14	Non-Executive Directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved, and the Council of Governors should be informed of subsequent changes.	Compliant	Time commitments investigated during recruitment process. On appointment NEDS are required to complete declaration of interests including other significant commitments and time requirements, and are required to update their declaration should their circumstances change

C.4: Board Appointments – Applicable to both NHS Foundation Trusts and NHS Trusts			
Ref	**Code Provisions**	**Trust Position**	**Evidence**
C.4.1	Directors on the Board of Directors and, for Foundation Trusts, Governors on the Council of Governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a Director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged).	Compliant	Evidence to support Fit and Proper Persons (FPP) collated and reviewed for all Directors New FPP Policy approved Governors complete fit and proper persons declaration. Completion of Annual Exec FPP
C.4.1	Trusts should have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Compliant	Fit & Proper Persons (FPP) Policy in place and reflects the new NHS England FPPT Framework.
C.4.2	The Board of Directors should include in the Annual Report a description of each Director's skills, expertise and experience. Alongside this, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust. Both statements should also be available on the Trust's website.	Compliant	Director Biographies, balance, completeness and appropriateness included in Annual Report and published on Trust website
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the Board of Directors and any decision to extend a term beyond six years should be subject to rigorous review.	Explain	The current Chair was appointed on 1 April 2026 One Non-executive director's tenure has been extended due to 31 March 2027. The decision to extend the term of the Deputy Chair was made to ensure leadership continuity during the transition to a new Chair, while also

			retaining valuable community healthcare expertise aligned to the Trust's strategic priorities. This was further supported by strong attendance, active contribution to Board and committee work, and consistently positive appraisal feedback reflecting an effective and collaborative approach. The Deputy Chair was first appointed in June 2019, and the extension of tenure remained compliant with the NHS Provider Trust Code of Governance, as it did not exceed the nine-year maximum from initial appointment. The decision to extend beyond six years was subject to rigorous review, confirming continued effectiveness, independence, and alignment with the requirements set out in section 4.3.
C.4.3	To facilitate effective succession planning and the development of a diverse Board, this period of nine years can be extended for a limited time, particularly where on appointment a Chair was an existing Non-Executive Director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming Chair after a three-year term as a Non-Executive Director would not trigger a review after three years in post as Chair.	Compliant	All NED terms are rigorously reviewed and reported..

C.4.4	Elected Foundation Trust Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	Compliant	Constitution details that members are subject to re-election every 3 years.
C.4.4	The Governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Compliant	Biographies included in governor elections/ re-elections.
C.4.4	Best practice is that Governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	Compliant	Governors do not serve more than 3 consecutive terms.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the Board of Directors, its Committees, the Chair and individual Directors.	Compliant	Annual evaluation of committees and Board in place and reported to the Board of Directors. Appraisals in place for Chair and individual directors.
C.4.5	For NHS Foundation Trusts, the Council of Governors should take the lead on agreeing a process for the evaluation of the Chair and Non-Executive Directors. The Governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the Chair.	Compliant	Chair and NED appraisal process approved by COG. The SID leads the evaluation of the Chair.
C.4.6	The Chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the Board of Directors. Each Director should engage with the process and take appropriate action where development needs are identified.	Compliant	Executive Director appraisal process in place Strong NED appraisal processes in place following NHSE approach. All members of the Board have completed an appraisal.
C.4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well Led Framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual Directors or Governors.	Compliant	External well led review undertaken by the Good Governance Institute between July and December 2022 with the final report published in February 2023.
C.4.8	Led by the Chair, the Council of Governors should periodically assess their collective performance and regularly communicate to members and the public	Compliant	An annual evaluation of the effectiveness of the Council of Governors is in place.

	how they have discharged their responsibilities, including their impact and effectiveness on: ▪ holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors ▪ communicating with their member constituencies and the public and transmitting their views to the Board of Directors ▪ contributing to the development of the Foundation Trust's forward plans The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in: ***Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors and Addendum to Your statutory duties – A reference guide for NHS Foundation Trust Governors.***		Each year, governors complete a survey and a subsequent report is presented, detailing the findings and identifying areas for improvement, which are then incorporated into the development plan for the following year Governor Working Groups are established to support effective discharge of their duties for example amalgamation of BCH and WHH Constitutions to develop the NCM Constitution in place from 1 April 2026. The membership strategy, originally covering the period 2023–2025, was extended to 2026 to maintain continuity and ensure ongoing alignment with organisational priorities following the formation of the enlarged Trust. Approved in 2023, the strategy remains relevant and provides a strong framework for effective communication and engagement with constituencies, supporting the integration of services and strengthening relationships and involvement with local communities.
C.4.9	The Council of Governors should agree and adopt a clear policy and a fair process for the removal of any Governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with the Governors.	Compliant	Included in Trust's constitution

C.4.10	In addition, it may be appropriate for the process to provide for removal from the Council of Governors if a Governor or group of Governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS Foundation Trust. NHS England's model core constitution suggests that a Governor can be removed by a 75% voting majority; however, Trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable.	Compliant	Constitution details a comprehensive list of reasons why a Governor can be removed.
C.4.10	NHS England can only use its enforcement powers to require a Trust to remove a Governor in very limited circumstances: where it has imposed an additional condition relating to governance in the Trust's licence because the governance of the Trust is such that the Trust would otherwise fail to comply with its licence and the Trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a Trust to remove a Director under its enforcement powers than a Governor.	For information	
C.4.11	The Board of Directors should ensure it retains the necessary skills across its Directors and works with the Council of Governors to ensure there is appropriate succession planning.	Compliant	Succession planning is incorporated in Nominations and Remuneration Committee (EXEC) TOR. Both nomination and remuneration committees (EXEC and NED) receive papers regarding succession planning.
C.4.12	The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of the Trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the Board first completing and approving a full risk assessment.	Compliant	The Nomination & Remuneration Committee agree dates of notice periods as part of their role in agreeing recruitment process and timelines as per the Committee ToR
C.4.13	The Annual Report should describe the work of the Nominations Committee(s), including: ▪ the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline.	Compliant	The annual report describes the work of both nomination and remuneration committees (exec and NED) and

	▪ how the Board has been evaluated, the nature and extent of an external evaluator's contact with the Board of Directors, Governors and individual Directors, the outcomes and actions taken, and how these have or will influence Board composition ▪ the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to Trust strategy, how it has been implemented and progress on achieving the objectives ▪ the ethnic diversity of the Board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the Board reflects the ethnic diversity of the Trust's workforce and communities served ▪ the gender balance of senior management and their direct reports.		appointments/ extensions or personnel changes within the current year. The Annual report includes details of Board diversity and overall workforce profile.

