North Cheshire and Mersey
NHS Foundation Trust

Trust Board – Part 1 (public)

Date and time:	7 October 2026, 10:00am – 12:30pm
Location:	Lecture Theatre, Education Centre - Halton Hospital

Agenda item	Time	Agenda item	Objective/ desired outcome	Process	Lead
BM/26/10/ 073	**10:00**	**Engagement Story** – Maternity Services	***To note***	***Presentation***	Chief Nurse / Director of Maternity
Opening Business					
BM/26/10/ 074	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/26/10/ 075	**10:17**	Minutes and Action Log of the previous Trust Board meeting held on: **5 August 2026**	***For approval***	***Minutes***	Chair
BM/26/10/ 076	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/26/10/ 077	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/26/10/ 078	**10:35**	Chair's Report	***For information / update***	***Verbal***	Chair
Trust Board matters					
BM/26/10/ 079	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports	***For assurance***	***Report***	All Executive Directors
a)		**Quality Dashboard Including** Assurance Reports Quality Safety and Assurance Committee 11.08.2026, 08.09.2026	***For assurance***	***Report***	Chief Nurse, Cliff Richards, Committee Chair
b)		**People Dashboard Including** Assurance Reports Strategic People Committee 19.08.2026, 16.09.2026	***For assurance***	***Report***	Chief People Officer, Julie Jarman,

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					Committee Chair
c)		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Performance Committee 24.08.2026, 28.09.2026	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
d)		**Audit Committee Including** Assurance Reports 27.08.2026	***For assurance***	***Report & Presentation***	Senior Independent Director Mike O'Connor Committee Chair
e)		**Charitable Funds Committee** Assurance Report 03.09.2026	***For assurance***	***Report & Presentation***	Senior Independent Director Andy Carter Committee Chair
Quality					
BM/26/10/080	**11:15**	Fragile Clinical Services Update	***To note for assurance***	***Report***	Chief Nurse / Executive Medical Director
BM/26/10/081	**11:25**	Compliance Update (CQC) Q1	***To note for assurance***	***Report***	Chief Nurse
BM/26/10/082	**11:35**	**Maternity and Neonatal Summary Update, including:** i. Maternity and Neonatal Quality Review Reports: June, July 2026 ii. Maternity Incentive Scheme, Year 8: August, September 2026 iii. Cheshire and Merseyside Perinatal Mortality Report, Q1 iv. Avoiding Term Admission into Neonatal Unit, Q2	***To note for assurance***	***Reports***	Director of Midwifery

		v. Maternity and Neonatal Voices Partnership Biannual report vi. Ockenden Amos 10 Point Plan: July, August 2026			
People					
BM/26/10/083	**11:50**	GMC Revalidation Annual Report, including Statement of Compliance	***To note for assurance***	***Report***	Executive Medical Director
BM/26/10/084	**11:55**	Communications and Engagement Report Q2	***For information / update***	***Report***	Director of Communications and Engagement
BM/26/10/085	**12:00**	Workforce Race Equality Standard and Workforce Disability Equality Standard Annual Reports	***To note for assurance***	***Reports***	Chief People Officer
Governance					
BM/26/10/086	**12:20**	Audit Committee Chair Annual Reports i. WHH ii. BCH	***For approval***	***Report***	Audit Committee Chair
BM/26/10/087	**12:25**	Cycle of Business - Strategic People Committee	***For approval***	***Report***	Company Secretary
Closing					
BM/26/10/088	**12:25**	Review of Meeting	***For information / update***	***Verbal***	Chair
BM/26/10/089		Any Other Business	***For information / update***	***Verbal***	Chair

Supplementary Papers for Noting:

Agenda item	Report Title	Assurance Committee	Objective/ desired outcome	Process	Lead
BM/26/10 /090	Learning From Experience Summary Report Q1	Ref: **QSAC/26/08/132** Date: 11.08.2026 Outcome: noted	To note	Report	Chief Nurse
BM/26/10/ 091	Infection Prevention and Control Update Q1	Ref: **QSAC/26/08/133** Date: 11.08.2026 Outcome: noted	To note	Report	Chief Nurse
BM/26/10/ 092	Learning from Deaths Q1	Ref: **QAC/26/09/152** Date: 08.09.2026 Outcome: noted	To note	Report	Executive Medical Director
BM/26/10/ 093	Guardian of Safe Working Report Q1	Ref: **SPC/26/08/093** Date: 19.08.2026 Outcome: noted	To note	Report	Executive Medical Director
BM/26/10/ 094	Senior Information Risk Owner Annual Report	Ref: **FSPC/26/09/110** Date: 28.09.2026 Outcome: noted	To note	Report	Chief Information Officer

Following the meeting, the Annual Members Meeting will take place from 3:30pm

Date and time of next meeting:
2 December 2026, starting at 10am. Trust Conference Room, Warrington Hospital

North Cheshire and Mersey
NHS Foundation Trust

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

- **Financial interests:**

Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**

Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**

Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**

Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

North Cheshire and Mersey
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North Cheshire and Mersey NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 5 August 2026 WELL Runcorn Hub and 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 via MS Teams
Julie Jarman (JJ)	Non-Executive Director via Ms Teams
John Somers (JS)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Jane Hurst (JH)	Chief Finance Officer
Ali Kennah (AK)	Chief Nurse
Apologies	
Paula Woods (PW)	Chief People Officer
In Attendance	
Kate Henry (KH)	Director of Communications & Engagement
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
John Culshaw (JC)	Company Secretary
David Hines (DH)	Patient **BM/26/08/042**
Jullie Griffiths (JG)	Ward Manager **BM/26/08/042**
Kate Newton (KN)	Business Administration, PALS & Complaints Service **BM/26/08/042**
Jennie Dwerryhouse (JD)	Deputy Chief People Officer
Eshita Hasan (EH)	Deputy Exec Medical Director
Tina Moors (TM)	Interim Director of Midwifery
Emily Kelso (EK)	Head of Corporate Governance (minutes)
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Zoe Tidman	HSJ

Agenda Ref	Agenda Item
BM/26/08/042	**Engagement Story** AC welcomed DH, JG and KH. JG outlined the wellbeing service, which supports patients on the Serious Mental Illness register who may not routinely engage with practice-based screening or mainstream services. JG explained that the service provides holistic assessment, basic diagnostics and mental health assessment, and can signpost to smoking cessation, weight management, social prescribing and financial or debt support. The Board noted the pathway relied on GP identification, community service expertise and wider partner links working around the patient. DH described a positive experience of being linked into services by his GP at a difficult point in his life. He described the assessment and diagnosis process as joined up, timely and clear, stating that letters and appointments happened

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	broadly as expected and that he had been able to re-engage with university study as part of his recovery. AK asked whether the GP response had been quick; DH confirmed it had, providing assurance on the responsiveness of the pathway. JS asked whether anything would have brought DH into the service earlier; DH reflected that, for him, the timing had happened naturally and at the right point. CR challenged the clarity of organisational roles within the pathway, noting the potential for confusion between Trust wellbeing services and wider wellbeing providers. JG and colleagues clarified that the service in this case was part of the Trust's community services, based at the Bridges Learning Centre, with other organisations brought in where needed. CR noted that the key assurance was that DH had not been expected to navigate services himself. NK explored the issue of trust and asked what services should do to build confidence. DH advised that trust was built when services did what they said they would do, even in small matters such as calls, letters and appointments. AC thanked DH and said the story demonstrated the importance of clear communication, joined-up care and keeping the patient at the centre. **The Trust Board noted the story and associated learning.**
BM/26/08/043	**Welcome, Apologies and Declarations of Interest** AC welcomed members to the first public Board meeting held at the WELL Runcorn Hub and noted the significance of the venue as a partnership space supporting neighbourhood care. AC welcomed SF as Governor Observer, members of the public online, JD and JJ joining remotely, JDw attending for PW, and EH attending as observer. No declarations of interest were made. **The Trust Board noted the apologies and declarations of interest.**
BM/26/08/044	**Minutes and Action Log of the previous meeting held on 3 June 2026.** AC invited comments or amendments on the minutes of the meeting held on 3 June 2026. The Board agreed that the minutes were a true reflection of the meeting. The Board then reviewed the action log and provided the following updates: • AK confirmed that learning from the ICU engagement story would be considered by the Patient Experience Sub-Committee in August and would return to Board through the biannual patient experience report. • JDw confirmed that workforce plan metrics had been corrected in the IPR, annual leave utilisation work was ongoing with a report expected to SPC, and vacancy and temporary staffing triangulation had been discussed through SPC and FSPC reporting routes. • AK advised that the complaints and PALS plan had been issued to Board members and shared with governors, but that a definitive reopening date was dependent on integration and consultation work. AC noted positive engagement with the complaints and patient engagement teams and requested an update at a furture Board Development session • JH confirmed that the estates action was to be taken to FSPC in September.

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	The Trust Board approved the minutes of the meeting held on 3 June 2026, along with the updates provided to the outstanding actions.
BM/26/08/045	**Matters Arising** No additional matters were raised by members. **The Trust Board noted that there were no matters arising.**
BM/26/08/046	**Chief Executive's Report** NK presented the report, highlighting work to embed the Trust values of kind, open, fair and one team. He reported that the values were beginning to be recognised across the organisation, including through recent consultant interviews, and advised that the new NCM Champion role would consolidate previous culture and people promise champion arrangements into a single point of contact for teams. NK also drew attention to the national NHS staff standards, which he described as focused on doing the basics brilliantly for staff, including management, health and wellbeing, violence prevention, social safety and tackling racism. NK updated on improvements to patient flow and corridor care, confirming that the Corridor Care Summit had brought together Trust teams, the ambulance service, local authorities and Healthwatch to identify practical actions. He stressed that eliminating corridor care was not solely an A&E issue but a Trust-wide and system-wide priority dependent on patient flow and partner support. NK also referred to person-centred care for people with learning disabilities and autism, noting the importance of listening, adapting care and working across organizational boundaries where patients required reasonable adjustments or more complex support. NK reported on inclusion, belonging and staff experience, including the race inclusion summit held in response to staff survey feedback, with themes of psychological safety, fairness and wellbeing. He also referenced South Asian Heritage Month and the importance of recognising the contribution of colleagues' diverse experiences. In relation to maternity, NK highlighted the national Ockenden review and advised that the Trust would need to learn from the themes of care, leadership, culture, accountability, discrimination and listening, with AK and PF taking forward the relevant work. NK also updated the Board on NCM 2030, confirming that staff engagement had commenced and would support the development of the organisation's vision, priorities and ambitions over the next three to five years. NK advised that the Trust continued to support the armed forces community through its armed forces and veterans network. He also updated on patient information and confidentiality, confirming that the Executive Team had reinforced expectations around legitimate access to patient records, the lawful basis for access and the consequences of non-compliance. In respect of regulation and performance, NK reported that the Trust had moved out of elective care tiering because of sustained progress, but remained in emergency care tiering. He advised that the Trust would seek clarity on what would be required to move out of emergency care tiering, noting that 12-hour waits, no criteria to reside and patient flow were likely to remain key areas of scrutiny. NK further reported that the latest government offer to resident doctors had been accepted, reducing the likelihood of further resident doctor industrial

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	action, although the position for consultants would continue to be monitored. He updated the Board on cyber security assurance, noting that NHS England had asked Boards to assure themselves on risks and mitigations, with ongoing reporting through internal audit and Audit Committee. NK also referred to the minimum standards for patient experience and advised that the Trust met the vast majority of requirements but had further work to complete against all eight standards, with progress to be monitored through normal governance routes. He also noted NHS England North West leadership changes, regional strategic priorities and the need to start focusing on medium-term plans alongside current-year delivery. JS welcomed the CEO dashboard and challenged the metric showing the percentage of patients referred to ED from UTC, asking whether it was a national or NOF metric and whether the position suggested inappropriate signposting into UTC. DM advised that it was not a NOF metric but was used in NHS England performance discussions as a proxy for whether UTCs were managing appropriate activity and not flowing too many patients to ED. JS asked what was behind the figure, and DM agreed that it required further analysis through the ED Improvement Group. AC requested a further update and deeper dive. AC highlighted the significant improvement in four-hour A&E performance and asked that the Board's thanks be passed to the teams. NK cautioned that the performance needed to be sustained and advised that the improvement reflected operational and clinical work, the repurposing of the Next Step model and the full UTC activity now coming to the Trust. NK confirmed that further improvement was still required on 12-hour waits, no criteria to reside and corridor care, but advised that the Trust was moving in the right direction and was also performing strongly in elective care. **The Trust Board noted and discussed the Chief Executive's Report. Further work was agreed on the UTC to ED referral metric**.
BM/26/08/047	**Chair's Report** AC reported stakeholder engagement with MPs and local authority leaders, including discussions on the acquisition of community services, the creation of NCM and the Trust's plans to improve services for local people. AC also welcomed Cllr Tony Higgins as partner governor. AC described visits to community and hospital teams, including bereavement, ophthalmology, district nursing, speech and language therapy, heart failure and Parkinson's services, highlighting the value of hearing directly from staff, patients and families. AC reported visiting maternity services with AK on the day Ockenden was published and encouraged Board members to spend time with departments and service users. JD commented that maternity had responded quickly to issues, including improvements to the induction of labour unit and C23, and that the ward manager and staff were inspirational. AC agreed that patient experience and team culture had improved. AC emphasised that patient flow and no criteria to reside required a system-wide solution, particularly in relation to social care. He formally thanked AK, noting that this was her final public Board meeting as Chief Nurse, and placed on record the Board's gratitude for her leadership, patient advocacy and contribution to the Trust.

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	The Trust Board noted the Chair's report and the formal thanks recorded for AK.
Trust Board Matters	
BM/26/08/048	**Board Assurance Framework** JC presented the Q1 BAF and confirmed that all nine strategic risks remained active and above target, with no new risks, closures, de-escalations or rating changes. The two highest-rated risks remained emergency care and delivery of the financial plan. JC advised that emergency care risk would continue to be monitored through QSAC and FSPC, particularly given recent improvements in four-hour performance and ongoing patient flow pressures. Assurance was provided that corporate risks were now aligned to strategic BAF risks and that work continued to embed the risk appetite statement across the organisation. JD welcomed the revised format but challenged whether the Board had sufficient visibility of BAF 4, particularly the health inequalities and quality elements and the overlap between assurance committees. AC agreed this would be useful to consider through Board Development, and JC agreed to take the point away. **The Trust Board approved and took assurance from the Q1 BAF position, with further consideration to be given to Board understanding of BAF 4.**
BM/26/08/049	**Integrated Performance Reports and Assurance Committee Report** NK introduced the IPR as a focused discussion on key areas of quality, people, performance and finance. **Quality** AK reported that the CDI threshold should be corrected to 64 and that year-to-date CDI cases stood at 33 against a threshold of 60. Assurance was provided that ribotyping had not identified cross-contamination; the focus was therefore on environmental cleaning, the constrained ward environment and the limited ability to undertake routine deep cleaning because of bed pressures. AK advised that she was working with IPC and domestic teams, considering wider probiotic use, and attending CDI case reviews to maintain senior clinical oversight. JD challenged the need to sustain improvements in key safety metrics such as falls and MUST, noting that previous gains could not be allowed to drift while attention was focused elsewhere. AK agreed and advised that overcrowding in wards and ED continued to create practical constraints. AC asked whether there were particular wards of concern, and AK confirmed that focused ward-level work was under way. CR challenged whether the Trust needed to look beyond existing approaches, given that the CDI toolkit and current measures had not yet brought the position down. AK confirmed that the Trust would revisit the Cheshire and Mersey toolkit and learning from other organisations, and AC suggested exploring university or research partnership opportunities. AK also reported that pressure ulcers had spiked to 18 but had reduced to five, with matrons and senior nurses focused on

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sustaining the improvement through basic preventative practice and ward-level oversight.

CR provided QSAC assurance by exception, including ongoing scrutiny of maternity PPH and ATAIN, completion of the typing backlog, transition issues for patients with complex needs, community equipment store concerns, the section 136 pathway and positive progress through the nursing and midwifery strategy annual report. PF clarified that the controlled drugs issue related to the controlled dealer licence and external supply arrangements, not the Trust's ability to manage controlled drugs internally.

People

JDw reported a £1.4m bank overspend, of which nearly £1m related to industrial action. Other drivers included UEC nursing, supernumerary staff, medical staffing in UEC and less than full-time medical staffing in surgery. AK highlighted that 21.5 whole-time equivalent supernumerary staff in June created both salary and backfill costs, which needed to be understood in future planning. PF clarified that UEC staff were not over establishment; rather, rota gaps were driving excess costs, with work ongoing on substantive improvements and changes to the ED medical model.

JJ provided SPC assurance by exception. She highlighted the national Band 5 nursing review as a significant piece of work and a potential risk for staff expectations, noting that the ICB was taking a unified Cheshire and Mersey approach. JJ reported that workforce reduction was ahead of target and that health and wellbeing discussions had focused on the day-to-day pressure staff were working under, rather than only formal wellbeing offers. JJ also advised that the training survey would form part of NOF in future; although the Trust usually scored strongly, recent results were worse than normal, particularly in maternity, and a deep dive was planned. Sickness was improving but remained above the required position, with hotspot reporting being developed. AC asked where the highest sickness hotspot was, and JDw confirmed B10 and B11 were highest at approximately 15.9%, followed by gastro, Warrington Adults and Halton Adults. AK advised that B10 and B11 were also subject to a culture review.

Performance

DM reported significant improvement in four-hour A&E performance, with July tracking close to plan, but confirmed that 12-hour time in department, ambulance handovers, corridor care and bed occupancy remained the greatest challenges. Assurance was provided that seven targeted ED improvement workstreams had been developed from the Corridor Care Summit and follow-up flow workshop, with reporting through EMT and FSPC. DM advised that reducing bed occupancy and improving flow remained central to reducing corridor care.

In relation to discharge delay days, DM advised that the data reflected Quarter 4 and that workforce challenges in Warrington Borough Council social work had been a key driver. AC challenged the council view that pathway 1 capacity was available and asked how this aligned with Trust discharge experience. DM advised that a daily tracker was now comparing available ICAT slots with scheduled discharges and had not yet identified unused residual capacity. JS challenged whether internal Trust processes such as diagnostics, medicines, transport and decision-making were also contributing.

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DM acknowledged internal opportunities and described work on board rounds, MDT decision-making, home first and earlier escalation of diagnostics.

AC emphasised the need to distinguish clearly between what the Trust controlled and what required partner action, and DM advised that early work on no criteria to reside had achieved a reduction in length of stay which was not yet reflected in the Quarter 4 data.

DM updated on over 52-week and 104-week waits, mainly driven by community paediatric neurodevelopmental pathways. He advised that risk stratification ensured the most acute children were prioritised, but that less acute children continued to wait due to demand exceeding capacity. A deeper service review would consider alternative models, non-medical workforce, voice-to-text technology and referral criteria, with an options paper due to the Executive Team and then QSAC. CR challenged the risk stratification process, noting dependency on referral quality, limited visibility of amber and green patients, and harm reviews being retrospective. PF acknowledged the pressure and advised that commissioning capacity and system-wide demand management were central. CR also challenged whether families were sufficiently informed. PF advised that communications had gone to schools and referrers to trigger re-stratification if circumstances changed, and that some children had been escalated. AC stated that the Trust should be open and transparent with families and seek ICB coordination. MOC challenged whether the reported figure of two community patients over 52 weeks outside neurodevelopmental services was accurate and whether it gave false assurance. DM agreed to review the individual circumstances raised offline.

Finance

JH reported a £14.3m deficit at month three, £900k worse than plan due to industrial action. CIP delivery was on track overall, but recurrent delivery remained below the required level, improving from 65% to 70% at month four. MOC challenged which risks were of greatest concern. JH identified CIP and income risk, linked to productivity, workforce restructuring, MARS and target operating models.

JS provided FSPC assurance by exception. He highlighted the Trust's £25.5m deficit support, noting that the first two quarters were expected to be supported through the compliant plan and signed contract, while later quarters would depend on the risk-adjusted forecast. JS advised that industrial action, income risk and productivity assumptions within CIP remained key risks. He reported committee scrutiny of CIP recurrency, run rate and cost pressures, with assurance on run-rate processes but less assurance on cost pressures. JS advised that services presenting cost pressures were expected to bring mitigation plans rather than simply requesting additional resources. The committee had also reviewed bed closures and elective recovery, with assurance that bed closures had been delivered without adverse consequences to date.

The Board then considered the cash support request. JH confirmed that the request was for £7.177m of cash support from NHS England for quarter three and that the paperwork had been completed for regional processing. The Board approved the request.

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	The Trust Board discussed the IPR and committee assurance reports, noted the actions and assurance provided, and approved the £7.177m cash support request.
	Quality
BM/26/08/050	**Fragile Clinical Services Update** PF introduced the fragile clinical services update and advised that four services remained under fragile services oversight, with encouraging progress in some areas. PF reported that planned care had seen significant improvement in NOF-related areas and that femoral fracture performance had improved sufficiently for that programme to step down into usual reporting routes. PF said mortality and time-to-operation figures had improved and that the team were focused on sustaining progress. He advised that mortality was measured nationally on a rolling 12-month basis and that it may be Quarter 2 or Quarter 3 before the Trust's improved position was reflected, assuming local safety actions continued to be completed. PF updated that chronic pain local safety actions had been completed and that commissioning of the community model could now progress. He reported emerging risk in urology linked to consultant workforce, with a paper due to EMT, but said waiting list precision was stable. Rheumatology had made significant improvements. AC asked about orthopaedic patients being placed in areas other than expected because of the challenged bed base and whether this affected the timeliness of surgery. PF confirmed that this was a known issue linked to operational efficiency and patient flow, with conversations under way about how teams manage demand, move patients quickly and ensure plans are in place each day. **The Trust Board discussed the fragile services update and noted current risks, progress and the need for continued oversight.**
BM/26/08/051	**Maternity & Neonatal Summary Update including Maternity & Neonatal Quality Review Report, MIS including SBLCB, ATAIN Q4, and update regarding Ockenden and Amos review** TM presented the maternity and neonatal update, noting that the papers had been through QSAC. She reported that there were no severe harms, no Regulation 28 notices, and two MNSI cases awaiting reports. TM identified ATAIN, postpartum haemorrhage and diabetes as the main areas of focus. On ATAIN, TM reported improvement from Quarter 3 into Quarter 4 and continued interventions, with respiratory issues remaining the primary cause. TM acknowledged that some admissions may reflect cautious thresholds, but emphasised that the Trust did not want to create harm by failing to admit babies when clinically appropriate. She said further recent data showed continuing improvement and would go to QSAC. On postpartum haemorrhage, TM reported increases in April and May and confirmed that the Trust remained above the Cheshire and Mersey average. Quality improvement methodology was being applied, simulation training had increased, and enhanced risk assessment had been implemented. TM said higher incidence appeared to be associated with instrumental deliveries, so the team had ordered equipment to support accurate measurement, was undertaking a main re-audit and would carry out a separate deep dive into instrumental births. Recent data showed improvement. On diabetes, TM explained that the pathway was established but workforce and capacity

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	challenges remained because of increased demand following guideline changes and limited specialist workforce availability. Mitigations included enhanced MDT working, interim support, recruitment to a specialist dietitian post and development of a future business case. TM reported sustained improvement in third and fourth degree tears and the induction of labour hub. She advised that there were no workforce escalations, that triage KPIs continued to be met, and that the Trust was compliant with national triage standards. TM said MIS year eight remained on track, although a workforce review would be undertaken because of Birthrate Plus requirements. SBLCB continued to be monitored, including the dietitian funding element. TM reported that the maternity self-assessment tool had demonstrated 87% compliance, with a small number of actions relating to policy and improvement planning. The Quarter 4 perinatal mortality review showed no stillbirths or neonatal deaths during the reporting period, with the rolling stillbirth rate and neonatal mortality rate below national equivalents. TM said the perinatal improvement plan continued with monthly executive and regionally led meetings providing assurance. TM reported that the Trust was completing a gap analysis against the Ockenden report and would align it with the perinatal improvement plan, with results going to QSAC in September. She said national guidance was awaited. AK added that the assurance statement required following Ockenden had been submitted on time and that the Ockenden report, Amos review, 10-point plan and triage specification were all being reviewed. CR noted that the Secretary of State had made a further statement on maternity and asked whether the Board should consider regular visits to maternity and mortuary services as part of pre-Board arrangements. AC agreed this should be considered and noted that a mortuary visit was already in his diary. **The Trust Board discussed the maternity and neonatal reports, noted assurance received, ongoing areas of risk and further work on Ockenden, Amos and Board visibility of services.**
People	
BM/26/08/052	**Communications and Engagement Report** KH highlighted the first Thank You Awards as an integrated organisation and the positive response from staff. She reported increasing use of the weekly newsletter, thank you messages on the intranet, public website interest in working here pages and urgent and emergency care pages, and communication support for integration and endoscopy hub activity. AC asked whether volunteering and apprenticeship information was clear on the website. KH confirmed volunteering information was available, and JDw provided assurance on widening participation, apprenticeship work and school engagement. **The Trust Board noted the Communications and Engagement Report**
BM/26/08/053	**Gender Pay Gap: Combined Report** JDw presented the combined report, noting that it had been approved by SPC. The data showed an increased gender pay gap because more men were represented in higher bands, rather than because of unequal pay within NHS pay structures. Actions would focus on women in leadership, particularly

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	medical and dental leadership, with quarterly review through the gender pay gap governance route. JJ added that analysis excluding the medical workforce showed no gender pay gap in the acute data, helping to focus the action plan. In response to a question on bonus pay, PF clarified that this related to clinical excellence awards. He explained that historical local awards, which had disproportionately benefited men due to previous application processes, would continue to have an impact until the relevant cohort of clinicians left or retired. **The Trust Board noted the reports and actions to address the gender pay gap.**
BM/26/08/054	**Living Well Hub - 2 year Review** LG presented the two-year review, highlighting the Warrington Living Well Hub as evidence for the new Runcorn Well Hub. She reported significant use of the Warrington hub, a broad range of services and strong reach into deprived communities. LG advised that the Runcorn hub had opened on 29 June, had already added further services and was seeing both appointments and drop-ins across areas including ante and postnatal support, children and young people, neurodevelopmental services, mental health, long-term conditions, health improvement, education, advice and signposting. PF noted the hubs' potential role in prevention and left shift, including falls prevention activity. MOC asked who provided such sessions, and LG clarified that the Trust provided space for voluntary sector organisations rather than directly delivering all activities. AC challenged how impact would be measured beyond activity levels. LG advised that an independent external review of the Warrington hub had found strong evidence of increased access to health and wellbeing services and medium evidence of overcoming barriers for deprived communities, although statistical evidence of overall wellbeing impact was harder to demonstrate. LG advised that business case metrics and the single improvement plan would support future impact assessment. **The Trust Board noted the Living Well Hub review and early progress of the Runcorn Well Hub.**
Finance, Sustainability and Productivity	
BM/26/08/055	**Emergency Preparedness Report** DM presented the report and advised that EPRR compliance had improved from non-compliant to partially compliant, with a work programme in place to reach substantial compliance. He confirmed that the former teams were working through joint meetings and that on-call arrangements were being aligned. A mass casualty exercise was planned, using the A11 modular space before its decant use. CR asked about the Bridgewater annual report cycle, and DM clarified that it would conclude in December before future combined NCM reporting. AC challenged preparedness for Creamfields. DM advised that planning was well developed, including site visits, assessment of event medical capability, signposting and EPRR Group oversight. AC asked whether the

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	current national terrorism threat level was built into planning; DM confirmed it was, with additional capacity planned in ED and ICU. AC and NK asked whether organisers should be billed if exceptional staffing was required. DM agreed this should be considered more robustly in future planning. MOC shared learning from large festival medical provision and suggested looking at what other events do to reduce offsite transfers and NHS pressure. **The Trust Board noted the report and requested consideration of event-related cost recovery and learning from other large events.**
Governance	
BM/26/08/056	**Committee Chairs Annual Reports - Quality and Safety Assurance Committee, Strategic People Committee, Finance, Sustainability and Productivity Committee** JC presented the annual reports for QSAC, SPC and FSPC, advising that the reports had been supported by the relevant committees and demonstrated discharge of the committees' terms of reference. **The Trust Board approved the Committee Chairs Annual Reports.**
BM/26/08/057	**Code of Governance Compliance and Provider Licence Annual Report (for Year End / Audit Committee)** JC presented the Code of Governance compliance assessment and advised that Audit Committee had reviewed and supported it. Two comply-or-explain items were noted: Non-Executive Director tenure beyond five years, which would be addressed through the new Chair arrangements, and the Senior Independent Director acting as Audit Committee Chair, which had been agreed due to skill set. JC also presented the continuity of service condition 7 declaration, advising that the Trust was making an unqualified declaration that it had sufficient resources and arrangements for the next 12 months. **The Trust Board approved the Code of Governance Compliance assessment and the continuity of service condition 7 of the NHS provider licence declaration.**
BM/26/08/058	**Fit and Proper Persons Test - Annual Report on Board Members** JC presented the Fit and Proper Persons Test annual report and advised that it had also been considered by Audit Committee. He reported that all relevant Board members and individuals within the scope of the framework had successfully passed the requirements. JC confirmed that the position had been signed off by the Chair and submitted to the regional team by the required deadline. **The Trust Board noted the Fit and Proper Persons Test annual report**.
Closing	
BM/26/08/059	**Review of the Meeting** EH provided reflections as an observer. She said the meeting had opened in a heartening way through the engagement story, which set the tone for the purpose of the organisation. EH observed robust governance, with open discussion about risks and failures rather than a defensive stance. She said Board members demonstrated good challenge and healthy dynamics rather

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	than passive discussion. EH also observed that a good amount of time had been spent on strategic areas, including quality, performance, sustainability and productivity challenges. AC thanked EH for her observations.
BM/26/08/060	**Any Other Business** AC invited any other business. No additional items were raised. AC drew attention to the supplementary reports for noting. No additional items were raised. **The meeting ended at 12.33**
Date and time of next meeting – 7 October 2026, starting at 10am. Halton Education Centre, Halton Hospital	

Supplementary Papers for Noting:

Agenda Ref	Report Title	Assurance Committee / outcome	Lead
BM/26/08/061	Compliance Update Q4 (CQC)	QSAC/26/06/060 - 09.06.2026 - noted	Chief Nurse
BM/26/08/062	Learning from Deaths Q4	QSAC/26/06/065 - 09.06.2026 - noted	Executive Medical Director
BM/26/08/063	Learning From Experience Summary Report Q4	QSAC/26/06/067 - 09.06.2026 - noted	Chief Nurse
BM/26/08/064	Mortuary Licensed Activity Report	QSAC/26/07/095 - 14.07.2026 - noted	Chief Nurse
BM/26/08/065	Infection Prevention and Control Board Assurance Framework Compliance	QSAC/26/07/097 - 14.07.2026 - noted	Chief Nurse
BM/26/08/066	Medicines Management	QSAC/26/07/108 - 28.07.2026 - noted	Executive Medical Director
BM/26/08/067	Controlled Drugs Annual Report	QSAC/26/07/109 - 28.07.2026 - noted	Executive Medical Director
BM/26/08/068	Director of Infection Prevention & Control Annual Report (DIPC)	QSAC/26/07/113 - 28.07.2026 - noted	Chief Nurse
BM/26/08/069	Safeguarding Report	QSAC/26/07/115 - 28.07.2026 - noted	Chief Nurse
BM/26/08/070	Health and Wellbeing Report	SPC/26/06/050 - 17.06.2026 - noted	Chief People Officer
BM/26/08/071	Safe Nurse Staffing	SPC/26/06/052 - 17.06.2026 - noted	Chief Nurse
BM/26/08/072	Guardian of Safe Working Annual Report	SPC/26/07/073 - 15.07.2026 - noted	Executive Medical Director

Signed:
Position: Chair
Date:

North Cheshire and Mersey
NHS Foundation Trust

Trust Board - Action Log

Agenda reference:	BM/26/10/75	Subject:	Action Log Trust Board	Date of meeting:	7 October 2026

1. Actions on agenda

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

2. Actions completed and closed off since last meeting

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/26/06/029	3 June 2026	**Workforce / People (IPR)**	Provide a clearer explanation of workforce plan compliance metrics.	PW	July	5 August 2026	workforce plan metrics had been corrected in the IPR.	
BM/26/06/029	3 June 2026	**Workforce / People (IPR)**	Triangulate and confirm vacancy and temporary staffing position.	PW	July	5 August 2026	discussed through SPC and FSPC reporting routes.	
BM/26/06/023	3 June 2026	**ICU Engagement Story**	Explore improvements to	AK/AI	Aug 2026	August 2026	considered by the	

			patient experience, including communication, patient resources and support, and report back to Board/QSAC.				Patient Experience Sub-Committee in August returned to Board through the biannual patient experience report.	
BM/26/06/029	3 June 2026	**Workforce / People (IPR)**	Report on annual leave utilisation patterns and associated risks to SPC to support staff wellbeing and planning.	PW	21.10.26		Absence Improvement Update Q2 being presented to SPC – 21 October 2026	
BM/26/06/032	3 June 2026	**Complaints / PALS**	Provide an update on plans and timescales for the safe reopening of the PALS office, including a future Board Development update.	AK	Future Board Development session	5 August 2026	complaints and PALS plan had been issued to Board members and shared with governors..	

3. Rolling tracker of outstanding actions

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/26/08/046	5 August 2026	**Chief Executive's Report**	Further analyse the UTC to ED referral metric and provide an update/deeper dive.	DM	TBC			
BM/26/08/048	5 August 2026	**Board Assurance Framework**	Schedule a Board session to further develop understanding and visibility of BAF 4, health inequalities with a focus on quality elements and committee overlap.	JC/LG	Board Development / TBC		Session date to be scheduled once the full National Board Development Programme has been confirmed, with the programme commencing in November 2026	
BM/26/08/055	5 August 2026	**Emergency Preparedness Report**	Consider event-related cost recovery arrangements and learning from other large events as part of future planning.	DM	Future event planning			

BM/26/06/029	3 June 2026	**IPR Finance / Estates Assurance**	Review estate lease and rental controls to provide further assurance following the historic estates issue.	FSPC/JH	September FSPC			

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/26/10/077**			
Subject:	**Chief Executive's Report**			
Date of meeting:	7 October 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 its previous meeting. Trust updates include changes in senior nursing and midwifery leadership, staff experience and recognition, workforce sustainability, work to improve patient flow, partnership working and the development of care closer to home. It also recognises the contribution of colleagues to organ donation and marks the 50th anniversary of Halton Hospital. The report summarises important national and regional developments, including the learning arising from the Thirlwall Inquiry, the Trust's Quarter 1 position under the revised NHS Oversight Framework, changes to regional access and tiering arrangements, and strengthened expectations for protecting confidential patient information. It also provides an overview of Trust performance and external engagement with partners across Cheshire and Merseyside. Overall, the report reflects continued progress alongside areas requiring sustained focus, particularly urgent and			

<table>
<tr><td></td><td colspan="3">emergency care, patient flow, finance, workforce and community waiting times.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Board is asked to note the content of the Chief Executive’s report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<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

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 5 August 2026, some of which are not covered elsewhere on the agenda for this meeting.

2. Key elements

2.1 Trust News

Chief Nurse retirement

Ali Kennah retired on 30 September 2026 following 34 years of NHS service, including nine years with the organisation and, most recently, as Chief Nurse. Ali made a significant contribution to nursing, quality and patient care, providing valued leadership during considerable organisational change. The Board places on record its sincere thanks for her commitment and dedicated service to patients, colleagues and the wider NHS, and wishes her well for the future.

Appointment of Nicola Martin as Chief Nurse

Following a competitive recruitment process, Nicola Martin has been appointed as the Trust's new Chief Nurse and is expected to join the organisation in December 2026. Nicola is currently Chief Nurse at The Walton Centre and brings more than 20 years of nursing experience, including senior leadership roles across the North West. Tracy Fennell will act as interim Chief Nurse until Nicola takes up post, supported by Emma Hackett as interim Deputy Chief of Nursing.

Appointment of Tina Moors as Director of Midwifery

Tina Moors has also been appointed as Director of Midwifery following an external recruitment process. Her appointment provides continuity of leadership as the Trust continues its maternity improvement journey and considers emerging national recommendations for maternity and neonatal services.

Staff voice, wellbeing and organisational culture

The 2026 NHS Staff Survey has launched, providing colleagues with an important opportunity to share their experience of working at North Cheshire and Mersey and help shape future priorities. Feedback from previous surveys and wider engagement has informed the NCM Behavioural Framework, expansion of executive and senior leader visits, the NCM Champions network, the Trust wide cultural review and further work on speaking up, wellbeing, recognition, leadership development and tackling bullying, harassment and violence at work.

The Trust also marked World Suicide Prevention Day by reinforcing the importance of compassionate conversations, psychological safety and access to support. Colleagues were encouraged to look after themselves and one another, to speak openly when

they are struggling and to use the Trust's occupational health and mental wellbeing resources where needed.

Supporting colleagues, recognition and career development

The Trust has continued to recognise and support colleagues through a range of workforce and wellbeing initiatives. A new staff running club has brought colleagues together to improve fitness, build connections across services and raise funds for the hospital charity, while the Long Service Awards will recognise staff reaching 25, 40 and 50 years of NHS service during 2026.

The nationally recognised 'Your Future Your Way' programme has also opened its fourth cohort. The programme combines inclusive leadership and sponsorship development for senior leaders with accredited leadership and career support for Black and ethnic minority colleagues in Bands 5 and 6. Since 2022, the programme has reached 26 departments, supported 43 senior leaders and enabled 54 colleagues to complete a Level 3 CMI accredited leadership programme, alongside a range of promotions, development moves and service improvement projects.

The work of the Women's Staff Network, Culture and Inclusion Team and Menopause Café has received national recognition, with the Trust shortlisted in the Most Open Culture category of the Menopause Friendly Employer of the Year Awards. This reflects continued progress in creating a workplace where colleagues feel able to discuss menopause openly and access practical support.

Workforce sustainability and organisational change

The Trust launched a voluntary redundancy scheme as part of work to develop a sustainable organisation and align its workforce with future models of care. The voluntary scheme was developed with Staff Side colleagues and through established governance processes. Applications are being assessed against future workforce requirements, service continuity, patient safety and the need to retain essential skills.

Improving patient flow and working across organisational boundaries

The Trust held its first Flow Support Week, building on the Corridor Care Summit, Improving Flow Workshop and Home First approach. The week focused on embedding consistent multidisciplinary board rounds, using the S.H.O.P. model, identifying discharge actions early, supporting patients to remain active and making effective use of the Discharge Lounge. Ward teams were supported to share progress and learning, with the aim of making these improvements part of routine practice and helping more patients return home safely and sooner.

A visit by the Trust Chair and Chief Executive to North West Ambulance Service strengthened shared understanding of the pressures across urgent and emergency care pathways. The visit highlighted the breadth of ambulance service responsibilities, including emergency response, NHS 111 and patient transport, and reinforced the importance of reducing handover delays, strengthening alternative pathways and supporting patients to receive the right care in the right place.

Partnership working and care closer to home

The Trust continues to work with the other provider organisations in Cheshire and Merseyside through the Cheshire and Merseyside Provider Collaborative. This includes closer working with neighbouring trusts through a regional alliance, with a focus on sharing expertise, strengthening service resilience, reducing unnecessary duplication and exploring opportunities to improve access and outcomes for patients. Regional collaboration is also one of the emerging themes informing the development of the NCM 2030 strategy.

WELL Runcorn has officially opened in the former Runcorn Library, bringing health, wellbeing, education and advice services together in a community setting. Developed with Halton Borough Council, Riverside College and Mersey Care, the hub supports the Trust's ambition to provide more care closer to home and builds on the partnership model established through the Living Well Hub in Warrington.

Celebrating Halton Hospital

Halton Hospital celebrated its 50th anniversary in September 2026. Since opening in 1976, the site has developed from its original outpatient and day patient services to include a wider range of care, supported by investment in theatres, endoscopy and the Warrington and Halton Diagnostic Centre. The anniversary provided an opportunity to recognise the contribution of staff and volunteers who have supported patients and communities throughout the hospital's history.

Organ donation

During Organ Donation Week, the Trust recognised the contribution of clinical teams, donors and families to lifesaving transplantation. Warrington Hospital recorded its highest number of consented and actual donors in the previous year, resulting in 28 transplants.

This local achievement comes against a challenging national position. NHS England and NHS Blood and Transplant have reported a continuing decline in eligible donors, referrals and family consent, alongside a record number of patients waiting for transplantation. NHS organisations have therefore been asked to maintain a strong focus on identifying and referring potential donors, supporting timely clinical decision making and ensuring that families receive high quality, sensitive support from appropriately trained teams.

The Trust will continue to work closely with specialist organ donation colleagues and use its established governance arrangements to review local data, identify any missed opportunities and support improvement. Colleagues, patients and members of the public are also encouraged to record their decision on the NHS Organ Donor Register and discuss their wishes with their families, as family awareness significantly increases the likelihood of donation proceeding.

2.2 National, Regional & ICB News

Learning from the Thirlwall Inquiry

The final report of the Thirlwall Inquiry sets out profound and distressing learning for the NHS following failures to protect babies and respond effectively to concerns. The findings require every NHS organisation, not only those providing neonatal care, to consider whether its leadership, governance and culture support professional curiosity, effective challenge and the timely escalation of concerns. The babies and families affected remain at the heart of this work.

NHS England has asked Trust Boards to consider the report and seek assurance about the safety of babies and children across all care settings. Immediate expectations include reviewing safeguarding arrangements and training, reinforcing the application of protocols for sudden and unexpected deaths in children, improving bereavement support and strengthening controls relating to medicines within neonatal services.

The Trust is reviewing the findings through its established quality, safeguarding and governance arrangements. This will provide assurance that colleagues know how to raise and escalate concerns, that those concerns are listened to and acted upon, and that appropriate support is available to families and staff. Any resulting actions will be monitored through the relevant Board and committee routes.

NHS Oversight Framework Quarter 1 position

Nationally, the Quarter 1 2026/27 NHS Oversight Framework results have been published using the revised methodology. Individual metrics continue to be scored from 1 to 4, but organisations are now allocated to an overall segment by comparing their average metric score with fixed thresholds, rather than through the previous quartile-based approach.

The Trust has been placed in Segment 3, improving from Segment 4 in the previous quarter. The Trust is ranked 97th out of 134 organisations, an improvement of five places from 102nd.

The results show stronger performance in diagnostic waiting times, 28-day cancer diagnosis, delayed planned inductions, 30-day readmissions and relative costs. Areas requiring continued focus include urgent and emergency care, community waiting times, finance, infection measures and workforce indicators.

Performance and patient care

The latest national core metrics continued to show encouraging progress across elective, cancer, diagnostic and urgent and emergency care. The Trust was first in the North West for both key cancer treatment standards, performed above the Cheshire and Merseyside peer average in six of the eight measures and improved faster than the national average in six measures over the preceding 12 months. The results reflect the collective contribution of teams across the organisation, while reinforcing the need

for continued focus on long waits in Emergency Departments, corridor care, patient flow, quality and patient experience.

Access standards and revised tiering arrangements

NHS England North West has strengthened its arrangements to improve waiting times across planned care, cancer, diagnostic services and urgent and emergency care. This includes agreed regional targets and making better use of available capacity across organisations. Trusts and integrated care boards will work together on recovery plans, with progress monitored by NHS England North West

From 1 October 2026, access support arrangements will also change. Trusts whose performance is significantly behind plan or getting worse may receive additional oversight and support, with their position reviewed each month. Outcomes will be shared with Trust Chairs and Chief Executives and considered by Boards and their relevant committees.

The Trust will continue to monitor its performance, deliver the required improvements and report progress through its established executive, committee and Board arrangements.

Protecting patient information and confidentiality

NHS England has reinforced its expectations following continued reports of staff accessing confidential patient information without a legitimate reason. Such access is unlawful, represents a serious breach of patient privacy and risks undermining public confidence in the NHS. NHS England has therefore called for a consistent and robust approach, with unauthorised, inappropriate or unjustifiable access expected to be treated as potential gross misconduct in almost all cases.

Organisations are expected to investigate suspected incidents promptly, involve their Data Protection Officer and consider any associated reporting obligations. Where allegations are substantiated, action may include disciplinary proceedings, referral to a professional regulator and, where appropriate, notification to the Information Commissioner’s Office, the police and the affected patient. NHS England has also emphasised the importance of proportionate access controls and effective monitoring, particularly where records may attract heightened interest.

The Trust has reinforced with colleagues that patient records must only be accessed where there is a legitimate work related reason. Existing information governance, audit and workforce arrangements will be reviewed against the updated national advice to ensure that suspected breaches are identified, investigated and addressed appropriately, while maintaining fair and consistent processes for those involved

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 5 – August 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:

August 2026

- World Breastfeeding Awareness
- Cycle to Work Day

September 2026

- Urology Awareness Month
- East and South East Asian heritage month
- Pulmonary Fibrosis Awareness Month
- Know Your Numbers Week (An annual week-long campaign encouraging adults to know their blood pressure numbers and take the necessary action to reach and maintain a healthy blood pressure)
- National Inclusion Week
- National Suicide Memorial Day
- World Patient Safety Day
- Migraine Awareness Week
- Rheumatoid Arthritis Awareness Week
- Occupational Health Week
- Organ Donation Week
- International Day of Sign Languages
- World Pharmacists Day
- Macmillan - World's Biggest Coffee Morning

2.5 Signed under Seal

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

- Licence to assign for a staff area in Warrington Hospital
- Deed of Variation relating to Unit 42 of Runcorn Shopping City (Halton Health Hub)

2.6 Meetings Attended

Since the last Board meeting, I have continued to engage with local, system and regional partners, representing the Trust and contributing to discussions on service transformation, collaboration and future delivery arrangements. This has included participation in the Cheshire and Merseyside Provider Collaborative Leadership Meeting and Delivery Board, alongside discussions on the Integrated Referral Programme and CMPC blueprint modelling.

I have also met with partners from the University of Chester and North West Ambulance Service, the CMPC Chief Executive, local authority leaders from Warrington and Halton, and Sir David Henshaw, Chair, NHS Cheshire and Merseyside ICB. These discussions have provided opportunities to strengthen strategic relationships, develop shared priorities and ensure that the Trust's perspective continues to inform work across Cheshire and Merseyside.

3. Recommendations

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

Appendix 1: CEO Dashboard – Month 5 (August 2026)
Appendix 2: National Oversight Framework Q1

Appendix 1 - CEO Dashboard Month 5 – August 26

North Cheshire and Mersey NHS Foundation Trust

Quality of Care

Indicator	target/limit	Actual	SPC
Incidents open over 40 days	0	42	
Sepsis Screening Emergency	above 90%	74.00%	
Sepsis Screening Inpatients	above 90%	95.00%	
Sepsis Antibiotics Emergency	above 90%	54.00%	
Sepsis Antibiotics Inpatient	above 90%	63.00%	
Inpatient Falls	below YTD 198	230 YTD	
VTE	above 95%	82.36%	
Acute Pressure Ulcers (Category 2)	below YTD 45	57 YTD	
Acute Pressure Ulcers (Category 3 and Category 4)	below YTD 4	6 YTD	
Community Pressure Ulcers (Category 2)	below YTD 78	91 YTD	
Community Pressure Ulcers (Category 3 and Category 4)	below YTD 21	20 YTD	
Medication Reconciliation (within 24 hrs)	above 80%	49.15%	
Complaints over 6 months	0	2	
Healthcare Infections - MRSA	below YTD 0	0 YTD	
Healthcare Infections - MSSA	below YTD 13	15 YTD	
Healthcare Infections – CDI (cumulative)	below YTD 25	39 YTD	
Healthcare Infections - E. coli (cumulative)	below YTD 30	37 YTD	
Healthcare Infections – Klebsiella (cumulative)	below YTD 10	11 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	below YTD 3	4 YTD	
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	3.90%	
MUST nutritional assessment completion	above 85%	71.94%	
Duty of Candor	100%	100.00%	

Workforce

Indicator	target/limit	Actual	SPC
Supporting Attendance	below 5%	6.08%	
Workforce FTE Plan Compliance	100% or below	99.86%	
Core/Mandatory Training	above 85%	91.26%	
PDR Compliance	above 85%	81.07%	

Operational Performance

Indicator	target/limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95% (M12 plan: 97.9%)	93.44%	
RTT 18 Weeks	above 92% (M12 plan: 72.0%)	65.30%	
RTT - patients waiting 52+ Weeks	0 (M12 plan: 130)	321	
RTT - patients waiting 65+ Weeks	0	0	
Elective Outpatient activity	104%	91%	
A&E Waiting Times (Type 1) – % patients waiting under 4 hours	above 78% (plan: 67.0%)	67.69%	
A&E % waiting longer than 12 hours	below 2.00%	24.68%	
% Patients referred to ED from UTC	below 3.00%	10.98%	
Cancer 28 Day Faster Diagnostic Standard	above 80% (plan: 80.1%)	80.21%	
Cancer 62 Day Wait	above 85% (plan: 79.1%)	83.67%	
Ambulance Vehicle Handovers within 45 mins	100% (plan: 94.5%)	81.03%	
Cancelled Operations – not rearranged within 28 days	0	11	
Capped Theatre Utilisation	above 85%	81.60%	
Average days from discharge-ready to actual discharge	1 day or below	1.26 days	
Urgent Community Response (UCR)	70.00%	94.80%	
% Of Community Waiters over 52 weeks (exc. Derm and Dental)	0.00%	22.53%	
Number of patients waiting over 52 weeks (inc. Derm & Dental)	0	2282	
Number of patients waiting over 65 weeks (inc. Derm & Dental)	0	1737	
Number of patients waiting over 104 weeks (inc. Derm & Dental)	0	634	

Finance

Indicator	target/limit	Actual	SPC
Income & Expenditure (£m)	-£15.3	-£16.7	
Capital Spend (£m)	£10.0	£4.5	
Cash Balance (£m)	£13.5	£17.8	
Better Practice Payment Code	above 95%	50%	
Agency Reduction (£m)	£0.9 (30% reduction from 2025/65 plan)	£0.5	
Bank Reduction (£m)	£11.1 (10% reduction from 2025/26 plan)	£12.9	
CIP In Year Delivered in relation to plan	90% of plan	100%	
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	73%	

Strategy

Well Runcorn

The WELL Runcorn Hub held its official opening ceremony on 10 September and is now providing a range of health, wellbeing and education services in Runcorn old town.

The Hub brings together NHS, local authority, education and community services under one roof.

WELL Runcorn is a key example of the Trust's neighbourhood health approach, supporting prevention, early intervention and improved access to services within local communities.

Since its initial opening to the public in June, WELL Runcorn has welcomed over 1,500 visitors.

Clinical Strategy Development Sessions

The clinical strategy development sessions held with individual groups of clinical services are now under way, with the first sessions covering Paediatrics and Care of the Elderly. The sessions bring clinical teams together to consider where services are now, what they should look like by 2030, and the priority changes needed to deliver our future vision.

Discussions are focusing on how services can support more care closer to home, strengthen prevention and early intervention, and respond to changing population needs.

Key themes emerging from the discussions include neighbourhood health, integration with partners, digital and estates transformation, operational excellence, and developing sustainable services for the future.

Feedback and insights from clinicians and stakeholders will help shape the development of the NCM 2030 Trust Strategy and Clinical Strategy.

UTC

Central funding has been secured to support initial design work for the development of an Urgent Treatment Centre in Warrington, and that work is now underway.

The design phase is expected to be completed by the end of February 2027 and will inform the production of the full business case for submission to NHS England in the summer of 2027.

The proposed location on the Warrington Hospital site remains subject to further assessment and approval. This includes wider aspects such as transport access and car parking provision.

We know there is strong public and media interest and will continue to keep staff updated throughout this process.

Appendix 2

NHS Oversight Framework - NCM Q1 2026/27

Trust Rank	Overall Segment	Average Score
97 out of 134	3	2.63
Previous quarter rank: **102** out of 134	Previous overall segment: 4	Previous Average Score: 2.60
Improvement of 5 places	Improvement of 1 segment	Deteriorated by 0.03

Access to services			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank / Segment**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q1 2026/27	1.00	**53** out of 116				Q4 2025/26	2.28	**61** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q1 2026/27	2.00	**20** out of 118				Q4 2025/26	1.00	**14** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Q1 2026/27	2.81	**55** out of 129			Yes	Q4 2025/26	1.00	**52** out of 130
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Q1 2026/27	2.66	**72** out of 129				Q4 2025/26	2.42	**62** out of 130
Diagnostics	% of referrals where the patient is waiting 6 weeks or longer for a diagnostic test	Quarterly	Q1 2026/27	1.35	**16** out of 131				**New Metric**		
Elective Care	Percentage of patients waiting less than 18 weeks for community services	Quarterly	Q1 2026/27	3.39	**67** out of 79				**New Metric**		
Elective Care	Percentage of patients waiting more than 52 weeks for community services	Quarterly	Q1 2026/27	3.62	**68** out of 79			Yes	Q4 2025/26	3.55	**37** out of 42
UEC	A&E within 4 hours	Quarterly	Q1 2026/27	2.83	**62** out of 123				Q4 2025/26	3.72	**112** out of 123
UEC	A&E within 12 hours	Quarterly	Q1 2026/27	3.98	**121** out of 122			Yes	Q4 2025/26	3.95	**117** out of 123
Elective care	Difference between planned and actual 18 week performance - **Non Scoring**	Quarterly	**Not yet published**						Q4 2025/26	1.00	**71** out of 130
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.63**	**3**				Q4 2025/26	**2.16**	**2**

Effectiveness of Care and Population Health			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Preventing ill health	Percentage of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Quarterly	Q1 2026/27	4.00	**97** out of 126				**New Metric**		
Effectiveness of Care	Summary Hospital-level mortality indicator	Annually	Q1 2026/27	2.00	Not Ranked				Q4 2025/26	2.00	Not Ranked
Effectiveness of Care	Rate of pregnant women with a planned induction that are delayed	Quarterly	Q1 2026/27	1.38	**16** out of 119				**New Metric**		
Experience of Care	30 day readmission rate band	Annually	Q1 2026/27	1.00	Not Ranked				**New Metric**		
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.10**	**2**				**New Domain**		

Experience of Care			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Experience of Care	NHS staff survey advocacy rate	Annually	Q1 2026/27	3.32	**104** out of 134				**New Metric**		
Experience of Care	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked				2024	2.00	Not Ranked
Experience of Care	Number of patients cared for in corridors - **Non Scoring Metric**	Quarterly	**Not yet published**						**New Metric**		
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.66**	**3**				**New Domain**		

Finance and productivity			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Finance	Planned surplus/deficit	Quarterly	Q1 2026/27	4.00	**126** out of 134				Q4 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Q1 2026/27	3.00	**98** out of 134				Q4 2025/26	4.00	**124** out of 134
Finance	Combined finance	Quarterly	Q1 2026/27	4.00	Not Ranked				Q4 2025/26	4.00	**124** out of 134
Productivity	Relative cost difference (National Cost Collection Index)	Annually	Q1 2026/27	1.00	**34** out of 134				**New Metric**		
Innovation	Data Quality Maturity Index	Quarterly	Q1 2026/27	2.17	**48** out of 134				**New Metric**		
Innovation	% of clinical trials set up within 90 days	Quarterly	**No data for Q1 for NCM**						**New Metric**		
Productivity	Implied productivity growth - **Non Scoring Metric**		**Not yet published**						**New Metric**		
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.39**	**3**				Q4 2025/26	**3.75**	**4**

Patient Safety			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Q1 2026/27	4.00	Not Ranked			Yes	Q4 2025/26	2.07	Not Ranked
Patient Safety	Proportion of C. difficile infections	Quarterly	Q1 2026/27	3.00	Not Ranked				Q4 2025/26	3.33	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	Q1 2026/27	2.74	**78** out of 134				2024	1.81	**37** out of 134
Patient Safety	Rate of inpatient falls that cause harm - **Non Scoring Metric**		**Not yet published**						**New Metric**		
Patient Safety	% of inpatients to acquire a new grade 3 or 4 pressure ulcer - **Non Scoring Metric**		**Not yet published**						**New Metric**		
Patient Safety	% of safety incidents causing harm - **Non Scoring Metric**		**Not yet published**						**New Metric**		
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.80**	**4**				Q4 2025/26	**2.44**	**2**

People and Workforce			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
People and culture	Sickness absence rate	Quarterly	Q1 2026/27	3.3	**119** out of 134			Yes	Q4 2025/26	3.19	**114** out of 134
People and culture	NHS Staff survey engagement theme sub-score	Annually	Q1 2026/27	3.01	**90** out of 134				Q4 2025/26	3.01	**90** out of 134
People and culture	National Education and Training Survey satisfaction rate	Annually	Q1 2026/27	3.93	**129** out of 134				**New Metric**		
People and culture	NHS staff standards score	Annually	Q1 2026/27	2.56	**70** out of 134				**New Metric**		
Workforce	Healthcare Worker Flu Vaccination Rate	Quarterly	Q1 2026/27	2.37	**70** out of 134				**New Metric**		
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**3.03**	**4**				Q4 2025/26	**3.10**	**4**

Segment 2 or lower
Segment 3
Segment 4
Contextual (Non Scoring)

No Change
Improvement
Concern

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/079**
Subject:	**Integrated Performance Report**
Date of meeting:	7 October 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 Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓

	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 **four indicators that are both failing and have special cause variation of a concerning nature**, 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 • **67.Number of patients waiting over 52 weeks to access community services (including dental and dermatology)** - Target zero • **69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology) -** Target zero There is **one indicator that have special cause variation of a concerning nature and do not have a target.** • **15. Mortality ratio - SHMI** There are **two indicators that consistently fail and cannot be measured for variation,** these are: • **79. CIP (recurrent) –** % delivered against plan • **81. Bank Reduction** – delivery against 15% reduction of 2025/26 plan There are **two indicators that has been requested via the action log to be monitored going forward,** these are:

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

38. A&E Waiting Times (Type 1, 2 &3) – % patients waiting under 4 hours from arrival to admission, transfer or discharge – Target > 78%
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>three indicators that has been highlighted via the latest published NHS Oversight Framework metrics table that are also not reported as exceptions,</u> they are:

% of patients waiting more than 52 Weeks for elective treatment
Proportion of E. coli bacteraemia
Sickness absence rate

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

Financial Position
At Month 5 the Trust has recorded a year to date deficit position of £16.7m which is £1.3m worse than plan. This is made of £1.0m due to the impact of MARS in July and £0.9m due to the impact of industrial action in April which has been partially offset with a non recurrent underspend of £0.6m.
</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to:
1. Note the contents of this report.
2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee.</td></tr>
<tr><td rowspan="3">Previously considered by:</td><td>Committee</td><td colspan="2">Finance, Sustainability and Performance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">FSPC/26/09/104 (vii)</td></tr>
<tr><td>Date of meeting</td><td colspan="2">28/09/2026</td></tr>
</table>

	Summary of Outcome	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**	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & NO SPC**
	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) 67. Number of patients waiting over 52 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)	**Quality** 1.Incidents 16. Medication Safety - Reconciliation within 24 hours 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 63. Capped Theatre Utilisation 68. Number of patients waiting over 65 weeks to access community services (including dental and dermatology) **Workforce** 70. Supporting Attendance 73. PDR compliance **Finance** 76. Capital Programme **(£4.5m - *£10m target*)** 77. Better Payment Practice Code **(50% - *95% target*)**	**Access & Performance** 37. A&E Waiting Times (Type 1) – % patients waiting under 4 hours from arrival to admission, transfer or discharge. 38. A&E Waiting Times (Type 1, 2 &3) – % patients waiting under 4 hours from arrival to admission, transfer or discharge. 48. Referral to treatment Open Pathways 49. RTT - Number of patients waiting 52+ weeks	**Finance** 81. Bank Reduction

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE	INCONSISTENTLY PASSING TARGET & NO SPC
 **Inconsistently Passes/Fails the Target**	**Quality** 2.Healthcare Acquired Infections (MRSA) ↓ 8. VTE Assessment ↓	**Quality** 3. Healthcare Acquired Infections (MSSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (E. coli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 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 23. Complaints over 6 months 29. Sepsis - % screening for all inpatients 32. Acute Kidney Injury 33. Maternity Postpartum Haemorrhage 36. Duty of Candor **Access & Performance** 47. Diagnostic Waiting Times 6 Weeks 50. 28 Day Faster Cancer Diagnosis Standard 56. Elective Outpatient Activity 62. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation **Workforce** 71. Workforce FTE Plan Compliance	**Access & Performance**	**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** 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** 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. 64. Urgent Community Response (UCR) 2-hour compliance %	**Access & Performance** 51. Cancer 31 Days First Treatment **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** 15. Mortality ratio – SHMI ⬇	**Quality** 14. Mortality ratio – HSMR 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 August 2026 is attached in **Appendix 6**.

The Trust submitted a deficit plan of £30.5m. The ICB has agreed £5m additional income therefore reducing the planned deficit to £25.5m, resulting in NHSE increasing the control total from £16.7m to £25.5m deficit. This has enabled the Trust to access Deficit Support Funding (DSF) of £25.5m to produce a breakeven plan. The plan for 2027/28 has also improved from a £17.5m deficit to a £10m deficit and 2028/29 remains at a £3.3m deficit. The Trust therefore has a compliant plan for each of the 3 years of the operational plan.

The Trust received DSF of £12.7m on 15 September relating to Q1 and Q2. The initial guidance for release of Q3 DSF was that the 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. Further guidance has been provided which states that there will be other considerations for eligibility:

- Year to date financial performance including underlying position.
- Continued delivery of CIP programme in line with plan, ensuring recurrent benefits are identified and realised as planned.
- Progress against conditions of plan acceptance and regulatory requirements.
- Delivery of workforce and operational plans alongside management of financial risk linked to achievement of access targets.

The specific considerations highlighted should be viewed as indicators that help inform judgement on the robustness and deliverability of the plan, rather than standalone pass/fail criteria.

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 and Voluntary Redundancy not received).
- Achieving the income plan through core capacity (improved productivity).
- Ability to access Q3 and Q4 DSF, the impact on the cash level and ability to access revenue cash support.
- Achieving the Endoscopy Hub activity plan through mutual aid referrals as demand from external providers was not seen in 2025/26.

- 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.
- Funding for band 5 to band 6 doesn't cover the cost of the uplift as well as any associated back pay.
- HMRC have ruled that overseas workers visas are a benefit in kind leading to additional tax and NI charges for employers, if this ruling remains it will become a cost pressure for the Trust.

Cash

The cash balance at the end of August is £17.8m of which £8.5m relates to capital creditors. Given the current cash position and the planned deficit for 2026/27 the Trust has been in receipt of cash support. The receipt of DSF in September means that the Trust currently does not require any further cash support. This will be reassessed following the outcome of whether Q3 and Q4 DSF will be received.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (50% against a target of 95%, 65% cumulative position in March 2026). Cash days are at 12 days which is a reduction of 1 day since last month (13 days). Cash operating days in August have deteriorated due to supplier payments being required to avoid late payment charges or accounts being place on stop.

CIP

At 31 August 2026, the Trust has delivered a CIP of £10.2m which is in line with plan. However, it should be noted that £2.8m has been achieved from non-recurrent vacancies and central items.

All the £36.8m CIP plan has been identified with 78% implemented / in delivery and 22% fully developed but not yet in delivery. There is a risk to the Trust if it cannot deliver recurrent CIP in 2026/27, therefore further work continues to turn current non-recurrent schemes recurrent or identify additional recurrent schemes. The full year effect of schemes delivering later in the year mitigate the non-recurrent schemes in 2026/27.

Capital Programme

The Trust total capital funding consists of £17.1m Capital Departmental Expenditure Limit (CDEL) and £7.2m external funding, a total of £24.3m.

The Trust capital spend for month 5 is £4.4m which is £5.6m below the plan of £10m. £2.3m 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. The current capital contingency fund is £2m which is an increase of £0.4m since last month relating to VAT recovery. The contingency includes ring fenced funding for a surgical robot.

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
- Quality & Safety Assurance Committee
- Strategic People Committee

5. Recommendations

The Trust Board is asked to:

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

North Cheshire and Mersey
NHS Foundation Trust

IPR – August 2026 Detail

Home
Community
Hospital

Introduction

There are **2 indicators that has been requested via the Action Log to be monitored going forward,** they are:

- **38. A&E Waiting Times (Type 1, 2 & 3) – % patients waiting under 4 hours**
- **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:

- **5. Healthcare Acquired Infections (E.coli)** - Threshold 75 (for 2026/27)
- **49. Referral to treatment - Number of patients waiting 52+ weeks**- Threshold zero (for 2026/27)
- **70. Supporting Attendance**- Target 5.00% (for 2026/27)

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
- **67. Number of patients waiting over 52 weeks to access community services (including dental and dermatology)** - Target zero
- **69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology)** – Target zero

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

- **15. Mortality ratio –** SHMI

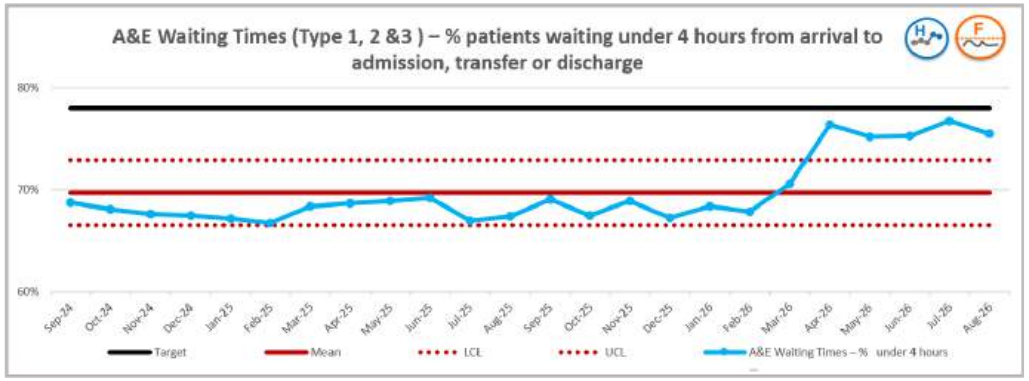
There are **2 indicators that consistently fail and cannot be measured for variation**, these are:

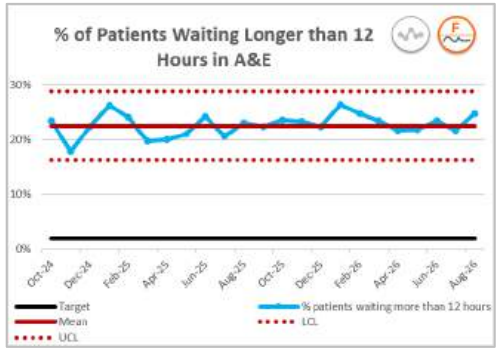
- **79. CIP (recurrent) –** % delivered against plan
- **81. Bank Reduction –** delivery against 10% reduction of 2025/26 plan

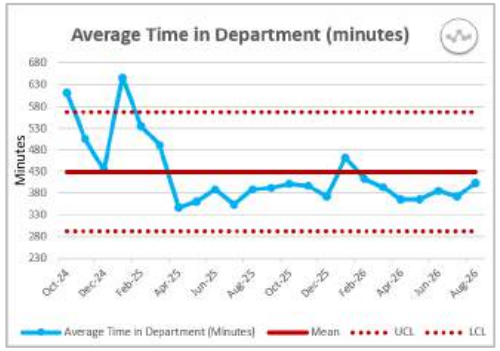
August 2026 IPR by Exception

38. A&E Waiting Times (Type 1, 2 & 3) – % patients waiting under 4 hours &

39. A&E Waiting Times – % patients waiting longer than 12 hours







Acute Provider Table Update

A&E 4-hour performance

53 out of 117

Sourced: Acute Provider Table
August 26 data published Sept 26

A&E 12-hour performance

116 out of 117

Sourced: Acute Provider Table
August 26 data published Sept 26

Reasons for variation and what is the impact

- 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%

How are we going to improve the position

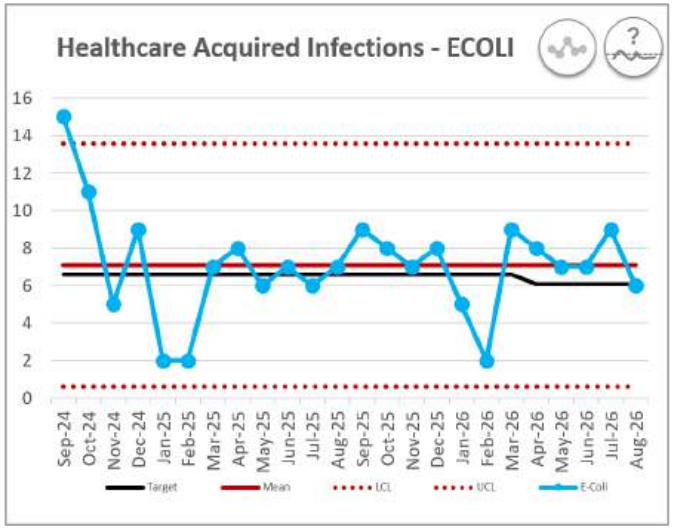
- An action plan of short- and long-term actions has been established and is monitored weekly via the executive chaired ED Improvement Group. Delivery externally is monitored via the bi-weekly NHSE Tiering meetings.
- More intensive support has been provided by the senior leadership to support a reduction 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

August 2026 IPR by Exception

5. Healthcare Acquired Infections (E.coli) - Threshold 75 (for 2026/27)

Healthcare Acquired Infections (E.coli) has been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for Q1 2026/27.

Patient Safety			Current					Previous		
Sub-domain	Description	Refreshed	Reporting Date	Metric Score	Rank	Performance Threshold	Trend	Reporting Date		Rank
Patient Safety	Proportion of E. coli bacteraemia	Quaterly	Q1 2026/27	4.00	Not Ranked	●	▲	Q4 2025/26	2.07	Not Ranked



Reasons for variation and what is the impact

- Q1 2026/27 NHS Oversight Framework data uses a rolling 12-month period Q1 2026/27 included April 25 to March 26
- Overall decreases in HCAI were seen in 2025/26 compared to the previous financial year.
- 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 threshold for E.coli has been reduced from 79 to 73 for 26/27

How are we going to improve the position

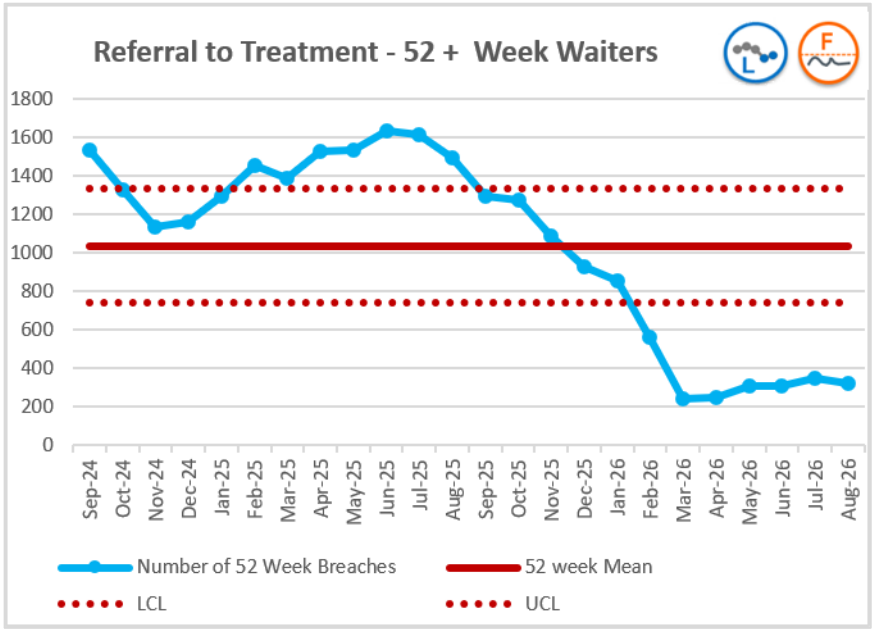
- For E.coli, Klebsiella, Pseudomonas aeruginosa: CAUTI surveillance continues and roll out of UTI prevention toolkit is being re-enforced for wards with UTI associated GNBSI cases. Urinary catheter prevalence survey took place in July, showing areas for improvement with urinary catheter care.

August 2026 IPR by Exception

49. Referral to treatment - Number of patients waiting 52+ weeks - Threshold zero (for 2026/27)

This indicator has been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for Q1 2026/27.

Access to services			Current					Previous		
Sub-domain	Description	Refreshed	Reporting Date	Metric Score	Rank / Segment	Performance Threshold	Trend	Reporting Date	Metric Score	Rank
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quaterly	Q1 2026/27	2.81	55 out of 129	●	▲	Q4 2025/26	1.00	52 out of 130



Reasons for variation and what is the impact

- The NHS Oversight Framework revised the 52-week wait metric from Q1 2026/27, with a score of 1 now requiring zero patients waiting over 52 weeks.
- Organisations reporting >0% are ranked and scored 2-4 based on their absolute percentage.
- This change methodology than 2025/26, when the threshold for the highest score was 1%.

How are we going to improve the position

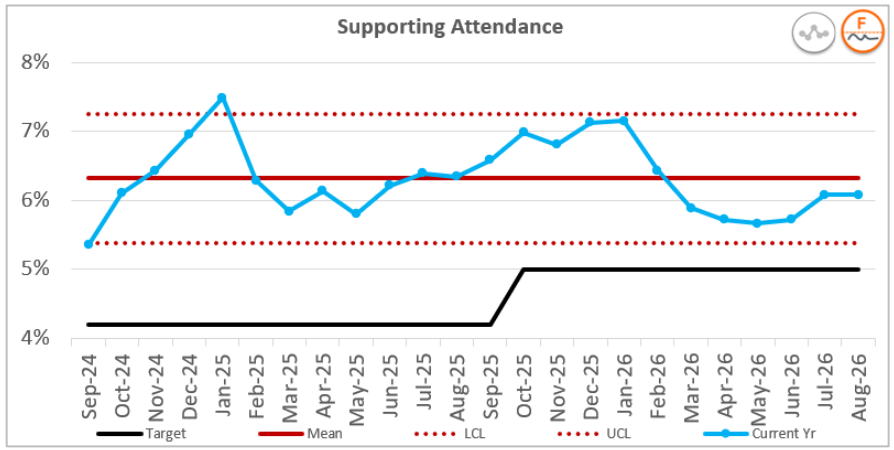
- The Trust has delivered in line with the annual planning submission

August 2026 IPR by Exception

70. Supporting Attendance - Target 5.00% (for 2026/27)

This indicator has been highlighted as it has shown a deteriorating performance on the data published on the NHS Oversight Framework (NOF) for Q1 2026/27.

People and Workforce			Current					Previous		
Sub-domain	Description	Refreshed	Reporting Date	Metric Score	Rank	Performance Threshold	Trend	Reporting Date		Rank
People and culture	Sickness absence rate	Quaterly	Q1 2026/27	3.3	**119** out of 134	●	▲	Q4 2025/26	3.19	**114** out of 134



Reasons for variation and what is the impact

The Trust has achieved a significant reduction in long-term sickness absence, decreasing from 4.8% in January 2025 to 3.38% in August 2026.

Whilst long-term absence continues to improve, short-term sickness absence remains an area of focus at 2.7%.

Sickness absence remains a key performance metric within the National Oversight Framework (NOF), underlining the importance of sustained improvement and effective attendance management.

How are we going to improve the position

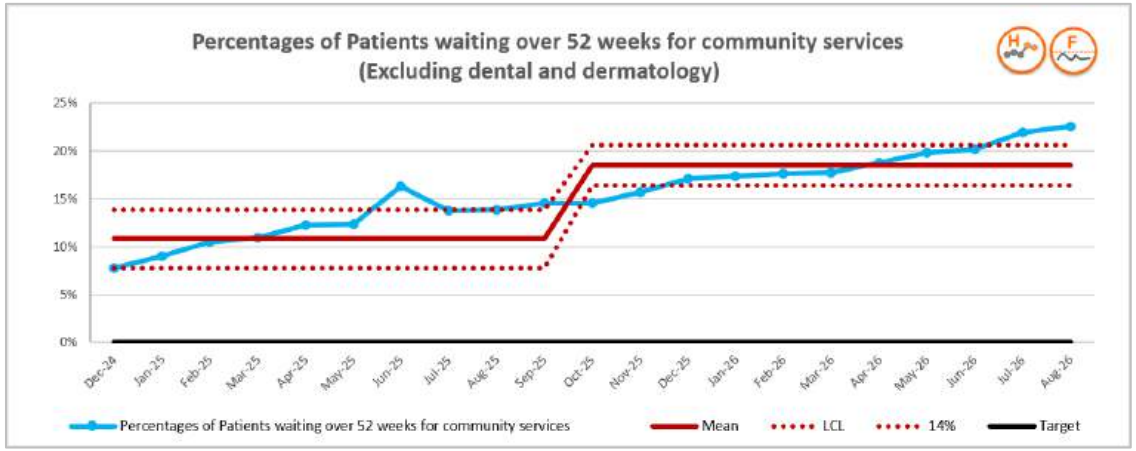
The 12 areas of focus have been refreshed and continue to receive enhanced multi-disciplinary support, including detailed case reviews, KPI monitoring, leadership engagement and executive escalation.

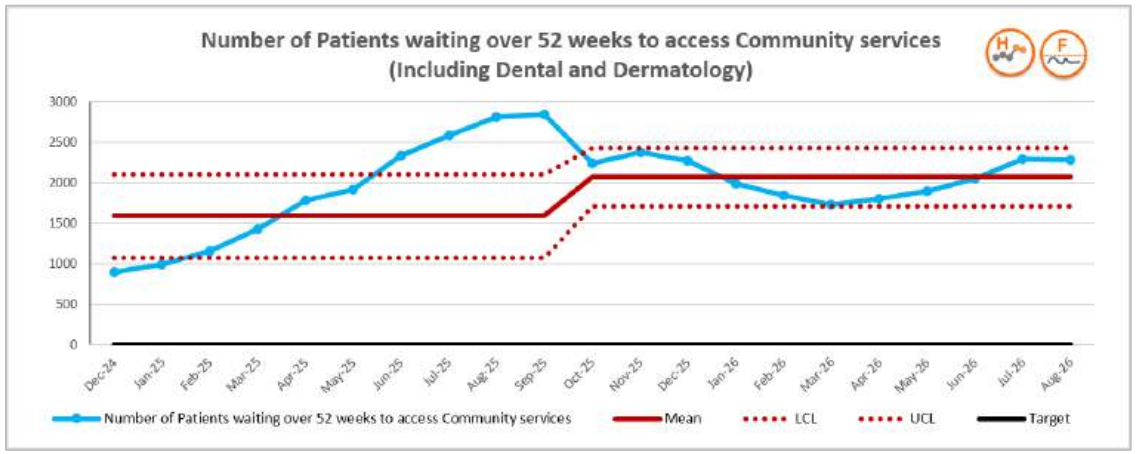
A new Supporting Attendance Policy was launched on 1st July 2026. On demand training is now available. Within People Performance Sub-Committee, Care Groups identify areas with high absence, supported required and ensure leaders are promoting the Health and Wellbeing initiatives.

August 2026 IPR by Exception

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

67. Number of patients waiting over 52 weeks to access community services (including dental and dermatology)





Reasons for variation and what is the impact

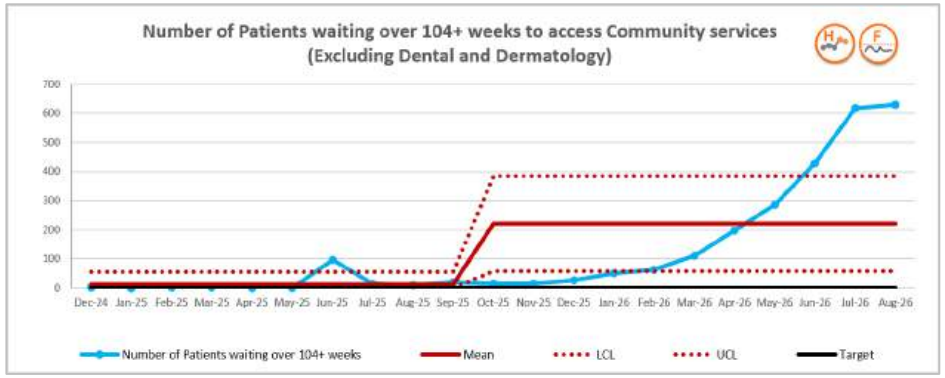
At Month 5, 1,001 children in Halton were waiting over 52 weeks, a decrease of 8 from Month 4, while Warrington reported 1,150 children, an increase of 174. The number of red-risk children increased by 4 to 23 in Halton and by 14 to 20 in Warrington. All red-risk cases will be clinically prioritised and expedited, with the wider cohort remaining subject to active validation and pathway management.

How are we going to improve the position

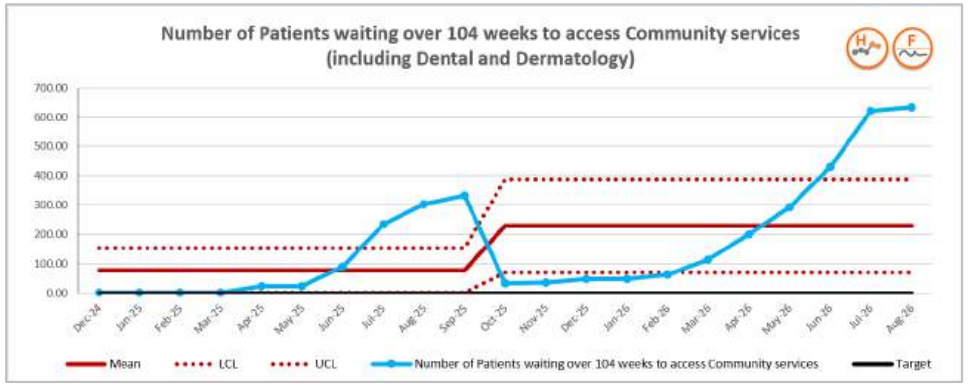
All red-risk children remain subject to active clinical oversight, regular review and prioritisation, with assessments expedited where clinically indicated. Recovery actions continue to focus on reducing the longest waits, increasing assessment capacity and improving pathway throughput, with progress monitored through monthly performance reviews.

August 2026 IPR by Exception

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)



Reasons for variation and what is the impact

At Month 5, 311 children in Halton were waiting over 104 weeks, an increase of 3 from Month 4, while Warrington reported 301 children, an increase of 10.

This longest-wait cohort remains a key operational priority and is subject to targeted validation, clinical oversight and active pathway management to support a sustained reduction in waits.

These longest-waiting children remain visible within pathway management arrangements and are subject to targeted clinical review and intervention.

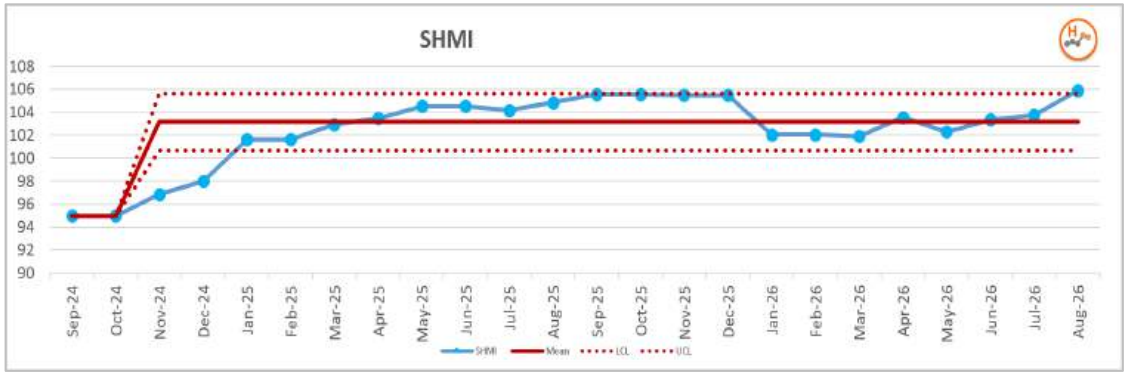
How are we going to improve the position

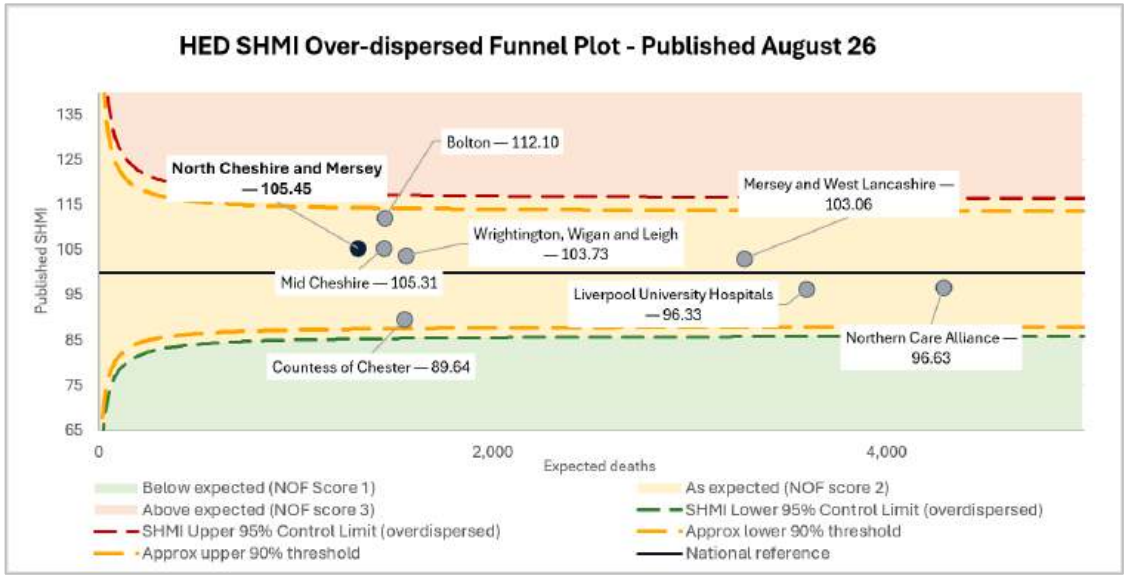
Red-risk cases are prioritised and expedited where required, while recovery activity remains focused on reducing the over-104-week cohort through additional assessment capacity, validation and active management of the longest waiters.