Section D: Audit, Risk and Internal Control

D: Principles			
D.1.1 - The Board of Directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements. D.1.2 – The Board of Directors should present a fair, balanced and understandable assessment of the Trust's position and prospects. D.1.3 – The Board of Directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the Trust is willing to take to achieve its long-term strategic objectives. D.1.4 – Organisations should also refer to ***Audit and assurance: a guide to governance for providers and commissioners***			
Ref	**Code Provisions**	**Trust Position**	**Evidence**
D.2.1	The Board of Directors should establish an Audit Committee of independent Non-Executive Directors, with a minimum membership of three or two in the case of smaller Trusts. The Board of Directors should satisfy itself that at least one member has recent and relevant financial experience. The Committee as a whole should have competence relevant to the sector in which the Trust operates.	Compliant	Audit Committee Terms of Reference – All Non-Executive Director members. The Audit Committee Chair has relevant financial experience.
D.2.1	The Chair of the Board of Directors should not be a member and the Vice Chair or Senior Independent Director should not chair the Audit Committee.	Explain	The Audit Committee is chaired by the Senior Independent Director. This arrangement was agreed by the Board of Directors following consideration of the skills, experience and within the Non-Executive Director cohort. At the time of appointment, the Committee and Board benefited from the individual's significant and recent audit and financial

			governance experience, and the need to maintain continuity and effective oversight during a period of Non Executive Director turnover and organisational change. The Board remains satisfied that the effectiveness and independence of the Audit Committee are not compromised by this arrangement, which is kept under regular review. Succession planning arrangements are in place to ensure future alignment with the Code of Governance.
D.2.2	The main role and responsibilities of the Audit Committee should include: ▪ Monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them ▪ Providing advice (where requested by the Board of Directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; ▪ Reviewing the Trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate Board risk committee composed of independent Directors, or by the board itself; ▪ Monitoring and reviewing the effectiveness of the Trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the Board of Directors	Compliant	The Audit Committee TOR set this out.

	▪ Reviewing and monitoring the external auditor's independence and objectivity ▪ Reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements ▪ Reporting to the Board of Directors on how it has discharged its responsibilities.		
D.2.3	A Trust should change its external audit firm at least every 20 years. Legislation requires an NHS Trust to newly appoint its external auditor at least every five years. An NHS Foundation Trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS Trust becoming a Foundation Trust.	Compliant	External Audit service re-tendered in 2024/25. Contract award approved by Council of Governors.
D.2.4	The Annual Report should include: ▪ The significant issues relating to the financial statements that the Audit Committee considered, and how these issues were addressed. ▪ An explanation of how the Audit Committee has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor, length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans. ▪ An explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Compliant	Included in Annual Report.
D.2.5	Legislation requires an NHS Trust to have a policy on its purchase of non-audit services from its external auditor. An NHS Foundation Trust's Audit Committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	Not applicable at present	The Trust does not procure non-audit services from the external auditor.
D.2.5	The Council of Governors is responsible for appointing the external auditor.	Compliant	Council of Governors approved award of External Audit contract in September 2024
D.2.6	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report & Accounts, and state that they consider the Annual Report & Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	Compliant	Included in Annual Report.

D.2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the Annual Report.	Compliant	Annual Governance Statement.
D.2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the Annual Report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the Annual Governance Statement in the Annual Report.	Compliant	Internal Auditor undertakes an annual review of the core controls in place for Risk Management and reported to the Audit Committee. High Assurance provided for 2024/25. Details of the Trust's risk management and internal controls are included in Annual Governance Statement.
D.2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC Group Accounting Manual and NHS Foundation Trust Annual Reporting Manual, which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	Compliant	Included in the Annual Accounts and Annual Report.

Section E: Remuneration

E: Principles
E.1.1 - Levels of remuneration should be sufficient to attract, retain and motivate Directors of quality, with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's ***Guidance on pay for very senior managers in NHS trusts and foundation trusts.***
E.1.2 – Any performance-related elements of Executive Directors remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS Foundation Trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.
E.1.3 – The Remuneration Committee should decide if a proportion of Executive Directors' remuneration should be linked to corporate and individual performance. The Remuneration Committee should judge where to position its NHS Foundation Trust relative to other NHS Foundation Trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.
E.1.4 – The Remuneration Committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.
E.1.5 – There should be a formal and transparent procedure for developing policy on Executive remuneration and for fixing the remuneration packages of individual Directors. No Director should be involved in deciding their own remuneration.
E.1.6 – The Remuneration Committee should take care to recognise and manage conflicts of interest when receiving views from Executive Directors or senior management or consulting the Chief Executive about its proposals.
E.1.7 – The Remuneration Committee should also be responsible for appointing any independent consultants in respect of Executive Director remuneration.
E.1.8 – Where Executive Directors or senior management are involved in advising or supporting the Remuneration Committee, care should be taken to recognise and avoid conflicts of interest.
E.1.9 – NHS Trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

Ref	Code Provisions	Trust Position	Evidence
E.2.1	Any performance-related elements of Executive Directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. (Provisions to be taken into account by Remuneration Committees when such schemes are in place are detailed in the Code of Governance, Section E.2)	Compliant	All Executive Directors' pay reviewed and scrutinised by the Nominations and Remuneration Committee

E.2.2	Levels of remuneration for the Chair and other Non-Executive Directors should reflect the ***Chair and Non-Executive Director remuneration structure*** (published by NHS England Dec 2019).	Compliant	Levels of Non-Executive remuneration are consistent with the guidance.
E.2.3	Where a trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the Director will retain such earnings.	Not applicable at present.	n/a
E.2.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointment would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing Director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a Director returns to the NHS within the period of any putative notice.	Compliant	The current employment contracts for Directors allows compensation to be reduced to reflect a departing director's obligation to mitigate loss or appropriate claw-back provisions in case of a director returning to the NHS within the period of any putative notice. In addition, earn back is also applied to all directors with a salary over £150,000 up to the value of 10% subject to performance in line with NHS England requirements. The VSM Contract has been reviewed in line with FPPT (November 2023) recommendations and has been utilised with new appoints including Chief Finance Officer and Chief Nurse.
E.2.5	Trusts should discuss any Director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Not applicable at present	n/a
E.2.6	The Board of Directors should establish a Remuneration Committee of independent Non-Executive Directors, with a minimum membership of three. The Remuneration	Compliant	Nomination and Remuneration Committee comprises the Chair and

	Committee should make its Terms of Reference available, explaining its role and the authority delegated to it by the Board of Directors. The Board member with responsibility for HR should sit as an advisor on the Remuneration Committee.		all Non-Executive Directors with the Chief People Officer to provide HR advice and support to the committee.
E.2.6	Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.	Not applicable at present	n/a
E.2.7	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments.	Compliant	Incorporated in Nomination and Remuneration Committee (Execs) Terms of Reference.
E.2.7	The Remuneration Committee should also recommend and monitor the level and structure of remuneration for senior management. The Board should define senior management for this purpose and this should normally include the first layer of management below Board level.	Compliant	The Nomination & Remuneration Committee review VSM annually. The level below this is governed through Agenda for Change.