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

August 2026 IPR by Exception

15. Mortality ratio – SHMI





Reasons for variation and what is the impact

It is noted that NCM began including Short Day Emergency Care (SDEC) data in the Emergency Care Data Set (ECDS) instead of the Inpatient Data Set in November 2023. The removal of low mortality risk patients from the SHMI data has resulted in an increased SHMI.

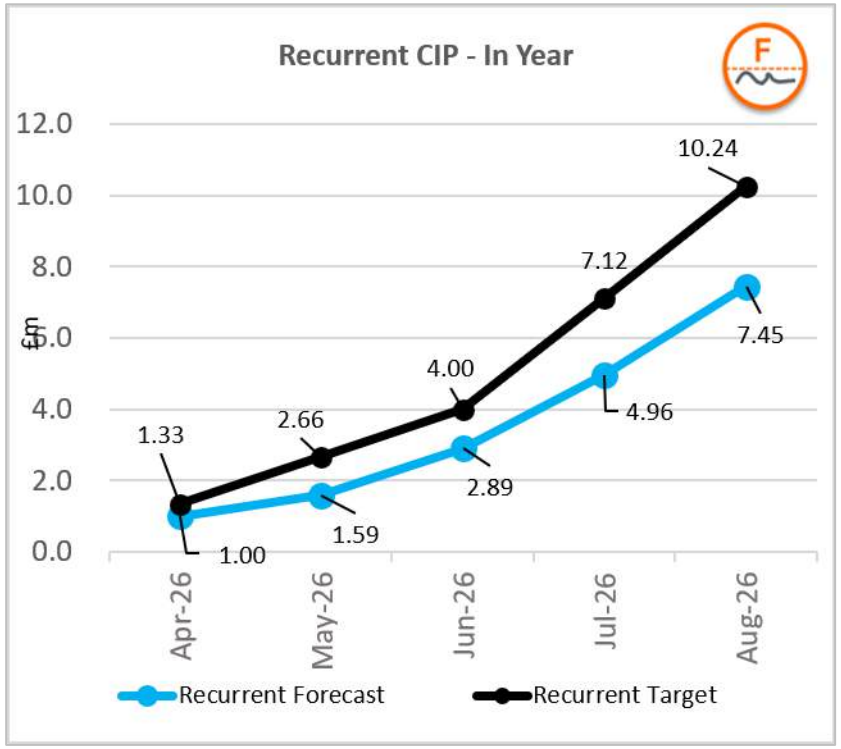
SHMI remains within the NHSE expected range, despite the coding related increase described above.

How are we going to improve the position

NHSE has advised that SDEC activity will return to the admitted patient data set from April 2027 - this is very likely to result in a reduction in SHMI towards previous levels.

August 2026 IPR by Exception

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



Reasons for variation and what is the impact

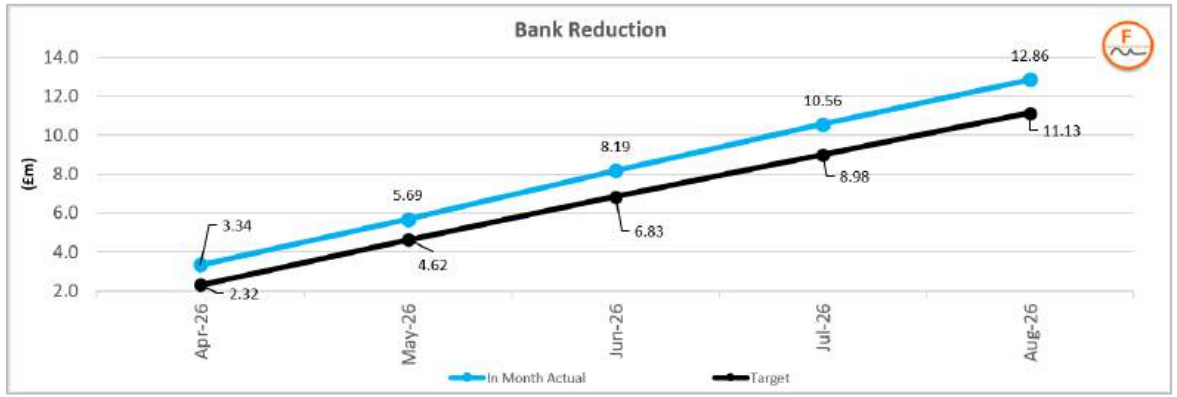
- £7.4m CIP has been delivered recurrently against the target of £10.2m.
- The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. The full year effect of recurrent schemes delivering later in the year mitigates the non-recurrent schemes into 2027/28.
- Where 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.

August 2026 IPR by Exception

81. Bank Reduction – delivery against 10% reduction of 2025/26 plan



Reasons for variation and what is the impact

- Bank expenditure is £12.9m at Month 5 compared to a plan of £11.1m
- At Month 5 bank expenditure is overspent by £1.7m. £1m is due to the impact of April industrial action and the remainder is mainly driven by Surgical SDEC and Halton UTC GP Cover, 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

Appendix 1

NHS Oversight Framework - NCM Q1 2026/27

Trust Rank	Overall Segment	Average Score
97 out of 134	3	2.63
Previous quarter rank: **102** out of 134	Previous overall segment: 4	Previous Average Score: 2.60
Improvement of 5 places	Improvement of 1 segment	Deteriorated by 0.03

Access to services			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank / Segment**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q1 2026/27	1.00	**53** out of 116				Q4 2025/26	2.28	**61** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q1 2026/27	2.00	**20** out of 118				Q4 2025/26	1.00	**14** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Q1 2026/27	2.81	**55** out of 129			Yes	Q4 2025/26	1.00	**52** out of 130
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Q1 2026/27	2.66	**72** out of 129				Q4 2025/26	2.42	**62** out of 130
Diagnostics	% of referrals where the patient is waiting 6 weeks or longer for a diagnostic test	Quarterly	Q1 2026/27	1.35	**16** out of 131					**New Metric**	
Elective Care	Percentage of patients waiting less than 18 weeks for community services	Quarterly	Q1 2026/27	3.39	**67** out of 79					**New Metric**	
Elective Care	Percentage of patients waiting more than 52 weeks for community services	Quarterly	Q1 2026/27	3.62	**68** out of 79			Yes	Q4 2025/26	3.55	**37** out of 42
UEC	A&E within 4 hours	Quarterly	Q1 2026/27	2.83	**62** out of 123				Q4 2025/26	3.72	**112** out of 123
UEC	A&E within 12 hours	Quarterly	Q1 2026/27	3.98	**121** out of 122			Yes	Q4 2025/26	3.95	**117** out of 123
Elective care	Difference between planned and actual 18 week performance - **Non Scoring**	Quarterly	**Not yet published**						Q4 2025/26	1.00	**71** out of 130
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.63**	**3**				Q4 2025/26	**2.16**	**2**

Effectiveness of Care and Population Health			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Preventing ill health	Percentage of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Quarterly	Q1 2026/27	4.00	**97** out of 126					**New Metric**	
Effectiveness of Care	Summary Hospital-level mortality indicator	Annually	Q1 2026/27	2.00	Not Ranked				Q4 2025/26	2.00	Not Ranked
Effectiveness of Care	Rate of pregnant women with a planned induction that are delayed	Quarterly	Q1 2026/27	1.38	**16** out of 119					**New Metric**	
Experience of Care	30 day readmission rate band	Annually	Q1 2026/27	1.00	Not Ranked					**New Metric**	
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.10**	**2**					**New Domain**	

Experience of Care			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Experience of Care	NHS staff survey advocacy rate	Annually	Q1 2026/27	3.32	**104** out of 134					**New Metric**	
Experience of Care	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked				2024	2.00	Not Ranked
Experience of Care	Number of patients cared for in corridors - **Non Scoring Metric**	Quarterly	**Not yet published**							**New Metric**	
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.66**	**3**					**New Domain**	

Finance and productivity			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Finance	Planned surplus/deficit	Quarterly	Q1 2026/27	4.00	**126** out of 134				Q4 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Q1 2026/27	3.00	**98** out of 134				Q4 2025/26	4.00	**124** out of 134
Finance	Combined finance	Quarterly	Q1 2026/27	4.00	Not Ranked				Q4 2025/26	4.00	**124** out of 134
Productivity	Relative cost difference (National Cost Collection Index)	Annually	Q1 2026/27	1.00	**34** out of 134					**New Metric**	
Innovation	Data Quality Maturity Index	Quarterly	Q1 2026/27	2.17	**48** out of 134					**New Metric**	
Innovation	% of clinical trials set up within 90 days	Quarterly	**No data for Q1 for NCM**							**New Metric**	
Productivity	Implied productivity growth - **Non Scoring Metric**		**Not yet published**							**New Metric**	
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.39**	**3**				Q4 2025/26	**3.75**	**4**

Patient Safety			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Q1 2026/27	4.00	Not Ranked			Yes	Q4 2025/26	2.07	Not Ranked
Patient Safety	Proportion of C. difficile infections	Quarterly	Q1 2026/27	3.00	Not Ranked				Q4 2025/26	3.33	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	Q1 2026/27	2.74	**78** out of 134				2024	1.81	**37** out of 134
Patient Safety	Rate of inpatient falls that cause harm - **Non Scoring Metric**		**Not yet published**							**New Metric**	
Patient Safety	% of inpatients to acquire a new grade 3 or 4 pressure ulcer - **Non Scoring Metric**		**Not yet published**							**New Metric**	
Patient Safety	% of safety incidents causing harm - **Non Scoring Metric**		**Not yet published**							**New Metric**	
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**2.80**	**4**				Q4 2025/26	**2.44**	**2**

People and Workforce			Current						Previous		
Sub domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Performance Threshold**	**Trend**	**Narrative provided**	**Reporting Date**		**Rank**
People and culture	Sickness absence rate	Quarterly	Q1 2026/27	3.3	**119** out of 134			Yes	Q4 2025/26	3.19	**114** out of 134
People and culture	NHS Staff survey engagement theme sub-score	Annually	Q1 2026/27	3.01	**90** out of 134				Q4 2025/26	3.01	**90** out of 134
People and culture	National Education and Training Survey satisfaction rate	Annually	Q1 2026/27	3.93	**129** out of 134					**New Metric**	
People and culture	NHS staff standards score	Annually	Q1 2026/27	2.56	**70** out of 134					**New Metric**	
Workforce	Healthcare Worker Flu Vaccination Rate	Quarterly	Q1 2026/27	2.37	**70** out of 134					**New Metric**	
Domain Summary	**Average score**	**Quarterly**	**Q1 2026/27**	**3.03**	**4**				Q4 2025/26	**3.10**	**4**

Segment 2 or lower
Segment 3
Segment 4
Contextual (Non Scoring)

No Change
Improvement
Concern

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

Appendix 2

Key:

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

		Latest				Previous		
	QUALITY	Target/Threshold	Actual	Period	Variation	Actual	Period	Assurance
1	Incidents	0	42	Aug-26		22	Jul-26	F
2	Healthcare Acquired Infections (MRSA)	0 (for 2026/27)	1	Aug-26	H	0	Jul-26	?
3	Healthcare Acquired Infections (MSSA)	32 (for 2026/27	5	Aug-26		4	Jul-26	?
4	Healthcare Acquired Infections (CDI)	65 (for 2026/27)	7	Aug-26		11	Jul-26	?
5	Healthcare Acquired Infections (Ecoli)	75 (for 2026/27)	6	Aug-26		9	Jul-26	?
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2026/27)	4	Aug-26		4	Jul-26	?
7	Healthcare Acquired Infections (PA)	8 (for 2026/27)	0	Aug-26		1	Jul-26	?
8	VTE Assessment	95.00%	82.36%	Aug-26	L	95.28%	Jul-26	?
9	Inpatient Falls	10% reduction from 2025/26	52	Aug-26		45	Jul-26	?
10	Acute - Total Pressure Ulcers (Category 2)	20% reduction from 2025/26	16	Aug-26		5	Jul-26	?
11	Acute - Total Pressure Ulcers (Category 3 & 4)	20% reduction from 2025/26	2	Aug-26		0	Jul-26	?
12	Community Acquired Pressure Ulcers (Category 2)	20% reduction from 2025/26	8	Aug-26		24	Jul-26	?
13	Community Acquired Pressure Ulcers (Category 3 and above)	20% reduction from 2025/26	6	Aug-26		4	Jul-26	?

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14	Mortality ratio - HSMR	No target set	90.08	Aug-26		91.64	Jul-26	No SPC
15	Mortality ratio - SHMI	No target set	105.45	Aug-26	H	103.74	Jul-26	No SPC
16	Medication Safety Reconciliation within 24 hours	80.00%	49.15%	Aug-26		47.74%	Jul-26	F
17	Acute Medication Incidents	No target set	157	Aug-26		141	Jul-26	No SPC
18	Community Medication Incidents	No target set	22	Aug-26		7	Jul-26	No SPC
19	Average Fill Rate - Day registered nurses / midwives	90%	88.76%	Aug-26		91.56%	Jul-26	?
20	Average Fill Rate - Day care staff	90%	94.44%	Aug-26		92.40%	Jul-26	P
21	Average Fill Rate - Night registered nurses / midwives	90%	93.26%	Aug-26		94.66%	Jul-26	?
22	Average Fill Rate - Night care staff	90%	104.42%	Aug-26		101.02%	Jul-26	P
23	Complaints	Zero complaints open over 6 months old/in the backlog	2	Aug-26		1	Jul-26	?
24	Friends and Family (Inpatients & Day cases)	95%	96.31%	Aug-26		96.69%	Jul-26	P
25	Friends and Family (ED and UCC)	87%	71.12%	Aug-26		71.13%	Jul-26	F
26	Friends and Family (Community)	90%	93.78%	Aug-26		95.11%	Jul-26	P
27	Mixed Sex Accommodation Breaches (ITU)	0	14	Aug-26		9	Jul-26	F

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28	Sepsis - % screening for all emergency patients.	90.00%	74.00%	Aug-26		90.00%	Jul-26	F
29	Sepsis - % screening for all inpatients	90.00%	95.00%	Aug-26		86.00%	Jul-26	?
30	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	54.00%	Aug-26		70.00%	Jul-26	F
31	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	63.00%	Aug-26		67.00%	Jul-26	F
32	Acute Kidney Injury	Less than previous month	134	Aug-26		157	Jul-26	?
33	Maternity Postpartum Haemorrhage	3.70%	3.90%	Aug-26		1.94%	Jul-26	?
34	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	35%	Aug-26		38%	Jul-26	No SPC
35	MUST nutritional assessment completion	above > 85%	71.94%	Aug-26		73%	Jul-26	F
36	Duty of Candor	100%	100.00%	Aug-26		100%	Jul-26	?

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	Target/Threshold	Actual	Period	Variation	Actual	Period	
37	A&E Waiting Times (Type 1) – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	78%	67.69%	Aug-26	H	70%	Jul-26	F
38	A&E Waiting Times (Type 1, 2 &3) – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	78%	75.48%	Aug-26	H	77%	Jul-26	F
39	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	24.68%	Aug-26		21.7%	Jul-26	F
40	Average time in department ED	No target set	403	Aug-26		372	Jul-26	No SPC
41	Ambulance Handovers within 15 minutes	65%	50.35%	Aug-26		51.88%	Jul-26	F
42	Ambulance Handovers within 30 minutes	95%	73.76%	Aug-26		76.97%	Jul-26	F
43	Ambulance Handovers within 45 minutes	100%	81.03%	Aug-26		85.02%	Jul-26	F
44	Type 5 attendances	No target set	2891	Aug-26	H	3001	Jul-26	No SPC
45	Percentage referred onto A&E from UTC	3% or below	10.98%	Aug-26		9.07%	Jul-26	F
46	Patients seen in the Fracture Clinic within 72 hours	95%	73.40%	Aug-26		75%	Jul-26	?
47	Diagnostic Waiting Times 6 Weeks	95.00%	93.44%	Aug-26		93.74%	Jul-26	?
48	Referral to treatment Open Pathways	92.00%	65.30%	Aug-26	H	64.45%	Jul-26	F
49	Referral to treatment - Number of patients waiting 52+ weeks	0	321	Aug-26	L	349	Jul-26	F

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- Consistently fails the target

50	28 Day Faster Cancer Diagnosis Standard	80%	80.21%	Jul-26		81.04%	Jun-26	
51	Cancer 31 Day Wait	96%	98.17%	Jul-26		98.29%	Jun-26	
52	Cancer 62 Day Wait	85%	83.67%	Jul-26		81.60%	Jun-26	
53	Reduction in Outpatient Follow Ups compared to 19/20 activity	No target set	77%	Aug-26		69%	Jul-26	
54	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA		NA	NA	
55	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA		NA	NA	
56	Elective Outpatient Activity	104%	91%	Aug-26		87%	Jul-26	
57	Super Stranded Patients	Trajectory	127	Aug-26		118	Jul-26	
58	No Criteria to Reside (NCTR)	No target set	140	Aug-26		150	Jul-26	
59	Average number of days from discharge ready date to actual discharge date	1 Day or less	1.26	Aug-26		1.79	Jul-26	
60	% Patients discharged to their usual place of residence	No current threshold	97%	Aug-26		96%	Jul-26	
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%	1.08%	Aug-26		0.99%	Jul-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	11	Aug-26		10	Jul-26	

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

Appendix 2

Key:

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

63	Capped Theatre Utilisation	85%	81.60%	Aug-26		73.80%	Jul-26	F
64	Urgent Community Response (UCR) 2 hour compliance %	70%	94.80%	Aug-26		97.20%	Jul-26	P
65	Percentage of patients over 52 weeks for community services (**excluding** dental and dermatology)	0%	22.53%	Aug-26	H	22%	Jul-26	F
66	Number of patients waiting over 104+ weeks to access community services (**excluding** dental and dermatology)	0	629	Aug-26	H	617	Jul-26	F
67	Number of patients waiting over 52 weeks to access community services (**including** dental and dermatology)	0	2282	Aug-26	H	2290	Jul-26	F
68	Number of patients waiting over 65 weeks to access community services (**including** dental and dermatology)	0	1737	Aug-26		1636	Jul-26	F
69	Number of patients waiting over 104 weeks to access community services (**including** dental and dermatology)	0	634	Aug-26	H	621	Jul-26	F

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

Appendix 2

Key:



Special Cause Variation of a improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fail the target



Consistently fails the target

		Latest				Previous		Assurance
	WORKFORCE	Target/Threshold	Actual	Period	Variation	Actual	Period	
70	Supporting Attendance	5.00%	6.08%	Aug-26		6.08%	Jul-26	
71	Workforce FTE Plan Compliance	100% Plan	99.86%	Aug-26		100%	Jul-26	
72	Core/Mandatory Training	85.00%	91.26%	Aug-26		91.43%	Jul-26	
73	PDR compliance	85.00%	81.07%	Aug-26		82.97%	Jul-26	

Statistical Process Control - Assurance & Variation

NHS
North Cheshire and Mersey
NHS Foundation Trust

Appendix 2

Key:



Special Cause Variation of a improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target

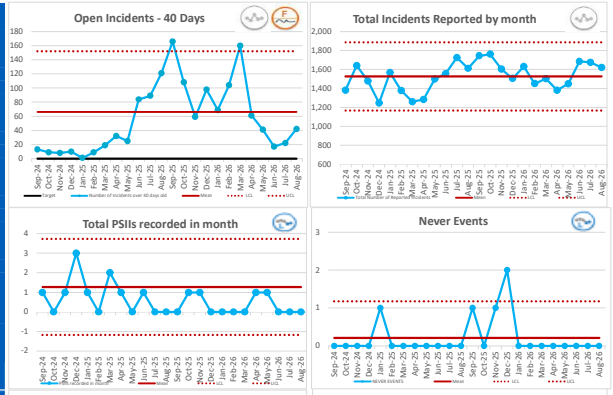
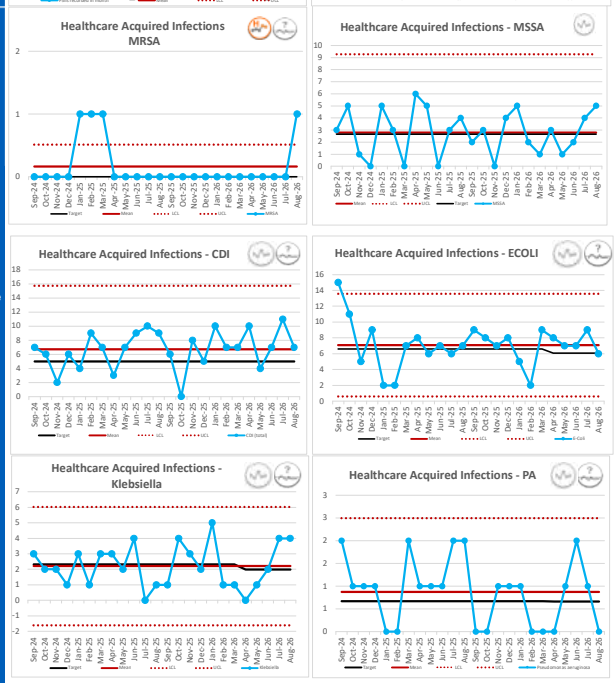
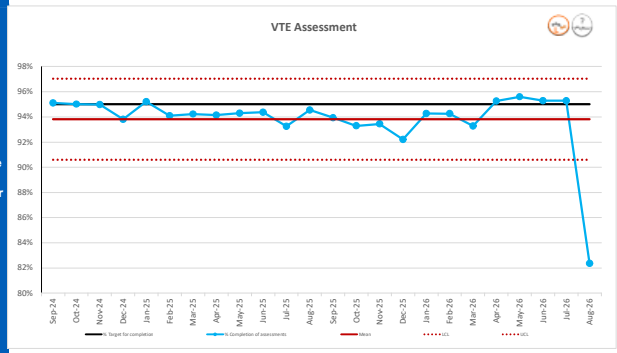


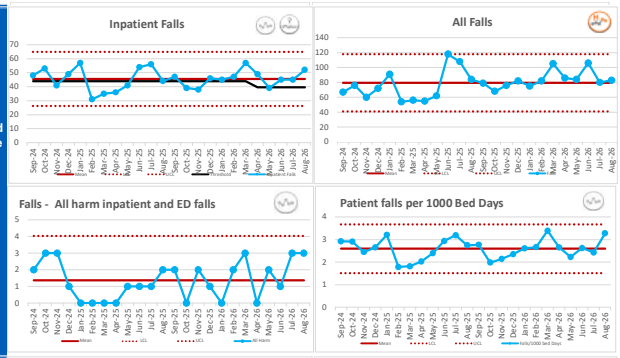
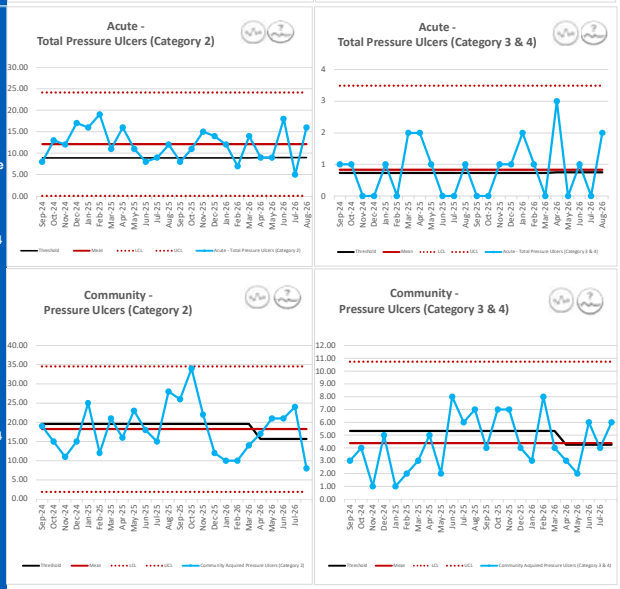
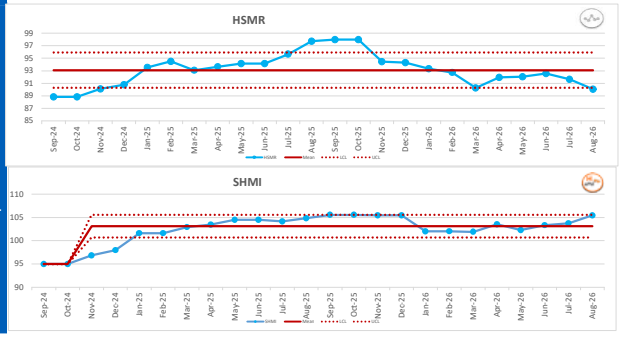
Inconsistently passes and fail the target

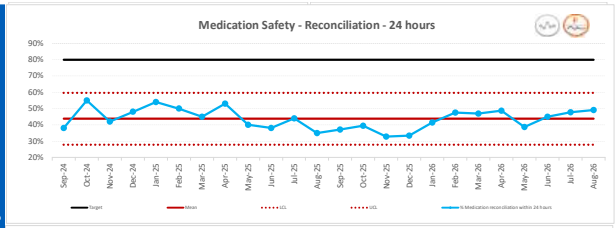
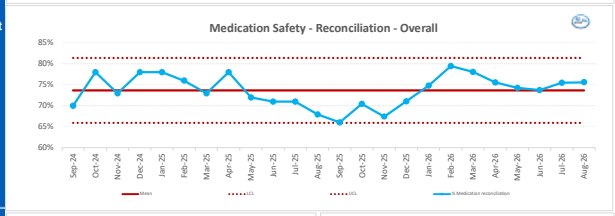
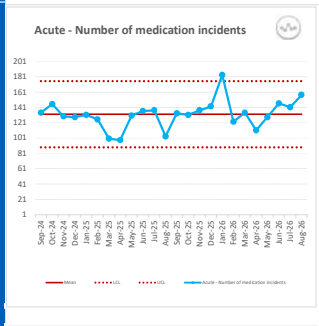
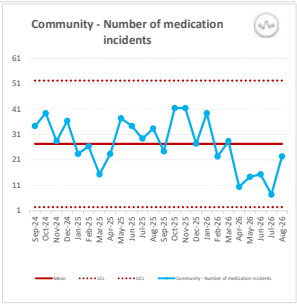
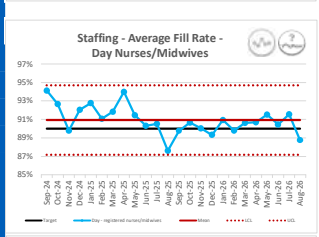
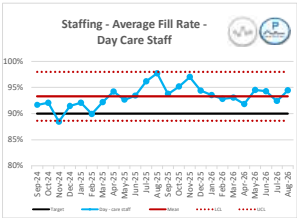
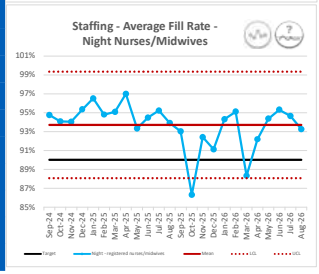
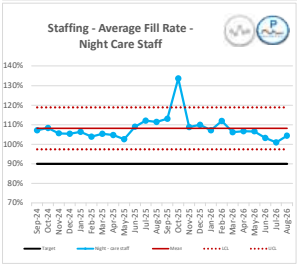


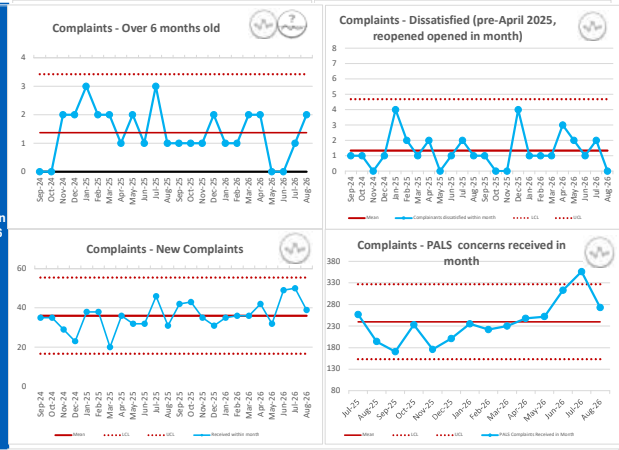
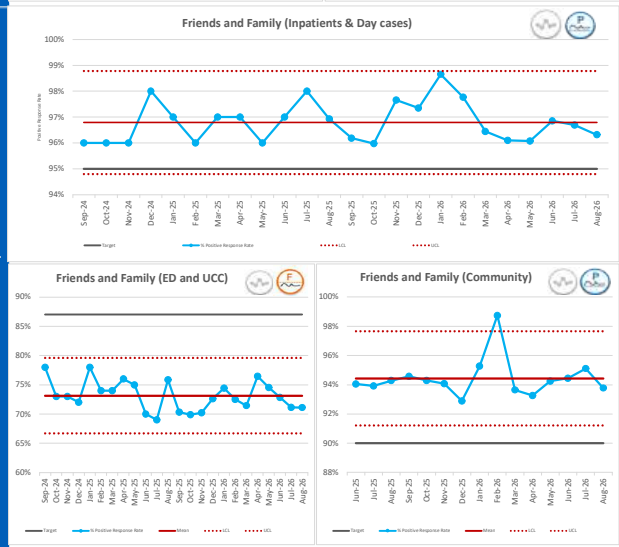
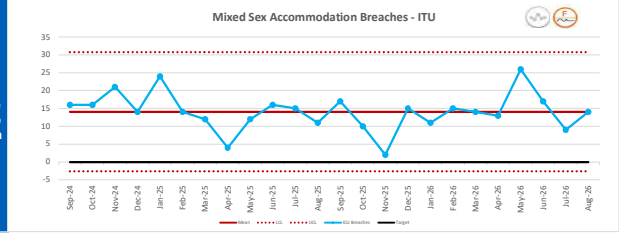
Consistently fails the target

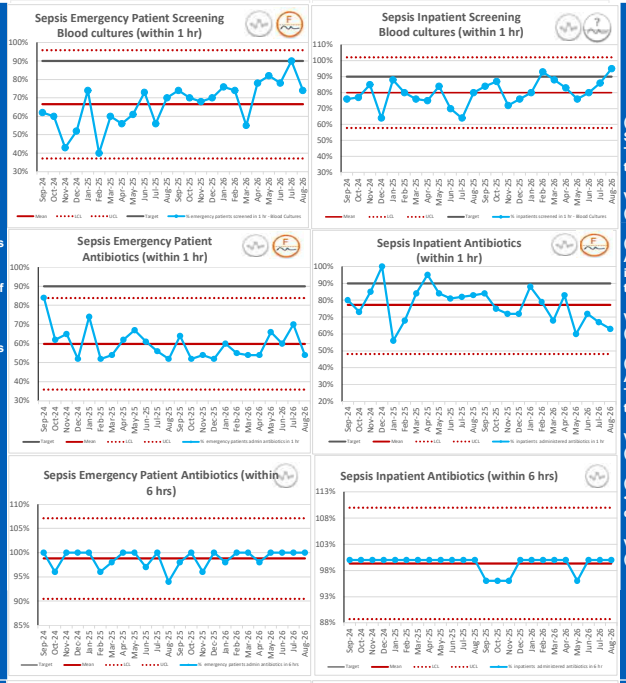
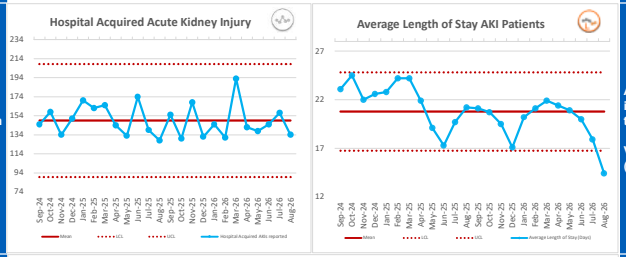
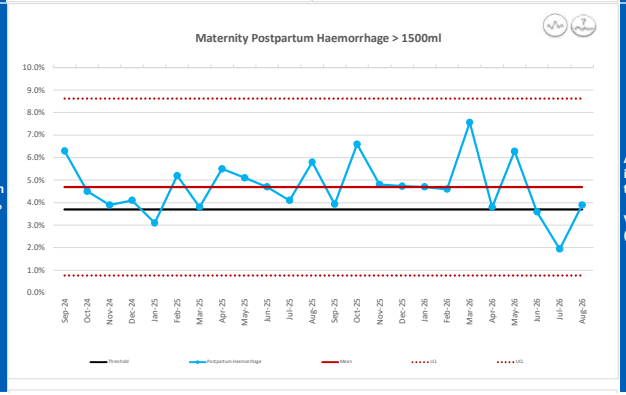
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
74	Trust Financial Position (£m)	-£15.34	-£16.66	Aug-26	No SPC	-£16.22	Jul-26	No SPC
75	Cash Balance (£m)	£13.50	£17.80	Aug-26	No SPC	£17.78	Jul-26	No SPC
76	Capital Programme (£m)	£9.95	£4.50	Aug-26		£2.76	Jul-26	F
77	Better Payment Practice Code (Cumulative)	95%	50%	Aug-26		52%	Jul-26	F
78	Cost Improvement Programme - In year (£m)	90% of plan	100%	Aug-26	H	100%	Jul-26	P
79	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	73%	Aug-26	No SPC	70%	Jul-26	P
80	Agency Reduction (£m)	£0.88	£0.48	Aug-26	No SPC	£0.39	Jul-26	?
81	Bank Reduction (£m)	£11.13	£12.86	Aug-26	No SPC	£10.56	Jul-26	F

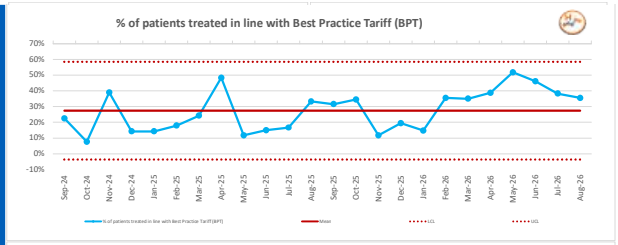
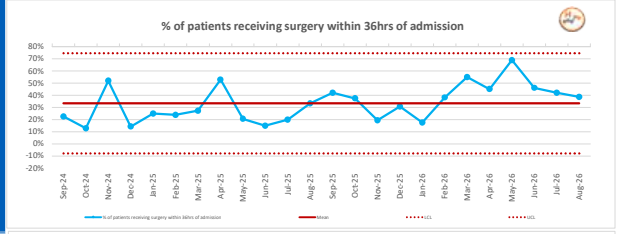
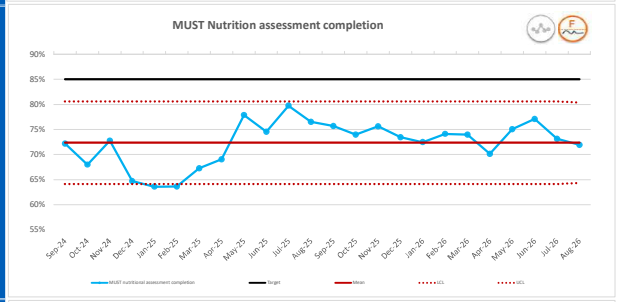
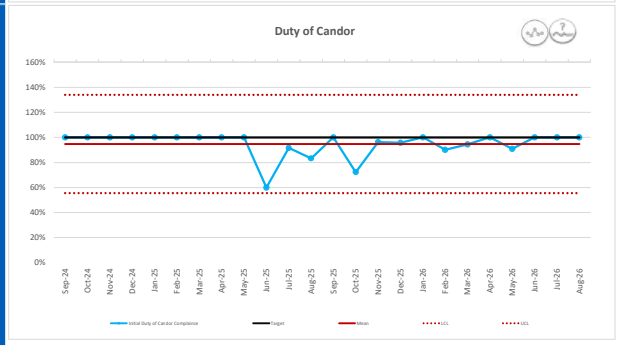
Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events** There was 42 incident/s over 40 days old.		Assurance: The Trust consistently fails the target. Variation: Common Cause Variation.	No Patient Safety Incident Investigations (PSIIs) were declared during August 2026, reflecting the absence of incidents meeting the threshold for a PSII response. At the time of reporting, 48 learning responses (excluding cluster reviews) were progressing through the investigation and learning process, supporting the Trust's continued focus on learning and improvement. There were no Never Events reported during August 2026. As of 1 September 2026, 42 incidents remained open for more than 40 days. Ongoing oversight and support are in place to progress investigations, facilitate learning, and achieve timely closure of outstanding incidents.	A weekly Governance Monitoring Report and Dashboard is reviewed by the Executive Team, providing oversight of reporting trends and triangulation across incidents, complaints, claims and inquests. Each Clinical Business Unit is supported by a designated Governance Lead to promote consistency and timely management of governance processes. The number of incidents open beyond 40 days increased in August 2026 compared with June and July 2026; however, the position is escalated daily to Care Group triumvirates and remains a key area of focus. Datix alerts are triggered at 30 days to enable early intervention, with daily reports on incidents exceeding 30 and 40 days, and outstanding actions, shared with Care Group triumvirates for oversight and management. PSIIs and other learning responses are monitored weekly through the Executive-led Safety Oversight Meeting, with escalation where required. In addition, targeted recovery meetings with senior Care Group leaders and Governance colleagues are undertaken to address areas of concern, remove barriers to progress and support sustained improvement.
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 1 cases YTD is above Threshold 0 YTD MSSA 15 cases YTD is above Threshold 13.35 YTD CDI 39 cases YTD is above Threshold 25 YTD ECOLI 37 cases YTD is above Threshold 30.4 YTD Klebsiella 11 cases YTD is above Threshold 10 YTD PA 4 cases YTD is above Threshold 3.35 YTD		(MRSA) Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a concerning nature. (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 decreases in HCAI were seen in 2025/26 compared to the previous financial year. The Trust is not flagging as a high outlier on cases/rates of HCAI. One hospital acquired MRSA bacteraemia case reported following a period of 16 months without a report MRSA bacteraemia. Changing population demographics with increasing numbers of older age persons are felt to be possible contributing factors to the increase in GNBSI cases. Increases noted nationally with CDT and MSSA bacteraemia cases. NHSE HCAI thresholds for 2026/27 are: - E. coli BC = 75 Klebsiella spp. BC = 24 P. aeruginosa BC = 8 CDI = 60 MRSA BC = zero tolerance to avoidable cases MSSA BC = no threshold	MRSA/MSSA Prevention Action Plan is in place to review peripheral cannula dwell times in line with EPIC 3 guidance and revise the Trust cannulation policy. A programme of training is in place for peer ANTT assessors and improvement in competency assessments of ANTT procedures is being sought via the CBUs. Nil source was identified for the MRSA bacteraemia. CDI Prevention Action Plan in place. Ribotyping of toxin positive cases continues. Surveillance in place to detect periods of increased incidence/wards with clusters of cases. To date all cases on each single ward have different ribotypes and therefore no outbreaks detected. Antimicrobial Stewardship ward round activity continues - compliance with the trust formulary is 87%. The antibiotic point prevance audit results are being shared at CBU and speciality governance meetings for improvement actions. Plan to look at expanding use of probiotics for prevention of CDI. Cleaning frequencies under review in areas where Domestic Assistant staffing level concerns have been raised, boarding is impacting on access for cleaning. Additional environmental training is being arranged for Housekeeper and domestic staff. ECOLI: Klebsiella: P. aeruginosa: CAUTI surveillance continues and roll out of UTI prevention toolkit is being re-enforced for all wards, with a focus on wards with UTI associated GNBSI cases. Urinary catheter prevalence survey took place in July, showing areas for improvement with urinary catheter care. Results of the survey have been shared at IPC sub-committee for improvement actions and reaudits scheduled at 3 and 6 months. National data shows an increasing trend of E. coli bacteraemia rates over the last 5 years.
8. VTE Assessment **Target: 95%** The Trust did not achieve the required target,recording 82.4% for VTE assessments in the month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a concerning nature.	Patient Safety Analysis Team at NHS England informed NHS trusts in May 2026 that the Venous Thromboembolism (VTE) Risk Assessment Data Collection guidance has been amended following updates to the National Institute for Health and Care Excellence (NICE) venous thromboembolism guideline (NG89). It has been updated to require risk assessments to be completed within 14 hours of the decision to admit (DTA) rather than time of admission with this change starting from July 2026 - this change in clock start results in a significantly more stringent measure of VTE and thus the reduction in performance seen VTE risk assessment (RA) performance target in August 2026 did not meet the mandatory threshold of 95%. The Trust achieved 82.36% due to the clock start change described above	Actions taken to improve VTE RA compliance: 1. VTE Risk Assessments - Power BI Report Server (whh.nhs.uk) Trust Information Analytics team have already updated current VTE data dashboard to reflect this on VTE dashboard. 2. Clinical Leads, Clinical Directors, CBUs and Care Groups are informed monthly of VTE risk assessment performance, highlighting potential patient group/area to improve VTE RA data within their respective clinical areas. 3. Focus for improvement will now move from ward based actions to actions to improve speciality wait to be seen (WTBS) following DTA with VTE assessments being undertaken as part of that initial speciality assessment Risks identified: Successful completions needed to meet the target of 95% will be on average 500/ month. Existing ward based improvement actions are likely to ineffective in delivering improvement against new timing standards PSCESC is sighted on changes and has escalated to QAC - focus will now shift to actions enabled by a reduction in Wait To Be Seen Recommendations: 1.VTE thromboprophylaxis assessment, prescribing and prompt administration will need to be completed as early as practical within 14 hours of DTA with ED and other admissions. 2. Improvement will be driven by reduction in WTBS following Decision to Admit 3.Care group/clinical directors/clinical leads in these ward areas to engages with thrombosis group

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)?
9. Inpatient Falls & harm levels **Target: 10% reduction from 2024/25**	 **83 total falls were reported in month. 52 of these were inpatient falls.** **YTD inpatient falls: 230 (above threshold 197.5)**	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause Variation.**	During August 2026, there were 47 falls reported across the acute sites, comprising 44 inpatient falls and 3 falls within the Emergency Department (ED). Of the 44 inpatient falls, 29 were categorised as no harm and 12 as low harm. Three falls resulted in more significant injury: with all three categorised as moderate harm. One patient sustaining a fractured rib, one patient sustained a fractured neck of femur and one patient sustained an injury causing the reopening of a surgical wound, which required them to return to theatre. All three falls reported within the ED, were categorised as no harm. Overall, the majority of falls resulted in no or low harm, with a small number of incidents leading to more significant injury that have been escalated and reported through the appropriate governance processes. There were eight falls at Padgate House in August 2026.	The continued use of the digital SWARM process enhanced the oversight provided by the Patient Safety Improvement Nurses, enabling more timely reviews of incidents, improved identification of emerging trends, and greater organisational learning from falls. This strengthened approach supported a more proactive response to falls and associated risks across the Trust. The Patient Safety Improvement Nurses also continued to promote information relating to bone protection for patients who had experienced a fall or who were at risk of fragility fractures, in line with NICE recommendations. To further embed this practice, the Clinical Education Team incorporated this information into Trust-wide falls education and induction programmes, helping to increase awareness and support preventative care across clinical services. National falls prevention week takes place in September. During this week the Patient Safety Improvement Nurses will be sharing falls prevention advice and education on the Trust Wide Safety Brief daily. These actions demonstrate the Trust's continued commitment to reducing falls-related harm, strengthening learning from incidents, and improving patient outcomes through enhanced surveillance, education, and evidence-based practice.
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 2025/26** **13. Community Acquired Pressure Ulcers (Category 3 or above)** **Target: 20% reduction from 2025/26**	 **Acute** **In month: 16 category 2 hospital-acquired pressure ulcers** **YTD: 57 (above threshold 44.6)** **In month: 2 category 3 & 4 pressure ulcers** **YTD: 6 (above threshold 3.75)** **Community** **In month: 8 category 2 community-acquired pressure ulcers** **YTD: 91 (above threshold 78.35)** **In month: 6 category 3 & 4 pressure ulcers** **YTD: 21 (under threshold 21.25)**	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Acute narrative** In August 2026, there were 18 Category 2 pressure ulcers reported across the acute site, occurring within the Emergency Department (ED) x4, A4, A5E, A5G x3, A7, A8, A9, ACCU, B19, B12 x2 and C21. There were two minimum category 3 pressure ulcers, occurring on ACCU and B19. Four patients developed two pressure ulcers (ACCU, A5G, B12 and B19). There were three device related pressures ulcer in August 2026 from TED stockings, a Repose wedge not being removed and an ED trolley (foot resting on trolley not mattress). Thematic review of the pressure ulcers in August, showed that 11 of the patients who developed one or more pressure ulcers was receiving end of life/palliative care. Pressure ulcer incidence remained an area of ongoing focus during the reporting period, particularly within clinical areas that had experienced a higher number of cases. The majority of pressure ulcers reported were Category 2, with one case identified as device related. Monitoring of pressure ulcer trends and contributory factors continued through established governance processes to support organisational learning and quality improvement. **Community Narrative** There were six confirmed category 3 pressure ulcer incidents reported in August 2026, an increase from two in July. Five were reported from Warrington Borough and one from Halton Borough. One category 3 pressure ulcer was identified in July but reported in early August. Of the six category 3 pressure ulcers, two deteriorated to a category 3 from category 2 following exacerbation of the co-morbidities. Four relate to palliative patients, with rapid deterioration in their complex health needs, with two being further impacted by exacerbation of contractures.	**Acute narrative** A number of measures were implemented during the reporting period to support a reduction in pressure ulcer incidence and strengthen prevention practices across the Trust. All pressure ulcers underwent SWARM review, with findings and learning shared locally within ward teams and through the Operational Patient Safety Group to promote organisational learning. Improvement plans were maintained across both Unplanned Care and Planned Care Groups, with progress monitored through established governance arrangements. Regular compliance and review meetings continued to provide oversight of pressure ulcer prevention and management, ensuring that learning from incidents was identified and shared. Additional support was introduced through the pressure-relieving mattress provider, including increased on-site technical capacity to undertake equipment checks and replace faulty mattress pumps promptly. Further preventative measures included the application of protective film dressings to patients' heels within the Emergency Department to reduce friction and shear-related injury. Trust-wide communications were also circulated to reinforce the safe use of TED stockings, supported by a single-point lesson and enhanced monitoring of any associated pressure damage. In addition, silicone tape was introduced to reduce the risk of device-related pressure ulcers affecting the ears and face, particularly in patients requiring prolonged use of medical devices. **Community Narrative** The teams continue to perform an audit of themes and learning on all pressure ulcers. These report to the Pressure Ulcer Priority Group, which meets quarterly.
14. Mortality ratio - HSMR **Target: Plan** **15. Mortality ratio - SHMI** **Target: Plan**	 **The Hospital Standard Mortality Ratio (HSMR) in month was 90.08. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 105.45.**	**(HSMR) Assurance: NA - no target** **Variation: Common Cause (Normal) variation.** **(SHMI) Assurance: NA - no target** **Variation: Special Cause Variation of a concerning nature.**	It is noted that NCM began including Short Day Emergency Care (SDEC) data in the Emergency Care Data Set (ECDS) instead of the Inpatient Data Set in November 2023. The removal of low mortality risk patients from the SHMI data has resulted in an increased SHMI. SHMI remains within the NHSE expected range, despite the coding related increase described above HSMR remains a low Outler by NHSE methodology	NHSE has advised that SDEC activity will return to the admitted patient data set from April 2027 - this is very likely to result in a reduction in SHMI towards previous levels

	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)?
16. Medication Safety **Reconciliation within 24 hours** **Target: 80%**	**Medicines reconciliation was completed within 24 hours of admission for 49.15% of patients. 75.62% of patients had MR completed during inpatient stay.**	 	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause variation of improving nature.**	**Pharmacy staffing capacity does not currently support daily medicines reconciliation coverage across all clinical areas, with available resource also required to meet competing priorities, including the supply of critical medicines and timely discharge to support patient flow. Pharmacy resource is therefore deployed using the internally developed prioritisation dashboard to identify patients most likely to benefit from early pharmacy intervention.** **Overall performance against the 24-hour medicines reconciliation standard has improved to 46% year to date in 2026/27, compared with 41% in 2025/26. Importantly, medicines reconciliation was completed within 24 hours for 78% of patients prescribed high-risk medicines and at some point during the inpatient episode for 92%. This provides assurance that, while overall coverage remains constrained, the prioritisation approach is effectively directing pharmacy resource towards patients with the greatest clinical need.**	**Performance has continued to improve within maternity services following the introduction of midwife medicines reconciliation recording in November 2025, with increasing numbers of reconciliations now being documented. Ongoing training and support from the Medication Safety Nurse are helping to further embed and strengthen practice.** **To support further improvement, a Quality Improvement Project is planned during Quarter 2 of 2026/27 to evaluate the impact of completing and recording medicines reconciliation prior to planned elective admissions.** **Progress and performance are subject to regular oversight through the Pharmacy Performance Meeting and the Medicines Safety and Optimisation Group, providing assurance that targeted actions are in place to support continued improvement.**
17. Acute Medication Incidents **Target: No target set** **18. Acute Medication Incidents** **Target: No target set**	**In month there were 157 acute medication incidents,** **and 22 community medication incidents**	 	**(Acute) Assurance: No Target Set** **Variation: Common Cause (Normal) variation.** **(Community) Assurance: No Target Set** **Variation: Common Cause (Normal) variation.**	**Analysis of medication incidents demonstrates a stable position across acute services, with monthly incident numbers remaining broadly within expected variation and no sustained upward trend evident. Community services have shown a gradual reduction in reported medication incidents over the reporting period, with recent months recording the lowest levels observed within the timeframe presented. Whilst incident reporting levels continue to fluctuate month to month, the overall trend provides assurance that medication safety remains under close surveillance. Medication incidents continue to be reviewed through established governance processes to identify themes, support learning and maintain a focus on reducing avoidable harm across both acute and community.**	**Medication incidents continue to be subject to routine review through established medicines safety governance arrangements, with trends, themes and learning monitored through the Medicines Safety and Optimisation Group. Targeted learning has been shared with clinical teams where recurrent themes have been identified, and ongoing work has focused on strengthening safe medicines management practices, promoting timely reporting, and improving the quality of incident investigation and learning. This ongoing oversight provides assurance that emerging risks are identified promptly and that appropriate actions are taken to support continuous improvement in medication safety across both acute and community services.**
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) 88.76%** **Day (Care Staff) 94.44%** **Night (Nurses/Midwife) 93.26%** **Night (Care Staff) 104.42%**	   	**(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.**	**Staffing challenges have been driven by sustained operational pressures across the Trust, including increased demand within the Acute Emergency Department (AED), higher levels of patient acuity, and a significant number of patients who do not meet Criteria to Reside but remain in hospital awaiting onward care or discharge arrangements.** **These factors have necessitated the opening of additional and escalated bed capacity, increasing the staffing resource required to maintain safe and effective care across inpatient services.** **There was a reduction in registered staff day and night fill rates during August 2026.**	**In August 2026, Registered Nurse remained above the Trust benchmark, with Band 5 vacancies representing the largest proportion of the workforce gap. Health Care Support Worker vacancies also continued to present workforce pressures. These challenges have been compounded by sustained operational demand, increased patient acuity, and the requirement to staff additional and escalated bed capacity associated with patients who do not meet Criteria to Reside but remain in hospital awaiting onward care or discharge arrangements. Despite these pressures, robust staffing oversight arrangements remain in place to support safe care delivery.** **Targeted recruitment activity has continued throughout the reporting period, including focused recruitment campaigns for Registered Nurses and Health Care Support Workers, engagement with final-year nursing students, and the successful allocation of recruits through the Care Support Worker Development Programme. Work is also progressing to strengthen workforce visibility across community services through the expansion of the vacancy tracker and enhanced reporting arrangements for Padgate House and District Nursing services.**

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)?
23. Complaints **Target: Zero complaints open over 6 months old/in the backlog**	In month there were 39 complaints received within month and 2 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 performance in the timely completion of complaints. In August 2026, the Trust had no dissatisfied complaints received and is reflective of the improved quality of investigations and responses. There were 2 complaints over 6 months, both of which had a 'stop the clock' in place due to absences in staff when arranging meetings and therefore were not truly over 6 months. The Trust PALS concerns did reduce in August 2025 from 348 in July to 273.	Complaints position of 144 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams, as well as follow up meetings upon receipt of the initial response letter. All CBUs have a designated complaints case handler to ensure consistency and Complaints Liaison Lead continues to look into areas where there are significant increases in concerns and complaints received. Weekly themes and actions taken from complaints closed are being monitored to identify areas requiring additional support. PALS Redesign is ongoing to create a more streamlined process which is expected to reduce the number of concerns and complaints received. This will include the reopening of a walk in service and a new process to support resolution in real time.
24. Friends and Family (Inpatients & Day cases) **Target: 95%**	The Trust achieved: **96.31% in month for Inpatient & Day Case FFT** **71.12% for ED/UCC FFT.** **93.78% 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 continue to perform strongly, maintaining positive response rates above the Trust target and consistently outperforming both regional and national averages. This provides ongoing assurance regarding the quality of care and patient experience delivered across inpatient services. Emergency Department and Urgent Care Centre Services continue to receive predominantly positive feedback through the Friends and Family Test; however, performance remains below regional and national averages. Feedback highlights staff attitude, waiting times, the care environment, communication and the delivery of care as the most commonly reported themes. Notably, these areas feature within both positive and negative feedback, indicating opportunities to improve the consistency of patient experience whilst building on the aspects of care that patients value most.	Trust-wide oversight of Friends and Family Test performance, themes and associated action plans continues through Clinical Business Units and the Patient Experience and Inclusion Sub-Committee, ensuring that patient feedback informs local improvement activity. Themes identified through FFT are triangulated with findings from Trust Board, Governor, senior leader, PLACE and Patient Experience Team observations to provide a comprehensive view of patient experience and support targeted action. In preparation for the transition to a new Friends and Family Test provider in September 2026, the Trust is working closely with the newly appointed supplier, I Want Great Care, to ensure a seamless implementation and to support future opportunities to increase response rates and strengthen patient insight. As part of the planned transition to the new supplier, a temporary reduction in response rates is anticipated during August 2026 while the Trust moves between platforms. This is an expected and time-limited implementation impact, rather than an indication of deterioration in patient experience. Response levels and feedback themes will continue to be closely monitored through established governance arrangements, with any emerging concerns escalated and addressed promptly. Similar transitional effects are expected regionally as other trusts undertake the same change in provider. Within Urgent and Emergency Care, a dedicated improvement programme remains in place with progress monitored through established governance arrangements. Learning and recommendations arising from internal and external reviews, including Healthwatch engagement and Governor visits, continue to inform service development. Improvements to patient communication have been supported through the introduction of new information screens displaying key messages on waiting times, treatment prioritisation and reasonable adjustments. A Trust-wide executive-led corridor care programme is focusing on improving both patient and staff experience across the whole urgent care pathway. Further initiatives include environmental enhancements, improved patient information displays, exploration of comfort packs for patients with learning disabilities and autism, and the continued development of the volunteer workforce to provide patient support and real-time feedback within the Emergency Department. These actions are intended to improve consistency of patient experience, strengthen communication and ensure patient feedback directly informs service improvement.
25. Friends and Family (ED and UCC) **Target: 87%**					
26. Friends and Family (Community) **Target: 90%**					
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 14 MSA incident(s) within the ITU.		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation**	There were 14 mixed sex breaches in August 2026, this is an increase from 9 in July. These were all within the Intensive Care Unit. Any delays in discharges are escalated to patient flow Team and the Tactical Manager of the day. They are also discussed at each bed meeting throughout the day. There were 0 breaches within any other ward areas.	Work continues within the care group and patient flow to ensure prioritisation is given to ITU to step down level 1 patients to the appropriate areas. Several reason for the delay have been identified and action plans are begging developed to look at these causes. The high number of no criteria to reside patients within the trust is a contributory factor. Work is ongoing to improve this position across the system.

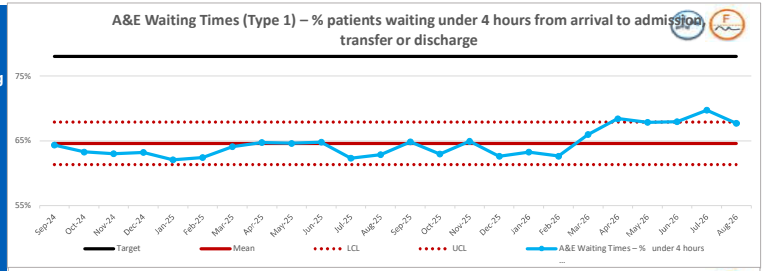
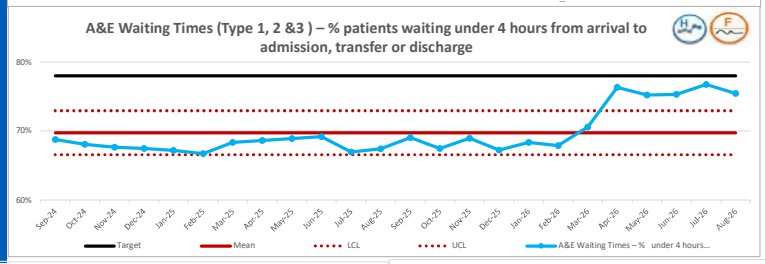
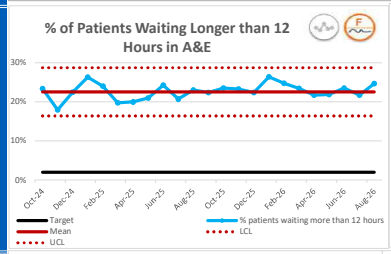
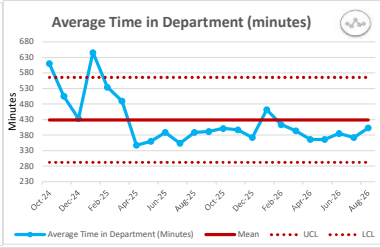
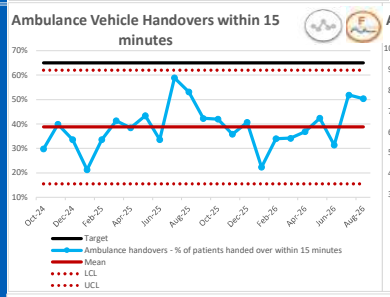
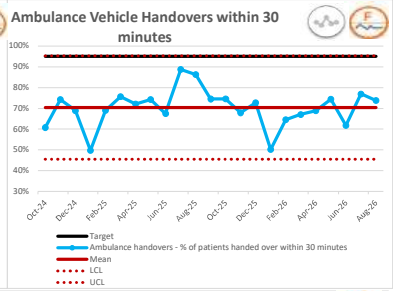
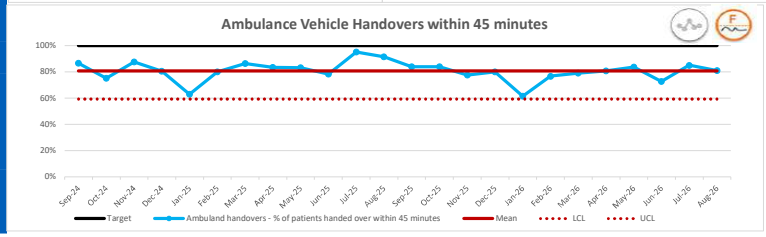
Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
28. Sepsis - % screening for all emergency patients. **29. Sepsis - % screening for all inpatients** **Target: 90%** **30. Sepsis - % of emergency patients receive antibiotics within 1 hour of diagnosis** **Target: 90%** **31. Sepsis - % of inpatients patients receive antibiotics within 1 hour of diagnosis**	**The Trust achieved:** **74% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **95% screening for all inpatients with suspected sepsis within 1 hour.** **54% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **63% 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**	**Performance against key elements of the sepsis pathway has shown variation across both Emergency Department and inpatient settings over the reporting period. Compliance with blood culture collection, lactate measurement and timely clinical review has fluctuated month to month, reflecting the operational pressures experienced across acute services. In the Emergency Department, performance has been impacted by sustained high attendances, increased patient acuity and flow pressures, which have affected the ability of clinical teams to consistently deliver all elements of the sepsis bundle within the recommended timescales. Despite this, blood culture completion rates remained above 70%.** **Within inpatient services, compliance has remained variable but generally compares more favourably than the Emergency Department, particularly in relation to blood culture collection. There is no evidence of a single clinical area driving the overall position, suggesting that variability is occurring across multiple wards and specialties rather than being isolated to a specific service. While some deterioration in performance has been observed at points during the year, particularly during periods of heightened operational pressure, overall compliance with key elements of the sepsis pathway has remained relatively stable.** **The Trust continues to monitor sepsis performance through established governance arrangements, with regular review of audit findings, identification of areas for improvement and targeted feedback to clinical teams. Ongoing emphasis is being placed on improving the timely completion and documentation of sepsis screening and treatment interventions to support early recognition and management of sepsis and improve patient outcomes.**	**A Trust-wide focus on improving sepsis recognition and management has continued throughout the year, supported through the Deteriorating Patient Group. Variability in compliance with blood culture collection, lactate measurement and timely clinical review has been subject to regular scrutiny, with particular focus on the reduction in blood culture and lactate completion observed during parts of the reporting period. Reviews have sought to identify barriers to timely delivery of the sepsis bundle and ensure improvement actions are targeted to areas of greatest need.** **To support improvement within the Emergency Department, Sepsis Bags have been reintroduced to improve the timely completion of blood cultures and reinforce adherence to the sepsis pathway. A sepsis bleep has been introduced to support timely escalation and response. Awareness of sepsis management expectations continues to be promoted through medical and nursing handovers, daily safety huddles and dedicated education sessions. Training has also been expanded to increase the number of Health Care Support Workers competent in obtaining blood cultures, improving workforce capacity to deliver timely interventions.** **The Trust's Sepsis Leads have reviewed the revised NICE sepsis guidance and are progressing updates to local policies and clinical pathways to ensure alignment with best practice. Targeted quality improvement activity has been undertaken within both inpatient and Emergency Department settings to better understand barriers to compliance. Learning from these initiatives is being used to inform further improvements to documentation, processes and staff education. In addition, a review of sepsis audit key performance indicators and benchmarking arrangements has been undertaken to ensure ongoing monitoring remains focused on the measures that best support improvements in patient outcome.**
32. Acute Kidney Injury **Target: Less than month in previous year**	**There were 134 acute kidney injuries reported in month compared to 157 last month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**The increase in hospital-acquired acute kidney injury (HA-AKI) occurred within the context of a wider rise in all AKI cases, including community-acquired AKI associated with hot weather. As HA-AKI would be expected to account for approximately one-third of all AKIs, the increase was consistent with the overall trend. Reporting HA-AKI as a percentage of total bed days, rather than solely as an absolute number, would provide a more meaningful comparison, and the expected number of HA-AKIs should be considered in the context of overall AKI activity.** **Length of stay continues to reduce, demonstrating the positive impact of the Acute Care Team, a focus on effective utilisation of the AKI clinic, and established discharge pathways. Whilst this represents a positive improvement in patient flow and management, review of the 30-day readmission rate will provide additional assurance that reductions in length of stay are being achieved safely and sustainably without unintended consequences.**	**Current work is focused on the development of a deteriorating patient bundle that integrates the sepsis and acute kidney injury (AKI) pathways at the front door. This will support the early identification and review of patients at risk of AKI, rather than only those with an established AKI diagnosis, ensuring timely assessment by the admitting physician and supporting the reduction of hospital-acquired AKI.** **An AKI audit is also underway to provide assurance that discharge processes are being consistently followed, including appropriate utilisation of the AKI clinic and adherence to the AKI discharge pathway. This work will help to identify opportunities to further strengthen care transitions, support timely discharge, and contribute to the continued reduction in length of stay while maintaining safe patient outcomes.**
33. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**Maternity Postpartum Haemorrhage was 3.90% in month compared to 1.94% last month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation**	**Rates for PPH >1500ml continue to fluctuate but demonstrates common cause variation. The service has received comparator data from the Cheshire and Mersey (C&M) LMNS which notes an average rate for C&M of 32/1000 births. The WHH rate is 48 cases per 1000 births.**	**Through ongoing improvement work, the Trust has established clear oversight of postpartum haemorrhage (PPH). All PPH incidents exceeding 1500ml are reviewed through the Intrapartum Review Group to identify learning and drive improvements in care. NCM rates remain an outlier when benchmarked across C&M** **Robust processes are in place to ensure accurate measurement and quantification of blood loss, supporting effective monitoring and clinical decision-making.** **The PPH Quality Improvement (QI) project is progressing and is currently in the testing phase, with targeted workstreams focused on:** **- Standardised risk assessment at each patient contact** **- Accurate quantification of blood loss with new pad devices** **- Clear escalation thresholds aligned to the regional guideline** **- Multidisciplinary simulation and emergency leadership training** **- Real-time learning and feedback mechanisms The Trust position re PPH is reported monthly to QAC alongside an SPC chart which currently shows common cause variation.** **- Deep dive into Assisted Deliveries PPH rate underway. This will be presented at Quality Assurance Committee**

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)?
34. Fractured Neck of Femur **Target: Best Practice Tariff**	**35.48% of patients were treated in line with Best Practice Tariff (BPT) in Aug-26.**	 	**Variation: Special Cause variation of improving nature.**	**Direct admission from A&E to the Orthopaedic Ward remained high (95%) and consistent with previous reporting periods.** **Performance against key elements of the Best Practice Tariff continued to demonstrate positive outcomes. Compliance with key quality measures remained excellent, with 100% achievement for pre-operative cognitive assessment, nutritional assessment, bone health assessment and falls assessment.** **Senior Orthogeriatric review performance remained strong, with all patients receiving an assessment with 87% reviewed within the recommended timeframe.** **Ongoing work continues to support timely access to surgery and optimise pathways of care for patients with fractured neck of femur.** **Day-one postoperative mobilisation remains an area of focus. A multidisciplinary quality improvement programme is underway to support earlier mobilisation, improve patient outcomes and align performance more closely with national benchmarks.** **Despite these operational pressures, average ward length of stay improved from 19 days in July to 16 days in August, whilst average Trust length of stay remained stable at 22 days. This suggests continued effectiveness of multidisciplinary rehabilitation and discharge planning processes.**	**A focused programme of improvement has continued across the hip fracture pathway to optimise patient flow, support timely access to theatre and improve compliance with Best Practice Tariff standards. Regular multidisciplinary reviews are undertaken to identify delays and opportunities for intervention, with close collaboration between Trauma and Orthopaedics, Orthogeriatric, Therapy Services and Bed Management teams. Work has also progressed to strengthen early postoperative rehabilitation through enhanced therapy input, daily mobility reviews and increased emphasis on day-one mobilisation. Performance is reviewed through routine governance processes, enabling learning to be shared promptly and ensuring targeted actions are implemented to drive sustained improvements in patient outcomes and experience.** **Plans are being developed to increase trauma theatre capacity and there will be recruitment of a Specialty Doctor into Orthogeriatrics to support the capacity to meet the 72 hour target for Orthogeriatric review.**
35. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 71.94% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance has continued to slowly improve with the current compliance now only 10% below the Trust target. There has also been significant improvement in the 7 day assessment metric. With the integration with community services the data now includes community assessment areas with work ongoing to try and incorporate this data into the Lion dashboard alongside the acute data to support teams to monitor compliance.**	**The Nutrition Food & Hydration monthly meeting has worked to drive a multi-disciplinary approach to the improvement of nutritional support to our patients. CBU & Key stakeholders produce high level briefing paers sharing local action plans to improve and also quality improvement initiatives that can be shared Trust wide. MUST continues to be a quality priority for 26/27. MUST continues to be included in the PSIRF approach of harms such as falls & pressure ulcers and a plan to improve training on MUST and its association with other elements of a patients care with our HCA workforce will be developed and implemented in 2026.**
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.**	**In August 2026 all initial duty of candour activity was completed in the required time scales. All incidents requiring duty of candour are identified at the daily incident triage meetings, which provides prompt assurance that required action has been identified and completed.**	**Duty of candour requirements are considered every day at the Trust wide incident triage meeting, which ensures prompt identification & oversight of all duty of candour requirements. Compliance is reported to SOM each week.**

North Cheshire and Mersey NHS Foundation Trust

Access & Performance - Trust Position

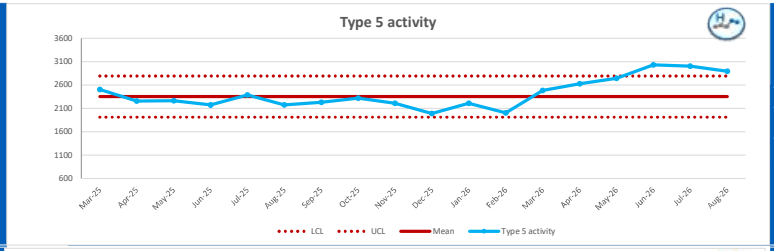
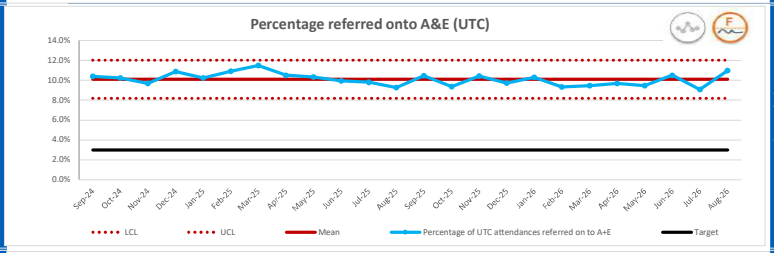
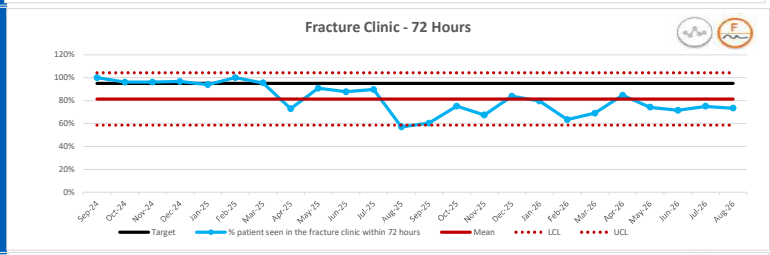
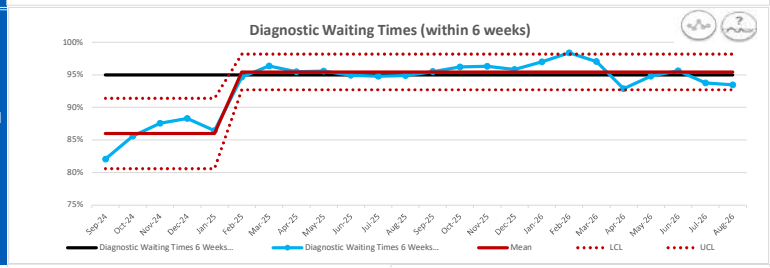
Appendix 3

	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 (Type 1) – % patients waiting under 4 hours from arrival to admission, transfer or discharge **Target: 78%**	The Trust achieved 67.69% in the month for Type 1 A&E waiting times under four hours. The operational plan for the month was 67.00%, against the national aspiration of 78% 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 (Type 1, 2 &3) – % patients waiting under 4 hours from arrival to admission, transfer or discharge. **Target: 78%**	The Trust achieved 75.48% in the month for Type 1,2 & 3 A&E waiting times under four hours. The operational plan for the month was 81.78%, against the national aspiration of 78% 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**	24.68% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 403 minutes.	 	Assurance: 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 ambulance handover performance: Within 15 minutes: 50.4% (plan: 57.6%; national aspiration: 65%) Within 30 minutes: 73.8% (national aspiration: 95%) Within 45 minutes: 81% (plan: 94.5%; national aspiration: 100%)	  	(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%**					

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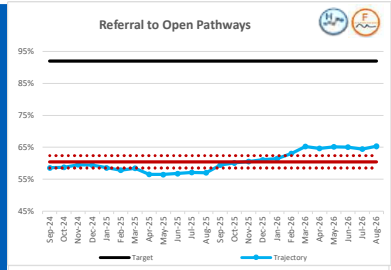
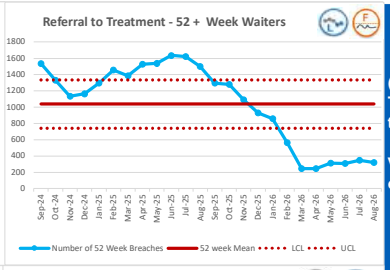
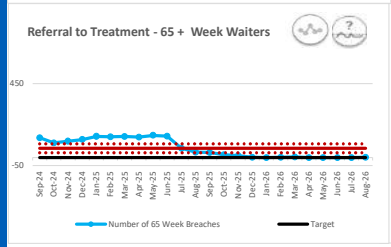
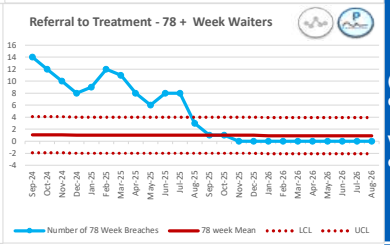
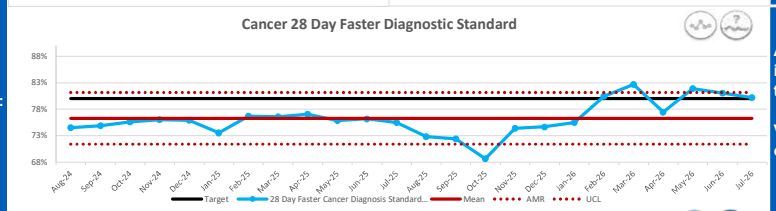
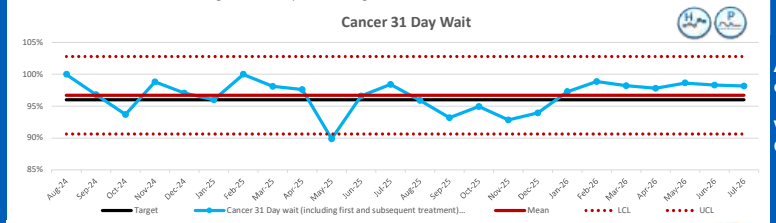
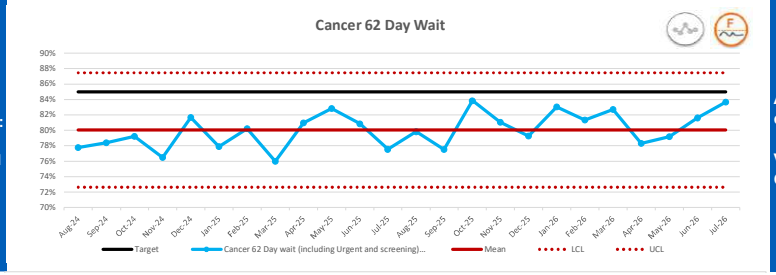
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
44. Type 5 activity **No Target**	In month there were 2891 Type 5 Attendances.		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: 11.0% of UTC patients were referred to ED. Runcorn UTC: 16.6% Widnes UTC: 5.5%		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 73.4% 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 93.4% in month, against an operational plan of 97.9% by March 2027 and the national aspiration of 95%.		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

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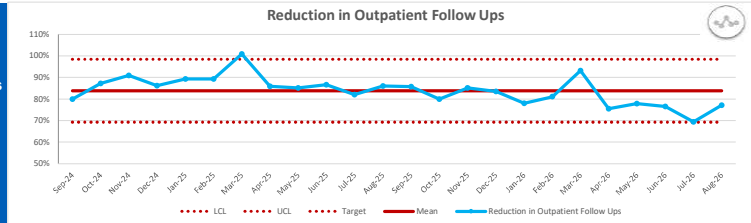
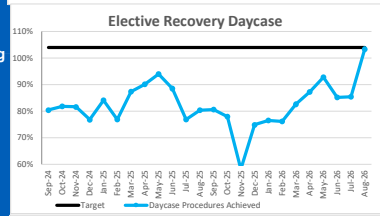
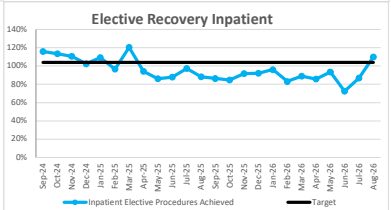
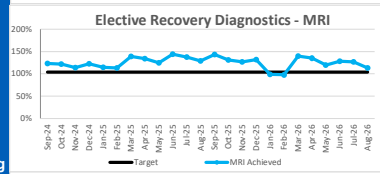
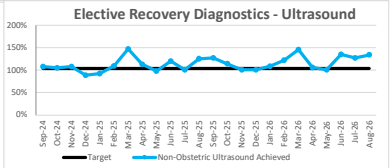
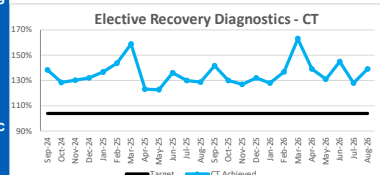
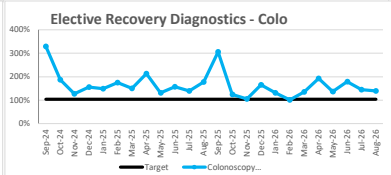
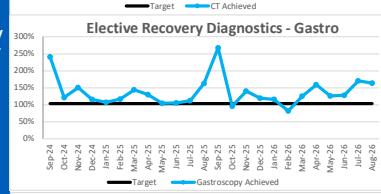
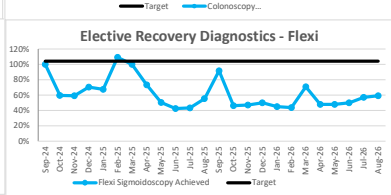
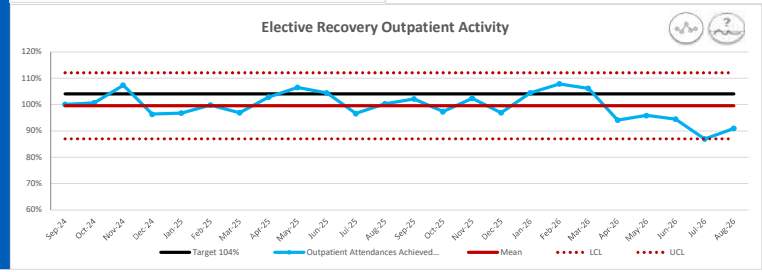
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. Referral to treatment Open Pathways **Target: 92%** **49. RTT - Number of patients waiting 52+ weeks** **Target: 0**	**In-month referral-to-treatment performance:** **Within 18 weeks: 65.3% (operational plan by March 2027: 72%; national aspiration: 92%)** **Over 52 weeks: 321 breaches (operational plan by March 2027: 130; national aspiration: 0)** **Over 65 weeks: 1 breaches** **Over 78 weeks: 0 breaches**	   	**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: Special Cause variation of improving nature.** **(52+) Assurance: The Trust consistently fails the target.** **Variation: There is special cause of improving nature.**	**The Trust has delivered in line with the annual planning submission**	
50. 28 Day Faster Cancer Diagnosis Standard **Target: 80%**	**28-day Faster Diagnosis Standard:** **In-month performance: 80.2% (operational plan: 80.1%; national aspiration: 80%)**		**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 98.2% in month for Cancer 31 Day Wait.**		**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%**	**Cancer 62-day Wait:** **In-month performance: 83.67% (operational plan: 79.07%; national aspiration: 85%)**		**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.**

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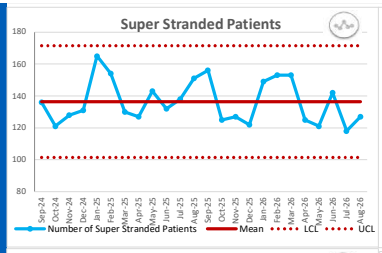
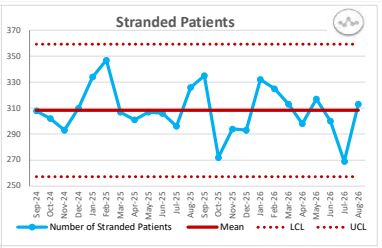
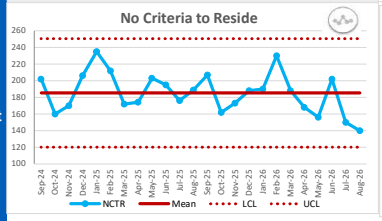
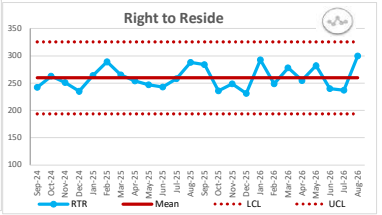
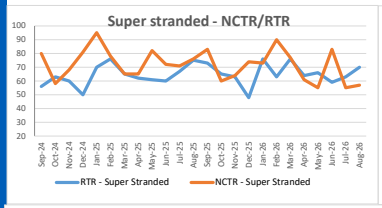
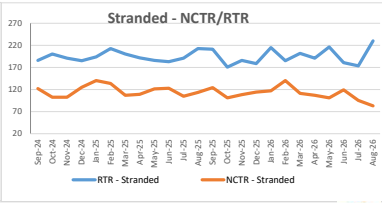
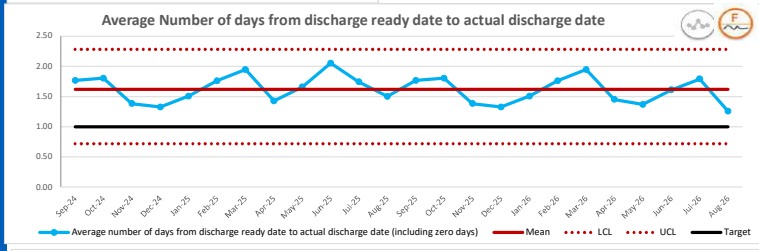
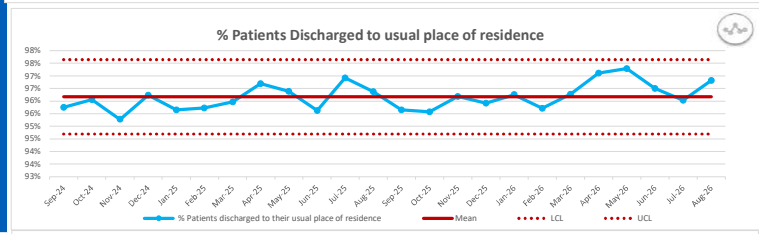
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	Outpatient follow ups have reduced to 77.16% 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 101% of activity against 2019. This included 103% of Daycase Procedures and 109.93% 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 124% of activity against 2019. This included: 104% of MRI 139% of CT 134% of Non-Obstetric Ultrasound 59% of Flexi Sigmoidoscopy 139% of Colonoscopy 164% 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 90.98% 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

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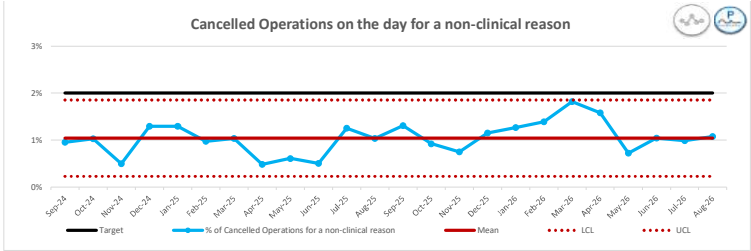
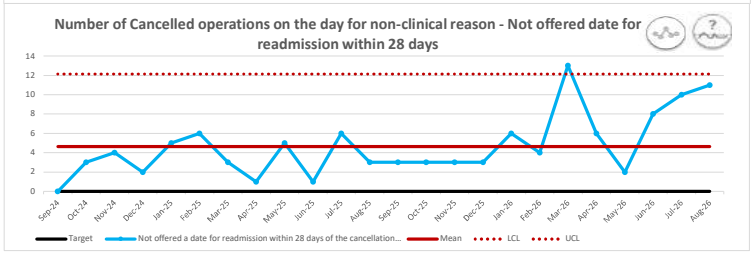
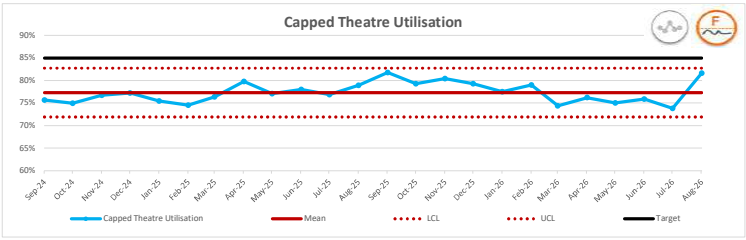
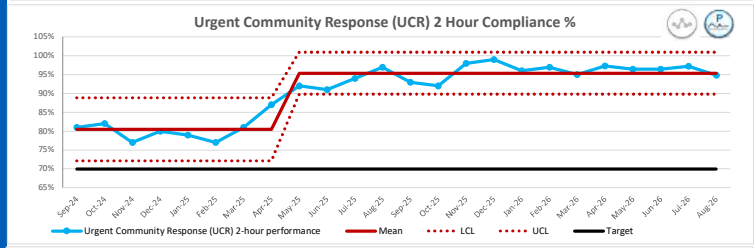
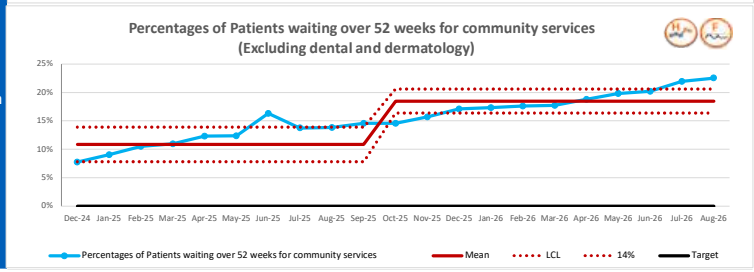
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Super Stranded Patients **Target: No Target Set**	There were 313 stranded and 127 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 1.26 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**	96.82% patients in month were discharged to their usual place of residence.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.		

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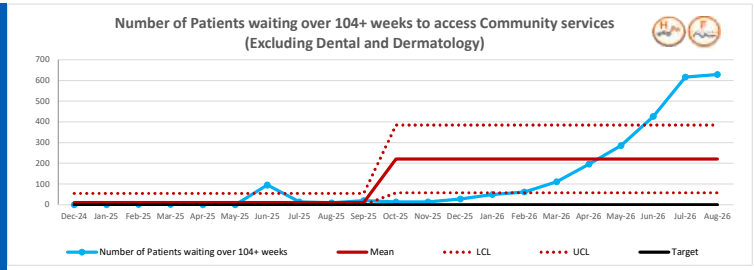
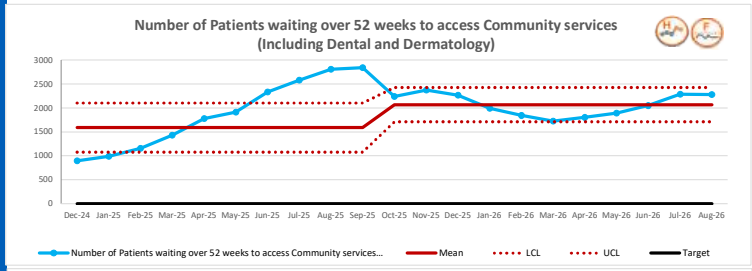
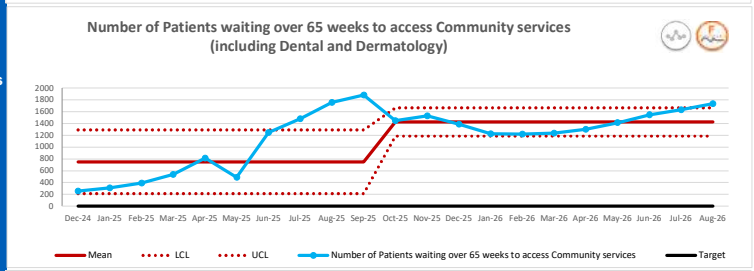
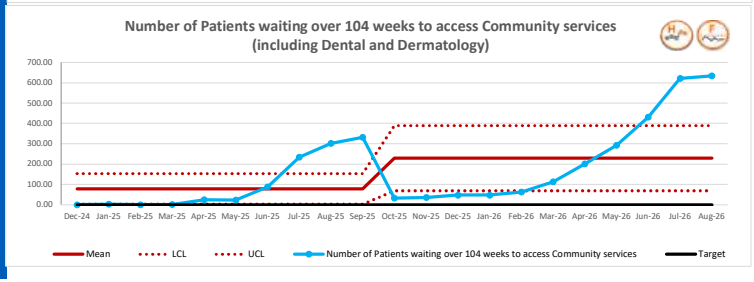
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
61. Cancelled Operations on the day for a non-clinical reason **Target: Less than 2%**	Cancelled operations for a non-clinical reason was 1.08% in month. 11 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 81.6% 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 94.8% 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 22.53% 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.	At Month 5, 1,001 children in Halton were waiting over 52 weeks, a decrease of 8 from Month 4, while Warrington reported 1,150 children, an increase of 174. The number of red-risk children increased by 4 to 23 in Halton and by 14 to 20 in Warrington. All red-risk cases will be clinically prioritised and expedited, with the wider cohort remaining subject to active validation and pathway management.	All red-risk children remain subject to active clinical oversight, regular review and prioritisation, with assessments expedited where clinically indicated. Recovery actions continue to focus on reducing the longest waits, increasing assessment capacity and improving pathway throughput, with progress monitored through monthly performance reviews.

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)?
66. Number of Patients waiting over 104+ weeks to access Community services (Excluding Dental and Dermatology) **Target: 0**	In month 629 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.	At Month 5, 311 children in Halton were waiting over 104 weeks, an increase of 3 from Month 4, while Warrington reported 301 children, an increase of 10.This longest-wait cohort remains a key operational priority and is subject to targeted validation, clinical oversight and active pathway management to support a sustained reduction in waits. These longest-waiting children remain visible within pathway management arrangements and are subject to targeted clinical review and intervention. Red-risk cases are prioritised and expedited where required, while recovery activity remains focused on reducing the over-104-week cohort through additional assessment capacity, validation and active management of the longest waiters.	
67. Number of Patients waiting over 52 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 629 patients are waiting over 52 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.	At Month 5, 1,001 children in Halton were waiting over 52 weeks, a decrease of 8 from Month 4, while Warrington reported 1,150 children, an increase of 174. The number of red-risk children increased by 4 to 23 in Halton and by 14 to 20 in Warrington. All red-risk cases will be clinically prioritised and expedited, with the wider cohort remaining subject to active validation and pathway management.	Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue
68. Number of Patients waiting over 65 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 1737 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.	At Month 5, 820 children in Halton were waiting over 64 weeks, an increase of 50 from Month 4, compared with 863 children in Warrington, an increase of 67. Red-risk waits increased by 4 to 20 in Halton and by 8 to 12 in Warrington. These red-risk children will be clinically prioritised and expedited, alongside targeted validation and active management of the longest waiters.	
69. Number of Patients waiting over 104 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 634 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.	At Month 5, 311 children in Halton were waiting over 104 weeks, an increase of 3 from Month 4, while Warrington reported 301 children, an increase of 10. This longest-wait cohort remains a key operational priority and is subject to targeted validation, clinical oversight and active pathway management to support a sustained reduction in waits.	

North Cheshire and Mersey NHS Foundation Trust

Workforce - Trust Position

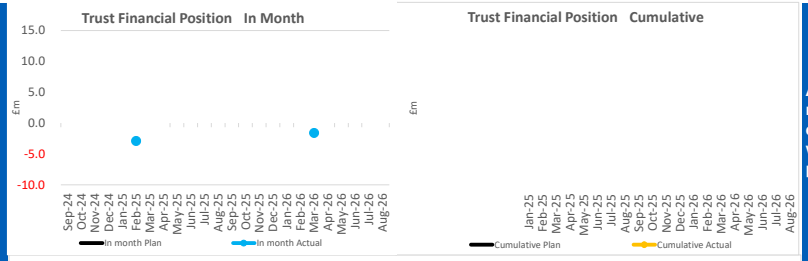
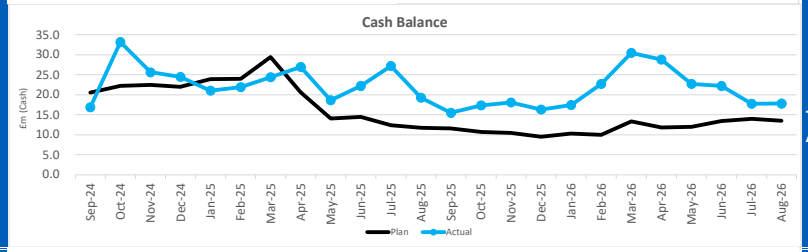
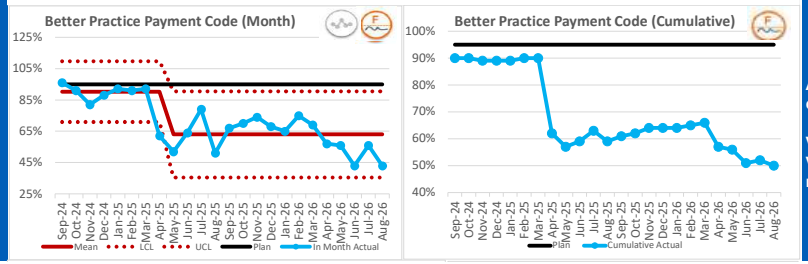
Appendix 3

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)?
		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 3.38% in August 2026. Whilst long term absence continues to improve, short term sickness absence remains an area of focus at 2.7%. Sickness absence remains a key performance metric within the National Oversight Framework (NOF), underlining the importance of sustained improvement and effective attendance management.	The 12 areas of focus have been refreshed and continue to receive enhanced multi disciplinary support, including detailed case reviews, KPI monitoring, leadership engagement and executive escalation. A new Supporting Attendance Policy was launched on 1st July 2026. On demand training is now available. Within People Performance Sub Committee, Care Groups identify areas with high absence, supported required and ensure leaders are promoting the Health and Wellbeing initiatives.
		Assurance: The Trust inconsistently passes/fails the target. Variation: Common cause (normal) variation.	The Trust is above plan by 8 FTE (August 26), which means we are using more 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 detailed programme of reviews has been agreed. 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 91.26% 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 has been observed since December 2025 and will continue to be closely monitored to ensure compliance levels are maintained. This is completed through People Performance Sub Committee with Care Group leads.	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 81.07% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	PDR compliance has sits at 81.07% in month, which is a reduction from previous months. 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 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 a new appraisal process is currently being reviewed and standardised as part of the integration programme which will bring consistency and alignment to the Management and Leadership Framework and NHS Staff Standards. 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.

North Cheshire and Mersey NHS Foundation Trust

Finance and Sustainability - Trust Position

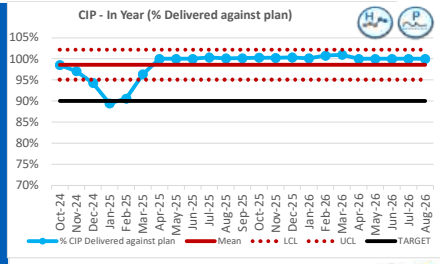
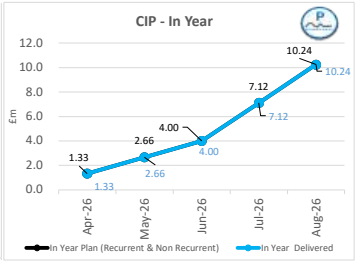
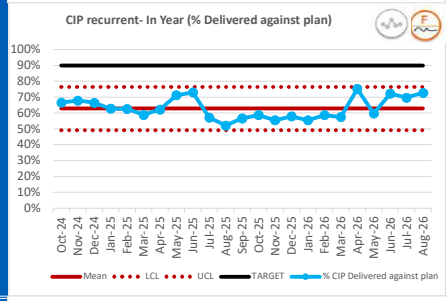
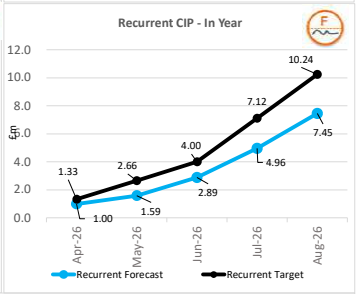
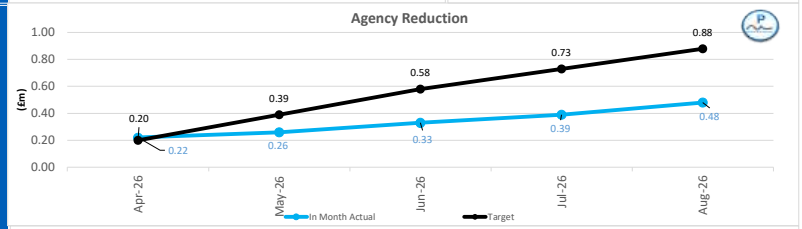
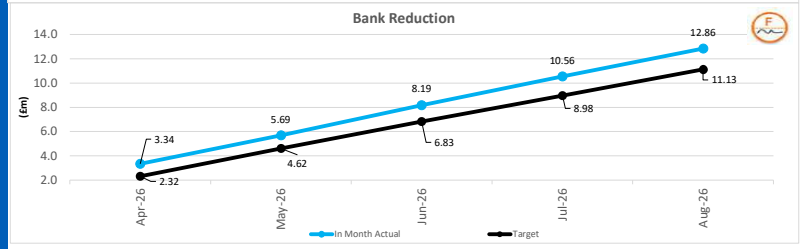
Appendix 3

	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 5 the Trust has recorded a deficit position excluding DSF of £16.7m which is £1.3m worse than plan.	At month 5, the deficit position is £1.3m worse than plan due to the impact of MARS in July (£1m) and the impact of industrial action in April (£0.9m) which has been partially offset with a non recurrent underspend of £0.6m.	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 31 August 2026 is £17.8m.	The current cash balance is £17.8m which is £3.8m 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 £17.8m cash, £8.5m is related to capital creditors.	The ICB has agreed £5m additional income therefore reducing the planned deficit to £25.5m, resulting in NHSE increasing the control total from £16.7m to £25.5m deficit. This has enabled the Trust to access Deficit Support Funding (DSF) of £25.5m to produce a breakeven plan. DSF is paid quarterly and the Trust received Q1 and Q2 in September (£12.7m). 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 5 is £4.5m against a plan of £10m. 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 50% which is below the national target of 95%. The main reason for this is due to cash management measures put in place to mitigate against the Trust s worsening cash position.	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.

North Cheshire and Mersey NHS Foundation Trust

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)?
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 5, 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.**	**£7.4m CIP has been delivered recurrently against the target of £10.2m.** **The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. The full year effect of recurrent schemes delivering later in the year mitigates 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 £0.5m at month 5 compared to a plan of £0.9m.**	**At month 5, 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 £12.9m at month 5 compared to a plan of £11.1m.**	**At month 5 bank expenditure is overspent by £1.7m. £1m is due to the impact of April Industrial Action and the remainder is mainly driven by Surgical SDEC and Halton UTC GP Cover, 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				
A&E Waiting Times (Type 1) – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	**37**	All patients who attend (Type 1) A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78% (national objective)	
A&E Waiting Times (Type 1, 2 &3) – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	**38**	All patients who attend (Type 1,2 & 3) 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 vehicle handover (A2VH), replacing the previous arrival to patient handover (A2PH) metrics. These changes aim to improve consistency, operational clarity, and performance reporting.
Ambulance Vehicle Handovers within 30 mins	**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%	
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	>80%	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 dental and dermatology)	**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.
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?

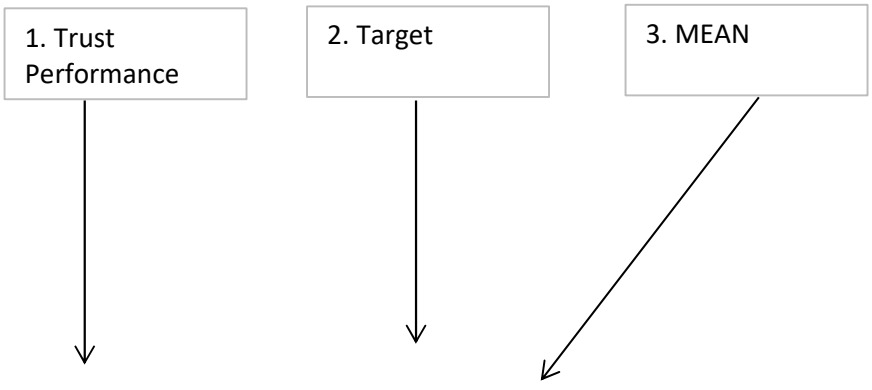
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

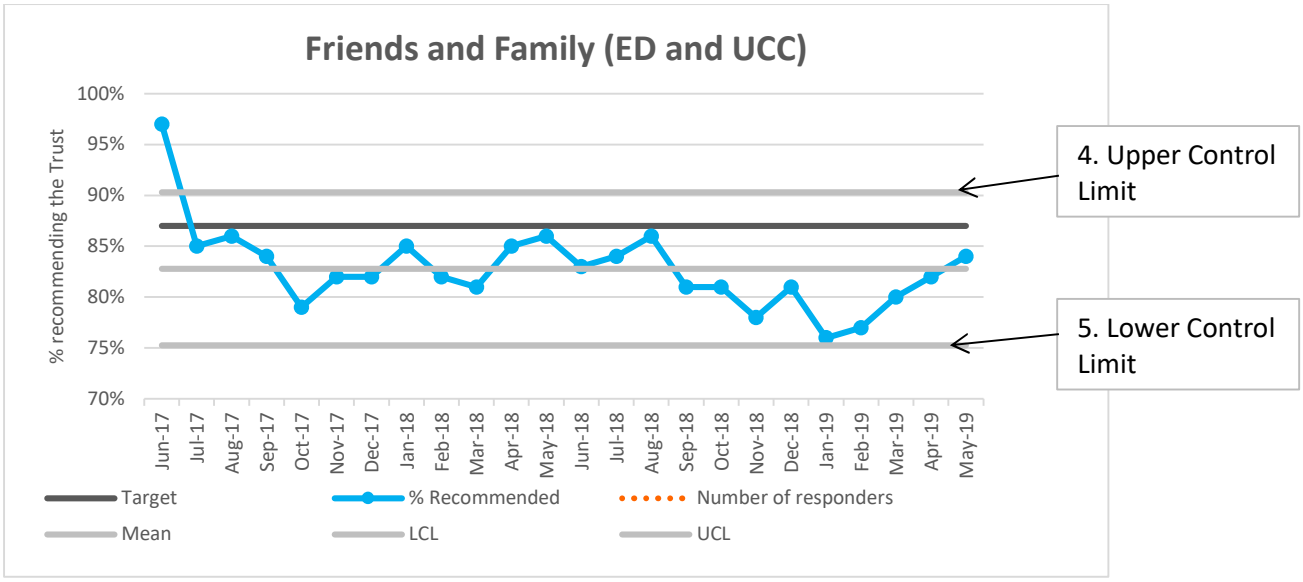
2.0 SPC Charts

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



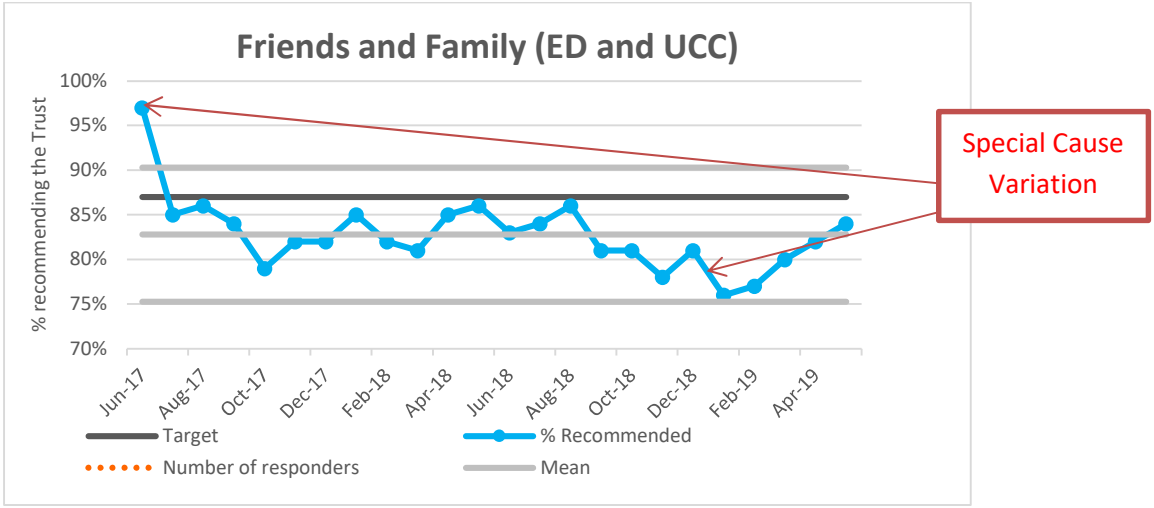


2.1 Interpreting a SPC Chart

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 31st August 2026

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**469,515**	**48,811**	**48,770**	**-41**	**195,792**	**193,884**	**-1,908**
Non NHS Clinical Income							
Private Patients	8	0	0	0	3	2	-1
Non NHS Overseas Patients	72	6	3	-3	30	66	36
Other non protected	818	68	64	-4	341	364	23
Community & Dental - Non NHS	16,897	1,458	1,320	-138	7,040	6,778	-262
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**17,795**	**1,532**	**1,387**	**-145**	**7,414**	**7,211**	**-204**
Other Operating Income							
Training & Education	13,646	1,137	1,181	44	5,686	5,890	204
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	18,387	1,531	1,420	-111	7,673	7,489	-184
Sub total	**32,033**	**2,668**	**2,602**	**-67**	**13,359**	**13,379**	**20**
Total Operating Income	**519,343**	**53,012**	**52,759**	**-253**	**216,565**	**214,474**	**-2,092**
Operating Expenses							
Employee Benefit Expenses	-361,647	-29,883	-29,915	-32	-153,072	-154,193	-1,121
Drugs	-24,238	-2,035	-1,882	152	-10,356	-9,530	827
Clinical Supplies and Services	-30,848	-2,586	-2,325	261	-13,719	-13,362	357
Non Clinical Supplies	-71,565	-6,040	-5,895	145	-31,204	-30,905	299
Depreciation and Amortisation	-25,254	-2,105	-2,155	-50	-10,523	-10,508	15
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	**-513,553**	**-42,647**	**-42,172**	**475**	**-218,874**	**-218,497**	**376**
Operating Surplus / (Deficit)	**5,791**	**10,365**	**10,586**	**222**	**-2,308**	**-4,024**	**-1,715**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0
Interest Income	842	70	126	56	350	726	376
Interest Expenses	-524	-44	-38	6	-221	-211	10
PDC Dividends	-6,777	-565	-565	-1	-2,823	-2,823	0
Total Non Operating Income and Expenses	**-6,459**	**-539**	**-477**	**61**	**-2,693**	**-2,307**	**386**
Surplus / (Deficit) - as per Accounts	**-668**	**9,826**	**10,109**	**283**	**-5,001**	**-6,331**	**-1,329**
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	668	54	56	2	274	279	5
Total Adjustments to Financial Performance	**668**	**54**	**56**	**2**	**274**	**279**	**5**
Adjusted Surplus / (Deficit) as per NHSE Return	**0**	**9,880**	**10,165**	**284**	**-4,727**	**-6,052**	**-1,325**
Deficit Support Funding	-25,471	-10,613	-10,613	0	-10,613	-10,613	0
Adjusted Surplus / (Deficit) - without deficit support funding	**-25,471**	**-733**	**-448**	**284**	**-15,340**	**-16,665**	**-1,325**

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/10/079ai	**Date of Board meeting:**	7 October 2026

Date of meeting:	11 August 2026
Name of meeting and chair:	Quality and Safety Assurance Committee, Chaired by Jayne Downey
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/26/08/123	**Deep Dive - National Oversight Framework**	The Committee reviewed the Trust's provisional position against the revised National Oversight Framework and noted a mixed picture across the quality indicators. Potential segment 4 areas included tobacco dependency, C. difficile, NHS Staff Survey measures and temporary staffing costs, with data quality and non-submission affecting some scores. Assurance was received that corrective actions were underway and that the dashboard would be routinely monitored, triangulated with wider performance reporting and developed to support trend analysis and targeted review.	**Moderate**	**Substantial**	Quarter 1 NOF update to Committee in October 2026.
QSAC/26/08/123	**Hot Topic – Maternity and**	The Committee reviewed the Trust's position against the NHS England Maternity and	**Substantial**	**Substantial**	Progress to be monitored

	Neonatal 10 Point Plan	Neonatal 10 Point Plan arising from the Ockenden and Amos reviews. Assurance was received that significant progress had been made through existing maternity improvement and governance arrangements, including executive and regional oversight. Remaining actions largely related to national guidance and further implementation work. The Committee requested that future reporting demonstrated how feedback from women and families had informed improvements and outcomes, and incorporate evidence from the Living Well programme.			through regular maternity and Board reporting.
QSAC/26/08/126	**ED Improvement Update**	The Committee reviewed the Emergency Department improvement programme and noted sustained improvement in four hour performance, ambulance handovers and the number of patients receiving corridor care. Assurance was received that the Red Lines Toolkit, streaming pathways and eight improvement workstreams were supporting reduced waits, improved patient experience and lower admission rates. The Committee recognised that eliminating corridor care remained dependent on whole hospital flow, length of stay, site occupancy and reductions in patients with no criteria to reside.	**Moderate**	**Substantial**	Progress to be monitored through the ED Improvement Group and routine Committee reporting.
QSAC/26/08/128	**Fractured Neck of Femur Update**	The Committee received assurance on continued improvement in fractured neck of femur performance, including time to theatre, post operative mobilisation and Best Practice Tariff achievement. Plans were progressing to extend Sunday trauma theatre capacity, with implementation dependent on completion of workforce processes. The Committee also noted ongoing recruitment to strengthen	**Moderate**	**Substantial**	The Committee would continue to receive monthly updates.

		orthogeriatric support and arrangements to provide specialist review where patients were temporarily cared for outside the designated trauma ward.			
QSAC/26/08/129	**Surgical Site Infection Update**	The Committee reviewed progress following the orthopaedic surgical site infection improvement programme and noted that the latest surveillance results compared favourably with national benchmarks, with no adverse trend or outbreak identified. Assurance was received on established controls covering theatre use, pre operative optimisation, screening and decolonisation, antimicrobial prophylaxis, aseptic practice and wound surveillance. Further work was underway to formalise local surveillance arrangements and strengthen reporting of post discharge concerns.	**Substantial**	**Substantial**	Progress to be monitored through established infection surveillance and governance arrangements.
QSAC/26/08/133	**Infection, Prevention and Control Report**	The Committee reviewed the quarterly infection prevention and control position. C. difficile remained the principal concern, although the Trust remained within the regional middle range and no outbreak or cross transmission had been identified. Assurance was received on strengthened surveillance, environmental hygiene, antimicrobial stewardship and infection prevention actions. E. coli remained within threshold, while a full review was underway following one MRSA bacteraemia case.	**Moderate**	**Substantial**	Progress to be monitored through routine infection prevention and control reporting.
QSAC/26/08/135	**Clinical Pharmacy 6 monthly update**	The Committee received assurance that the clinical pharmacy triage model was embedded and prioritising patients at greatest clinical risk. Improvements were noted in omitted critical medicine doses, medicines reconciliation for high risk patients and discharge prescription turnaround times. Further review was required	**Substantial**	**Substantial**	The Committee received assurance on progress and agreed that a further update would be

		to determine whether higher omitted dose reporting in maternity and urgent and emergency care reflected clinical risk or data quality issues, alongside continued evaluation of the impact of the triage model.			provided in 6 months.

Further items discussed and received for assurance:

QSAC/26/08/125 Compliance Update – Quarter One
QSAC/26/08/127 Patient Safety and Clinical Effectiveness Sub Committee Exception Report
QSAC/26/08/130 Quality IPR Metrics
QSAC/26/08/131 Maternity Reports
(i) Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB) –
(ii) Cheshire and Merseyside Perinatal Mortality Report (PMRT) Q1
(iii) Maternity and Neonatal Quality Review Report
(iv) MVNP Biannual Report
QSAC/26/08/132 Learning from Experience Report – Quarter One
QSAC/26/08/134 Sepsis High Level Update – Quarter One
QSAC/26/08/136 Clinical Audit Report
QSAC/26/08/137 High Level Enquires and External Assessment/Inspections

Items received for information:

QSAC/26/08/138 Safe Staffing Report – July 2026
QSAC/26/08/139 Quality Improvement Progress 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: Committee Assurance Report

Agenda reference:	BM/26/10/079aii	**Date of Board meeting:**	7 October 2026

Date of meeting:	8 September 2026
Name of meeting and chair:	Quality and Safety Assurance Committee, Chaired by Jayne Downey
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/26/09/147	**Deep Dive – Neurodevelopment Update**	The Committee reviewed the continuing demand and capacity gap within the neurodevelopment pathway, with referrals exceeding available commissioned capacity and waiting times continuing to increase. Clinical risk stratification remained in place to prioritise children with the greatest need, although extended waits for other children remained a significant quality and safety concern. Assurance was received that outstanding harm reviews had been completed and that strengthened monitoring arrangements were in place. The Committee noted continuing work with commissioners on pathway redesign, digital development and medication management, alongside the	**Moderate**	**Substantial**	Further update in January 2027 following receipt of the GIRFT report and the outcome of funding discussions.

		positive initial feedback from the GIRFT review.			
QSAC/26/09/148	**ED Improvement Programme Update**	The Committee reviewed the Emergency Department improvement programme and noted continuing pressures relating to four hour performance, 12 hour waits, ambulance handovers, corridor care and capacity. Assurance was received on targeted improvement work, including ambulance handover arrangements, enhanced streaming and strengthened sepsis governance. The Committee noted that sustainable improvement remained dependent on whole hospital flow, timely discharge and bed capacity, with work continuing to develop a straight to specialty model.	**Moderate**	**Substantial**	Further deep dive on specialty streaming to be presented to the Committee.
QSAC/26/09/151	**MIAA Theatre Safety Audit**	The Committee recognised the positive safety culture improvements achieved within theatres, including the continued reduction in never events. However, further assurance was required that theatre safety standards were being applied consistently through a reliable and auditable system. The Committee therefore retained oversight and requested a gap analysis and improvement plan covering the digital solution, checklist arrangements, evidence requirements, accountability and delivery timescales.	**Moderate**	**Moderate**	Improvement plan to return to the Committee in November 2026 following PSCESC review.
QSAC/26/09/155	**Maternity items**	The Committee reviewed maternity performance and improvement reports and noted continued progress across a number of key quality measures. Improvements included induction of labour performance, neonatal term admissions and postpartum	**Substantial**	**Substantial**	The Committee received the reports for assurance and would continue

		haemorrhage rates, while maternity triage continued to meet its key performance indicators. The Committee noted continuing medical staffing pressures within triage and a midwifery workforce gap that could affect compliance with one element of the Maternity Incentive Scheme. Assurance was received that a workforce review had been completed and that a funding proposal was being developed.			to receive regular updates.
QSAC/26/09/156	**Risk Management Strategy Report**	The Committee reviewed the proposed Risk Management Strategy and requested clarification on whether the document should be presented as a strategy or policy. Further advice will be obtained from MIAA before a recommendation is made to the Board. Opportunities were also identified to strengthen reporting on residual risk, the impact of mitigating actions and the connection between service changes, quality impact assessments, the Corporate Risk Register and the Board Assurance Framework.	**Moderate**	**Moderate**	Advice to be sought from MIAA on the appropriate status of the document. Update to be presented in October.

Further items discussed and received for assurance:

QSAC/26/09/145 Matters arising
1. QSAC/26/07/114 – Safeguarding update on Channel Panel Arrangements for legacy BCH services
2. QSAC/26/08/136 – National Oversight Framework Clinical Audit Scoring
3. QSAC/26/08/137 – High Level Enquiries – Tongue-Tie corrective actions update

QSAC/26/09/146 Patient Story – Halton 0-19 Children's Services - One Families Journey
QSAC/26/09/149 Patient Safety and Clinical Effectiveness Sub Committee Exception Report
QSAC/26/09/150 Fractured Neck of Femur Update
QSAC/26/09/152 Learning from Deaths Q1 Report

QSAC/26/09/153 Quality Priorities Report Q1
QSAC/26/09/154 Mental Health Update
QSAC/26/09/155 Maternity Reports
(i) Maternity and Neonatal 10 Point Plan assurance process
(ii) Perinatal Improvement Plan
(iii) Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
(iv) Maternity and Neonatal Quality Review Report
(v) Avoiding Term Admission into Neonatal Unit (ATAIN) Q1
(vi) Transitional Care Audit Q1 – deferred to October 2026
QSAC/26/09/157 Health and Safety Annual Report
QSAC/26/09/158 RD&I Biannual Progress Report
QSAC/26/09/159 High Level Enquires and External Assessment/Inspections
QSAC/26/09/160 Committee Effectiveness Annual Review

Items received for information:
QSAC/26/09/161 WELL Runcorn Hub CQC registration update
QSAC/26/09/162 Safe Staffing Report – August 2026
QSAC/26/09/163 QIA high level briefing report – deferred to October 2026
QSAC/26/09/164 Information Governance and Corporate Records Group Report Q1

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/26/10/079bi	Date of Board meeting:	7 October 2026

Date of meeting:	19 August 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/26/08/084	**Chief People Officer Report**	The Committee received an update on the publication of the revised EHRC Code of Practice (same sex facilities). A new corporate risk (Risk 2620) has been added to reflect the challenges of implementing the guidance consistently across the Trust estate. This risk is to be escalated to Board and is being actively mitigated. More guidance is awaited from NHSE. The Committee discussed the inclusion of the NHS Staff Standards within the NHS Oversight Framework and the implications of comparative ranking between organisations. As staff survey results form a key measure, it was agreed that the workforce IPR and cycle of business would be reviewed to ensure	**Moderate**	**Substantial**	September 2026

		appropriate governance, oversight and assurance of the standards throughout the year.			
SPC/26/08/083	**Hot Topic – NHS Staff Standards**	The Committee received a presentation focused on the recently introduced NHS Staff Standards, of which there are 6. The Committee noted that the staff standards are a national mandated requirement and will be monitored. The standards are programmes of work that are already underway via the staff survey and people promise. NHS England want NCM (and other Trusts) to show same level of grip and control as managing finance and performance. Oversight of reporting likely to be quarterly rather than annual but still being worked up. The committee received an update as to where the Trust is currently ranking on staff standards within the upper quartile at 7.51 out of 10. The committee received an update re governance and assurance and next steps. The committee sought assurance on plans to improve appraisal scores and wellbeing.	**Moderate**	**Substantial**	N/A
SPC/26/08/084	**Workforce Brief on National, Regional, ICB, or Local Workforce Issues**	The Committee were updated on an impact assessment carried out on the Employment Rights Act 2025, as superseding the ERA 1996. The impact of the changes in law, risk, mitigations and actions were noted with some discussion around third party harassment. Approaches to zero tolerance, the issuing of red cards and application of current policies was referred to.			
SPC/26/08/086	**Workforce Plan Update**	The Committee received a paper in relation to the workforce plan which provided assurance that the Trust is currently under plan by 21 wte reduction but £92K behind CIP plan. It was highlighted that some Care Groups were over plan as per the broken down plans	**Moderate**	**Substantial**	September 2026

		provided and there was targeted work and support in place in relation to that.			
SPC/26/08/087	**Annex 31 – Delivery Plan Update**	The Committee received an update on both the B5 and annex 31 task and finish groups and programmes of work. The committee were assured by the update and the delivery plan submitted on 31st July 2026.	**Substantial**	**Substantial**	COB
SPC/26/08/088	**Equality, Diversity and Inclusions Strategy Bi-Annual Update**	The Committee received an update on the EDI strategy. The strategy is aligned to the NHS People Promise, NHS EDI Improvement Plan, WRES, WDES and wider organisational priorities and is structured around four strategic objectives focused on belonging, workforce safety, anti-racism and strengthening staff voice. Overall, delivery remains on track, with significant progress made in establishing the foundations required to support long-term cultural and inclusion improvements across NCM. During the first six months of implementation, activity has focused on strengthening governance, understanding lived experience, developing workforce intelligence and translating national EDI priorities into local action.	**Substantial**	**Substantial**	February 2027
SPC/26/08/089	**Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standard (WDES)**	WRES and WDES 2025/26 reports have been completed using legacy WHH and BCH data, in line with national requirements. Combined Trust-wide WRES and WDES action plans for 2026/27 have been developed, focusing on anti-racism, disability inclusion, leadership development, wellbeing, reasonable adjustments, staff voice, career progression, and reducing bullying, harassment and discrimination. Progress will be monitored through the EDI governance framework. Reports approved to go to Board.	**Substantial**	**Substantial**	August 2027

The Committee also received the following reports:

Reports for Assurance:
SPC/26/08/085 - Workforce Brief on National, Regional, ICB, or Local Workforce Issues
SPC/26/08/090 - Safer Staffing Report
SPC/26/08/091 – Midwifery Staffing Report – Q1
SPC/26/08/093 - Guardian of Safe Working – Annual Report
SPC/26/08/094 – Committee terms of reference
Matters to note for assurance:

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.
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North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/10/079/b/ii**	**Date of Board meeting:**	7 October 2026

Date of meeting:	16 September 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/26/09/101	**Gender Pay Gap**	The Committee received a detailed review of the gender pay gap which indicated that the position is predominantly influenced by workforce composition, particularly medical and dental staffing, not equal-pay . A more targeted programme of work is being developed around career pathways, appraisal quality, recruitment, leadership development, wellbeing and flexible working. New governance arrangements will provide ongoing oversight and future reporting is expected to align gender pay gap monitoring more closely with other workforce equality measures.	**Moderate**	**Substantial**	

SPC/29/09/102	**National Education and Training Survey (NETS)**	The Committee undertook a detailed review of the NETS position. The overall experience score for the former WHH was 69.14%, sixth from bottom nationally, the former Bridgewater was 93.33%, but was based on only 12 responses. The Committee recognised the low response rates but these did not fully explain the position and improvement is required. Postgraduate medicine is the main area of concern. Survey results had deteriorated across all measures compared with 2024, with particular concerns around overall experience, wellbeing and workload. This was triangulated with feedback from the GMC survey, resident doctor forums and Guardian of Safe Working information. Significant operational pressures, rota and rostering arrangements and the availability of specialty training time were identified as contributing factors. Actions already undertaken include changes to medical rotas intended to increase speciality time, additional registrar-level cover and work to improve ward staffing arrangements. An overarching action plan will return to the Committee, together with safe medical staffing information and indicators that will enable improvement to be monitored through the IPR. For maternity education historically high student numbers had affected placement experience and access to learning opportunities. Student numbers will reduce in a phased approach alongside increased	**Limited**	**Moderate**	

		student engagement, listening mechanisms, additional educational support and strengthened oversight.			
SPC/26/09/103	**Chief People Officer Report**	The Voluntary Redundancy Scheme has received around 400 expressions of interest, with weekly oversight arrangements established and Executive panels scheduled in October. The planned departure date remains 30 November, although some cases may extend beyond this due to needing pension quotations.	**Moderate**	**Substantial**	
SPC/26/09/105	**Workforce Plan Update**	The Committee reviewed delivery against the workforce plan which was 8.4 WTE worse than plan, with significant variation between care groups. Unplanned care was the biggest concern at 93.3 WTE worse than plan, with substantial financial pressures and reliance on non-recurrent delivery. Unplanned care attended Committee to explain their position. The Committee recognised their significant operational constraints including urgent and emergency care pressures, but challenged whether non-recurrent delivery could be converted into recurrent reductions given bed closures on A8. The Committee was assured that enhanced executive scrutiny is in place, including oversight of medical rotas and review of vacancies. Nevertheless, the Committee considered that further assurance is required on delivery of the unplanned care workforce plan and noted that this has been escalated to EMT.	**Moderate**	**Substantial**	

SPC/26/0/108	**Safe Staffing Report**	The Committee received assurance that staffing was safe during the reporting period, although this required significant intervention from senior nursing teams to maintain appropriate staffing and skill mix. Operational pressures remained considerable, including high emergency demand, enhanced mental health care requirements and use of escalation capacity.	**Moderate**	**Substantial**	
SPC/26/09/111	**Committee Effectiveness – Annual Survey**	The Committee effectiveness review was positive overall, although improving the clarity and quality of reports, particularly executive summaries, was identified as an opportunity for further improvement.	**Substantial**	**Substantial**	
SPC/26/09/112	**Updated Committee Cycle of Business**	The Committee approved an updated cycle of business intended to strengthen its future assurance arrangements. This will include: • monthly National Oversight Framework scorecard; • quarterly reporting on workforce elements of the Single Improvement Plan from January; • strengthened monthly workforce IPR reporting supported by quarterly narrative analysis; and • consolidation of existing people and culture reports to reduce duplication. • The Committee effectiveness review was positive overall, although the clarity and quality of reports need further improvement.	**Substantial**	**Substantial**	

The Committee also received the following reports:

Reports for Assurance:
SPC/26/09/104 - Workforce Brief on National, Regional, ICB, or Local Workforce Issues
SPC/26/09/106 – Workforce IPR Report
SPC/26/09/107 – Culture Plan Biannual Update
SPC/26/09/109 - General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA) and Responsible Officer Annual Report
SPC/26/09/110 – General Medical Council (GMC) National Trainee Survey
SPC/26/09/113 – People and Culture Sub Committees Chair's Log

Matters to note for assurance:
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/26/10/079ci	Meeting	Trust Board	Date Of Meeting	7 October 2026

Date of Meeting	24 August 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/27/08/081	**Deep Dive – Planned Care Recovery Plans**	The Committee reviewed the planned care recovery position and noted that activity and income remained materially below plan, with workforce gaps, theatre productivity, case mix and elective recovery funding contributing to the shortfall. Recovery actions were underway and performance was expected to improve during the second half of the year. However, the Committee was not assured that the plan, as presented, would deliver the required full year activity, weighted activity and income trajectory. Further quantified evidence was required on each intervention, including its impact on activity, RTT, income, ownership, timescale and delivery confidence.	The Committee received **Limited** assurance	The Committee **noted** the report and received **Limited** assurance	**Revised recovery plan to Committee in September 2026 and Board in October 2026.**
FSPC/26/08/082	**Hot Topic – Financial Recovery Plan**	The Committee reviewed the developing Financial Recovery Plan and noted that it remained an early working document. The plan was aligned with the integration Full Business Case and set out a phased route towards financial sustainability, supported by productivity, CIP and further system opportunities. Assurance	The Committee received **moderate** assurance	The Committee received **moderate** assurance.	**Revised plan to Committee in September 2026 before Board approval.**

		was received on the developing governance and executive oversight arrangements. However, further quantified delivery evidence and stronger alignment with operational recovery plans were required before a higher level of assurance could be provided.			
FSPC/26/08/084 (i)	**Finance Report M4**	The Committee reviewed the Month 4 financial position and noted that the Trust remained adverse to plan. CIP delivery was on plan, with an improving proportion delivered recurrently, although continued reliance on non recurrent measures and delivery of productivity schemes remained key risks. Assurance was received on financial controls, executive oversight and actions to strengthen recurrent savings, workforce control and delivery against the recovery trajectory	The Committee received **moderate** assurance	The Committee **noted** the report and received **substantial** assurance	**Progress to be monitored through monthly finance reporting.**
FSPC/26/08/084 (vii)	**Capital Expenditure and Schemes over £500k**	The Committee reviewed the capital programme and approved the proposed contingency movements. Capital expenditure remained behind plan and several major schemes were subject to cost, timing or delivery pressures. Particular attention was given to the timetable for the Emergency Department escalation scheme and its dependency with the Urgent Treatment Centre programme. The Committee requested clear confirmation that any temporary use of available capital funding would be distinguished from a decision to delay the underlying scheme	The Committee received **moderate** assurance, pending clarification of the delivery timetable and the impact on linked schemes.	The Committee **noted** the paper receiving **substantial** assurance.	**Revised timetable and dependency assessment to be reported following review.**
FSPC/26/08/089	**Corporate Performance Report**	The Committee reviewed the Corporate Performance Report and noted continued positive performance in elective care, cancer and outpatients, alongside improvement in four hour Emergency Department performance. Twelve hour waits remained the principal area of concern, with improvement dependent on	The Committee received **moderate** assurance, recognising positive performance in	The Committee **noted** the paper receiving **substantial** assurance	**Further update through the next corporate performance reporting cycle**

		reducing length of stay, bed occupancy and patients with no criteria to reside. RTT performance was slightly below trajectory, while diagnostics were improving and cancer standards had been achieved in month. The Committee requested clearer visibility of community and dental performance in future reports.	several areas alongside the continuing 12-hour performance challenge		

Items for noting

FSPC/26/08/083 *Delivery Unit Update*
FSPC/26/08/084 (ii) *Cost Pressures*
FSPC/26/08/084 (iii) *Cash Support Update Q2*
FSPC/26/08/084 (iv) *Monthly CIP Updates M4*
FSPC/26/08/084 (v) *PwC Update*
FSPC/26/08/084 (vi) *Monthly Productivity Update*
FSPC/26/08/084 (vii) *Capital Expenditure M4 including schemes over £500k – supported and approved the movement in capital contingency*
FSPC/26/08/085 *Workforce Plan Update*
FSPC/26/08/086 *Pay Assurance Report*
FSPC/26/08/087 *Benefits Realisation Quarterly Report Q1*
FSPC/26/08/088 *Medical Workforce Review Group Quarterly Report Q1 - deferred*
FSPC/26/08/089 *Corporate Performance Report*
FSPC/26/08/090 *Recovery Update*
FSPC/26/08/091 *Radiology WLI Revenue Request*
FSPC/26/08/092 *Digital Strategy Group Update*
FSPC/26/08/093 *EPRR Update*
FSPC/26/08/094 *Capital Planning Group Annual Report*

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*

North Cheshire and Mersey NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/10/079cii	Meeting	Trust Board	Date Of Meeting	7 October 2026

Date of Meeting	28 September 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/26/09/100	**Electronic Patient Record funding**	The Committee reviewed the funding position for the acute Electronic Patient Record and noted that national funding was unlikely to be available in 2026/27, with the future funding route remaining uncertain. The programme could not progress as planned until funding was confirmed. This remained a significant strategic, operational and financial risk, with options continuing to be explored with partner organisations and NHS England.	The Committee received **Moderate** assurance	The Committee **noted** the report and received **limited** assurance	**Further update to Committee on 26 October 2026.**
FSPC/26/09/101	**Deep Dive - Planned Care Recovery**	The Committee reviewed the planned care recovery position and noted a materially improved August position, including stronger theatre productivity and delivery broadly in line with the monthly activity and income plan. The year to date shortfall remained, with delivery dependent on approved recovery schemes, resolution of the elective restoration funding gap and management of winter capacity. The Committee was more assured but required continued evidence that improvement would be sustained and the residual gap closed.	The Committee received **moderate** assurance	The Committee **noted** the report and received **moderate** assurance	**Quantified recovery update to Committee on 26 October 2026.**

FSPC/26/09/102	**Financial Recovery Plan Update**	The Committee reviewed the developing Financial Recovery Plan, including analysis of the underlying deficit and actions relating to workforce, productivity, non-elective flow, fragile services and corporate costs. Progress was noted, together with strengthened governance arrangements. Further evidence and clearer links between finance, activity, workforce and benefits were required to support completion of a fully quantified three year plan.	The Committee received **moderate** assurance	The Committee **noted** the report and received **moderate** assurance	**Final plan to Committee on 26 October and Board on 4 November 2026.**
FSPC/26/09/104	**Finance, workforce and productivity - Month 5**	The Committee reviewed the Month 5 finance, workforce and productivity position. The Trust remained adverse to plan, while cost improvement delivery was on plan with an increasing recurrent proportion and variable activity had improved in August. Key risks remained in recurrent CIP, unplanned care workforce and pay pressures, bank expenditure, delivery of activity and income plans, future deficit support and the capital trajectory. Assurance was received on the controls, Delivery Unit oversight and external scrutiny in place	The Committee received **moderate** assurance	The Committee **noted** the report and received **moderate** assurance	**Monthly reporting to FSPC on 26 October 2026**
FSPC/26/09/106	**Corporate Performance and national access tiering**	The Committee reviewed the 12 hour urgent and emergency care position, which remained the principal performance concern. The position reflected continuing pressures on patient flow and corridor care. Assurance was received that improvement actions were underway and subject to established oversight, with the position to remain visible to the Board.	The Committee received **limited** assurance	The Committee **noted** the report and received **moderate** assurance	**Progress to be monitored through monthly performance reporting.**

Items for noting

FSPC/26/09/103	*Delivery Plan Update*
FSPC/26/09/104(ii)	*Cost Pressures*
FSPC/26/09/104(iii)	*Cash Support Update*
FSPC/26/09/104(iv)	*Monthly CIP Updates M5*

FSPC/26/09/104(v)	*PwC Update*
FSPC/26/09/104(vi)	*Monthly Productivity Update* • *Theatres (inc. CIP opportunities in session usage)* • *Outpatients* • *UEC Improvement*
FSPC/26/09/104(vi)	*Capital Expenditure*
FSPC/26/09/105	*Workforce Plan Update*
FSPC/26/09/107	*Single Improvement Plan*
FSPC/26/09/108	*Winter Board Assurance*
FSPC/26/09/109	*Elective Recovery Update*
FSPC/26/09/110	*Senior Risk Information Owner Annual Report*
FSPC/26/09/111	*Committee Effectiveness Review*
FSPC/26/09/112	*Minutes / Action Log of the EPR Procurement Oversight Group*
FSPC/26/09/113	*Digital Strategy Group Update*

Assurance Key:

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

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North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/10/078d**	**Date of Board meeting:**	7 October 2026

Date of meeting:	Thursday 27 August 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/26/08/046	**Finance, Sustainability and Performance Committee update**	The Committee received an update on the Trust's financial position and the developing financial recovery plan. As the plan was still being developed, the Committee was not yet able to take assurance on delivery. Successful delivery would depend on recovery of planned care activity, improved productivity and implementation of the identified recovery actions. The plan remained subject to further Executive, Committee and Board scrutiny before finalisation. **Lead officer:** Chief Finance Officer.	**Limited**	**Substantial**	Revised plan to FSPC on 28 September and Extraordinary Trust Board on 1 October 2026. Ongoing monitoring through FSPC and Trust Board.
AC/26/08/048	**Internal Audit follow-up**	The Committee noted continued progress in completing outstanding Internal Audit actions and agreed extensions where these were considered	**Substantial**	**Substantial**	Confirmation required when Safe Staffing

		reasonable in light of organisational integration and system changes. It requested confirmation once the Safe Staffing actions had been independently verified and further justification for the proposed longer extension relating to a Critical Application Review action. **Lead officer:** Associate Director of Finance (Operational).			actions have been verified by MIAA. Further rationale required for the Critical Application Review extension.
AC/26/08/050	**Internal Audit Progress Report**	The Committee received the E-Rostering Review, which provided Moderate Assurance. The principal area for improvement related to the timely approval of rosters and the implications for staffing oversight, workforce planning and assurance over safe staffing arrangements. The Committee also received the Data Security and Protection Toolkit review, which identified a number of areas requiring improvement. Management had accepted the recommendations and provided comprehensive responses, with delivery to be closely monitored. The position will be reported to the Board, alongside wider consideration of cyber security through a forthcoming Board Development Session. **Lead officers:** Deputy Chief Nurse / Chief Finance Officer / Interim Digital lead.	**Moderate**	**Substantial**	E-Rostering actions and progress against the Data Security and Protection Toolkit recommendations to be monitored through the Internal Audit follow-up process and Audit Committee.
AC/26/08/052	**MIAA Workforce CIP Governance Review**	The Committee received the independent MIAA review of the governance arrangements supporting delivery of the Workforce CIP. The review recognised the significant work already underway and the strengthening of executive accountability, while identifying further opportunities to improve triangulation between	**Substantial**	**High**	Further report to Audit Committee in November 2026. Relevant workforce and financial actions to be reported

		workforce, financial and operational information. All recommendations had been accepted and a further report requested to demonstrate implementation and the effectiveness of the enhanced arrangements. **Lead officers:** Company Secretary / Chief Finance Officer.			through the appropriate Board committees, including FSPC.
AC/26/08/053	**External Audit update**	The Committee received confirmation that the Trust had received an unqualified external audit opinion, consistent with the position previously reported. The opinion had been issued ahead of the statutory deadline and no further matters requiring escalation were identified. **Lead officer:** Chief Finance Officer.	**High**	**High**	n/a

Other agenda items:
AC/26/08/045 Board Assurance Framework
AC/26/08/046 Committee Chairs Updates - Quality and Safety Assurance Committee update, including resolution of the outpatient typing backlog and transition to Lyrebird
AC/26/08/047 Report from the Risk Oversight and Performance Assurance Forum
AC/26/08/048 Progress Report on Internal Audit follow-up actions
AC/26/08/049 Internal Audit progress on legacy BCH follow-up actions
AC/26/08/051 MIAA External Quality Assessment results and action plan
AC/26/08/054 Counter Fraud progress update
AC/26/08/055 Anti-Fraud, Bribery and Corruption Policy
AC/26/08/056 Losses and Special Payments
AC/26/08/057 Quotation and Tender Waivers
AC/26/08/058 North West Skills Development Network Biannual Report
AC/26/08/059 Standing Financial Instructions
AC/26/08/060 Freedom of Information Policy
AC/26/08/061 Committee Chair's Annual Report
AC/26/08/062 Committee Effectiveness Review

Delivery assurance: Assurance in achieving outcomes
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Warrington and Halton Hospitals' Charity
An NHS Charity

NHS
North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/10/079e**	**Date of Board meeting:**	7 October 2026

Date of meeting:	3 September 2026
Name of meeting and chair:	Charitable Funds Committee, chaired by Andy Carter, NCM Chair
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
CFC/26/09/005	**Charity Annual Impact Report**	The Committee welcomed the stronger focus on impact, personal stories and testimonials and agreed the report should be promoted widely. The report will also be presented to the Trust Board as part of the Charity annual reporting arrangements. **Lead:** Deputy Director of Comms and Engagement (HS)	**High** The report demonstrated the breadth and impact of charitable activity across patient care, staff wellbeing and community engagement.	**High** Annual impact reporting is in place and provides the Committee and Board with evidence of how charitable funds are used.	October 2026
CFC/26/09/008	**Bid Applications**	The Committee approved the Emergency Department staff room refurbishment bid. A proposed Reasonable Adjustments Room was approved in principle, subject	**Substantial** The staff room scheme can proceed, but	**High** The Committee applied appropriate	October 2026 / December 2026

		to written clarification on its operation and eligibility criteria. **Lead:** Director of Comms and Engagement (KH)	delivery assurance for the Reasonable Adjustments Room remains dependent on the requested operational clarification.	scrutiny and conditions before final approval of the Reasonable Adjustments Room.	
CFC/26/09/010	**Charity Risk Register and Risk Statement**	The Committee reviewed the two open risks, approved continued use of the Risk Management Statement and received assurance that Charity systems operate within Trust procurement, IT and cyber security controls. Learning from the supplier insolvency, including possible payment protection measures, will be reviewed. **Lead:** Head of Fundraising (HH), Director of Comms and Engagement (KH)	**Substantial** Existing risks are actively monitored and no outstanding actions were reported, with further learning identified from the supplier incident.	**High** Risks have been reviewed through the Risk Review Group and the Committee approved the Risk Management Statement.	December 2026
CFC/26/09/011	**Annual Report and Accounts 2025/26**	The Committee reviewed the draft Annual Report and Accounts. The accounts will undergo independent examination, be presented to Audit Committee in November and return to the Committee in December before Charity Commission submission. **Lead:** Financial Planning Accountant (TL)	**Substantial** The year-end position showed a positive movement in funds and the statutory reporting timetable is progressing.	**High** Independent examination and sequential review by Audit Committee, Charitable Funds Committee and Trust Board are built into the approval process.	November 2026 / December 2026 / 31 January 2027

Other Agenda Items
CFC/26/09/004 Impact Story – Intensive Care Unit

CFC/26/09/006 Fundraising Report and Quarterly Workplan
CFC/26/09/007 Finance Report
CFC/26/09/009 Review of Reserves Policy
CFC/26/09/012 Committee Chair's Annual Report to Board
CFC/26/09/013 Committee Effectiveness Annual Review – advise of survey

Assurance key:
Delivery assurance: Assurance in achieving outcomes
Governance assurance: Assurance in the internal controls in place

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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

Agenda reference:	**BM/26/10/080**			
Subject:	**Fragile Clinical Services Update**			
Date of meeting:	7 October 2026			
Action required:	**Note**			
Author(s):	Paul Fitzsimmons, Executive Medical Director			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
	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 4: Embedded Health Equity			
	BAF 5: Workforce Capacity, Capability and 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:	This report 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			

<table>
<tr><td></td><td colspan="3">• Rheumatology
Services de-escalated from Fragile Services oversight since last report:
• Chronic Pain Service
Services entering Fragile Services oversight since last report:
• None
Neurodevelopment Service</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 current list of Fragile Services, associated clinical risk and high-level progress updates
• Note significant progress and improvement within Planned Care Fragile
• Note de-escalation of Chronic Pain
• Note escalation of the Neurodevelopment service into fragile services oversight
• Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">None</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

Following recognition of a need for a systematic oversight mechanism for Fragile Services a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QASC and on to Trust Board since July 2023.

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

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

2. Fragile Services De-Escalated From Oversight Since Last Board

Chronic Pain Service

The service has completed the internal safety actions, with robust protocols, standardised GP communications and patient advice for opioid and gabapentin medications implemented. All new patient injection therapy is in line with NICE guidance.

Further service transformation and improvement is now dependant on commissioner led decommissioning of the and recommissioning, Trust engagement and progression in this will be managed through the relevant group of the NCM 2030 programme

3. Services Entering Fragile Services Oversight Since Last Board

Paediatric Neurodevelopment Services

Escalated into Fragile Service Oversight following deep dive presented to QASC September 2026. Significant demand capacity mismatch.

First fragile services report will be presented to PSCESC October 2026

4. Services Remaining Under Fragile Services Oversight

Orthopaedics – Fractured Neck of Femur

Summary

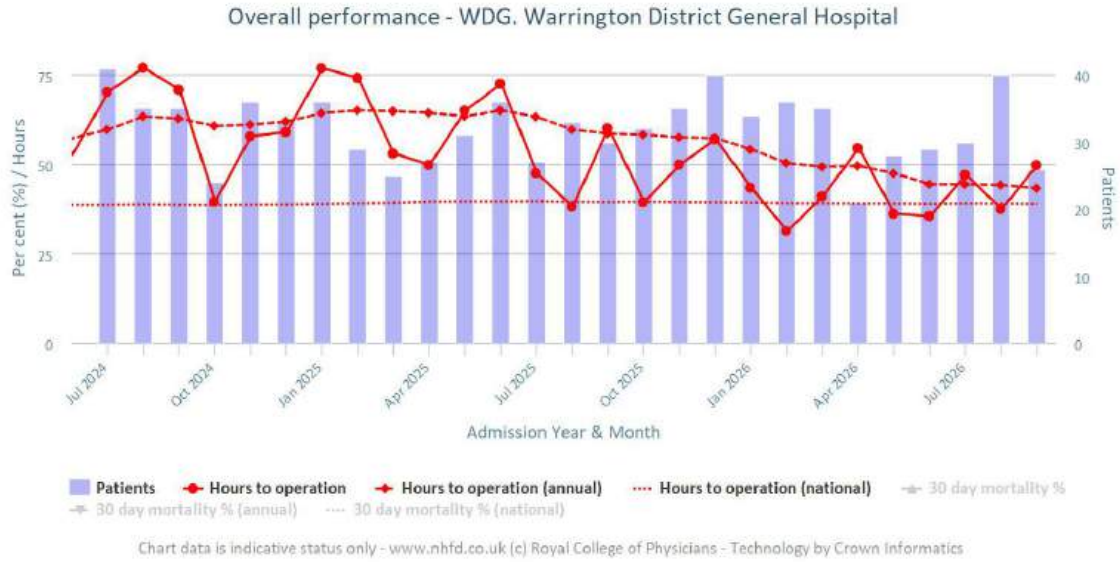
Improvement has been seen in key performance indicators and outcome measures, with time to operation falling towards the national average and crude mortality falling to, or below the national average in the last 5 months.

As Case mix adjusted mortality is reported on an annualised basis, despite these improvements, the Trust remains an alert outlier for Q1 (Jan-Mar) 2026 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 subject to theatre staff consultation will go live in November 2026.

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

Urology

Summary

Service remains fragile from staffing and capacity / demand profile perspectives

Middle grade rota now fully populated

Clinical risk regarding Kidney and Prostate cancer surveillance now addressed through introduction of dedicated cancer surveillance access plans and completed 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, locum consultant recruitment approved to support recovery. Medium term plan to return to Executive Team
- P3 waiting lists and P4 waiting lists stable
- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance and diagnostic cystoscopy position improved from initial position – recent increase in undated surveillance patients – recovery of position will be supported by consultant and middle grade recruitment

Completed Actions

- Nurse delivered cystoscopy now live
- OP Clinic template standardisation completed
- Middle grade rota now fully populated
- Locum consultant recruitment underway
- 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 validation completed and dedicated surveillance access plans in use

Key Actions for Next Reporting Period

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

Medium Term Actions:

- Urology to be included in system blueprint 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 with resolution of prescribing backlog, patient enquiry backlog, and improvement in DMARD monitoring and prescription process 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 failsafes 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 to support demand/capacity mismatch
- Completed capital case for proprietary DMARD monitoring system
- Virtual DMARD education programme developed with communications department support to release consultant and specialist nurse capacity

Key Actions for Next Reporting Period

- Progress capital case for proprietary DMARD monitoring system
- Implement virtual DMARD education programme for patients
- Undertake demand capacity exercise and progress GIRFT pathway review to manage OP backlog

5. Recommendations

The 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
- Note de-escalation of Chronic Pain
- Note escalation of the Neurodevelopment service into fragile services oversight
- Receive further Fragile Service Oversight reports

.

Appendix 1

Chronology of Fragile Service Status

	Month Escalated to Fragile Services Oversight	Month Deescalated from Fragile Services Oversight
Fractured Neck of Femur	June 2022	Ongoing
Histopathology Turnaround Times	July 2022	June 2023
Paediatric Ophthalmology	Feb 2023	May 2024
Diabetic Foot Clinic	April 2023	June 2023
Age-Related Macular Degeneration	May 2023	Sept 2023
Gynaecology	July 2023	Sept 2024
Urology	Jan 2024	Ongoing
ENT	Nov 2023	March 2025
Stroke Services	May 2024	Sept 2024
Theatres (procedural safety)	Jun 2024	Nov 2024
Cardiology and Cardiorespiratory	Sept 2024	Nov 2025
Cancer Services	June 2025	March 2026
Chronic Pain Service	June 2025	October 2026
Rheumatology Service	Nov 2025	Ongoing
Paediatric Neurodevelopment	October 2026	Ongoing

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/081**			
Subject:	**Compliance Assurance Report Q1 2026/27**			
Date of meeting:	7 October 2026			
Action required:	**For noting**			
Author(s):	Jen McCartney, Head of Compliance and Clinical Effectiveness			
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:	Tracy Fennell, Interim Chief Nurse			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	This paper provides an overview of compliance activity undertaken during Quarter 1 2026/27 and the assurance gained in relation to regulatory compliance, organisational assurance and continuous improvement during the Trust's first quarter as an integrated organisation. During the reporting period, work has focused on embedding compliance and assurance arrangements across acute, community and dental services. This included revised governance through the Quality Compliance Oversight Group (QCOG), ongoing engagement with the Care Quality Commission (CQC), oversight of CQC enquiries, development of inspection preparedness arrangements and extension of the Internal Mock Inspection Programme to community services.			

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.

<table>
<tr><td></td><td colspan="3">Internal mock inspections completed during the reporting period provided assurance regarding the services reviewed, with no immediate patient safety concerns identified requiring escalation.

The paper also provides an update on national developments relating to the CQC assessment approach and outlines the Trust's ongoing work to ensure local assurance arrangements continue to reflect emerging regulatory expectations.

Quarter 2 will focus on continuing to embed the Trust's compliance and assurance arrangements, including progression of the Internal Mock Inspection Programme, implementation of agreed inspection preparedness initiatives and continued oversight of regulatory activity through the Trust's established governance arrangements.</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 paper.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QSAC/26/08/125</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11.08.2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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 Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England and is responsible for assessing whether providers are delivering safe, effective, caring, responsive and well-led services. Alongside CQC oversight, the Trust is required to maintain compliance with a range of statutory and regulatory requirements, ensuring appropriate governance, assurance and continuous improvement arrangements are in place.

This paper provides the Trust Board with an overview of compliance and regulatory assurance activity undertaken during Quarter 1 (April to June 2026). The report includes updates on regulatory engagement, management of CQC enquiries, governance and oversight through the Quality Compliance Oversight Group (QCOG), and key developments undertaken to strengthen organisational compliance and inspection preparedness across North Cheshire and Mersey NHS Foundation Trust.
Following the establishment of North Cheshire and Mersey NHS Foundation Trust on 1 April 2026, Quarter 1 focused on aligning and strengthening compliance and assurance arrangements to support effective regulatory oversight, organisational learning and Board assurance.

Throughout the reporting period, QCOG has continued to provide corporate oversight of compliance, regulatory activity and organisational preparedness, ensuring emerging risks, regulatory developments and key assurance activities are routinely reviewed and escalated through the Trust's governance framework where appropriate.

2. Quality Compliance Oversight Group Overview

QCOG provides corporate oversight of quality assurance, compliance and regulatory requirements, supporting the Trust to meet its statutory and regulatory responsibilities. Through effective governance and oversight, the Group supports the delivery of safe, effective and high-quality care and experience for patients, whilst promoting a positive culture and environment for staff.

Following the establishment of North Cheshire and Mersey NHS Foundation Trust on 1 April 2026, the QCOG Terms of Reference and Annual Cycle of Business were reviewed to reflect the requirements of the integrated organisation. This included updating the governance arrangements to fully incorporate acute, community and dental services, supporting a consistent approach to quality assurance, compliance and regulatory oversight across all Care Groups.

During Quarter 1, QCOG received its first integrated Care Group assurance submissions, including governance minutes, data packs and accompanying AAA report. The AAA report enables Care Groups to interpret the information provided, identify where assurance exists and describe actions being taken to address areas requiring improvement. This has improved the quality of discussion at QCOG by focusing not only on what the data is showing, but what it means for the service and how improvement is being led locally.

The first cycle of Care Group submissions has provided greater visibility of local priorities, areas of good practice, emerging risks and improvement activity across the

integrated organisation. This has enabled QCOG to identify common organisational themes, promote shared learning and strengthen oversight of quality, compliance and regulatory requirements. As the approach continues to mature, it is expected to provide increasingly consistent assurance across acute, community and dental services.

3. CQC Engagement and Regulatory Activity

3.1. CQC Engagement meetings

The Trust maintains regular engagement with the CQC through formal provider engagement meetings and ongoing dialogue between meetings. This includes routine correspondence, regulatory enquiries and requests for information, supporting an open and transparent relationship with the regulator and enabling emerging issues to be discussed and managed in a timely way.

The first formal provider engagement meeting following the establishment of North Cheshire and Mersey NHS Foundation Trust was held on 8 July 2026. Whilst taking place shortly after the end of Quarter 1, the meeting provided an opportunity to discuss the Trust's progress following integration and review key areas of quality, safety, governance and organisational performance.

Key themes discussed included:

- Progress following the integration of community services and future regulatory oversight.
- Urgent and Emergency Care, including patient flow and service developments.
- Maternity services, including ongoing improvement work. Following the meeting, the CQC also undertook a visit to the Maternity service.
- Workforce, leadership and organisational culture.
- National audit performance and improvement programmes.
- Learning Disability services and reasonable adjustments.
- Fragile services and organisational oversight.

The meeting enabled discussion of organisational achievements, challenges and improvement programmes, while gaining insight into the CQC's focus and expectations.

The Trust's continued approach to open and constructive engagement with the CQC supports ongoing organisational learning, enables regulatory feedback to be considered alongside internal assurance processes and helps ensure the organisation remains prepared for future regulatory assessment.

3.2. CQC Enquiries

The Trust continues to maintain oversight of all CQC enquiries through established governance arrangements, ensuring enquiries are coordinated, responded to in a timely manner and monitored through to formal closure. Oversight is provided through the QCOG, providing assurance that regulatory activity is actively managed and appropriately governed.

During Quarter 1, the Trust continued to manage a range of ongoing CQC enquiries relating to quality and patient safety, including previous Never Event investigations, urgent and emergency care, maternity services, medicines management, safeguarding, discharge processes, infection prevention and patient care concerns.

A number of enquiries related to the CQC seeking assurance regarding investigations undertaken, actions implemented and improvements made in response to previously reported incidents or concerns.

Throughout the reporting period, the Trust maintained constructive dialogue with the CQC, providing supplementary information, investigation updates and assurance where enquiries remained ongoing or additional information was requested.

As of 30 July 2026, the Trust has four open CQC enquiries, with a further 16 enquiries where responses have been submitted and formal confirmation of closure from the CQC is awaited. No formal enforcement action was taken during the reporting period.

The Trust continues to work collaboratively with Care Groups and corporate teams to ensure enquiries are responded to promptly, investigations are progressed appropriately and assurance is provided to the CQC through established governance arrangements.

During Quarter 2, thematic reporting of CQC enquiries will be introduced to support identification of recurring themes, organisational learning and areas requiring further assurance or improvement.

4. CQC Assurance and Inspection Preparedness

4.1 Organisational Preparedness

During Quarter 1, the Trust continued to strengthen its approach to compliance assurance and inspection preparedness following the establishment of North Cheshire and Mersey NHS Foundation Trust. Work focused on embedding consistent arrangements across the integrated organisation to support ongoing regulatory compliance, organisational assurance and inspection readiness.

This built on the successful transfer of the Trust's CQC registration, including locations, regulated activities and Statement of Purpose, which was completed prior to 1 April 2026, ensuring appropriate regulatory arrangements were in place from the commencement of the new organisation.

Key developments during the reporting period included:

- **Development of the Trust's integrated CQC Mobilisation Plan,** bringing together the Trust's arrangements for responding to future CQC assessment activity across acute, community and dental services, with clearly defined in-hours and out-of-hours mobilisation arrangements. Formal approval is planned during Quarter 2.
- **Commencement of the Trust's Quality Walk Round programme**, undertaken jointly by the Head of Compliance and Clinical Effectiveness and Associate Chief Nurses. The programme supports routine assurance through engagement with frontline teams, provides additional visibility of compliance with the CQC Fundamental Standards and operates a rolling programme of visits across the Trust.

- **Development of a Trust-wide CQC Staff Guide**, providing practical guidance to support staff in understanding the CQC Fundamental Standards, what this means in practice and how they can demonstrate the quality of care they provide every day. The content was approved during Quarter 1, with publication planned for Quarter 2 following completion of the design process.
- **Preparatory work for implementation of the Trust's Assurance Management and Accreditation Tool (AMaT)** continued during Quarter 1. AMaT is intended to provide a single platform to support the management of compliance and assurance activity across the Trust, including internal inspections, mock inspections, quality walk rounds, action tracking and organisational evidence. Implementation will commence during Quarter 2, with Trust onboarding and evidence migration aligned to the wider rollout of the programme.

Nationally, the CQC continues to review its future assessment approach. During Quarter 1, the Trust maintained awareness of these developments through national engagement, specialist training and review of emerging guidance. This has enabled local assurance arrangements to remain under review and ensures the Trust is well placed to adapt its approach as further national detail becomes available.

Together, these developments have continued to strengthen the Trust's arrangements for compliance assurance and inspection preparedness and established a foundation for the next phase of work. During Quarter 2, the focus will be on further embedding assurance processes and developing the Trust's approach to evidencing compliance through AMaT.

4.2 Internal Mock Inspection Programme

The Trust's Internal Mock Inspection Programme provides independent assurance against the CQC Fundamental Standards, helping services identify areas of good practice, improvement opportunities and areas requiring further assurance. It also supports organisational preparedness, strengthens local governance and promotes continuous quality improvement.

During Quarter 1, the programme was extended to include community services through the introduction of a service-specific community mock inspection methodology. The methodology reflects the way community services are delivered and provides a consistent approach to reviewing compliance with the CQC Fundamental Standards across community regulated services.

Internal mock inspections were completed within:

- Halton District Nursing
- Warrington District Nursing
- Padgate House
- Community Equipment Store

The inspections were undertaken using the Trust's Internal Mock Inspection Methodology and included discussions with frontline staff and service leaders, review of governance arrangements, supporting documentation and service performance information, with observations undertaken where appropriate.

The inspections have provided assurance regarding the services reviewed and identified no immediate patient safety concerns requiring escalation. Opportunities for improvement identified through the inspections will be shared with the relevant services following completion of the Trust's governance process, supporting local action planning and continuous quality improvement.

At the end of Quarter 1, inspection reports were in development and have since been finalised. The reports are now progressing through the Trust's governance process before being shared with services and reported to QCOG. This ensures inspection findings are reviewed, actions agreed and organisational assurance provided.

During Quarter 1, the programme focused on community services to support assurance across the newly integrated organisation. A further internal mock inspection of the Neurodevelopmental Pathway is planned for 4 September 2026, with organisational learning and emerging themes reported through future Compliance Assurance Reports following completion of the agreed governance process.

5. Next Steps

During Quarter 2, work will continue to strengthen the Trust's compliance and assurance arrangements. Key priorities include:

- Publication and implementation of the Trust's CQC Staff Guide to support organisational understanding of regulatory requirements and inspection preparedness.
- Formal approval and implementation of the Trust's integrated CQC Mobilisation Plan.
- Progression of the Assurance Management and Accreditation Tool (AMaT) programme, including Trust onboarding and initial configuration to support the Compliance and Clinical Effectiveness portfolio.
- Continuation of the Trust's Quality Walk Round programme across acute, community and dental services to support routine assurance and engagement with frontline teams.
- Delivery of the rolling Internal Mock Inspection Programme, including the planned inspection of the Neurodevelopmental Pathway.
- Introduction of thematic reporting of CQC enquiries to strengthen organisational learning, identify recurring themes and enhance regulatory assurance.
- Continued review of national CQC developments and emerging regulatory expectations to ensure the Trust's assurance arrangements remain aligned with national requirements.
- Continued oversight of CQC enquiries, organisational preparedness and compliance assurance through the Trust's established governance arrangements.

6. Recommendations

The Trust Board is asked to note the contents of this paper.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM26/10/082**			
Subject:	**Maternity & Neonatal Update June July 2026**			
Date of meeting:	7th October 2026			
Action required:	**To note**			
Author(s):	Tina Moors 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 June and July 2026, with no maternal deaths and no severe harm incidents reported during the reporting period. Workforce indicators remain positive, mandatory training compliance remains above target, maternity triage performance continues to exceed national standards, and induction of labour delays have significantly improved. Key areas requiring ongoing Board oversight are: • Neonatal admissions to the Neonatal Unit (ATAIN), which remain above national and regional targets, although sustained improvement has been demonstrated with rates meeting target by June and July 2026.			

	• Postpartum haemorrhage (PPH) rates which remain above regional comparator rates had recent improvement. • Workforce and capacity pressures within the diabetes service. • Compliance with Maternity Incentive Scheme Year 8 workforce requirements, particularly the identified midwifery staffing shortfall. • Delivery of actions arising from the national 10 Point Plan, the Ockenden Review and the Amos Review. • Medical workforce capacity within maternity triage. The Board can take assurance that governance arrangements, quality improvement programmes, audit processes and oversight mechanisms remain in place to monitor risks and drive improvement. Residual risks remain in relation to neonatal admissions, postpartum haemorrhage, diabetes workforce capacity, maternity staffing establishment and implementation of national maternity improvement requirements. 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: Cheshire and Merseyside Perinatal Mortality Report Q1 Appendix 4: Avoiding Term Admission into Neonatal Unit Q2 Appendix 5: Maternity and Neonatal Voices Partnership Biannual Report Appendix 6: Ockenden Amos 10 Point Plan		
Purpose: (please select as appropriate)	Approval	To note ✓	Decision
Recommendation:	The Trust Board is asked to note the contents of this report.		
Previously considered by:	Committee	Quality Assurance Committee	
	Agenda Ref.	QSAC/26/09/155i QSAC/26/09/155ii	

		QSAC/26/09/155iii QSAC/26/09/155iv QSAC/26/08/131ii QSAC/26/08/131iv
	Date of meeting	June 2026 and July 2026
	Summary of Outcome	Submit to Trust Board
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***	
Freedom of information status (foia):	Release Document in Full	
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 June and July 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: Cheshire and Merseyside Perinatal Mortality Report Q1
Appendix 4: Avoiding Term Admission into Neonatal Unit Q2
Appendix 5: Maternity and Neonatal Voices Partnership Biannual Report
Appendix 6: Ockenden Amos 10 Point Plan

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 June and July 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 June or July 2026.
- 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
The service continues to demonstrate a stable safety profile with:
- No maternal deaths reported during June or July 2026.
- No severe harm events reported.
- Moderate harm incidents primarily relating to Obstetric Anal Sphincter Injury (OASI).
- Sustained incident reporting levels supporting a positive safety culture.

OASI

- June: 1.03% (2 cases)
- July: 0.97% (2 cases)

The Board can take assurance that OASI performance demonstrates common cause variation with no emerging concerns identified. Learning continues through governance and review processes.

2.2 Areas of Focus & Improvement
Avoiding Term Admissions to Neonatal Unit (ATAIN)

Appendix 4: Avoiding Term Admission into Neonatal Unit Q2

Quarter 1 performance remains above the national target of 6% and NWNODN target of 5.6%, with an overall Q1 position of 9.02%.
However, significant improvement has been demonstrated during the latter part of the quarter:
- June: 4.6% (within target)
- July: 4.37% (within target)

Respiratory symptoms continue to account for approximately 73% of admissions. The avoidable admission rate was 18.2%, below the NHS England expected threshold of 20%.

Improvement Actions
- Development and implementation of respiratory distress pathways.
- Expansion of Transitional Care.
- Continued use of the PEEP for 30 pathway.
- Introduction of NEWTT2 neonatal monitoring.
- Enhanced multidisciplinary review processes.
- Development of admission decision-making proformas.
- Formal dissemination of learning through governance structures.

Board Assurance
The Board can take partial assurance that improvements are beginning to demonstrate early evidence of improvement of reductions in neonatal admissions. Whilst quarter performance remains above target, June and July performance data suggests implemented actions are having a positive impact. Residual risk remains and progress continues to be monitored through the Perinatal Improvement Board, governance committees and quarterly audit reporting.

Postpartum Haemorrhage (PPH)
- June rate: 3.59% (7 cases)
- July rate: 1.94% (4 cases)
- Rolling mean remains above regional comparator levels
- Improvement work continues through the PPH Quality Improvement Programme and implementation of the Northwest Regional Guideline.

Board Assurance
The Board can take partial assurance that improvement initiatives are demonstrating early positive impact. However, residual risk remains as rolling performance continues to exceed regional benchmarks. Continued oversight is provided through the Intrapartum Review Group and Perinatal Improvement Board.
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.

Induction of Labour
July demonstrated the strongest performance recorded to date:

- IOL rate reduced to 35.4%.
- Delays >12 hours reduced from 8.5% in June to 1.37% in July.
- No delays greater than 24 hours were recorded.

Board Assurance
The Board can take assurance that significant and sustained improvement has been achieved in relation to induction of labour delays. The risk remains on the CBU Risk Register and progress continues to be monitored through established governance arrangements.

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

2.3 Workforce Position
- Mandatory training compliance: 86% (above target)
- Safeguarding compliance: 92%
- Vacancy rate: 5.3%
- Turnover: below Trust target 7.49%

Improvement
- PDR compliance improved to 89%

2.4 Performance & Activity
Maternity Triage
Performance continues to exceed national standards:
July:
- 96.8% seen within 15 minutes.
- 99.3% seen within 30 minutes.

Whilst performance remains strong, concerns have been raised regarding delays in registrar reviews following initial triage assessment. A medical workforce review group has therefore been established and triage improvement actions have been incorporated into the Perinatal Improvement Plan.

Actions and Improvements
- Establishment of a Medical Workforce Review Group to review obstetric medical cover arrangements across maternity services.
- Inclusion of maternity triage within the Perinatal Improvement Plan.
- Commencement of a maternity triage audit aligned to the national 10 Point Plan and NHS England Maternity Triage Specification.
- Continued escalation processes by triage midwives, with transfer to Birth Suite where immediate review is required.
- Return of an Advanced Clinical Practitioner to the triage service during Autumn 2026 to enhance clinical review capacity.

Service User Experience
Six complaints were received across June and July 2026, reducing from five complaints in June to one complaint in July. Themes related to communication, continuity of care, delays within care pathways, postnatal support and patient

experience. All complaints are reviewed through established governance arrangements and learning is incorporated into ongoing quality improvement programmes

3. Governance and Assurance

The Trust continues to engage fully with the national Maternity and Newborn Safety Investigations programme, with robust governance arrangements in place to ensure oversight and organisational learning.

Current Position

- Two MNSI investigations remain in progress.

Board Assurance

The Board can take assurance that all cases eligible for referral continue to be managed in line with national requirements and that learning arising from investigations is reviewed through established governance arrangements. Progress and emerging themes are monitored through maternity governance processes, the Perinatal Improvement Board, Quality and Safety Assurance Committee and Trust Board reporting arrangements

Key Risks identified

- Neonatal admissions remain above national target despite recent improvement.
- Postpartum haemorrhage remains above regional comparator rates.
- Diabetes workforce and service capacity pressures.
- Midwifery workforce establishment requirements for Maternity Incentive Scheme Year 8 compliance.
- Medical workforce capacity within maternity triage.
- Ongoing delivery of the Perinatal Improvement Plan, Ockenden Review, Amos Review and national 10 Point Plan actions

Risk Area	Current Position	Mitigation	Monitoring Route	Timescale
Neonatal Admissions (ATAIN)	Q1 ATAIN rate 9.02%, above the national target of 6% and NWNODN target of 5.6%, although performance improved to 4.6% in June and 4.37% in July	Respiratory distress pathway, PEEP for 30, NEWTT2 monitoring, enhanced Transitional Care provision, admission proforma development, fortnightly MDT reviews and learning dissemination	Perinatal Improvement Board, Maternity Governance, QSAC and Trust Board	Quarterly review

PPH	Improvement demonstrated, with rates reducing from 3.59% in June to 1.94% in July; however rolling performance remains above regional comparator levels.	PPH QI Programme, guideline implementation, audit	Intrapartum Review Group. Perinatal Improvement board and QSAC	Q3 2026
MIS	Midwifery establishment remains below Birthrate Plus requirement with a 2.6 WTE shortfall. Failure to secure funding may impact achievement of MIS Year 8 compliance	Revenue request submitted, workforce review completed, executive oversight through MIS governance arrangements and workforce planning processes	Perinatal Improvement Board, Workforce Governance, QSAC and Trust Board	November 2026
Diabetes Capacity	Workforce pressure and rising demand	Dietitian recruitment and service redesign	Women's & Children's Governance	Q4 2026
Ockenden, Amos and 10 Point Plan	National actions emerging	Gap analysis and PIP integration	QSAC and Board	Q3 2026

4. Maternity Incentive Scheme MIS Year 8

Appendix 2: Maternity Incentive Scheme MIS Year 8

The Trust is progressing towards MIS Year 8 compliance and can currently demonstrate full compliance or progress towards compliance across Safety Actions B to F.

Key strengths include:

- 100% consultant presence compliance audit.
- Robust governance and board oversight arrangements.
- Fully compliant PMRT processes.
- Strong engagement with women and families.
- Continued progress against Saving Babies' Lives Care Bundle standards.

The principal risk remains achievement of the required midwifery establishment. Failure to achieve workforce requirements by November 2026 could affect overall MIS compliance.

5. 10 Point Plan, Ockenden and Amos Reviews

Appendix 6 Ockenden Amos 10-point Plan
The Trust has undertaken an assessment against the national 10 Point Plan and continues to demonstrate good progress across all areas.

Key achievements include:

- Implementation of Martha's Rule within neonatal services.
- Establishment of a maternity implementation group.
- Enhanced Board oversight through the Perinatal Improvement Board.
- Strengthened patient experience and listening arrangements.
- Development of maternity inequalities dashboards.
- Review of homebirth and triage services.
- Continued implementation of PSIRF principles.

A formal baseline assessment has been submitted to the Regional Maternity Team in September 2026.

6. Maternity and Neonatal Voices Partnership (MNVP)

Appendix 5: Maternity and Neonatal Voices Partnership Biannual Report

The Trust continues to work closely with the Maternity and Neonatal Voices Partnership (MNVP) to ensure the experiences of women, families and service users directly influence service development and improvement. The MNVP remains an important component of the Trust's approach to patient experience, co-production and compliance with Maternity Incentive Scheme (MIS) Year 8 Safety Action D.

The MNVP has maintained strong engagement across Warrington and Halton through quarterly meetings, community events, Walk the Patch visits, 15 Steps reviews and targeted service-user engagement activities. The partnership continues to provide valuable insight into the experiences of women and families accessing maternity and neonatal services and supports the Trust in identifying improvement priorities.

Key Highlights

- 35 women and families contributed to the MNVP maternity experience survey during 2025/26.
- 60% of respondents rated their overall experience as good or very good.
- Positive feedback focused on compassionate and professional staff, involvement in decision making, supportive birth environments and high-quality care across the maternity pathway.
- Twelve women requested further support following engagement activity, with nine participating in additional conversations and referrals being facilitated to services including Birth Reflections.
- The MNVP continues to contribute to Trust workstreams including EPAU improvements, Ward C23, neonatal services, infant feeding, maternity inequalities and perinatal mental health initiatives.

Areas for Improvement Identified by Women and Families
Feedback themes highlighted opportunities for improvement in:

- Communication and consistency of information.
- Continuity of care and handovers between teams.
- Postnatal support, including breastfeeding support and discharge processes.
- Support for women whose babies require neonatal admission.
- Timely escalation and responding to concerns.

Board Assurance
The Board can take assurance that the Trust continues to demonstrate effective engagement with women, families and service users through established partnership working with the MNVP. Feedback is actively used to influence service improvement priorities and provides evidence of compliance with national expectations regarding co-production, patient experience and equity. Residual risks identified through service-user feedback are incorporated into existing quality improvement programmes and governance arrangements.

7. Diabetes

The diabetes service continues to face workforce and capacity challenges due to increasing demand and limited specialist resilience. Mitigating actions include:

- Centralised diabetes oversight arrangements.
- Recruitment of a specialist dietitian.
- Development of a Diabetes Specialist Midwife post.
- Business case development for a Diabetes Specialist Nurse.
- Enhanced competency training for maternity staff.

Residual risk remains and continues to be monitored through governance arrangements and the Perinatal Improvement Board.

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. Key Highlights: Quarter 1 2026/27 Perinatal Mortality Review Tool (PMRT)

Appendix 3: Cheshire and Merseyside Perinatal Mortality Report Q1

- Five cases were reported to MBRRACE-UK during Quarter 1 2026/27, comprising one stillbirth, one late fetal loss and three neonatal deaths (1 in April

and 2 in May 2026). Two of the neonatal deaths were associated with extreme prematurity.

- The Trust stillbirth rate for Quarter 1 was 1.64 per 1,000 births, which remains below the most recently reported national rate of 3.9 per 1,000 births.
- There were no intrapartum stillbirths reported during the quarter.
- The neonatal mortality rate for Quarter 1 was 4.9 per 1,000 live births. Whilst higher than the national comparator, this reflects very small numbers and included two neonatal deaths associated with extreme prematurity.
- One PMRT review panel was completed during the quarter, with parental feedback sought and incorporated into the review process. Findings will be reported within Quarter 2 reporting to maintain anonymity and confidentiality.
- No concerns were identified through the Maternity Outcomes Signal System (MOSS), and no alerts were triggered during the reporting period.
- The Trust remains fully compliant with all requirements of Maternity Incentive Scheme Year 8 Safety Action C, including reporting, parental involvement, external review arrangements, thematic learning and governance oversight.
- There are currently no outstanding PMRT actions, with all identified actions monitored through established governance arrangements.