Appendix B: Council of Governors

Appendix B: Principles
1.1 – The powers and obligations of Governors of NHS foundation trusts are set out in the 2006 Act as amended by the 2012 Act. Appendix B describes the relevant areas of the Governors' role. In addition, ***Your statutory duties: A reference guide for NHS foundation trust governors*** (August 2013) examines how Governors can deliver their duties and an addendum to this document, ***System working and collaboration: The role of foundation trust Councils of Governors*** (October 2022) clarifies how Governors can continue to perform their duties within the context of system working. 1.2 - The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust. 1.3 - The Council of Governors is responsible for representing the interests of NHS foundation trust members, the public at large and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct. 1.4 – To discharge their duty to represent the public, Councils of Governors are required to take account of the interests of the public at large. This includes the population of the local system of which the Trust is part and the whole population of England as served by the wider NHS. 1.5 - Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members, the public at large and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty. 1.6 - Governors should discuss and agree with the Board of Directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice. 1.7 - Governors should work closely with the Board of Directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan. 1.8 - Governors should use their voting rights to hold Non-Executive Directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the Council of Governors does withhold consent for a major decision, it must justify its reasons to the Chair and the other Non-Executive Directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The Council of Governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

Ref	Code Provisions	Trust Position	Evidence
2.1	The Council of Governors should meet sufficiently regularly to discharge its duties. Typically the Council of Governors would be expected to meet as a full Council at least four times a year. Governors should make every effort to attend the meetings	Compliant	Incorporated in the Constitution.

	of the Council of Governors. The NHS Foundation Trust should take appropriate steps to facilitate attendance.		The CoG met on 4 occasions in 2023/24 with an additional working parties to support Governors in place. Attendance reported at each meeting to the CoG.
2.2	The Council of Governors should not be so large as to be unwieldy. The Council of Governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the Council of Governors should be reviewed regularly.	Compliant	The CoG comprises of 31 members plus Chair. The composition of the Council was most recently reviewed when the current constitution was drafted and ratified, this constitution was effective from April 2026 Composition is considered when elections take place.
2.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments.	Compliant	Included in Annual Report.
2.3	The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.	Compliant	Annual Report. Records of attendance held and reported to each meeting of the CoG.
2.4	The roles and responsibilities of the Council of Governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the Council of Governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Compliant	The Role of Governor is included in induction presentations given to new Governors and is included within the Governors Handbook. The Council of Governors Standing Orders form part of the Trust Constitution
2.5	The Chair is responsible for leadership of both the Board of Directors and the Council of Governors but the Governors also have a responsibility to make the	Compliant	The Chief Executive, Executive Directors and Non-Executive

	arrangements work and should take the lead in inviting the Chief Executive and other Executives and Non-Executives, as appropriate, to their meetings. In these meetings other members of the Council of Governors may ask the Chair or their deputy, or any other relevant Director present at the meeting, questions about the affairs of the NHS Foundation Trust.		Directors routinely attend Council meetings. Governors meet to agree the agenda for the Council of Governor meetings. The agenda includes a standing item for Governor questions for which Executive Directors routinely attend to provide a response alongside the Non-Executive Directors.
2.6	The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners.	Compliant	Policy for raising serious concerns included within the Annex 6 (section 9) of the Constitution.
2.6	The Council of Governors should input to the Board's appointment of a Senior Independent Director.	Compliant	The Board proposal for a new SID was approved through the CoG.
2.7	The Council of Governors should ensure its interaction and relationship with the Board of Directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Compliant	CoG Cycle of Business in place and formal calendar of meetings agreed and in place. Monthly Q&A session with the Chair in place CoG development sessions/ Working parties in place.
2.8	The Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board of Directors. The Council should raise any issues with the Chair or with the Senior Independent Director in the first instance.	Compliant	The Trust Constitution along with the Board Standing Orders details the process for removal of the Chairperson or other Non-Executive Directors.
2.9	The Council of Governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	Compliant	Agreed meeting Cycle of Business in place.

			Reports include Committee Assurance Reports. Strategy updates, Chair & Chief Executive Reports and complaints reports. Monthly Q&A with the Chair of the Trust. Governors observe Board Committees Lead Governor observes private Board Meetings. Assessment completed to ensure compliance with Addendum for Governors.
2.10	The Chair (and the Senior Independent Director and other Directors as appropriate) should maintain regular contact with the Governors to understand their issues and concerns.	Compliant	All NEDs routinely attend Council meetings. Executive Directors attend the CoG as required. Monthly Q&A with the Chair of the Trust.
2.11	Governors should seek the views of members and the public on material issues or changes being discussed by the Trust. Governors should provide information and feedback to members and the public at large regarding the Trust, its vision, performance and material strategic proposals made by the Trust Board.	Compliant	Governor and membership arrangements well established including the Governor Engagement Group New Membership Strategy agreed and implemented in 2023. Annual General Meeting in place at which Governors held a 'Marketplace' to engage with members and the public.

2.12	It is incumbent on the Board of Directors to ensure Governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	Compliant	Governor and membership arrangements well established. New Membership strategy approved in 2023. Governors observe Board Committees and submit written reports to the CoG. Governor Engagement Group in place. Monthly Q&A with the Chair of the Trust.
2.13	The Chair should ensure that the views of Governors and members are communicated to the Board as a whole. The Chair should discuss the affairs of the NHS Foundation Trust with Governors. Non-Executive Directors should be offered the opportunity to attend meetings with Governors and should expect to attend them if requested to do so by Governors. The Senior Independent Director should attend sufficient meetings with Governors to hear their views and develop a balanced understanding of their issues and concerns.	Compliant	The Chair will communicate views accordingly as part of the Chair's Report to Board. Non-Executive Directors, including the SID, are routinely in attendance at Council meetings to hear Governors' views. Monthly Q&A with the Chair of the Trust.
2.14	The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between Governors and members from its constituencies. Contact procedures for members who wish to communicate with Governors and/or Directors should be clear and made available to members on the Trust's website and in the annual report.	Compliant	Contact procedures publicly available via Trust website, Annual Report and Newsletters. Members matters regular produced. Governor Engagement Group in place.
2.15	The Board of Directors should state in the annual report the steps it has taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, e.g. through attendance at meetings of the Council of	Compliant	Included in Annual Report.

	Governors, direct face-to-face contact, surveys of members' opinions and consultations.		
3.1	The Council of Governors has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.	Compliant	As set out in the Trust Constitution.
3.2	The 2006 Act, as amended, gives the Council of Governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS Foundation Trust Annual Reporting Manual: A) The annual accounts; B) Any report of the auditor on them; and C) The annual report	Compliant	Annual Report & Accounts published having been laid before Parliament. Documents received by the COG and presented at the Annual Members meeting.
3.3	The Directors must provide Governors with an agenda prior to any meeting of the Board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of Board meetings should be exempted from being shared with the Governors. In practice, it may be necessary to redact some information, e.g. for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	Compliant	Agendas and minutes included in Board papers published on the Trust's website. Governors are encouraged to attend public Board meetings. The Lead Governor observes the Private Board Meetings and provides a report to the CoG.
3.4	The Council of Governors may require one or more of the Directors to attend a meeting to obtain information about the Trust's performance of its functions or the Directors' performance of their duties, and to help the Council of Governors decide whether to propose a vote on the Trust's or Directors' performance.	Compliant	Directors regularly attend the COG meetings as required. Governors meet to agree the agenda for the Council of Governor meetings. The agenda includes a standing item for Governor questions for which Executive Directors routinely attend to provide a response alongside the Non-Executive Directors.
3.5	Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the Board of Directors. These voting powers require:	Partial Compliance	Included in the Constitution See 48 – amendments to constitution

	▪ More than half the members of the Board of Directors who vote and more than half the members of the Council of Governors who vote to approve a change to the Constitution of the NHS foundation trust. ▪ More than half the Governors who vote to approve a significant transaction. ▪ More than half the Governors to approve an application by a trust for a merger, acquisition, separation or dissolution. ▪ More than half the Governors who vote to approve any proposal to increase the proportion of the Trust's income earned from non-NHS work by 5% a year or more. For example, Governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the Trust's total income. ▪ Governors to determine together whether the Trust's non-NHS work will significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.		See 49 - mergers etc and significant transactions
3.6	NHS Foundation Trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the Trust's Constitution. Alternatively, with the agreement of the Governors, Trusts may choose not to give a definition, but this would need to be stated in the Constitution.	Compliant	see 29 – NCM Constitution
3.7	In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, Governors need to be assured that the process undertaken by the Board was appropriate, and that the interests of the public at large were considered. A Council may disagree with the merits of a particular decision of the Board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken.	Compliant	See 49 NCM Constitution
3.8	The external auditors of a Foundation Trust must be appointed or removed by the Council of Governors at a general meeting of the Council.	Compliant	Appointment of external auditors approved by COG in September 2026

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/057(ii)**			
Subject:	**Provider Licence**			
Date of meeting:	5 August 2026			
Action required:	**Approval**			
Author(s):	Jan McCartney – Deputy director of corporate governance			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	As part of the annual governance cycle, the Trust is required to undertake self-certification against the conditions of the NHS Provider Licence. This process provides formal assurance that the Trust is complying with the licence conditions and exercising its statutory functions in accordance with the terms of its provider licence and relevant legislation. Where full compliance cannot be confirmed, the Trust is required to explain the reason for non-compliance and to agree a proportionate action plan setting out how compliance will be achieved. This report, together with its supporting appendices, presents the outcome of the Trust's annual assessment and provides contextual information and sources of assurance to support the Board with the self-certification.			

<table>
<tr><td></td><td colspan="3">During the annual self-certification process, the Board will confirm its compliance with the relevant conditions of the NHS Provider Licence, as set out in the body of the report and detailed within the supporting appendices.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Board is asked to:

1. note the outcome of the Trust's annual self-assessment against the relevant requirements of the NHS Provider Licence, as set out in this report and the supporting compliance review; and

2. endorse the proposed CoS7 declaration and accompanying narrative recommended from the Audit Committee.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Audit Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">AC/26/06/037</td></tr>
<tr><td>Date of meeting</td><td colspan="2">22 June 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">The committee agreed to recommend the declaration to the Board</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

NHS England is responsible for overseeing compliance with the NHS Provider Licence, which forms part of the regulatory and oversight framework for NHS providers. The licence sets out the conditions that providers of NHS funded services must meet to support the delivery of safe, effective, sustainable and well governed services.

The Trust is required to hold a provider licence and, as part of its annual governance cycle, to review its arrangements against the relevant licence conditions and confirm compliance where applicable. This provides a structured assessment of whether the Trust is operating in accordance with the terms of its licence and the relevant statutory and regulatory framework.

The NHS Provider Licence was updated in April 2023 to reflect legislative and policy changes, including the Health and Care Act 2022, and to strengthen expectations in relation to system working, the triple aim, health inequalities and climate change.

Where the Trust identifies that full compliance cannot be confirmed, the position should be explained and supported by proportionate actions to address the relevant issue through established governance arrangements

2. The Self-certification requirements

Since 2024, the requirement for self-certification, in relation to General Condition 6 and Corporate Governance Statement FT4, were removed within the new licence to reduce duplication with other reporting mechanisms and oversight arrangements incorporated in the NHS Oversight Framework, Annual Report and Annual Governance Statement.

The Trust is required to make a self-certification with regards to 'Continuity of Services 7 - Availability of Resources' which requires all NHS Providers of Commissioner requested services (CRS) to self-certify that they have the required resources available to continue delivering essential services for the next 12 months.

Whilst there is no requirement for the Trust to submit the Self-Certification to NHSE, the Trust is required to make the Self-Certification public on its website.

3. Continuity of Services 7 (CoS7) – Availability of Resources

An NHS Foundation Trust is required at all times to act in a manner calculated to secure that it has, or has access to, the required resources. Under CoS7, the Board of Directors must determine which of the prescribed statements should be confirmed and provide a statement of the factors taken into account in making that declaration.

The three statement options are:

1a
"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

1b
"After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".

1c
"In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

The Board is therefore required to determine which CoS7 statement should be confirmed. Statement 1a represents an unqualified confirmation that, having made appropriate enquiries, the Board has a reasonable expectation that the Trust will have the required resources available for the relevant 12-month period. Statement 1b provides a qualified confirmation where the Board wishes to draw attention to factors that may cast doubt on the Trust's ability to continue to provide Commissioner Requested Services. Statement 1c would indicate that, in the opinion of the Board, the Trust will not have the required resources available.

Having considered the available evidence and assurance, it is proposed that the Board confirm **statement 1a**. In reaching this view, the Board may properly take account of the Trust's financial position, operational performance, cash position, capital programme, going concern assessment and the assurance received through Board, Committee, system and NHS England oversight arrangements. The Board may also take account of the enforcement undertakings accepted in February 2026 and the arrangements in place to oversee delivery of the actions arising from them through established governance and reporting routes.

The Trust's current position does not support statement 1c. The Trust continues to operate with established governance arrangements, regular reporting to the Executive, Board and Committees, and continuing oversight through NHS England and system processes. The enforcement undertakings remain an important part of the

context considered by the Board, but the Board is also able to take account of the monitoring and oversight arrangements in place, together with progress reported against the undertakings and the controls supporting the Trust's financial and operational management.

On that basis, it is considered that statement 1a can be supported, provided the Board is satisfied that, having made appropriate enquiries, it has a reasonable expectation that the Trust will have the required resources available to continue to provide Commissioner Requested Services for the relevant 12 month period.

Proposed narrative for inclusion in the CoS7 template

In making this declaration, the Board has considered the Trust's financial position, operational performance, cash position, capital programme, going concern assessment, and the assurance received through Board, Committee, system and NHS England oversight arrangements.

The Board has also taken account of the enforcement undertakings accepted by the Trust in February 2026 and the arrangements in place to oversee delivery of the actions arising from them, including regular reporting and review through established governance and oversight processes.

In reaching its view, the Board has considered the controls and monitoring arrangements in place in relation to financial performance, forecast outturn, capital and cash, together with the assurance available through regular Executive, Committee, Board, system and NHS England oversight.

Having made appropriate enquiries, the Directors have a reasonable expectation that the Trust will have the required resources available to continue to provide Commissioner Requested Services for the relevant 12 month period.

4. Recommendations

The Board is asked to endorse the Audit Committee's recommendation to:

1. note the outcome of the Trust's annual self-assessment against the relevant requirements of the NHS Provider Licence, as set out in this report and the supporting compliance review; and
2. approve the proposed CoS7 declaration and accompanying narrative for submission

Appendix 1 – Provider Licence conditions

Appendix 2 – Self Certification for 2026-27

North Cheshire and Mersey
NHS Foundation Trust

Appendix 1

Condition	Summary / Description	Accountability	Context / Comments	Action Required
Section 1 : Integrated Care				
IC1: Provision of Integrated care	1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i) is integrated with the provision of such services by others, and ii) is integrated with the provision of health-related services or social care services by others and iii) enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph	Chief Strategy and Partnerships Officer / Chief Finance Officer	North Cheshire and Mersey NHS Trust acts in the interests of patients, service users and local communities by delivering integrated, person-centred care across acute, community and out-of-hospital services. As a newly established organisation formed through the merger of Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust, the Trust is well placed to support seamless care pathways and coordinated service delivery. The Trust works collaboratively with NHS providers, primary care, local authorities, mental health services, ambulance services and voluntary sector partners across the Cheshire and Merseyside Integrated Care System (ICS). Through shared care pathways, multidisciplinary working, integrated discharge arrangements and effective information sharing, the Trust seeks to ensure that care is coordinated and delivered in the most appropriate	As Required