Board Assurance

The Board can take assurance that mortality review processes remain robust, nationally compliant and supported by effective governance arrangements. Stillbirth performance remains below the national benchmark, there have been no intrapartum stillbirths, no MOSS alerts have been triggered and full compliance has been maintained with Maternity Incentive Scheme Year 8 Safety Action C. Learning arising from PMRT reviews continues to be monitored through established governance processes with a clear route of assurance to the Board

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. There were no maternal deaths or severe harm incidents reported during the reporting period. Workforce indicators, training compliance, maternity triage performance and induction of labour pathways remain positive. The Trust continues to demonstrate robust mortality review processes, effective engagement with women and families through the Maternity and Neonatal Voices Partnership (MNVP), and ongoing progress against the requirements of Maternity Incentive Scheme Year 8, the Perinatal Improvement Plan and the national 10 Point Plan.

Residual risks remain in relation to:

- Neonatal admissions above national and regional benchmarks, despite sustained improvement being demonstrated during June and July 2026.
- Postpartum haemorrhage rates remaining above regional comparator performance.
- Workforce and capacity pressures within the diabetes service.
- Midwifery workforce establishment requirements required for full compliance with Maternity Incentive Scheme Year 8.
- Medical workforce pressures within maternity triage and the timeliness of obstetric review.

- Continued delivery of the Perinatal Improvement Plan, Ockenden Review, Amos Review and national 10 Point Plan actions.

The Board can be assured that these risks are actively managed through established governance arrangements, quality improvement programmes, audit activity, mortality review processes, service-user engagement mechanisms and executive oversight through the Perinatal Improvement Board, Quality and Safety Assurance Committee and Trust Board reporting framework.

11. Assurance committee

The contents of this report have previously been noted and discussed at Quality and Safety Assurance Committee on 11th August 2026 and 8th September 2026.

12. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082ia**			
Subject:	**Maternity & Neonatal Quality Review – June 2026 Data**			
Date of meeting:	7 October 2026			
Action required:	**For information and to note**			
Author(s):	Tina Moors – Interim Director of Midwifery Kimberley Farrell 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 June 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 June 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 June 2026 mandatory training compliance and role specific training across maternity and Neonatal colleagues is above 88%. Compliance with PDR completion is below Trust Target with an improved position of 92%. 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 Neonatal staff is 7.7% which is below the Trust target. The vacancy rate for Maternity and Neonatal staff is 5.99% The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work continues regarding induction of labour (IOL) particularly in sustaining improvement 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 • Perinatal Improvement Plan (PIP) • Ockenden Nottingham Report 2026 • AMOS review 2026

	5 complaints were received in the Maternity and Neonatal Services in June 2026 No Regulation 28 enquiries have been received.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	For Trust Board members to receive and note the contents of this report.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QSAC/26/08/131iii**	
	Date of meeting	11 August 2026	
	Summary of Outcome	Submit to Trust Board	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

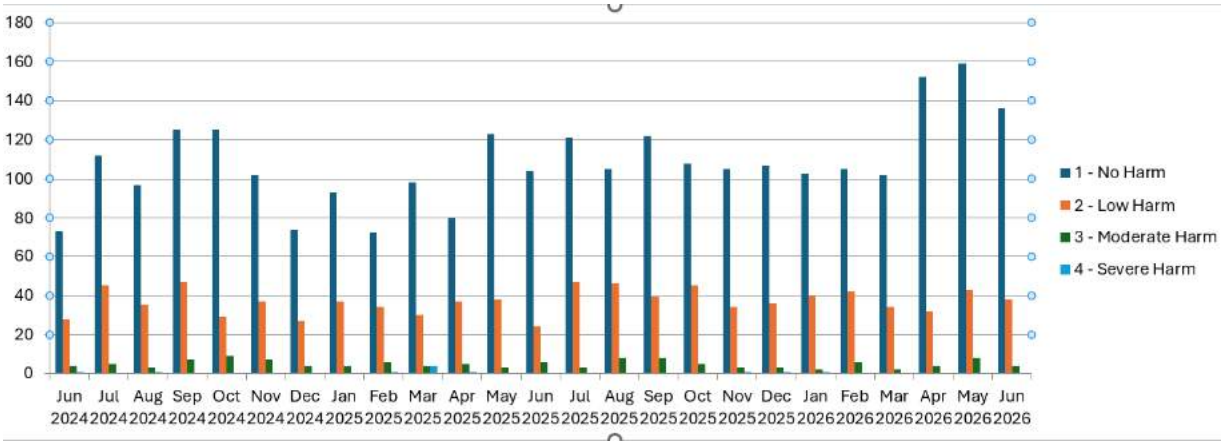
1. Background/context

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

The paper provides Quality, Safety and Assurance Committee (QSAC) with oversight of the NCM 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 June 2025 – June 2026



There were 174 patient safety events reported across the CBU in June 2026.

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

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

PPH & ATAIN feature in the perinatal improvement plan
Most others reported are reviewed through IRG
NND - 30 weeker deteriorated at 20 days and passed away (PMRT). Referred to coroner
Late fetal loss, NND and OASI will all be tracked through the learning responses for June and will go through WH Governance.

OASI – 2 Cases

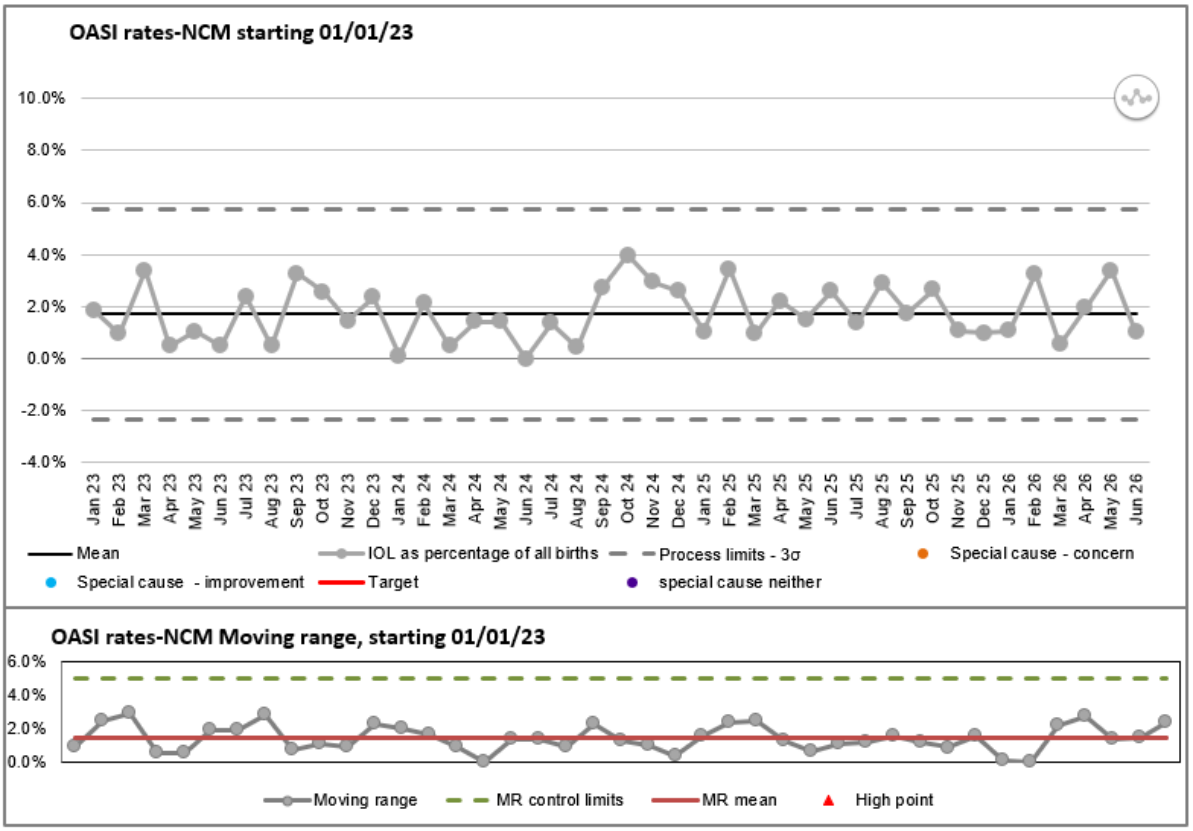
June rate: 1.03% (2/195) – 10.3 per 1000 births

12-month rolling mean: 1.89% (46/2435, 01/07/25-30/06/26) – 18.9 per 1000 births

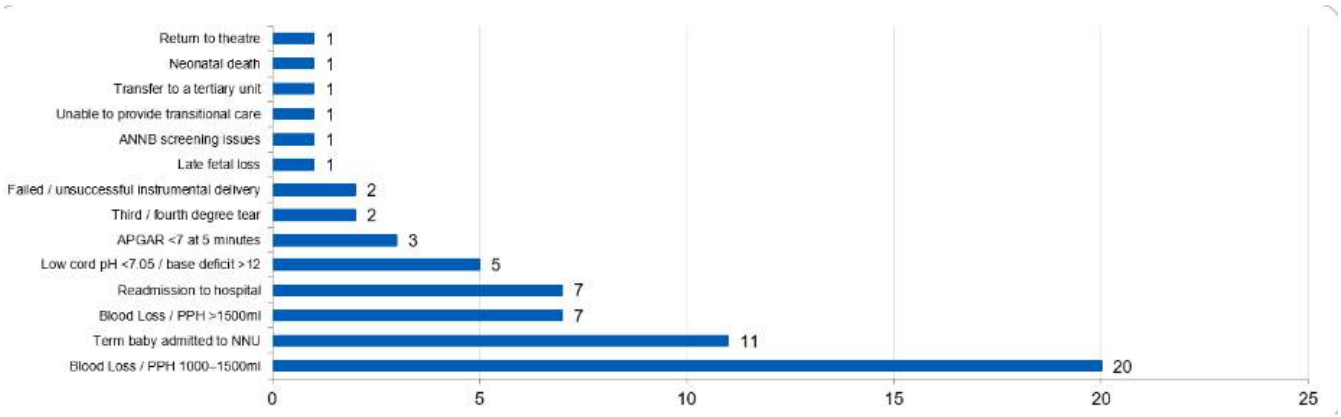
There were 2 instances of a 3rd-degree tear in June 2026, a reduction from the 8 reported in May. The SPC chart continues to show common cause variation.

Mode of birth:

- Two cases with spontaneous vaginal birth (3a tear, 3b tear)



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



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

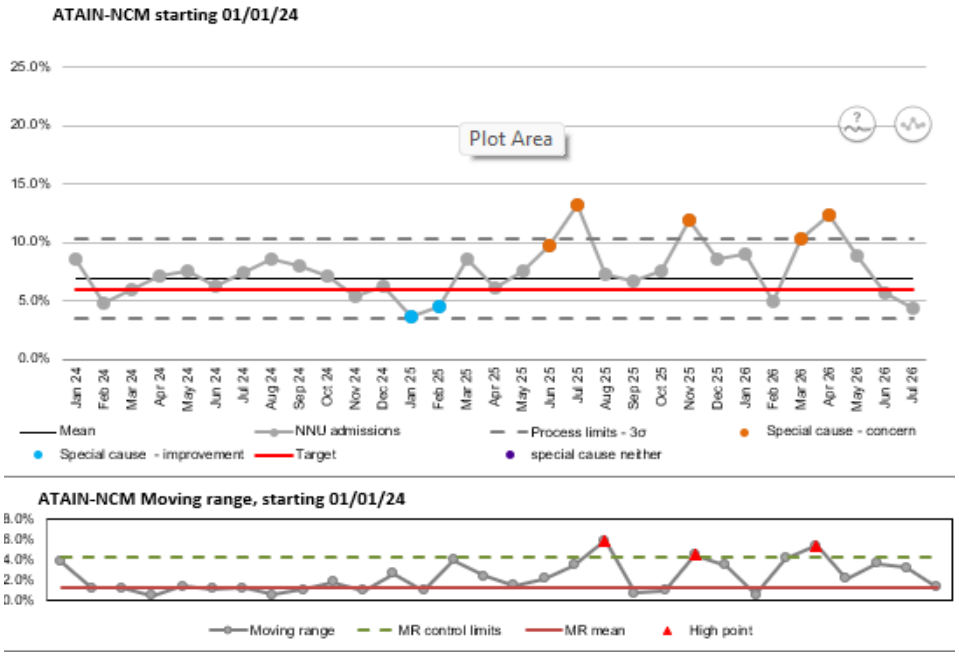
- Admission of term babies admitted to Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml

PPH & ATAIN feature in the perinatal improvement plan
Most others reported are reviewed through IRG
NND - 30 Weeks deteriorated at 20 days and passed away (PMRT). Referred to coroner
Late fetal loss, NND and OASI will all be tracked through the learning responses for June and will go through WH Governance.

Admission of term babies admitted to Neonatal Unit (NNU)

Term admissions to the Neonatal Unit continue to be reviewed fortnightly by the ATAIN Team consisting of colleagues from neonatal, midwifery, obstetrics and CBU management. The national target for ATAIN is 6% (Percentage of live births admitted to the neonatal unit at term.) The target was set with the aim of reducing separation between women and their babies. NCM have been a significant outlier for term admissions for the last two years. Following a slight reduction in Q4, the ATAIN rate for Q1 26/27 9.01%, this demonstrates a similar rate to Q4. The team is committed to identifying areas of improvement and driving this improvement.

Current position
In June 2026, 11 term babies were admitted to the Neonatal Unit. The admissions followed previous months' trends where most 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. The term newborn respiratory distress pathway has also been implemented. Following a peak in April of 26 admissions, the monthly admissions have continued to decline. Progress with improving the ATAIN rate continues to be escalated through the Perinatal Improvement Board.



Work continues to be monitored through our Perinatal Improvement Board

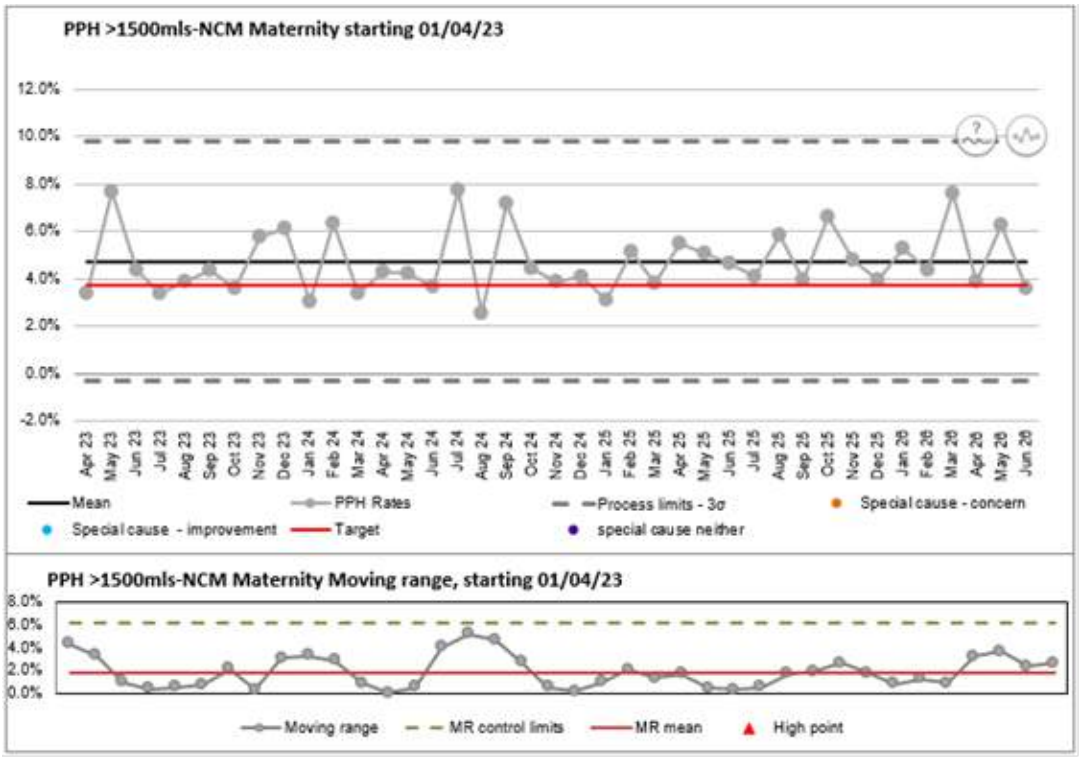
Post Partum Haemorrhage

June rate: 3.59% (7/195) – 35.9 per 1000 births
12-month rolling mean: 4.23% (103/2435, 01/07/25-30/06/26) – 42.3 per 1000 births

There were 18 instances of PPH 1000-1499ml in June, and 7 instances of PPH >1500ml. June data demonstrates common cause variation and a reduction compared to May data.

Modes of birth for PPH >1500ml in June were as follows:

- 3 occurred with Caesarean Section
- 2 occurred with forceps birth
- 2 occurred with a spontaneous vaginal birth



There were 18 instances of PPH 1000-1499ml in June, and 7 instances of PPH >1500ml. June data demonstrates common cause variation and a reduction compared to May 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.

Improvement work:

- Ongoing audit and review of PPH >1500ml to identify any thematic learning. Cases are reviewed in the Incident Review Group [IRG].
- Focus on instrumental births and earlier PPH management, considering the use of TXA earlier. Request submitted to the Trust knowledge and evidence service to complete a literature search on the risk of VTE with TXA administration, and the risk of VTE with PPH >1000mls, to identify if there is any evidence base to support or oppose this test of change idea. The minimum turnaround time for a response is 2 weeks (request submitted 02/07/26).
- Audit commenced on assisted vaginal births, to identify if there are any themes with third-stage management to support learning or ideas for further tests of change.
- Under-buttock drapes to support contemporaneous weighing of loss in instrumental births – these have been ordered and will be implemented as a test of change.

Work continues to be monitored through our Perinatal Improvement Board

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 June 2026 compliance for mandatory training across maternity and child health colleagues is 87% for Trust mandatory training and 86% 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 92%. 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.

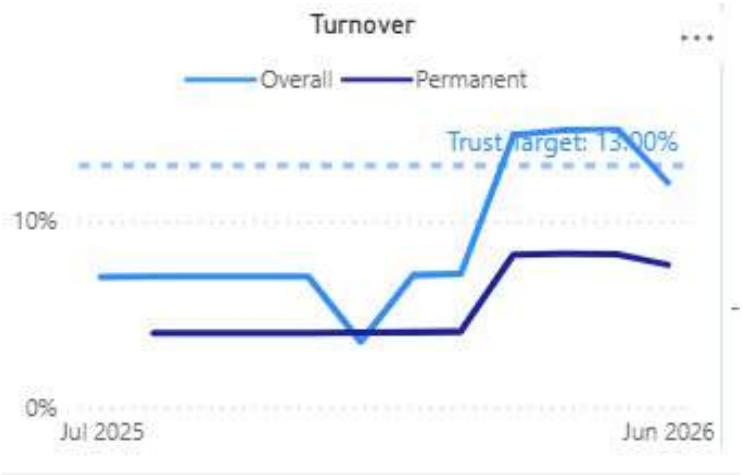
Currently in discussions with trust learning and development team to incorporate Maternal AIMS into PROMPT.

Two cancelled MAMU2 sessions due to sickness, all staff have been re-booked.

June

	PROMPT MDT skills training	MAMU 2 (fetal surveillance	K2 Fetal Surveillance compliance	Newborn Life Support (level 2)	Maternal AIMS
Midwives	98.75%	87.50%	96%	93%	
Obstertric Consultants	100%	100%	93%		
other Obstetric	100%	100%	100%		
other Anaesthetic	90%				
Maternity Support workers	99%				
Neonatal Medical and ANNP	na	na	na	awaiting data	

Turnover for Maternity and Neonatal staff (permanent staff) in June 2026 is 7.7%, below the Trust target. This is illustrated in the graph below:



The vacancy rate for maternity and Neonatal staff remains positive at 6%, remains below trust target. 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 considering significant regional and national scrutiny of triage services.

Current performance

Triage attendances June 2025-June 2026

Month	Attendances
June	587
July	602
August	588
September	623
October	668
November	562
December	564
January	571
February	552
March	615
April	628
May	618
June	696

- In June 2026 696 triage attendances (427 Women) were recorded on the BadgerNet patient record system.
- The longest wait recorded for initial review was 53 minutes.
- ↓**95.5%** 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.
- 0.9% Women categorised as red on arrival.

<u>Triage Action Plan</u>

- Triage CISCO phone line continues to be explored to ensure best practice
- Friends and family/patient experience work under way to improve feedback collection
- Results management escalated, Obstetric Consultant exploring ways to improve
- Gap analysis has begun in line with the 10-point plan
- Current review of medical staffing reviews in triage

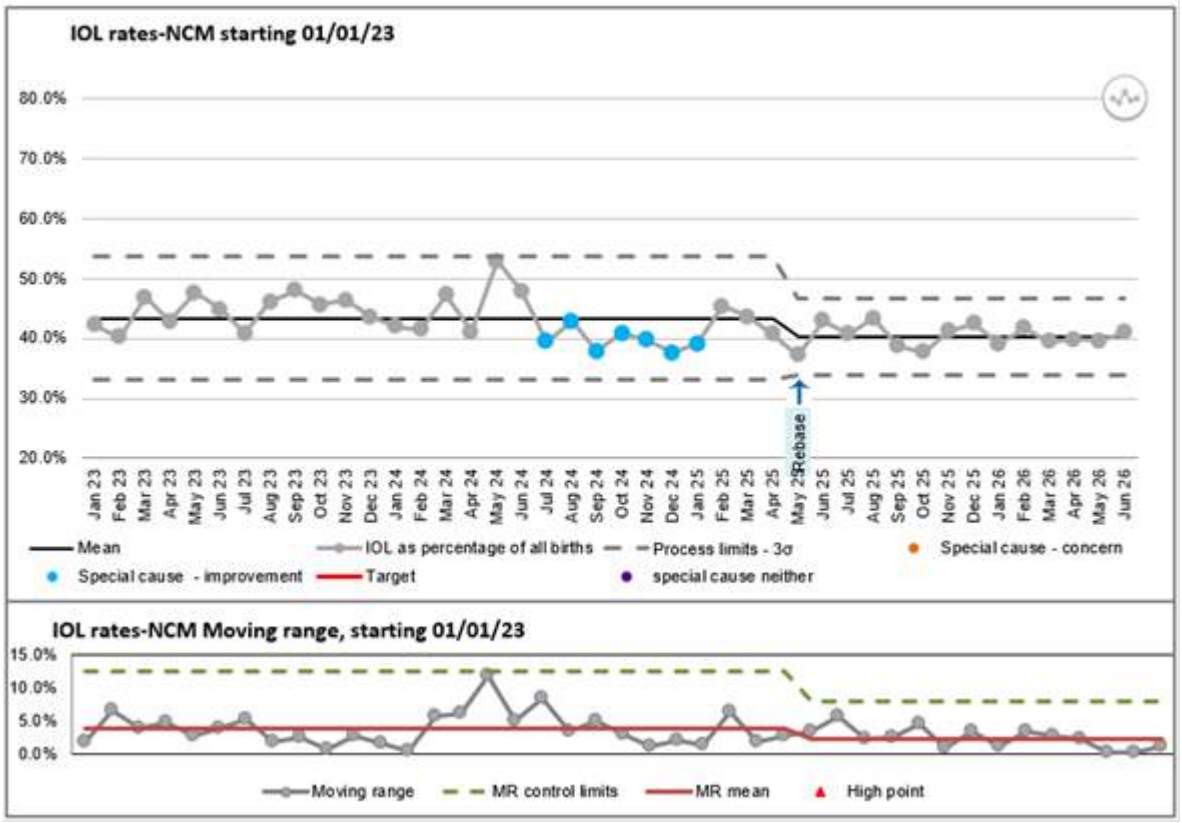
6. Induction of labour (IOL)

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 NCM from April 23 to June 2026, presented as a percentage of all births.

The SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated.

June rate: 40.93% (79/193) – 409 per 1000 births
12-month rolling mean: 40.36% (976/2418, 01/07/25-30/06/26) – 403.6 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 40.37%, 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

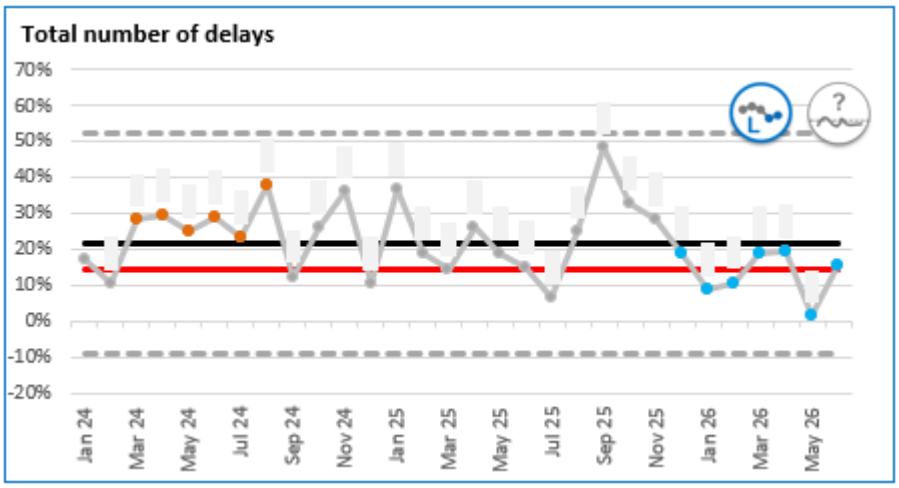
June data shows that the IOL rate was 40.93% which has increased slightly from May's rate. Delays >12 hours were 8.54% and delays >24 hours remained low at 1.96%. All delays over 12 hours and 24 hours related to women awaiting ARM, with no delays identified in commencing induction or augmentation. Regional benchmarking for June shows North Cheshire and Mersey had the third lowest percentage of delays across the Cheshire and Merseyside LMNS, with 15.69% of women experiencing a delay compared to the regional average of 30.80%.

Work has continued on the introduction of cervical ripening balloons, with sample devices now received from the supplier. This work will continue alongside training for both the obstetric and midwifery teams ahead of implementation.

Recruited new IOL Lead and will support the ongoing development of the induction pathway. Two new SOPs have been submitted for the September Guideline Review Group covering Outpatient/Expectant Management at 41+0 weeks and Escalation of IOL Delays.

The IOL patient information leaflet and video have been completed and shared with the MNVP for feedback. Work is now underway to develop voiceovers in a range of languages to improve accessibility and support informed decision-making for women undergoing induction of labour.

The SPC chart continues to show a sustained reduction in delays compared to 2025. Although there is some month-to-month variation, performance has remained consistently lower than previous levels throughout 2026.



Cheshire and Mersey position

	COC	LWH	MCHT	MWL S&O	MWL Whiston	North Cheshire and Mersey	WUTH	Grand Total
Total number undergoing Induction of Labour	59	102	62	33	98	51	56	461
Total Delayed	41	3	35	0	36	8	19	142
% of Total	69.49%	2.94%	56.45%	0.00%	36.73%	15.69%	33.93%	30.80%

Action Plan

Implementation of Cervical Ripening Balloons for 1st line IOL	Amelia Crowther	27/03 – AC and RA to meet with rep 21/04 – Rep to attend audit to discuss process of CRB with Obstetric colleagues 26/05 – Awaiting update from procurement, awaiting update regarding PEG rep 03/06 – Confirmation of PEG representation direct swap therefore to be discussed at PEG by lead nurse 28/07 – Samples of CRB arrived at NMC	01/09/2026	
Development and implementation of a SOP) for the management of low-risk women who decline post-dates induction of labour	Faye Riley-Joyce	31/06 - SOP out for comment with Birth Suite Manager and Planned Care Manager, then to be circulated to the wider team for comment 28/07 – Guideline out for comment to wider team	31/07/2026	
Develop SOP for management of delays in induction of labour. To include escalation flowchart for delays of 12hrs 24hrs criteria, review responsibilities, ARMable definitions and documentation standards.	Lauren Hassall	To be presented at December guideline review group, to use learning from LWH, Arrowe Park and Whiston visits. 10/12 – As visits are now late December, SOP to be drafted and completed following visit to other LMNS sites 01/03 – To await agreement of CRB and for this to be included in SOP/addendum to regional guideline 20/07 – Guideline circulated to staff for comment	01/07/2026	
Patient IOL video and leaflet to be created and shared with women prior to IOL	Amelia Crowther	08/01 – Filming of IOL video taking place 20/03 – No update re Comms video, however IOL patient leaflet created and shared with admin team 27/04 – IOL leaflet to reader panel as final draft 01/07 – Video complete, shared with SLT and MNVP for feedback, voiceovers to be completed. Leaflet to be shared at WH Gov and ratified. 22/07 – IOL video voiceovers to be completed in alternative languages awaiting feedback from MNVP	31/07/2026	

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

MNSI position for June

Two cases in progress. One new case referred in May MI-060160 Term Stillbirth during the IOL process

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

8. Update on other workstreams

8.1 Diabetes

Through the last QSAC, risks relating to the diabetes service were escalated and have also been escalated through Perinatal Improvement Board. Immediate actions were taken, as previously outlined.

The centralised diabetes inbox has supported greater oversight of the service and a more consistent approach to escalation pathways. The challenge remains around the escalation support provided on Fridays and the diabetes team have reviewed additional options for support.

The diabetes service continues to the support the maternity service, however additional support is needed in this area regarding knowledge and prescribing. A business case is currently being prepared to support the recruitment of a DSN to sit within maternity. The absence of the Diabetes Specialist Midwife (DSM) has further highlighted the lack of resilience within the service. A business request is progressing for a fixed term band 7 diabetes specialist midwife post for 12 months. There are currently three additional midwives and maternity support workers who are supporting diabetes. These staff are completing their TREND competencies over the next two months. This will support the service now and provide resilience going forward.

The dietitian post has been successfully recruited to with an expected start date in September.

In April 2026, NCM provided data to the LMNS to support a diabetes gap analysis exercise across Cheshire and Mersey. The LMNS have stated the outcome of the analysis will be shared in September.

8.2 Perinatal Improvement Plan

Following the Regional Maternity Team Assurance Visit in March 2026, North Cheshire and Mersey remains in a period of Mandated Regional Enhanced Oversight**.** A comprehensive Perinatal Improvement Plan (PIP) has been developed in response to the recommendations identified through the assurance process and is now being actively delivered.

Delivery of the Plan is overseen through a monthly Perinatal Improvement Programme Board**,** chaired by an Executive Director and attended by representatives from the Regional Maternity Team, providing robust assurance, support and challenge regarding progress against agreed actions and milestones.

The PIP is structured across key improvement workstreams with clear executive and operational accountability. Progress is monitored through established governance arrangements, with evidence of improvement reviewed through the Perinatal Improvement Programme Board for assurance.

The Trust continues to work collaboratively with regional colleagues and has received positive feedback regarding progress and engagement with the improvement programme. Ongoing oversight and assurance of delivery will be provided through the Quality, Safety and Assurance Committee (QSAC)**,** with regular updates escalated to the Board as required.

8.3 Amos Review and Ockenden Response: Progress Update

See Appendix 2 Ockenden 10 Point Plan

Following publication of the Ockenden and Amos Reviews in June 2026, North Cheshire and Mersey have undertaken an initial assessment against the national 10-point improvement plan. Existing governance and assurance arrangements provide a strong foundation, with further actions being embedded through the Perinatal Improvement Board and maternity improvement programme.

Key achievements to date include:

- **Martha's Rule** successfully implemented within Neonatal Services (June 2026), with maternity implementation planning underway in line with the national programme.
- **Strengthened listening to women and families**, with a review of feedback mechanisms underway and enhanced reporting of patient experience through maternity and neonatal governance structures.
- **Robust Board-level oversight** established through the Perinatal Improvement Board, chaired by the Chief Nurse and Medical Director, providing enhanced scrutiny of safety, quality and improvement actions.
- **Staff engagement mechanisms** remain in place through weekly senior leadership drop-in sessions and Professional Midwifery Advocate support, with further national staff listening activity expected through the NHS England Amos programme.
- **Continued focus on reducing inequalities**, supported by utilisation of the Maternity and Neonatal Equality Dashboard and preparation for participation in the national Perinatal Equity and Anti-Discrimination Programme.

- **Enhanced maternity triage assurance**, with monthly audits in place, monitoring of red flag indicators and development of a dedicated Triage and ANDU Working Group from September 2026.
- **Post-death care oversight** has been strengthened, with mortuary governance reviewed through Quality, Safety and Assurance Committee reporting arrangements.

Next Steps

- Complete a comprehensive gap analysis against all Amos and Ockenden recommendations. To be shared at QSAC September 2026
- Implement maternity Martha's Rule requirements following national guidance.
- Further develop real-time patient experience reporting and audit outcomes for Board assurance.
- Finalise reviews of homebirth services, 24/7 safety arrangements and incident response processes.
- Continue monitoring delivery through the Perinatal Improvement Board and Quality, Safety and Assurance Committee.

Board Assurance

The Board can be assured that delivery of the Trust's Amos and Ockenden action plan is being undertaken in line with the direction of the National Maternity Taskforce, with local actions monitored through established governance arrangements and adapted as further national guidance is released.

9. Complaints

5 complaints were received relating to care in the maternity and neonatal services in June 2026

Complaint description	Lead	Position
Patient has multiple concerns regarding her antenatal and postnatal care provided.	LL/CP	
Complainant would like to raise concerns regarding the support provided from the Perinatal Mental Health team.	LL	
Patients state her concerns about her wound were dismissed. There are also concerns relating to the care on the ward after the caesarean section.	CH	

10. Coroner regulation 28 enquiries

11.1 No Regulation 28 enquiries have been received.

11. Recommendations

The Trust Board Committee is asked to note the findings of this paper.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082ib**			
Subject:	**Maternity & Neonatal Quality Review – July 2026 Data**			
Date of meeting:	7 October 2026			
Action required:	**To note**			
Author(s):	Tina Moors, 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 July 2026 there were 0 fatal, 0 severe harm events in the maternity or Neonatal Services. There were 2 moderate harm event (OASI) 3rd/4th degree tears Themes from Maternity/Neonatology patient safety events in July 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 July 2026 mandatory training compliance and role specific training across maternity and Neonatal colleagues is above 86%. Compliance with PDR completion is above Trust Target with a sustained position of 89%. Work continues to achieve full compliance, and progress is being monitored on a weekly basis. Full compliance is expected by the end of October. Turnover for Maternity and Neonatal staff is 7.49% which is below the Trust target. The vacancy rate for Maternity and Neonatal staff is 5.3% The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work continues regarding induction of labour (IOL) particularly in sustaining improvement reducing delays. Transitional care is no longer set out as a requirement within the Maternity Incentive Scheme. From October, updates relating to transitional care will be outlined within this report. Term admissions to the neonatal unit have fallen for the third consecutive month. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. An update regarding Maternity Workstreams

<table>
<tr><td></td><td colspan="3">Diabetes
Perinatal Improvement Plan (PIP)
1 complaint received in the Maternity and Neonatal Services in July 2026.

No Regulation 28 enquiries have been received.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">For the QSAC members to receive and discuss this report and 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/26/09/155iii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">8 September 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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>

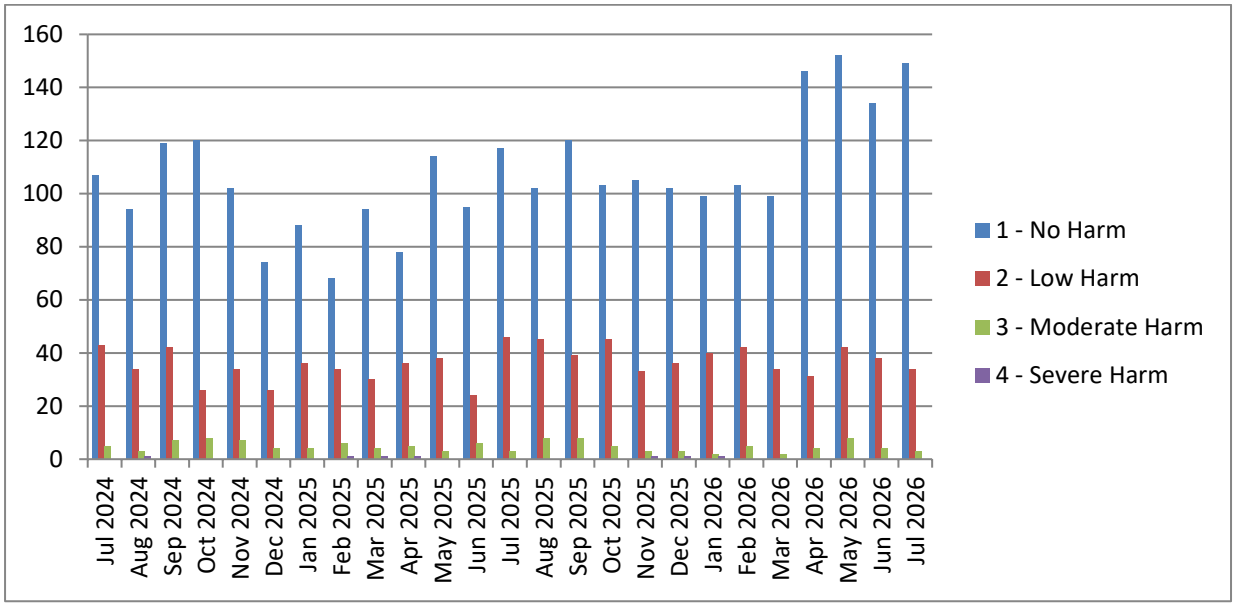
1. Background/context

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

The paper provides Quality, Safety and Assurance Committee (QSAC) with oversight of the NCM 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 July 2025 – July 2026



There were 186 patient safety events reported across the CBU in July 2026.

There were no fatal or severe harm events in the Maternity or Neonatal services in June 2026.

There were two moderate harm events involving third or fourth degree obstetric anal sphincter injury (OASI).

Postpartum haemorrhage (PPH) and admission of term babies to the neonatal unit are including in the Perinatal Improvement Plan (PIP). Other reported events are reviewed through the Incident Review Group.

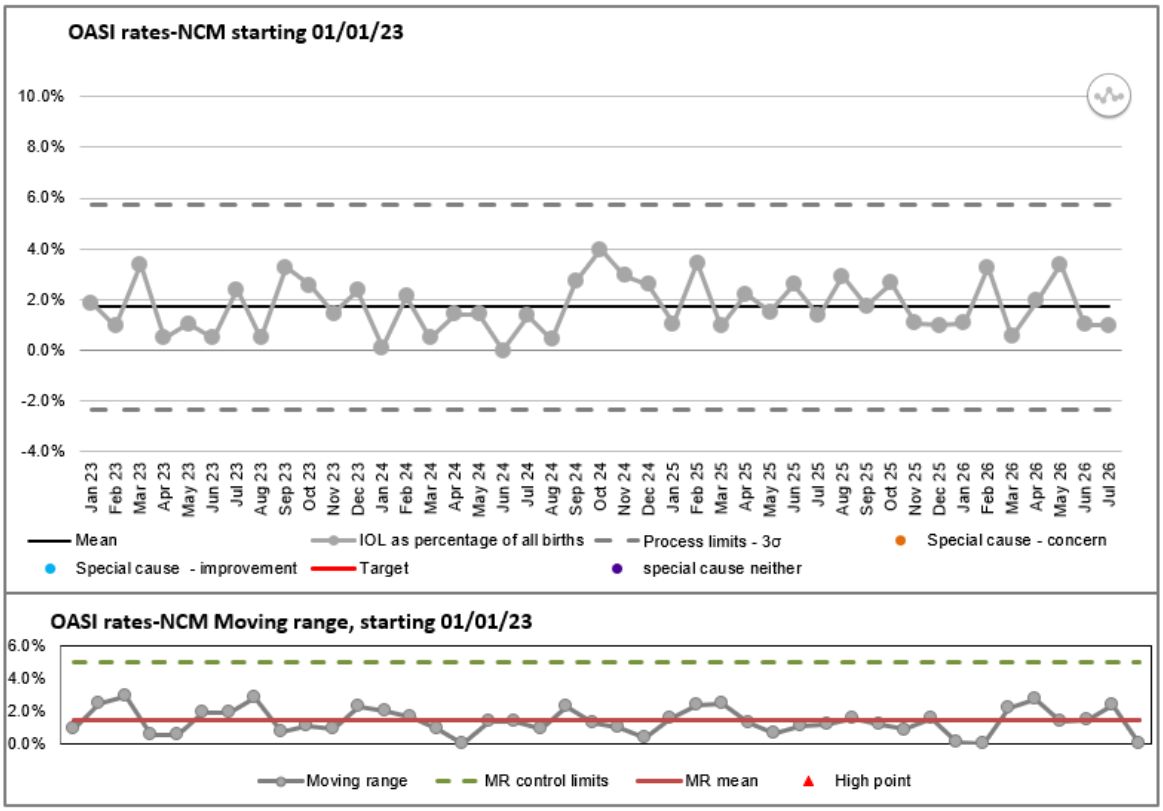
A notable increase in no-harm events has been observed during the last quarter. This trend aligns with the introduction of Datix reporting for periods when the homebirth service was unavailable, which commenced in May. The increase therefore reflects a

change in reporting practice and improved visibility of these events rather than an increase in clinical harm.

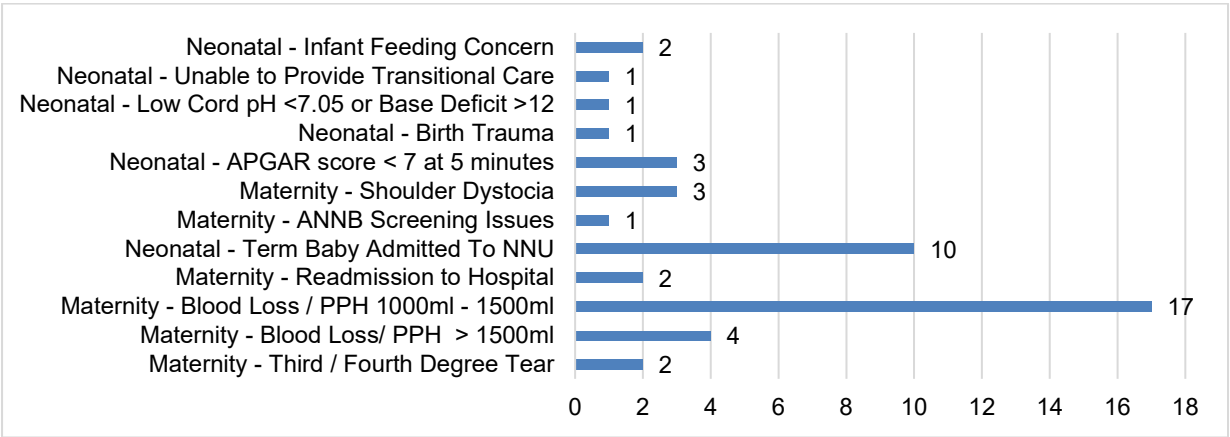
OASI – 2 Cases

July rate: 0.97% (2/206) – 9.7 per 1000 births

12-month rolling mean: 1.86% (45/2422, 01/08/25-31/07/26) – 18.6 per 1000 births



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



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

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

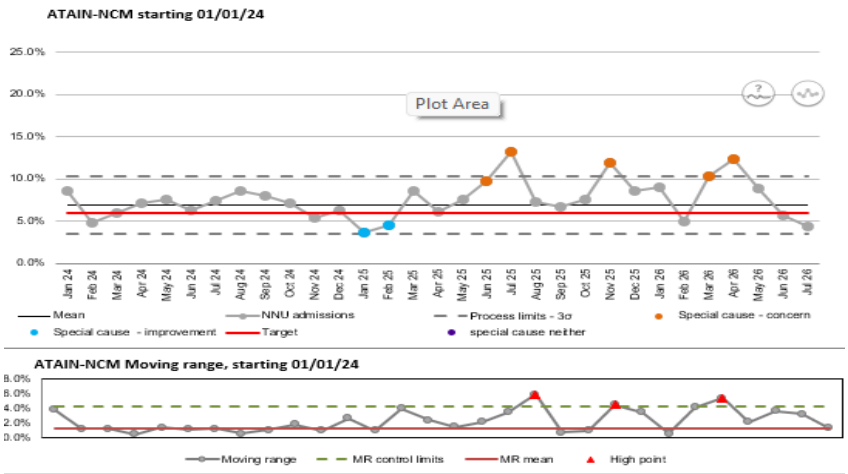
PPH & ATAIN feature in the perinatal improvement plan

Admission of term babies admitted to Neonatal Unit (NNU)

Term admissions to the Neonatal Unit continue to be reviewed fortnightly by the ATAIN Team consisting of colleagues from neonatal, midwifery, obstetrics and CBU management. The national target for ATAIN is 6% (Percentage of live births admitted to the neonatal unit at term.) The target was set with the aim of reducing separation between women and their babies. NCM have been a significant outlier for term admissions for the last two years. Following a slight reduction in Q4, the ATAIN rate for Q1 26/27 9.01%, this demonstrates a similar rate to Q3. The team is committed to identifying areas of improvement and driving this improvement.

Current position

In July 2026, 9 term babies were admitted to the Neonatal Unit. This is the third consecutive month where term admissions to the neonatal unit have reduced. The admissions followed previous months' trends where most admissions were due to respiratory distress. The service previously completed a QI project 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. The neonatal team have provided additional support on Birth Suite for up to one hour, where acuity allows, to reduce separation and prevent admission. The term newborn respiratory distress pathway has also been implemented. Learning from ATAIN is now being shared more formally across the CBU with monthly updates. Progress with improving the ATAIN rate continues to be escalated through the Perinatal Improvement Board.



Work continues to be monitored through our Perinatal Improvement Board.

Post Partum Haemorrhage

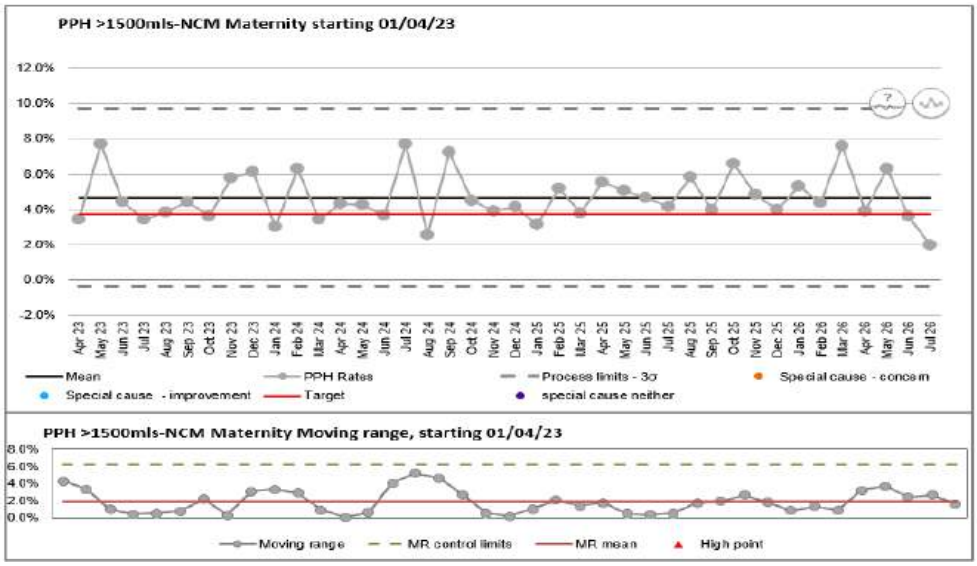
July rate: 1.94% (4/206) – 19.4 per 1000 births

12-month rolling mean: 4.83% (117/2422, 01/08/25-31/07/26) – 48.3 per 1000 births

There were 17 instances of PPH 1000-1499ml in July, and 4 instances of PPH >1500ml. July data demonstrates common cause variation and a reduction compared to June data.

Modes of birth for PPH >1500ml in July were as follows:

- 2 occurred with Caesarean Section
- 2 occurred with a spontaneous vaginal birth



The Northwest Regional PPH Guideline is now fully embedded, and early changes in behaviour and practice are being observed, although these are not yet reflected in the reported rates. Case reviews, safety huddles and intrapartum governance indicate strengthened risk assessment, improved escalation, and more consistent third-stage management.

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 remains on track and will provide a robust assessment of compliance with the new guideline and the impact of the quality improvement measures. The findings will inform the next phase of the improvement plan and support further refinement of the approach. The audit will be presented to QSAC in October 2026.

Improvement work:

- Ongoing audit and review of PPH >1500ml to identify any thematic learning. Cases are reviewed in the Incident Review Group [IRG].
- Focus on instrumental births and earlier PPH management, considering the use of TXA earlier. Request submitted to the Trust knowledge and evidence service to complete a literature search on the risk of VTE with TXA administration, and the risk of VTE with PPH >1000mls, to identify if there is any evidence base to support or oppose this test of change idea.
- Audit commenced on assisted vaginal births, to identify if there are any themes with third-stage management to support learning or ideas for further tests of change.
- Under-buttock drapes to support contemporaneous weighing of loss in instrumental births – these have been ordered and will be implemented as a test of change.

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 July 2026 compliance for mandatory training across maternity and neonatal colleagues is 86.9% for Trust mandatory training and 89% 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 89%. 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.

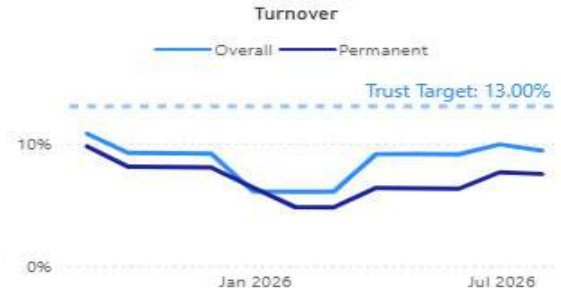
Currently in discussions with trust learning and development team to incorporate Maternal AIMS into PROMPT.

Two cancelled MAMU2 sessions due to sickness, all staff have been re-booked.

JULY

	PROMPT MDT skills training	MAMU 2 (fetal surveillance	K2 Fetal Surveillance compliance	Newborn Life Support (level 2)	Maternal AIMS
Midwives	99.00%	83.00%	96%	98%	no session in discussion with Education to incorparate in PROMPT
Obstertric Consultants	100%	100%	93%		
other Obstetric	100%	100%	100%		
other Anaesthetic	90%				
Maternity Support workers	100%				
Neonatal Medical and ANNP	na	na	na	awaiting data	

Turnover for Maternity and Neonatal staff (permanent staff) in July 2026 is 7.49%, below the Trust target. This is illustrated in the graph below:



The vacancy rate for maternity and Neonatal staff remains positive at 5.3%, remains below trust target.

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 bi-annual newsletter.

Staff have raised concerns relating to the registrar provision for maternity triage. The concerns outlined the delays for registrar review for women who are waiting in triage. There is not a dedicated registrar just for triage. Staff reported multiple examples of women waiting significantly longer than the timescales for review based on the triage categorisation In some examples, women have chosen to leave triage rather than wait for review. These concerns have been added to the risk register and will also form part of the triage audit, required as part of the 10 Point Plan.

To address the issues identified, a medical workforce review group will be established to review the current medical cover arrangements and maternity triage has been added to the Perinatal Improvement Plan. An ACP will be returning to triage, following a two year secondment with NHSE and a one year maternity leave, in the Autumn. This will help improve prompt reviews of women in triage.

5. Maternity triage

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

Current performance

Triage attendances July 2025-July 2026

Month	Attendances
July	602
August	588
September	623
October	668
November	562
December	564
January	571
February	552
March	615
April	628
May	618
June	696
July	716

- In July 2026 716 triage attendances (481 Women) were recorded on the BadgerNet patient record system.
- The longest wait recorded for initial review was 53 minutes.
- **96.8 ↑%** of all attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- **99.3 ↑%** of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 0.58% Women categorised as Red on arrival.

<u>Triage Action Plan</u>

- Triage CISCO phone line continues to be explored to ensure best practice
- Friends and family/patient experience work under way to improve feedback collection
- Focus on medical staffing impact on medical breaches in triage. Work underway to provide accurate evidence. Triage midwives to continue to escalate appropriately and transfer to birth suite when concerns.
- Triage audit has begun in line with the 10-point plan
- Medical workforce review group to be established to review medical staffing within triage. Registrar cover for triage is currently covered by the registrar on call.

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.

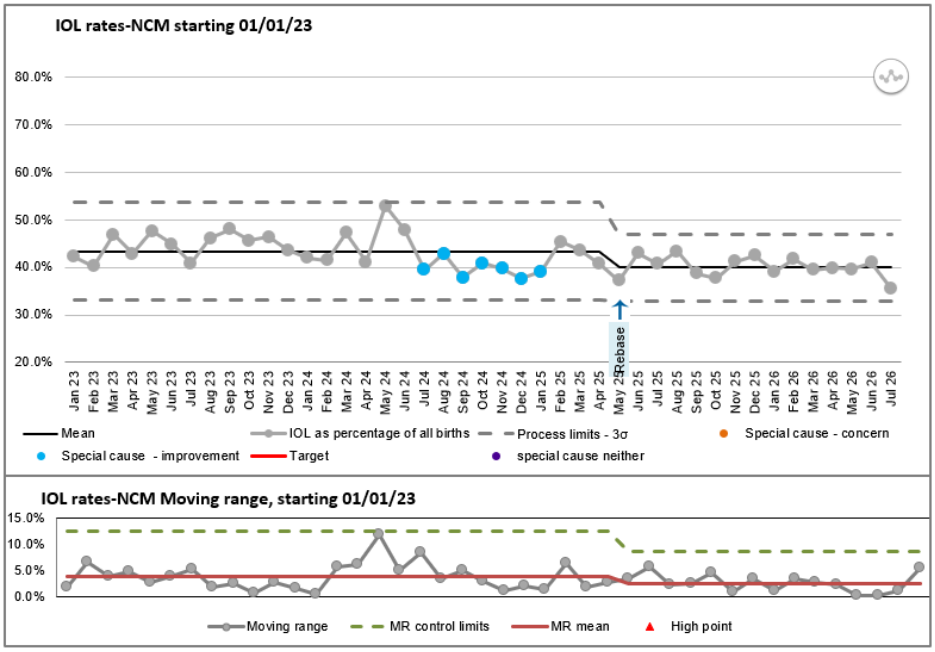
As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at NCM from Jan 23 to July 2026, presented as a percentage of all births.

The SPC chart demonstrates special cause improving variation, with sustained improvement demonstrated.

July rate: 35.44% (73/206) – 354 per 1000 births

12-month rolling mean: 39.91% (961/2408, 01/08/25-31/07/26) – 399.1 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 40.37%, 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

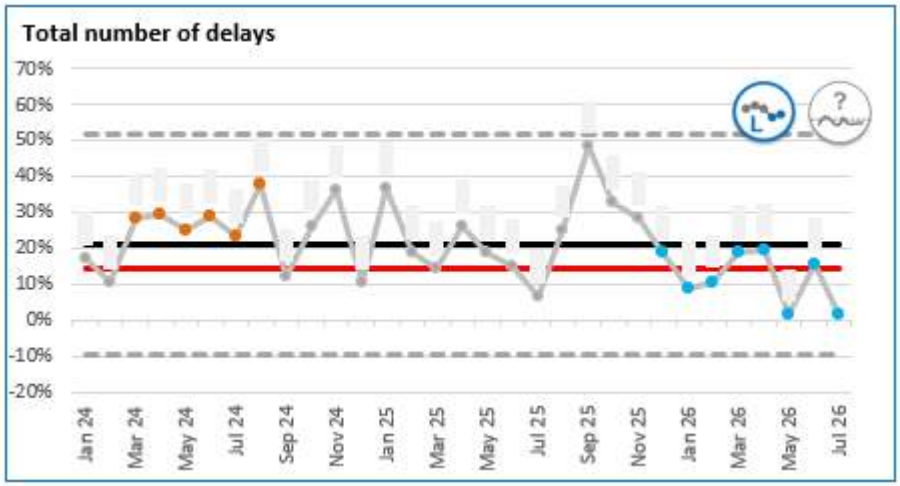
July data demonstrates a further improvement in IOL delays. The IOL rate reduced to 35.44%, compared to 40.93% in June.

IOL delays >12-hour delays reduced from 8.54% in June to 1.37% in July, with no women delayed >24 hours.

This represents the lowest level of delays reported to date. The SPC chart demonstrates a sustained downward trend throughout 2026, with July recording the lowest delay rate since monitoring commenced. Whilst some month-to-month variation has been seen, delays have remained consistently lower than those reported throughout 2025, demonstrating sustained improvement across the induction pathway.

Implementation of cervical ripening balloons continues to progress. Samples have now been received from the supplier and training resources have been obtained from Liverpool Women's Hospital to support local implementation. Training will be rolled out to both the obstetric and midwifery teams prior to introducing the new pathway. Two new SOPs have been submitted to the September Guideline Review Group covering Outpatient/Expectant Management at 41+0 weeks and Escalation of IOL Delays. The IOL patient information leaflet and video have been completed and shared with the MNVP for feedback. Work is now underway to develop voiceovers in a range of languages to improve accessibility and support informed decision-making.

The SPC chart continues to show a sustained reduction in delays compared to 2025.



Cheshire and Mersey position

Cheshire & Merseyside Induction of Labour (IOL) – over 12 hr delays

Data correct as of 13th August 2026

NHS Cheshire and Merseyside

- This slide reports the total number and percentage **awaiting commencement / next stage of IOL procedures over 12 hours** from **1st to 31st July 2026** across Cheshire and Merseyside together with the type and cause of delay.
- The data below shows the number and percentage of delays >12 hrs by provider and by week.

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	North Cheshire and Mersey	WUTH	Grand Total	% of Total
29/06/2026	6	0	1	2	4	1	1	15	20.55%
06/07/2026	3	6	0	0	4	0	2	15	20.55%
13/07/2026	3	3	0	0	4	0	2	12	16.44%
20/07/2026	11	1	0	0	2	0	3	17	23.29%
27/07/2026	4	1	0	1	7	0	1	14	19.18%
Grand Total	27	11	1	3	21	1	9	73	100.00%
% of total	36.99%	15.07%	1.37%	4.11%	28.77%	1.37%	12.33%	100.00%	

- There has been a **11.0%** decrease in the number of women delayed > 12 hrs from **82** in June to **73** in July.
- The greatest number of women **awaiting IOL >12 hrs** was reported week commencing 20th July **(17) (23.29%).**
- **COC** had the greatest number of women awaiting IOL **>12 hrs** reported at **27 (36.99%)**, followed by **MWL Whiston** at **21 (28.77%).**

Cheshire & Merseyside Induction of Labour (IOL) – over 24 hr delays

Data correct as of 13th August 2026

NHS Cheshire and Merseyside

- The data below reports the total number and percentage **awaiting commencement / next stage of IOL procedures over 24 hours** from **1st to 31st July 2026** across Cheshire and Merseyside.

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	North Cheshire and Mersey	WUTH	Grand Total	% of Total
29/06/2026	3	1	0	0	0	0	0	4	10.53%
06/07/2026	3	0	0	0	0	0	2	5	13.16%
13/07/2026	3	0	0	0	0	0	1	4	10.53%
20/07/2026	12	1	0	0	0	0	1	14	36.84%
27/07/2026	1	0	0	0	8	0	2	11	28.95%
Grand Total	22	2	0	0	8	0	6	38	100.00%
% of total	57.89%	5.26%	0.00%	0.00%	21.05%	0.00%	15.79%	100.00%	

- There has been a **2.6%** decrease of women awaiting IOL >24 hrs from **39** in June to **38** in July.
- The greatest number **14 (36.84%)** awaiting IOL **>24 hrs** was reported in week commencing 20th July.
- **COC** had the greatest number of women **awaiting IOL >24 hrs** reported at **22**, followed by **MWL Whiston** at **8.**

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 QSAC has oversight of cases being investigated by MNSI, an updated is provided each month.

7.2 Current position

MNSI position for July

Two cases remain in progress. One new case referred in May MI-060160, involving a term stillbirth during the induction of labour process.

Case MI-041711, referred in April 2025, and related to hypoxic ischaemic encephalopathy and neonatal death, remains in progress. The draft report is delayed pending confirmation of the cause of death following the post-mortem examination. The inquest has been deferred until October 2026.

8. Update on other workstreams

8.1 Diabetes

Through the last QSAC, risks relating to the diabetes service were escalated and have also been escalated through Perinatal Improvement Board. Immediate actions were taken, as previously outlined.

The centralised diabetes inbox has supported greater oversight of the service and a more consistent approach to escalation pathways. The challenge remains around the escalation support provided on Fridays and the diabetes team have reviewed additional options for support.

The diabetes service continues to the support the maternity service, however additional support is needed in this area regarding knowledge and prescribing. A business case is currently being prepared to support the recruitment of a DSN to sit within maternity. The absence of the Diabetes Specialist Midwife (DSM) has further highlighted the lack of resilience within the service. A business request is progressing for a fixed term band 7 diabetes specialist midwife post for 12 months. There are currently three additional midwives and maternity support workers who are supporting diabetes. These staff are completing their TREND competencies over the next two months. This will support the service now and provide resilience going forward.

The dietitian post has been successfully recruited to with an expected start date in September.

In April 2026, NCM provided data to the LMNS to support a diabetes gap analysis exercise across Cheshire and Mersey. The LMNS have stated the outcome of the analysis will be shared in September.

8.2 Perinatal Improvement Plan

Following the Regional Maternity Team Assurance Visit in March 2026, North Cheshire and Mersey remains in a period of Mandated Regional Enhanced Oversight**.** A comprehensive Perinatal Improvement Plan (PIP) has been developed in response to the recommendations identified through the assurance process and is now being actively delivered.

Delivery of the Plan is overseen through a monthly Perinatal Improvement Programme Board**,** chaired by an Executive Director and attended by representatives from the Regional Maternity Team, providing robust assurance, support and challenge regarding progress against agreed actions and milestones.

The PIP is structured across key improvement workstreams with clear executive and operational accountability. Progress is monitored through established governance arrangements, with evidence of improvement reviewed through the Perinatal Improvement Programme Board for assurance.

The Trust continues to work collaboratively with regional colleagues and has received positive feedback regarding progress and engagement with the improvement programme. Ongoing oversight and assurance of delivery will be provided through the Quality, Safety and Assurance Committee (QSAC), with regular updates escalated to the Board as required.

9. Complaints

One complaint relating to care in the maternity and neonatal services was received in July 2026.

Complaint description	Lead	Position
*** Dissatisfied *** Multiple concerns relating to patients' pregnancy, delays in assessments, scans and neglect. Also concerns regarding patient safety and transfer of care		

10. Coroner regulation 28 enquiries

10.1 No Regulation 28 enquiries have been received.

11. Recommendations

The Trust Board members are requested to receive and note the content of this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082/iia**			
Subject:	**Maternity Incentive Scheme Year 8 – August update**			
Date of meeting:	7 October 2026			
Action required:	**For information, discussion and to note**			
Author(s):	Helen Wall – Assurance & Improvement Manager (Women and Childrens 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. 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 maternal deaths, and brain injuries by the end of 2025, compared to the 2010 baseline.			

<table>
<tr><td></td><td colspan="3">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 Trust Board members to receive and note this report 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/26/08/131i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11 August 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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 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 Safety Action A: Workforce and Capacity

There are currently no concerns for escalation relating to Safety Action A. All requirements are on track to be met within the MIS reporting period.

	Requirement	Current position
A1	Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations	Q1 Consultant presence audit completed and reviewed by the Associate Clinical Director identifying 100% compliance.
A2	Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.	Database continues to be maintained to ensure eligibility of short-term locums.
A3	Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).	Neonatal nursing staff review to be completed to ensure fully funded establishment. Medical workforce to be included on the Perinatal Improvement Plan.
A4	Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate.	Birthrate plus report completed in March 2025. Workforce review completed by the interim DOM and interim DDOM with support from the LMNS. The shortfall is currently 2.6WTE. There are plans in place to address the shortfall which is on track to be completed within the reporting period.

		To support a fully operational homebirth service shift model a business case has been prepared for an additional 1.45WTE. This supports professional judgement above the minimum establishment set out within the birthrate plus report.
A5	Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained Anaesthetic Assistant available 24/7 in line with ACSA standards 1.3.1.2.	There is a maternity specific anaesthetic rota in place.
A6	Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (pre-operative assessment → theatre → recovery → post-natal ward).	Capacity mapping to be completed in Q2.
A7	Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.	Workforce staffing reviews continue to take place across the service.

2.2 Safety Action B: Training

There are currently no concerns for escalation relating to Safety Action B. All requirements are on track to be met within the MIS reporting period.

MIS requires all staff to have attended the annual training outlined in the table below. A minimum of 90% compliance must be achieved for every staff group at two points during the MIS year and one other Trust selected checkpoint. This will be agreed in August.

B1	Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness.	There is an annual MDT training plan in place. Anaesthetists also attend the training half of the training day. Impacted fetal head has been included on the PROMPT training since January 2026. Training compliance is above 90% in all staff groups, in line with the requirements of MIS.
B2	As a minimum, Trusts must ensure that all staff who may act as an	Training is on track for meeting this requirement.

	unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard.	
B3	Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.	Obstetric consultants and trainees are fully compliant with this training. Midwifery staff are currently 83% compliant with this training. Training is scheduled to increase the compliance for September.
B4	Trusts must deliver at least two in-situ multiprofessional maternity emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g., labour ward, obstetric theatre, triage, Emergency Department (ED), NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.	There have been two multiprofessional simulations which have taken place in July from the hospital setting including the use of escalation pathways. Maternity emergencies at home training day is scheduled in August in collaboration with NWAS. This will provide an opportunity for a community simulation to be completed.
B5	Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using SPC charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout future years.	Training compliance continues to be reported monthly through governance and QSAC.

2.3 Safety Action C: Learning from reviews and investigations

There are currently no concerns for escalation relating to Safety Action B. All requirements are on track to be met within the MIS reporting period.

C1	All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis.	NCM processes remain in place to ensure appropriate reporting continues.

C2	For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	NCM were compliant in Q1.
C3	For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.	There was one PMRT review in Q1. NCM were compliant with external member attendance.
C4	Provide relevant information regarding the role of MNSI, NHSR Early Notification (EN) scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	Relevant information was shared with families during Q1.
C5	Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	This is in place.
C6	The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.	Thematic reports are shared through local governance and reported quarterly to QSAC.

2.4 Safety Action D: Service-user voice and equity

There are currently no concerns for escalation relating to Safety Action D. All requirements are on track to be met within the MIS reporting period.

D1	Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on	Trust interpretation and translation policy remains in place including the use of face to face and telephone support. Additional tablets have been purchased to be used across maternity to support the use of translation services.

	family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.	
D2	Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plan. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.	Feedback continues to be gathered across all areas of the service through FFT, feedback forms and conversations with women and families. The Consultant Midwife (patient experience lead) is currently reviewing how we gather and share feedback across the service to support improvement. The service continue to work closely with the MNVP to ensure feedback is fed back and improvements made which is reflective of the demographic of NCM.

2.5 Safety Action E: Care Bundles

There are currently no concerns for escalation relating to Safety Action D. All requirements are on track to be met within the MIS reporting period.

E1	The provider must report quarterly to the Trust Board on progress against SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the Care Bundle based on local progress, implementation status, and any relevant safety intelligence, including learning from local adverse incidents.	The SBL position is reported monthly to QSAC which is then shared at all Trust Board meetings. There are challenges relating to the diabetes service and the multidisciplinary support in a one-stop clinic. A dietitian is due to start in September and business cases are currently in progress for a Diabetes Specialist Midwife and a Diabetes Specialist Nurse. This will ensure compliance with SBL element 6.
E2	In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.	NCM's current position against the Maternal Care Bundle has been reviewed and will be shared with the LMNS. This review will form the basis of the implementation plan which will be shared at QSAC in September.
E3	Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between two and 24 hours of age, with	Neonatal pulse oximetry is completed at 6 hours of age for all babies. This is outlined within the Congenital Heart Disease guideline.

	clear escalation processes for babies in the amber and red pathways.	

2.6 Safety Action F: Board oversight, Governance, Culture and Leadership

There are currently no concerns for escalation relating to Safety Action D. All requirements are on track to be met within the MIS reporting period.

F1	Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles as outlined in Safety Actions A–E.	The Board continues to receive an assessment of maternity and neonatal safety through monthly QSAC reporting. The QSAC cycle of business ensures regular reporting. The Perinatal Improvement Board (PIB) was established in June 2026 to provide enhanced executive oversight and external scrutiny from the Regional Chief Midwife.
F2	Trusts must evidence that the critical safety check (Annex one of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill was carried out. An accountable trust Board Executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills.	There have been no MOSS alerts in Q1. A test drill will be completed to ensure compliance if there are no alerts received during the MIS reporting period.
F3	Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board.	Safety champions continue to meet monthly to complete walkarounds of the service and discuss safety concerns. Safety champions attend the MNVP meetings to ensure collaboration and two-way communication.
F4	Trusts must demonstrate that they have a perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six-monthly.	Perinatal Culture Improvement Plan to be updated and escalated to Trust Board through QSAC.

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 August 2026 to ensure continued oversight and alignment with service improvement priorities.

4. Recommendations

Trust Board members are requested to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082iib**			
Subject:	**Maternity Incentive Scheme (MIS) monthly update (September) including Saving Babies Lives Care Bundle**			
Date of meeting:	7 October 2026			
Action required:	**To note**			
Author(s):	Helen Wall, Assurance & Improvement Manager (Women's and Children's)			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: 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 provides assurance to the Quality and Safety Assurance Committee on the Trust's progress against the six core safety actions NHS Resolution's Maternity Incentive Scheme Year 8. This paper also provides an overview of current progress with the Saving Babies' Lives Care Bundle 2. For Safety Actions B-F, NCM can demonstrate full compliance or are on track for achieving full compliance.			

<table>
<tr><td></td><td colspan="3">Positive assurance is evidenced by 100% compliance in the Q1 consultant presence audit; established locum, anaesthetic and workforce governance processes; annual multiprofessional training programmes, with most staff meeting the require compliance threshold; compliant Q1 perinatal mortality review arrangements; active engagement with women, families and the Maternity and Neonatal Voices Partnership: regular reporting of Saving Babies' Lives Care Bundle progress and enhanced executive oversight through the Perinatal Improvement Board.

There are areas, where we need to ensure action is taken to for compliance to be achieved. These are outlined throughout the report. In particular;

- Midwifery staffing – this is not currently in line with the Birthrate plus report recommendation. There is a shortfall of 2.6wte. If funding for this shortfall is not agreed by 30 November 2026, NCM will not meet the requirements of MIS.

The reporting period for MIS Year 8 ends on 30 November 2026. If there are requirements which are not compliant by this date, NCM will not achieve overall compliance. The Trust will be reported publicly as non-compliant and will not receive any funds.

QSAC is asked to take assurance from the progress achieved, the strength of the oversight arrangements and the active management of the remaining actions, and to support onward reporting to the Trust Board.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">For the QSAC members to receive and discuss this report and 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/26/09/155ii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">8 September 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit to Trust Board</td></tr>
</table>

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

NHS Resolution has now commenced year eight of the Clinical Negligence Scheme for Trusts (CNST) MIS will 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 for all 6 safety actions will recover 10% of their CNST contribution and receive a share of unallocated funds.

2. Current position

2.1 Safety Action A: Workforce and Capacity

There is one concern for escalation relating to Safety Action A. This relates to the midwifery staffing not currently being in line with the birthrate plus report.
To support a fully operational homebirth service shift model a revenue request has been prepared for an additional 1.45WTE. This supports professional judgement above the minimum establishment set out within the birthrate plus report.

If the revenue request for the 2.6WTE shortfall is not agreed and 1.45WTE to support a sustainable homebirth model, NCM will not be compliant with MIS.

	Requirement	Current position
A1	Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations	Q1 Consultant presence audit completed and reviewed by the Associate Clinical Director identifying 100% compliance.
A2	Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.	Database continues to be maintained to ensure eligibility of short-term locums.
A3	Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).	Neonatal nursing staff review to be completed to ensure fully funded establishment. Medical workforce review is now included in the Perinatal Improvement Plan.
A4	Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum	Birthrate plus report completed in March 2025. Workforce review completed by the interim DOM and interim DDOM with support from the LMNS.

	baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate.	The shortfall is currently 2.6WTE. A review has been undertaken within the planned care group to assess available funding. A revenue request is now being prepared to address this shortfall. Funding must be approved for the shortfall to ensure compliance with MIS. To support a fully operational homebirth service shift model a revenue request has been prepared for an additional 1.45WTE. This supports professional judgement above the minimum establishment set out within the birthrate plus report.
A5	Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained Anaesthetic Assistant available 24/7 in line with ACSA standards 1.3.1.2.	There is a maternity specific anaesthetic rota in place which demonstrates 24/7 cover for maternity.
A6	Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (pre-operative assessment → theatre → recovery → post-natal ward).	Capacity mapping to be completed in Q2.
A7	Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.	Workforce staffing reviews continue to take place across the service. The workforce position is reported quarterly to Strategic People Committee.

2.2 Safety Action B: Training

There are currently no concerns for escalation relating to Safety Action B. All requirements are on track to be met within the MIS reporting period.

MIS requires all staff to have attended the annual training outlined in the table below. A minimum of 90% compliance must be achieved for every staff group at two points during the MIS year and one other Trust selected checkpoint. This will be agreed in September.

B1	Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness.	There is an annual MDT training plan in place. Anaesthetists also attend the training half of the training day.

		Impacted fetal head has been included on the PROMPT training since January 2026. Training compliance is above 90% in all staff groups, in line with the requirements of MIS. Unfortunately, the training days in August and September were cancelled due to staff sickness and the absence of a practice development midwife. The practice development midwife role has been successfully recruited to and is expected to start in November. Staff have been moved to training days in Q3. This should maintain the compliance for the reporting period.
B2	As a minimum, Trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard.	Training is on track for meeting this requirement.
B3	Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.	Obstetric consultants and trainees are fully compliant with this training. Midwifery staff are currently 83% compliant with this training. Training is scheduled to increase the compliance to over 90% in September.
B4	Trusts must deliver at least two in-situ multiprofessional maternity emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g., labour ward, obstetric theatre, triage, Emergency Department (ED), NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.	There have been two multiprofessional simulations which have taken place in July from the hospital setting including the use of escalation pathways. The first Maternity Emergencies at Home training day took place in August in collaboration with North West Ambulance Service (NWAS) and Mersey West and Lancashire (MWL). The immersive training was delivered at Safety Central, Lymm and has received excellent feedback from all organisations involved. This will provided an opportunity for a community simulation to be completed.
B5	Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through	Training compliance continues to be reported monthly through governance and QSAC.

	established governance routes, presented in a clear trend-based format (ideally using SPC charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout future years.	

2.3 Safety Action C: Learning from reviews and investigations

There are currently no concerns for escalation relating to Safety Action C. NCM are fully compliant with all areas of this safety action, to date.

C1	All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis.	NCM processes remain in place to ensure appropriate reporting continues. To date, NCM are fully compliant.
C2	For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	NCM were compliant in Q1. To date, NCM are fully compliant.
C3	For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.	There was one PMRT review in Q1. NCM were compliant with external member attendance. To date, NCM are fully compliant.
C4	Provide relevant information regarding the role of MNSI, NHSR Early Notification (EN) scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	Relevant information was shared with families during Q1. To date, NCM are fully compliant.
C5	Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	To date, NCM are fully compliant.
C6	The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF)	Thematic reports are produced and shared through local governance and reported quarterly to QSAC. To date, NCM are fully compliant.

	reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.	

2.4 Safety Action D: Service-user voice and equity

There are currently no concerns for escalation relating to Safety Action D. All requirements are on track to be met within the MIS reporting period.

D1	Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.	Trust interpretation and translation policy remains in place including the use of face to face and telephone support. Additional tablets have been purchased to be used across maternity to support the use of translation services.
D2	Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plan. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.	Feedback continues to be gathered across all areas of the service through FFT, feedback forms, QR codes and conversations with women and families. The Consultant Midwife (patient experience lead) is currently reviewing how we gather and share feedback across the service to support improvement. The service continue to work closely with the MNVP to ensure feedback is fed back and improvements made which is reflective of the demographic of NCM. The MNVP have shared feedback relating to experiences in triage, EPAU and C23.

2.5 Safety Action E: Care Bundles

There are currently no concerns for escalation relating to Safety Action E. All requirements are on track to be met within the MIS reporting period.

E1	The provider must report quarterly to the Trust Board on progress against SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of	The SBL position is reported monthly to QSAC within this report which is then shared at all Trust Board meetings.

	the Care Bundle based on local progress, implementation status, and any relevant safety intelligence, including learning from local adverse incidents.	There are challenges relating to the diabetes service and the multidisciplinary support in a one-stop clinic. A dietitian is due to start in September and business cases are currently in progress for a Diabetes Specialist Midwife and a Diabetes Specialist Nurse. This will ensure compliance with SBL element 6.
E2	In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.	NCM's current position against the Maternal Care Bundle has been submitted to the LMNS. A meeting has been arranged with the LMNS on 28th September to discuss our progress.
E3	Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between two and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.	Neonatal pulse oximetry is completed at 6 hours of age for all babies. This is outlined within the Congenital Heart Disease guideline.

Saving Babies' Lives Update

Regular reporting on compliance with the Saving Babies' Lives Care Bunde (SBL) 3.2 to Trust board is required to ensure MIS compliance. NCM are currently 88% compliant for overall implementation. This is a reduction compared with the previous retrospective self-assessment, which was 91%. The current position against each element is outlined below with actions in place to drive improvement.

Summary of current position:

- **Element 1 – Full compliance:** Targets achieved.

- **Element 2 – Full compliance:** Exception reporting of fetal growth FGR cases who were identified as low risk at booking in place. Challenges ongoing with GAP compliance for knowledge assessment. Individual emails sent and escalated to senior team. Target achieved within the last 3 months but requires close monitoring.

- **Element 3 – Full compliance:** Continued oversight is needed to ensure ultrasound assessment is undertaken when recurrent reduced fetal movements

are identified. Learning shared with the team. Target achieved within the last 3 months but requires close monitoring.

- **Element 4 – Partial compliance:** Reduction in MAMU2 compliance due to cancelled study day. An additional study day has been arranged for 2nd October (soonest available date).

- **Element 5 – Partial compliance:** Patient information leaflets are not yet available in multiple languages, and compliance with antenatal steroid administration and deferred cord clamping has remained below target over the past 12 months when assessed using the 12-month mean. IVH 3 or 4 is above target at 12.5% for 12 month mean. The booking in pregnancy guideline is overdue for review; this is awaiting update prior to Guideline Review Group.

- **Element 6 – Partial compliance:** The diabetes MDT does not currently include a dietitian however, the dietitian is due to commence in post in September. There have been three missed third trimester HbA1Cs. This has been escalated to the senior team and through the diabetes working group, with actions agreed.

2.6 Safety Action F: Board oversight, Governance, Culture and Leadership

There are currently no concerns for escalation relating to Safety Action F. All requirements are on track to be met within the MIS reporting period.

F1	Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles as outlined in Safety Actions A–E.	The Board continues to receive an assessment of maternity and neonatal safety through monthly QSAC reporting. The QSAC cycle of business ensures regular reporting. The Perinatal Improvement Board (PIB) was established in June 2026 to provide enhanced executive oversight and external scrutiny from the Regional Chief Midwife.
F2	Trusts must evidence that the critical safety check (Annex one of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill was carried out. An accountable trust Board Executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills.	There have been no MOSS alerts in Q1. A test drill will be completed to ensure compliance if there are no alerts received during the MIS reporting period.
F3	Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including	Safety champions continue to meet monthly to complete walkarounds of the service and discuss safety concerns.

	the MNVP Lead where they are in commissioned in line with MNVP guidance), embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board.	Safety champions attend the MNVP meetings to ensure collaboration and two-way communication.
F4	Trusts must demonstrate that they have a perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six-monthly.	Perinatal Culture Improvement Plan to be updated and escalated to Trust Board through QSAC.

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 September 2026 to ensure continued oversight and alignment with service improvement priorities.

4. Recommendations

The Trust Board members are requested to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082iii**			
Subject:	**Perinatal Mortality Review/Audit Quarter 1 2026/27**			
Date of meeting:	7 October 2026			
Action required:	**For information and assurance**			
Author(s):	Tina Moors, Interim Director of Midwifery, Lisa Davies Governance Lead Midwife			
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 the care of women and families during pregnancy and the postnatal period and highlights opportunities to improve outcomes for this protected group.			
Executive summary:	The Perinatal Mortality Review Tool was developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution has incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action C of the Maternity Incentive Scheme (Year 8) to ensure the Trust Board receives quarterly perinatal mortality review reports. This report presents the North Cheshire and Mersey NHS Foundation Trust (NCM) Quarter 1 (Q1) PMRT report for the period covering 1 April 2026 to 30 June 2026.			

	During Q1, NCM reported five babies for review to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK): One stillbirth: • One baby born at 41+0 weeks One late fetal loss: • One baby born at 23+1 weeks Three neonatal deaths: • One baby born at 22+1 weeks • One baby born at 22+3 weeks • One baby born at 30+2 weeks (Table 1 also includes one additional BadgerNet recorded neonatal death involving a baby born alive before 24 weeks, which does not meet the criteria for PMRT review and is therefore shown separately). NCM stillbirth rate for Q1 2026/27 was 1.64 per 1000 births. NCM annual stillbirth rate (2025/26) was 3.8 per 1000 births. The MBRRACE-UK national stillbirth rate is 3.9 per 1000 births. NCM neonatal mortality rate during Q1 2026/27 was 4.9 per 1000 live births. NCM annual neonatal death rate (2025/26) was 2.1 per 1000 live births. The MBRRACE-UK national neonatal rate is 3.0 deaths per 1000 live births (Two of the three deaths were due to extreme prematurity) There has been no alert of concern through the Maternity Outcomes Signal System (MOSS). During Q1, NCM undertook one PMRT review panel for one of the three reported neonatal deaths. Parental perspective of the care they received was sought in this case. The panel reviewed: One neonatal death: • One baby was born at 22+1 weeks

<table>
<tr><td></td><td colspan="3">As only one PMRT panel was held during Q1, the findings will be included within the Q2 2026/27 report to maintain anonymity and confidentiality.

All PMRT action plans are shared at Safety Oversight Meeting and monitored through Women’s and Children’s CBU Governance Meeting.

To date, full compliance is reported in relation to the Maternity Incentive Scheme Year 8; Safety Action C standards.</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 Trust Board members to receive and note 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/26/08/131ii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11 August 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) confidential enquiries reported that 60-80% of term perinatal deaths might have been prevented and recommended that Trusts undertake robust reviews and develop learning to reduce the rate of stillbirth.

NHS Resolution (NHSR) has incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action C of the Maternity Incentive Scheme (MIS) Year 8 standards and recommends that each maternity service audits all stillbirths and neonatal deaths and reports these to its Trust Board using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all NCM perinatal deaths reviewed and action plans implemented. It presents NCM Quarter 1 PMRT audit data for 2026/27 and highlights good practice and learning 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 400 grams or more and lives but dies within 7 days of being born.
- **Neonatal mortality rate** refers to the number of babies who 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 1 2026/27 stillbirths & neonatal mortality

The Perinatal Mortality Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. This paper summarises the key findings for information and assurance.

Five cases were reported to MBRRACE-UK for review during the Q1 reporting period.

2.1 Q1 2026/27 NCM Stillbirth Rate:

- The NCM Q1 stillbirth rate for 2026/27 was 1.64 per 1000 births.
- The rolling 12-month stillbirth rate shown in Table 1, covering Q2 2025/26 to Q1 2026/27, is 1.64 per 1000 births.
- The MBRRACE-UK national stillbirth rate is 3.9 per 1000 births.
- NCM had no intrapartum stillbirths.
- NCM had one term stillbirth (babies born from 37 weeks gestation).

In view of the small number of stillbirths, it is important to review the data over a longer period to provide wider context for rates and learning. The NCM annual stillbirth rate for Q1-Q4 2025/26 was 3.8 per 1000 births. The rolling 12-month rate shown in Table 1 covers Q2 2025/26 to Q1 2026/27 and is 1.64 per 1000 births. The MBRRACE-UK national stillbirth rate is 3.9 per 1000 births.

Table 1: NCM Mortality Data Over 12-month Period

Metric	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	12-month total
Number of live births	652	610	555	610	**2427**
Total number of stillbirths >24 weeks	1(+*1)	2(+*2)	0(+*1)	1(+*1)	**4**
Total Stillbirth Rate >24 weeks (per 1000 births)	1.53	3.27	0.00	**1.64**	**1.64**
Number of intrapartum stillbirths	0	0	0	0	**0**
Number of term stillbirths (>37 weeks)	0	0	0	1	**1**
Neonatal deaths before 28 days (per 1000 live births)	1.53	0.00	0.00	**4.9**	**1.64**
Neonatal deaths before 28 days	1 (+**1)	0 (+***1)	0	3(+1**)	**4**

*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 NCM who died elsewhere and not included in NCM PMRT data.

2.2 Q1 2026/27 NCM Neonatal Mortality Rate:

- NCM neonatal mortality rate during Q1 2026/27 was 4.9 per 1000 live births.
- NCM rolling 12-month neonatal mortality rate is 1.64 per 1000 live births.
- The MBRRACE-UK national neonatal mortality rate is 3.0 deaths per 1000 live births.

3. Quarter 1 2026/27 PMRT review findings

3.1 Quarter 1 PMRT Review Panel Key Findings

As only one PMRT panel was held during Q1, the findings will be included within the Q2 2026/27 report to maintain anonymity and confidentiality.

3.2 PMRT reporting for Saving Babies' Lives Care Bundle v3 – Q1 2026/27

As part of the Saving Babies' Lives Care Bundle version three, there is a requirement to consider whether fetal growth restriction (FGR), reduced fetal movement (RFM), and/or intrapartum monitoring were contributory factors in perinatal mortality. Table 2 details the outcomes of the PMRT reviews completed in Q1 against these interventions:

Table 2: 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%

3.3 Maternity Incentive Scheme Year 8 Compliance

NCM is compliant with all elements of the Perinatal Mortality Review Tool (PMRT), in line with the requirements of the Maternity Incentive Scheme Year 8, as shown in Table 3.