North Cheshire and Mersey
NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
			setting. The Trust is committed to integrating health, health-related and social care services, and to cooperating with other NHS providers where this improves patient outcomes, experience, service quality and the efficient use of resources. The Trust actively participates in provider collaboratives, place-based partnerships and system-wide initiatives to support the delivery of joined-up, sustainable care for the populations it serves.	
	2. The objectives are: a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b. reducing inequalities between persons with respect to their ability to access those services, and c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services	Chief Strategy and Partnerships Officer	The Trust is committed to improving the quality, safety and effectiveness of the NHS services it provides and the outcomes achieved for patients through continuous quality improvement, innovation and service transformation. The Trust seeks to deliver efficient and sustainable services by optimising care pathways, reducing unwarranted variation and making effective use of resources. The Trust is committed to reducing inequalities in access to healthcare services by identifying and addressing barriers to care, targeting support to underserved communities and ensuring services are responsive to the diverse	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
			needs of the population it serves. The Trust also seeks to reduce inequalities in health outcomes through the use of population health intelligence, evidence-based interventions and continuous monitoring of outcomes, ensuring that all patients have equitable opportunities to achieve the best possible health outcomes.	
	3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.	Chief Strategy and Partnerships Officer	As above	As Required
	4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests	Chief Strategy and Partnerships Officer /Chief Finance Officer	Noted	As Required
IC2: Personalised Care and Patient Choice	1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.	Chief Operating Officer	The Trust uses a personalised care approach to all patients which aligns to the national shared decision-making principles	As Required
	2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.	Chief Operating Officer	As per the above	As Required
	3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a	Chief Operating Officer	Choice of provider is determined by the GP and information about the Trust is	As Required

North Cheshire and Mersey
NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.		available via NHS Choices.	
	4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	Chief Operating Officer	Acknowledged.	
	5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.	Chief Operating Officer	Acknowledged	
	6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	Chief Finance Officer	The Trust will comply in accordance with the Standards of Business Conduct, Standing Financial Instructions and bribery policy. These documents are reviewed annually.	
Section 2 – Trusts Working in Systems				
WS1: Cooperation	1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	Chief Executive Officer	Noted	
	2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.	Chief Executive Officer/ Chief Strategy and Partnerships Officer	The Trust recognises and fulfils its statutory duty to cooperate with NHS bodies and local authorities in the planning, commissioning and delivery of	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
			services. The Trust works collaboratively with the Cheshire and Merseyside Integrated Care Board, NHS providers, primary care partners, Warrington Borough Council and Halton Borough Council to improve population health, enhance service quality and ensure the effective use of resources. The Trust actively participates in Integrated Care System (ICS) governance arrangements, place-based partnerships and joint programmes of work, supporting the development and delivery of integrated services that meet the needs of local communities. Through these arrangements, the Trust promotes coordinated care, shared decision-making and collaborative approaches to addressing health and care challenges across Warrington, Halton and the wider Cheshire and Merseyside system.	
	3. Without prejudice to the generality of paragraph 2, the Licensee shall: a. consistently co-operate with: • other providers of NHS services; and • other NHS bodies, including any Integrated Care Board of which it is a partner; i. as necessary and appropriate for the purposes of developing and delivering system plan(s).	Chief Finance Officer/ Chief Operating Officer/ Chief People Officer	The Trust is committed to working with system partners to develop and deliver a financial strategy to recover the position. The Trust provides operational, financial and strategic support to other C&M providers.	As Required

North Cheshire and Mersey
NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans b. consistently co-operate with: • other providers of NHS services; • other NHS bodies, including any Integrated Care Board of which it is a partner; and • any relevant local authority in England i. as necessary and appropriate for the purposes of delivering NHS services. ii. as necessary and appropriate for the purposes of improving NHS services.		The Trust has contributed to the delivery of C&M financial strategic objectives.	
	4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: 8 | NHS provider licence a. the Secretary of State for Health and Social Care; or b. NHS England. For the purposes of this condition, cooperation is considered synonymous to collaboration.	Chief Executive Officer	Noted	
WS2: The Triple Aim	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	Chief Executive Officer	Noted	
	2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.	Chief Strategy and Partnerships Officer	Noted	

North Cheshire and Mersey
NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.	Chief Strategy and Partnerships Officer	The strategic objectives of the North Cheshire and Mersey NHS Foundation Trust focus on three key areas: • Quality: Ensuring safe and effective care and an excellent patient experience. • People: Creating a diverse and engaged workforce that is fit for the future. • Sustainability: Working in partnership to achieve social and economic wellbeing in communities	
	4. In this condition, “the triple aim” refers to the aim of achieving: a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c. more sustainable and efficient use of resources by NHS bodies, and “duty relating to the triple aim” means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	Chief Strategy and Partnerships Officer	As above	
WS3: Digital Transformation	1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.	Medical Director	Noted.	
	2. The Licensee shall comply with information	Medical Director	Acknowledged and the Trust are	

North Cheshire and Mersey NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).		committed to complying with the information standards as and when they are published. NCM collaborates regionally and nationally with other NHS bodies and shares information in the interest of the NHS and its patients.	
	3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	Medical Director	The Trust acknowledges and is fully compliant with digital maturity assessments and standards as and when they are published.	
Section 3: General Conditions				
G1: Provision of information	1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition	Chief Executive Officer	Noted	
	2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.	Chief Executive Officer	Noted	
	3. The Licensee shall take all reasonable steps to ensure that information is: a. in the case of information or a report, it is accurate, complete and not misleading; b. in the case of a document, it is a true copy of the document requested.	Chief Executive Officer	Noted	
	4. This Condition shall not require the Licensee to provide any information which it could not be	Chief Executive Officer	Noted	

North Cheshire and Mersey NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.			
G2: Publication of information	1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.	Chief Executive Officer	Noted	
	2. For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals.	Chief Executive Officer / Chief Finance Officer	Noted	
G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)	1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.	Company Secretary	The Trust constitution sets the criteria for a fit and proper person. The Council has the power to remove a Governor due to certain criteria set out in the constitution. All Governors are required to complete an annual declaration. Compliance with this requirement is reported to the Council of Governors.	
	2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit	Chair (SID in case of the Chair)/	Fit and Proper Persons policy is in place to formalise and ensure adequate	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	and proper.	Company Secretary	checks are maintained on existing directors and new appointments to the Board. Annual review by Chair. FPPT completion reported to Board. FPPT process audited by internal audit (MIAA) – substantial assurance	
	3. For the purposes of paragraph 2, a person is not fit and proper if that person is: a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b. an organisation which is a body corporate, or a body corporate with a parent body corporate: i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986; 14 | NHS provider licence iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking; iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; v. which passes any resolution for winding up;	Chair (SID in case of the Chair)/ Company Secretary	Fit and Proper Persons policy and process are in place to formalise and ensure adequate checks are maintained on existing directors and new appointments to the Board. Annual review by Chair. FPPT completion reported to Board and NHS England.	

North Cheshire and Mersey NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	vi. which becomes subject to an order of a Court for winding up; or vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.			
G4: NHS England guidance	1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.	Company Secretary	Acknowledged – All guidance issued by NHSE is reviewed and any mandatory recommendations implemented promptly.	
	2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	Chief Executive Officer	Noted	
G5: Systems for compliance with licence conditions and related obligations	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: a. the Conditions of this Licence, b. any requirements imposed on it under the NHS Acts, and c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	Chief Executive/	The Trust: (a) Reviews the provider licence on an annual basis and take into account its conditions within the Board Assurance Framework and risk processes (b) Assess as and when a provision of the NHS Act arises (c) Completed an annual review against the NHS constitution.	
	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b. regular review of whether those processes and systems have been implemented and of their effectiveness.	Chief Nurse / Company Secretary	The Trust has a Risk Management Policy that provides a framework for managing risk across the Trust. Real time assessment of the risks and mitigation at all levels within the Trust are reviewed within the Governance Structure.	

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			Independent Assurance is provided by the Trust's internal and external auditors. Strategic risk review and risk appetite statement set by the Board.	
G6: Registration with the Care Quality Commission	1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.	Chief Nurse	Acknowledged - The Trust has its services registered with CQC in order to be lawfully able to provide authorised services.	
	2. The Licensee shall notify NHS England promptly of: a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	Chief Nurse	Acknowledged - The Trust would comply with this requirement.	
	3. A notification given by the Licensee for the purposes of paragraph 2 shall: a. be made within 7 days of: i. the making of an application in the case of paragraph (a), or ii. becoming aware of the cancellation in the case of paragraph (b), and b. contain an explanation of the reasons (in so far as they are known to the Licensee) for: i. the making of an application in the case of paragraph (a), or ii. the cancellation in the case of paragraph (b).	Chief Nurse	Acknowledged - The Trust would comply with this requirement.	
G7: Patient eligibility and selection criteria	1. The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom	Chief Operating Officer	The Trust applies the NHS Contractual (Service Conditions) position in terms of the acceptance of referrals.	

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	to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them			
	2. "Eligibility and selection criteria" means criteria for determining: a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b. if the person is selected, the manner in which the services are provided to the person.	Chief Operating Officer	As above	
G8: Application of section 6 (Continuity of Service)	1. The Conditions in Section 6 shall apply: a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service, b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2, c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension), d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service), e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider	Chief Finance Officer	Noted	
	2. A service is designated as a Commissioner Requested Service if: a. it is a service which the Licensee is required to	Chief Finance Officer	Noted	

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	provide to a Commissioner under the terms of a contract which has been entered into between them, and b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.			
	3. A notice in accordance with this paragraph is a notice: a. in writing, b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.	Chief Finance Officer	Noted	
	4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable	Chief Finance Officer	Noted	
	5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a	Chief Finance Officer	Noted	

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	Commissioner for which no extension or renewal has been agreed.			
	6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either: a. an instruction of the sort referred to in paragraph 7, or b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.	Chief Finance Officer	Noted	
	7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.	Chief Finance Officer	Noted	
	8. A service shall cease to be a Commissioner Requested Service if: a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or b. NHS England has issued a determination in writing that the service is no longer a Commissioner	Chief Finance Officer	Noted	

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	Requested Service; or c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.			
	9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.	Chief Finance Officer	Noted	
	10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.	Chief Finance Officer	Noted	
	11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.	Chief Finance Officer	Noted	
	12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.	Chief Finance Officer	Noted	
	13. In this Condition “NHS contract” has the meaning	Chief Finance	Noted	

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	given to that term in Section 9 of the 2006 Act.	Officer		
Section 4 – Trust Conditions				
NHS1: Information to update the register	1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	Chief Finance Officer	Noted	
	2. The Licensee shall make available to NHS England written and electronic copies of the following documents: a. the current version of Licensee's constitution; b. the Licensee's most recently published annual accounts and any report of the auditor on them, and c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.	Chief Finance Officer / Company Secretary	All documents are also available on the trust's internet	
	3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee	Chief Finance Officer / Company Secretary	Noted	
	4. The obligation in paragraph 3 shall not apply to: a. any document provided pursuant to paragraph 2; b. any document originating from NHS England; or c. any document required by law to be provided to NHS England by another person.	Chief Finance Officer / Company Secretary	Noted	

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	5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.	Chief Finance Officer / Company Secretary	Noted – The Trust will continue to follow guidance issued by NHSE.	
	6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	Chief Finance Officer / Company Secretary	Noted	
NHS2: Governance arrangements	1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	Company Secretary	Noted	
	2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	Company Secretary	Corporate governance arrangements set out within the Constitution. The Corporate Governance Manual is a comprehensive suite of governance documents and this is reviewed annually and changes approved through the Audit Committee	
	3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate	Chief Operating Officer / Chief Strategy and Partnerships Officer	The Trust has governance and control arrangements in place to support compliance with the relevant licence requirements and to enable ongoing review and improvement where needed Any guidance issues via NHS England is reported, actioned and monitored through these governance mechanisms.	

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	change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.			
	4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation.	Chief Executive / Chair/ Company Secretary	Clear Committee organogram in place and each committee has an approved TOR and workplan. Committee mapping exercise and extensive review of Committee effectiveness completed in 2025/26 Clear structures, with clinical leadership and accountability throughout the organisation.	.
	5. The Licensee shall establish and effectively implement systems and/or processes: a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or	Chief Executive / Chief Finance Officer / Chief Nurse	This condition is directly relevant to the enforcement undertakings accepted in February 2026, which identified concerns in relation to financial governance, Board oversight, financial management, compliance with healthcare standards, risk management and business planning. The Trust has strengthened its governance and reporting arrangements in these areas, including controls over expenditure decisions, escalation routes, performance oversight and regular review through Board, Committee and NHS England oversight processes. These arrangements provide supporting assurance; however, this remains an	Ongoing monitoring through the undertakings governance process, with evidence of progress reported through Board and Audit Committee oversight

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	processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements.		area of ongoing monitoring and improvement until the undertakings are fully discharged * These arrangements should be read in the context of the enforcement undertakings accepted in February 2026 and the related improvement and oversight processes now in place	
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with	Chief Executive / Chair/ Director of Nursing, Quality and Safety	Annual appraisals and reviews of Board / Committee effectiveness. Quality Impact assessments of CIPs. Escalation of reporting embedded in the Trust. Systems and structures in place to allow for escalation to the Board as required.	

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	patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.			
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	Chief Executive	This condition is relevant to the February 2026 enforcement undertakings. The Trust keeps Board and senior leadership capacity, capability and succession arrangements under review, including consideration of skills, leadership coverage and effectiveness through appropriate governance processes. This provides assurance that arrangements are in place to support compliance with licence conditions; however, this remains an area for continued review as part of the undertakings and wider governance improvement programme	Continue review of Board and senior leadership capacity, capability and succession through established governance arrangements, with progress reflected through the undertakings assurance process where relevant.
Section 5 – NHS Controlled Providers Conditions				
CP1: Governance arrangements for NHS-controlled providers	1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.	N/A	N/A	
	2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.	N/A	N/A	

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	3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d. comply with the following paragraphs of this Condition.	N/A	N/A	
	4. The Licensee shall establish and implement: a. effective board and committee structures; b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).	N/A	N/A	
	5. The Licensee shall establish and effectively implement systems and/or processes: a. to operate efficiently, economically and effectively; 27 | NHS provider licence b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	N/A	N/A	

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	c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. to ensure compliance with all applicable legal requirements			
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care	N/A	N/A	

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	considerations; c. the collection of accurate, comprehensive, timely and up to date information on quality of care; d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and 28 | NHS provider licence f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.			
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	N/A	N/A	
Section 6 – Continuity of Services				
Section 6 – Continuity of Services	1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.	Chief Finance Officer	Amendment to Service Specifications would be in accordance with commissioner agreement prior to variation of the contract.	
	2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this	Chief Finance Officer	As above	

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	condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.			
	3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except: a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.	Chief Finance Officer	As above	
	4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.	Chief Finance Officer	Noted	