Table 3: PMRT MIS Safety Action C Compliance

Safety action C: Learning from reviews and investigations		
Standard Required – Q1-Q3 2026/27 (April-December)		**Compliant Y/N**
Reporting & Review		
1)	**Notify all qualifying events** All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.	Assessed as compliant
2)	**Seek parents' views of care** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.	Assessed as compliant
3)	**External multi-disciplinary reviewers** For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review, and this should be documented within the PMRT.	Assessed as compliant
Sharing information with families		
4)	**Provide relevant information** Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	Assessed as compliant
5)	**Offer parents a meeting with relevant specialists** Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	Assessed as compliant
Learning and governance		
6)	**Thematic reports of learning and actions**	

	The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.	Assessed as compliant

3.4 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 4: PMRT Action Plan

In progress and outstanding actions	Lead	Due Date	RAG rating
There are no outstanding PMRT actions			

4. Summary

NCM Q1 PMRT audit recorded five babies reported to MBRRACE-UK between 1 April 2026 and 30 June 2026.

- NCM stillbirth rate for Q1 2026/27 was 1.64 per 1000 births. The NCM annual stillbirth rate for Q1-Q4 2025/26 was 3.8 per 1000 births, compared with the MBRRACE-UK national stillbirth rate of 3.9 per 1000 births. The rolling 12-month rate shown in Table 1, covering Q2 2025/26 to Q1 2026/27, was 1.64 per 1000 births.
- NCM neonatal mortality rate during Q1 2026/27 was 4.9 per 1000 live births. The MBRRACE-UK national neonatal mortality rate is 3.0 deaths per 1000 live births.
- One baby required a PMRT review panel in Q1, and the findings and learning will be shared within Q2 data to preserve anonymity and confidentiality.

- Full compliance is reported in relation to the Maternity Incentive Scheme Year 8; Safety Action C standards are being met.

5. Monitoring/reporting routes

This report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting in September 2026.

6. Recommendations

The Trust Board Committee is asked to note the findings of this paper in line with MIS Year 8 recommendations.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082v**			
Subject:	**Avoiding Term Admissions into Neonatal Unit (ATAIN) report Quarter 1**			
Date of meeting:	7 October 2026			
Action required:	**To note**			
Author(s):	Annabel Grossmith – Consultant Obstetrician & Gynaecologist Delyth Webb – Consultant Paediatrician Kat Woodger – Consultant Paediatrician Helen Wall – Assurance & Improvement Manager 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:	• Q1 2025/26 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 9.02%, which does not meet the national target (6%) or the NWNODN target (5.6%). However, during this quarter, we note a month by month sustained reduction in ATAIN rate resulting in a rate of 4.6% in June 2026, with the rate remaining in target moving forwards into July 2026 at 4.37% (the first month of quarter 2).			

<table>
<tr><td></td><td colspan="3">All term admissions of any duration in Q1 were reviewed and learning from these cases has informed the ATAIN action plan, to improve and now maintain the service position against ATAIN standards.
The ATAIN action plan is monitored at the monthly Women’s & Children’s (WCH) Governance Meeting.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">To note this report 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/26/09/155iv</td></tr>
<tr><td>Date of meeting</td><td colspan="2">8 September 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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 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 North Cheshire and Mersey NHS Foundation Trust (NCM) against ATAIN standards.

2. Key elements

2.1 NCM 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 Q1 reporting period from 1 April 2026 to 30 June 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. The ATAIN team have also received support from NWNODN and JOS to try to reduce our ATAIN rate.

2.2 Summary of term admissions to NNU

The 26/27 Q1 ATAIN rate was 9.02%. This does not meet the national target of 6% or the NWNODN target of 5.6%. NCM remains an outlier in the NWNODN for term admissions and overall, the rate of admissions this quarter has increased from Q4. This is due to a significant number of admissions during the month of April (12.8%). However, the rate for subsequent months showed a significant reduction in term admissions, reaching national and NWNODN targets by the end of June (4.6%). At the time of writing this report, this reduction has been sustained into July with an admission rate of 4.37%, suggesting that all sustained MDT actions to improve care

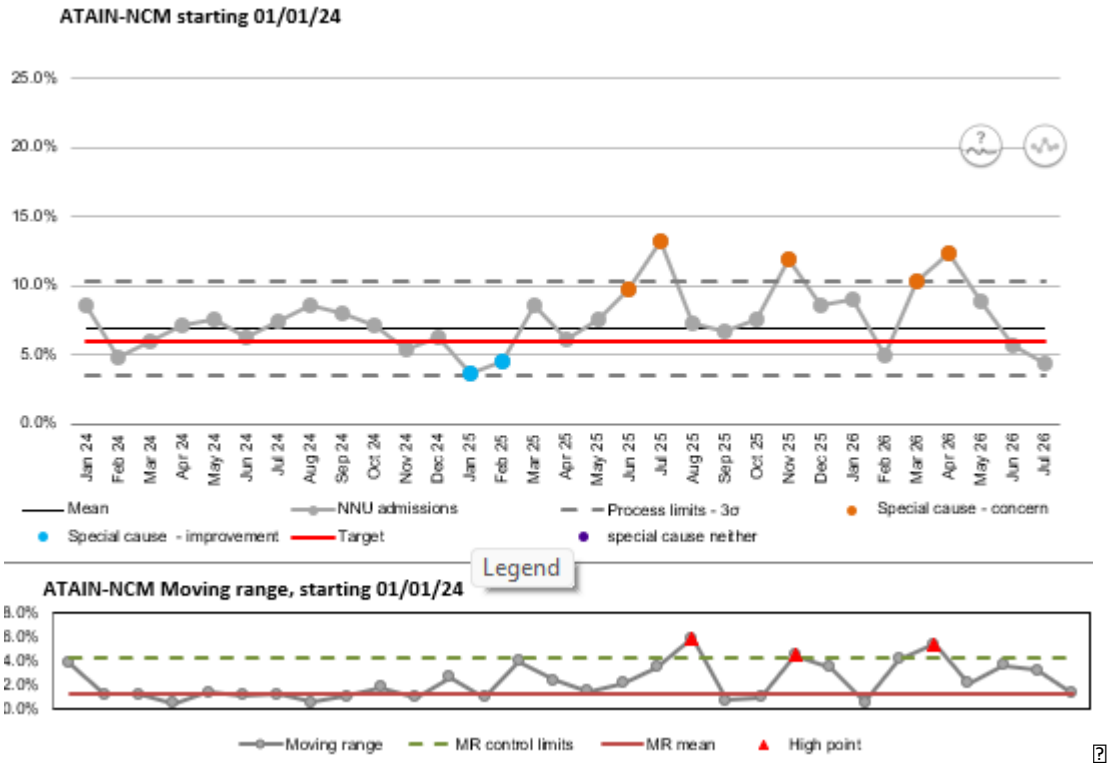
and address recurring themes including overcautious admission, have had an impact on patient safety in our unit.

NCM has remained an outlier for much of the last three years despite careful MDT analysis and understanding of our data, recent Joint oversight support and robust projects put in place to address recurring themes, including 'PEEP for 30' project, expansion of Transitional Care offered, change in training and guidance in fetal monitoring in low risk settings, ongoing MDT CTG training, collaborative work with the Diabetes MDT, and change in opiate policy. In Q4 25/26 the NEWTT2 scoring system for newborns afforded earlier detection of deteriorating babies. JOS clinicians' and ODN's input did not result in further understanding of our position as a regional outlier, but they were satisfied that our review processes, actions to date and level of scrutiny of our practices are robust and thorough. Advice from a nearby unit achieving ATAIN targets to observe babies requiring initial respiratory support for longer periods prior to considering admission, where possible, may be one of the reasons that our ATAIN rate has improved over the past few months.

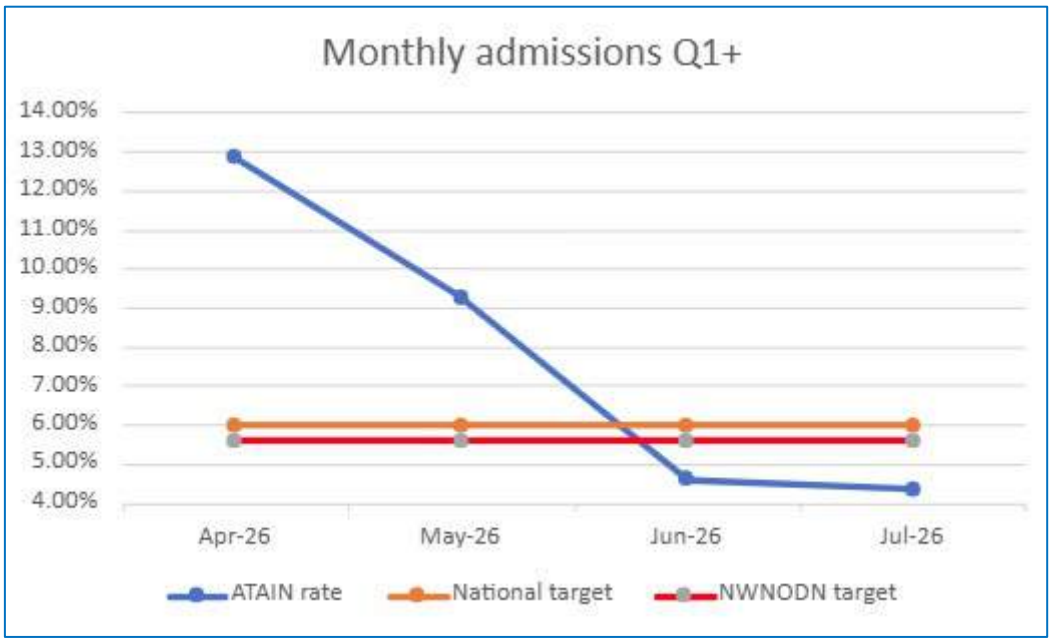
Despite April's high number of admissions this quarter, the avoidable admission rate is lower (18.2%) than the NHS expectation of 20%. We continue to analyse the data of our unavoidable admissions (where care was optimal/according to current policy) to see if there is more we can understand about our specific demographic in NCM in order to identify whether we need to change policy in order to reduce the number of babies born requiring additional respiratory support, in particular.

NCM 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%		
Q1 Apr – Jun 2026	610	55	9.02%		

Below is a summary of unanticipated term admissions to Neonatal Unit from January 2021 – June 2026.



Downward trend of monthly ATAIN rate: April, May and June, and July (Q2)



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 remained fairly steady (but under the NHS England expectation of 20%) with again a significant number of unavoidable admissions. 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, again suggesting that it may be difficult to reduce this figure.

Ongoing QI projects including the further development of the maternal diabetic pathway and recent 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.

NCM 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%
Q1 Apr – Jun 2026	55	10	45	18.2%

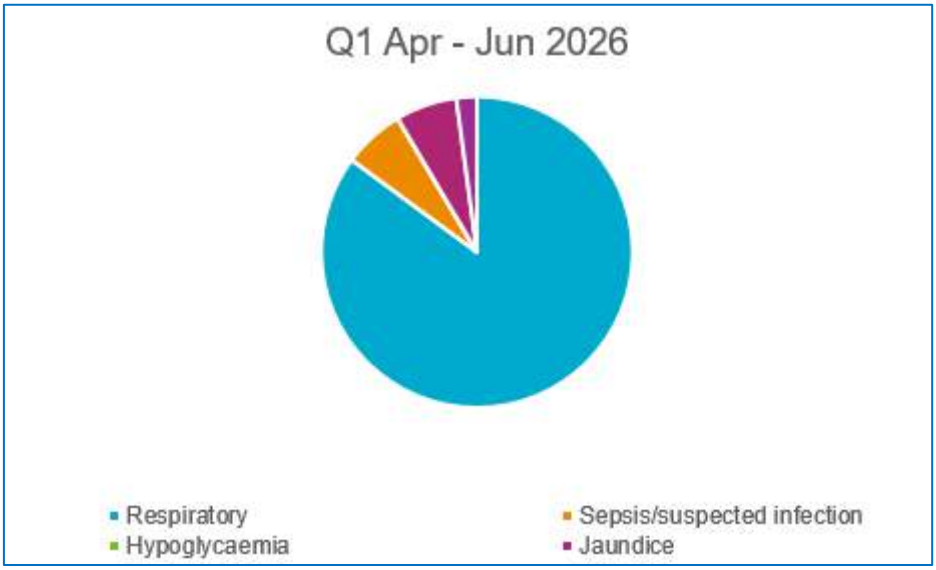
1.3 Reasons for term admissions in Q1 (recorded on BadgerNet by ATAIN admission criteria)

As in all quarters, the majority (73%) 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.

Ten cases were deemed avoidable as outlined below in section 2.4.

NCM 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%
Q1 Apr – Jun 2026	610	55	9.02%	40	73%	3	5.5%	0	0%	3	5.5%	1	1.8%

The table below details primary reasons for term admissions to NNU at NCM as per ATAIN groups. (8 babies did not fall within one of the 5 main admission categories. Their reasons for admission have been outlined below.)



Most admissions are for respiratory distress.

There were 8 babies whose reason for admission did not fall into respiratory, suspected sepsis, hypoglycaemia and jaundice.

- One baby was admitted as they required a minimum of two weeks of observations due to maternal history of hyperparathyroidism (anticipated admission).
- Two babies were admitted due to a high lactate level.
- One baby was a social admission prior to discharge to foster care, who could not be cared for outwith the Neonatal Unit, although other options were explored. The baby was well.
- One baby was admitted due to bilious vomiting with suspicion in order to exclude intestinal obstruction.
- One baby was admitted due to low birth weight.
- One baby was admitted due to feeding concerns.
- One baby was admitted for observation following an episode of choking.

2.4 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- Baby 1:

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/26/10/082v**			
Subject:	**Maternity and Neonatal Voices Partnership – Biannual Report**			
Date of meeting:	7 October 2026			
Action required:	**For information and to note**			
Author(s):	Colette Wiles, MNVP Lead Helen Wall, Assurance and Improvement Manager			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	Maternity and Neonatal Voices Partnership (MNVP) have produced their biannual report identifying the work they have collaborated on with the Trust and the ongoing engagement they have with women and families. The Trust continues to work closely with the MNVP leads to hear the voices of women and families and collaborate to drive improvements across the service.			
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
Recommendation:	For Trust Board members to receive and note the contents of this report.			
Previously considered by:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QSAC/26/08/131iv**		
	Date of meeting	11 August 2026		

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

1. Background/context

The Maternity and Neonatal Voices Partnership listen to the voices of women and families, bring together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. For Maternity Incentive Scheme (MIS) Year 8 Safety Action D, MNVP engagement to help provide service-user insight is highlighted as good practice.

2. Current position

2.1 MNVP structure

The Maternity and Neonatal Voices Partnership (MNVP) is a collaborative forum bringing together women, birthing people, families, maternity and neonatal professionals, commissioners and service users to improve care across Warrington and Halton. Its purpose is to listen to the real experiences of those using maternity and neonatal services and ensure these voices shape future care that is inclusive, safe and person-centred. The Warrington & Halton MNVP, led by Lisa Welch and Colette Wiles, meets quarterly and includes service users, community representatives, healthcare professionals and commissioners. The group works in partnership with the Trust and local providers to review feedback, co-design improvements and ensure that the experiences of families remain central to service development.

2.2 Engagement

MNVP leads continue to attend annual events across Warrington and Halton to drive engagement. The leads have recently attended Warrington Pride and Warrington Disability Awareness Day. The 15 steps toolkit continues to take place to give feedback to the Trust on areas across the service. The engagement activities and feedback from the MNVP survey are outlined within the MNVP report (Appendix 1). The Trust met with the MNVP leads in July to respond to the findings and identify ways to improve. The leads will work closely with the Trust to improve the EPAU pathway for women.

3. Monitoring/reporting routes

The content of this report will be shared at Women's Health Governance in September 2026.

4. Recommendations

The Trust Board Committee is asked to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082via**			
Subject:	**10 Point Plan**			
Date of meeting:	7 October 2026			
Action required:	**For information, discussion 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:			
Executive summary:	The 10-point plan is a set of urgent actions which have been set out by NHS England. The actions align with the recommendations made within the Amos national investigation and the Ockenden Review. The senior leadership team have attended webinars with the Regional Maternity Team where the plan was outlined. The Trust have been advised to commence benchmarking our current position and to prepare for the national direction which will be set out in the coming months. This report sets out the current position of the Trust against the 10 Point Plan and the plans to implement the remaining actions.			

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	For Trust Board members to receive and note this report as part of the quarterly maternity and neonatal overview.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QSAC-26-08-124**	
	Date of meeting	11 August 2026	
	Summary of Outcome	Submit to Trust Board	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

In June 2026, the Ockenden Report and Amos review were published. These reviews focused on the review of the maternity and neonatal services in Nottingham and the wider impact of these failings across maternity and neonatal services nationally.

Following the publication of these reviews, NHS England developed the 10-point plan, outlining urgent actions within maternity and neonatal services. The national taskforce will lead on the rollout of the majority of the actions to ensure a consistent national approach to improvements.

2. Current position

2.1 Listening to women and their families by rolling out Martha's Rule

Martha's Rule was implemented within the neonatal unit on 8 June 2026. Information relating to the implementation of Martha's Rule is on display around the unit and on the Trust website for parents and families. The information has also been shared with Maternity and Neonatal Voices Partnership (MNVP) and Dad Matters which is a support group for Dads who attend the service twice a week, for cascading. A leaflet is currently being developed to further support parents' awareness of Marthas Rule and Call for Concern.

The implementation of the Martha's Rule programme in maternity services will be led by the national team who will provide support and guidance. The Intrapartum Matron will lead on the implementation of Martha's Rule within our maternity service. The Intrapartum Matron has already met with the Trust Lead for Martha's Rule. Plans are in place for the phone holder and escalation procedures.

There is a national webinar taking place on 12 August 2026. The maternity senior leadership team, ward managers and specialist midwives will be in attendance. Following this webinar the Intrapartum Matron will proceed with the implementation.

2.2 Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level

The gathering of feedback from women and their families is currently being reviewed across the service. It has been identified, due to the nature of the services provided across the unit, different ways to give feedback in each area is the most appropriate. The Consultant Midwife is the lead for patient experience and is leading on this work.

There are a combination of feedback forms and QR codes available across the unit to encourage and support women to share feedback on their experience.

NCM work closely with the MNVP to ensure the voices of women and their families are heard and responded to. The maternity and neonatal oversight report which is presented at QSAC will be updated to include more feedback from women and their families.

The forward audit plan will be updated in August for the remainder of the financial year. The outcomes from audit will continue to feed into this workstream.

2.3 Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care

The Chief Nurse and Medical Director fully understand and act upon their accountability within maternity and neonatal services at NCM. The monthly maternity and neonatal service oversight report is report to QSAC where they are both committee members.

To continue to monitor and drive improvement within the maternity and neonatal service, the Perinatal Improvement Board has been established. Following from the site visit by the Regional Maternity Team the Board was established to provide an enhanced oversight of the service. The Board is chaired by the Chief Nurse or Medical director in their absence. The Regional Chief Midwife is also in attendance. The meeting ensures any necessary escalation has been completed.

The Board has been a positive addition to the CBU ensuring enhanced oversight and support. The Perinatal Action Review meeting takes place the week before to ensure actions from the Perinatal Improvement Plan are on track and there is executive approval of evidence for the completion of PIP actions.

2.4 ‘Amos into action’ staff listening exercise

The staff listening exercise will be led by NHS England to support the work of the maternity taskforce.

There are currently weekly maternity SLT ‘drop-in’ sessions for staff to speak with the SLT. The SLT are reviewing additional ways to encourage and support staff engagement and feedback.

Professional Midwifery Advocates are in place across the service who organise regular events and support for staff.

2.5 Addressing inequalities in maternity and neonatal outcomes

NHS England has now confirmed the rollout of the Perinatal Equity and Anti-discrimination Programme. NHSE have advised this will be available to all trusts by the end of 2026.The senior leadership team have executive support for attending this training. NCM begin this programme in September (Cohort 2).

The Trust will continue to incorporate the information available from the maternity and neonatal equality dashboard to inform decision-making and improvements across the service. The service is currently completing a benchmarking exercise against the maternal care bundle to share with the LMNS. Progress towards implementation of the maternal care bundle is incorporated into the monthly MIS reporting to QSAC.

2.6 Ensuring 24/7 safety and responsiveness of maternity and neonatal services

The Board takes accountability for ensuring safe service arrangements for the maternity and neonatal service at NCM. There is executive oversight over the workforce and workforce progress is reported through Perinatal Improvement Board and QSAC.

Operationally, there are daily staffing meetings and staff are deployed across the service in response to staffing demands. A board-level review will be completed in line with the recommendations.

A workforce review was completed earlier this year by the interim Director of Midwifery and interim Deputy Director of Midwifery with support from the LMNS. This supported improved oversight of the workforce and further alignment with the recommendations set out within the birthrate plus report.

The 10-point plan sets out that where specialist roles exist, other staff should have the knowledge and skills to ensure care is not compromised when these staff are not immediately available. The service has already been improving resilience in this area. For example, there are bereavement champions in place and birth suite coordinators have also completed additional training to support women and families, in the absence of a bereavement midwife, Additional midwives are also being trained to support the diabetes service.

2.7 Trusts to review their homebirth services

Trusts are required to have reviewed their homebirth service following the request of the Chief Midwifery Officer in November 2025. In the last year there have been significant changes to the model of the homebirth service at NCM. Through learning, the homebirth service model has changed to a shift model from an on-call model. When fully staffed, this will ensure two staff are always on shift to support 24/7 operation of the homebirth service. This way of working has received support from the LMNS and Regional Maternity Team. The ongoing improvement work within the service is reported through the Perinatal Improvement Board with executive and Regional Maternity Team oversight.

The Consultant Midwife has been involved in the development of a national homebirth guideline as part of the regional homebirth working group. Through this ongoing involvement, the service is assured that the current way of working aligns with the new national direction.

The national homebirth guidance and framework is expected to be rolled out in the Autumn. Following the rollout, the service will implement the national guidance.

2.8 Responding to patient safety incidents, complaints and concerns with humanity, candour and trauma-informed approach

The service continues to respond to patient safety incidents, complaints and concerns with humanity, candour and trauma-informed approach. The maternity and neonatal service has a dedicated governance lead to ensure incidents and concerns are responded to appropriately.

The service understands the importance of responding appropriately to incidents. In response, birth suite coordinators have recently completed additional training in PSIRF.

Incidents, complaints and concerns are reported through Women's Health and CBU Governance to ensure oversight and drive improvement in this area.

The Trust will implement the national blueprint for responding with humanity and compassion following the national release to further enhance the compassionate support provided.

2.9 Deliver safe and effective triage in maternity services

The Trust is committed to delivering a safe and effective triage service. A board-level audit will be completed by October 2026 to review the triage service. The audit will be conducted in line with the recently published NHS England National Maternity triage Specification.

The Board will continue to be updated on maternity triage quality and performance through monthly QSAC data reporting. The triage service will continue to use a national recognised tool (BSOTS) to triage women who contact the service.

NCM Maternity Triage service has been benchmarked against the RCOG Good Practice Paper No. 8: Maternity Triage and is aligned with the national standards for safe and effective triage care. Performance is monitored through governance, audit and Safe Care reporting, with ongoing service improvements.

To support improvement, work an ANDU (antenatal day unit) and Triage working group has been established. In line with the requirements, improvement plans will be shared with the Board and NHS England regional team.

2.10 Post death care

The actions set out following the Fuller and NUH reviews have been reported to QSAC through the Mortuary Report which was presented in July. This supports the Trust's accountability for ensuring the deceased are treated with the dignity, compassion and respect they deserve.

3. Monitoring/reporting routes

This report will be monitored through Women's and Children's CBU Governance and Perinatal Improvement Board.

4. Recommendations

Trust Board members are requested to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/082/vib**			
Subject:	**10 Point Plan – August data**			
Date of meeting:	7 October 2026			
Action required:	**To note**			
Author(s):	Helen Wall, Assurance & Improvement Manager			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	The 10-point plan is a set of urgent actions which have been set out by NHS England. The actions align with the recommendations made within the Amos national investigation and the Ockenden Review. The Senior Leadership Team have attended webinars with the Regional Maternity Team where the plan was outlined. The Trust have been advised to commence benchmarking our current position and to prepare for the national direction which will be set out in the coming months. This report sets out the current position of the Trust against the 10 Point Plan and the plans to implement the remaining actions.			

	1. Martha's Rule was successfully implemented in the neonatal unit on 8 June 2026. An implementation lead has been identified for maternity and a working group established. 2. There are multiple ways the service receives feedback from women and families. The Trust continue to work closely with MNVP to gather both general and targeted feedback which leads directly to improvements within the service. 3. Dual board-level accountability with the Chief Nurse and Medical Director is fully embedded. Both the Chief Nurse and Medical Director are executive leads for the Perinatal Improvement Plan. 4. The staff listening exercise will be led nationally. There are multiple avenues for staff to give feedback across the unit including feedback forms, QR codes and listening events. Senior Leadership walkarounds will formally commence in October to further increase staff feedback. 5. The national inequalities dashboard is reviewed in line with improvement work. A local dashboard has also been developed. 6. A medical workforce review group will be established, in September, to identify areas of improvement and action required. Maternity triage has been highlighted as an area where additional medical support is required. Midwifery staff have received additional training to support specialist roles; such as bereavement. 7. The homebirth service has been reviewed and requires an additional 1.45wte to deliver a fully operational homebirth service. Homebirth staff have received additional training with NWAS in maternity emergencies at home. 8. There are robust processes in place to deliver PSIRF with kindness and compassion at the centre of programme delivery. Birth suite coordinators have also attended additional training in PSIRF. Family liaison officers (FLO) are allocated, in line with the framework. 9. A triage audit is currently in progress. This will identify areas of required investment for triage

<table>
<tr><td></td><td colspan="3">such as medical staffing and the recorded phone service.
10. The Trust have met their responsibilities relating to post death care by responding to the Fuller Report. Confirmation of the Trust's response has also been shared with the Regional Chief Midwife.

The Trust has made good progress with all 10 points set out within the plan, in line with national expectations. A baseline assessment is required to be submitted to the Maternity Regional Team by 26 September 2026 for review. This is the first stage of the assurance process. Feedback from the team will be shared at QSAC, when received.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">To note 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/26/09/155i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">8 September 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit 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="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

In June 2026, the Ockenden Report and Amos review were published. These reviews focused on the review of the maternity and neonatal services in Nottingham and the wider impact of these failings across maternity and neonatal services nationally.

Following the publication of these reviews, NHS England developed the 10-point plan, outlining urgent actions within maternity and neonatal services. The national taskforce will lead on the rollout of the majority of the actions to ensure a consistent national approach to improvements.

2. Current position

2.1 Listening to women and their families by rolling out Martha's Rule

Neonatal

Martha's Rule was implemented within the neonatal unit on 8 June 2026. Since implementation, no calls have been received. An initial review of the implementation has identified that communication around implementation can be improved. The MNVP (Maternity and Neonatal Voices Partnership) have agreed to support the implementation and will be sharing information across their social media channels. They are also gathering feedback from women and families about their awareness of Martha's Rule. The posters on display within the neonatal unit do not appear to stand out against the backdrop of multiple information posters across the unit. The team are reviewing the posters, to have a greater impact on the unit.

Maternity

A national webinar took place on 12 August 2026 outlining the national direction for implementing Martha's Rule. This was attended by the interim Intrapartum Matron who will lead on the implementation within maternity.

The intrapartum matron has established a working group, with meetings commencing in September. The learning from the rollout within the neonatal service will inform and support the implementation within maternity.

A timeline for implementation will be shared with QSAC in October, following the working group meeting.

Our current position is in line with the national expectation. Implementation leads have been directed to make contact with maternity colleagues and build awareness and understanding of the three components of Martha's Rule.

A recording of the national webinar can be accessed via

Martha's Rule Maternity and Neonates welcome webinar - 12 August 2026 - National Deterioration Forum - Futures.

2.2 Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level

The gathering of feedback from women and their families is currently being reviewed across the service. It has been identified, due to the nature of the services provided across the unit, different ways to give feedback in each area is the most appropriate. The Consultant Midwife is the lead for patient experience and is leading on this work.

Feedback is currently gathered via:

- QR codes across the units and information packs
- FFT
- MNVP feedback forms
- MNVP feedback through engagement sessions

Feedback from women is also gathered in response to concerns and trends highlighted through workstreams across maternity. For example, MNVP are currently asking women about feedback on the induction experience following the recently identified increase in women refusing induction and choosing a maternal request caesarean section.

The maternity and neonatal oversight report which is presented at QSAC will be updated to include more feedback from women and their families.

2.3 Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care

The Chief Nurse and Medical Director fully understand and act upon their accountability within maternity and neonatal services at NCM. The monthly maternity and neonatal service oversight report is report to QSAC where they are both committee members.

To continue to monitor and drive improvement within the maternity and neonatal service, the Perinatal Improvement Board has been established. Following from the site visit on 11 March 2026 by the Regional Maternity Team the Board was established to provide an enhanced oversight of the service. The Board is chaired by the Chief Nurse or Medical director in their absence. The Regional Chief Midwife is also in attendance. The meeting ensures any necessary escalation has been completed.

The Board has been a positive addition to the CBU ensuring enhanced oversight and support. The Perinatal Action Review meeting takes place the week before to ensure actions from the Perinatal Improvement Plan are on track and there is executive approval of evidence for the completion of PIP actions.

2.4 ‘Amos into action’ staff listening exercise

The staff listening exercise will be led by NHS England to support the work of the maternity taskforce.

Staff feedback is currently gathered in multiple ways across the service. These include:

- Weekly maternity SLT 'drop-in' sessions
- Microsoft forms – with targeted areas for review e.g. escalation
- Continuity of Carer listening events
- Ward manager meetings
- Bleepholder walkarounds

Professional Midwifery Advocates are in place across the service who organise regular events and support for staff.

Results have been shared and discussed with the senior team from the escalation survey. Feedback included senior leadership visibility and how to raise concerns. From Q3, members of midwifery SLT will be allocated to complete senior leadership walkarounds across the unit each week.

In September, a staff survey will be launched to assess if staff feel able to raise concerns and if feel listened to when they do. Feedback from this survey will be shared at QSAC in October.

2.5 Addressing inequalities in maternity and neonatal outcomes

NHS England has now confirmed the rollout of the Perinatal Equity and Anti-discrimination Programme. NHSE have advised this will be available to all trusts by the end of 2026.The Senior Leadership Team have executive support for attending this training. NCM begin this programme on 4 September 2026 (Cohort 2). The perinatal leadership team and MNVP leads will be in attendance.

A local maternity inequalities dashboard has been set up within the CBU to support improvement work. This dashboard is utilised for all improvement work and informs decision-making. The dashboard was created by the maternity data quality and training specialist and can be accessed at Maternity-Equalities - Power BI Report Server. In recognition of their hard work, they will receive a You Made A Difference Award in September.

The Trust continue to incorporate the information available from the national and local maternity and neonatal equality dashboards to inform decision-making and improvements across the service. The service is currently completing a benchmarking exercise against the maternal care bundle to share with the LMNS. Progress towards implementation of the maternal care bundle is incorporated into the monthly MIS reporting to QSAC.

2.6 Ensuring 24/7 safety and responsiveness of maternity and neonatal services

The Board takes accountability for ensuring safe service arrangements for the maternity and neonatal service at NCM. There is executive oversight over the

workforce and workforce progress is reported through Perinatal Improvement Board and QSAC.

Operationally, there are daily staffing meetings and staff are deployed across the service in response to staffing demands. A board-level review will be completed in line with the recommendations.

A workforce review was completed earlier this year by the interim Director of Midwifery and interim Deputy Director of Midwifery with support from the LMNS. This supported improved oversight of the workforce and further alignment with the recommendations set out within the birthrate plus report. Following a review of the budget within the planned care group. A revenue request will be submitted to meet the requirements of Birthrate plus and the interim Director of Midwifery's professional judgement on the needs of the service. These requirements must be met, to ensure compliance with MIS. This must be achieved by 30 November 2026.

A medical workforce working group will be established, in September, following feedback received regarding the current medical provision across obstetrics. Midwifery colleagues in maternity triage have raised concerns regarding the length of time women are waiting in triage for a registrar review. The length of time for medical review will be reported through the maternity and neonatal oversight report that is presented monthly to QSAC.

The 10-point plan sets out that where specialist roles exist, other staff should have the knowledge and skills to ensure care is not compromised when these staff are not immediately available. The service has already been improving resilience in this area. For example, there are bereavement champions in place and birth suite coordinators have also completed additional training to support women and families, in the absence of a bereavement midwife. Additional midwives are also being trained to support the diabetes service with an additional diabetes specialist midwife post currently being advertised.

2.7 Trusts to review their homebirth services

Trusts are required to have reviewed their homebirth service following the request of the Chief Midwifery Officer in November 2025. In the last year there have been significant changes to the model of the homebirth service at NCM. Through learning, the homebirth service model has changed to a shift model from an on-call model. When fully staffed, this will ensure two staff are always on shift to support 24/7 operation of the homebirth service. This way of working has received support from the LMNS and Regional Maternity Team. The ongoing improvement work within the service is reported through the Perinatal Improvement Board with executive and Regional Maternity Team oversight.

A revenue request is currently being prepared to recruit 1.47wte. This would ensure the homebirth service is fully staffed to be operational 24/7 and support training.

The Consultant Midwife has been involved in the development of a national homebirth guideline as part of the regional homebirth working group. Through this ongoing

involvement, the service is assured that the current way of working aligns with the new national direction.

The National Homebirth guidance and framework is expected to be rolled out in the Autumn. Following the rollout, the service will implement the national guidance.

2.8 Responding to patient safety incidents, complaints and concerns with humanity, candour and trauma-informed approach

The service continues to respond to patient safety incidents, complaints and concerns with humanity, candour and trauma-informed approach. The Trust PSIRF policy outlines the importance of compassionate engagement throughout the process. The maternity and neonatal service has a dedicated governance lead to ensure incidents and concerns are responded to appropriately. The governance lead is supported by a quality and safety midwife following a review of the governance structure.

The service understands the importance of responding appropriately to incidents. In response, birth suite coordinators have recently completed additional training in PSIRF.

Incidents, complaints and concerns are reported through Women's Health and CBU Governance to ensure oversight and drive improvement in this area.

Throughout PSIRF investigations families are supported with compassion by family liaison officers (FLO).

2.9 Deliver safe and effective triage in maternity services

The Trust is committed to delivering a safe and effective triage service. A board-level audit will be completed by 26 September 2026 to review the triage service. The audit will be conducted in line with the recently published NHS England National Maternity triage Specification.

The Board will continue to be updated on maternity triage quality and performance through monthly QSAC data reporting. The triage service will continue to use a national recognised tool (BSOTS) to triage women who contact the service.

NCM Maternity Triage service has been benchmarked against the RCOG Good Practice Paper No. 8: Maternity Triage and is aligned with the national standards for safe and effective triage care. Performance is monitored through governance, audit and Safe Care reporting, with ongoing service improvements.

Staff have raised concerns about the length of time women are waiting for registrar review in triage. Once reviewed by a midwife, some attendees to triage require a review by a registrar, timescales for review are determined by the categorisation at triage. When people are waiting for a significant length of time, some are choosing to self-discharge. The midwifery team are currently mitigating the risk through escalation, red flag reporting and appropriate transfer of patients who require immediate review. The team maintain good oversight of the waiting room to ensure deterioration is escalated.

To support improvement work, an ANDU (antenatal day unit) and Triage working group has been established. In line with the requirements, improvement plans will be shared with the Board and NHS England regional team.

2.10 Post death care

The actions set out following the Fuller and NUH reviews have been reported to QSAC through the Mortuary Report which was presented in July. This supports the Trust's accountability for ensuring the deceased are treated with the dignity, compassion and respect they deserve.

The Trust has completed the required responses relating to post death care by 31 July 2026 and confirmed to the Regional Midwife on 6 August 2026.

3. Monitoring/reporting routes

This report will be monitored through Women's and Children's CBU Governance and Perinatal Improvement Board.

4. Recommendations

The Trust Board members are requested to note the comments within this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/083i**			
Subject:	**2025–2026 Annual Submission to NHS England North West – Appraisal, Revalidation and Medical Governance for Warrington and Halton Hospitals NHS FT**			
Date of meeting:	7 October 2026			
Action required:	**Approval**			
Author(s):	Dr Anne Robinson, Responsible Officer Dr Ian Kilroy, Associate Medical Director for Appraisal and Revalidation Kate Davidson, Medical Education Manager			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: Workforce equality considerations apply. Assurance includes analysis by protected characteristic and, where available, country of primary medical qualification, supported by equality impact assessment and policy governance arrangements.			
Executive summary:	This report provides assurance on appraisal, revalidation and medical governance arrangements for 1 April 2025 to 31 March 2026.			

	The designated body remained compliant with the Medical Profession (Responsible Officers) Regulations 2010, as amended. At 31 March 2026, 375 doctors had a prescribed connection; 334 appraisals were completed and 34 missed appraisals were approved. Twenty-one revalidation recommendations were submitted to the GMC: 19 positive recommendations and two deferrals. No recommendations were late, no doctor failed to revalidate, and one non-engagement referral to the GMC was made. Quality assurance was maintained through individual feedback, ASPAT and local review, reporting through the Appraisal and Revalidation Group and Educational Governance Committee, and regional peer review. Six new appraisers were trained in November 2025. Medical governance arrangements continued to support decisions through information on incidents, claims, complaints and concerns, with established arrangements for equality assurance, employment checks, Freedom to Speak Up and information transfer between Responsible Officers. The principal residual risk is insufficient funded appraisal capacity. A requirement for 404 appraisals or equivalent reviews leaves a shortfall of 45. Priorities for 2026/27 are to record and manage this risk; review funding, remuneration and capacity; complete integration of the North Cheshire and Mersey Appraisal and Revalidation Team; ratify revised policies; maintain appraisal quality improvement; update the Medical Practice Information Transfer procedure; and participate in further external peer review.		
Purpose: (please select as appropriate)	**Approval** ✓	**To note**	**Decision**
Recommendation:	The Board is asked to note the compliance position and governance updates, approve submission of the Annual Responsible Officer Report for 2025/26, and support the improvement actions for 2026/27.		
Previously considered by:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/26/09/108	
	Date of meeting	16 September 2026	

	Summary of Outcome	Report considered for assurance and onward submission to the Trust Board.
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	Following Board approval, submit the Annual Responsible Officer Report to NHS England North West by 30 October 2026. Monitor delivery of the 2026/27 actions through established governance routes.	
Freedom of information status (foia):	Release Document in Full	
Freedom of information exemptions applied: ***(if relevant)***	None	

1. Background/context

This report presents the designated body's annual assurance for 1 April 2025 to 31 March 2026. It summarises compliance with the Medical Profession (Responsible Officers) Regulations 2010, as amended; the quality of appraisal and revalidation arrangements; medical governance controls; and preparations for the transition to North Cheshire and Mersey NHS Foundation Trust following the acquisition of Bridgewater Community Healthcare on 1 April 2026. Dr Anne Robinson remained Responsible Officer, supported by the Appraisal and Revalidation Team and the Trust's medical leadership and governance structures.

2. Key elements

Compliance and operational assurance. Revalidation panels operated within expected timescales, doctors were notified in advance, and outstanding evidence was actively managed. SARD and GMC records were reconciled monthly, and new, bank and short-term doctors received induction and one-to-one support. Overdue appraisals and non-engagement were managed through reminders, individual support and escalation to the Responsible Officer.

Quality assurance. Appraisers maintained evidence of education, network participation and continuing professional development. Six new appraisers were trained in November 2025. ASPAT, local review and individual feedback supported improved appraisal quality, with assurance reported through the Appraisal and Revalidation Group and Educational Governance Committee. Actions from the October 2024 peer review were completed, and an action plan followed participation in a neighbouring Trust peer review in October 2025.

Medical governance. Regular liaison with the Governance Department ensured appraisal and revalidation decisions were informed by serious incidents, claims, complaints and individual concerns. Monthly medical triangulation and case oversight arrangements supported timely review. The MHPS policy was ratified in May 2026.

Equality analysis, employment checks, Freedom to Speak Up arrangements and Medical Practice Information Transfer processes provided further assurance.

Policies and organisational transition. Appraisal and revalidation policies were reviewed for the new team structure and the scope of North Cheshire and Mersey NHS Foundation Trust. Formal ratification remains outstanding.

3. Actions required/responsible officer

Complete implementation of the combined North Cheshire and Mersey Appraisal and Revalidation Team, including clear roles, leadership transition and ongoing capacity review.	Responsible Officer, Associate Medical Director and Medical Education Manager
Record the appraisal-capacity shortfall on the Trust risk register and review appraisal and medical leadership budgets.	Medical Director, Associate Medical Director and Finance
Deliver development on fairer feedback, SMART personal development plans and improved appraisal summaries.	Appraisal and Revalidation Leads
Participate in the planned external peer review and continue regional network development and appraisal quality assurance.	Responsible Officer and Appraisal and Revalidation Leads

4. Measurements/evaluations

Appraisals completed	334
Approved missed appraisals	34
Unapproved missed appraisals	7
Revalidation recommendations	21: 19 positive and 2 deferrals
Late recommendations / doctors who did not revalidate	0 / 0
Non-engagement referrals	1
Appraisers and wider demand	78 appraisers; 404 appraisals or equivalent reviews required; shortfall of 45
Medical concerns / completed processes	4 / 1

New doctors / pre-employment checks completed	90 / 90

5. Trajectories/objectives agreed

- Maintain compliance with statutory appraisal, revalidation and medical governance requirements.
- Resolve and formally manage the appraisal-capacity and funding shortfall.
- Complete integration of the North Cheshire and Mersey Appraisal and Revalidation Team and clarify leadership responsibilities.
- Ratify revised policies and embed consistent processes across the new Trust.
- Improve appraisal quality through fairer feedback, SMART PDPs, stronger summaries, ASPAT review and calibration.
- Increase use of specialty benchmarking data and strengthen information transfer arrangements.
- Continue external peer review, regional networking and shared learning.

6. Monitoring/reporting routes

Performance, quality assurance and governance matters will be monitored through the Appraisal and Revalidation Group and Educational Governance Committee, with medical concerns reviewed through monthly medical triangulation and case oversight arrangements. Wider assurance will continue through the Operational People Committee, Strategic People Committee, regional Responsible Officer networks, NHS England North West reporting and external peer review. Progress against the 2026/27 actions and the appraisal-capacity risk will be reported through these established routes.

7. Timelines

Milestone	Timeline
Strategic People Committee consideration	16 September 2026
Trust Board consideration and approval	7 October 2026
Submission to NHS England North West	By 30 October 2026
External peer review	Late 2026
Team integration, policy ratification, capacity review and quality improvement actions	During 2026/27, monitored through established governance arrangements

8. Assurance committee (if relevant)

The Strategic People Committee provides assurance on appraisal, revalidation, workforce and medical governance matters before onward reporting to the Trust Board. Supporting assurance is provided by the Appraisal and Revalidation Group, Educational Governance Committee and Operational People Committee.

9. Recommendations

1. Note the compliance position and governance updates for 2025/26.

2. Approve submission of the Annual Responsible Officer Report for 2025/26 to NHS England North West.
3. Support the improvement actions for 2026/27, including formal management of the appraisal-capacity risk, review of funding and capacity, completion of team integration, policy ratification and continuing quality assurance.

Appendix 1 2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **30 October 2026**

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Warrington and Halton Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	NHS

	Name	**Email**
Responsible Officer	Dr Anne Robinson	anne.robinson9@nhs.net
Medical Director	Dr Paul Fitzsimmons	paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Hilary Furniss	hilary.furniss@nhs.net
Deputy AMD Appraisal & Revalidation	Dr Ian Kilroy	i.kilroy@nhs.net
Medical Education Manager	Mrs Kate Davidson	kate.davidson4@nhs.net
Appraisal and Revalidation Manager	Ms Paula Harris	Paula.Harris6 @nhs.net
Medical Workforce Development Administrator – A&R	Mrs Sosanna Thomas	Sosanna.thomas@nhs.net

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses.

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

……
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes

Action from last year:	Dr Anne Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings
Comments:	Completed
Action for next year:	Dr Anne Robinson to continue as Responsible Officer supported by the A&R Team following the acquisition of Bridgewater Community Healthcare and change of organisation to North Cheshire and Mersey Foundation Trust from 1st April 2026.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes

Action from last year:	• Retirement of Revalidation Lead March 2025 – Review of organisational structure and roles – Recruitment to new posts • Review capacity and resources in preparation for acquisition of Bridgewater
Comments:	• Restructure of A&R Team and recruitment to Medical Workforce Development Team Leader – A&R and Medical Workforce Development Administrator – A&R • Meetings with equivalent A&R staff from Bridgewater to understand roles and responsibilities and plan for combining workloads.
Action for next year:	• Establishing clear roles and responsibilities within the combined A&R team for NCM. • Retirement of AMD, Deputy AMD to take over as AMD and review of Deputy AMD Role and recruitment as necessary as part of restructuring of NCM. • Ongoing monitoring and review of capacity and resources.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Continuation of processes surrounding cohesive SARD accounts and GMC registrations.
Comments:	A monthly review is completed and is working efficiently.
Action for next year:	Continue the same processes

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review policies in line with structure change within the department and Trust Update ARG ToR and schedule of work to support new structure
Comments:	Policies reviewed in relation to the restructure within the Team and scope of policies reviewed to ensure they meet the new Trust North Cheshire and Mersey NHSFT

Action for next year	Policies to receive ratification by the relevant approval structure.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	WHH to take part in a peer review of a neighbouring Trust, Royal Liverpool University Foundation Trust, scheduled for October 2025, alongside Mersey and West Lancashire Foundation Trust. To continue work on the action plan from the WHH peer review in October 2024.
Comments:	Peer review undertaken 3/10/24 by two neighbouring Trusts (RLUFT and MWLFT). Report and Action plan devised following feedback which is monitored by the ARG group and reports to OPC. Actions now completed: 1. Recruitment of new appraisers – appraiser training in November 2025 (last appraiser training October 2024) 2. Review MPIT process. Report back to ARG every two months **Review the use of a common platform for newly started doctors** 1. Action plan for WHH developed after peer review of neighbouring Trust (LUHFT) in October 2025: 2. Creation of Microsoft form for doctors new to the Trust to request A&R information 3. New starters to be invited to an induction meeting with the A&R team to give an overview of the Trust's processes and appraisal system 4. Job descriptions for Responsible Officer and Associate Medical Director 5. Discussions with managing concerns.
Action for next year:	Attendance at the peer review of Mersey and West Lancashire Foundation Trust alongside Royal Liverpool University Foundation Trust, scheduled for November 2026.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	- Continue focus work regarding A&R with FY2 doctors - Establish 1 to 1 meetings with newly appointed doctors

Comments:	- AMD attends FY2 teaching session to deliver and overview of A&R. - All new starter doctors including short term and Bank doctors have a 1:1 meeting with the AMD or Deputy AMD.
Action for next year	Continue with the same process.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Review educational supervisor's appraisals to ensure they meet the required standards.
Comments:	Regular updates at appraiser forum regarding educator appraisal and the supporting information requirements.
Action for next year:	Continue with the same process.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue with current processes.
Comments:	All colleagues are treated on an individual basis with particular circumstances considered when entering into discussions. Regular reminders are sent out via the SARD electronic platform and one-to-one meetings are offered to support confidential discussions and create personal support plans to provide the best opportunity to engage with the process. The Trust prioritises shared understanding of the objectives behind appraisal ensuring the exercise is meaningful and achieves intended outcomes bringing continued professional development to the forefront. If, following the offer of support mechanisms above, engagement continues to be an ongoing concern, a face-to-face appointment is scheduled with the RO in line with the escalation process.

	In order to ensure triangulation of doctors having difficulty and the support being offered the RO has open discussion with GMC to provide awareness and assurance.
Action for next year:	Continue with current processes.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Review policy following completion of the organisational and departmental structure change
Comments:	Policies reviewed in relation to the restructure within the Team and scope of policies reviewed to ensure they meet the new Trust North Cheshire and Mersey NHSFT
Action for next year:	Policies to receive ratification by the relevant approval structure.

1B(iv) Our organisation has the necessary number of trained appraisers1 to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No
Action from last year:	Appraiser training booked 5th November 2025 6 new appraisers following training on 5th November 2025.
Comments:	Following the training the Trust has 78 current appraisers for 389 doctors at 31st March 2026. The Trust job plans 0.125 PAs for appraising up to 4 appraisees. 9 appraisers appraise up to 8 appraisees with 0.25 PAs in their job plans. The outstanding issues of concern are: The budget has not risen year on year in accordance with the increasing number of Trust doctors requiring an appraisal each year and does not have sufficient funding to cover all appraisals. There is currently a shortfall of 45 appraisals. In 2022 the number of doctors connected to the Trust was 298 plus 20 Physician Associates, totalling 318 appraisals required and equating to 9.938 job planned PAs for appraisal (0.125 PAs = 4 appraisals). On the 31st March 2026 the number of doctors connected to the Trust had risen to 389 plus 13 Physician Associates and 2 Anaesthetics

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	Associates totalling 404 appraisals required and 12.625 job planned PAs for appraisal (0.125 PAs = 4 appraisals). Actions agreed with the Medical Director: 1. Following the acquisition of Bridgewater, ensure parity of renumeration and appraisee allocation for all appraisers across the new Trust. 2. Ensure all business cases for new consultants/specialty doctors include allocated funding for appraisal and revalidation. 3. Annual review form introduced for some Bank and temporary contract doctors, instead of full formal SARD appraisal, as an interim episode of appraisal. The form is completed with the doctor by clinical/educational supervisor, clinical lead or supervising consultant. 4. The Medical Director to review the medical leadership budget to ascertain any available funding.
Action for next year:	Add shortfall of appraisers as a risk to the risk register. Review budget with Medical Director and AMD and Finance in light of the Bridgewater acquisition and re-alignment of medical leadership budget.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Review the process for managing overdue appraisals in line with the organisational structure change to consider responsibilities of the new roles and departmental structure Offer support and training to appraisers who are lower performing on QA
Comments:	Process for managing overdue appraisals reviewed and established within the new roles of the A&R Team. The QA and ASPAT scores highlight an improvement. Individual feedback on every appraisal summary is provided to be appraiser and appraisee.
Action for next year:	Arrange a session on Fairer Feedback and offer training on SMART PDPs and improved appraisal summaries.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes

Action from last year:	Continue with reporting of QA appraisal
Comments:	Reporting structure has changed to include Educational Governance Committee as an additional mechanism for assurance.
Action for next year:	Continue with current QA process.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Options appraisal to decide most effective presentation of information for revalidation decision making panels
Comments:	Options appraisal completed and decision to continue with the same process for revalidation panels. Recommendations are made within the expected timescales.
Action for next year:	Continue with current processes.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue current processes
Comments:	Upcoming recommendations are reviewed in advance as per our policy and correspondence shared with doctors advising them of the date and requirements at least 6 weeks prior. Individual emails are also sent if there is a particular outstanding requirement such as MSF. Panels are scheduled with time prior to the revalidation deadline so if outcome is not positive the Doctor has time to complete outstanding requirements, and a further review take place. Anyone still not meeting the criteria when the submission is due will be deferred and contacted with a comprehensive explanation of requirements and timeframe for completion.
Action for next year:	Continue current processes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	Regular contact is maintained between the appraisal and revalidation group and the Governance department. The governance department supply information on request. • Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion. • Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims • Ad-hoc reports to inform governance requests on individual doctors.
Action for next year:	Continue with current processes

1D(ii) Effective systems in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Use of NCIS data and other relevant benchmarking data to be incorporated into individual appraisals
Comments:	This is included in appraisals by individual doctors in the specialties it is available for. Doctors are encouraged to upload any benchmarking data appropriate to the specialty, e.g. NCIS, JAG, NJR
Action for next year:	Explore opportunities for increased declaration of benchmarking data.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Continue current processes

Comments:	SARD - governance reports, Appraiser training dates, previous appraisals, PDPs, MSFs all uploaded
Action for next year:	Continue current processes

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	The MHPS Policy was ratified at OPC in May 2026 and the next review date for this policy is May 2029.
Comments:	The MHPS policy follows the national guidance on maintain high professional standards and incorporates all of arrangements listed above.
Action for next year:	No action required.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue current processes
Comments:	The Trust has established governance and quality assurance arrangements for managing concerns about doctors. The MHPS and employee relations frameworks incorporate the principles of a just and learning culture, with clear requirements for proportionate action, minimising and regularly reviewing exclusions, timely case progression, effective communication and access to appropriate health and wellbeing support. Individuals appointed to formal case roles, including case managers, investigating officers and hearing chairs, receive role-specific training and are supported by qualified HR professionals. Compassionate and inclusive leadership development is available to managers and medical staff to reinforce fairness, respect and appropriate handling of concerns. Medical triangulation meetings are held monthly, chaired by the Medical Director and attended by the Responsible Officer with HR Business Partner support. Monthly case oversight is also undertaken by the Chief People Officer. The Head of HR and OD contributes to meetings with the

	GMC Responsible Officer and Employer Liaison Adviser, alongside the Responsible Officer and Medical Director, supporting appropriate external oversight and information sharing. Case management information is reviewed through regular debriefs and lessons-learned processes. Assurance reporting is provided to the Operational People Committee and Strategic People Committee, including case volumes, themes, outcomes, timeliness and analysis by protected characteristic. This enables trends, potential disparities and areas for improvement to be identified, monitored and addressed.
Action for next year:	Continue current processes.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	MPIT process review to be undertaken as part of the organisational restructure
Comments:	Use of recognised process for sharing information between Responsible Officers (RO) via a Medical Practice Information Transfer form (MPIT) which is provided by NHS England. We request information for new starters to WHH from their previous employer's RO and also respond to requests we receive to provide information regarding doctors who have previously worked at WHH. However, the MPIT process is not restricted to when doctors change employers, and we use this process to share information of note about a doctor as and when the need arises. An example of this would be when a doctor works at WHH as well as an independent healthcare provider and there is information of note which our RO needs to share.
Action for next year:	Update SOP as part of team and organisational restructure

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes

Action from last year:	Continue with current process.
Comments:	The Trust has a robust and established process for completing equality impact assessments for all new and revised policies. Assessments are scrutinised through the relevant ratification arrangements, and policies are reviewed at least every three years. The assessment considers protected characteristics, socioeconomic factors, health inequalities, and the Armed Forces and military veterans community. This enables potential adverse impacts to be identified and addressed, while also highlighting opportunities to promote positive outcomes and ensure that policies and processes are fair and free from bias and discrimination. The Workforce Equality, Diversity and Inclusion Team undertakes a quality assurance review of completed assessments, providing further assurance that equality considerations are applied consistently and embedded within the Trust's policy governance arrangements.
Action for next year:	Continue with current process

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	MHPS policy review and ratification
Comments:	The policy was ratified in May 2026. The Trust's Sexual Safety at Work arrangements have been embedded across the organisation and are supported by an approved policy, providing a clear framework for prevention, reporting, response and ongoing assurance.
Action for next year:	Continue with current process

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review.

Action from last year:	Continue with current processes Implementation of Sexual Safety at work in WHH
Comments:	**All actions identified for the reporting period have been completed. These were:** • Full embedding of Good Medical Practice 2024 within the SARD appraisal system, with relevant information communicated to appraisers and appraisees.

	• Implementation and Trust-wide dissemination of the Medical Internal Professional Standards. • Embedding of the Sexual Safety at Work arrangements, supported by an approved policy and associated awareness and engagement activity, including the planned GMC session. Completion of these actions provides assurance that national professional standards requirements and learning have been incorporated into the Trust's systems, policies and organisational practice.
Action for next year:	Continue with current processes

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Continue with current processes. Agency - For all agency workers we are required to check BLS/ALS/APLS and advise department which level the doctor currently has. For ST3+ O&G short term locums in maternity care we have been asked to check if they have a Certificate of Eligibility (as per RCOG requirements) and MRCOG.
Comments:	The Trust's Recruitment Team ensure that the 6 Employment Checks as per the NHS Employers are carried out for all Doctors recruited into the organisation as follows, with governance processes in place to ensure any risks identified are reviewed in conjunction with the HR Business Partnering Team: - • Identity • Right to Work • Professional Registration & Qualifications • Employment History & Reference Standards • Criminal Record • Work Health Assessment Standards
Action for next year:	All pre-employment check processes remain unchanged so will continue to be followed.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	The Trust has launched its **Our Values in Action** Behavioural Framework to provide Medical and Dental staff, alongside colleagues across the organisation, with clear and consistent expectations based on being **Kind, Open, Fair and One Team**. Supported by dedicated communications, practical resources, flexible learning sessions and guidance for constructive conversations, the framework helps colleagues recognise and address behavioural concerns, strengthen teamwork and inclusion, support staff wellbeing and enhance patient care. The Trust is embedding these expectations throughout recruitment, induction, development, leadership and workforce processes, while using Staff Survey feedback and other measures to evaluate impact and drive continued cultural improvement across the wider Trust.
Action for next year:	Continue with current processes

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue to embed the principles of compassionate and inclusive leadership, as well as alignment to the Staff Survey results and targeted training. For example, reasonable adjustments and inclusive leadership. Implement in full the active bystander programme.
Comments:	These practices are now embedded within the Trust's routine governance and organisational culture arrangements. Staff networks contribute to the review of policies and processes and are integral to the equality impact assessment process. The Trust's Culture Plan reinforces equality, diversity, compassion and inclusion across the organisation. The FREDA principles of fairness, respect, equality, dignity and autonomy are embedded within the impact assessment framework alongside consideration of protected characteristics. Equality, diversity, inclusion and culture-related risks are routinely monitored through the Trust's

	established governance arrangements, with medical leadership represented within the relevant oversight forum. The Trust's annual equality, diversity and inclusion reporting provides ongoing assurance and oversight. The Medical Internal Professional Standards have also been embedded following their review and alignment with Good Medical Practice 2024, Trust values, NHS Staff Survey findings and identified workforce themes.
Action for next year:	Continue with current processes.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	Since 2024 there has been more dedicated time allocated for the FTSU Guardian. This has enabled further engagement work with colleagues within the People Directorate namely HR BP team and Culture and inclusion team to develop and deliver sexual safety in the workplace training and to have more time to manage FTSU cases. The disclosures from FTSU are triangulated with staff survey results and other workforce data to provide more support to areas in the Trust highlighted as requiring this.
Action for next year:	Continue with current processes

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Targeted work on sexual safety and active bystander, including alignment with refreshed results from the NHS Staff Survey.
Comments:	During 2025–2026, engagement with the Medical and Dental workforce has continued through established organisational arrangements, supported by the Culture and Inclusion and Freedom to Speak Up functions. This has included ongoing engagement on Good Medical Practice 2024, Sexual Safety at Work, professional standards and relevant NHS Staff Survey findings. The Medical Internal Professional Standards are now embedded and aligned with Good Medical Practice 2024 and the Trust's values. Feedback from engagement activity,

	staff survey results and workforce intelligence is routinely considered to identify themes, inform improvements and provide assurance that professional standards processes remain responsive, inclusive and subject to ongoing review. Established routes remain available for doctors to raise concerns or provide feedback, including Freedom to Speak Up and the Trust's formal complaints and employee relations processes.
Action for next year:	Continue with current processes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act

Y/N	Yes
Action from last year:	Review the Policy and ensure that when the acquisition takes place that this is smooth and does not lend itself to any misunderstanding of use of the Policy.
Comments:	All Medical and Dental staff are managed where applicable under the MHPS framework. Where there is necessity to invoke the disciplinary policy there has been a new process implemented where a review of the situation is conducted, and a decision is made as to what is the appropriate next steps. This falls under the Trust Disciplinary Policy which is for all staff and is due to be reviewed to ensure EDI equality.
Action for next year:	Continue with current processes.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Complete outstanding actions as listed above. Continue with meeting attendances and networking
Comments:	Attendance and networking at regional RO meetings and Revalidation Lead meetings, by the A&R team. Actions from peer review in October 2024 now completed: • **Recruitment of new appraisers** – appraiser training in November 2025 (last appraiser training October 2024) • **Review MPIT process. Report back to ARG every two months**

	• **Review the use of a common platform for newly started doctors** Action plan for WHH developed after peer review of neighbouring Trust (LUHFT) in October 2025: • Creation of Microsoft form for doctors new to the Trust to request A&R information • New starters to be invited to an induction meeting with the A&R team to give an overview of the Trust's processes and appraisal system • Job descriptions for Responsible Officer and Associate Medical Director • Discussions with managing concerns.
Action for next year:	Attendance at the peer review of Mersey and West Lancashire Foundation Trust alongside Royal Liverpool University Foundation Trust, scheduled for October 2026.

Section 2 – metrics
Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	375
Total number of appraisals completed	334
Total number of appraisals approved missed	34
Total number of unapproved missed	7
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	21
Total number of late recommendations	0
Total number of positive recommendations	19
Total number of deferrals made	2
Total number of non-engagement referrals	1
Total number of doctors who did not revalidate	0
Total number of trained case investigators	7 MHPS
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer[2]	4
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	256
Median duration of concerns processes closed (working days)[3]	0
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	90 (including foundation doctors)
Total number of new employment checks completed before commencement of employment	90
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary
This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Overall, the majority of actions identified in the previous reporting period have been completed or embedded into routine practice. Key achievements include: • The Appraisal and Revalidation Team was restructured, with recruitment completed to the new team roles and preparatory work undertaken with Bridgewater colleagues. • Appraisal and revalidation policies were reviewed and updated to reflect the new team and organisational structure. • Monthly reconciliation of SARD records and GMC registrations continued effectively. • Targeted support for FY2 doctors and one-to-one induction meetings for new, bank and short-term doctors were established. • Educational supervisor appraisal requirements continued to be reinforced through appraiser forums. • The process for managing overdue appraisals was reviewed and incorporated into the new team structure. • Six new appraisers were trained in November 2025, increasing the Trust's appraiser pool. • Appraisal quality assurance arrangements were strengthened, including individual feedback and reporting through the Educational Governance Committee. • The options appraisal for revalidation panel information was completed, with the existing process retained. • The MHPS policy was reviewed and ratified in May 2026. • Governance, benchmarking, information-sharing, equality assurance and Freedom to Speak Up processes continued to operate and were further embedded. • Actions arising from the October 2024 peer review were reported as completed, including new appraiser recruitment, review of the MPIT process and consideration of a common platform for new starters. • Good Medical Practice 2024, Medical Internal Professional Standards and Sexual Safety at Work arrangements were embedded across relevant Trust systems and processes
Actions still outstanding
The following actions are not yet fully complete or require further review: • Formal ratification of the revised appraisal and revalidation policies remains outstanding. • Full implementation of the combined North Cheshire and Mersey Appraisal and Revalidation Team structure, including clarification of roles, leadership transition and ongoing capacity monitoring, remains in progress. • The Trust continues to have insufficient funded appraisal capacity, with a reported shortfall of 45 appraisals. This requires formal risk registration and further budget review. • Further work is needed to increase consistent declaration and use of specialty benchmarking data within appraisal. • The MPIT standard operating procedure requires updating to reflect the new team and organisational structure.

- The action plan arising from the October 2025 peer review includes further work on new-starter information, induction arrangements, job descriptions and links with the managing-concerns process.
- The next external peer review is scheduled for late 2026.

Current issues

Main challenges: insufficient appraisers and financial constraints
The Trust's current challenges are an insufficient number of appraisers with funded capacity and an inadequate budget to meet sustained workforce growth. At 31 March 2026, 78 appraisers supported 389 connected doctors. Including 13 Physician Associates and two Anaesthesia Associates, 404 appraisals or equivalent reviews were required. Existing appraiser availability and job-planned capacity cannot meet this demand, leaving a shortfall of 45 appraisals.

The capacity problem is driven by financial constraint. Appraisal activity is normally allocated at 0.125 programmed activities (PAs) for up to four appraisees; nine appraisers receive 0.25 PAs for up to eight appraisees. Demand has increased substantially since 2022, when 318 appraisals were required, but the budget has not increased proportionately. Required job-planned capacity has risen from approximately 9.94 to 12.63 PAs, without the funding needed to recruit, allocate or remunerate sufficient appraisers.

Risk and interim control
Unless both the appraiser shortfall and the underlying financial gap are addressed, the Trust may be unable to provide timely appraisal coverage for all eligible practitioners. Interim annual review arrangements have been introduced, where appropriate, for some bank and temporary-contract doctors and are completed with a clinical or educational supervisor, clinical lead or supervising consultant. These arrangements provide interim oversight but neither increase the substantive appraiser workforce nor resolve the recurring funding deficit.

Agreed actions
- Record the appraisal-capacity shortfall on the Trust risk register.
- Review the appraisal and medical leadership budgets with the Medical Director, Associate Medical Director and Finance following the Bridgewater acquisition and organisational realignment.
- Ensure parity of remuneration and appraisee allocation for appraisers across the new Trust.
- Require business cases for new consultant and specialty doctor posts to include appropriate funding for appraisal and revalidation.
- Continue to review capacity, demand and the effectiveness of interim arrangements during implementation of the combined organisational structure.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

The **new actions for next year**, excluding actions that simply continue or repeat last year's activity, are:
- **1A(i)**: Support Responsible Officer following the acquisition of Bridgewater Community Healthcare and the establishment of North Cheshire and Mersey Foundation Trust from 1 April 2026.
- **1A(ii)**:
    - Establish clear roles and responsibilities within the combined North Cheshire and Mersey Appraisal and Revalidation Team.

    - Manage the retirement of the Associate Medical Director, transition the Deputy Associate Medical Director into the role, and review and recruit to the vacant deputy role as required.
    - Monitor and review team capacity and resources following organisational restructuring.
- **1A(iv):** Obtain ratification of the revised appraisal and revalidation policies through the relevant approval structure.
- **1A(v):** Participate in the peer review of Mersey and West Lancashire Teaching Hospitals NHS Trust alongside Liverpool University Hospitals, scheduled for late 2026.
- **1B(iv):**
    - Add the shortfall in appraisal capacity to the Trust risk register.
    - Review the appraisal budget with the Medical Director, Associate Medical Director and Finance following the Bridgewater acquisition and realignment of the medical leadership budget.
- **1B(v):**
    - Arrange a session on fairer feedback.
    - Provide training on SMART personal development plans and improving appraisal summaries.
- **1D(ii):** Explore opportunities to increase doctors' declaration and use of specialty benchmarking data within appraisal.
- **1D(vi):** Update the standard operating procedure for Medical Practice Information Transfers as part of the team and organisational restructure.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

During 2025–2026, the organisation continued to strengthen its appraisal, revalidation and medical governance arrangements. Appraisal quality improved, as evidenced by ASPAT scoring and recognition through the Appraiser of the Year award. The Appraisal and Revalidation Team was successfully reorganised, preparatory work supported the integration of Warrington and Halton and Bridgewater services, and appraisal and revalidation policies were updated for the new Trust. The new behavioural framework was introduced, and continued participation in peer review supported shared learning and improvement across organisations.

The principal challenges remain insufficient appraisers with funded capacity and the financial constraints affecting the Trust's ability to provide timely appraisal coverage for its growing workforce. Addressing the appraiser shortfall and securing sustainable funding will therefore remain key priorities.

For the coming year, the organisation aims to fully integrate the Appraisal and Revalidation Team following the Bridgewater acquisition, embed revised policies and consistent processes across North Cheshire and Mersey NHS Foundation Trust, and continue improving appraisal quality. Priorities also include a successful handover of the Associate Medical Director role, appointment of a new deputy, and continued collaboration with other Trusts through peer review and shared learning. These actions will support safe, equitable and sustainable appraisal, revalidation and professional standards arrangements across the new organisation.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Warrington and Halton Hospitals NHSFT

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Anne Robinson
Email address:	Anne.robinson9@nhs.net

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/083ii**			
Subject:	**2025-2026 Annual Submission to NHS England North West – Appraisal, Revalidation and Medical Governance for Bridgewater Community Healthcare NHS FT**			
Date of meeting:	7 October 2026			
Action required:	**Approval**			
Author(s):	Dr Anne Robinson, Responsible Officer & Medical and Dental Appraisal Lead Brittney Chu, Business Manager to the Medical Director			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
	Further Information / Comments:			
Executive summary:	This report provides an overview of the Trust's compliance with the Medical Profession (Responsible Officers) Regulations 2010, covering appraisal, revalidation, and medical governance for the period 1 April 2025 to 31 March 2026. It demonstrates governance oversight and supports ongoing quality improvement. During this year, Bridgewater Community Healthcare NHS Foundation Trust (BCHFT) had 13 doctors with a prescribed connection, 100% of whom had their annual appraisal during this period. No revalidation recommendations were required during this year. Appraiser capacity has remained sufficient, with plans in 2026 to incorporate appraisal responsibilities into job			

<table>
<tr><td></td><td colspan="3">plans. This will ensure appraisers have dedicated time to undertake appraisal activities effectively and maintain the quality of the appraisal.

Ongoing training, peer review, and participation in regional RO networks will continue. Monitoring and reporting systems for professional standards, induction, and appraisal—including for locum doctors—will be maintained.

The key priority for the coming year will be aligning appraisal and revalidation policies, governance processes, quality assurance arrangements and the combined appraiser pool to ensure a consistent approach across the newly integrated organisation of NCM. The focus will remain on maintaining high-quality appraisal processes, supporting doctors' professional development and ensuring compliance with national revalidation requirements.</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">This report provides assurance that the Trust is meeting its statutory responsibilities regarding medical appraisal and revalidation and medical governance. Key actions below highlighted the improvement planned in 2026/207:

1. Continue participation in Responsible Officer and appraisal network events and apply relevant learning to local processes.

2. Introduce the quality assurance of appraisal through the use of Appraisal Summary and PDP Audit Tool (ASPAT) and peer review.

3. Complete implementation of the combined Medical Appraisal Policy and ensure it remains aligned with national guidance.

Include incorporation of appraisal responsibilities into job planning arrangements for doctors previously employed by BCHFT so that all appraisers across the new Trust have same amount of protected time.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td colspan="2">Committee</td><td>Strategic People Committee</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td>SPC/26/09/108</td></tr>
<tr><td colspan="2">Date of meeting</td><td>16 September 2026</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td>Report considered for assurance and onward submission to the Trust Board.</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting</td><td colspan="3">Following Board approval, submit the Annual Responsible Officer Report to NHS England North West</td></tr>
</table>

or requires additional monitoring	by 30 October 2026. Monitor delivery of the 2026/27 actions through established governance routes.
Freedom of information status (foia):	Release Document in Full
Freedom of information exemptions applied: ***(if relevant)***	None

1. Background/context

This report provides updates on medical appraisal compliance and revalidation recommendations. It also describes the arrangement for appraisal and revalidation in the transition to the new integrated Trust.

2. Key elements - Medical Appraisal and Revalidation Compliance

2.1. There were 13 doctors attached to Bridgewater as a designated body for appraisal and revalidation.

2.2. During the reporting period, the Trust demonstrated full compliance with medical appraisal requirements. 13 doctors attached to BCHFT completed their appraisal within the required timescales, ensuring full compliance. The appraisals were conducted in line with the Trust's updated medical appraisal policy, which incorporated a new supporting toolkit and was aligned with the 2024 Good Medical Practice (GMP2024) framework.

2.3. Governance oversight of appraisal activity was maintained throughout the year, with systems in place to monitor compliance and address any issues promptly

2.4. In relation to revalidation, there were no recommendations required during the 2025/2026 reporting year. The Responsible Officer ensured continuous oversight of medical performance and confirmed compliance with statutory revalidation responsibilities.

2.5. Engagement with peer review programmes, regional responsible officer (RO) networks, and quality assurance activities ensured that revalidation processes remained aligned with national standards and best practice.

3. Key Elements –

a) Quality Assurance

3.1 Updated training for appraisers and appraisees for introduction of SARD system in May 2025. SARD was introduced successfully and all 13 doctors have had one appraisal in the new system.

3.2 Medical appraisers are expected to maintain an annual record of their participation in appraisal education, appraisal network meetings and continuing professional development (CPD) within their appraisal portfolios, including reflection on learning. During the reporting period, 8 Trust appraisers were invited to attend joint appraiser update sessions with WHH, held on 3 April 2025, 11 April 2025 and 22 October 2025.

3.3 At the end of the reporting period, the Appraisal Summary and PDP Audit Tool (ASPAT) was introduced to further strengthen the quality assurance of medical appraisals by supporting the review of appraisal quality and consistency across appraisers. Appraisers now receive regular ASPAT scores quantifying the quality of their appraisal summaries.

3.4 Following the acquisition of BCHFT by WHHFT in April 2026, the Responsible Officer (RO) is now the RO of NCM. The RO has attended all regional RO Network meetings in 2025/2026 and will continue attending the regional RO Network meetings in 2026/2027 to ensure she remains up-to-date with the knowledge required for the role.

b) Medical Governance

3.5 Monthly Medical and Dental Professional Governance meetings took place, attended by the RO, Medical Appraisal Lead, Dental Clinical Director, HR Manager, Appraisal and Revalidation Manager and administrator. Any concerns about a doctor's performance were discussed at that meeting, actions agreed and monitored.

3.6 There were no significant concerns raised about doctors in the reporting period.

3.7 Any concerns raised would be reported anonymously as part of an HR report to the Strategic People Committee.

3.8 Following the formation of the new Trust NCM, plans were made for the medical governance meeting to be replaced by the new Trust triangulation meeting with the same structure.

3.9 In the lead up to the formation of NCM, the medical appraisal and revalidation compliance was reviewed monthly and discussed at the joint Trust Appraisal and Revalidation Group (ARG) Meeting (this occurs every four months).

4. Responsible Officer Annual Report

4.1 The 2025/2026 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance report is submitted today for its approval by the Board, before it is submitted to NHS England

5. Actions Required

Action	Person responsible
Complete Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance report 2025/2026 (submitted today for its approval by People Committee on 16 September 2026).	RO, Business Manager and Executive Medical Director
Submit report to Board on 7 October 2026, before it is shared with NHS England by 31 October 2026	RO, Business Manager and Executive Medical Director
Continue participation in Responsible Officer and appraisal network development events, including Small Designated Body updates, and apply relevant learning to local processes.	RO
Continue quality assurance of appraisal processes through ASPAT, peer review and calibration of appraisal practice.	RO & Business Manager
Introduction of Medical Appraisal Policy and ensure alignment with national guidance.	RO & Business Manager
Allocation of time for medical appraisers within job plan	Clinical Directors, appraisers, Job Planning Team

6. Conclusion

6.1. This report provides assurance that the Trust is meeting its statutory responsibilities regarding medical appraisal and revalidation and medical governance, and that these matters are discussed and monitored on a regular basis at the Appraisal and Revalidation Group (ARG) meeting at NCM.

6.2. The Trust maintained robust compliance with statutory requirements for medical appraisal and revalidation throughout the reporting period. All appraisals were completed within the required timeframe, no revalidation concerns arose, and governance processes remained effective in managing professional standards. The outcome reflected the strength of the Trust's oversight arrangements and its commitment to ensuring safe, high-quality medical practice.

7. Recommendations

The Board is asked to:

- Note the compliance position and governance updates.

- Approve submission of the Annual RO Report for 2025/2026.

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **30 October 2026**

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Bridgewater Community Healthcare NHS Foundation Trust
What type of services does your organisation provide?	Community Healthcare

	Name	**Email**
Responsible Officer	Dr Anne Robinson	anne.robinson9@nhs.net
Medical Director	Dr Paul Fitzsimmons	paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Anne Robinson	anne.robinson29@nhs.net
Appraisal and Revalidation Manager	Brittney Chu	poyan.chu@nhs.net
Additional Useful Contacts		

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?
~~No~~

This report concerns Bridgewater doctors only. We provide responsible officer services to two hospices. Separate reports are provided for each hospice, who share the same Responsible Officer.

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A
Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Bridgewater Community Healthcare NHS Foundation Trust
……
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Dr Robinson attended the virtual Responsible Officer Network on 5 February 2025 and will join the regional RO Network meetings in 2025/26 to ensure she remains up-to-date with the knowledge required for the role.
Comments:	During the reporting period, Dr Robinson served as the Trust's Responsible Officer and reported to the Deputy Medical Director, David Mills, until his retirement on 1 April 2026. The acting Medical Director, Dr Paul Fitzsimmons, has an alternative R/O provided by Liverpool University Hospitals to avoid an inverse reporting relationship with BCHFT R/O. Following the integration of Bridgewater Community Healthcare NHS Foundation Trust with Warrington and Halton Teaching Hospitals NHS Foundation Trust in April 2026, Responsible Officer governance arrangements continue to be reviewed and maintained as part of the new integrated organisational

	structure to ensure continued compliance with statutory requirements.
Action for next year:	To continue with current processes

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Ensure integration work with Warrington and Halton Hospital includes review of RO responsibilities together with medical and dental appraisal responsibilities.
Comments:	Sufficient resources have been provided by the Designated body to allow the RO to complete her responsibilities. The RO is employed for 6 hours per week and is also the medical and dental appraisal lead. The RO is supported by 1 WTE medical manager Ms Brittney Chu. The Trust has used SARD, an online platform for the management of doctors appraisals with an integral 360-degree feedback tool as part of the electronic platform. This mirrors the system used at WHH. Appraisers are supported with initial and refresher training and 2/3 update forums per year.
Action for next year:	To continue with current processes

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Introduce the new SARD electronic appraisal platform into Bridgewater Community Healthcare FT together with appropriate training for medical staff. Work has commenced with the relevant supplier (SARD) to facilitate the users' training and data transfer.
Comments:	Accurate and up-to-date records have been maintained throughout the reporting period for all licensed medical practitioners with a prescribed connection to the Responsible Officer. This includes records relating to appraisal, revalidation, investigations and the management of concerns, supported by information from Electronic Staff Records (ESR), e-Rostering and Human Resources processes for new starters and leavers. During 2025–2026, the SARD web-based appraisal and revalidation system was fully implemented, with all doctors now using SARD for their appraisal documentation. The system

	provides a secure, robust and auditable repository for appraisal and revalidation information, supporting effective governance and compliance with Responsible Officer regulations.
Action for next year:	Continue to maintain accurate practitioner records through established governance processes, ensure ongoing use of the SARD appraisal and revalidation system for all doctors, and provide continued training and support to maximise effective use of the system.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	To upload the Medical Appraisal Policy and Job Planning Policy to the new SARD appraisal platform once the system went live.
Comments:	All policies supporting medical appraisal and revalidation are actively monitored and regularly reviewed to ensure they remain compliant with current statutory and regulatory requirements. These policies are available to all staff via the Trust intranet. A formal review schedule is in place, with policies normally reviewed on a three-year cycle, although they may be updated sooner in response to changes in national guidance, legislation or regulatory requirements. During the reporting period, the existing policy remained in place and accessible throughout the year. Following the integration of the two organisations in April 2026, work commenced to develop a single medical appraisal and revalidation policy for the newly formed Trust.
Action for next year	To ensure that the revised policies supporting medical revalidation. in relation to the newly formed Trust, North Cheshire and Mersey NHSFT are ratified by the relevant approval structure and introduced into the Trust.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Ensure continued R/O attendance at yearly small, designated body updates. Apply any appropriate learning from large body peer review to BW processes.
Comments:	Dr Anne Robinson continues to lead the peer review process for large, designated bodies across Cheshire and Merseyside and has considered and applied relevant learning to local processes where appropriate. Dr Robinson also attends the annual Small Designated Bodies Responsible Officer update

	and incorporates relevant learning into local appraisal and revalidation arrangements.
Action for next year:	Continue to attend the annual Small Designated Bodies Responsible Officer update and apply relevant learning to local appraisal and revalidation processes. Following the peer review with Warrington and Halton Teaching Hospitals NHS Foundation Trust, implement any identified improvements and align appraisal and revalidation processes across the integrated organisation. Attendance at the peer review of Mersey and West Lancashire Foundation Trust alongside Royal Liverpool University Foundation Trust, scheduled for November 2026.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	To continue with current processes
Comments:	All locum doctors had a comprehensive local departmental induction on starting work at Bridgewater. The Trust had a Temporary Staffing Policy and Mandatory Training and Induction Policy which outline the induction requirements for temporary staff including doctors. Doctors had a local review of their work at BCHFT and were provided with evidence to take to their appraisal at their relevant designated body. A new Service Level Agreement (SLA) with our intermediate care provider who included provision to receive details of relevant appraisers and appraisal dates to ensure Bridgewater's RO can influence development needs if required.
Action for next year	To continue with current processes

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	To work with governance department at Bridgewater and two hospices to ensure that all relevant information about significant events and complaints is proactively uploaded to SARD system prior to a doctor's appraisal
Comments:	The action identified in the previous reporting period has been completed. Governance processes have been strengthened to ensure that relevant information is available to support annual appraisal. Accurate records have been maintained throughout the reporting period, including appraisal and revalidation records, investigations, management of concerns and Human Resources processes relating to new starters. The SARD web-based appraisal system continues to provide a secure and auditable repository for appraisal documentation for all doctors with a prescribed connection. The Medical Appraisal Policy is regularly reviewed and supported by an appraisal toolkit that clearly outlines the information required for appraisal. Information relating to complaints, concerns and other governance matters is incorporated into the appraisal process through doctor self-declarations and supporting governance information.
Action for next year:	Continue with current appraisal and governance processes. Following integration with Warrington and Halton Teaching Hospitals NHS Foundation Trust, ensure appraisal governance reports incorporate incident information from the Datix reporting system to support comprehensive appraisal discussions.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	N/A
Comments:	N/A
Action for next year:	N/A

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	To upload the medical appraisal policy to the new electronic appraisal platform-SARD
Comments:	Policies are being reviewed in relation to the new Trust and will be uploaded unto the electronic appraisal system when rectified.
Action for next year:	To continue with current processes. To complete and implement the updated Medical Appraisal Policy for the newly integrated Trust, ensuring it is compliant with national guidance and approved through the appropriate governance processes.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	To provide appraisal training for doctors at BCHFT alongside training for new appraisers at Warrington and Halton Hospitals on 5 November 2025.
Comments:	The action identified in the previous reporting period has been completed. There has been a sufficient number of appraisers in place throughout the year. NHS England recommends an appraiser-to-appraisee ratio of between 1:20 and 1:5. Within the Trust, the current ratio exceeds 1:5 (approximately 1:3) to ensure a sufficiently large pool of appraisers and maintain compliance with the requirement that no appraisee is allocated the same appraiser for more than three consecutive appraisal cycles. The integration with WHH means that the some appraisers who originate from BW will work across the new organisation NCM and appraise doctors from the WHH.
Action for next year:	To review the appraiser-to-appraisee ratio across the newly integrated organisation and align arrangements with Warrington and Halton Teaching Hospitals NHS Foundation Trust.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	Appraisers from BW to have job plan review to ensure equitable renumeration for appraiser activity in alignment with WHH's appraiser

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to ensure there are sufficient trained appraisers in place and that update training is provided to all appraisers 3 times per year.
Comments:	The action identified in the previous reporting period has been completed and these arrangements will continue. Medical appraisers are expected to maintain an annual record of their participation in appraisal education, appraisal network meetings and continuing professional development (CPD) within their appraisal portfolios, including reflection on learning. During the reporting period, Trust appraisers attended joint appraiser update sessions with Warrington and Halton Teaching Hospitals NHS Foundation Trust, held on 3 April 2025, 11 April 2025 and 22 October 2025. Appraiser training requirements were completed, supporting ongoing quality assurance, consistency and calibration of appraisal practice.
Action for next year:	To continue with current processes

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	To continue current processes for reporting appraisal compliance to the Board. To introduce the ASPAT tool within the SARD electronic appraisal system to provide individual appraisers with feedback on the quality of appraisals, with outcomes to be incorporated into Board reporting.
Comments:	The action identified in the previous reporting period has been completed. The appraisal system is subject to an ongoing quality assurance process, with appraisal compliance and quality reports presented to the Trust's People Committee, a subcommittee of the Board, twice each year. During the reporting period, the ASPAT (Appraisal Support and Peer Assessment Tool) was introduced to further strengthen the quality assurance of medical appraisals by supporting the review of appraisal quality and consistency across appraisers.
Action for next year:	Continue to undertake regular quality assurance of the appraisal system using the ASPAT tool and report appraisal

	compliance and quality outcomes through the appropriate governance committees across the integrated organisation.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with current practices
Comments:	No doctors were referred to the GMC with concerns about fitness to practice. The responsible officer makes effective use of the opportunities presented by NHS Resolution and discussion with the regional GMC liaison.
Action for next year:	To continue with current practices

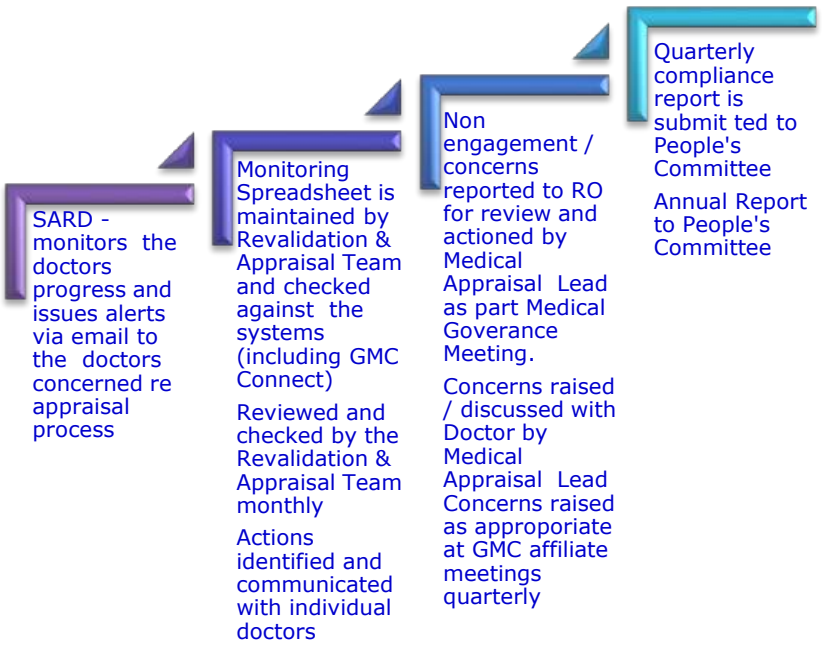
1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with current practices
Comments:	There have been no reported non-engagements within this reporting period. All recommendations to revalidate were made to the GMC within the proscribed timeframes and doctors who were revalidated were informed of those decisions.
Action for next year:	Continuing with current Trust processes

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To continue with the same governance arrangements
Comments:	The Trust has a clearly defined organisational structure. The Board receives regular information regarding clinical governance information regarding doctors through the Strategic People Committee and Quality & Safety Committee. This includes information about incidents, complaints and litigation in addition to appraisal and revalidation information. Clinical directors and team managers meet regularly with their teams to discuss learning from complaints, incidents and litigation. There are weekly departmental governance meetings and monthly learning meetings for all staff when incidents, complex cases etc are discussed. Doctors are expected to take part and contribute to improvements and to lead their teams in these improvements. One to one meetings between the deputy medical director and clinical directors occur when governance issues are discussed [DIRG and PSIRFalp] Senior team leaders [clinical directors] meet with the deputy medical director and appraisal lead on a monthly basis to discuss current clinical and non-clinical issues with actions agreed and monitored. Monthly Medical and Dental Professional Governance meetings take place, attended by the RO, Medical Appraisal Lead, Dental Clinical Director, HR Manager, Appraisal and Revalidation Manager and administrator. Any concerns about a doctor's performance are discussed at that meeting, actions agreed and monitored. All doctors at the Trust currently use the online appraisal system provided by SARD. The administrator, Appraisal and Revalidation Manager, Medical Appraisal Lead and RO have access to all the appraisals, including dates and progress of the process within the system. All doctors are offered support via the appraisal team on how to use the system and within the system itself there is training guidance/ video demonstrations to explain all the functions of the system.