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	5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in: a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	Chief Finance Officer	Noted	
CoS 2: Restriction of the disposal of assets	1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	Chief Finance Officer	The Trust maintains an asset register, and this is independently audited as required	
	2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	Chief Finance Officer	As above	
	3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	Chief Finance Officer	As above	
	4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the	Chief Finance Officer	Acknowledged	

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	ability of the Licensee to carry on as a going concern.			
	5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a. with the consent in writing of NHS England, and b. in accordance with the paragraphs 6 to 8 of this Condition.	Chief Finance Officer	Noted	
	6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	Chief Finance Officer	Noted	
	7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	Chief Finance Officer	See 5 above	
	8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i. transactions of a specified description; or ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.	Chief Finance Officer	See 5 above	
	9. In this Condition: "disposal" means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease,	Chief Finance Officer	Noted	

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	licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly; "relevant asset" means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced; "relinquishment of control" includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.			
	10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding: a. the manner in which asset registers should be established, maintained and updated, and b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested	Chief Finance Officer	Acknowledged – The Trust will have regard for any guidance provided by NHSE.	

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	Services should be regarded as materially prejudiced			
CoS 3: Standards of corporate governance, financial management and quality governance	1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.	Chief Finance Officer	This condition is directly relevant to the enforcement undertakings accepted in February 2026, which identified concerns in relation to financial governance and the adequacy of systems and standards of corporate governance and financial management. The Trust has governance and oversight arrangements in place to monitor compliance with funding conditions, financial performance, recovery actions and related reporting requirements. In addition, the recent MIAA Workforce CIP Governance Review Final Report, commissioned by the Trust, found that formal governance arrangements were in place throughout 2025/26 and that workforce delivery risks, financial pressures and recurrent savings challenges were visible through existing governance routes. The review also identified that arrangements now need to be more integrated, forward looking and operationally actionable to support delivery of recurrent workforce transformation. These matters are relevant to the ongoing strengthening of governance, financial management and delivery assurance arrangements and remain subject to continued oversight through the undertakings and wider governance framework	Continued monitoring through the undertakings governance process, with relevant management actions arising from the recent MIAA Workforce CIP Governance Review incorporated into the wider governance improvement and assurance framework

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			The Trust continues to comply with reporting requirements in relation to support financing and wider NHS England oversight, including routine returns and structured assurance discussions. The findings of the recent MIAA Workforce Governance Review also provide relevant evidence that governance routes were established and that key risks were visible, while highlighting the need for further development in governance integration, accountability, triangulation and delivery confidence. The Trust is taking these findings forward through management actions and ongoing oversight arrangements.	
	2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	Chief Finance Officer	The Trust will comply with all reporting requirements issued by NHS England in relation to support financing. This includes the timely submission of required financial returns, participation in regular assurance and oversight meetings, and provision of updates on financial performance, recovery actions and delivery against plan. Reporting has been undertaken through established mechanisms, including routine submissions, ad hoc requests and structured engagement with NHS England through formal oversight arrangements	

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CoS 4: Undertaking from the ultimate controller	1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.	Chief Finance Officer	Noted	
	2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	Chief Finance Officer	Noted	
	3. The Licensee shall: a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;	Chief Finance Officer	Noted	

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	b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c. comply with any request which may be made by NHS England to enforce any such undertaking.			
	4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others	Chief Finance Officer	Noted	
	5. A person is not an ultimate controller if they are: a. a health service body, within the meaning of section 9 of the 2006 Act; b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d. a trustee of the Licensee and the Licensee is a charity.	Chief Finance Officer	Noted	
CoS 5: Risk pool levy	1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by	Chief Finance Officer	Noted	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.			
	2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	Chief Finance Officer	Noted	
CoS 6: Cooperation in the event of financial or quality stress	1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c. the ability of the Licensee to carry on as a going concern.	Chief Executive Officer/ Chief Finance Officer/ Chief Nurse	Noted	
	2. When this paragraph applies the Licensee shall: a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	Chief Executive Officer	Noted: The Trust would respond as required.	
CoS 7: Availability of resources	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	Chief Finance Officer	Noted	

North Cheshire and Mersey
NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee	Chief Finance Officer	Noted	
	3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the	Chief Finance Officer	As required	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	period of 12 months referred to in this certificate".			
	4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	Chief Finance Officer	Noted	
	5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	Chief Finance Officer	As required	
	6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.	Chief Finance Officer	Noted	
	7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	Chief Finance Officer/ Company Secretary	Noted	Publication of the certificate to be made available on the Trust's Website.
	8. In this Condition: "distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; "Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts; "Required Resources" means such: a. management resources including clinical leadership, b. appropriate and accurate information pertinent to the governance of quality c. financial resources and financial facilities, d. personnel,	Chief Finance Officer	Noted	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	e. physical and other assets including rights, licences and consents relating to their use, f. subcontracts , and g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.			
Section 7 – Costing Conditions				
C1: Submission of costing information	1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	Chief Finance Officer	Acknowledged and the Trust has established financial systems, independently audited.	
	2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.	Chief Finance Officer	The Trust is compliant with the NHSE costing guidance.	
	3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:	Chief Finance Officer/ Chief Operating Officer	For sub-contracted services the Trust will have service level agreements/ contracts in place which would adhere to the requirements and adhere to standard contract guidelines.	

North Cheshire and Mersey NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b. provides that information to NHS England in a timely manner			
	4. Records required to be maintained by this Condition shall be kept for not less than six years.	Chief Finance Officer	Noted	
	5.In this Condition: "the Approved Guidance" means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England. "other relevant information" means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.	Chief Finance Officer	Noted	
C2: Provision of costing and costing related information	1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.	Chief Finance Officer	Noted	
	2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a. in the case of information (data) or a report, it is accurate,	Chief Finance Officer	Acknowledged - The Trust would provide information as a 'true and fair view', applying recommended accounting policies.	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	complete and not misleading; b. in the case of a document, it is a true copy of the document requested;			
	3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	Chief Finance Officer	Noted	
C3: Assuring the accuracy of pricing and costing information	1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.	Chief Finance Officer	Noted	
	2. This may include but is not limited to a. Regular assessments by the providers internal and/or external auditor b. specific work by NHS England or NHS England nominated representative on costing related issues and c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	Chief Finance Officer	Noted	
Section 8 – Pricing Conditions				
P1: Compliance	1. Except as approved in writing by NHS England,	Chief Finance	Noted – the Trust complies with the	

North Cheshire and Mersey NHS Foundation Trust

Condition	Summary / Description	Accountability	Context / Comments	Action Required
with the NHS payment scheme	the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.	Officer	NHS Payment Scheme	
Section 9 – Interpretation and Definitions				
Condition D1: Interpretation and Definitions	1.In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table. "the 2006 Act" - the National Health Service Act 2006 c.41; "the 2008 Act" - the Health and Social Care Act 2008 c.14; "the 2009 Act" - the Health Act 2009 c.21; "the 2012 Act" - the Health and Social Care Act 2012 c.7; "the 2022 Act" - The Health and Care Act 2022; "the Care Quality Commission" - the Care Quality Commission established under section 1 of the 2008 Act; "Commissioner Requested Service" - a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition; "Commissioners" - NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB; "Director" - includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a	Company Secretary	Noted	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	company constituted under the Companies Act 2006; "Governor" - a Governor of an NHS foundation trust; "Hard to replace provider" - has the meaning given in condition G8 of the licence; "Integrated Care Board" - a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act; "the NHS Acts" - the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act; NHS Controlled provider - An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10; "NHS England" - the body named as NHS England in section 1 of the 2022 Act; "NHS foundation trust" - a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act; "NHS Trust" - an NHS trust established under section 25 of the 2006 Act; "Relevant bodies" - NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act; "Trusts" - means NHS foundation trusts and NHS trusts.			
	2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.	Company Secretary	Noted	
	3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.	Company Secretary	Noted	
	4. Any reference in the Licence to any provision of a	Company Secretary	Noted	

Condition	Summary / Description	Accountability	Context / Comments	Action Required
	statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.			