	All doctors have access, via their Clinical Director/ Operational Manager, to relevant supporting information for their appraisal portfolio. The information is updated via the Qlik dashboard monthly and includes routine performance data (e.g. contacts, DNAs, cancellations, waiting times). Quality performance data is also made available monthly such as complaints, compliments, incidents, audits etc. Colleague and patient feedback surveys are undertaken using the multisource feedback tool provided through SARD. In addition, patient experience data from services is routinely collated and discussed at team meetings to support ongoing quality improvement and reflective practice. During the reporting period, the Deputy Medical Director retired on 1 April 2026. Following the integration with Warrington and Halton Teaching Hospitals NHS Foundation Trust in April 2026, work has commenced to establish a single clinical governance framework for the integrated organisation. Existing governance arrangements will transition to the new processes and structures to provide consistent oversight across the merged Trust. 
Action for next year:	Introducing new Trust's governance processes following the formation of NCM. DATIX is the system used across NCM for the reporting of incidents This system will be used and provide governance

	information for the appraisal portfolios for medical staff previously from BW, from 1st April 2026.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	To continue to use the systems in place at the Trust to monitor conduct and performance of all doctors in organization. The practice will align with Warrington and Halton Hospital.
Comments:	Conduct, Capability, Ill-Health and Appeals Policy has been being reviewed. Advice was also taken from Practitioner Performance Advice (PPA) if there are any concerns about a doctor's performance. Performance concerns had been managed in line with the Conduct, Capability, Ill-Health and Appeals Policy and in line with advice received from PPA. All policies and procedures could be viewed via the Trust's intranet.
Action for next year:	To develop and implement a single Conduct and Performance Policy for the newly integrated Trust, ensuring consistent processes for monitoring, managing and supporting doctors across the combined organisation.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	To provide training on the new appraisal system to doctors at the Trust To work with governance team to upload governance reports onto doctors' portfolios prior to their appraisal
Comments:	The action identified in the previous reporting period has been completed. The Trust adopted the new SARD appraisal system in August 2025 and implemented the revised appraisal processes across the organisation.
Action for next year:	To continue to use the appraisal systems and processes currently in place across the Trust.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	To continue with the established process for responding to concerns about a doctor's fitness to practice
Comments:	Concerns are monitored through the Medical and Dental Professional Governance Group, which reports to the People Committee, a sub-Committee of the Board. Data regarding any ongoing or completed investigations are presented to the People Committee, which meets every 2 months. Where such concerns have arisen, the number, type and outcome of the concerns, and consideration of protected characteristics, are reported. The Medical and Dental Professional Governance Group has continued to meet regularly during 2025/26, discussing doctors about which there have been performance concerns and ensuring that appropriate action plans and support are in place as necessary. There have been no formal investigations of doctors within this reporting period. Any concerns raised are taken seriously and results fed back to those who have raised concerns. Trust policies include measures in support of a just and learning culture with timeline requirements for review to ensure minimal case delays. Support for hearing chairs, case

	managers and case investigators is provided by HR professionals. An annual HR dashboard is fed into the Trusts Strategic people committee which includes case themes and protected characteristics.
Action for next year:	To adopt and implement the policies of the newly integrated Trust.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continuing with current Trust processes
Comments:	Concerns are monitored through the Medical and Dental Professional Governance Group, which reports to the People Committee, a sub-Committee of the Board. Data regarding any ongoing or completed investigations are presented to the People Committee, which meets every 2 months. Where such concerns have arisen, the number, type and outcome of the concerns, and consideration of protected characteristics, are reported.
Action for next year:	To adopt and implement the policies of the newly integrated Trust.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To continue to use MPIT forms in communicating with other Trusts
Comments:	Since April 2017, Medical Practice Information Transfer (MPIT) forms have been used when required to hand over information between ROs when a doctor transfers in or out of the Trust. The Trust engages with this provision. Where concerns have arisen about locum doctors, the supplying agency and/ or the doctor's RO have been informed accordingly. There has been one issue with a locum doctor in relation to the recording of data on system

	one and concerns about the use of smart cards. This has been addressed informally through learning objectives.
Action for next year:	To continue to use MPIT forms in communicating with other Trusts To review process for gathering information on locum doctors when commencing work in Trust

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	To continue to use the Trust policies when dealing with concerns about doctors
Comments:	The Trust's Conduct, Capability, Ill-Health and Appeals Policy and Procedure for Medical and Dental staff includes the following: All managers and directors (whether internal or external to the Trust) who are involved in undertaking investigations or sitting on disciplinary/ capability panels or appeals panels shall have undertaken formal equal opportunities training prior to undertaking such duties. Case Managers, Case Investigators and Panel Members shall be trained in the operation of the disciplinary and capability procedures. The Equal Opportunities Policy details the Trust's commitment to equal opportunities in employment and service delivery and further supports this approach to ensure that processes are fair and free from bias. All Trust HR policies undergo an Equality Impact Assessment. There have been no concerns expressed within this reporting period. There are 10 members of staff trained as case investigators across the Trust
Action for next year:	To adopt and implement the policies of the newly integrated Trust.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	To continue with current Trust processes
Comments:	If there are changes in National Guidance/law/clinical guidance the guidance is disseminated to the relevant executive lead /subject matter expert who is responsible for integrating it into BCHFT policies and then appropriate operational leads/clinical directors/medical director responsible for operationalising the guidance. The Trust implemented the Patient Safety Incident Response Framework in November 2023 with the development of a policy and plan. Incidents are reviewed within Directorates before discussion at PSIRF Alp which then feeds into the Quality & Safety Council which is a subcommittee of the Board. The Trust has a number of processes in place to capture learning which is shared across the Trust. Incident reports are discussed at would be shared and reported to the Trusts' Quality Council Meeting.
Action for next year:	To adopt and implement the policies of the newly integrated Trust.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	To continue to update BCHFT policies in line with national/local guidance ensuring consistency amongst all healthcare professionals
Comments:	Systems outlined in 1D[viii] apply to this section also Examples include the launch of GMP2024 This document was published by the GMC and the medical appraisal and revalidation policy was reviewed to incorporate the changes /updates to GMP. In preparation for the acquisition of BW by WHH, the behavioural framework of the new Trust has been developed.
Action for next year:	To adopt and implement the policies of the newly integrated Trust. To introduce the NCM behavioural framework.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes

Action from last year:	No actions
Comments:	The Trust carries out pre-employment checks in accordance with its Recruitment & Selection Policy and the NHS Employment Check Standards. The policy was reviewed and updated in December 2024. These include 1. Employment references 2. Verification of identity 3. Eligibility to work in the UK and work permits 4. Qualifications 5. Registrations status with Regulatory and Professional Bodies 6. Disclosure and Barring Checks 7. References 8. Work Health Assessment/ Occupational Health Checks 9. Appraisal and revalidation status The Trust had an "Alert Notice System" in place to receive health professional alerts from Practitioner Performance Advice. All external alerts received in relation to health professionals are reviewed at Executive level and by the Trust's HR team. Locum Doctors are provided by an Agency or an in-sourcing company. The Trust has agreements with both to undertake full pre-employment checks, and these are routinely checked by the Trust.
Action for next year:	To continue pre-employment checks in line with NHS Employment check standards To adopt and implement the policies of the newly integrated Trust.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	To continue with current Trust processes
Comments:	The Trust has the following guidelines and policies in place 1. A Just Culture Guide 2. Civility and Respect Policy

	3. Conduct, Capability, Ill-Health and Appeals Policy and Procedures for Medical and Dental Staff 4. Equal Opportunities Policy 5. Patient Safety Incident Response Framework (PSIRF) Concerns are monitored through the Quality Committee and shared with the Chief Executive/ Trust Board if deemed necessary by the Responsible Officer. Any outcomes from Patient Safety Incidents will be used to assist the Directorates and the Trust with its Quality Improvement work. The improvement work will be shared across the organisation via Committee and Board Papers, newsletters, Time to Shine meetings and the annual Quality Report.
Action for next year:	To adopt and implement the policies of the newly integrated Trust.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue to promote compassion, fairness, respect, diversity and inclusivity across the Trust in all that we do.
Comments:	• Just Culture underpins all HR policy and practice, including disciplinary, grievance, wellbeing and sickness absence. Where appropriate policy includes medical workforce, or where specific policy exists the fundamentals of Just Culture are used. • Equal Opportunities and Dignity at Work provide the overarching policy and commitments to equality, diversity, and inclusion and anti-discrimination and harassment cultures. • The EDI Strategy establishes the framework for delivery of the EDI Priorities Action Plan led by the EDI Working Group. • New Behavioural Framework launched in 2024, used from recruitment throughout the employment journey. • Choose Kindness is the main Trust campaign for civility, respect, and anti-bullying and harassment. This is supported by the Creating Kinder Cultures programme. • People Promise Champions provide the leadership and direct team interface for all work around the NHS Our People Promise activities.

	• Staff Inclusion Networks provide a space and voice for minoritised voices, including members of the medical workforce. • A universal as well as individual level training and development offer is open to all staff.
Action for next year:	To continue to embed processes that promote compassion, fairness, respect, diversity and inclusivity, while supporting the implementation of the new Trust values and ensuring they are reflected across leadership, governance and workforce practices.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue implementing the Trust behavioural framework
Comments:	This has continued throughout this year and will be taken forward following the formation of the New Trust.
Action for next year:	Continue supporting the implementation of the new Trust values and ensure they are reflected across leadership, governance and workforce practices, strengthening a culture of openness, transparency and continuous learning.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	To review feedback from medical staff completing staff survey and compare with feedback from other staff groups
Comments:	The annual staff survey includes feedback from doctors and utilization of this data can be used to inform staff voices. There is also a quarterly pulse survey to which doctors can provide feedback anonymously The feedback from medical staff in the staff survey was used in the 'Fairer feedback learning session' which was organised for appraisers in Nov 2025.
Action for next year:	Review feedback from medical staff through the staff survey and compare findings with feedback from other staff groups to identify areas for improvement. Continue to embed existing feedback processes and support the implementation of the new Trust values and framework

	across the organisation.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	To continue with current Trust processes
Comments:	• Just Culture underpins all HR policy and practice, including the conduct, capability, ill-health, and appeals policy for medical and dental practitioners. • All managers/staff involved in an employee relations case complete the relevant HR Skills training and are supported throughout by the Trust's HR team. • Equal Opportunities and Dignity at Work provide the overarching policy and commitments to equality, diversity, and inclusion and anti-discrimination and harassment cultures. • Equal opportunities qualitative data is also monitored through the annual NHS Staff Survey, with data available by ethnicity, international recruits, staff group and other disaggregation. The Trust published employee relations data in the Medical Workforce Race Equality Standard report in 2023 - the reporting was stood down nationally in 2024 and 2025. In addition, the Trust publishes data on all staff involved in formal disciplinary processes in the annual Workforce Race Equality Standard Report, with numbers for both reports too small for providing actual numbers
Action for next year:	To continue with existing processes for monitoring fairness and parity within concerns and disciplinary procedures, while supporting the implementation of the new Trust values and framework to ensure equality, diversity and inclusion principles remain embedded across workforce and governance practices.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes

Action from last year:	To continue attending regional RO Network meetings
Comments:	Responsible Officer (RO) attended regional RO Network meetings in 2025/26 to ensure he/she remained up to date with the knowledge required for the role. The RO met the GMC Liaison officer regularly throughout the period. The RO had regular meetings with NHS Resolution about the doctor who presented concerns and who had an ongoing action plans in place. The R/O attends the annual update for small, designated bodies
Action for next year:	RO will continue to attend regional RO Network meetings on 16 Sept 2026 and Employer Liaison Adviser Meetings in 2026/2027. Attendance at the peer review of Mersey and West Lancashire Foundation Trust alongside Royal Liverpool University Foundation Trust, scheduled for November 2026.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.
All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	13
Total number of appraisals completed	13
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	0
Total number of late recommendations	0
Total number of positive recommendations	0
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	10
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2]	0
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	0
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The introduction of SARD and the continued development of quality assurance arrangements have strengthened the medical appraisal and revalidation framework. Appraiser capacity has remained sufficient, with plans to incorporate appraisal responsibilities into job planning arrangements to ensure appraisers have dedicated time to undertake appraisal activities effectively and maintain the quality of the appraisal process. The key priority for the coming year will be the integration with Warrington and Halton Teaching Hospitals NHS Foundation Trust. This will include aligning appraisal and revalidation policies, governance processes, quality assurance arrangements and the combined appraiser pool to ensure a consistent approach across the newly integrated organisation. The focus will remain on maintaining high-quality appraisal processes, supporting doctors' professional development and ensuring compliance with national revalidation requirements. An SLA was developed with providers of intermediate care to improve oversight and management of arrangements where doctors provide services to the organisation but are not connected through the Responsible Officer structure, for example General Practitioners who are not linked to the Trust as their designated body. During 2025/26, all 13 doctors with a prescribed connection to the designated body received timely annual appraisals. No concerns were identified that required referral to the GMC, and no doctors were due for revalidation during this period.
Actions still outstanding
• Complete the alignment of medical appraisal and revalidation processes following integration with Warrington and Halton Teaching Hospitals NHS Foundation Trust. • Develop and implement a combined Medical Appraisal Policy and supporting framework for the newly integrated Trust. • Align governance arrangements, quality assurance processes and reporting structures across the new organisation. • Complete the integration of the appraiser pool and incorporate appraisal responsibilities into job planning arrangements to ensure appraisers have dedicated time to undertake their role. • Continue quality assurance of the appraisal process, including peer review, calibration of appraisal practice and use of ASPAT to support consistency and improvement.
Current issues

- The main focus is the transition to the new integrated Trust arrangements and ensuring consistent appraisal, revalidation and governance processes across both organisations.
- Further peer review opportunities will be developed through the combined organisation to share learning, identify best practice and ensure consistency of professional judgement across appraisers.
- Work is ongoing to align policies, systems and reporting arrangements while maintaining continuity and quality of support for doctors.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

1. Undertake peer review of the combined medical appraisal and revalidation processes with Warrington and Halton Teaching Hospitals NHS Foundation Trust and implement learning identified.
2. Continue participation in Responsible Officer and appraisal network development events, including Small Designated Body updates, and apply relevant learning to local processes.
3. Continue quality assurance of appraisal processes through ASPAT, peer review and calibration of appraisal practice.
4. Complete implementation of the combined Medical Appraisal Policy and ensure alignment with national guidance.
5. Develop a sustainable combined appraiser model, including incorporation of appraisal responsibilities into job planning arrangements to provide protected time for appraisers.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Achievements: During 2025/26, the organisation has continued to maintain effective medical appraisal and revalidation arrangements, ensuring all doctors with a prescribed connection received timely appraisals and that appropriate governance processes remained in place. The implementation of the SARD appraisal system has strengthened the security, consistency and quality of appraisal documentation. The Medical Appraisal Policy was updated to incorporate GMP2024 requirements and supported by an appraisal toolkit to provide clarity on expectations and required supporting information. Quality assurance processes, including ASPAT and peer review activity, have continued to support continuous improvement and consistency of appraisal practice. Challenges: The main challenge during the reporting period has been preparing for and managing the transition associated with integration with Warrington and Halton Teaching Hospitals NHS Foundation Trust. This has required alignment of policies, governance arrangements, appraisal systems and reporting processes while ensuring continuity of support for doctors. Further work is required to harmonise processes and establish consistent arrangements across the newly integrated organisation. Aspirations for the coming year: The key priority for the coming year is to establish a fully integrated medical appraisal and revalidation framework across the new organisation. This will include implementing a combined Medical Appraisal Policy, aligning quality assurance and peer review processes, developing a combined appraiser pool and incorporating appraisal responsibilities into job planning arrangements to provide protected time for appraisers. The organisation will continue to promote a culture of openness, learning and professional development, ensuring that medical governance arrangements remain robust and aligned with national standards.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Bridgewater Community NHSFT

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Anne Robinson	Brittney Chu
Email address:	Anne.robinson9@nhs.net	Poyan.Chu@nhs.net

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/084**			
Subject:	**Communications and engagement activity report, July to August 2026**			
Date of meeting:	7 October 2026			
Action required:	**N/A**			
Author(s):	Mike Baker and Alison Aspinall, head 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:	The report highlights activity, campaigns and performance across internal and external communications, social media, patient information and engagement during July and August. Communications and engagement support has continued to play an important role in helping to strength awareness of the North Cheshire and Mersey NHS Foundation Trust			

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.

<table>
<tr><td></td><td colspan="3">brand while supporting a range of organisational programmes and service developments.
The period included extensive engagement activity with patients, public representatives and community stakeholders, including discussion around chronic pain services through the Patient and Public Reference Group, ongoing growth of the Experts by Experience network, and participation in community events across Warrington and Halton.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the contents of this update on communications and engagement activity during the reporting period.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (FOIA):</td><td colspan="3">Release document in full</td></tr>
<tr><td>Freedom of information exemptions applied (if relevant):</td><td colspan="3">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

July-August 2026 activity report

Communications and Engagement Team

Home
Community
Hospital

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Above, the Communications and Engagement Team with NCM colleagues at the annual Disability Awareness Event, held at Walton Gardens in July

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 staff, patients and communities during July / August 2026.

Reporting highlights:

- Communications and engagement activity during the reporting period focused on continuing to build awareness of the North Cheshire and Mersey NHS Foundation Trust brand among staff, patients and local communities following integration. The first phase of integration communications work was completed in July, with support requests embedded within business as usual operations from August.
- The new Smartsheet function to log job requests is ensuring high impact communications requests are prioritised. Teams will be given guidance and feedback to support low impact requests that can be managed within their departments, where appropriate. In the longer term this will enable the Communications and Engagement Team to spend more time on proactive communications aligned with the approved NCM Brand and Reputation Plan and future strategic work.
- Healthwatch Warrington and Halton is continuing to lead on the delivery of the Patient and Public Reference Group until the end of Q4 2026-27. July's session focused on chronic pain services, which highlighted increased demand and challenges around waiting times and capacity (*see slide 26*). Further updates will be provided in future communications and engagement board reports, as well as clinical workstream updates presented to the NCM2030 Delivery Group.
- In August work began to further strengthen communication with acute and community staff. This has included a 'board to ward' review with a particular focus on frontline staff. Day and evening visits are taking place in hospital and community locations to understand communication preferences and identify any barriers to accessing trust platforms.

Communications and engagement job requests

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Support requests

The team continued to complete a high number of requests for communications and engagement support over the summer period. Job numbers remained steady, with a small increase in July to support internal communications.

July:

- 68% of requests were submitted by corporate services
- Top job types requested: Intranet updates / internal comms / social media
- Key job request examples for this month which the team supported included:
  - development of new intranet workspaces and updates post integration
  - internal communications to share development opportunities for staff
  - comms support and guidance for the length of stay ‘Home first’ campaign
  - support to produce social media videos to share trust performance update

August:

- 79% of requests were submitted by corporate services
- Top job types requested: Intranet updates / social media / design and branding
- Key job request examples for this month which the team supported included:
  - Experts by Experience feedback on the Living Well Warrington website
  - communications to raise awareness of charity fundraising activities and drive involvement with staff and external supporters
  - internal communications support for Flow Support Week
  - external communications to share the appointment of the new North Cheshire and Mersey chief nurse

July job requests at a glance

Total no of requests: 76

Approved: 70

More information needed: 5

Rejected (out of scope): 1

Jobs completed: 39

Month on month comparison: 52 (up 24)

August job requests at a glance

Total no of requests: 43

Approved: 35

More information needed: 4

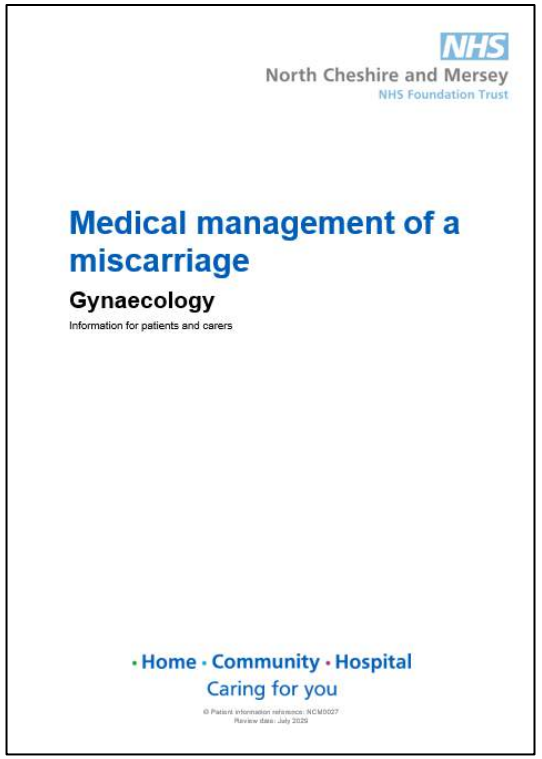
Rejected (out of scope): 0

Jobs completed: 36

Month on month comparison: 76 (down 33)

Patient information (PINFO)

PINFO activity	July leaflets	August leaflets
Number of new leaflets finalised in month	3	7
Number of reviewed / reissued leaflets finalised in month	3	5
Total number of leaflets* across all care groups (including community and dental)	605	611
*Leaflets identified as beyond their review date	180	171
Percentage of expired leaflets	30%	28%



Next steps:

Testing of the new PINFO system is underway with an expected go-live date in September. This will enable the team to accurately record how many new and existing leaflets are being processed by the Communications and Engagement Team prior to them being finalised or reissued.

Key activity

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Caring for you

July at a glance: Internal communications

Intranet – key stats (no. of)	Total
Thank you messages	83
Approved message board posts	8
News articles	17
Announcements	38
Good morning messages*	11

Intranet – top 3 news stories	Views
1. Take That raffle see 635 entries from staff – winners contacted	290
2. Dr Lalitha Chinnappan attends NHS reception at Downing Street	282
3. What will NCM look like in 2030?	275

Team Brief

Thursday 23 July, 1pm

Live attendees: 255
Questions: 33
Total views incl. recording: 284

Month on month comparison
June: 271 (down 16)

NCM news (staff bulletin)

Email views (number of times NCM news email accessed):

- 27 July: 7,764
- 20 July: 7,404
- 13 July: 7,800
- 6 July: 8,818

Month average: 7,946

Top stories:

- Dr Lalitha Chinnappan attends NHS reception at Downing Street
- What will North Cheshire and Mersey look like in 2030?
- Thank You Awards – save the date!
- Living Well Live event brings partners together in Warrington

* Morning messages included: Inclusion summits, supported internship programme, NCM 2030 trust strategy, South Asian Heritage Month, TYAs save the date, NHS Staff Standards and protecting patient data.

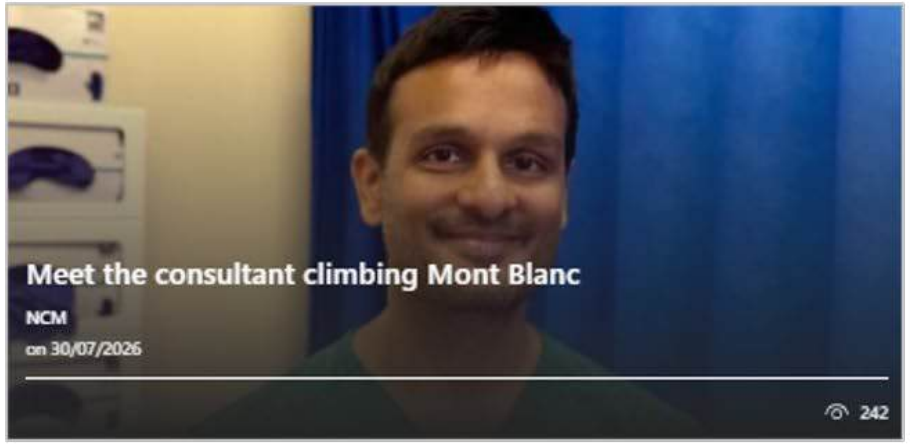
Examples:



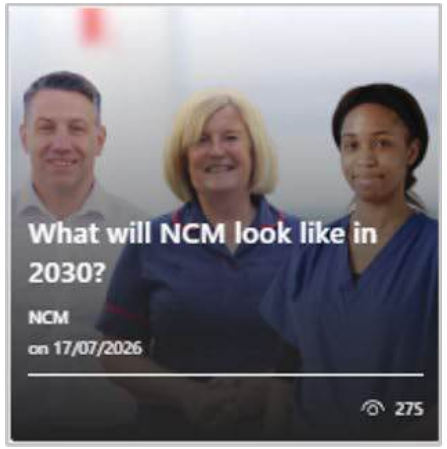
Laura Wade: Laura's always positive, cheerful and supportive, helping colleagues whenever needed, consistently strives to achieve the best outcomes for patients.

Claire Stirrup and Sharon Murphy: Thank for going above and beyond in a very difficult situation yesterday to safeguard a very vulnerable person. You undoubtedly saved their life.

Victoria Royle: For being an amazing person! You're such a kind and caring person and it's a pleasure to work with you. You always make the day brighter.









July at a glance: External communications

2. Urgent and emergency care wait times	9,122
3. Our locations – Warrington Hospital	2,398
4. Our services – Blood test phlebotomy clinics	2,343
5. Our services – Urgent Treatment Centre Runcorn	2,277

Trust website – top 3 news stories	Views
1. Our name change to North Cheshire and Mersey NHS Foundation Trust	285
2. Get to the help you need – use 111	160
3. North Cheshire and Mersey NHS Foundation Trust to introduce robotic assisted knee replacement surgery	131

Media

Coverage / enquiries handled during the reporting period:

Proactive requests: 15
- Media releases written: 4
- News stories published: 7
- Charity articles published: 4

Reactive requests: 4
- Support (e.g. fact checking): 1
- Statements issued: 3
- No response provided: 0
- Interviews / visits: 0

Highlights of the month:
- Positive coverage of new surgical robot at Halton Hospital
- Staff achievements including visit to Downing Street and MBE Award

Examples:



North Cheshire and Mersey Doctor invited to NHS reception at Downing Street

Monday 13 July 2026



Warrington safeguarding nurse awarded MBE from His Majesty King Charles

Thursday 16 July 2026



North Cheshire and Mersey NHS Foundation Trust to introduce robotic-assisted knee replacement surgery

Tuesday 28 July 2026



Maternity mural brings joy to new families at Warrington Hospital

Friday 31 July 2026

August at a glance: Internal communications

Intranet – top 3 news stories	Views
1. Launch of Voluntary Redundancy Scheme – applications now open	700
2. Congratulations to our NCM preceptees!	255
3. A first look at the Willow Tree Hub	241

Team Brief

Tuesday 25 August

Live attendees: 337
Questions: 41 (mostly VR related)
Total views incl. recording: 383

Month on month comparison: 284 (up 99)

NCM news (staff bulletin)

Email views (number of times NCM news email accessed):

- 24 August: 7,873
- 17 August: 6,670
- 10 August: 7,711
- 3 August: 8,097

Month average: 7,588

Top stories:

- Patients benefit from faster diagnosis and treatment
- NCM to introduce robotic-assisted knee replacement surgery
- Help shape the NCM's future
- New chief nurse announced for North Cheshire and Mersey

* Morning messages included: An update from the August Board meeting, Long Service Awards, VR scheme launch, insight into NWAS visit, Flow Support Week, launch of Your Future Your Way cohort 4 applications.

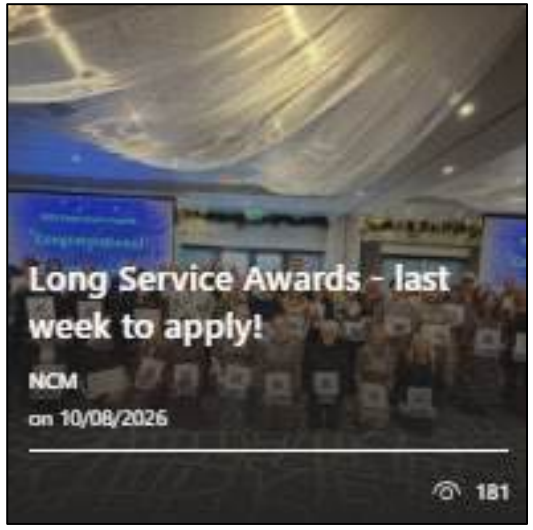
Examples:



Ailsa Witherington and Bethan Bruford: Thank you for dealing with the challenging situation involving a patient last week, in such a professional manner. You are a credit to the service.

Rachael Martin: Well done to Rachael for organising the charity park run and bringing everyone together to raise an amazing amount of money for such a great cause!

Susan Cardus: Thank you so much Sue for being flexible and responsive to the needs of the services we support, stepping up last minute and providing great support!









August at a glance: External communications

2. Urgent and emergency care wait times	3,859
3. Our locations – Warrington Hospital	1,089
4. Contact us	943
5. Hospital shuttle bus	929

Trust website – top 3 news stories	Views
1. New chief nurse announced for North Cheshire and Mersey NHS Foundation Trust	195
2. Our name change to North Cheshire and Mersey NHS Foundation Trust	56
3. Maternity mural brings joy to new families and Warrington Hospital	50

Media

Coverage / enquiries handled during the reporting period:

Proactive requests: 7
- Media releases written: 3
- News stories published: 2
- Charity articles published: 4

Reactive requests: 4
- Support (e.g. fact checking): 2
- Statements issued: 2
- No response provided: 0
- Interviews / visits: 0

Highlights of the month:
- Announced the appointment of our new chief nurse, shared a first look at the Willow Tree Hub and coverage of our improved ED performance.

Examples:



New chief nurse announced for North Cheshire and Mersey NHS Foundation Trust

Thursday 13 August 2026



Three quarters of people now seen within four hours at North Cheshire and Mersey NHS Foundation Trust

Friday 07 August 2026

Warrington Guardian
https://www.warringtonguardian.co.uk › news › 26471...

First designs revealed for Willow Tree Hub at Warrington ...

18 Aug 2026 — DESIGNS have been revealed for a dedicated support **hub** for bereaved families at **Warrington** Hospital.



BusinessGreen

North Cheshire and Mersey NHS Foundation Trust to install new solar arrays

Project at Warrington and Halton hospital sites funded through wider £74m national programme to upgrade public sector buildings.



Warrington Guardian

This is the new chief nurse who has been appointed at Warrington Hospital

A NEW chief nurse has been appointed at Warrington Hospital.



Social media

• Home • Community • Hospital

Caring for you

July at a glance: Social media

Examples of the best performing posts (based on interactions):







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 July page followers:
14,718
Post engagement:
11,726
Page reach:
128,035

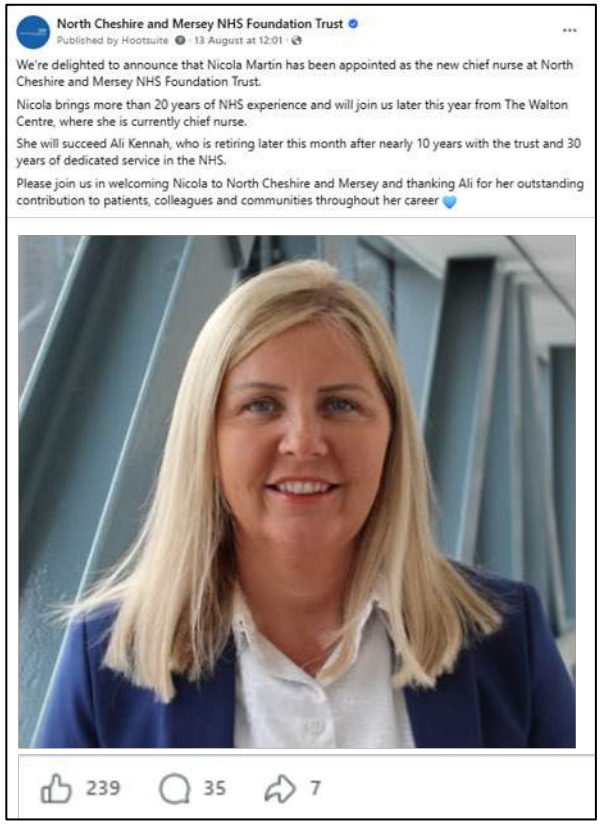
Month on month comparison:
Followers increased slightly by 18, while engagement fell by 8.1%. In contrast, reach rose significantly by 114.5%, indicating that July content reached a much wider audience than June.

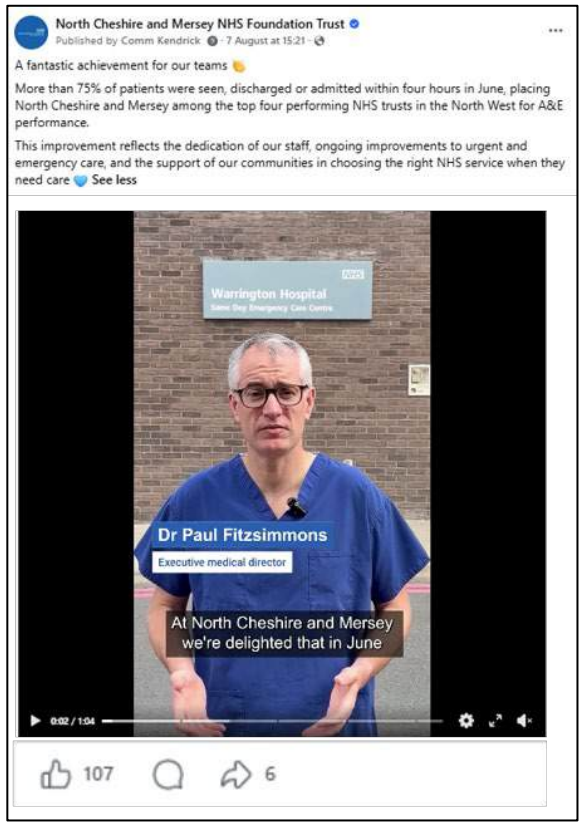
Maternity FB page:
Followers:
11,928
Page engagement:
22,324
Page reach:
101,357

August at a glance: Social media

Examples of the best performing posts (based on interactions):







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 August page followers: 14,858
Page engagement: 21,430
Page reach: 149,746

Month on month comparison:
Followers increased by 140, while engagement rose significantly by 82.8%. Page reach also increased by 17%, indicating that content reached a wider audience than July.

Maternity FB page:
Followers: 12,004
Page engagement: 6,015
Page reach: 26,375

What worked well / next steps

Achievements and successes

July:

- People-centred content performed best, with stories celebrating colleagues, achievements and positive developments generating strong engagement and reinforcing the value of showcasing the people behind our services.
- Page reach increased by 114.5%, more than doubling the number of people reached compared with June and significantly increasing visibility across the platform.
- Staff spotlights and video content were introduced, helping to share authentic stories in a more engaging format and broaden audience reach.

August:

- Monthly engagement increased by 35.5%, while reach increased by 17%. This shows that more people are seeing our content and engaging with it. The results provide strong evidence that our people-first approach is working.
- Content celebrating colleagues, leadership appointments and service achievements performed particularly well and generated positive engagement.
- Service updates performed strongly when they focused on the impact for patients, communities and colleagues.

Exec update on performance video



Your Future, Your Way programme



Next steps

Areas for development

- Introduce a 12-month Social Media Plan with the following aims and objectives:
    - build a more engaging and positive NCM presence online
    - increase reach and engagement across our main channels
    - improve how we explain services to patients and the public
    - support staff pride and a ‘one team’ culture
    - tailor content for each platform and audience
    - use engagement data to understand what works best
    - reduce low-value content that does not connect with our audiences
    - support the wider Brand and Reputation Management Plan

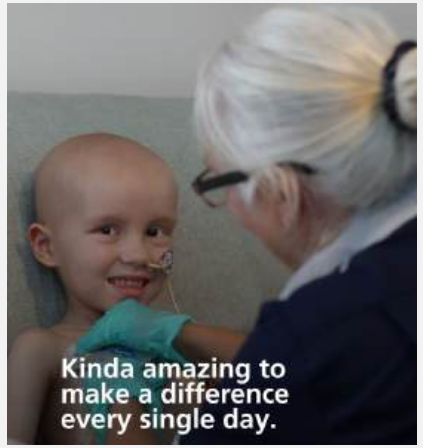
Further updates on the plan rollout will be provided in the September / October report.

- Increase the use of video content to highlight the achievements of colleagues and teams across NCM (three times more video content published in August than in July).

- Create content from a wider range of services, including community and dental teams, to highlight the impact of our work across local communities.

- Promote the diversity of roles across the trust, helping audiences understand the breadth of expertise and services that support patient care every day.

Identifying social media trends



Promoting our staff networks



Projects and campaigns

• Home • Community • Hospital

Caring for you

Key projects

Project	Progress / actions	Impact / outcomes
Digital information screens	The latest information screen has been installed. Screens are now located at: • Warrington main entrance • Warrington ED waiting area • Halton Nightingale Building Entrance 2	Increased visibility of trust information, providing updates for patients and visitors attending our hospitals and showcasing key initiatives.
Home First	As part of the length of stay work, a Home First approach across the organisation is to be created.	This project will help support home being the first consideration for patients who are on a discharge pathway.
WELL Runcorn Hub	Final preparations for the official opening of WELL Runcorn Hub on 10 September are underway following its soft launch. We are liaising closely with partner communications teams and senior colleagues to confirm final guests and speakers.	Communications activity focused on building momentum ahead of the launch, including media engagement and preparation of a comprehensive partnership news release to maximise both internal and external coverage.
Your Future, Your Way	NCM continues to create fairer career opportunities through the Your Future, Your Way programme. A communications plan and supporting information video have now been developed.	The case study video continues to be promoted across the organisation and has also been featured by NHS Employers as part of an NCM case study on its website.
Delamere Centre	Work is underway to raise the profile of the Delamere Centre and increase awareness of the cancer support services available.	A communications brief has been developed, with a focus on creating and delivering a communications plan to support the centre at Halton Hospital throughout the autumn.

Integration update

July: Communications support remained weighted towards integration, as wider trust activity begins to take shape around the creation of a new NCM trust strategy and NCM clinical strategy. Other established daily and monthly requests continued to settle into a business-as-usual campaign rhythm across the wider organisation.

August: Integration support has become more targeted, with activity mostly centred on the Patient and Public Reference Group and emerging clinical workstream activity. A proposal to close down the communications and engagement integration workstream has been submitted, as communications support requests are now being embedded within business as usual operations.

Highlights this period	Status	Next steps
Summer engagement campaign underway to raise awareness of NCM across local communities.	Ongoing	Additional planning of late summer events to increase engagement and involvement.
Final production of a new North Cheshire and Mersey corporate film, with launch planned in October to coincide with 6-month anniversary of NCM.	Ongoing	Final sign off and launch plan.
Continued development of the Patient and Public Reference Group (PPRG) in partnership with Healthwatch, with ongoing engagement activity planned. Meeting held on 20 July covered chronic pain management and the latest digital developments supporting integration.	Ongoing	The next PPRG meeting, focusing on chronic heart failure, will take place on Tuesday 13 October at The Old Police Station, Runcorn. Invitations to be issued.
Planning is underway for a season of clinical strategy development sessions to help shape the future direction of services. Sessions will require both communications and engagement support.	Ongoing	Sessions for clinical colleagues will run until the end of October 2026.
Launch of board to frontline engagement survey to obtain acute / community clinical staff communications preferences and accessibility.	Ongoing	Engagement work to be completed mid September with initial results fed back via EMT.

Engagement and involvement report

• Home • Community • Hospital

Caring for you

Key activity

Community engagement

Disability Awareness Day 2026

Disability Awareness Day (DAD), Warrington's annual pan-disability event, led by Warrington Disability Partnership, celebrated its 35th anniversary on Sunday 12 July. Thousands of visitors attended the event at Walton Hall and Gardens, with our stand one of more than 200 exhibitors.





The North Cheshire and Mersey NHS Foundation Trust stand was supported by the Communications and Engagement Team alongside staff from Orthotics, Breast Screening Services, Macmillan, Diabetes Services, Warrington and Halton Maternity and Neonatal Voices Partnership and public governors.

The team gathered public feedback on trust services and recruited 21 more EbyE volunteers. Thanks to everyone who joined on the day.

Thanks to everyone's combined efforts, NCM was awarded DAD's **Best Statutory Service Exhibitor award** on the day.

Key activity

Community engagement

Patient and Public Reference Group (PPRG)

Chaired by Healthwatch Warrington on 20 July 2026, the PPRG was attended by 28 individuals including trust staff, community stakeholders, public governors and Experts by Experience. The session focused on chronic pain services in Warrington and Halton, highlighting growing demand, waiting times and MDT capacity.

Participants emphasised the need for support while awaiting treatment, as well as improved information, peer support, physiotherapy, medication reviews and psychological support. Improving quality of life, mental wellbeing and independence were identified as key priorities for future development.

The group also received an update on the Lyrebird AI transcription system, which is helping to significantly reduce administrative backlogs and free up clinician time.

Feedback was largely positive, with participants recognising the potential benefits of AI while stressing the importance of digital inclusion, data security and effective information sharing.

Overall, attendees welcomed the opportunity to influence service improvements and supported the use of technology to enhance, rather than replace, person-centred care.





Key activity

www.northcheshireandmersey.nhs.uk

Website accessibility update

Since updating the Trust website to www.northcheshireandmersey.nhs.uk in April 2026, the team have continued to monitor the site's accessibility through insights from Silktide, a web governance platform that monitors and helps organisations to improve the quality, accessibility and performance of websites.

The latest Silktide review of websites across the NHS (August 2026) shows the site achieving an accessibility score of 95%, rated as 'excellent' and ranking us 28th place across NHS organisations nationally.

The website demonstrates strong compliance with Web Content Accessibility Guidelines (WCAG 2.2 standards) and a high standard of accessibility. It scores 96.7% against the essential accessibility requirements (Level A), 94.5% against the recommended accessibility standards (Level AA), and 88.1% against the highest accessibility standards (Level AAA). This means most site visitors, including those using screen readers, keyboard navigation and other assistive technologies, should be able to access and use the website successfully.



Experts by Experience (EbyEs)

At a glance

Total EbyEs July 2026	Total EbyEs July 2025	+/- change yr on yr	Total EbyEs Aug 2026	Total EbyEs Aug 2025	+/- change yr on yr
256	205	+51	257	205	0 (same as July)

New requests:

- **NCM Organisational Strategy session** – an online MS Teams meeting to support EbyE feedback to shape the organisation's vision and clinical strategy for 2030 (5 EbyEs, 3 public governors and 1 stakeholder).
- **Day-case hip and knee surgery posters** – request for EbyE' feedback on patient facing posters reassuring patients about same day discharge following orthopaedic day surgery (6 EbyEs).
- **Pulse advertising campaign, Silver Cross** – request for EbyE feedback on a Silver Cross advertising within the antenatal waiting area at Warrington Hospital (4 EbyEs and 2 public governors).

Existing requests:

- **Living Well Warrington website feedback** – EbyEs invited to share their experiences of the Living Well website, to evaluate the site's effectiveness and impact (EbyE involvement unknown).
- **WELL Runcorn hub update** – EbyEs invited to attend an online session to explore the hub's beginnings, building design / layout, service provision, user feedback and future aims (2 EbyEs).

External campaigns: EbyE engagement also encouraged in national campaigns (the Big Conversation on Care - shaping the future of adult social care in England and the National Conversation - developing how communities can become stronger and more connected), regional campaigns (shaping children and young people's hospital services across Cheshire and Merseyside, the Trans Without Abuse Ambassador programme, developing specialist gynaecology and maternity care in Liverpool and informing changes to breast surgery policies in Cheshire and Merseyside) and local consultations (Warrington Borough Council's draft pavement policy, encouraging feedback on accessibility and inclusion).

Upcoming events

Date	Event	Time	Venue	Event purpose
6 September			Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	
21 September	Halton Hospital 50th birthday	11am to 1pm	George Lloyd Restaurant, Nightingale Building	Staff celebrations to mark 50 years since the official opening of Halton Hospital.
7 October		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 past year and plan for the forthcoming year.
June 2027 (date tbc)		10am to 4.30pm	Warrington town centre / Golden Square	
26 June 2027		10am to 6pm	Crosfields Rugby Club, Great Sankey, Warrington, WA5 1XU	Annual partnership event supporting veterans and those serving in the Armed Forces.
18 July 2027				Annual family pan-disability event supporting independent living, led by Warrington Disability Partnership.

To join #TeamNCM at any of the events please email ncm.engagement@nhs.net

WHH Charity

Comms and engagement support

• Home • Community • Hospital

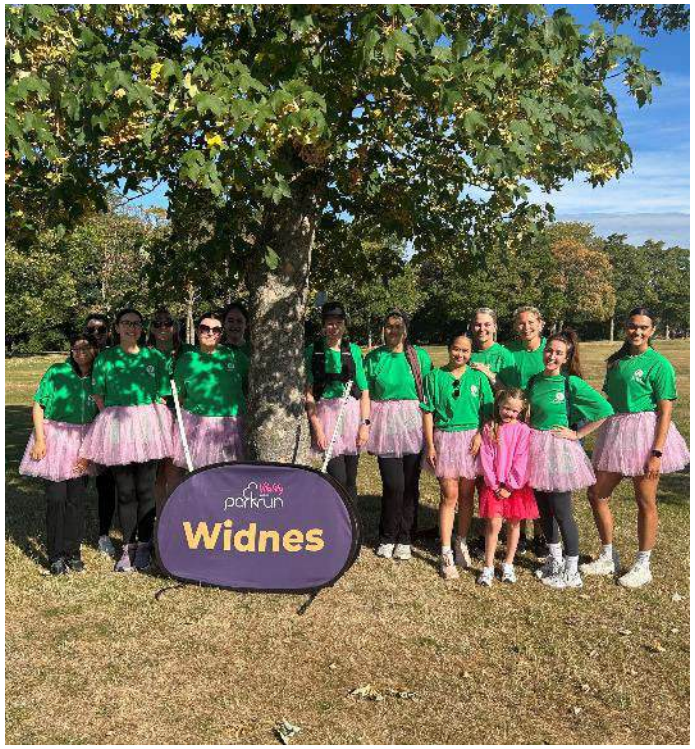
Caring for you

Warrington and Halton Hospitals' Charity

July communications and engagement support

This month's highlights:

- First half marathon challenge to support WHH Charity
- Breast Screening Team step out for patients at Widnes parkrun
- Consultant takes on Mont Blanc challenge for WHH Charity's 30th anniversary
- NCM colleagues lace up for Warrington Running Festival challenge
- Karen takes on the Lakeland 100 challenge



Next steps / upcoming events:

- Internal and external promotion of the Warrington Running Festival will continue
- Complete the Impact Report

CHARITY newsletter – June/July 2026

Warrington and Halton Hospitals' Charity

August communications and engagement support

This month's highlights:

- Celebration of Hope concert raises £6,633 for Willow Tree Hub Appeal
- Why our Cardiac Rehabilitation team are taking on the Warrington Running Festival
- A first look at the Willow Tree Hub
- Dementia-friendly mural helps create calmer hospital environment
- HR colleagues sign up for the Warrington Running Festival
- New equipment helps respiratory team provide better asthma care



Next steps / upcoming events:

- Final promotional drive for the Warrington Running Festival
- September social media campaign for Remember a Charity Week
- Promote the build and completion the ophthalmology garden, with its opening planned for October

Contact us

Email: ncm.communications@nhs.net

Website: northcheshireandmersey.nhs.uk

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North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/085**			
Subject:	**Workforce Race Equality Standard and Workforce Disability Equality Standard – Combined Report 2025/26**			
Date of meeting:	7 October 2026			
Action required:	**For approval**			
Author(s):	Adam Harrison-Moran, Deputy chief people 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: The report is based on data associated with protected characteristics and incorporate equality analysis within the associated appendices.			
Executive summary:	The 2025/26 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports have been completed using legacy WHH and BCH data in line with national reporting requirements. The findings demonstrate progress in workforce diversity, disability disclosure and representation across both organisations. However, significant inequalities remain. Ethnically diverse and disabled colleagues continue to report poorer workplace experiences than their White and non-disabled peers, particularly in relation to bullying, harassment, discrimination, career progression, feeling			

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.

<table>
<tr><td></td><td colspan="3">valued at work and representation in senior leadership positions.

WHH reported improvements in workforce representation and reductions in some indicators of discrimination and harassment, although disparities persist in recruitment outcomes, disciplinary processes and experiences of abuse from patients and the public. BCH demonstrated continued improvement in workforce representation and disability disclosure, but experienced deterioration across several staff experience indicators, including bullying, harassment, discrimination, career progression and reasonable adjustments.

To address these findings, combined Trust-wide WRES and WDES action plans have been developed for 2026/27. These focus on anti-racism, disability inclusion, leadership development, wellbeing, reasonable adjustments, staff voice, career progression and reducing bullying, harassment and discrimination. Delivery will be monitored through the Workforce Equality, Diversity and Inclusion Strategy governance framework.</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 receive the contents of this paper, appendices and approve the action plans, found in sections 2.1 and 2.2, for submission to NHS England and publication on the Trust website by 31 October 2026.</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/26/08/089</td></tr>
<tr><td>Date of meeting</td><td colspan="2">19 August 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 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are nationally mandated NHS workforce equality frameworks designed to measure and improve the experiences of staff from protected characteristic groups in the workplace. Both standards form part of the NHS Standard Contract and require NHS organisations to undertake annual assessments of workforce data, staff experience and organisational culture to identify inequalities and opportunities for improvement.

Introduced in 2015, the Workforce Race Equality Standard (WRES) focuses on the experiences of Black, Asian and Minority Ethnic (BAME) staff and measures performance across nine indicators. These include workforce representation, recruitment, disciplinary processes, access to training and development, experiences of bullying, harassment and discrimination, perceptions of career progression and representation within senior leadership and Board positions. The purpose of WRES is to ensure that colleagues from ethnically diverse backgrounds have equitable access to opportunities and are treated fairly within the workplace.

Introduced in 2019, the Workforce Disability Equality Standard (WDES) assesses the experiences of disabled staff and those living with long-term health conditions through ten indicators. These include disability representation across the workforce, recruitment outcomes, experiences of bullying and harassment, career progression, workplace adjustments, staff engagement, wellbeing and Board representation. The standard aims to support organisations in creating workplaces where disabled staff are able to contribute fully and access the support they require to thrive.

Together, WRES and WDES provide important insight into how different groups of staff experience working within NHS organisations. The standards enable organisations to understand where disparities exist, monitor progress over time and benchmark performance against national comparators. They also contribute to wider assessments of organisational culture, leadership and inclusion and are considered by NHS England and the Care Quality Commission as part of broader workforce and well-led assessments.

Importantly, both standards recognise that a diverse, inclusive and representative workforce is fundamental to delivering high-quality patient care. National evidence demonstrates that organisations where staff feel respected, valued, included and able to progress are more likely to achieve improved staff wellbeing, greater retention, better patient experience and improved patient safety outcomes. As such, WRES and WDES form a key part of the NHS approach to creating equitable workplaces and improving organisational culture for all colleagues.

2. Key elements

The Board is asked to note that the reports for the WRES and WDES have been completed based on the legacy organisations for 2025/26 as per required reporting.

These reports can be found as:

- **Appendix One:** WHH WRES 2025/26
- **Appendix Two:** BCH WRES 2025/26
- **Appendix Three:** WHH WDES 2025/26
- **Appendix Four:** BCH WDES 2025/26

Whilst reports are found separately, it is noted that combined action plans have been produced. The WRES plan can be found in **section 2.1** and the WDES plan can be found in **section 2.2** of this report.

2a) Summary of performance – WRES:

At North Cheshire and Mersey (formerly WHH), the 2025/26 WRES data shows continued growth in the ethnic diversity of the workforce, with BME representation increasing from 19.3% to 20.1%, primarily driven by growth within the clinical workforce. There were positive improvements in staff experience, including reductions in the proportion of BME staff reporting bullying, harassment or abuse from colleagues and reductions in discrimination from managers and colleagues. However, inequalities remain evident. The likelihood of BME staff being appointed from shortlisting deteriorated, with White applicants becoming more likely to be appointed and BME staff were also slightly more likely to enter formal disciplinary processes. Reports of harassment, bullying and abuse from patients, visitors and the public increased and overall there remains a significant disparity in the experience of BME and White staff despite progress in representation and anti-racism activity.

At Bridgewater Community Healthcare (BCH), the 2025/26 WRES report highlights steady long-term growth in racially minoritised workforce representation, reaching 7.2% of the workforce, alongside equitable access to non-mandatory training and development and no ethnic minority staff entering formal disciplinary processes during the reporting period. Improvements were also seen in experiences of harassment, bullying and abuse from patients, relatives and the public. However, deterioration was identified in staff survey measures, with higher levels of bullying, harassment and abuse from colleagues, lower confidence in career progression opportunities and increased reports of discrimination at work. Although Board representation remains broadly reflective of workforce diversity, the findings demonstrate that inequalities in workplace experience persist and require continued focus.

2b) Summary of performance – WDES:

At North Cheshire and Mersey (formerly WHH), the 2025/26 WDES findings demonstrate improving disability representation and disclosure rates, with the proportion of staff declaring a disability increasing from 5.16% to 5.8%, alongside reductions in unknown disability status declarations. Improvements were also seen in workforce representation across clinical, non-clinical and medical staff groups and historically strong recruitment outcomes for disabled applicants. The Trust has strengthened support through reasonable adjustment arrangements, disability awareness initiatives and governance structures. Nevertheless, disabled staff continue to report a less positive workplace experience than non-disabled colleagues, including

higher levels of harassment, bullying and abuse, lower confidence in career progression, lower feelings of being valued at work and a slight reduction in staff reporting that reasonable adjustments had been made. Disabled staff also remain underrepresented in senior leadership positions.

At Bridgewater Community Healthcare (BCH), the 2025/26 WDES report shows continued improvement in disability representation, with workforce disability declaration increasing to 5.9%, particularly within the clinical workforce. Progress was also evident through improved reporting of bullying and harassment incidents and sustained low levels of formal capability processes involving disabled staff. However, a number of staff experience indicators deteriorated during the year, including increased reports of harassment, bullying and abuse from patients, managers and colleagues, a reduction in disabled staff feeling valued at work, a decline in the proportion of disabled staff reporting reasonable adjustments were in place and lower staff engagement scores. While disclosure rates and representation continue to improve, the report highlights ongoing disparities in workplace experience and the need for continued focus on inclusion, reasonable adjustments and organisational culture.

2.1. Combined Workforce Race Equality Standard (WRES) action plan 2026/27

The combined WRES data shows continuing disparities in bullying, harassment, discrimination, career progression and representation at senior levels, despite improvements in overall ethnic diversity and network engagement. WHH data highlights ongoing disparities in appointment likelihood, disciplinary likelihood and experiences of harassment and discrimination. BCH data identifies deterioration in harassment by colleagues, discrimination and perceptions of career progression.

Theme / WRES indicator	Action	Timescale	Success Measures
Health and Wellbeing	Implement Mental Wellbeing Champion role and training programme with targeted promotion to ethnically diverse colleagues and staff networks.	September 2026	Improved wellbeing support uptake and positive feedback from staff networks.
Cultural competence	Implement Cultural Competency Training for managers and senior leaders. Priority targeting of managers leading internationally recruited and ethnically diverse teams.	November 2026 to March 2027	Improvement in Staff Survey questions relating to inclusion and belonging.
Anti-racism programme	Develop and launch the NCM Anti-Racism Programme aligned to the North West Race Equity Assembly, LCR Anti-Racism Strategy and NHS Race and Health Observatory recommendations.	April 2026 onwards	Single Trust anti-racism framework adopted and monitored.
Anti-racism assurance	Complete benchmarking exercise against regional and national anti-racism frameworks.	July 2026	Gap analysis completed and incorporated into implementation plan.

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Lord mann review	Implement Lord Mann Review recommendations across workforce policies, reporting mechanisms, education and staff support.	March 2027	Delivery plan approved and monitored through WICSC and SPC.
Training and Development	Embed anti-racism within EDI in Practice training.	August 2026	Increased confidence scores and manager capability.
Safety, Bullying and Harassment	Deliver Belonging Programme incorporating anti-bullying, harassment, sexual safety and violence reduction initiatives.	September 2026	Reduction in Staff Survey reports of bullying, harassment and discrimination.
Active bystander	Implement Active Bystander training programme across all services (including launch within Community and Dental services).	September 2026 start	Increased training participation and reporting confidence.
Career Progression and Representation	Target leadership development, talent management, reciprocal mentoring and succession planning to increase ethnic diversity in Bands 8a+ and leadership roles.	February 2027	Improved ethnic representation in senior leadership and talent pipelines.
Staff Voice and Networks	Strengthen the Multi-Ethnic Staff Network through targeted summits, anti-racism workshops and regular listening events.	September 2026	Increased network membership and action tracking from listening events.

2.2. Combined Workforce Disability Equality Standard action plan 2026/27

The combined WDES report highlights improvements in disability disclosure, but continuing concerns regarding bullying and harassment, feeling valued, reasonable adjustments, staff engagement and representation within senior grades. BCH data also highlights deterioration in harassment, bullying, feeling valued and reasonable adjustments.

Theme / WDES Indicator	Action	Timescale	Success Measures
Health and Wellbeing	Implement Mental Wellbeing Champion role and training programme, ensuring strong links into disability and long-term condition support.	September 2026	Increased wellbeing support awareness and uptake.
Disability disclosure	Increase disability disclosure through targeted communications, self-declaration campaigns and manager awareness.	March 2027	Reduction in unknown disability declaration rates and increased disclosure levels.
Workplace passport	Complete review of Workplace Passport informed by NHS Staff Survey disability findings.	October 2026	Updated passport approved and accessible across all services.
Workplace passport resources	Develop on-demand manager and staff resources supporting completion of Workplace Passports.	October 2026	Resources published and monitored.
Passport relaunch	Launch revised Workplace Passport and targeted communications programme.	November 2026	Increased passport utilisation and positive feedback.
Reasonable adjustments	Review low-scoring Staff Survey findings regarding reasonable adjustments and target EDI in Practice training towards managers.	March 2027	Improvement in future Staff Survey reasonable adjustment scores.

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Safety, Bullying and Harassment	Deliver Belonging Programme incorporating bullying, discrimination, sexual safety, violence reduction and disability inclusion.	September 2026	Reduction in bullying and harassment indicators for disabled staff.
Active bystander	Implement Active Bystander training programme across all services (including launch within Community and Dental services).	September 2026 start	Increased confidence to challenge inappropriate behaviours.
Reasonable adjustments culture	Embed reasonable adjustments guidance, Workplace Passport use and disability awareness through leadership development, EDI in Practice and manager training.	March 2027	Increased proportion of staff reporting adjustments are implemented effectively.
Staff Voice and Disability Network	Strengthen the Disability Awareness Network through targeted summits, disability knowledge workshops and regular listening events.	October 2026	Increased network membership and visible actions from staff feedback.
Leadership and Career Development	Target mentoring, talent management and leadership development opportunities for disabled staff and colleagues with long-term conditions.	September 2026 start	Improved representation at senior grades and improvement in staff feeling valued and career progression metrics.

3. Actions required/responsible officer

The Chief People Officer is the executive lead for workforce equality, diversity and inclusion. This includes all statutory reporting requirements.

4. Measurements/evaluations

As detailed in the reports, located appendix one to four.

5. Trajectories/objectives agreed

As detailed in section 2.1 and 2.2.

6. Monitoring/reporting routes

Actions associated with the WRES and WDES will be integrated into the Workforce Equality, Diversity and Inclusion Strategy 2026-27 delivery dashboard.

Monitoring of the Workforce Equality, Diversity and Inclusion Strategy 2026-27 delivery dashboard is completed by the People and Culture Sub-Committee, chaired by the Chief People Officer on a bi-monthly basis. From September 2025, quarterly WRES and WDES oversight groups led by the Chief People Officer with Staff Network leads are in place for enhanced scrutiny of activity.

In addition, as part of the NHS standard contract, progress updates associated with the WRES and WDES are reported bi-annually to the Clinical Quality Focus Group (CQFG) for assurance.

7. Timelines

Data reporting of the WRES and WDES were completed by 31 May 2026.

Following approval of the associated action plans, found in sections 2.1 and 2.2, the Trust is required to submit the plan to NHS England and publish on its website by 31 October 2026.

8. Assurance committee (if relevant)

Strategic People Committee

9. Recommendations

The Trust Board is asked to receive the contents of this paper, appendices and approve the action plans, found in sections 2.1 and 2.2, for submission to NHS England and publication on the Trust website by 31 October 2026.

North Cheshire and Mersey
NHS Foundation Trust

Workforce Race Equality Standard

North Cheshire and Mersey NHS Foundation Trust

(previously known as Warrington and Halton Teaching Hospitals NHS Foundation Trust)

2025-26

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Workforce Race Equality Standard

1. Background

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015 to improve equality of access to career opportunities and fair treatment for Black, Asian and Minority Ethnic (BAME) staff. NHS organisations must annually analyse performance against nine metrics and develop a Trust-wide improvement action plan, with Board oversight and approval.

The Trust must demonstrate progress against nine workforce equality indicators, including representation at all levels, including the Board. WRES measures help show the experience of our racially diverse workforce and support improved staff inclusion, patient care, safety and satisfaction.

WRES data was drawn from ESR, National Staff Survey results and the HR Business Partnering Team and submitted nationally in May 2026. The data is included at **section four**.

The 2025/26 WRES Action Plan has been informed by data analysis and comparison with the previous year at **section two**. WRES compliance and action plans are monitored by NHS England and the CQC as local intelligence for the well-led domain.

This report uses the WRES terminology Black and Ethnic Minorities (BME), with Black, Asian and Minority Ethnic (BAME) also used within indicator descriptions and the action plan.

2. Progress made in the previous year

The Trust has continued to deliver against the WRES action plan through partnership working with the Multi-Ethnic Staff Network and alignment with the NHS BAME Assembly Anti-Racist Organisation Framework.

Completed actions:
The Trust has successfully strengthened governance and organisational arrangements supporting race equality through the approval and establishment of the Anti-Racist Working Group and the wider Anti-Bullying and Harassment Working Group. The "See it. Report it. Stop it." campaign and regular Active Bystander training programme have been implemented and continue to support improvements in reporting, awareness and inclusive workplace behaviours.

The "Supporting Staff Who Become Patients" standard operating procedure has been launched, providing additional support for internationally recruited and ethnically diverse staff. Governance structures supporting inclusion and wellbeing

have also been further enhanced through new steering groups and oversight arrangements.

Several headline anti-racism actions have progress. Work continues with the North West Race Equity Assembly regarding the future Silver Anti-Racist Organisation Framework accreditation, with proposals now being aligned to the first North Cheshire and Mersey submission. Engagement with the Liverpool City Region Race Equality Hub also continues to support regional strategy development.

Actions in progress:
A number of workforce development initiatives are progressing, including cultural competency training, anti-racist learning programmes, reciprocal mentoring and Board development activity. While some milestones were revised to reflect capacity constraints and organisational integration, development work has continued and programmes are to continue to be progressed in the updated action plan.

3. Key findings in 2025/26

The full datasets identified as part of the Workforce Race Equality Standard (WRES) for 2025/26, can be found in **section four**. This section provides a high-level analysis of the key findings from the WRES reporting.

Analysis of the Trust's WRES data has identified improvements against a number of the WRES indicators, including:

- The Trust workforce profile for BME workforce increased from 19.32% to 20.10% in 2025/26, specifically within the clinical (Agenda for Change) workforce.
    - For the **non-clinical workforce** there were improvements in clusters two and three in 2025/26 whilst a slight reduction from 8.4% to 7.5% in cluster one and cluster four remained the same. It is noted that the overall workforce headcount for non-clinical reduced from 1358 to 1312 in the reporting period.
    - For the **clinical workforce** there were improvements in all clusters, apart from cluster three where the headcount remained the same but the percentage reduced from 9.9% to 9.4% with the total BME clinical workforce increasing from 19.2% to 20.6%.
    - For the **Medical and Dental workforce**, the percentage of BME consultants increased from 52.86% to 55.65%, however there was a reduction in the other grades. Overall, the total BME Medical and Dental workforce reduced from 59.66% to 57.88%.
- The percentage of BME staff who experienced harassment, bullying or abuse from other colleagues decreased slightly in 2025/26 from 26.04% to 22.03%.
- The percentage of BME staff who in the last 12 months experienced discrimination at work from staff decreased slightly in 2025/26 from 15.40% to 13.78%.

Analysis of the Trust's WRES data has also identified areas of deterioration in comparison with the 2024/25 results. They include:

- The relative likelihood of BME staff being appointed from shortlisting compared to White staff in 2024/25 is 1.49. This is a deterioration, whereby previously, this was reported as a disparity for White staff.
- The relative likelihood of BME staff entering the formal disciplinary process compared to White staff increased slightly to 1.16 in 2025/26. Whilst a negative ratio for BME staff, this has reflected the higher volume of casework in the organisation.
- The percentage of staff who experienced harassment, bullying or abuse from patients, visitors or the public increased in 2025/26.

Analysis of the Trust's WRES data has also identified areas of no change in comparison with the 2024/25 results. They include:

- The percentage of BME Board membership and the overall workforce remained static at 12.5%.

Overall, there remains a significant disparity in the experience of BME staff and White staff at the Trust. Although this is an improving picture, there remains work to be done to remove the imbalance. This is monitored through the Board Assurance Framework, under risk 2103.

4. Data report for 2025/26

Metric 1: Percentage of staff in each of the Agenda for Change Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

- Non-Clinical staff
- Clinical staff - of which, non-medical staff and Medical and Dental staff

Non-clinical workforce	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	72	7.5%	894	92.5%	0	0.0%	966
Cluster 2: AfC bands 5 to 7	11	4.7%	222	95.3%	0	0.0%	233
Cluster 3: AfC bands 8a and 8b	2	3.1%	63	96.9%	0	0.0%	65
Cluster 4: AfC bands 8c to VSM	3	6.3%	45	93.8%	0	0.0%	48
Total non-clinical	88	6.7%	1224	93.3%	0	0.0%	1312

Clinical workforce	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	135	14.8%	775	84.9%	3	0.3%	913
Cluster 2: AfC bands 5 to 7	463	24.6%	1378	73.3%	39	2.1%	1880
Cluster 3: AfC bands 8a and 8b	17	9.4%	162	89.5%	2	1.1%	181
Cluster 4: AfC bands 8c to VSM	1	6.7%	14	93.3%	0	0.0%	15
Total clinical	616	20.6%	2329	77.9%	44	1.5%	2989

Medical and Dental	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Medical & Dental Staff, Consultants	128	55.65%	96	41.74%	6	2.61%	230
Medical & Dental Staff, Non-Consultants career grade	55	74.32%	17	22.97%	2	2.70%	74

Medical & Dental Staff, Medical and dental trainee grades	63	52.07%	57	47.11%	1	0.83%	121
Total Medical and Dental	246	57.88%	170	40.00%	9	2.12%	425

Total workforce	**BME**		**White**		**Unknown**		**Total**
	Num	%	Num	%	Num	%	
Number of staff in workforce	950	20.10%	3723	78.78%	53	1.12%	4726

Metric 2: Relative likelihood of staff being appointed from shortlisting across all posts.

2025/26	2024/25
The relative likelihood of White staff being appointed from shortlisting compared to BME staff was **1.49**. This indicates BME candidates are less likely to be appointed compared to White candidates.	The relative likelihood of White staff being appointed from shortlisting compared to BME staff was **0.83**. This indicates BME candidates are more likely to be appointed compared to White candidates.

N.B. A value of "1.0" for the likelihood ratio means that White and BME staff are equally likely to be appointed from shortlisting, whilst a value above 1 indicates that white candidates are more likely to be appointed than BME candidates and a value below 1 indicates that White candidates are less likely to be appointed than BME candidates.

Metric 3: Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation.

2025/26	2024/25
The relative likelihood of BME staff entering the formal disciplinary process compared to White staff was **1.17**. This indicates that BME staff are more likely to enter the formal disciplinary proceeding compared to White staff.	The relative likelihood of BME staff entering the formal disciplinary process compared to White staff was **0.89**. This indicates that BME staff are less likely to enter the formal disciplinary proceeding compared to White staff.

N.B. A value of “1.0” for the likelihood ratio means that BME and White staff are equally likely to enter formal disciplinary proceedings, whilst a value above 1 indicates that BME staff are more likely to enter formal disciplinary proceedings than White staff and a value below 1 indicates that BME staff are less likely to enter formal disciplinary proceedings than White staff.

Metric 4: Relative likelihood of staff accessing non-mandatory training and CPD.

2025/26	2024/25
The relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff was **0.83**. This indicates that BME staff are more likely to access non-mandatory training or CPD in comparison to White staff.	The relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff was **0.95**. This indicates that BME staff are more likely to access non-mandatory training or CPD in comparison to White staff.

N.B. A value of “1.0” for the likelihood ratio means that white and BME staff are equally likely to access non-mandatory training or CPD, whilst a value above 1 indicates that white staff are more likely to access non-mandatory training or CPD than BME staff and a value below 1 indicates that white staff are less likely to access non-mandatory training or CPD than BME staff.

Metric 5 to 8 (linked to the Staff Survey 2025):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7. Percentage of staff believing that their organisation provides equal opportunities for career progression/promotion (It is noted that this question has changed and therefore does not have comparable data to previous years).
8. In the last 12 months have you personally experienced discrimination at work from any of the following? (b) Manager/team leader or other colleagues.

Question	White				Black, Asian and Minority Ethnic (BAME)			
	2022	2023	2024	2025	2022	2023	2024	2025
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	21.21%	19.69%	19.75%	**18.88%**	25.50%	28.24%	29.51%	**33.10%**
Q14b/c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	21.76%	17.60%	17.81%	**17.29%**	30.87%	21.88%	26.04%	**22.03%**
Q15) Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion	Change in question and therefore no comparable data is available			**57.70%**	Change in question and therefore no comparable data is available			**49.13%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	4.74%	5.35%	4.75%	**5.47%**	18.92%	13.33%	15.40%	**13.78%**

N.B. What follows is a breakdown of metrics 6 and 8 (questions 14c and 16b, respectively) to allow for the analysis of which ethnic groups are experiencing more instances of bullying, harassment, abuse and discrimination in the organisation. This would then allow for more direct positive action.

Question	White - British			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	17.04%	14.52%	13.65%	**13.73%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	4.57%	5.29%	4.49%	**5.21%**

Question	White - Irish			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	10.00%	13.33%	10.00%	**28.57%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	0.00%	12.50%	11.11%	**7.69%**

Question	White – Any other background			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	22.22%	16.22%	23.53%	**32.14%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	11.11%	5.41%	12.00%	**18.52%**

Question	Asian/Asian British – Indian			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	27.59%	19.47%	21.30%	**21.24%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	22.41%	13.27%	15.52%	**18.26%**

Question	Asian/Asian British – Pakistani			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	N/A	23.08%	19.05%	**22.73%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	N/A	23.08%	14.29%	**17.39%**

Question	Asian/Asian British – Chinese			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	8.33%	13.33%	21.74%	**15.38%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	9.09%	0.00%	13.04%	**0.00%**

Question	Asian/Asian British – Any other background			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	26.67%	31.58%	27.54%	**17.65%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	20.00%	18.42%	11.76%	**11.76%**

Question	Black/African/Caribbean/Black British - African			
	2022	2023	2024	2025
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	N/A	8.70%	30.00%	**15.63%**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	N/A	8.70%	16.00%	**6.45%**

Metric 9: Percentage difference between the organisation's Board voting membership and its overall workforce.

Percentage difference between:

i. the organisations' Board voting membership and its overall workforce
ii. the organisations' Board executive membership and its overall workforce

	2025/26			2024/25		
	WHITE	**BAME**	**ETHNICITY UNKNOWN**	**WHITE**	**BAME**	**ETHNICITY UNKNOWN**
Total Board members - % by Ethnicity	**92.86%**	**7.14%**	**0.00%**	93.3%	6.7%	0%
Voting Board members - % by Ethnicity	**90.00%**	**10.00%**	**0.00%**	91.7%	8.3%	0%
Non-Voting Board Member - % by Ethnicity	**100.00%**	**0.00%**	**0.00%**	100%	0%	0%
Executive Board Member - % by Ethnicity	**87.50%**	**12.50%**	**0.00%**	87.5%	12.5%	0%
Non-Executive Board Member - % by Ethnicity	**100.00%**	**0.00%**	**0.00%**	100%	0%	0%
Overall workforce - % by Ethnicity	**78.8%**	**20.1%**	**1.1%**	79.5%	19.3%	1.2%
Difference (Total Board compared to Overall Workforce)	**14%**	**-13%**	**-1%**	14%	-13%	-1%

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Workforce Race Equality Standard

2026

Date: August 2026



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Introduction

The Trust is committed to intentional anti-racism, taking action to identify and address the structural, systemic, and personal racism that impacts on racially minoritised staff in the workplace, and that contributes to an inequitable and exclusive society.

The Workforce Race Equality Standard has been mandated for all NHS providers since 2015. It was established to focus action to reduce the disparity in representation and experience of racially minoritised staff in the NHS, this followed the publication in 2014 of Roger Kline's The Snowy White Peaks of the NHS report.

The nine indicators look at difference in workplace experience for racially minoritised and white staff, from likelihood of being recruited, to career advancement, involvement in disciplinary processes, and experiences of bullying and harassment and discrimination from different sources.

The WRES is a mandatory requirement set out in the NHS Standard Contract, and in additional to online submission of results to NHS England all Trusts must publish an annual report detailing the results against the nine indicators and an action plan to address identified disparity in the results. The timeline for compliance is as follows:

- Submission of results against nine indicators by 31st May.
- Publication of full report and action plan by 31st October.

Data is collated from the electronic staff record and the annual NHS Staff Survey before being presented to stakeholder groups, in the case of this Trust the Race Inclusion Network, for co-design of action plans.

Responsibility for delivery of the report and action plan sits with the Equality, Diversity, and Inclusion Working Group, with oversight of the action plan ultimately resting with the Trust Board for sign off and approval.

In addition to being monitored by NHS England, compliance with the WRES and subsequent action plans are also monitored by Trust commissioners and by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

In this report are detailed key findings from the 2026 WRES metrics; progress made in 2025/26 against the WRES action plan; and data for the nine indicators, including annual comparisons since 2019, and for the 2026 ethnicity pay gap reporting.

The outline WRES Action Plan 2026 - 2027 can be viewed at page 23 of this report.

Key findings

Key findings in brief are as follows.

Indicator 1:

- Overall workforce representation of racially minoritised staff has continued to increase since WRES reporting began in 2015, with representation now at 7.2%.
- The percentage of unknown ethnicity staff representation increased by 0.4% in the year to 0.3%, this represents less than 20 staff in total who have chosen to not self-report their ethnicity.
- Disaggregation by staff group shows:

    - Racially minoritised staff represent 7.2% of the non-clinical workforce, a percentage that continues to increase. The non-clinical workforce is over-represented against the overall ethnicity profile of the workforce in Agenda for Change (AfC) band cluster 5 to 7 but is under-represented in other pay bands.
    - The clinical workforce is under-representative against the overall workforce ethnicity figure, though percentage representation is increasing. Racially minoritised staff are over-represented in AfC band cluster 8c to Very Senior Managers against the overall workforce.
    - The medical and dental workforce is over-represented by a significant percentage, a similar pattern to that seen across the NHS.

Indicator 2:

- Due to a reporting issue within NHS Jobs the Trust is unable to report on indicator 2, and issue affecting other Trusts also using the NHS Jobs recruitment function and an issue that is being worked on nationally.
- Analysis does show that of the staff recruited in 2025 – 2026, 14.9% self-reported as from racially minoritised backgrounds, more than two times that of the overall workforce representation figure.

Indicator 3:

- The likelihood of racially minoritised staff being involved in formal disciplinary processes has improved to a figure of 0.00, indicating that there were no racially minoritised staff in formal disciplinary processes during the reporting period.

Indicator 4:

- At 0.97 the access to non-mandatory training and career development result for indicator 4 represents equity, with a very slight bias in favour of racially minoritised staff.

Indicator 5:

- At 17.8% the percentage of racially minoritised staff experiencing harassment, bullying, or abuse from patients, family or public has improved by 3.0% and is 4.4% better than the average for comparator Trusts. This figure also matches that of white staff in the Trust.

Indicator 6:

- At 28.9% the percentage of racially minoritised staff who have experienced harassment, bullying, or abuse from colleagues has deteriorated by 6.3%, and the Trust result is 11.9% worse than the average for comparator Trusts. The gap to white staff has also increased to 9.2%.

Indicator 7:

- At 35.6% the percentage of racially minoritised staff who believe the Trust provides equity for career progression and promotion has decreased by 8.6%, and there is negative a gap of 17.3% with the average for comparator Trusts. The gap to white staff increased to 18.8%.

Indicator 8:

- At 15.6% the percentage of racially minoritised staff who experienced discrimination at work in the last 12 months has deteriorated by 2.4%. There is a gap of 5.1% against the average for comparator Trusts, and 10.6% to white staff.

Indicator 9:

- The Board, including Non-Executive Directors is broadly representative of racially minoritised staff.

Ethnicity pay gap:

- The ethnicity pay gap for the overall workforce was in favour of ethnically diverse staff. The mean result was – 38.79%, or - £8.43 in favour of ethnically diverse staff, and the median result was – 15.57%, or - £3.08 in favour of ethnically diverse staff. More analysis by staff group can be found in the relevant section.

Activities in 2025 - 2026

During the past year the following actions that should positively impact on the experiences of racially minoritised staff have been started and/or finished:

- Successful accreditation as an NHS Anti-Racist Framework bronze level Trust. And beginning collaborative work with Warrington and Halton Teaching Hospitals NHS Foundation Trust on Framework progression as a single organisation.

- Ongoing support provided to the NHS North West Race Equity Assembly as a volunteer assessor for the NHS Anti-Racist Framework.

- Continued involvement with the Liverpool City Region Anti-Racism Strategy public sector leads steering group.

- Collaborative partnership work between the Race Inclusion Network and Warrington and Halton Teaching Hospitals NHS Trust's Multi Ethnic Staff Network in preparation for integration as one organisation, including communications around Ramadan, and Black History Month.

- Publication of the new international staff welcome pack, and embedding international staff support further in recruitment processes.

- Continued focus on racially minoritised staff in Equality and Health Inequalities Assessments, including focused support through integration engagement, and formal Transfer of Undertakings (Protection of Employment) processes.

Data sets

Indicator 1

Indicator 1 reports the percentage of staff by pay band. This data is disaggregated by non-clinical, clinical, and medical and dental staffing groups, and reporting is by pay band clusters as follows:

- Cluster 1 = Agenda for Change (AfC) under band 1 to band 4
- Cluster 2 = AfC bands 5 to 7
- Cluster 3 = AfC bands 8a and 8b
- Cluster 4 = AfC band 8c to Very Senior Managers (VSM – Executive Board Members)

The percentage breakdown by non-clinical, clinical, and medical and dental staff is provided in tables 1 to 3.

Table 1: Showing the percentage of non-clinical staff by ethnicity, disaggregated by pay band cluster at 31st March 2026.

Non clinical staff	Racially minoritised	White staff	Unknown ethnicity
Cluster 1: AfC <1 to 4	4.3%	93.5%	2.2%
Cluster 2: AfC 5 to 7	16.5%	81.3%	2.2%
Cluster 3: AfC 8a and 8b	3.4%	96.6%	0.0%
Cluster 4: 8c to VSM	4.8%	95.2%	0.0%
Total for non clinical workforce:	7.2%	90.9%	1.9%

Table 2: Showing the percentage of clinical staff by ethnicity, disaggregated by pay band cluster at 31st March 2026.

Clinical staff	Racially minoritised	White staff	Unknown ethnicity
Cluster 1: AfC <1 to 4	5.9%	93.7%	0.3%
Cluster 2: AfC 5 to 7	5.2%	93.9%	0.8%
Cluster 3: AfC 8a and 8b	1.8%	96.4%	1.8%
Cluster 4: 8c to VSM	10.0%	90.0%	0.0%
Total for clinical workforce:	5.3%	93.9%	0.8%

Table 3: Showing the percentage of medical and dental staff by ethnicity, disaggregated by consultants, career grade medical and dental staff, and where relevant medical and dental staff as very senior managers, at 31st March 2026.

Medical and dental staff	Racially minoritised	White staff	Unknown ethnicity
Consultants	50.0%	30.0%	20.0%
Of which very senior managers	0.0%	100.0%	0.0%
Non consultant career grade	28.8%	68.5%	2.5%
Trainee	-	-	-
Other	-	-	-
Total for medical and dental workforce:	31.3%	63.9%	4.8%

Tables 4 to 7 to follow show the results for the overall workforce, and the three staff groups from 2015 to 2026, showing patterns of change of ethnic representation.

Table 4: Showing the ethnicity breakdown of the workforce from 2015 to 2026.

Full workforce	Racially minoritised staff	White staff	Not known	Total Staff Number
2015	2.5%	95.6%	1.9%	3,325
2016	2.4%	93.5%	4.1%	3,251
2017	2.6%	90.8%	6.6%	3,305
2018	2.8%	90.6%	6.6%	3,005
2019	3.0%	89.9%	7.2%	3,016
2020	5.7%	89.1%	5.1%	2,048
2021	5.4%	90.5%	4.2%	1,730
2022	5.8%	90.7%	3.5%	1,722
2023	6.2%	92.0%	1.8%	1,541
2024	6.3%	91.8%	1.9%	1,660
2025	6.6%	92.5%	0.9%	1,652
2026	7.2%	91.5%	1.3%	1,513*

* Note: Total and workforce calculations exclude six Non-Executive Directors as per WRES technical guidance. These staff are included in calculating indicator 9, as per guidance.

Table 5: Showing the percentage of ethnic representation in non-clinical staff from 2015 to 2026.

Non clinical staff	Racially minoritised staff	White staff	Not known
2015			1.9%
2016	2.1%	94.3%	3.6%
2017	2.2%	89.5%	8.3%
2018	2.5%	89.4%	8.1%
2019	2.4%	91.8%	5.8%
2020	3.0%	92.1%	4.9%
2021	3.7%	91.6%	4.7%
2022	4.4%	91.6%	4.0%
2023	5.3%	92.7%	2.0%
2024	6.2%	91.1%	2.7%
2025	6.9%	91.7%	1.4%
2026	7.2%	90.0%	1.9%

Table 6: Showing the percentage ethnic representation in clinical staff from 2015 to 2026.

Clinical Staff	Racially minoritised staff	White staff	Not known
2015			1.9%
2016	1.8%	93.8%	4.4%
2017	2%	92.3%	5.7%
2018	2.1%	92.0%	5.9%
2019	2.4%	90.0%	7.6%
2020	3.5%	91.6%	4.9%
2021	4.3%	91.9%	3.8%
2022	4.6%	92.2%	3.2%
2023	6.6%	91.8%	1.6%
2024	4.5%	94.1%	1.4%
2025	4.7%	94.8%	0.5%
2026	5.3%	93.9%	0.8%

Table 7: Showing the percentage ethnic representation of Medical and Dental staff from 2015 to 2026.

Medical and Dental Staff	Racially minoritised staff	White staff	Not known
2015			3.6%
2016	18.4%	79.6%	2.0%
2017	19.3%	70.1%	10.5%
2018	22.3%	68.1%	9.6%
2019	20.5%	70.5%	9.0%
2020	36.6%	55.2%	8.2%
2021	30.5%	64.4%	6.1%
2022	30.1%	63.9%	6.0%
2023	34.5%	57.1%	4.8%
2024	34.7%	60.0%	5.3%
2025	33.8%	62.3%	3.9%
2026	31.3%	63.9%	4.8%

Indicator 2

The second indicator looks at recruitment and the likelihood of racially minoritised staff being successful in recruitment from shortlisting to appointment. As a likelihood figure the following applies to the results:

- A result below 1.0 indicates a greater likelihood of success for racially minoritised applicants.
- A result above 1.0 indicates a greater likelihood of success for white applicants.
- A result of 1.0 indicates equity between racially minoritised and white applicants.

Table 8: Showing the likelihood of racially minoritised applicants being successfully recruited compared to white applicants from 2015 to 2026. Also showing the numbers of applicants recruited by ethnicity for this period.

	Likelihood	Total racially minoritised staff recruited	Total white staff recruited	Total not stated staff recruited
2015				*
2016	1.72	24	532	160
2017	1.30	31	498	120
2018	1.24	24	418	30
2019	1.28	23	395	10
2020	1.39	13	224	17
2021	0.61	36	310	*
2022	1.17	23	276	*
2023	1.44	23	209	*
2024	Not available	22	272	*
2025	Not available	17	167	*
2026	Not available	11	59	*

Indicator 3

Indicator 3 details the relative likelihood of racially minoritised staff entering formal disciplinary processes compared to not white staff.

A likelihood figure above 1 indicates that racially minoritised staff are more likely to enter formal disciplinary processes than white staff. A likelihood figure of 1 indicates equity between racially minoritised and white staff.

Table 9: Showing the likelihood of racially minoritised staff entering formal disciplinary processes compared to white staff from 2015 to 2026.

	Likelihood
2015	6.46
2016	4.93
2017	3.83
2018	1.99
2019	2.72
2020	2.40
2021	0.00
2022	0.00
2023	2.46
2024	1.53
2025	1.13
2026	0.00

Indicator 4

Likelihood of racially minoritised staff undertaking non-mandatory training and professional development compared to white staff.