Worksheet "CoS7"

Financial Year to which self-certification relates 2026/27

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (designated CRS only)

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — **Confirmed**

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

In making this declaration, the Board has considered the Trust's financial position, operational performance, cash position, capital programme, going concern assessment, and the assurance received through Board, Committee, system and NHS England oversight arrangements.

The Board has also taken account of the enforcement undertakings accepted by the Trust in February 2026 and the arrangements in place to oversee delivery of the actions arising from them, including regular reporting and review through established governance and oversight processes.

In reaching its view, the Board has considered the controls and monitoring arrangements in place in relation to financial performance, forecast outturn, capital and cash, together with the assurance available through regular Executive, Committee, Board, system and NHS England oversight.

Having made appropriate enquiries, the Directors have a reasonable expectation that the Trust will have the required resources available to continue to provide Commissioner Requested Services for the relevant 12 month period.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/08/058**			
Subject:	**Fit and Proper Persons Test - Annual Report on Board Members**			
Date of meeting:	5 August 2026			
Action required:	**To note**			
Author(s):	Emily Kelso, Head of corporate governance			
Executive director sponsor:	Andy Carter, Chair			
Link to strategic aim:	2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving.			
Link to risks on the board assurance framework:	BAF 5: Workforce Capacity, Capability & Wellbeing			
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 NHS England Fit and Proper Persons Test (FPPT) Framework came into effect on 30 September 2023 and strengthened the requirements for retaining evidence, assessing Board director competencies and supporting enhanced references for directors leaving an NHS Board. The Trust's Fit and Proper Persons Policy has been updated to align with the NHS England FPPT Framework and the NHS Leadership Competency Framework for Board Members. The 2026 annual FPPT review has been completed for all individuals within scope. Evidence has been collated across physical and electronic records and ESR. A small number of administrative anomalies were identified during the review; these do not present a cause for concern and are being managed in line with the policy.			

<table>
<tr><td></td><td colspan="3">The Audit Committee considered the annual FPPT report on 22 June 2026, and supported submission of the Annual NHS FPPT return to the Regional Director, NHS England.

The return was signed by the Chair and Senior Independent Director and submitted by the required 30 June 2026 deadline. This report provides Trust Board with assurance that the annual submission has been completed successfully.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note:
• the Fit and Proper Persons Test has been completed in line with the NHS England Fit and Proper Person Framework and the NHS Leadership Competency Framework for Board Members;
• the Trust holds evidence that all current directors and other individuals within scope satisfy the FPPT requirements;
• the Annual NHS FPPT return was signed by the Chair and Senior Independent Director and submitted to the Regional Director, NHS England by the 30 June 2026 deadline; and
• ongoing monitoring and record keeping will continue through the Trust's established governance arrangements.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td colspan="2">Committee</td><td>Audit Committee</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td>AC/26/06/038</td></tr>
<tr><td colspan="2">Date of meeting</td><td>22 June 2026</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td>The Audit Committee received and noted the Fit and Proper Persons Test Annual Report and supported submission of the Annual NHS FPPT return to the Regional Director, NHS England by 30 June 2026.</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>

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

1. Background/context

The Fit and Proper Persons Test is set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and is intended to ensure that individuals with authority in organisations delivering care are suitable for their roles and accountable for the quality and safety of that care.

Following the Kark Review, NHS England introduced the Fit and Proper Person Test Framework for Board Members, which came into effect on 30 September 2023. The framework strengthened arrangements for retaining FPPT evidence, introduced a consistent set of core competencies for Board directors and established enhanced reference requirements when a director leaves an NHS Board.

The Trust's Fit and Proper Persons Policy has been updated to align with the NHS England FPPT Framework and the NHS Leadership Competency Framework for Board Members. The annual review and submission process provides assurance that all individuals within scope continue to meet the relevant requirements.

2. Key elements

The 2026 annual FPPT review was undertaken in line with the CQC Fit and Proper Person Requirements, the NHS England FPPT Framework, the NHS Leadership Competency Framework for Board Members and the Trust's Fit and Proper Persons Policy.

The scope includes Executive Directors, Non-Executive Directors, interim and permanent appointments, Deputy Director roles, the Company Secretary and the Freedom to Speak Up Guardian, irrespective of voting rights where applicable.

Evidence has been reviewed across individual personnel files, electronic records and ESR. This includes required pre-employment checks, annual declarations, appraisal documentation, self-attestation and appropriate sign-off. A small number of administrative anomalies were identified during the review; these did not present a cause for concern and are being managed in line with the policy.

The Annual NHS FPPT return was signed by the Chair and Senior Independent Director and submitted to the Regional Director, NHS England by the required 30 June 2026 deadline, following Audit Committee consideration on 22 June 2026.

3. Actions required/responsible officer

The Trust Board is asked to receive and note this report. The Chair retains ultimate responsibility for confirming that all relevant post holders meet the FPPT requirements and do not meet any of the unfit criteria.

Operational oversight of the checks and evidence base is maintained by the Chief People Officer and Company Secretary, supported by Corporate Governance and relevant workforce processes.

4. Measurements/evaluations

Completion has been assessed through review of the retained FPPT evidence for each individual within scope, including evidence held on personal files, electronic records and ESR.

The annual review confirmed that the Trust holds appropriate evidence to support the FPPT declaration. The administrative anomalies identified during the review have been considered, do not present a cause for concern and will remain under review through the normal governance process.

5. Trajectories/objectives agreed

The objective is to maintain full compliance with the NHS England FPPT Framework and ensure that FPPT records remain complete, current and readily available to support annual submission and any relevant regulatory assurance.

6. Monitoring/reporting routes

FPPT compliance is monitored through the annual review process, with assurance provided to the Audit Committee and Trust Board. The annual NHS FPPT return is submitted to the Regional Director, NHS England as required by the national framework.

7. Timelines

The Audit Committee considered the 2026 annual FPPT report on 22 June 2026. The Annual NHS FPPT return was submitted by the required deadline of 30 June 2026. This report is presented to the August 2026 Trust Board to confirm completion of the submission and provide assurance on the annual process.

8. Assurance committee

The Audit Committee received the annual FPPT report on 22 June 2026 under agenda reference AC/26/06/038 and supported submission of the Annual NHS FPPT return to the Regional Director, NHS England.

9. Recommendations

The Trust Board is asked to note:

- the Fit and Proper Persons Test has been completed in line with the NHS England Fit and Proper Person Framework and the NHS Leadership Competency Framework for Board Members;
- the Trust holds evidence that all current directors and other individuals within scope satisfy the FPPT requirements;
- the Annual NHS FPPT return was signed by the Chair and Senior Independent Director and submitted to the Regional Director, NHS England by the 30 June 2026 deadline; and
- ongoing monitoring and record keeping will continue through the Trust's established governance arrangements.