A likelihood figure above 1 indicates that racially minoritised staff are more likely to enter formal disciplinary processes than white staff. A likelihood figure of 1 indicates equity between racially minoritised and white staff.

Table 10: Showing the likelihood of racially minoritised staff accessing non-mandatory training and career development opportunities from 2015 to 2026.

	Likelihood
2015	0
2016	0.55
2017	0.9
2018	1.1
2019	1.74
2020	0.6
2021	1.09
2022	0.57
2023	1.79
2024	1.05
2025	1.05
2026	0.97

Indicators 5 to 8 are taken from the NHS Staff Survey 2025.

- For indicator 5 there were 45 racially minoritised, and 763 white respondents.
- For indicator 6 there were 45 racially minoritised, and 765 white respondents.
- For indicator 7 there were 45 racially minoritised, and 754 white respondents.
- For indicator 8 there were 45 racially minoritised, and 765 white respondents.
- In total 52.5% of all staff responded to the NHS Staff Survey 2025. When mapped against workforce totals at 41.3% the number of racially minoritised respondents was below that for the overall workforce.

Indicator 5 – Harassment, bullying, or abuse from patients, families, or the public

Table 11: Showing the percentage of staff experiencing at least one incident of harassment, bullying, or abuse from patients, family members, or the public in the last 12 months.

	Bridgewater racially minoritised staff	Bridgewater white staff	Benchmark Trusts racially minoritised staff	Benchmark Trusts white staff
2015	0.0*	28.0%	25.0%	26.0%
2016	23.0%	29.0%	24.0%	24.0%
2017	28.6%	25.8%	26.9%	23.4%
2018	37.5%	26.0%	26.1%	25.7%
2019	28.0%	23.1%	23.7%	25.2%
2020	30.3%	18.2%	23.4%	21.9%
2021	22.2%	20.1%	24.3%	20.6%
2022	29.2%	21.6%	24.2%	21.5%
2023	28.6%	16.2%	21.8%	18.9%
2024	20.8%	13.5%	21.6%	17.6%
2025	17.8%	17.8%	22.2%	17.8%
Trust Trend 2024 to 2025	Improved by 3.0%			
Against benchmark group for 2024	Positive by 4.4%	*Note: Figure too low to report in 2015		

Indicator 6 – Harassment, bullying, or abuse from managers or colleagues

Table 12: Showing the percentage of staff who have experienced at least one incident of harassment, bullying, or abuse from colleagues in the last 12 months.

	Bridgewater racially minoritised staff	Bridgewater white staff	Benchmark Trusts racially minoritised staff	Benchmark Trusts white staff
2015	0.0*	23.0%	24.0%	22.0%
2016	26.0%	24.0%	24.0%	18.0%
2017	21.4%	20.4%	21.8%	18.6%
2018	16.7%	17.5%	24.0%	19.6%
2019	20.0%	20.8%	23.8%	19.6%
2020	15.6%	17.8%	22.9%	16.9%
2021	13.3%	16.9%	20.0%	15.9%
2022	25.0%	16.9%	22.4%	15.6%
2023	19.1%	16.5%	19.4%	15.5%
2024	22.6%	14.7%	17.1%	14.2%
2025	28.9%	19.7%	17.7%	13.9%
Trust Trend 2023 to 2024	Deteriorated by 6.3%			
Against benchmark group for 2024	Negative by 11.9%			

Indicator 7 – Belief that the Trust provides equal opportunities for career progression

Table 13: Showing the percentage of staff who believed the Trust provided equal opportunities for career progression.

	Bridgewater racially minoritised staff	Bridgewater white staff	Benchmark Trusts racially minoritised staff	Benchmark Trusts white staff
2017	50.0%	55.6%	47.3%	61.7%
2018	48.0%	59.1%	47.5%	60.7%
2019	48.0%	58.4%	47.8%	62.5%
2020	33.3%	60.1%	46.8%	66.3%
2021	51.1%	58.9%	50.3%	66.0%
2022	45.8%	62.0%	50.2%	65.9%
2023	34.2%	61.1%	53.7%	65.8%
2024	44.2%	62.7%	54.6%	63.4%
2025	35.6%	54.4%	52.9%	60.2%
Trust Trend 2023 to 2024	Deteriorated by 8.6%			
Against benchmark group for 2024	Negative by 17.3%			

Indicator 8 – Experiences of discrimination from line managers or colleagues

Table 14: Showing the percentage of staff experiencing discrimination from managers or colleagues in the last 12 months.

	Bridgewater racially minoritised staff	Bridgewater white staff	Benchmark Trusts racially minoritised staff	Benchmark Trusts white staff
2015	*	4.0%	12.0%	5.0%
2016	6.0%	7.0%	4.0%	11.0%
2017	11.1%	8.1%	12.1%	5.5%
2018	8.3%	4.4%	10.7%	4.9%
2019	16.0%	4.9%	12.2%	4.3%
2020	12.1%	4.4%	13.5%	4.3%
2021	13.3%	3.6%	12.7%	4.3%
2022	10.4%	3.8%	12.1%	4.2%
2023	7.5%	3.0%	10.8%	4.3%
2024	13.2%	4.7%	10.8%	4.4%
2025	15.6%	5.0%	10.5%	4.7%
Trust Trend 2023 to 2024	Deteriorated by 2.4%			
Against benchmark group for 2024	Negative by 5.1%			

Indicator 9 – Board representation

Percentage difference between the organisation's Board overall membership and its overall workforce.

Table 15: Showing Board representation of racially minoritised and white staff compared to the overall workforce from 2015 to 2026.

	Racially minoritised	White	Not known
2015	*	*	*
2016	-2.5%	2.5%	0.0%
2017	-2.6%	9.2%	-6.6%
2018	-2.9%	-4.1%	7.0%
2019	-3.0%	-8.1%	11.0%
2020	3.4%	-25.6%	22.2%
2021	8.9%	-19.0%	10.1%
2022	7.6%	-17.4%	9.8%
2023	8.1%	-20.7%	12.6%
2024	0.8%	-6.0%	5.2%
2025	9.0%	-8.0%	-1.0%
2026	8.0%	-7.0%	-1.0%

Ethnicity Pay Gap March 2026

As part of the NHS EDI Improvement Plan all Trusts have been required to publish ethnicity pay gap data from April 2024.

Pay gap reporting is based on a set point in time every year, for ordinary pay this is all staff who were paid at 31st March – termed relevant staff. For bonus pay this is all staff paid bonus pay in the year from 1st April to 31st March, in the Trust this relates to clinical excellence awards.

Results for 2026 are to follow, and the results for 2024 and 2025 can be found in the WRES 2025 report, available on request.

Ordinary pay

On 31 March 2026 we employed 1,419 staff who were relevant to ethnicity pay gap reporting, including any bank staff paid for work in the relevant period, and excluding substantive staff on statutory sick or maternity pay only on that date.

Table 16 shows the number of racially minoritised and white staff in each pay quartile, the division of female and male staff into four roughly equal groups based on hourly pay.

Table 16: Showing the numbers and percentage of ethnically diverse and white staff in quartiles based on hourly pay at 31st March 2026.

Racially minoritised staff	Total	Percentage %	White staff	Total	Percentage %
1	17	4.8%	1	337	95.2%
2	23	6.5%	2	332	93.5%
3	21	5.9%	3	333	94.1%
4	36	10.1%	4	320	89.9%

The table to follow provides annual quartile breakdowns, it will be observed that the numbers of racially minoritised staff have remained stable, while the numbers of white staff in the quartiles has reduced, particularly between 2025 and 2026.

Table 17: Showing the number of staff by ethnicity and quartiles from 2024 to 2026.

	Racially minoritised staff					White staff			
	1	2	3	4		1	2	3	4
2024	19	17	23	38		361	379	384	367
2025	17	20	26	36		370	368	363	351
2026	17	23	21	36		337	332	333	320

The table to follow details the ethnicity pay gap as a monetary value and percentage. A positive value indicates a pay gap in favour of white staff, a negative value indicates a pay gap in favour of racially minoritised staff.

Table 18: Showing the ethnicity pay gap results at 31st March 2026 as a monetary figure, and a percentage, based on hourly rates of pay for racially minoritised and white staff.

	Mean hourly rate of pay	Median hourly rate of pay
Racially minoritised staff		**£22.86**
White staff	**£21.72**	**£19.78**
Pay Gap monetary value	**- £8.43**	**- £3.08**
Pay Gap percentage value	**- 38.79%**	**- 15.57%**

It is observed in the table above that there is a positive pay gap in favour of ethnically diverse staff, particularly in relation to mean pay.

Th following table shows the results for mean and median ethnicity pay gaps from 2024 to 2026.

Table 19: Showing the mean and median ethnicity pay gaps from 2024 to 2026.

	Mean Ethnicity Pay Gap %	Mean Ethnicity Pay Gap £	Median Ethnicity Pay Gap %	Median Ethnicity Pay Gap £
2024				**-£2.12**
2025	**-27.68%**	**-£5.64**	**-8.00%**	**-£1.49**
2026	**-38.79%**	**-£8.43**	**-3.08%**	**-£15.57**

To understand ethnicity pay gaps better the Trust has undertaken further analysis by staff group as we understand that the Medical and Dental staff is over-representative of ethnically diverse staff compared to the overall workforce, and with the larger percentage of this group in quartile 4 the figures overall can be impacted.

- Within the total relevant staff for ethnicity pay gap reporting 6.8% are racially minoritised, and 93.2% are white.

Non-clinical staff

- Ethnicity pay gap analysis for non-clinical staff provides the following results:

    - A mean ethnicity pay gap of – 26.73% (equating to - £5.95) in favour of ethnically diverse staff.
    - A median ethnicity pay gap of – 38.8% (equating to - £5.40) in favour of racially minoritised staff.

- In the Trust 24.9% of the workforce are in non-clinical roles, this includes some of the Executive Directors and all Non-Executive Directors.

- At 7.1% of the non-clinical workforce racially minoritised staff representation is reflective of the overall workforce.

Clinical staff

- Ethnicity pay gap analysis for clinical staff provides the following results:

    - A mean ethnicity pay gap of 5.12% (equating to £1.09) in favour of white staff.
    - A median ethnicity pay gap of 7.4% (equating to £1.55) in favour of white staff.

- The clinical workforce, excluding Medical and Dental represents 69.7% of the overall workforce.

- At 4.95% the clinical workforce is under-representative of racially minoritised staff when compared to the overall workforce.

Medical and Dental staff

- Medical and Dental roles represent 5.4% of the overall workforce, and at 29.9% ethnically diverse staff are over-representative of the overall workforce.

- Ethnicity pay gap analysis for medical and dental staff provides the following results:

    - A mean ethnicity pay gap of – 21.74% (equating to - £10.40) in favour of ethnically diverse staff.
    - A median ethnicity pay gap of 12.50% (equating to £5.97) in favour of white staff.

Bonus pay

There were no clinical excellence awards in the Trust awarded in 2025/2026, therefore the result is 0.00% or £0.00.

Contact details

Thank you for taking the time to read our 2026 WRES 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

Workforce Disability Equality Standard

North Cheshire and Mersey NHS Foundation Trust

(previously known as Warrington and Halton Teaching Hospitals NHS Foundation Trust)

2025-26

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Workforce Disability Equality Standard

1. Background

The Workforce Disability Equality Standard (WDES) was introduced in 2019 to support NHS organisations in understanding and improving the workplace and career experiences of disabled staff. NHS organisations are required to report annually against ten national indicators and develop an action plan for improvement, with Board oversight and approval.

The indicators assess workforce representation, staff experience and organisational inclusion, helping to create a more supportive and equitable working environment. Research continues to demonstrate links between an inclusive workforce, improved staff wellbeing, better patient outcomes and enhanced patient safety.

WDES data has been drawn from ESR, the National Staff Survey and local workforce data and has been used to inform the 2025/26 WDES Action Plan. Progress against the action plan is monitored through established governance arrangements and forms part of the evidence considered by NHS England and the Care Quality Commission within the well-led framework.

This report uses the terminology "disabled staff" and "non-disabled staff" in line with WDES technical guidance, with references to long-term health conditions where relevant to National Staff Survey indicators.

2. Progress made in the previous year

The Trust has made good progress in delivering the majority of actions arising from the previous WDES action plan, providing evidence of sustained commitment to improving the experience of disabled staff. Several actions are now complete and embedded, whilst others remain in progress as part of longer-term cultural and organisational change programmes. The action plan has been developed in partnership with the Disability Awareness Network and continues to be monitored through established governance arrangements.

Completed actions:
Significant progress has been achieved in relation to reasonable adjustments. The Reasonable Adjustments Hub has been successfully relaunched, updated resources and guidance have been introduced and resources to support disability disclosure during recruitment and employment checks have been implemented. Easy-read reasonable adjustments guidance has also been developed and launched for staff and managers, helping improve accessibility and awareness across the organisation.

The organisation has strengthened awareness of Access to Work and related support mechanisms through refreshed standard operating procedures, targeted communications and supporting attendance resources. The anti-bullying and harassment improvement programme has also been launched, including the "See it. Report it. Stop it." campaign, Active Bystander training and establishment of the Anti-

Bullying and Harassment Working Group. Governance arrangements have been strengthened through the creation of a Culture, Inclusion and Wellbeing Steering Group in 2025/26 and associated terms of reference.

Work continues to improve disability disclosure rates, particularly amongst medical and dental staff, through targeted communications, appraisal discussions and educational interventions. Further work is underway with Medical Education to strengthen awareness of reasonable adjustments and improve confidence in disability declaration.

Actions in progress:
Several strategic initiatives remain ongoing, including review and relaunch of the Workplace Passport, further development of a manager bitesize learning package, exploration of an insourced reasonable adjustments service and continued work to increase engagement with the Disability Awareness Network through the Networks in Common model.

The Trust is also progressing a wider programme of disability awareness and leadership development through training, reciprocal mentoring, Board development sessions and the review of organisational EDI objectives to align with the emerging priorities of NCM.

3. Key findings in 2025/26

The full datasets identified as part of the Workforce Disability Equality Standard (WDES) for 2025/26, can be found in **section four**. This section provides a high-level analysis of the key findings from the WDES reporting.

Analysis of the Trust's WDES data has identified improvements against several of the WDES indicators, including:

- Reporting of disability declarations improved year on year for clinical and non-clinical staff. This is an increase to:
    - 5.16% of staff declaring a disability in 2024/25 compared 5.8% in 2025/26.
    - 79.97% of staff declaring they do not have a disability in 2024/25 compared with 81.61% in 2026.
    - 14.87% of staff not declaring their disability status (unknown declaration) in 2024/25 compared with 12.59% in 2025/26. A decrease of 2.28%
- For non-clinical staff, there was an improvement in clusters one, two and four compared to 2023/24 with the overall workforce who have declared a disability increasing from 6.6% to 8.3% in 2025/26
- For clinical staff, there was an improvement in all clusters compared to 2023/24 with the overall workforce who have declared a disability increasing from 4.9% to 5.4%
- For Medical and Dental staff, there was an improvement in all roles with the overall reporting increasing from 2.2% to 2.7%
- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts decreased from 0.95 in 2024/25 to

0.82%. This demonstrates another significant improvement in the ratio since the WDES was published in 2019.

Analysis of the WDES data has also identified areas of deterioration in comparison with the 2024/25 results. This includes:

- The percentage of staff who say they reported the last time they experienced harassment, bullying or abuse at work.
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- The percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.
- The percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
- The percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months
- The percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.
- The percentage of staff satisfied with the extent to which their organisation values their work.
- A slight reduction for the percentage of disabled staff who stated the Trust made reasonable adjustments to enable them to carry out their work.
- The percentage difference between the organisation's Board voting membership and its organisation's overall workforce reduced from 1.77% in 2023/24 to -5.16% in 2024/25.

It is noted that although deterioration is noted, the Trust remains above the national average for Acute and Acute and Community Trusts in these metrics in 2025. Additionally, the performance in 2025 represents an improvement compared to the 2022 results with a larger staff engagement response rate.

Although there have been improvements, data still highlights that there are gaps in the Trust workforce profile at Band 8a and above for staff living with a disability or long-term health condition. Specifically, work is required to improve the diversity of the senior leadership of the Trust, as well as support those who have not declared their disability status to feel comfortable to do so.

Additionally, there is still a significant disparity between disabled staff and non-disabled staff when reviewing the results in the NHS Staff Survey. This is particularly significant when looking at the percentage of staff experiencing harassment, bullying or abuse in the workplace. Overall, this remains a targeted area for focus for disabled staff and non-disabled staff as evidenced within the action plan.

4. Data report for 2025/26

Metric 1: Percentage of staff in Agenda for Change (AfC) pay bands 1-9 or medical and dental subgroups and very senior managers (VSM) including Executive Board members compared with the percentage of staff in the overall workforce disaggregated by:

Non-clinical workforce	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	80	8.3%	730	75.6%	153	16.1%	966
Cluster 2: AfC bands 5 to 7	16	6.9%	188	80.7%	29	12.4%	233
Cluster 3: AfC bands 8a and 8b	2	3.1%	58	89.2%	5	7.7%	65
Cluster 4: AfC bands 8c to VSM	4	8.3%	42	87.5%	2	4.2%	48
Total non-clinical	**102**	**7.8%**	**1018**	**77.6%**	**225**	**16.6%**	**1312**

Clinical workforce	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	48	5.3%	778	85.2%	87	9.5%	913
Cluster 2: AfC bands 5 to 7	103	5.5%	1570	83.5%	207	11%	1880
Cluster 3: AfC bands 8a and 8b	9	5.0%	154	85.1%	18	9.9%	181
Cluster 4: AfC bands 8c to VSM	0	0.0%	13	86.7%	2	13.3%	15
Total clinical	**160**	**5.4%**	**2515**	**84.1%**	**314**	**10.5%**	**2989**

Medical and Dental	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Medical & Dental Staff, Consultants	4	1.74%	172	74.78%	54	23.48%	230
Medical & Dental Staff, Non-Consultants career grade	2	2.70%	56	75.68%	16	21.62%	74
Medical & Dental Staff, Medical and dental trainee grades	6	4.96%	96	79.34%	19	15.70%	121

Total Medical and Dental	**12**	**2.82%**	**324**	**76.24%**	**89**	**20.94%**	**425**

Total workforce	**Disabled**		**Non-disabled**		**Unknown**		**Total**
	Num	%	Num	%	Num	%	
Number of staff in workforce	**274**	**5.80%**	**3857**	**81.61%**	**595**	**12.59%**	**4726**

Metric 2: Relative likelihood of staff being appointed from shortlisting across all posts.

2025/26	2024/25
The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is **1.16**. This indicates that non-disabled staff are more likely to be appointed from shortlisting compared to disabled applicants.	The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is **0.95**. This indicates that non-disabled staff are less likely to be appointed from shortlisting compared to disabled applicants.

To note:

i) A relative likelihood of 1 indicates that there is no difference: i.e. non-disabled applicants are equally as likely of being appointed from shortlisting as disabled applicants.

ii) A relative likelihood **above** 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 2 indicates non-disabled applicants are twice (2 times) as likely to be appointed from shortlisting as disabled applicants.

iii) A relative likelihood **below** 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 0.5 indicates non-disabled applicants are half (0.5 times) as likely to be appointed from shortlisting as disabled applicants.

Metric 3: Relative likelihood of disabled staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation.

2025/26	2024/25
There is less likelihood of disabled staff entering the formal capability process compared to non-disabled staff.	There is no difference between the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.

To note:

i) A relative likelihood of 1 indicates that there is no difference, i.e. disabled staff are equally as likely as non-disabled staff to enter formal capability processes.

ii) A relative likelihood **above** 1 indicates that disabled staff are more likely to enter formal capability processes than non-disabled staff: e.g. a likelihood ratio of 2 indicates that disabled staff are twice (2 times) as likely to enter a formal capability process compared to non-disabled staff.

iii) A relative likelihood **below** 1 indicates that disabled staff are less likely to enter formal capability processes compared to non-disabled staff: e.g. a likelihood ratio of 0.5 indicates disabled staff are half (0.5 times) as likely to enter a formal capability process compared to non-disabled staff.

Metric 5 to 8 (linked to the Staff Survey 2025):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7. Percentage of staff believing that their organisation provides equal opportunities for career progression/promotion (It is noted that this question has changed and therefore does not have comparable data to previous years).
8. In the last 12 months have you personally experienced discrimination at work from any of the following? (b) Manager/team leader or other colleagues.

Question	Staff with a long-term health condition or illness			Staff without a long-term health condition or illness		
	2023	2024	2025	2023	2024	2025
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25.75%	25.04%	**25.47%**	18.83%	20.05%	**20.05%**
Q14b/c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	11.47%	10.07%	**10.44%**	5.68%	6.55%	**6.74%**
Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	22.68%	18.86%	**20.80%**	12.45%	14.38%	**12.93%**

Q14d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	53.88%	49.76%	**51.50%**	48.74%	50.32%	**52.25%**
Q15) Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion	58.04%	57.83%	**51.88%**	64.80%	62.37%	**57.72%**
Q11e) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	22.70%	21.53%	**23.56%**	15.63%	14.82%	**14.26%**
Q4b) Percentage of staff satisfied with the extent to which their organisation values their work	40.77%	38.51%	**33.33%**	50.65%	47.53%	**42.45%**

	Warrington and Halton Teaching Hospitals NHS Foundation Trust			National benchmark median		
	2023	2024	2025	2023	2024	2025
Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	79.45%	77.96%	**77.05%**	73.38%	73.98%	**73.65%**

Metric 9: Percentage difference between the organisation's Board voting membership and its overall workforce.

Percentage difference between:

i. the organisations' Board voting membership and its overall workforce
ii. the organisations' Board executive membership and its overall workforce

	2025/26			2024/25		
	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown
Total Board Members	0%	92.86%	7.14%	0%	100%	0%
of which: Voting Board members	0%	90.91%	9.09%	0%	100%	0%
Non-voting Board members	0%	100%	0%	0%	100%	0%
Exec Board members	0%	100%	0%	0%	100%	0%
Non-exec Board members	0%	83.33%	16.67%	0%	100%	0%
Number of staff in workforce	5.8%	81.61%	12.59%	5.16%	79.97%	14.87%
Difference (Total board - Overall workforce)	-6%	11%	-5%	-5.16%	20.03%	-14.87%

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Workforce Disability Equality Standard

2026

Date: August 2026



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Introduction

Workplace disability equality is important as evidence[i] shows that an inclusive, engaged, and healthy workforce contributes positively to improved patient outcomes. Diversity in the workforce is also evidenced[ii] to impact positively on innovation, collaboration, efficiency, and positive experiences for all.

The Workforce Disability Equality Standard (WDES) was introduced in 2019. Modelled on the Workforce Race Equality Standard it was established to focus action to reduce the disparity in experience of disabled staff in the NHS, evidenced nationally in areas such as the NHS Staff Survey, and the research[iii] undertaken and published by Middlesex University, and the University of Bedfordshire.

The WDES is a mandatory requirement set out in the NHS Standard Contract, and in additional to online submission of results to NHS England all Trusts must publish an annual report detailing the results against ten metrics and an action plan to address identified disparity in the results. The timeline for compliance is as follows:

- Submission of results against 10 metrics by 31st May.
- Publication of full report and action plan by 31st October.

Data is collated from the electronic staff record and the annual NHS Staff Survey before being presented to stakeholder groups, in the case of this Trust the Enabled Staff Network, for co-design of action plans.

Responsibility for delivery of the report and action plan sits with the Equality, Diversity, and Inclusion Working Group, with oversight of the action plan ultimately resting with the Trust Board for sign off and approval.

In addition to being monitored by NHS England, compliance with the WDES and subsequent action plans are also monitored by Trust commissioners and by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

In this report are detailed key findings from the 2026 WDES metrics; progress made in 2025/26 against the WDES action plan; and metric data, including annual comparisons since 2019.

The outline WDES Action Plan for 2026 - 2027 can be viewed at page 22.

Key findings

Key findings for 2026 are as follows.

Metric 1:

- The percentage of disabled staff in the overall workforce has continued to increase since WDES reporting began, with self-reporting through the Electronic Staff Record (ESR) at 31st March 2026 totalling 5.9% disabled staff.

- Disaggregation by staff group shows:

    - Disabled staff represent 6.9% of the non-clinical workforce, a percentage that remains the same as 2025. Analysis reveals that disabled staff representation is broadly similar to the overall workforce in all pay band clusters except AfC band cluster 8c to VSM where there is significant over-representation.
    - Disabled staff represent 6.1% of the clinical workforce, a percentage increase of 0.8% since 2025. The clinical workforce is broadly representative of the overall workforce percentage of disabled staff, except for slight under-representation at AfC band cluster 8a to 8b, and over-representation at AfC band cluster 8c to VSM.
    - As in previous WDES reporting years there are no self-reported disabled staff in the medical and dental staff group, meaning under-representation by 5.9% against the overall workforce disability figure.

- The Trust understands that there is a percentage gap between disabled staff records (5.9%) and the number of staff through the NHS Staff Survey stating they have a disability (29.8%). The definition in the NHS Staff Survey differs to the legal definition of disability in that it omits asking if an impairment or illness has a significant impact on daily life, but Bridgewater, in line with most NHS Trusts, is working to encourage self-reporting through awareness raising messages and guidance for staff.

Metric 2:

- We have been unable to report the likelihood figure for disabled applicants progressing successfully through recruitment. This relates to a reporting issue in NHS Jobs, an issue that is affecting a number of NHS Trusts and that is being addressed nationally.
- Applicants who report that they have a disability on their application form are flagged, via application reference number, to recruiting managers and the Trust's Disability Confident interview scheme guarantees an interview to all disabled applicants who meet the essential criteria for the role.

- In 2025 to 2026, 6.76% of successful applicants self-reported having a disability.

Metric 3:

- In the two year period 2024 – 2026 there were a very small number of capability cases related to staff performance managed through formal processes.

- There were no staff who had self-reported as having a disability within the Electronic Staff Record, the likelihood figure for metric 3 therefore being 0.0.

- Reasonable adjustments for disabled staff, and the potential impact of disability, would be considered in all capability cases related to performance.

Metric 4a:

- Disabled staff experience of harassment, bullying, or abuse from patients/families/public has increased to 22.7%, a deterioration on previous years and a negative figure when compared to the overall workforce and to comparator Trusts.

- Disabled staff experience of harassment, bullying, or abuse from managers has increased to 13.5%, a deterioration of 3.1% from 2025, and a negative figure when compared to the overall Trust workforce and comparator Trusts.

- Disabled staff experience of harassment, bullying, or abuse from colleagues has increased to 24.9%, a deterioration of 9.1% and a negative figure when compared to the overall workforce and to comparator Trusts.

Metric 4b:

- Reporting of harassment, bullying, or abuse by disabled staff has improved by 3.1% this year to 61.1%, this is the highest score the Trust has achieved in this metric. The result however is still 0.8% lower than that for comparator Trusts.

Metric 5:

- Due to changes in the NHS Staff Survey 2025 wording for this question the results are not comparable to previous years. Data is shown in table 13 for information. What is comparable is that of the Trust's results against the benchmark group, where the Trust's results at 45.5% were 9.3% lower than our comparator group.

Metric 6:

- Presenteeism for disabled staff remained the same as in 2024 results, showing that 15.9% of disabled staff felt pressured to be in work while feeling unwell enough that they would struggle to perform their role. This is the best result for the Trust in this metric since WDES reporting began, and is 6.4% better than the average for comparator Trusts.

Metric 7:

- The result for disabled staff feeling valued for their contribution in the workplace deteriorated by 11.9% this year to 30.5%. This result was also 10.6% below the average of comparator Trusts.

Metric 8:

- At 78.5% the percentage of disabled staff stating that reasonable adjustments have been made to support them in the workplace has deteriorated by 9.8%, from the previous year, returning the results to the average seen in most WDES reporting years. The result was 2.0% worse than for comparator Trusts.

Metric 9:

- Staff engagement with disabled staff has deteriorated by 0.8 to 6.1 this year. This is 0.7 lower than the result for comparator Trusts.

Metric 10:

- At 8.0% the Executive membership of the Board is over-representative of disabled staff.

Disability pay gap:

- The mean disability pay gap result at 31st March 2025 was 4.69% (equating to £1.05) in favour of not disabled staff. The median disability pay gap result for the same period was 4.21% (equating to £0.85) in favour of not disabled staff. Further analysis is provided by staff group in the relevant section of this report.

Activities in 2025 - 2026

- Collaborative partnership work between the Enabled Network and Warrington and Halton Teaching Hospitals NHS Trust's Disability Awareness Network in preparation for integration as one organisation. This has included:
    - Engagement between staff network Chairs.
    - Regular communications through established merged mailing lists.
    - Access to lunch and learn sessions focusing on topics chosen by Network members, including autism, sensory processing, and dyslexia.

- Publication of a reasonable adjustment toolkit based on that of Warrington and Halton Hospitals, to provide current and future guidance on staff reasonable adjustments.

- Continued and proactive provision of staff reasonable adjustments through collaboration with Occupational Health, Access to Work, Health and Safety, Learning and Development, Human Resources, and line managers.

- Support for the annual Warrington Disability Awareness Day.

- Regular planned communications, including collaborative work, on disability awareness, including Deaf Awareness Week, Mental Health Awareness Week, and International Day for People with Disabilities.

- Promotion of wellbeing at work action plan (staff passport) as part of health and wellbeing conversations, annual personal development conversations, absence management processes, and line manager support.

- Continued focus on disabled staff and reasonable adjustments in Equality and Health Inequalities Assessments, including focused support through integration engagement, and formal Transfer of Undertakings (Protection of Employment) processes.

Data sets

Metric 1

Metric 1 reports the percentage of staff by pay band. This data is disaggregated by non-clinical, clinical, and medical and dental staffing groups, and reporting is by pay band clusters as follows:

- Cluster 1 = Agenda for Change (AfC) under band 1 to band 4
- Cluster 2 = AfC bands 5 to 7
- Cluster 3 = AfC bands 8a and 8b
- Cluster 4 = AfC band 8c to Very Senior Managers (VSM – Executive Board Members)

The percentage breakdown by non-clinical, clinical, and medical and dental staff is provided in tables 1 to 3.

Table 1: Showing the percentage of non-clinical staff by disability, disaggregated by pay band cluster at 31st March 2026.

Non clinical	Disabled	Not Disabled	Not known
AfC1 4	6.3%	73.9%	19.7%
AfC5 7	6.6%	83.5%	9.9%
AfC8a 8b	6.9%	72.4%	20.7%
AfC8c VSM	14.3%	76.2%	9.5%
Total non clinical workforce %	6.9%	76.3%	16.9%

Table 2: Showing the percentage of clinical staff by disability, disaggregated by pay band cluster at 31st March 2026.

Clinical	Disabled	Not Disabled	Not known
AfC1 4	5.9%	76.6%	17.5%
AfC5 7	6.1%	79.3%	14.6%
AfC8a 8b	5.5%	74.5%	20.0%
AfC8c VSM	10.0%	80.0%	10.0%
Total clinical workforce %	6.1%	78.3%	15.6%

Table 3: Showing the percentage of staff by disability, disaggregated by consultants, and career grade medical and dental staff at 31st March 2026

Medical and Dental Grades:	Disabled	Not Disabled	Not known
Consultants	0.0%	90.0%	10.0%
Non Consultant Career Grade	0.0%	79.5%	20.5%
Trainee Grades	0.0%	0.0%	0.0%
Total medical and dental workforce %	0.0%	80.7%	19.3%

Tables 4 to 6 to follow show the results for the overall workforce and the staff groups from 2019 to 2026, showing patterns of change of disability representation.

Table 4: Showing the disability breakdown of the total workforce from 2019 to 2026.

Full workforce	Disabled staff	Not disabled staff	Not known
2019	3.4%	63.9%	32.7%
2020	2.8%	74.2%	23.1%
2021	2.7%	75.0%	22.3%
2022	3.0%	74.4%	22.5%
2023	3.2%	80.5%	16.4%
2024	4.0%	80.7%	15.3%
2025	5.5%	78.9%	15.7%
2026	5.9%	78.0%	16.1%

Table 5: Showing the percentage of disability representation in non-clinical staff from 2019 to 2026.

Non clinical Staff	Disabled	Not Disabled	Not Known
2019	3.9%	66.5%	29.5%
2020	2.8%	75.5%	21.7%
2021	2.7%	75.3%	21.9%
2022	3.3%	74.9%	21.9%
2023	4.5%	80.4%	15.1%
2024	4.9%	79.5%	16.0%
2025	6.9%	78.4%	14.7%
2026	6.9%	76.3%	16.9%

Table 6: Showing the percentage of disability representation in clinical staff from 2019 to 2026.

Clinical Staff	Disabled%	Not Disabled	Not Known
2019	3.3%	64.6%	32.1%
2020	3.1%	75.1%	21.8%
2021	2.8%	75.1%	22.0%
2022	3.1%	74.3%	22.6%
2023	2.8%	80.6%	16.6%
2024	4.1%	80.9%	14.9%
2025	5.3%	78.9%	15.8%
2026	6.1%	78.3%	15.6%

Medical and dental is not detailed, however between 2019 and 2026 WDES reporting shows that there were no staff who self-reported disability in the medical and dental group.

Metric 2

Metric 2 reports the likelihood of disabled applicants being successful in recruitment from shortlisting to appointment. As a likelihood figure the following applies:

- A result below 1.0 indicates a greater likelihood of success for disabled applicants.
- A result above 1.0 indicates a greater likelihood of success for non-disabled applicants.
- A result of 1.0 indicates equity between disabled and non-disabled applicants.

Table 7: Showing the likelihood of successful appointment following shortlisting and interview for disabled, not disabled, and not known applicants from 2019 to 2026.

	Likelihood	Total Disabled Staff Recruited	Total Non Disabled Staff Recruited	Total Not Stated Staff Recruited
2019	1.45	13	352	-
2020	3.03	*	210	40
2021	1.50	*	174	55
2022	0.69	17	199	84
2023	1.00	11	183	42
2024	Not available	18	177	101
2025	Not available	*	92	85
2026	Not available	*	38	31

Metric 3

Metric 3 details the relative likelihood of disabled staff entering formal capability processes compared to not disabled staff. This is for performance related capability only.

Table 8: Showing the likelihood of disabled staff entering formal capability processes compared to non-disabled staff, from 2019 to 2026.

	2019	2020	2021	2022	2023	2024	2025	2026
Likelihood	0.0 No disabled staff in formal capability processes						7.2	0.0

NHS Staff Survey 2025

Metrics 4a to 9 are taken from the NHS Staff Survey 2025.

- For metric 4a there were 561 non-disabled staff responded to this question, and 238 disabled staff.
- For metric 4b there were 136 non-disabled members of staff, and 90 disabled members of staff responded to the question.
- For metric 5 there were 557 non-disabled staff, and 233 disabled staff responded to this question.
- For metric 6 there were 293 non-disabled staff, and 176 disabled staff responded to this question.
- For metric 7 there were 559 non-disabled staff, and 236 disabled staff responded to this question.
- For metric 8 there were 158 disabled staff responded to this question.
- For metric 9 there were 563 non-disabled staff, and 238 disabled staff responded to this question.

Metric 4a – Harassment, bullying, or abuse from patients, their families, or the public

Table 9: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying or abuse from patients, their families, of the public in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	31.1%	28.7%	27.4%	27.5%	25.4%	22.3%	16.4%	22.7%	Deteriorated by 6.3%	Positive by 0.9%
Not Disabled	25.3%	21.6%	16.6%	17.6%	20.8%	14.8%	13.3%	15.7%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	31.2%	29.5%	26.6%	26.8%	26.5%	24.6%	23.7%	23.6%		
Not Disabled	23%	23.3%	20.7%	19.5%	20.5%	16.6%	16.8%	15.7%		

Metric 4a – Harassment, bullying, or abuse from managers

Table 10: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying, or abuse from managers in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	12.2%	15.2%	14.4%	12.8%	10.4%	13.3%	10.4%	13.5%	Deteriorated by 3.1%	Negative by 4.1%
Not Disabled	7.8%	9.8%	7.2%	5.1%	6.6%	4.4%	4.8%	8.0%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	14.6%	15.1%	14.8%	12.2%	10.7%	10.3%	10.2%	9.4%		
Not Disabled	8.6%	7.6%	6.9%	6.5%	5.5%	5.3%	4.4%	4.4%		

Metric 4a – Harassment, bullying, or abuse from other staff

Table 11: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who experienced harassment, bullying, or abuse from colleagues in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	21.6%	20.7%	17.4%	18.7%	22.1%	18.4%	15.8%	24.9%	Deteriorated by 9.1%	Negative by 9.3%
Not Disabled	11.4%	11.2%	11.6%	12.6%	10.7%	11.8%	11.4%	11.2%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	22.5%	22.3%	19.2%	19.0%	18.5%	18.7%	15.6%	15.9%		
Not Disabled	12.8%	12.2%	11.6%	10.7%	10.0%	10.4%	9.3%	9.4%		

Metric 4b – Reporting bullying, harassment, and abuse incidents

Table 12: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported incidents of harassment, bullying, or abuse in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	45.6%	47.6%	60.3%	40.5%	48.6%	44.7%	57.3%	61.1%	Improved by 3.8%	Negative by 0.8%
Not Disabled	52.0%	51.7%	48.3%	55.6%	51.4%	57.1%	51.8%	64.0%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	54.1%	53.7%	56.8%	55.7%	55.8%	57.6%	60.3%	61.9%		
Not Disabled	55.3%	57.2%	57.5%	58.1%	57.8%	60.1%	61.9%	61.2%		

Metric 5 – Equal opportunities for career progression

Table 13: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who believe their organisation provides equal opportunities for career progression.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	51.0%	48.5%	55.1%	51.8%	56.2%	55.7%	58.4%	45.5%	* See below	Negative by 9.3%
Not Disabled	60.9%	60.6%	59.6%	60.0%	62.0%	61.8%	61.7%	55.8%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	55.6%	55.2%	59.2%	60.1%	60.5%	60.9%	59.0%	54.8%		
Not Disabled	61.0%	61.2%	65.0%	65.1%	65.2%	65.6%	63.9%	61.9%		

* It should be noted for this indicator that due to changes in the wording for question 15 of the 2025 NHS Staff Survey results are not comparable to previous years. WRES reporting results up to 2024 have been shown for information only.

Metric 6 – Feeling pressure from a manager to attend work despite not feeling well enough to perform duties

Table 14: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who felt pressured to be in work while unwell.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	25.7%	27.2%	19.6%	28.3%	19.0%	22.5%	15.9%	15.9%	Remained the same	Positive by 6.4%
Not Disabled	18.7%	16.7%	19.5%	10.1%	15.8%	12.8%	13.1%	17.4%		
Benchmark	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	29.2%	25.8%	24.9%	22.4%	20.5%	19.2%	19.4%	22.3%		
Not Disabled	18.9%	16.7%	17.9%	14.3%	14.0%	13.1%	13.6%	13.2%		

Metric 7 – Satisfaction with how the Trust values their work

Table 15: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported feeling valued by their organisation in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	34.7%	32.9%	41.0%	35.5%	40.8%	43.3%	42.4%	30.5%	Deteriorated by 11.9%	Negative by 10.6%
Not Disabled	45.4%	48.6%	49.1%	50.1%	48.3%	51.5%	48.4%	40.4%		
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	39.8%	42.4%	47.5%	43.0%	44.7%	46.4%	43.9%	41.1%		
Not Disabled	51.3%	53.8%	56.1%	54.2%	54.8%	56.5%	54.4%	54.3%		

Metric 8 – Percentage of disabled staff who say reasonable adjustments have been made to support them in fulfilling their role

Table 76: Showing the percentage of disabled and not disabled staff in Bridgewater and comparator Trusts who reported that reasonable adjustments had been made to support them in their role in the last 12 months.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	70.3%	75.8%	75.8%	73.4%	85.6%	78.2%	88.3%	78.5%	Deteriorated by 9.8%	Negative by 2.0%
Benchmark:	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	77.4%	77.0%	81.5%	77.4%	78.5%	79.3%	83.0%	80.5%		

Metric 9 – Staff engagement

Metric 9 looks at the staff engagement theme, and scores out of 10.0.

Table 17: Showing the staff engagement score, out of 10, for disabled and not disabled staff in Bridgewater and comparator Trusts from 2018 to 2025.

Bridgewater:	2018	2019	2020	2021	2022	2023	2024	2025	Trust Trend 2024 to 2025	Against benchmark group for 2025
Disabled	6.6	6.6	6.8	6.7	6.9	7.0	6.9	6.1	Deteriorated by 0.8	Negative by 0.7
Not Disabled	7.2	7.1	7.2	7.3	7.2	7.4	7.3	6.8		
Benchmark	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**		
Disabled	6.8	6.9	7.0	6.9	6.9	7.0	6.9	6.7		
Not Disabled	7.2	7.4	7.4	7.3	7.3	7.4	7.3	7.2		

Metric 10 – Board representation

Metric 10 shows the percentage difference between:

- The organisation's Board total membership and its overall workforce.
- The organisations' Board voting membership and its overall workforce
- The organisations' Board executive membership and its overall workforce

Table 18: Showing percentage Board level representation of disabled and not disabled staff from 2019 to 2026.

		2019	2020	2021	2022	2023	2024	2025	2026
Board overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	10.0%	2.0%	2.0%
	Not disabled %	-22.0%	-29.0%	-32.0%	-32.0%	-23.0%	-31.0%	-10.0%	-9.0%
	Not known %							7.0%	7.0%
Voting membership overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	10.0%	2.0%	-5.0%
	Not disabled %	-22.0%	-29.0%	-32.0%	-32.0%	-23.0%	-31.0%	-10.0%	-9.0%
	Not Known %							7.0%	7.0%
Executive membership overall workforce	Disabled %	-3.0%	-3.0%	-3.0%	-3.0%	-3.0%	13.0%	11.0%	8.0%
	Not disabled %	-4.0%	-8.0%	-4.0%	-3.0%	-9.0%	-31.0%	4.0%	8.0%
	Not known %							-16.0%	-16.0%

Disability Pay Gap Report 31st March 2026

As part of the NHS EDI Improvement Plan all Trusts are required to publish disability pay gap data from April 2025.

Pay gap reporting is based on a set point in time every year, for ordinary pay this is all staff who were paid at 31st March – termed relevant staff. For bonus pay this is all staff paid bonus pay in the year from 1st April to 31st March, in the Trust this relates to clinical excellence awards.

Results for 2026 are to follow.

Ordinary pay

On 31st March 2026 we employed 1,202 staff who were relevant to disability 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 for example. The figures excluded all staff who had chosen to not self-report disability status within their electronic staff record, a total of 233 staff.

Table 19 shows the number of disabled and not disabled staff in each pay quartile, the division of staff into four roughly equal groups based on hourly pay.

Table 19: Showing the numbers and percentage of disabled and not disabled staff in quartiles based on hourly pay at 31st March 2026.

Disabled staff	Total	Percentage %	Not disabled staff	Total	Percentage %
1	25	8.3%	1	275	91.7%
2	24	8.0%	2	277	92.0%
3	18	6.0%	3	280	94.0%
4	21	6.9%	4	282	93.1%

The following table shows the numbers of staff by quartile in 2025 and 2026, demonstrating the reduction in not disabled staff in all quartiles, reflective of a smaller workforce in 2026.

Table 20: Showing the number of disabled and not disabled staff by quartile in 2025 and 2026.

	Disabled staff					Not disabled staff			
	1	2	3	4		1	2	3	4
2025	23	22	15	22		306	307	313	308
2026	25	24	18	21		275	277	280	282

The table to follow details the disability pay gap as a monetary value and percentage. A positive value indicates a pay gap in favour of not disabled staff, a negative value indicates a pay gap in favour of disabled staff.

Table 21: Showing the ethnicity pay gap results at 31st March 2026 as a monetary figure, and a percentage, based on hourly rates of pay for disabled and not disabled staff.

	Mean hourly rate of pay	Median hourly rate of pay
Disabled staff		**£19.33**
Not disabled staff	**£22.36**	**£20.18**
Pay Gap monetary value	**£1.05**	**£0.85**
Pay Gap percentage value	**4.69%**	**4.21%**

It is observed in the table above that there is a positive pay gap in favour of not disabled staff, with a slightly higher mean pay gap. The next table shows a comparator to reporting at 31st March 2025, detailing initial trends as we start to analyse and publish disability pay gap information.

Table 22: Showing the mean and median disability pay gaps from 2025 to 2026.

	Mean Disability Pay Gap %	Mean Disability Pay Gap £	Median Disability Pay Gap %	Median Disability Pay Gap £
2025	**6.58%**	**£31.69**	**2.29%**	**£0.44**
2026	**4.69%**	**£1.05**	**4.21%**	**£0.85**

- There has been a significant improvement in the mean pay gap in relation to monetary value, this is likely resulting from the significant changes observed in not disabled staff representation in each quartile, while disabled staff numbers in the quartiles have remained largely static. Disabled staff mean pay has also increased by nearly one third as a result of self-reporting in higher pay bands.

- The median result shows a slight increase in both percentage and monetary value, likely as a result of the slightly lower reduction in not disabled staff in quartile 4, reflective of workforce changes as a result of integration with our local hospital Trust.

To understand disability pay gaps better the Trust has undertaken further analysis by two staff groups – non-clinical and clinical staff. Medical and dental have been excluded from further analysis as there are no staff who have self-reported a disability in this group.

Non-clinical staff

- At 8.3% of the non-clinical workforce disabled staff representation is higher than the overall workforce.

- Disability pay gap analysis for non-clinical staff provides the following results:

    - A mean disability pay gap of -2.44% (equating to -£0.47) in favour of disabled staff.
    - A median disability pay gap of 3.27% (equating to £0.46) in favour of not disabled staff.

Clinical staff

- At 7.5% of the clinical workforce disabled staff representation is higher than the overall workforce.

- Disability pay gap analysis for clinical staff provides the following results:

    - A mean disability pay gap of – 4.54%% (equating to - £0.96) in favour of disabled staff.
    - A median disability pay gap of 0.00% (equating to £0.00) highlighting disability pay equity for median hourly rates of pay.

Bonus pay

There were no clinical excellence awards in the Trust awarded in 2025/2026, therefore the result is 0.00% or £0.00.

Contact details

Thank you for taking the time to read our WDES 2026 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*

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[i] https://assets.publishing.service.gov.uk/media/5a7c8e0d40f0b62aff6c27d9/dh_129662.pdf
[ii] https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-matters-even-more-the-case-for-holistic-impact
[iii] https://repository.mdx.ac.uk/item/86196

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/086**			
Subject:	**Audit Committee Chair Annual Reports: WHH & BCH**			
Date of meeting:	7 October 2026			
Action required:	**For approval**			
Author(s):	Mike O'Connor, Audit Committee Chair			
Executive director sponsor:	Andy Carter, Chair			
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:	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 aims to provide assurance to the Board that the WHH and BCH Audit Committees fulfilled their Terms of Reference in 2025-26 and obtained assurance throughout the reporting period regarding the effectiveness of the Trust's internal control framework. WHH: The Head of Internal Audit's overall opinion for the period from 1 April 2025 to 31 March 2026 is one of **Substantial Assurance**. BCH: The Head of Internal Audit's overall opinion for the period from 1 April 2025 to 31 March 2026 is one of **Substantial Assurance**.			

	In conclusion, there is a robust system of internal control in place that is appropriately designed to support the organisation's objectives, with controls generally operating consistently		
Purpose: (please select as appropriate)	**Approval** ✓	**To note**	**Decision**
Recommendation:	The Trust Board is asked to review and approve the report, taking assurance that the Audit Committee has fulfilled its purpose and Terms of Reference.		
Previously considered by:	**Committee**	Audit Committee	
	Agenda Ref.	AC/26/08/061i & ii	
	Date of meeting	27 August 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):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

Appendix 1: Audit Committee Chairs Annual Report - WHH

1. Background/context

The Audit Committee (WHH) is required to provide an annual report to both the Board and the Council of Governors, summarising its activities over the reporting period and highlighting any areas of concern where appropriate.

This report presents the activity of the Audit Committee, covering the reporting period 1 April 2025 to 31 March 2026.

Acting on behalf of the Board, the Audit Committee is responsible for the independent review of the Trust's systems of integrated governance, risk management, assurance, and internal control. Its remit spans the entirety of the Trust's governance agenda, supporting the delivery of organisational objectives.

This report outlines the Committee's membership, its role, and the work undertaken during the year.

2. Key elements

Terms of Reference and Cycle of Business

The Committee's Terms of Reference were reviewed in February 2025 and April 2026, and the cycle of business reviewed in November 2025. This included a review of the membership, quoracy, duties and responsibilities of the Committee to ensure they continued to remain fit for purpose for the 2026-27 financial year.

Committee Membership and Attendance

Throughout the reporting period, the committee comprised a minimum of three Non-Executive Directors, with meetings quorate at two members. The Committee convened five times during the year. Non-Executive Director, Michael O'Connor served as Chair of the Audit Committee.

All Committee members possessed the relevant and recent financial expertise required for effective oversight. In accordance with best practice, the Chair of the Trust was not a member of the Audit Committee.

The summary of member attendance is provided below:

Member	Attendance (Actual v Max)
Michael O'Connor, Non-Executive Director	5/5
Jayne Downey, Non-Executive Director	5/5
Julie Jarman, Non-Executive Director	5/5
Cliff Richards, Non-Executive Director	2/5
John Somers, Non-Executive Director	3/5

Regular attendees at committee meetings included representatives from the Trust's external auditors, **Grant Thornton, Mersey Internal Audit Agency (MIAA)** - providing internal audit and counter-fraud services – plus the **Chief Finance Officer** and the **Company Secretary**.

The Work of the Audit Committee

The most persistent issues requiring repeated assurance reviews were theatre-related concerns, including fractured neck of femur performance, the clinical typing backlog, consultant job planning, and IT control weaknesses. The Committee considered financial statements, operations and compliance which were addressed through inclusion in the Internal Audit work plan and assurance sought for each element:

1. High assurance was provided in the following: risk management core controls.

2. Substantial assurance was provided in the following: Patient Safety Incident Response Framework (PSIRF), Recruitment Process Review, Learning from Deaths, Patient Activity Data Capture (Cancer Performance).

3. Limited assurance was provided for the following: Theatre Productivity / WHO Checklist / NatSSIPs-related, IT Management Around Medical Devices, IT Third Party Suppliers

No areas were reported as providing no assurance.

Governance & Risk Management

During the year the Trust continued to enhance its governance and risk management systems and processes. It continued to oversee the key strategic risks allocated to a committee or the Executive Management Team Meeting for focused oversight and scrutiny.

The Board Assurance Framework (BAF) was reviewed in full by the Board at each of its bi-monthly meetings, and at committee meetings and committee in common meetings. In February 2026, a major review of the BAF was reported which included a clearer link between strategic risks and operational controls; improved visibility of assurance arrangements and alignment with the merged organisation. Following this, the revised BAF and refreshed Risk Appetite Statement were scheduled for Board approval in April 2026.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance was fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provided a solid foundation to support a **Substantial Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as internal auditors for the Trust during the year. Internal audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is discussed and agreed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the committee uses a three-cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, were presented regularly to the committee by internal audit throughout the year. All such information and reports were fully recorded in the minutes and papers prepared for each Audit Committee meeting.

2025-26 Head of Internal Audit Opinion

The overall opinion for the period 1st April 2025 to 31st March 2026 provided **Substantial Assurance**, that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

Counter Fraud Activity

The Trust's Anti-Fraud programme was delivered by MIAA's Anti-Fraud Service (AFS), in accordance with a plan agreed with the Audit Committee. The AFS supports the Trust in fostering an anti-fraud culture, deterring and detecting fraud, investigating allegations, and pursuing appropriate sanctions and redress.

During 2025–26:

- 1 referral was brought forward from 2024-25
- 16 potential fraud referrals were received
- 6 referrals progressed to formal investigations
- 9 referrals were closed
- 2 referrals remained open and will be carried forward into 2026-27

The Trust continued to achieve an overall 'green' rating in its self-assessment against the Government Functional Standard 013 for Counter Fraud.

Data Security and Protection Toolkit (DSPT)

MIAA conducted the required annual independent assessment of the Trust's DSPT submission review following the Cyber Assessment Framework - aligned DSPT Independent Assessment Framework and guidance published by NHS England to provide assurance regarding the validity of the organisation's intended final DSPT submission. This review considered not only whether the submission was reasonable

based on the supporting evidence but also evaluated the extent to which information risk was effectively managed within this context.

Outcomes of the review:

- **Assessment of the Self-Assessment**: *Substantial Assurance*
- **National Data Guardian Standards**: *Moderate Assurance*

External Audit

Grant Thornton LLP commenced its initial three-year term as Auditors to the Trust in January 2017. The company then commenced a two-year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contained the option to extend for additional years and following support from the Audit Committee and approval by the Council of Governors, an extension up to 30 September 2024 was agreed. In September 2024 a new three-year contract, with the option of one 12-month extension, for the provision of an external audit service by Grant Thornton LLP was approved.

Opinion on Financial Statements

During the year the external auditors reported on the 2025-26 financial statements. No material or significant issues were raised in respect of these statements and accounts. Technical support has been provided on an ongoing basis to the Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

In auditing the financial statements, it was concluded that the Accounting Officer's use of the **going concern basis** of accounting in the preparation of the financial statements was appropriate.

Fit and Proper Persons – Board Compliance

The Committee reviewed assurance that all directors continued to meet the requirements of the NHS England Fit and Proper Persons Test Framework and the Trust's Fit and Proper Person Policy. The annual report was submitted to the Regional Director of NHS England by the statutory deadline of 30 June 2025.

Issues Carried Forward

The Audit Committee remained committed to ensuring that the Trust's system of internal controls and assurance processes were robust and fit for purpose and supported the integration of Warrington and Halton Hospitals NHS FT with Bridgewater Community NHS FT to become North Cheshire and Mersey NHS FT on 1 April 2026.

No significant or material issues were escalated to the Board of Directors or the Council of Governors during the reporting period.

The Committee will continue to monitor risk areas identified in the 2025-26 Internal Audit Plan, which may be prioritised over those in the 2026-27 plan, subject to alignment with the Trust's strategic risk assessment.

Board Assurance Committees

During 2025–26, three Board assurance committees operated alongside the Audit Committee:

1. Quality Assurance Committee (WHH), succeeded by the Quality and Safety Assurance Committee in Common with BCH from 1 February 2025 to 31 March 2026.
2. Finance & Sustainability Committee (WHH), succeeded by the Finance, Sustainability and Performance Committee in Common with BCH from 1 July 2025 to 31 March 2026.
3. Strategic People Committee in Common.

Each committee was chaired by a non-executive director and included at least two non-executive directors, one from WHH and one from BCH. WHH Committee Chairs provided verbal updates to the Audit Committee, facilitating cross-committee assurance and enabling the identification of any gaps in oversight.

Summary

Throughout the year, the Audit Committee considered a broad range of matters relating to financial statements, operational performance, regulatory compliance and the pending integration of the Trust with Bridgewater Community Healthcare NHS FT. Assurance was sought through collaboration with Internal Audit, other board committees, and key personnel across the Trust.

As the Chair of the Committee, I report regularly to the Board of Directors via the Committee Assurance Reports, highlighting key assurance outcomes and any matters requiring escalation.

Committee meetings were observed by an elected governor, who reported quarterly to the Council of Governors on the conduct of meetings and the effectiveness of Non-Executive Directors in fulfilling their accountability role.

I would like to thank Committee members, directors, staff, and internal and external advisors for their support, engagement and contributions throughout the year.

Mike O’Connor, Chair of Audit Committee

3. Recommendations

The Board is asked to review and approve the report, taking assurance that the Audit Committee has fulfilled its purpose and Terms of Reference.

Appendix 1: Audit Committee Chairs Annual Report - BCH

1. Background/context

The Audit Committee (BCH) is required to provide an annual report to both the Board and the Council of Governors, summarising its activities over the reporting period and highlighting any areas of concern where appropriate.

This report presents the activity of the Audit Committee, covering the reporting period 1 April 2025 to 31 March 2026.

Acting on behalf of the Board, the Audit Committee is responsible for the independent review of the Trust's systems of integrated governance, risk management, assurance, and internal control. Its remit spans the entirety of the Trust's governance agenda, supporting the delivery of organisational objectives.

This report outlines the Committee's membership, its role, and the work undertaken during the year.

2. Key elements

Terms of Reference and Cycle of Business

The Committee's Terms of Reference were reviewed in July 2025 and January 2026, and the cycle of business reviewed in July 2025. This included a review of the membership, quoracy, duties and responsibilities of the Committee to ensure they continue to remain fit for purpose for the remainder of the 2025-26 financial year.

Committee Membership and Attendance

Throughout the reporting period, the committee comprised a minimum of three Non-Executive Directors, with meetings quorate at three members. The Committee convened six times during the year. Non-Executive Director Bob Chadwick served as Chair of the Audit Committee.

All Committee members possessed the relevant and recent financial expertise required for effective oversight. In accordance with best practice, the Chair of the Trust was not a member of the Audit Committee.

The summary of member attendance is provided below:

Member	Attendance (Actual v Max)
Bob Chadwick, Non-Executive Director (Chair)	6/6
Gail Briers, Non-Executive Director	5/6
Elaine Inglesby, Non-Executive Director	3/6
Abdul Siddique, Non-Executive Director	4/6
Tina Wilkins, Non-Executive Director	6/6

Regular attendees at committee meetings included representatives from the Trust's external auditors, **KPMG** and **Mersey Internal Audit Agency (MIAA)** - providing internal audit and counter-fraud services – plus the **Executive Director of Finance** and the **Director of Corporate Governance (Company Secretary)**.

The Work of the Audit Committee

The Committee considered financial statements, operations and compliance which were addressed through inclusion in the Internal Audit work plan and assurance sought for each element:

1. High assurance was provided in the following: Risk Management Core controls, Quality Impact Assessments (QIAs), Fit and Proper Person Test Process, Declarations of Interest, Freedom to Speak Up, Key Financial Transaction Controls.

2. Substantial assurance was provided in the following: Advantage System, Emergency Preparedness Resilience and Response (EPRR).

The Patient Safety Incident Response Framework (PSIRF) was noted as having a positive outcome with comprehensive controls noted.

There were no areas reported as providing no assurance.

Governance & Risk Management

During the year the Trust continued to enhance its governance and risk management systems and processes. It continued to oversee the key strategic Board Assurance Framework (BAF) risks allocated to a committee or the Executive Management Team Meeting for focused oversight and scrutiny. The BAF was reviewed in full by the Board at each of its bi-monthly meetings when the cycle for committees, committees in common or Executive Management Team was completed.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance was fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Substantial Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as internal auditors for the Trust during the year. Internal audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is discussed and agreed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the committee uses a three-cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented regularly to the committee by internal audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

2025-26 Head of Internal Audit Opinion

The overall opinion for the period 1st April 2025 to 31st March 2026 provides **Substantial Assurance**, that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

Counter Fraud Activity

The Trust's Anti-Fraud programme was delivered by MIAA's Anti-Fraud Service (AFS), in accordance with a plan agreed with the Audit Committee. The AFS supports the Trust in fostering an anti-fraud culture, deterring and detecting fraud, investigating allegations, and pursuing appropriate sanctions and redress.

During 2025–26:

- 2 referrals were brought forward from 2024-25
- 4 potential fraud referrals were received
- 3 referrals progressed to formal investigations
- 3 referrals were closed
- 0 referrals remained open

The Trust continued to achieve an overall 'green' rating in its self-assessment against the Government Functional Standard 013 for Counter Fraud.

Data Security and Protection Toolkit (DSPT)

MIAA conducted the required annual independent assessment of the Trust's DSPT submission review following the Cyber Assessment Framework - aligned DSPT Independent Assessment Framework and guidance published by NHS England to provide assurance regarding the validity of the organisation's intended final DSPT submission. This review considered not only whether the submission was reasonable based on the supporting evidence but also evaluated the extent to which information risk was effectively managed within this context.

Outcomes of the review:

- **Assessment of the Self-Assessment**: *High Assurance*
- **National Data Guardian Standards**: *Moderate Assurance*

External Audit

KPMG commenced its initial three-year term as External Auditors to the Trust in 2019 and continued to provide this by means of extensions up to 31 March 2026.

Opinion on Financial Statements

During the year the auditors reported on the 2025-26 financial statements. No material or significant issues were raised in respect of these statements and accounts. Technical support has been provided on an ongoing basis to the Trust and representatives of KPMG have attended each Audit Committee meeting.

In auditing the financial statements, it was concluded that the Accounting Officer's use of the **going concern basis** of accounting in the preparation of the financial statements was appropriate.

Technical support has been provided on an ongoing basis to the Trust and representatives of KPMG have attended each Audit Committee meeting.

Fit and Proper Persons – Board Compliance

The Committee reviewed assurance that all directors continued to meet the requirements of the NHS England Fit and Proper Persons Test Framework and the Trust's Fit and Proper Person Policy. The annual report was submitted to the Regional Director of NHS England by the statutory deadline of 30 June 2025.

Issues Carried Forward

The Audit Committee remained committed to ensuring that the Trust's system of internal controls and assurance processes were robust and fit for purpose and supported the integration of Bridgewater Community NHS FT with Warrington and Halton Hospitals NHS FT to become North Cheshire and Mersey NHS FT on 1 April 2026.

No significant or material issues were escalated to the Board of Directors or the Council of Governors during the reporting period and a single review which remained to be finalised would be transferred post-integration with Warrington and Halton Hospitals NHS FT to North Cheshire and Mersey NHS FT Audit Committee.

Board Assurance Committees

During 2025–26, three Board assurance committees operated alongside the Audit Committee:

1. Quality and Safety Committee (BCH), succeeded by the Quality and Safety Assurance Committee in Common with WHH from 1 February 2026 to 31 March 2026.
2. Finance & Performance Committee (BCH), succeeded by the Finance, Sustainability and Performance Committee in Common with WHH from 1 July 2025 to 31 March 2026.
3. Strategic People Committee in Common.

Each committee was chaired by a non-executive director and included at least two non-executive directors, one from WHH and one from BCH. BCH Committee Chairs escalated matters which required oversight by another committee and provided written updates to the Board, facilitating cross-committee assurance and enabling the identification of any gaps in oversight.

Summary

Throughout the year, the Audit Committee considered a broad range of matters relating to financial statements, operational performance, regulatory compliance and the pending integration of the Trust with Warrington and Halton Hospitals NHS FT. Assurance was sought through collaboration with Internal Audit, other board committees, and key personnel across the Trust.

Sovereign and Committee in Common meetings were observed by an elected governor, who reported bi-monthly to the Council of Governors on the conduct of meetings and the effectiveness of Non-Executive Directors in fulfilling their accountability role.

On behalf of my colleague, Bob Chadwick of Bridgewater Community Healthcare NHS FT, I would like to thank Committee members, directors, staff, and internal and external advisors from both organisations for their support, engagement and contributions throughout 2025-26.

Mike O'Connor, Chair of Audit Committee (WHH)

3. Recommendations

The Board is asked to review and approve the report, taking assurance that the Audit Committee (BCH) fulfilled its purpose and Terms of Reference.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/087**			
Subject:	**Strategic People Committee Cycle of Business 2026/27**			
Date of meeting:	7 October 2026			
Action required:	**Approval**			
Author(s):	John Culshaw, Company Secretary			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
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 Strategic People Committee reviewed the updated Cycle of Business for 2026/27 at its meeting on 16 September 2026 and supported its submission to the Trust Board for formal approval. The revisions ensure that the Committee's programme remains aligned with the Trust's developing assurance arrangements, the Single Improvement Plan and the NHS Oversight Framework. They also consolidate related reports, clarify reporting frequencies and responsibilities, and introduce a structured programme of deep dives for the remainder of 2026/27. The revised Cycle of Business is attached at Appendix 1.			
Purpose: (please select as appropriate)	**Approval** ✓	**To note**	**Decision**	
Recommendation:	The Trust Board is asked to approve the revised Strategic People Committee Cycle of Business for 2026/27, as supported by the Strategic People			

	Committee on 16 September 2026 and attached at Appendix 1.	
Previously considered by:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/26/09/111
	Date of meeting	16 September 2026
	Summary of Outcome	The Committee supported the proposed amendments and recommended the revised Cycle of Business to the Trust Board for formal approval.
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

In order to provide effective assurance to the Trust Board, each Committee of the Board is required to maintain an agreed Cycle of Business that supports the discharge of its delegated responsibilities.

The Strategic People Committee Cycle of Business for 2026/27 was developed to provide structured oversight of the people agenda, including workforce strategy and planning, culture, staff experience, equality, diversity and inclusion, workforce performance, education and training, professional standards, governance, risk and regulatory compliance. It also provides for routine assurance reporting, focused deep dives and consideration of emerging issues.

The Cycle of Business has been reviewed to reflect developments since its approval in April 2026 and to ensure that the Committee's programme remains appropriately focused on the Trust's principal workforce priorities, risks and improvement requirements. The revised Cycle of Business was considered and supported by the Strategic People Committee on 16 September 2026.

2. Key elements

2.1 National Oversight Framework scorecard

The National Oversight Framework scorecard will be added as a monthly assurance item from October 2026. This will provide the Committee with a regular view of relevant workforce measures and support consideration of the Trust's position against the applicable oversight requirements.

2.2 Single Improvement Plan programmes

A quarterly Single Improvement Plan programmes report will be introduced from January 2027. The report will provide assurance on the delivery of relevant people and workforce improvement programmes, including progress, risks, dependencies and areas requiring further action.

2.3 Deep dive programme

The deep dive programme has been updated to provide focused scrutiny of priority areas within the Committee's remit. The revised programme includes six deep dives relating to NHS staff standards, one relating to the leadership and management framework and two relating to equality, diversity and inclusion. The individual subjects, presenters and scope will be agreed through the Committee's agenda setting arrangements.

2.4 Workforce Integrated Performance Report

The Workforce Integrated Performance Report will become a monthly item for data, supporting consistent oversight of workforce performance and enabling the Committee to identify areas requiring further assurance, escalation or corrective action. A

separate quarterly Workforce IPR Narrative will provide an assessment of the overall position, key themes, risks, actions and expected impact.

2.5 People and Culture Strategic Updates

The People Strategy Update, Staff Survey Organisational Priorities Update and Culture Plan Update will be consolidated into a single quarterly People and Culture Strategic Updates report. This will provide a more integrated assessment of progress against the Trust's people, culture and staff experience priorities. The first report is scheduled for October 2026.

2.6 Other scheduling and responsibility changes

The revised Cycle of Business also updates the timing, frequency, presenter and lead responsibility for a number of reports. The changes are intended to align reporting with the availability of complete and meaningful information, reduce duplication, clarify accountability, balance substantive items across the meeting programme and maintain capacity for deep dives, staff stories and emerging hot topics.

3. Monitoring/reporting routes

The Cycle of Business will be maintained as a live document through the Strategic People Committee's agenda setting process. Material changes to the agreed programme will be considered by the Committee and reported to the Trust Board through the Committee assurance report where appropriate.

4. Recommendations

The Trust Board is asked to approve the revised Strategic People Committee Cycle of Business for 2026/27, attached at Appendix 1

STRATEGIC PEOPLE COMMITTEE
CYCLE OF BUSINESS

CALENDAR YEAR (APRIL 2026 - MARCH 2027)				2026									2027		
	Reporting Frequency	Process	Lead	April	May	June	July	August	September	October	November	December	January	February	March
OPENING BUSINESS															
Apologies for Absence	Standing Item	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	Standing Item	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting	Standing Item	**Approval**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising / Action log	Standing Item	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
STANDING ITEMS															
Staff Story	Quarterly	**Noting**	CPO	✓			✓			✓			✓		
Deep Dive	Monthly	**Assurance**	CPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hot Topic	As required	**Assurance**	CPO	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓
BAF & Corporate Risk Register - Workforce	Quarterly	**Assurance/ Approval**	CS				✓			✓			✓		
Chief People Officer Report (including Agenda for Change Update (including rebanding/banding creep/B5 work/Integration/new roles, re-banding or related changes)	Monthly	**Assurance**	CPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
National Oversight Framework (NOF) Scorecard	Monthly	**Assurance**	CS	✓2027	✓2027	✓2027	✓2027	✓2027	✓2027	✓	✓	✓	✓	✓	✓
Workforce Brief on National, Regional, ICB, or Local Workforce Issues	Monthly	**Assurance**	CPO/DCPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NCM 2030 - Post Integration Plan Update (PTIP) and Due Diligence Update	Final report in Oct 26	**Assurance**	CPO/CS&PO				✓			✓					
Workforce Integrated Performance Report	Monthly	**Assurance**	DCPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Workforce IPR Narrative	Quarterly	**Assurance**	DCPO		✓2027		✓2027		✓2027		✓		✓		✓
Workforce Integrated Performance Recommendations	Annually	**Assurance**	DCPO											✓	
Single Improvement Plan Programmes	Quarterly	**Assurance**	DCPO	✓2027			✓2027			✓2027			✓		
People and Culture Strategy Update	Quarterly	**Assurance**	DCPO	✓2027			✓2027			✓			✓		
Absence Improvement Update (from July 2026)	Quarterly	**Assurance**	ACPO							**Q2**			**Q3**		
Equality, Diversity and Inclusion Strategy Update	Bi-Annually	**Assurance**	DCPO					✓						✓	
Workforce Policies and Procedures Overview Report	Bi-Annually	**Assurance**	DCPO		✓ **(Q3&Q4)**						✓ **(Q1&Q2)**				
Workforce Plan Update	Monthly	**Assurance**	CPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Improving People Practices Report (including Employee Relations data)	Bi-Annually	**Assurance**	CPO	✓ **Bi-annual Report**						✓ **Bi-annual Report**					
National Staff Opinion Survey	Annually	**Assurance**	CPO												✓
Freedom to Speak Up Report	Bi-Annually	**Assurance**	CFO/FTSUG		✓ **Bi-annual Report**						✓ **Bi-annual Report**				
Health and Wellbeing Update (including the Health & Wellbeing Guardian Report)	Bi-Annually	**Assurance**	CPO/ H&WBG			✓ **Bi-annual Report**						✓ **Bi-annual Report**			
Safer Staffing Report – Key Issues Report to include Red Flag data quarterly	Monthly	**Assurance**	CN	✓ **(Q4 Red Flag Data)**	✓	✓	✓ **(Q1 Red Flag Data)**	✓	✓	✓ **(Q2 Red Flag Data)**	✓	✓	✓ **(Q3 Red Flag Data)**	✓	✓
Volunteer Report	Annually	**Assurance**	CN		**Deferred**	✓									
Internal Audit Action Plans	As required	**Assurance**	DCPO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NATIONAL/ STATUTORY REPORTS															
Midwifery Staffing Report	Quarterly	**Assurance**	CN/DoM			✓ **Q4**		✓ **Q1**			✓ **Q2**			✓ **Q3**	
General Medical Council (GMC) National Trainee Survey	Annually	**Assurance**	EMD						✓						
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA) and Respsonsible Officer Annual Report	Annually	**Assurance**	EMD						✓						

NHSE Self Assessment Report for Education and Training	Annually	**Assurance**	CPO								✓				
National Education and Training Survey (NETS) Report	Annually	**Assurance**	CPO		**Deferred**	✓									
Guardian of Safe Working Hours Report	Quarterly	**Assurance**	EMD		✓ **Q4**			✓ **Q1**			✓ **Q2**			✓ **Q3**	
Guardian of Safe Working Annual Report	Annually	**Assurance**	EMD				✓								
Resident Doctors Improving Workers Lives	Annually	**Assurance**	EMD								✓				
EQUALITY DIVERSITY & INCLUSION – REGULATED REPORTS															
EDI Annual Report (Public Sector Equality Reporting – Patients and Workforce) – including: - Equality Duty Assurance Report - Workforce Equality Assurance Report - Pay Gap Reporting (Race and Disability) - National EDI Improvement Plan - Anti-Racism Framework Update	Annually	**Approval**	DCPO											✓	
Equality Delivery System (EDS)	Annually	**Approval**	DCPO											✓	
Gender Pay Gap Report	Annually	**Approval**	DCPO		**Deferred**	✓		✓**for 2027**							
Workforce Race Equality Standard (WRES) including Bank and Medical Workforce Race Equality Standard	Annually	**Approval**	DCPO					✓							
Workforce Disability Equality Standard (WDES)	Annually	**Approval**	DCPO					✓							
GOVERNANCE															
Terms of Reference	Annually	**Approval**	CS												✓
Annual Cycle of Business	Annually	**Approval**	CS	✓											
Annual Review of BAF risks	Annually	**Approval**	Chair/CS						**Deferred**						
Committee Chairs Annual Report to Trust Board	Annually	**Approval**	CS			**Deferred**	✓								
Committee Effectiveness – Annual survey	Annually	**Assurance/Approval**	CS						✓						
SUB-COMMITTEE CHAIR'S LOGS															
People and Culture Sub Committee	Bi monthly	**Noting**	CPO		✓		✓		✓		✓		✓		✓
Workforce Review Group	Bi-monthly	**Noting**	Chief Nurse			✓		✓		✓		✓		✓	✓
CLOSING MATTERS															
Review of Meeting	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Items for Escalation to the Trust Board	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any Other Business	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Key

CPO - Chief People Officer
DCPO - Deputy Chief People Officer
CS - Company Secretary (WHH)
CS&PO - Chief Strategy and Partnerships Officer
CFO - Chief Finance Officer
ACPO - Associate Chief People Officer
DoC&E - Director of Communications and Engagement
CN - Chief Nurse
FTSUG - Freedom to Speak Up Guardian
H&WBG - Health and Wellbeing Guardian
EMD - Executive Medical Director
DoM - Director of Midwifery
GOSW - Guardian of Safe Working

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/10/090 – BM/26/10/094**			
Subject:	**Supplementary Papers**			
Date of meeting:	7 October 2026			
Action required:	**To note**			
Author(s):	As noted on each paper			
Executive director sponsor:	Chief Nurse, Executive Medical Director			
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:	In following best NHS corporate governance practice, and to support NCM's commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 3 June 2026 No actions are required from the Trust Board they are provided for information only. The papers provided are: **Quality Safety and Assurance committee – 11 August 2026** • **BM/26/10/090** Learning From Experience Summary Report Q1 **QSAC/26/08/132** • **BM/26/10/091** Infection Prevention and Control Update Q1 **QSAC/26/08/133** **Quality Safety and Assurance committee – 11 August 2026**			

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

- **BM/26/10/092** Learning from Deaths Q1 **QAC/26/09/152**

Strategic People Committee – 19 August 2026

- **BM/26/10/093** Guardian of Safe Working Report Q1 **SPC/26/08/093**

Finance Sustainability and Productivity Committee – 28 September 2026

- **BM/26/10/094** Senior Information Risk Owner Annual Report **FSPC/26/09/110**

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<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 supplementary papers provided for information.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">As detailed above</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">As detailed above</td></tr>
<tr><td>Date of meeting</td><td colspan="2">As detailed above</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">As detailed above</td></tr>
<tr><td>Next steps:</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

Quality and Safety Assurance Committee

Agenda reference:	**QSAC/26/08/132**			
Subject:	**Learning from Experience, Quarter 1 2026/27**			
Date of meeting:	11 August 2026			
Action required:	**For noting**			
Author(s):	Nicola Edmondson, Associate Director of Governance Abby Bird, Datix Administrator With input from Care Groups and Corporate Leads.			
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 report provides the first Learning from Experience overview for the integrated North Cheshire and Mersey NHS Foundation Trust, bringing together acute and community learning from incidents, complaints, claims, patient experience, audit, compliance and research activity during Q1 2026/27. The report presents both quantitative and qualitative analysis, with triangulation of information to demonstrate how learning is used to drive improvements in patient care and strengthen organisational capability. The report provides oversight and assurance across the following key areas: • Incidents • Complaints and Compliments • Quality Improvement • Health and Safety			

	• Claims and Inquests • Patient Experience • Clinical Audit • Compliance • Research A total of 4,517 incidents were reported across the Trust during Q1. Reporting levels remain within expected control limits, providing assurance of a stable reporting culture across the organisation. Moderate or above harm incidents accounted for 2.13% of all incidents reported. Learning from incident investigations identified themes relating to clinical escalation, recognition of deteriorating patients, referral management, communication, documentation, medicines safety and coordination of care. Improvement actions have been implemented across acute and community services to address these themes Community services have been incorporated into Trust-wide reporting for the first time following integration, with learning identified from falls prevention, pressure ulcer management, safeguarding practice, waiting list management and multidisciplinary care coordination. The Trust received 123 complaints across the integrated organisation during Q1, a reduction of 5.13% compared with Q4. Clinical Treatment remained the most frequently reported complaint theme, with complaint investigations continuing to inform service improvements and targeted learning across clinical teams. Progress has continued in embedding the Patient Safety Incident Response Framework (PSIRF), including strengthened patient safety training, stakeholder engagement to enhance support for patients, families and staff following patient safety incidents, and commencement of the first integrated review of the Trust's Patient Safety Incident Response Plan (PSIRP). Patient Safety Partners and Patient Safety Specialists are contributing to this work. Positive learning has also been identified through Safety II reviews, multidisciplinary working and quality improvement projects, demonstrating examples of excellent practice, innovation and collaborative working that have contributed to safer care and improved patient outcomes.

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Quality and Safety Assurance Committee is asked to note the contents of this paper.		
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):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	Section 41 – confidentiality		

1. Learning Overview

The purpose of this report is to provide assurance to the Quality and Safety Assurance Committee (QSAC) that North Cheshire and Mersey NHS Foundation Trust (NCM) is effectively managing its key governance workstreams, including incidents, complaints and compliments, quality improvement, health and safety, claims, inquests, patient experience, clinical audit, compliance and research and development. The report also outlines how the Trust continues to learn from experience and apply that learning to minimise risks to patients, staff and the wider organisation.

The report presents findings from data reported in Quarter 1 (Q1) 2026/27, covering the period 01 April to 30 June 2026, with comparisons to Quarter 4 (Q4) 2025/26 where relevant. The analysis draws on both quantitative and qualitative information from the Datix Risk management System and other governance sources. This triangulated approach supports the identification of key themes, trends and learning across the workstreams outlined and sets out the actions taken to support sustained improvement across the Trust.

As this reporting period represents the first quarter following the integration of Warrington and Halton Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) into NCM, the report may also include information taken from legacy systems and processes. Comparisons with previous quarters may therefore rely on data collected under pre-integration reporting arrangements, Work continues to align governance, reporting and assurance frameworks across the Trust, and any limitations relating to data consistency or reporting methodology have been highlighted where relevant.

1.1 Key Highlights

- Integrated learning and assurance reporting established:
  This report represents the first combined Learning from Experience Report following the establishment of North Cheshire and Mersey NHS Foundation Trust, bringing together learning from acute, community and dental services into a single organisational reporting framework. Initial analysis demonstrates alignment of governance processes and provides a baseline for future integrated reporting.
- Stable incident reporting across the integrated organisation:
  A total of 4,517 incidents were reported during Q1. Reporting levels remain within expected control limits, providing assurance of a positive reporting culture across acute and community services. Moderate or above harm incidents attributable to the Trust accounted for 2.13% of all incidents reported.

- Recognition and escalation of deteriorating patients identified as a key learning theme:
  Learning from incident investigations highlighted opportunities to strengthen the recognition, assessment and escalation of deteriorating patients, including patients presenting with Diabetic Ketoacidosis (DKA), sepsis and neurological deterioration. Improvement actions have been implemented including escalation bundles, enhanced training, simulation exercises and strengthened clinical pathways.
- Strengthened governance oversight across community services:
- Community services have been incorporated into organisational reporting for the first time, with learning identified from falls prevention, pressure ulcer management, safeguarding, waiting list management and care coordination. Community governance arrangements have demonstrated effective oversight of investigations, learning and service improvement activity.
- Referral management, communication and care coordination remain learning themes:
  Learning from incidents, complaints, claims and investigations identified recurring opportunities to strengthen referral processes, information sharing, pathway oversight, documentation and multidisciplinary communication to support timely assessment, diagnosis and treatment.
- Continued embedding of PSIRF and patient safety improvement:
  The Trust has continued to embed the Patient Safety Incident Response Framework (PSIRF), strengthening systems-based learning, patient safety capability and organisational oversight. The first integrated review of the Patient Safety Incident Response Plan (PSIRP) is now underway, supported by broad stakeholder engagement, including Patient Safety Partners and Patient Safety Specialists.
- Positive learning and improvement culture demonstrated across the Trust:
  Examples of Safety-II learning, multidisciplinary collaboration and completed quality improvement projects demonstrate a continued commitment to recognising good practice.

2. Learning from Incidents

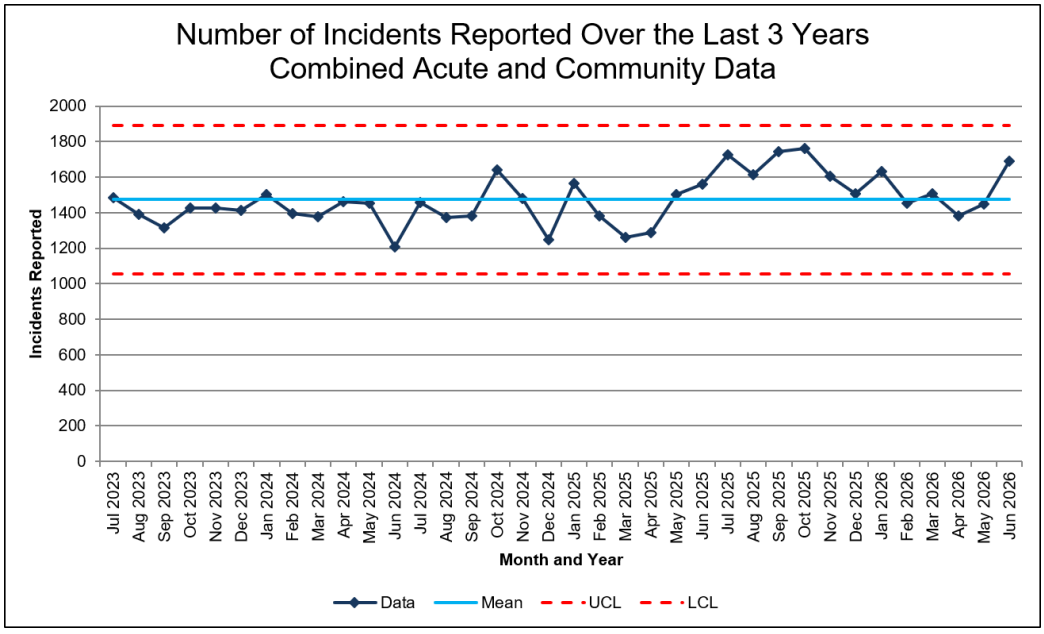
2.1 Incident Reporting Position

Historical incident reporting data has been retrospectively combined across acute and community services in **Graph 1**, to provide a consistent organisational trend. Data was extracted from the current Risk Management System (Datix) and the legacy community Risk Management System (Ulysses) to support this analysis. The statistical process control (SPC) chart has been recalculated using the combined data, generating a revised Trust average and control limits to support meaningful trend analysis and interpretation of incident reporting levels across NCM.

The number of incidents reported across both acute and community services in the last 3 years has remained within the expected control limits, indicating a stable reporting process. However, a sustained shift is noted between May 2025 and January 2026, during which incident reporting remained consistently above the average expected number. This does represent special cause variation, suggesting a meaningful change in the reporting process during this period. Following January 2026, reporting levels returned to a pattern consistent with common cause variation around the Trust average, with subsequent months remaining within the expected control limits. Given the integration of acute and community services and the joining of legacy data, the average and control limits have not been recalculated following the sustained shift. This is to support trend interpretation across the integration transition period. The Trust average and control limits will be reviewed once sufficient post-integration data is available to establish a stable organisational baseline.

A look at acute and community incident reporting separately prior to the integration, showed that incident reporting increased for both Trusts during mid to late 2025. This suggests that the increase is more likely to reflect a change in reporting behaviour and organisational changes. This is further supported by an incident review, specific to acute incidents, completed and presented in the previous Learning from Experience (LFE) Report where an analysis of incident severity and themes over the last 3 financial years did not indicate an increase in serious patient harm incidents during that time.

Graph 1



2.2 Incident Reporting Position by CBU

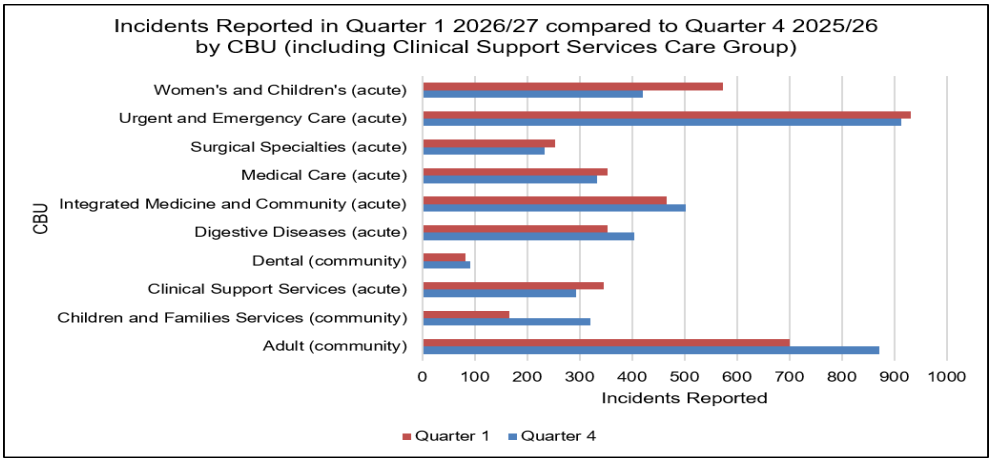
In Q1, a total of 4517 incidents were reported, representing a decrease of 75 incidents (1.63%) compared to Q4. Of these, 4226 incidents were reported across the CBUs and the Care Group, Clinical Support Services. The remaining 303 incidents were reported under Corporate Support Services (acute), Corporate (community) and External Site/Organisation.

A comparison of Q1 and Q4 incident reporting across the CBUs demonstrates mixed variation. The new community CBUs, Adult, Children and Families Services and Dental have all shown decreases in incident reporting in Q1, with the Children and Families Services showing the largest decrease of 46.79% (146 incidents) compared to Q4. This is likely to reflect the ongoing transition from staff using Ulysses to Datix. To support staff during this transition and promote consistent incident reporting practices, an e-learning package has been developed and made available across community services. Digestive Diseases and Integrated Medicine and Community also showed decreases in incident reporting, though these were both below 15% and are considered consistent with normal variation.

All other acute CBUs, including the Clinical Support Services Care Group, reported increases, with Women's and Children's showing the largest increase of 36.43% (153 incidents) compared to Q4. Whilst the Urgent and Emergency Care CBU only showed a 1.97% increase (18 incidents) between Q4 and Q1, there was a notable month on month increase observed between May and June 2026, with an increase of 69.84% incidents reported. This increase was primarily driven by incidents relating to Access, Transfer and Discharge which rose from 27 to 130 incidents, predominantly relating to delays in admission and bed availability. The increase was mainly reported within the Emergency Department (ED) Majors location, with incidents rising from 103 to 254.

A comparison of the incidents reported across the CBUs and the Clinical Support Services Care Group between Q4 and Q1 is illustrated in **Graph 2**.

Graph 2



Due to differences in harm classification methodologies used by acute and community services prior to the integration, a direct comparison of Q1 and Q4 harms is not currently possible. Historically, community services recorded only the highest level of actual physical and/or psychological harm associated with a patient safety incident. In contrast, acute services, historically and continue to report physical and psychological harm to the patient separately alongside a Trust attributable harm field, which is used as the primary severity classification for reporting purposes. However, following the implementation of a standardised reporting approach, harm data will be comparable in future reports.

In Q1, incidents resulting in moderate or above harm that were attributable to an act or omission of the Trust accounted for 2.13% of all incidents reported. The table below presents the distribution of incident harm levels in Q1:

Severity	Incidents Reported	Percentage of total incidents reported in Q1
No Harm	3512	77.75%
Low Harm	909	20.12%
Moderate Harm	87	1.93%
Severe Harm	6	0.13%
Fatal	3	0.07%

2.3 Themes and Learning from Incidents by CBU

2.3.1 Clinical Support Services Care Group

2.3.1.1 Learning Themes Identified in the Q4 Report

Radiology – Prevention of Extravasation Injury

Learning from a severe harm incident reported in Q4 identified opportunities to strengthen the Standard Operating Procedure (SOP) for Prevention of Extravasation Injuries within CT (computed tomography). Progress against actions includes:

- Completion of the revised SOP.
- Development of a digital education resource to support staff awareness and understanding.
- Use of visual prompts and clinical examples to reinforce staff awareness.

These actions are anticipated to be completed throughout Quarter 2, and effectiveness of these interventions will continue to be monitored through incident reporting trends and severity reviews.

Radiology – Delayed Identification of Pancreatic Malignancy

The Q4 report included learning from a severe harm incident where a retrospective review of a patients care confirmed that a pancreatic malignancy was visible on earlier

imaging and not identified at the time of reporting. A Multi-Disciplinary Team (MDT) Review identified learning regarding the potential identification of pancreatic abnormalities on ultrasound imaging and the limitations of MRCP (magnetic resonance cholangiopancreatography) imaging in assessing the pancreas. The incident and investigation findings were submitted to the Radiology Events and Learning Meeting (REALM) for wider professional learning. Additional questions have subsequently been raised by the patient's family regarding the visibility of the abnormality on previous imaging and outsources reporting processes. The Radiology Team are currently progressing a response to these concerns.

Radiology – Missed Mediastinal Mass

Q4 learning identified a severe harm incident where a mediastinal mass was not recognised across a number of imaging investigations undertaken over a prolonged period of 29 months. The MDT Review established that the examinations performed were not specifically intended to assess the mediastinum, however the case reinforced the importance of ensuring all available imaging, including planning images and anatomical structures visible at the periphery of scans, are considered during reporting. The learning was shared through both the MDT Review and the REALM. All identified actions have now been completed for this incident.

Pharmacy – Medication Calculation and Dispensing Accuracy

In Q4, learning was identified from an incident involving incorrect tuberculosis (TB) medication dose calculation. Learning was shared across the Pharmacy Team and several system improvements were introduced. Progress against actions includes:

- Embedding the use of the WellSky calculation function within the dispensing SOP.
- Publication of a quick reference training guide for staff on the Pharmacy Medicines Safety Team channel to support staff and provide an accessible ongoing reference resource.
- Ongoing near-miss auditing to identify trends and opportunities for improvement.

These actions appear to have been effective, with no further reports of TB medicine dose miscalculations reported since the implementation of learning actions. Audit findings continue to be fed back to staff to support ongoing learning and enable corrective actions to be implemented before errors reach patients.

2.3.1.2 Clinical Support Services Q1 Incident Update

A total of 344 incidents were reported during Q1 compared to 294 incidents in Q4. This represents an increase of 50 incidents (17.01%). Radiology remained the top reported specialty with 150 incidents reported, followed by Pharmacy (63) and

Outpatients (59). Across Clinical Support Services, there were 5 moderate harm, 2 severe harm and 1 fatal harm incident reported.

Examples of incidents and learning identified in Q1 are detailed below:

- **Fatal harm incident** – a 92-year-old patient attended the ED following a fall with a CT angiogram of the aorta confirming there was no acute aortic injury or acute abdominal pathology. The CT angiogram did not identify small volume pulmonary emboli and 12 days later the patient re-attended ED with shortness of breath. A CT pulmonary angiogram was completed, identifying bilateral pulmonary emboli with a moderate clot burden. The patient was discharged after being commenced on treatment, however attended ED 2 days later with following a syncopal episode and query seizure activity and a CT angiogram of the aorta was arranged. A cardiac arrest call was placed while the patient was in CT and the patient sadly died.

  The patients scan of 8 April 2026 showed a small volume pulmonary emboli and whilst this scan was not intended specifically to look for these, the clots were identifiable on the scan but were not reported on by the Radiologist. As a result of this there was a 12-day delay in the patient being commenced on treatment (apixaban) for the pulmonary emboli.
  - The case was submitted to the REALM to enable the team to reflect and learn from the case.

- **Severe harm incident** – a 49-year-old female patient attended the Same Day Emergency Care (SDEC) Unit with a 2-week history of worsening abdominal pain. A CT scan showed a collection anterior to the rectum. Following a second Radiology opinion, it was noted that 2 collections were seen, and an image guided drainage was arranged. A consent form was completed, explaining there were risks of bleeding and bowel injury. There were no immediate post procedure complications, however the patient deteriorated following the procedure and 5 days later a CT scan was completed that could not rule out a persistent bowel perforation with recurrent abscess; the patient was taken to theatre where operative findings revealed the pigtail drain had perforated two loops of bowel, resulting in a collection of small bowel content in the left iliac fossa. The patient underwent a small bowel resection due to the two perforations and a loop jejunostomy and double-barrelled mucous fistula procedure was performed. Learning points included:
  - Perforation is a recognised risk of CT guided abdominal drainage, and the correct measures were taken to manage this.
  - When a second Radiology opinion is requested, the Radiologist should record this on the Radiology Information System.

- A separate incident has been reported to address any concerns regarding the escalation of the patient's condition, and an MDT Review will be completed.

- **Severe harm incident** – a 59-year-old female patient had a CT scan of her abdomen in March 2026 following a GP (General Practitioner) referral to investigate persistent, debilitating abdominal pain adjacent to her left renal angle (T9-T12 level). The report did not identify any cause for the patient's symptoms. Towards the end of May 2026, the patient attended ED with a flare up of chronic abdominal pain and low-level vomiting. The pain was felt to be radicular rather than intra-abdominal but given her long standing symptoms the patient was referred for an outpatient gastroenterology opinion and MRI (magnetic resonance imaging) scan. The MRI scan demonstrated a large soft tissue mass at the T7 to T10 level extending from the vertebral bodies into the left paravertebral tissues. It was noted that the abnormality had been present on the previous scan but had not been reported on. Further imaging (CT and MRI) was completed, and the patient was recalled to SDEC where the imaging findings were discussed with her. A CT guided biopsy of the lesion has since been completed.
  - The case was submitted to the REALM for shared learning amongst the Radiologists and the case will also be shared with the Radiologist from a neighbouring Trust who completed the initial report.

2.3.1.3 Learning from Q1

Radiology Follow Up Alert Process

Learning from Q1 is focused on the radiology alerts process. When follow-up imaging is recommended, a specific code is added to the report by the Radiologists which is subsequently actioned by the Radiology Booking Team. 2 incidents reported in recent months, alongside a historic similar incident, identified occasions where the required follow-up imaging was not arranged, resulting in delays to surveillance imaging and diagnosis.

Whilst a review has confirmed that large volumes of alerts are processed successfully each month by the Radiology Department with a low overall error rate, the incidents demonstrated the vulnerability of a manual process, prone to human error. Contributing factors identified included staffing pressures and environmental distractions within clerical work areas. Measures have already been implemented to reduce these risks including changes to working arrangements to minimise interruptions. A large scale review of the Radiology alerts process is underway to:

- Review the current system end to end.
- Identify opportunities to strengthen assurance and reduce reliance on manual processes.

- Explore additional safeguards for follow-up imaging requests.
- Further reduce the potential for delayed diagnoses associated with missed surveillance imaging.

Pharmacy Patient Information and Counselling

Learning was identified following an incident involving Lugol's iodine oral solution for a planned procedure. A patient contacted the Pharmacy reporting a burning sensation on their tongue after taking 0.3mL of Lugol's iodine oral solution. The patient advised they had taken the medication directly as they had not been informed that the dose should be diluted prior to administration and also reported that the bottle supplied in January 2026 had an expiry date of March 2026. An investigation established that the medicine had originally been supplied in January for a planned procedure that was subsequently delayed until June, resulting in the product expiring before use. The patient also reported that no counselling or patient information leaflet had been provided at the time of supply. On review, it was identified that the dispensing label did not contain the required British National Formulary (BNF) warning advising the patient to dilute the product with a full glass of water.

The investigation learning highlighted issues relating to patient counselling, expiry management of medicines supplied for delayed procedures, dispensing label warnings and the accuracy of supporting patient information leaflets. Learning and actions following this include:

- The BNF warning for mandatory dilution instructions has been incorporated into the Lugol's iodine drug profile within the dispensing system to ensure that all future dispensing labels automatically include clear instructions.
- Learning has been shared across the Pharmacy Department during the weekly departmental meeting to reinforce the importance of clear patient information and robust counselling processes.
- A review of Trust-produced patient information leaflets has been commissioned to identify and update outdated documents relating to unlicensed medicines to ensure patients received safe and effective medication guidance.

The Medication Safety Officer is involved in the review of investigations, identification of learning and development of improvement actions.

2.3.2 Digestive Diseases

2.3.2.1 Learning Themes Identified in the Q4 Report

Hepatology Follow Up and Surveillance Learning Example.

The Q4 report highlighted a significant incident involving a patient with Primary Biliary Cholangitis Cirrhosis who did not receive a planned follow up appointment or

subsequent liver surveillance imaging following review in July 2023. The patient later presented with a suspected hepatoma and is currently awaiting the outcome of a specialist liver MDT Review. The review identified that, although the patient had been offered an appointment in December 2024 which they were unable to attend, there was a wider backlog of approximately 3000 delayed follow up patients that consultants were unaware of.

The incident was reviewed through the Safety Oversight Meeting (SOM). Whilst the review concluded that the patient's treatment pathway has not changed, opportunities for earlier diagnosis and additional support may have been missed.

The incident has been highlighted as part of a wider organisational risk associated with outpatient follow up management and is forming part of a broader Trustwide programme of work led by the Deputy Chief Medical Officer to strengthen outpatient follow up processes and oversight arrangements. A review has been completed, with the findings due to be presented at the next Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC).

2.3.2.2 Digestive Diseases Q1 Incident Update

There were 353 incidents reported in Q1 compared to 405 in Q4, a decrease of 52 incidents (12.84%). All incidents are reviewed locally, with further actions and management plans then identified. There were 20 Initial Safety Reviews completed. 2 After Action Reviews, 2 Swarm Huddles and 1 Patient Safety Incident Investigation (PSII) were declared in Q1. 4 After Action Reviews and 2 MDT Reviews were closed in Q1.

The PSII related to a patient admitted with a periprosthetic fracture following a fall. Surgery was delayed until day 5 despite appropriate escalation and, following the procedure, the patient deteriorated after transfer from recovery to the ward. The patient subsequently developed bilateral pleural effusions and died 17 days after admission. The following learning and actions have been identified:

- Improve management and documentation of delayed surgery.
- Strengthen recovery monitoring, NEWS escalation, and documentation.
- Ensure discharge criteria are met before transfer from recovery.
- Standardise post-operative observation requirements.
- Improve safety during patient handovers and transfers.
- Reinforce correct emergency escalation procedures.
- Improve documentation during patient deterioration and emergency responses.

General Surgery was the top reported specialty (127), followed by Theatres (59) and Gastroenterology (47). There were 11 moderate harm incidents and 1 fatal harm

reported. The top 2 incident themes in Q1 were Medication (43) and Access, Transfer and Discharge (36).

Medication

9 (20.93%) incidents were categorised as medical administration, 13 (30.23%) as medication management, 11 (25.58%) as prescribing issues, 7 (16.28%) as medicines discharge process related incidents, 1 (2.33%) incorrect monitoring and 1 (2.33%) pharmacy review. Medication incidents continue to be monitored through the Medication Safety and Optimisation Steering Group, with quarterly high-level reports providing assurance that learning from incidents is identified, disseminated, and embedded into practice. Pharmacy representation at the CBU Governance Meeting supports an MDT Review of medication incidents, including recurring themes such as paracetamol prescribing. Emerging themes are escalated via the Medical Governance Lead to Specialty Governance Meetings, ensuring learning is shared, discussed, and reflected upon by both junior and senior clinical teams to support ongoing quality improvement.

Access, Transfer and Discharge

4 incidents (11.11%) related to Ward B3, the escalation ward opened in January 2026 to support the Trust’s response to winter pressures and has since closed. Of the incidents reported, 10 (23%) related to failures to follow Infection Prevention Control (IPC) SOP's, Protocols or Clinical Procedures within the Surgical SDEC (SSDEC) unit. Thes findings have been reviewed, shared with the team and escalated to the IPC team to support increased visibility, monitoring and assurance activity within the unit. SSDEC opened in February 2026 and, during its implementation period, staffing and medical resource were escalated, along with an increase in the use of bank and agency staff to maintain service delivery. Mitigations were implemented throughout this period to strengthen processes and address identified risks.

2.3.2.3 Learning from Q1

Fatal Harm Incident – Recognition and Escalation of the Deteriorating Patient

In April 2026, a patient attended a pre-operative assessment with their daughter, who holds Lasting Power of Attorney (LPA) for Health. Following review by the Pre-Operative Nurse and Consultant Anaesthetist, the patient was deemed unsuitable for a general anaesthetic and surgery. An elevated pulse of 105bpm was recorded, and although an ECG (electrocardiogram) had been performed within the previous 3 months, a repeat ECG was clinically indicated but not completed. The patient's oxygen saturations were within normal target range (88–92%) due to known type 2 respiratory failure. The patient was documented as sleepy and non-verbal; however, there is no evidence that staff confirmed with the patient’s daughter whether this differed from

usual baseline. There were no documented clinical indicators of sepsis, although it was identified that the appointment was a potential missed opportunity to recognise deterioration.

The review found that temperature is not routinely recorded during pre-operative assessments, and that NEWS2 (National Early Warning Score) is not intended for use as a standalone outpatient assessment tool, with clinical judgement remaining essential. While earlier recognition may have supported more appropriate end-of-life planning, it is unlikely that the patient's outcome would have changed.

Learning and Actions Identified

- Review pre-operative assessment pathways and SOPs.
- Consider introducing a deteriorating patient recognition tool for the outpatient setting.
- Review anaesthetic assessment documentation standards.
- Confirm staff completion of sepsis recognition and deteriorating patient (AIMS) training.
- Provide team feedback following the SOM decision.
- Deliver a single-point lesson to the pre-operative team on the detection and management of sepsis.

Moderate Harm Incidents – Fundamental Care, Patient Safety, Communication, Teamworking and Safe Surgical Practice

Upon review, these incidents cover a range of themes including hospital-acquired pressure ulcers, manual handling, patient falls, clinical deterioration, staff injury, safeguarding, and intraoperative errors. The learning identified from these incidents highlights several opportunities to strengthen patient safety and clinical practice. For hospital-acquired pressure ulcers, learning includes reinforcing the completion of skin assessments within six hours of admission, ensuring pressure ulcer risk assessments are reviewed daily, repositioning patients in accordance with their care plans, escalating promptly when specialist pressure-relieving equipment is unavailable and improving the quality of pressure area care documentation. The review also identified the need to reinforce staff awareness of recognising and escalating signs of patient deterioration and ensuring consistent implementation of pressure ulcer prevention bundles. To support sustained improvement, the Matron and Ward Manager will continue to undertake regular audits and compliance reviews, with findings addressed by targeted improvement actions.

Learning identified from manual handling incidents involving patients and staff has highlighted the need to reinforce safe moving and handling practices through targeted refresher training. Key learning includes ensuring that transfers are undertaken using the appropriate equipment and with sufficient staff support, together with promoting a culture that encourages staff to stop, reassess and seek assistance where a transfer is becoming unsafe.

Learning from patient falls has identified the importance of completing falls risk assessments on admission and whenever a patient's condition changes, ensuring call bells and mobility aids remain accessible, consistently implementing falls prevention measures and undertaking medication reviews where medicines may increase the risk of falls. Compliance with falls prevention requirements will continue to be monitored through regular audits undertaken by the Matron and Ward Manager.

For intraoperative recognised complications, learning has focused on strengthening compliance with the World Health Organisation (WHO) Surgical Safety Checklist, enhancing communication between theatre teams through effective time-outs, reinforcing high standards of clinical documentation, and conducting multidisciplinary debriefs following unexpected events to identify opportunities for shared learning and service improvement.

2.3.3 Surgical Specialties

2.3.3.1 Learning Themes Identified in the Q4 Report

Ophthalmology – Glaucoma Follow Up Pathway

The Q4 report highlighted a severe harm incident involving a patient on the glaucoma pathway who had been lost to follow up, with no documented specialist review since 2015. An SBAR (Situation, Background, Assessment and Recommendation) Review was taken to the SOM, and a Learning Response was sent to the patient. The review identified the need for stronger systems to manage glaucoma surveillance, clearer ownership of follow up arrangements, improved tracking of patients at risk of disease progression and enhances communication with patients regarding waiting time sand deteriorating vision. Learning and actions implemented include:

- Strengthened follow up booking processes, with the outpatient department now responsible for arranging all follow-up appointments.
- Enhanced oversight of overdue glaucoma patients through risk-stratified monitoring at monthly governance meetings.
- Increased consultant capacity through recruitment of an additional consultant.
- Improved communication with patients about waiting times and the need to report any deterioration promptly.
- Reviewed medium-risk patient pathways to support earlier identification of disease progression.
- Continued monitoring and escalation of ophthalmology waiting list pressures and clinic capacity.
- Reinforced urgent referral pathways to ensure timely assessment of patients with suspected glaucoma progression.

2.3.3.2 Surgical Specialties Q1 Incident Update

There were 256 incidents reported in Q1 compared to 234 in Q4, an increase of 22 incidents (9.40%). Trauma and Orthopaedics was the top reported specialty (145), followed by Medical Outliers (34) and Surgical outliers (20). There were 7 moderate harm and 1 severe harm incident reported in Q1. There were 18 Initial Safety Reviews completed. 1 Swarm Huddle has been declared, and no learning responses were completed in Q1. The top 2 reported themes were Access, Transfer and Discharge (44) and Slips, Trips and Falls (24).

Access, Transfer and Discharge

Access, Transfer and Discharge was the most frequently reported incident theme in Q1, with 44 incidents recorded, including 11 patient who required urgent blue light transfer from the Halton site to the Warrington site. This reflects ongoing operational pressures relating to bed capacity and patient flow across the Trust, with increased demand resulting in a higher volume of patient transfers. As each transfer requires a clinical handover and coordination across teams and sites, there is an inherent risk associated with communication, continuity of care and the timely transfer of clinical information, which is reflected in the reporting profile.

The following measures are in place to mitigate these risks:

- Ensuring patients are clinically appropriate and medically optimised before transfer.
- Providing senior nursing oversight of transfer decisions.
- Prioritising patients awaiting discharge by addressing delays related to packages of care, equipment provision and care home placement.

Slips, Trips and Falls

Slips, Trips and Falls was the second most frequently reported incident theme in Q1, with 24 incidents recorded. Falls continue to represent a patient safety risk and reflect the complexity and frailty of the patient population. Ongoing falls prevention measures remain in place, including falls risk assessments, individualised care planning and MDT Review and targeted interventions for patients identified as being at increased risk.

2.3.3.3 Learning from Q1

Strengthening Referral Pathways and Administrative Processes Learning Example.

An incident was reported following a delay in the assessment and diagnosis of an infant with a significant family history of retinoblastoma. Although the family history was disclosed to the antenatal team, appropriate follow-up actions, including cord blood collection for genetic testing, were not completed.

An urgent referral to the Paediatric Ophthalmology Service was made on 24 February 2026; however, due to failures within a paper-based referral process, the referral was not received by the Appointments Team until 15 May 2026. The location of the referral during this period could not be established. A subsequent urgent electronic referral was submitted following a routine six-week GP review but was downgraded during triage after a normal examination. As the original referral was not visible within the system, the significance of the family history and associated risk was not fully recognised.

Following identification of the original referral, the infant was seen on 3 June 2026 and diagnosed with bilateral retinoblastoma. The patient required urgent referral to a specialist tertiary centre for treatment. Clinical review identified that delays within the referral pathway may have reduced opportunities for earlier specialist assessment. The patient subsequently required specialist treatment and has experienced permanent sight impairment in one eye.

The incident was reviewed through established governance processes and considered at the Safety Oversight Meeting (SOM).

The review highlighted several opportunities for service improvement:

- Ensuring significant family history and hereditary risk factors are recognised and acted upon appropriately throughout the patient pathway.
- Strengthening processes to support timely genetic testing and follow-up where indicated.
- Reducing reliance on paper-based referral systems and improving referral tracking, visibility and oversight.
- Enhancing communication and information sharing between teams to ensure critical clinical information is available during triage and decision-making.
- Reinforcing the importance of incorporating hereditary and risk-related factors into clinical triage assessments.
- Developing clear referral pathways for patients with known familial risk factors requiring specialist surveillance and assessment.

Communication, Information Sharing, Clinical Escalation and Risk Assessment Learning Example.

Analysis of the moderate harm incidents reported during the period identified themes relating to delays in referral, diagnosis and treatment, communication and information-sharing challenges, and weaknesses within administrative referral processes.

Learning Identified

The principal learning identified from these incidents is the importance of robust referral and administrative processes to ensure patients are assessed and treated in a timely manner. Effective tracking and oversight of referrals are essential in reducing the risk of delays and ensuring urgent cases receive appropriate prioritisation.

Incidents also highlighted the need for strong communication and information-sharing arrangements across teams and services, ensuring that relevant clinical information is available to support safe and informed decision-making. Clinical triage and escalation processes should consistently consider patient-specific risk factors and be undertaken in accordance with established pathways and clinical guidance.

In addition, the reviews reinforced the importance of accurate documentation, ongoing clinical assessment and proactive governance oversight to identify delays, monitor compliance with procedures and support early intervention where concerns arise. Collectively, these improvements will help strengthen patient safety, enhance pathway reliability and reduce the risk of avoidable harm.

2.3.4 Women's and Children's

2.3.4.1 Learning Themes Identified in the Q4 Report

Maternity – Initial Safety Review – Medication Safety

The Q4 report detailed a maternity learning example related to a medication safety incident on the maternity ward where Clexane was inadvertently administered to the wrong woman. The review identified a prompt and transparent response, with immediate recognition of the error, open communication with the woman and an apology offered. The learning reinforced the importance of robust patient identity checks, uninterrupted medication administration and strengthened application of the Rights of Medicines Administration, including mandatory wristband scanning.

Since the last report, the learning has continued to be taken forward through medicines safety oversight and ward manager support. A supervised medication round has been completed, and Ward Managers have been asked to complete Medication Competency Assessments as part of annual reviews. Work has also commenced to support a centralised SharePoint process for competency assessment information and assessment dates, with progress to be monitored through monthly one-to-ones between Ward Managers and Matrons. The CBU will continue to monitor effectiveness through reported medication events at Women's Health and CBU Governance Meetings, with thematic review undertaken if any increase in events is identified.

Maternity and Neonatology – Initial Safety Review – Positive learning via Multidisciplinary Working

The report also included a maternity and neonatology positive learning example following an Initial Safety Review which demonstrated effective multidisciplinary teamwork and high-quality intrapartum care. The case highlighted prompt escalation following abnormal CTG (cardiotocography) findings, clear communication between midwifery, obstetric, anaesthetic and neonatal teams, and coordinated management of a Category 1 caesarean section. Although neonatal admission and postpartum haemorrhage occurred, both were managed effectively, with no harm attributable to the Trust.

This learning continues to be reflected in current maternity governance discussions, particularly through the Intrapartum Review Group (IRG), Safety-II learning and shared MDT review. The case remains a useful example of strong situational awareness, rapid escalation and collaborative working under pressure, and supports the continued focus on making good practice visible alongside learning from incidents. Ongoing monitoring will continue through maternity governance routes, with positive learning shared across teams to support consistent practice and reinforce the behaviours that contribute to safe care for women and babies.

Gynaecology – Swarm Huddle – Pressure Ulcer Prevention

Since the previous quarter's LFE report, actions have been undertaken to address the learning identified following the development and deterioration of a pressure ulcer. Documentation standards relating to skin assessments, and care planning have been reviewed via quality metrics and there is education on documentation standards being developed.

Access to senior nursing support has also been strengthened through consistent ward manager presence. There have been no further pressure ulcers on Ward C20 to date reflecting increased staff awareness and confidence in recognising deterioration. Further education, supervision, and oversight are planned to support embedding the learning and reducing the risk of similar incidents occurring in the future.

Gynaecology – Swarm Huddle – Controlled Drug Safety

There has been a reduction in controlled drug-related incidents following staff education, suggesting improved staff awareness, increased compliance with controlled drug procedures, and safer medicines management practices. Ongoing monitoring and audit activity will continue to ensure these improvements are sustained and to identify any further opportunities for learning and development.

Gynaecology – Staffing Levels

The staffing establishment paper for the Gynaecology Assessment Unit (GAU) has been developed however, approval remains outstanding. In the absence of an agreed staffing model, the service continues to utilise NHSP (NHS Professionals) staff and receives support from Surgical Specialties to maintain safe service delivery. Recruitment to vacant posts is ongoing to improve workforce resilience and reduce reliance on temporary staffing. workforce pressures continue to be monitored through governance processes

Paediatrics – Staffing Levels

The staffing establishment paper for the GAU has been developed however, approval remains outstanding. In the absence of an agreed staffing model, the service continues to utilise NHSP staff and receives support from Surgical Specialties to maintain safe service delivery.

Recruitment to vacant posts is ongoing to improve workforce resilience and reduce reliance on temporary staffing. workforce pressures continue to be monitored through governance processes

The Paediatrics ward continue to support ED Paediatrics with any concerns are highlighted through Datix, and the Lead Nurse liaises with the ED lead nurse regarding any concerns that may occur. Development of the SOP for staff movement across paediatric services remains outstanding, and further work is required to identify and implement ongoing joint training sessions to ensure staff maintain the knowledge, skills, and confidence required to work safely across the ward, neonates, and the Paediatric ED.

2.3.4.2 Women's and Children's Q1 Incident Update

There were 573 incidents reported in Q1 compared to 420 in Q4, an increase of 153 incidents (36.43%). The top 3 incident themes this period were Maternity/Neonatology (294), Staffing Levels (60) and Medication (40).

Maternity was the top reported specialty (294), followed by Paediatrics and Neonatology (110) and Gynaecology (86). There were 17 moderate harm incidents and no severe or fatal harm incidents reported in Q1. There were 11 Initial Safety Reviews completed in Q1. There were no PSIIs declared or closed in Q1. There was 1 After Action Review, 1 Cluster Review and 2 MDT Reviews declared, and 1 Swarm Huddle closed in Q1.

The increase in maternity incidents may be attributable to improved reporting following enhanced triangulation with BadgerNet, which was undertaken during Q1. It is anticipated that reporting levels will stabilise as this process becomes embedded.

For Q2 reporting, the CBU will undertake a further review of the top three incident themes, recognising that these were the same top three themes reported in the previous Q4, to identify whether any consistent sub-themes are emerging across services. It is recognised that the CBU covers multiple specialties and, as such, there may not always be a single common sub-theme within each category. However, this additional review will provide assurance that any recurrent patterns, specialty-specific issues or areas requiring further learning are identified, monitored and escalated through the appropriate governance routes where required.

2.3.4.3 Learning from Q1

Maternity and Neonatology – Avoiding Term Admissions to Neonatal (ATAIN)

Monthly ATAIN reviews for April, May and June 2026 identified a reduction in term admissions over the quarter, from 27 in April to 19 in May and 11 in June. Avoidable admissions also reduced from 8 in April to 3 in May and 1 in June. The reviews highlighted recurrent learning relating to admission decision-making, use of transitional care and respiratory pathways, escalation, communication of sepsis concerns, temperature management and completion of the warm care bundle.

In April, learning focused on supporting labour to progress where CTG remained reassuring, recognising normal transitional physiology in the first minutes of life, timely escalation where concerns persisted, early use of warming measures, prompt communication of sepsis concerns and avoiding neonatal admission where there was no ongoing clinical need. In May and June, the same learning continued, with particular emphasis on ensuring neonatal unit admissions are clinically justified, using the Positive End-Expiratory Pressure (PEEP) for 30 and term respiratory distress pathways appropriately, and maximising transitional care where safe to do so.

Actions already taken include displaying the PEEP for 30 and respiratory distress pathway flowcharts in maternity areas, sharing reminders for staff to familiarise themselves with pathway criteria, reinforcing completion of the warm care bundle including neonatal temperature checks, and reiterating the need to use a crash call when requesting urgent paediatric registrar or consultant attendance. Learning has also reinforced that where deviation from the norm is suspected following maternity triage, transfer to birth suite should be facilitated without delay.

Good practice was also identified, including appropriate recognition and treatment of jaundice, facilitation of delivery room cuddles using a longer Continuous Positive Airway Pressure lead, timely identification of an abnormal CTG in triage with transfer to birth suite, and midwifery support for transitional care which enabled women and babies to remain together where clinically appropriate. The reduction in avoidable admissions suggests early improvement, although continued monitoring through

monthly ATAIN MDT review is required to confirm sustained improvement and to ensure admissions continue to be based on ongoing clinical need with clear documentation of the rationale for admission decisions.

Maternity IRG – Embedding Multidisciplinary Learning to Improve Intrapartum Care

During Q1, the Intrapartum Review Group reviewed 59 incidents through multidisciplinary discussion, including Obstetric Anal Sphincter Injury (OASI), postpartum haemorrhage above 1500mls, shoulder dystocia, low cord pH and Apgar scores below 7 at 5 minutes. The reviews identified shared learning across intrapartum care, with key themes relating to documentation, prevention and escalation, communication at handover, and consistent application of current clinical guidance.

Learning from IRG has been shared with maternity teams to support improvements in documentation, timely escalation and adherence to agreed pathways. This is now shared as a structured approach for sharing learning across the service, supporting consistent communication of themes, actions and examples of good practice. This supports the wider aim of translating learning from individual events into collective improvement, ensuring that insights extend beyond those directly involved and reach the broader clinical workforce. The group will continue to use MDT review to monitor recurring themes, support targeted quality improvement work and identify any further actions required to reduce variation in practice. Monitoring will continue through IRG governance processes, with themes escalated through maternity governance where wider learning or assurance is required.

Positive practice was also identified, including effective multidisciplinary working in emergencies, exemplar documentation, timely escalation and compassionate care for women and families. These examples demonstrate the value of IRG in supporting a learning culture and recognising where practice is working well, alongside identifying opportunities for further improvement.

Cluster Review – Strengthening OASI Prevention, Documentation and Follow-Up Reliability

A Q1 OASI cluster review was undertaken following 14 OASI cases reported between 6 April and 24 June 2026. The review provided assurance that immediate clinical response standards were consistently achieved, with 100% compliance for documented PR (rectal) examination, repair in theatre, repair by an ST3+ clinician, antibiotics and laxatives prescribed, and episiotomy angle documented where applicable. SPC interpretation identified the May increase as common cause variation, with a reduction in June.

The review identified key risk signals and learning themes relating to instrumental birth, postpartum haemorrhage (PPH) overlap, lithotomy birth position, macrosomia, prevention documentation and postnatal follow-up. Nine of the 14 cases also had a PPH recorded, with a mean estimated blood loss of 821ml. The main reliability gaps related to OASI follow-up, controlled delivery documentation, antenatal discussion of OASI risk, physiotherapy referral and completion of key data fields. These findings appear to reflect gaps in documentation and pathway reliability rather than gaps in immediate clinical care, as individual review through IRG ensured follow-up and referrals were addressed where identified.

Actions agreed include standardising OASI prevention documentation, ensuring antenatal discussion, manual perineal protection and controlled delivery are reliably captured in the patient record, developing an OASI discharge bundle to support consistency in physiotherapy referral, OASI clinic follow-up and written discharge information, and strengthening MDT case review and shared learning. Further work is also planned to improve data capture through mandatory fields or prompts where feasible, supported by targeted education.

Improvement will be monitored through the continuous audit cycle, with a target of achieving at least 90% compliance for prevention documentation, referral and follow-up reliability while maintaining the 100% assurance already demonstrated for repair and prescribing standards. Named owners have been identified through governance for each action, with progress to be tracked through Datix and maternity governance processes. Ongoing quarterly shared learning will support sustained improvement and provide assurance that pathway reliability is improving alongside safe clinical response.

Safety-II Positive Learning

A Safety-II review was shared as a positive learning example following an intrapartum case where the team created safety in real time under pressure. CTG concerns were recognised during labour and escalated promptly. Although the registrar was already scrubbed in theatre, live CTG access was used to support senior review, leading to a Category 1 caesarean section decision. The team activated the emergency pathway, coordinated a second theatre team to create capacity and maintained safe flow despite competing theatre pressures.

The review highlighted effective multidisciplinary working across midwifery, obstetric, anaesthetic and theatre teams. Good practice included early recognition of CTG concerns, adaptive use of technology, timely escalation, senior decision-making, clear coordination of theatre capacity and recognition that the regional block was inadequate before surgery commenced, with general anaesthetic agreed in advance. Documentation was clear and timely, supporting review and shared understanding of the sequence of events.

The key learning is that safety was actively created through staff recognising risk, adapting to the circumstances and working together to maintain safe care. This example will be shared to make good practice visible, repeatable and valued, and to encourage teams to report examples of excellent practice as well as incidents where harm or near-miss events occur. Sharing Safety-II learning supports a balanced learning culture by strengthening what works well in practice.

The learning will be shared through maternity governance, team safety briefings and wider PSIRF learning routes. Monitoring will focus on whether positive learning examples continue to be identified and shared, and whether teams are encouraged to recognise adaptive practice, escalation, communication and teamwork as important contributors to safe care for women and babies.

Paediatrics Initial Safety Review – Paracetamol Administration via Multiple Routes

A medication incident was identified when a nurse recognised that an infant had received a higher than intended dose of paracetamol over a 24-hour period. The patient was being treated for sepsis and required paracetamol administration via different routes during the admission. Paracetamol was prescribed both rectally and as two separate intravenous (IV) stat doses. During administration, the nurse checked only one administration route and did not identify the cumulative dose administered across both routes.

A review found that the paracetamol had been administered via rectal and intravenous routes within the same 24-hour period, resulting in the total prescribed and administered dose exceeding the intended amount. The infant was reviewed by the medical team, and no harm occurred as a result of the incident. No additional treatment or intervention was required. The patient's parents were informed of the error and provided with a full explanation.

The incident highlighted the importance of checking all prescribed and administered medications across multiple administration routes when calculating cumulative doses, particularly where separate prescriptions may exist on the electronic prescribing system.

Learning and Actions Identified

- The Digital Specialist Pharmacist will undertake a test patient review to determine whether the electronic prescribing system generates an alert when the same medication is administered via different routes and, if not, explore whether additional safeguards can be implemented.

- A ward safety brief will be shared with nursing staff to reinforce the requirement to review all medication administration routes over a 24-hour period when administering medicines and calculating total doses.
- Learning will be shared with clinical teams to increase awareness of the risks associated with administering the same medication via multiple routes and to promote safer medicines management practices.

Delay in Large Loop Excision of the Transformation Zone (LLETZ) Treatment Requiring General Anaesthetic

A review was undertaken following concerns regarding the time between diagnosis of CIN3 and definitive treatment. The patient was first seen in the Colposcopy Clinic on 21 July 2025 following referral with high-risk HPV and severe dyskaryosis. At the initial appointment, LLETZ under local anaesthetic was not possible due to prolapsing vaginal walls and the position of the abnormality, requiring treatment to be undertaken under general anaesthetic.

Biopsy results, received on 26 August 2025, confirmed cervical intraepithelial neoplasia grade 3 (CIN3) with no evidence of cervical glandular intraepithelial neoplasia or invasion in the sample obtained. The patient was appropriately added to the waiting list as a Priority 2 case by the Nurse Colposcopist. However, a delay of approximately seven months occurred before treatment was undertaken. A pre-operative assessment was initially scheduled for 2 March 2026 but was cancelled by the Trust and subsequently rearranged for 19 March 2026, before the patient underwent LLETZ on 31 March 2026.

The review identified that the delay was primarily associated with waiting for treatment under general anaesthetic rather than a delay in diagnosis or initial clinical decision-making. Histology from the LLETZ subsequently confirmed Grade 2 squamous cell carcinoma, with MRI staging demonstrating Stage 2B disease requiring chemoradiotherapy. The patient reported multiple cancellations and the need to repeatedly contact the service for updates, highlighting the impact of delays on patient experience and the importance of robust waiting list management and communication processes.

Learning and Actions Identified

- Create a separate P2 Cancer Faster Treatment (CFT) waiting list for patients with CIN3, ensuring improved oversight and treatment within the expected 3-month timeframe.
- Align the management of CIN3 patients with the existing process used for patients with endometrial hyperplasia.

- The Assistant CBU Manager, Service Lead and Appointments Manager to work with IT to implement changes to referral and waiting list processes.
- Update local policies and guidance to reflect the revised referral and waiting list arrangements.
- Share guidance with clinical and administrative teams regarding the management and monitoring of the separate CIN3 waiting list. Strengthen monitoring and escalation processes for high-priority patients to reduce the risk of delays in treatment.

2.3.5 Integrated Medicine and Community (IMC)

2.3.5.1 Learning Themes Identified in the Q4 Report

The Q4 LFE Report identified recurring themes relating to violence and aggression, staffing pressures, falls prevention and medication safety. Actions implemented included enhanced de-escalation training, the introduction of the Risk-Taking Behaviours Risk Assessment, ongoing workforce recruitment initiatives, enhanced falls review processes and continued medication safety auditing.

IMC Q1 Incident Update and Learning

In Q1, IMC reported 466 incidents, a reduction of 36 incidents (7.17%) from Q4. General Medicine remained the highest reported specialty, with 328 incidents in Q1, followed by Frailty (55) and the Department of Medicine for Older People (41). In Q1, there were 7 moderate and 1 severe harm incident reported. The severe harm incident relates to the failure to act on the deterioration of a patient resulting in a delay in possible sepsis diagnosis. A PSII has been declared for the incident and the investigation is ongoing. The top 5 reported themes in Q1 were Antisocial/Abusive/Violent Behaviour (103), Staffing Levels (59), Medication (48), Slips, Trips and Falls (46) and Access, Transfer and Discharge (32).

Antisocial/Abusive/Violent Behaviour

The top reported theme in Q1 was Antisocial/Abusive/Violent Behaviour with 103 incidents reported. This was also the top reporting theme in Q4 (85). The majority of incidents related to patient antisocial behaviour and patient on staff physical assaults. There were cases regarding a patient's lacking capacity, therefore limiting the use of the Trusts Unacceptable Behaviour Policy.

All staff are required to complete Conflict Resolution Training and compliance for IMC is 90.91%. Staff are also supported to complete their De-escalation Training to facilitate the management of these situations. Current compliance for this training in IMC is 60.14%.

Learning and Actions

- Additional De-escalation Training by IMC Nurse Clinical Educator, training dates for the rest of the year have been shared with the CBU's staff have been encouraged to book on at the next available date.
- Staff affected by incidents are supported by their line manager and CBU Team, with input from Health and Safety, Occupational Health and/or the Wellbeing Hub as required. Wellbeing conversations also take place if a period of absence has been required. This is monitored in the Care Group People meetings
- Trauma-informed approach (to support violence and abuse prevention and reduction) commenced.
- Post-incident debriefs and wellbeing support implemented if required.
- Additional security arranged for areas with increased risk of aggression if necessary. Staff have accessed additional security when required as detailed in the incidents

Staffing Levels

37 of the incidents related to Nurse/Health Care Assistant staffing levels and 9 relate to medical workforce.

Learning and Actions

- Ward Managers continue to undertake clinical shifts at least twice weekly to support safe staffing levels and operational oversight.
- Recruitment activity remains ongoing across all wards to address workforce vacancies. CBU wide recruitment events are held regularly.
- Recruitment to substantive medical posts continues and is monitored through the monthly Care Group People Meeting.
- Weekly requirement panels are held within the CBU.

Medication

All medication incidents reported during the period were categorised as low harm/no harm incidents

Learning and Actions

- Reflective learning is requested from staff members following medication errors to support individual learning and reduce the risk of recurrence.
- One-to-one support is provided by Ward Managers.

- Medication and prescription audits are undertaken to monitor compliance and identify opportunities for improvement.
- Key messages regarding medicines management and adherence to Trust policy are routinely reinforced through ward safety briefs.
- All wards undertake the DUTHIE audits, in partnership with pharmacy colleagues, with action plans developed for areas of non-compliance. This is overseen by Matrons and Lead Nurses and discussed at the Medicines Safety and Optimisation Group.

Slips, Trips and Falls

A reduction of falls related incidents was seen across the Care Group during Q1 with 46 incidents reported, 64 in Q4. 4 of those incidents were classed as moderate harm, the rest, low or no harm. The moderate harm incidents occurred on Wards A7, A8 and B19 all with one moderate harm incident each, there was also a moderate harm fall that occurred in the patient flow office with a staff member harmed. Themes from the moderate harm incidents relate to bathroom transfers.

Learning and Actions

- Ward Manager collaborating with the Patient Safety Nurses to deliver additional Falls Prevention Training, reinforcing understanding of enhanced care levels and requirements, this is ongoing across the wards.
- Weekly review of falls incidents undertaken at new incident review meeting, led by the Patient Safety Nurses, ensuring proactive monitoring and risk mitigation by reviewing incidents within 72 hours.
- Lessons learned disseminated across teams to strengthen awareness and improve practice around enhanced care. This is shared in safety briefs, handovers ward meetings
- Individualised falls action plans are in in place within all ward areas to support continuous improvement.

Access, Transfer and Discharge

32 incidents were recorded on Q1 that related to access, transfer and discharge, this is a decrease from 40 in Q4. All reported incidents were recorded as low or no harm. The common themes in the reported incidents include delays in discharges and bed availability.

Learning and Actions

- Board round improvement work commenced during Q2 to support with safe and efficient discharges and improve patient flow efficiencies.

- A daily clinical call has been implemented to review bed demand across specialities, providing enhanced oversight and reinforcing the importance of safe discharge practices and effective patient flow management.

2.3.6 Medical Care

2.3.6.1 Learning Themes Identified in the Q4 Report

The Q4 report identified learning themes relating to patient flow and transfer delays, medication safety, management of violence and aggression and falls prevention. Actions implemented included escalation of bed capacity concerns through Patient Flow and Senior Operational Teams, ward-level medication action plans, increased senior support to clinical areas managing challenging patient behaviours and enhances falls review processes through Swarm Huddles and Harm Free Care Meetings. During Q1, these actions have continued to be embedded within practice.

2.3.6.2 Medical Care Q1 Incident Update and Learning

In Q1 Medical Care reported 339 incidents, an increase of 6 incidents (1.80%) in Q4 where 333 were reported. General Medicine was the highest reporting speciality in Q1 with 84 incidents reported. There were 4 moderate harm incidents reported in Q1. These are discussed below in the highlight reported themes however there was also a pressure ulcer on admission reported on Ward A3.

In Q1, there were 10 Initial Safety Reviews completed, with 1 progressing to MDT Review. This incident related to clinical care concerns raised following discussions at the Mortality Review Group. There was no learning responses completed in Q1.

The top reporting themes in Q1 were Access, Transfer and Discharge (51), Antisocial/Abusive/Violent Behaviour (40), Medication (30), Slips, Trips and Falls (29) and Clinical Care – Ongoing and Review (26).

Access, Transfer and Discharge

Access, Transfer and Discharge incidents have reduced during Q1. Of the incidents reported, 25 related to bed availability and Mixed Sex Accommodation Breaches. These breaches were related to delays in stepping patients down from the Intensive Care Unit (ICU), arising from wider Trust wide capacity pressures. In line with the Trust's policy Eliminating Mixed Sex Accommodation in Critical Care and ICU, clinically justified breaches may occur in exceptional circumstances such as bed shortages or predictable fluctuations in demand**.** In these instances, decisions were made to prioritise patient safety whilst continuing to seek appropriate placement at the earliest opportunity.

Learning and Actions:

- ICU teams continue to cohort Level 1 patients by sex wherever practicable. This control remains in place from previous quarters.
- Delays in patient transfers and associated capacity pressures are escalated regularly to the
  Patient Flow Team and senior managers through the daily bed and staffing meetings.
- Compliance with Single Sex Accommodation guidance continues to be monitored

Antisocial/Abusive/Violent Behaviour

Antisocial/Abusive/Violent Behaviour incidents increased during Q1. One moderate harm incident was reported within the ICU, where a member of staff was assaulted by a patient experiencing confusion. Whilst no specific leaning was identified from the incident, appropriate support was provided to the staff member.

There was a spike of antisocial behaviour in Q4 observed on ward A2. This trend was not evident during this quarter.

Learning and Actions

- Debriefs are offered to individual staff members or teams following incidents involving violence, aggression, abuse or assault to support staff wellbeing, facilitate reflection, and identify any learning opportunities.
- Occupational Development/rugby league cares support explored for staff to utilise.
- Increased leadership visibility in clinical areas continues to provide enhanced support to frontline teams, promote a positive safety culture, and enable timely intervention where concerns arise
- Conflict resolution training compliance is currently 94.53% and de-escalation compliance is 68.2%
- Action is being undertaken to increase de-escalation training compliance in line with Trust targets.

Medication

Medication incidents have shown a slight reduction during Q1. One moderate harm incident was reported on Ward A3, this related to prescribing undertaken by the GP and was therefore classified as an external incident. A review of the incident concluded that there was
no further learning identified for the Trust.

Learning and Actions

- Reflective learning is requested from staff members following medication errors to promote shared learning, reinforce safe practice, and reduce the risk of recurrence.
- One-to-one discussions with ward managers to offer senior support.
- Medication and prescription audits are completed in line with Trust Policy, with findings reviewed and discussed at the Medicines Safety Oversight Group
- Key messages relating to medicines management and compliance with Trust medicines policies are routinely communicated to ward teams through local safety briefs.
- All wards complete DUTHIE audits, undertaken in conjunction with pharmacy colleagues, to assess compliance with standards for the safe and secure handling of medicines. Action plans are developed for any areas of non-compliance, with oversight provided by Matrons and Lead Nurses and assurance reported through the Medicines Safety and Optimisation Group.

Slips, Trips, Falls

There has been an increase of 3 incidents reported within this category during Q1. No moderate harm or above incidents have been reported.

Of the 29 incidents reported, 10 occurred on ward C21, 8 occurring on A3, 6 on A2, 3 on B18 and 2 on ICU.

Learning and Actions

- Swarm Huddles and weekly review of falls incidents undertaken at the Harm Free Care Meeting, led by the Patient Safety Nurses, ensuring proactive monitoring and risk mitigation.
- Lessons learned are disseminated across teams to strengthen awareness and improve practice around enhanced care.

Clinical Care – ongoing review

This theme has newly emerged within the top five categories in Q1 with 26 incidents reported. Common themes relate to delay in attending/ assessing patient (6 reported) and Cardiac Arrest events (5 reported). There was also a moderate harm reported under this category relating to gaps in end-of-life management. An initial safety review was completed, and it was determined that an MDT was required, awaiting learning.

Learning and Actions

- Ongoing work continues to support patient flow through both the front and back door pathways.
- A corridor care summit has been undertaken, which has identified actions to support the safe and timely transfer of patients.
- Ongoing monitoring of mandatory training related to clinical care such as life support.
- Learning from mortality reviews shared widely with teams.
- Deteriorating patient task and finish group ongoing to strengthen processes and pathways.

2.3.7 Urgent and Emergency Care (UEC)

2.3.7.1 Learning Themes Identified in the Q4 Report

The Q4 report identified key learning themes relating to patient flow and transfer delays, pressure ulcer prevention, medication safety and the recognition and management of deteriorating patients. A number of improvement actions have progressed during Q1 and continue to be embedded across UEC.

2.3.7.2 UEC Q1 Incident Update

A total of 925 incidents were reported in Q1, this is an increase of 12 incidents (1.31%) from Q4 where 913 incidents were reported. Emergency Medicine remained the highest reporting speciality with 650 incidents reported. This was followed by Acute Medicine (158) and Patient Flow (115). There were 10 moderate harm incidents reported and no severe or fatal incidents identified.

During Q1 36 Initial Safety Reviews were completed. An After-Action Review was declared following completion of an SBAR, this related to the failure to act on a deteriorating patient. 4 After Action Reviews, 1 Cluster Review, 7 MDT Reviews and 1 Swarm Huddle was closed during Q1.

The top reported themes in Q1 were Access, Transfer and Discharge (186), Present on Admission Pressure Ulcer (131), Medication (75), Antisocial/Abusive/Violent Behaviour (70) and Moisture Associated Skin Damage (MASD) or Other Wound to Skin (61).

Access, Transfer and Discharge

There were 186 reported incidents during Q1, regarding Access, Transfer and Discharge. This is an increase from 110 in Q4. This increase has largely been

impacted by Trust wide capacity pressures with the highest sub-theme being in relation to delay in admission (109) and inappropriate transfer (18). There were 2 moderate harms incidents in this category relating to a patient being asked by the Northwest Ambulance Service (NWAS) to make their own way to hospital and the second moderate harm related to a patient being transferred to the ED with a high NEWS score (both external incidents).

Most reported incidents continue to relate to Emergency Department patients exceeding the 24-hour time frame. These incidents are reviewed and investigated by the patient flow team, to identify contributory factors and opportunities for improvement.

Learning and Actions

- Access, transfer and discharge delays continue to be escalated through internal operational forums and reviewed at NWAS monthly meetings, with a focus on system-wide patient flow and escalation processes.
- All escalation actions are taken by the Patient Flow and Operational teams to facilitate patient movement and are discussed throughout the day at bed meetings.

The Corridor Care and Escalation Spaces Standard Operating Procedure (SOP) has been completed, providing a clear framework for managing periods of escalation within the Emergency Department. The SOP ensures that patients who are on the corridor:

- Are risk assessed and selected appropriately to ensure suitability for corridor care and maintain safety. Receive appropriate care whilst on the corridor and any concerns are escalated promptly and effectively.
- The Senior Doctor at Triage SOP has been updated to prompt direct referrals to specialities in lie with Speciality Accepted Patient Policy and guidance on supporting in the identification of type 4-5 patients for streaming to alternative assessment areas to improve flow.
- The Streaming SOP is scheduled for presentation at UEC Governance in August 2026.
- Increased auditing of the intentional rounding has been implemented to improve patient flow and expedite discharging and admissions.
- Ongoing workstreams with the senior nursing teams to improve flow to areas such as SSDEC.
- Implementation of the NWAS streaming and handover process is planned for the the end of July 2026.

Pressure Ulcer on Admission

Pressure ulcers recorded as present on admission have decreased during Q1, however incident numbers remain high with 131 incidents reported. which supports the identification of pressure damage on arrival. This provides assurance that pressure damage is being identified, documented and reported at the earliest opportunity on presentation to Urgent and Emergency Care services.

Learning and Actions

- To further strengthen the prevention and management of pressure-related harm, the Ward Manager is working with external suppliers and partner agencies to explore the feasibility of procuring airflow mattresses suitable for use on patient trolleys for those patients identified as being high risk
- Pressure ulcer and skin integrity incidents continue to be reported on Datix and shared as interface incidents with community services and other healthcare providers. Safeguarding referrals are completed when concerns are identified.
- Repose wedges have been introduced and are now routinely available within the department to support pressure redistribution, patient positioning and pressure area management.
- The redesigned ED documentation booklet, developed in line with the Red Lines Toolkit, incorporates prompts for pressure area care, repositioning, body map completion, and ongoing comfort and care assessments, supporting staff to deliver consistent, evidence-based care and improve the early identification and management of pressure damage.
- Quality walk rounds continue to be undertaken by the ED leadership team to identify any concerns. Spot checks have been introduced, with a focus on risk assessments.
- The allocation of Health Care Assistants to support care and comfort rounds, alongside increased pressure relieving equipment.

Medication

Medication errors consist of both prescribing and administration, with the most frequently reported themes relating to missed/omitted doses, medication administration and medication prescribing.

One moderate harm incident related to antibiotics not being available on the unit which caused a delay in administration. A formal MDT review is to take place following an Initial Safety Review.

As an immediate action stock levels of intravenous Tazocin (Broad Spectrum Antibiotic) have been reviewed. In addition, the antimicrobial formulary compliance

and patient accurate weights are to be incorporated into the ongoing sepsis improvement quality improvement.

- Time critical medications (TCM) A Quality Improvement (QI) project is underway, a dashboard has been designed to support in timely and accurate prescribing of TCM.
- Prompts have been included within the ED booklet design to flag for prescription of all medications within the first hour of care.
- Dedicated ED Pharmacist will support with learning, processes and staff support.
- In line with an existing risk "*If experiencing delays to be seen by a clinician in ED then there will delays to prescribing regular medications resulting in missed doses of patients regular medications and potential patient harm*", the ED Lead Pharmacist is developing a Self-Administration of Medication policy for use for patients within the ED waiting room.
- Medication-related incidents are reviewed at the speciality level, with learning shared through safety huddles and governance meetings to reinforce safe prescribing, administration, and monitoring practices.

Antisocial/Abusive/Violence

Incidents relating to antisocial/abusive/violence have increased during Q1 and have now moved into the top 5 categories reported for UEC. One moderate harm incident was reported relating to an assault on a member of staff, which caused injury.

Current compliance with Conflict Resolution Training is 87.23%, while De-escalation Training compliance is 54.48%.

Learning and Actions

- Increased leadership visibility within clinical areas continues to provide support to frontline teams.
- All staff currently outstanding for de-escalation training have been booked onto training sessions scheduled over the next two months.
- Any staff involved in any acts of antisocial or abusive nature are provided direct support from their line managers with the offer of support from occupational health and wellbeing services.
- Enquiries have been made to Rugby League Cares to explore additional wellbeing and emotional support opportunities.

MASD or other wound to skin

Incidents relating to Moisture Associated Skin Damage (MASD) or other wound to skin have decreased slightly during Q1, reflecting the continued focus and improvements on pressure area care in UEC. Despite this improvement, challenges remain due to the prolonged periods that some patients spend within the Emergency Department.

Learning and Actions

- Body mapping continues to be completed on arrival to the ED as part of initial patient assessment, supporting early identification of pressure damage and skin integrity issues. Referrals to the Tissue Viability Nurse are made, when clinically indicated.
- Pressure ulcer prevention equipment has been ordered and is now available within the ED, including repose mattresses for patients on trolleys and repose wedges to prevent pressure damage to heels.

2.3.7.3 Learning from Q1

MDT Review – Recognition and Escalation of Deteriorating Patients

An MDT Review was completed in Q1 following the care of a 57 year old patient who presented to the ED following a fall, with confusion, shortness of breath, raised blood glucose levels and elevated ketones. The review identified that the patient met the clinical criteria for Diabetic Ketoacidosis (DKA) at initial assessment, however this was not recognised at the earliest opportunity, resulting in a delay in the initiation of the appropriate treatment pathway and specialist input.

The review found that this reflected a combination of system and process factors, including pressures within a busy Emergency Department environment, competing clinical demands, variability in escalation processes, gaps in monitoring and documentation, and the limitations of NEWS2 in identifying metabolic deterioration. The findings highlighted opportunities to strengthen the early recognition and management of DKA, improve escalation arrangements, support monitoring and documentation compliance, and ensure timely senior clinical and critical care involvement.

In response to the review, the following improvement actions have been implemented

- Introduction of a mandatory ED DKA escalation bundle.
- Enhanced medical and nursing education.
- Simulation-based DKA training.
- Insulin safety awareness initiatives.

- Strengthened documentation requirements.
- Development of an early ICU escalation pathway.
- Exploration of electronic alerting solutions.

After Action Review – learning example

An After-Action Review was completed in Q1 following the care of an adult patient with multiple long-term health conditions who presented to the ED with abdominal pain and suspected infection. The patient was initially assessed as clinically stable and commenced on treatment for a urinary tract infection and acute kidney injury. Over the subsequent 24 hours, the patients condition deteriorated, with reduced consciousness and the development of type 2 respiratory failure requiring escalation to the ICU for non-invasive ventilation and specialist support.

The review focused on the patient's transfer from the ED to the Acute Medical Unit at a point when their neurological condition had deteriorated. The review identified opportunities to strengthen the recognition, assessment and escalation of neurological deterioration, particularly where clinical presentation may not be fully reflected by NEWS2 scores.

Key learning highlighted the importance of:

- Ensuring clinical judgement and concern appropriately inform escalation decisions, regardless of NEWS2 scores.
- Maintaining ongoing holistic assessment of patients with complex co-morbidities who may deteriorate despite an initially stable presentation.
- Early recognition and assessment of changes in consciousness through the effective use of AVPU and Glasgow Coma Scale (GCS) scoring.
- Supporting safe patient transfers through effective communication, structured SBAR handovers and appropriate consideration of clinical escort requirements.

In response, learning has been embedded through enhanced staff education on neurological observations and AVPU/GCS assessment, reinforcement of escalation processes where clinical concern exists, improvements to transfer and handover guidance, and a review of Trust training to strengthen the recognition and management of neurological deterioration. Learning has been shared across the ED and Acute Medicine services to support ongoing improvement in patient care and safety.

2.3.8 Community and Dental Care Group – Adults CBU

2.3.8.1 Learning Themes Identified in the Q4 Report

Community Services did not contribute to the Q4 report as the reporting period preceded the formal integration of services. Consequently, no update is available for this reporting cycle. Community Services will be included in future reports to provide assurance on relevant activity, learning and improvement initiatives.

2.3.8.2 Community Adults Q1 Incident Update

There were 701 incidents reported in Q1 a decrease of 141 incidents (16.75%) from the 842 reported in Q4. There were 481 no harm, 210 low harm and 11 moderate harm incidents reported. There were no severe or fatal incidents identified in Q1. All incidents are reviewed within the Weekly Directorate Incident Review and Learning Group (DIRLG) meeting, with further actions and management plans then identified and requested.

The top 3 themes reported in Q1 were Slips, Trips and Falls (146), MASD or Other Wound to Skin (127) and Trust Acquired Pressure Ulcers (75).

Slips, Trips and Falls

The most frequently reported incident theme within Community Adult Services during Q1 was slips, trips and falls. In response to an increase in falls occurring at Padgate House, the Community Intermediate Care Residential Facility, an audit was undertaken by the Clinical Lead for Intermediate Care to review compliance with falls risk assessments, falls documentation and post-falls management processes.

The audit provided assurance that there was a high level of compliance with falls care planning and post-falls assessments. No direct correlation was identified between the specific area of the fall; the time of day the fall took place and the activity being undertaken by the patient at the time of the fall.

Following the audit, the service implemented several improvement measures, including the introduction of chair-based exercises and the provision of Steady Now leaflets. Falls data within Padgate House continue to be monitored through the monthly Falls Priority Group and reported quarterly to the Quality Governance Meeting to support ongoing oversight and learning.

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It is also noted that the majority of falls reported within community settings relate to unwitnessed falls occurring in patients' own homes, or falls disclosed by patients when Trust staff were not present. These incidents are reported by staff via Datix to support organisational monitoring, trend analysis and learning, rather than indicating that the fall occurred during direct care delivery.

Moderate Harm Fall – Padgate House-learning example

In Q1, a moderate harm incident was reported following an unwitnessed fall at Padgate House involving a patient assessed as being at high-risk of falls and with cognitive impairment. The patient sustained a pelvic fracture.

An SBAR was presented to the Safety Oversight Meeting, which identified opportunities to strengthen the management of patients at increased risk of falls. Recommendations included trigger-based escalations for patients experiencing 2 or more falls during admission, alongside the adoption the Trusts Enhanced Care Support Pathway for complex patients.

An After-Action Review has been commissioned to further explore the circumstances surrounding the incident and identify and further learning and improvement actions. This is progressing during Q2 and any learning recommendations and associated actions will be reported through the next LFE report.

MASD or Other Wound to Skin

Skin wound and Moisture Associated Skin Damage (MASD) incidents continue to be subject to robust governance and oversight arrangements. All incidents are reviewed weekly through the DIRLG, with oversight provided by the Community Tissue Viability Nursing (TVN) Team. Where emerging patterns or trends are identified within specific teams, the TVN Team works directly with services to provide targeted support, guidance and improvement actions.

Of the 127 incidents reported during the period, 81 were identified as Trust-acquired. Recognising the significance of MASD incidents, this was established as a quality improvement priority for 2025/26. A Task and Finish Group was formed, supported by a comprehensive action plan to monitor, drive improvements and reduce the incidence of MASD. At the time of reporting, all actions have been completed except for one outstanding action relating to the development of patient information leaflets.

Ongoing analysis has identified a recurring seasonal pattern in MASD and skin wound reporting, with incident numbers typically increasing during the warmer summer months. This trend has been observed consistently over several years. To provide continued assurance, Q2 data will be closely monitored and should the upward trend continue, a targeted records audit will be undertaken to identify any emerging themes, contributory factors or further opportunities for improvement.

Trust Acquired Pressure Ulcers

There were 75 Trust Acquired Pressure Ulcers reported during Q1, of which 11 were categorised as category 3 or 4 pressure ulcers. 6 of these were graded as moderate

harm and were subject to a Pressure Ulcer AMaT (Audit for Management and Tracking) review to identify any gaps in care and opportunities for learning.

All category 4 pressure ulcers reported during Q1 had previously been reported as category 3 pressure ulcers and proportionate responses were completed with learning identified where applicable.

2.3.8.3 Learning from Q1

Investigations Completed – Strengthening Clinical Escalation, Patient Safety and Safeguarding Practice

The DIRLG maintained oversight of incident investigations and organisational learning throughout Q1. During the quarter, the DIRLG requested 21 Rapid Reviews, a community-specific review process used for incidents such as falls, pressure ulcers or unexpected deaths, alongside 6 After Action Reviews and 9 Learning from Death Reports.

During the same period, there were 20 Rapid Reviews, 8 Learning from Death Reports, 6 After Action Reviews and 1 PSII closed in Q1. In addition to this, the DIRLG approved and finalised 16 Action Plans created from investigation reports.

Learning and improvements arising from investigations completed during Q1 included:

- Implementation of escalation processes and supporting flowcharts for high risk and complex patients to promote timely assessment by the most appropriate clinician and referral to relevant specialist services
- Reinforcement of effective pressure ulcer huddles and visual management tools to support the identification monitoring and review of patients requiring pressure ulcer management.
- Incident reporting and incident management training for senior clinical staff to strengthen adherence to Trust procedures and investigation standards.
- Reinforcement of the use of care and support planning tools to ensure patient preferences and individual needs are considered when planning and delivering care.
- Reminders regarding the timely escalation of safeguarding concerns and the availability of safeguarding supervision to support staff caring for patients with complex needs and circumstances.

Pressure Ulcers

Pressure ulcer incidents are reviewed through the monthly Pressure Ulcer Priority Group. Learning and actions from pressure ulcer incidents in Q1 included:

- Reinforcing the importance of regular full body skin inspections and ensuring assessments are clearly documented within patient records.
- Raising awareness of the increased risk of skin breakdown in patients living with dementia and the need for enhanced vigilance and preventative interventions.
- Improving consistency and standardisation of clinical handovers to support continuity of care and risk management.
- Promoting the timely escalation of concerns where recurrent incidents are identified within the same care provision.
- Reinforcing the importance of reporting incidents within Trust timescales to support timely review, learning and intervention.
- Ensuring appropriate pressure-relieving equipment is in place when patients transfer between acute and community settings to maintain continuity of preventative care.

Alongside areas for improvement, reviews also identified examples of positive practice that contribute to effective pressure ulcer prevention and management, including:

- Ongoing education and engagement with patients and families regarding skin integrity and pressure ulcer prevention.
- Effective multidisciplinary working across Trust services and partner organisations, including care providers and social care services.
- Person-centred decision-making that considers patient preferences and prioritises comfort, particularly for patients receiving end-of-life care.

In addition to ongoing investigation and review processes, collaborative work is continuing between the Acute and Community Tissue Viability Nursing Teams to develop a formal reporting process for pressure ulcers. This work aims to improve reporting arrangements, strengthen oversight across care settings and reduce duplicate incident reporting when patients transfer between acute and community services

2.3.9 Community and Dental Care Group – Children's Services

2.3.9.1 Learning Themes Identified in the Q4 Report

Community Services did not contribute to the Q4 report as this reporting period pre-dated the integration of services. Consequently, no comparative update is available for this section. Community Services will be incorporated into future reports to enable trend analysis, assurance reporting and oversight of learning and improvement activity across the integrated service

2.3.9.2 Community Children's Q1 Incident Update

There were 166 incidents reported in Q1, representing a reduction of 146 incidents (46.79%) compared with 312 incidents reported in Q4. Of the incidents reported, 154 were categorised as no harm, 9 as low harm, and 3 as moderate harm. No severe harm or fatal incidents were reported during Q1. All incidents were reviewed through the DIRLG, with further actions and management plans identified where required to support learning and service improvement.

The 3 moderate harm incidents reported in Q1 all related to waiting times within the Child Community Neuro-Developmental Pathway Service and the associated impact these waits have had on the young people involved. An SBAR report was completed for each incident and presented to the SOM, to support harm review and consideration of any additional actions. Following discussion, It was agreed that no further investigations was required for these incidents, and no additional actions were identified. A further incident relating to an extended wait for further neuro-developmental assessment has been referred to the Integrated Care Board (ICB) through the SOM process.

The top 3 themes reported in Q1 were Manual Handling (46), Appointment Issues (19), Communication and Consent Issues (12) and Staffing Levels (12).

Manual Handling

All manual handling incidents reported within Community Children's Services reported in Q1 relate to clinical holds completed within the Paediatric Phlebotomy Service. No harm was reported and all clinical holds were safe and effective. Staff completing clinical holds will require updated and ongoing training relevant to these procedures and will access Trust training as needed.

Appointment Issues

The majority of appointment issue incidents reported concerned short notice cancellations resulting from staff unavailability. No harm was reported and all affected appointments were rescheduled. One incident related to a delay in making an onward referral, which resulted a delay in assessment, however no harm was identified. Learning from this incident highlighted the importance of providing clear information to families regarding timescales, alongside maintaining clear documentation in records.

Communication and Consent

Communication incidents reported during Q1 related to both internal and external communication processes. One low harm incident was reported in relation to

documentation and decision making following a child protection medical. Review of the incident reinforced the importance of timely and accurate documentation. All remaining incidents were reported as no harm with no trends of themes identified.

Staffing Levels

Staffing-related incidents primarily reflected occasions where workforce capacity impacted the ability to undertake clinical or administrative activities as planned. One of these incidents was associated with the moderate harm incidents relating to waiting times within the Community Neurodevelopmental Pathway Service.

2.3.9.3 Learning from Q1

Investigations Completed – Learning to Strengthen Safeguarding, Documentation and Care Coordination

During the quarter, DIRLG requested 5 Learning from Death Reports in Q1. In the same period there were 6 Learning from Death Reports and 4 After Action Reviews closed. In addition, 1 interface incident response report and 11 finalised Action Plans arising from investigation reports were approved. Actions from the investigations closed in Q1 included:

- Additional training will be delivered by the Safeguarding Children's Team for 0-19 Staff to strengthen professional challenge, curiosity and escalation using the Pan Cheshire Escalation Policy.
- Reinforcement of the importance of accurate, contemporaneous and timely clinical record keeping across Children's Services.
- Review and update of Standard Operating Procedures (SOPs) relating to waiting list management and administrative processes, including the use of clear, accessible language to improve communication and understanding between administrative and clinical teams.
- Exploration of the use of care pathways for children and young people with complex needs to strengthen care planning, coordination and communication across services. This will include reviewing documentation and considering the development of standardised templates to support consistency in record keeping for review appointments.
- Reminders to clinicians regarding the application of the Think Family approach.

2.3.10 Community and Dental Care Group – Dental

2.3.10.1 Learning Themes Identified in the Q4 Report

Community Dental Services did not contribute to the Q4 report as this reporting period pre-dated the integration of services. Consequently, no comparative narrative is

available. Community Dental Services will be incorporated into future reports to support trend analysis, assurance reporting and oversight of learning and improvement activity.

2.3.10.2 Community Dental Q1 Incident Update

There were 82 incidents reported within the Community Dental services, during Q1, representing a reduction of 8 incidents (8.89%) compared with Q4. The majority of incidents were categorised as no harm (73) with 9 classified as low harm. No moderate or above harm incidents were identified.

The top 3 reported themes of incidents reported were Equipment/Medical Devices (13), Infrastructure, Environment and Resource (11) and Antisocial/Abusive/Violent Behaviour (10).

Equipment/Medical Devices

A range of incidents relating to equipment and medical devices were reported during the quarter. Review of these incidents did not identify any recurring themes, or specific learning requirements. Incidents were managed locally in line with established processes.

Infrastructure, Environment and Resource

The majority of incidents within this category related to environmental conditions, specifically elevated temperatures within two dental clinic sites during periods of hot weather. The affected facilities do not currently have air conditioning, and these incidents were reported to ensure appropriate oversight of environmental risks impacting patient and staff experience.

Antisocial/Abusive/Violent Behaviour

Incidents within this category predominantly involved patients displaying distressed or challenging behaviours during treatment, this is predominantly due to the patient cohort cared for. A smaller number of incidents related to unacceptable behaviour towards reception and administrative staff, either in person or via telephone.

2.3.10.3 Learning from Q1

Learning from Death Review – Assurance of Care and Policy Reinforcement

One Learning from Death report was completed within the Dental services during Q1. The review related to a patient with a learning disability who died 10 days following a new patient dental assessment.

The review was completed by the Greater Manchester Clinical Director, supported by the Principal Lead for Public health. The review identified that there were no lapses in care, themes or contributory factors.

The case was discussed at DIRLG, where it was agreed that no further actions were required, and a LeDeR (Learning from Lives and Deaths – People with Learning Disability and Autistic People) submission was completed. Enquiries with the local Learning Disability Team confirmed that the individual was not previously known to that service.

Although no care-related concerns were identified, the case provided an opportunity to Remind staff of the Learning from Deaths Policy and of the process to follow via a Dental Network-wide Communication.

2.4 PSIRF – Learning and Improving Patient Safety

Patient Safety Training Compliance is:

- Patient Safety Level 1: 91%
- Patient Safety Level 1 for Board of Directors and Senior Leadership Teams: 81%
- Patient Safety Level 2: 89%57 staff have completed Oversight of learning from patient safety incidents oversight
- 26 staff have completed oversight of learning from patient safety incidents oversight
- 57 staff have completed the Systems approach to learning from patient safety incidents
- 21 members of staff have attended Patient, Family and Staff Involvement in Learning from Patient Safety Incidents Training provided by Gateway Training and Consultancy Limited. This is assisting enhanced patient, family and/or carer involvement and support of those affected.
- 4 members of staff have successfully completed levels 3 and 4 of the NHS Patient Safety Syllabus. A further 4 members of staff are currently undertaking the programme, and funding has been identified to support an additional 4 members of staff to complete the training in 2026/2027.

As part of a training review with Learning and Development Services, it was identified that the initial interpretation of the TNA was incorrect based on NHS England Guidance, and all staff are required to complete Level 1 Patient Safety. This will increase the current numbers by 1800 at an additional cost of around £2,500. Following the recent integration of Community Services, there is also a requirement to review the Community TNA to ensure training requirements are fully aligned across the integrated organisation. Given the need for this further review, the matter has not

yet been presented to the Medical Learning Oversight Group (MLOG). The update will be added to the next Meeting agenda for consideration and review.

Learning themes from PSIIs Learning themes have been triangulated with complaints data, identifying consistent organisational priorities including communication, clinical decision-making, and coordination of care. These insights have directly informed Quality Priority setting for 2026/27.

Work has commenced in line with the Trust's Quality Priorities to strengthen the wellbeing and emotional support available to patients, families, carers and staff following patient safety incidents.

To support the development of the objectives relating to staff engagement following incidents and the inclusion of patient, family and carer feedback within Learning Responses, a dedicated stakeholder engagement event was undertaken. The event brought together key stakeholders, including Patient Safety Specialists and representatives from relevant clinical and corporate services, to collaboratively design and shape the proposed approach. Feedback gathered through the engagement process has informed the associated action plan, helping to ensure that the proposed arrangements are practical, person-centred and aligned with the Trust's patient safety and organisational learning priorities.

The outputs from the engagement event are being used to develop sustainable approaches that support meaningful involvement, strengthen organisational learning and enhance the support available to those affected by patient safety incidents. This work will continue throughout 2026/27, with progress monitored through established governance arrangements.

PSIRP Review Update

The 2026 Patient Safety Incident Response Plan (PSIRP) represents the first combined plan developed following the establishment of North Mersey & Cheshire NHS Foundation Trust. The plan reflects both acute and community service priorities and was informed by initial stakeholder engagement undertaken during the integration period.

Data extraction has now been completed, and draft data packs have been developed to support a broader programme of stakeholder engagement, which is scheduled to commence in August 2026 as part of the planned post-integration review. This engagement will include representation from clinical and operational teams, Patient Safety Specialists, Patient Safety Partners and other key stakeholders to ensure the PSIRP remains aligned to the risks, priorities and learning needs of the newly integrated organisation.

The review process will provide an opportunity to validate emerging themes, consider the priorities of both acute and community services, and ensure that future PSIRP

objectives are informed by a comprehensive understanding of patient safety risks across the Trust.

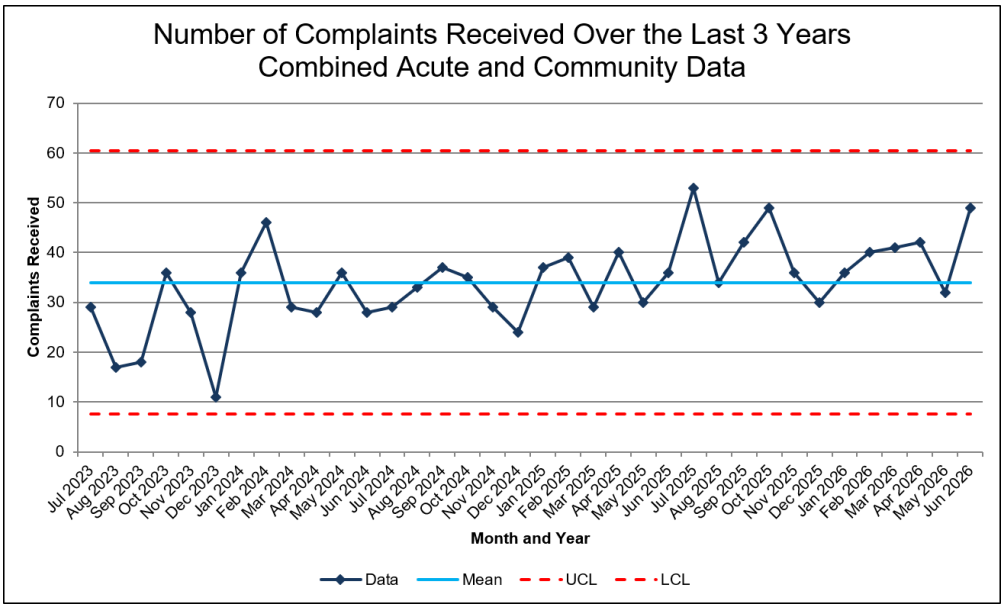
3. Learning from Complaints and PALS

3.1 Complaints

3.1.1 Complaints Received Position

Historical complaints received data from Datix and Ulysses has been retrospectively combined across acute and community services in **Graph 3**, to provide a consistent organisational trend. The SPC chart has been recalculated using the combined data and shows normal variation.

Graph 3

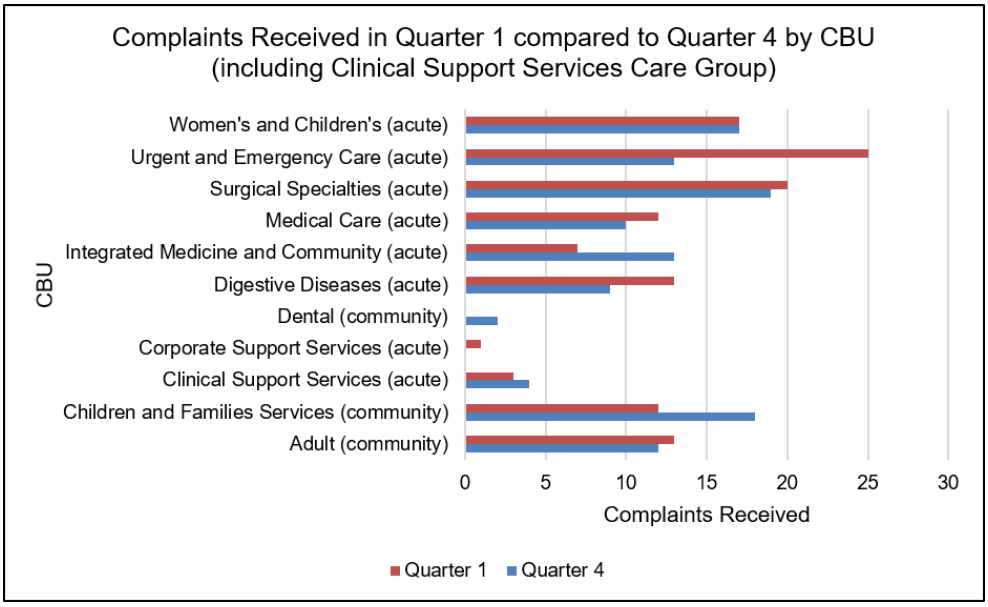


In Q1, a total of 123 complaints were received, representing a decrease of 6 complaints (5.13%) compared to Q4. Of these, 122 were reported across the CBUs and the Care Group, Clinical Support Services. The remaining 1 complaint was reported under Corporate Support Services (acute).

A comparison of complaints received in Q1 and Q4 across the CBUs and Clinical Support Services Care Group demonstrates mixed variation. Increases were observed in Adult, Digestive Diseases, Medical Care, Surgical Specialties and Urgent and Emergency Care, with the largest increase within Urgent and Emergency Care (increase of 12 complaints, 92.31%). Complaints received decreased in Children and Families Services, Clinical Support Services, Dental and Integrated Medicine and Community, with the largest percentage decrease within Dental (decrease of 2

complaints, 100%) and the largest number decrease within Children and Families Services (decrease of 6 complaints, 33.33%) and Integrated Medicine and Community (decrease of 6 complaints, 46.15%). Women's and Children's stayed the dame, receiving 17 complaints in Q1 and Q4. This comparison is illustrated in **Graph 4**.

Graph 4



Due to the multifactorial nature of complaints, which can involve multiple linked themes, the Complaints Team categorise complaint themes according to the primary subject identified.

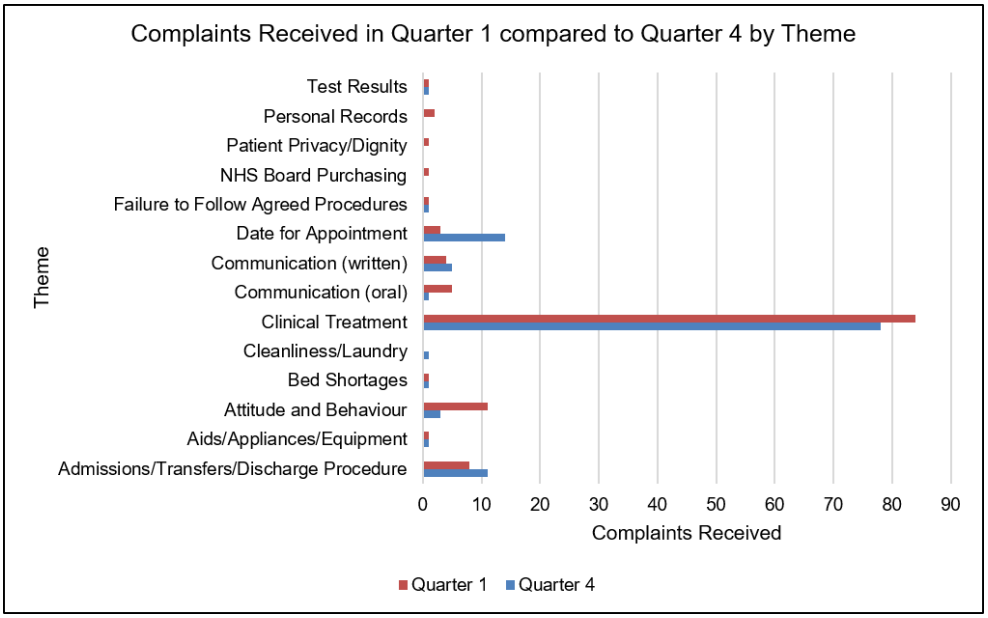
The themes of historic community complaints recorded in Ulysses were categorised using a different classification framework from that used in Datix. However, a review of the themes identified sufficient alignment between community and acute data to enable meaningful comparison.

For the purposes of trend analysis, complaint data in Ulysses has been mapped to the most appropriate Datix complaint subject, with data below presented during the current Datix terminology.

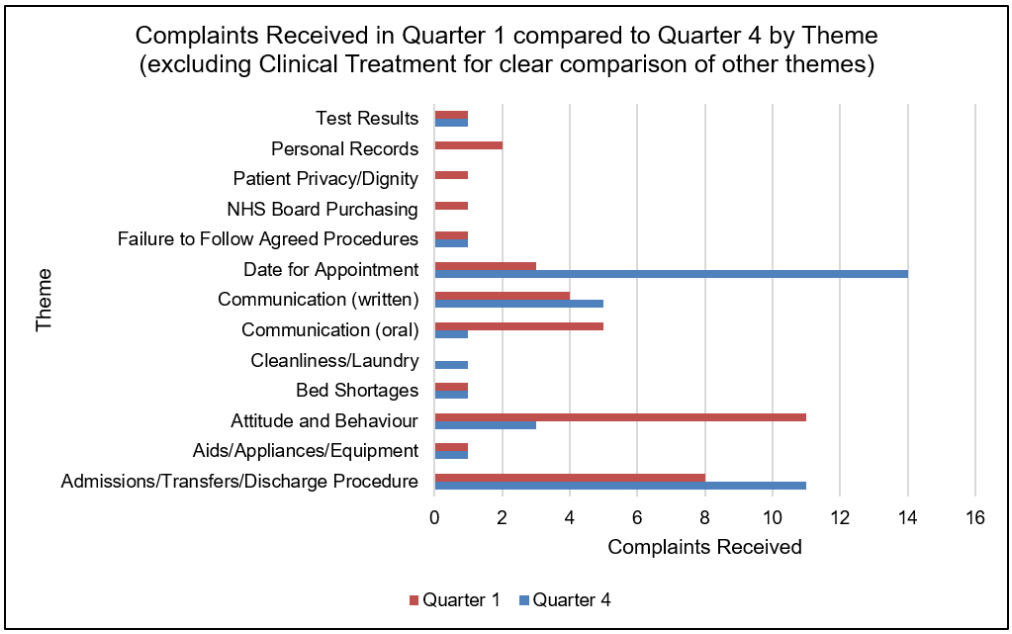
Clinical Treatment continues to be the most frequently reported complaint theme. In Q1, 84 Clinical Treatment complaints were received compared to 78 in Q4, an increase of 6 complaints (7.69%). The top 3 sub-themes within Clinical Treatment during Q1 were Coordination of Medical Treatment (56), Wrong Diagnosis (8) and Delay in Treatment (7). All CBUs recorded complaints within the Clinical Treatment theme in Q1.

See **Graphs 5** and **6** for a comparison of themes for complaints received between quarters.

Graph 5



Graph 6



There has been a notable increase in complaints relating to staff attitude and behaviour during Quarter 1. A thematic review of these concerns will be undertaken to better understand the underlying factors, with findings and any emerging themes reported through the Quarter 2 report.

3.1.2 Complaints Closed Position

There were 116 complaints closed in Q1, a decrease of 5 complaints (4.13%) compared to Q4 where 121 complaints were closed. The following table demonstrates the outcomes of these complaints. Of note, partially upheld complaints are those where aspects of the complaint are upheld but the main issues are not.

Outcome	Q1	Q4
Not Upheld	48	49
Partially Upheld	53	49
Upheld	14	22
Complaint Withdrawn	1	1
Total	**116**	**121**

3.1.3 Learning Examples from Complaint Investigations

You Said	We Did
Clinical Support Services	
An x-ray undertaken on an 8-month infant was initially reported as a healing/healed fracture. Following specialist review, an alternative interpretation of the imaging findings was reached. The case provided an opportunity to reinforce multidisciplinary review processes where imaging findings are complex or uncertain. .	The Radiology Team met with the child's parents. Learning was shared with the team to reinforce the importance of careful consideration, where scan findings are unclear. This included the need for timely multi-disciplinary discussion and review of imaging to support informed decision-making and ensure that the most appropriate course of action is agreed before proceeding.
Digestive Diseases	
A paediatric patient was admitted and had an inconclusive diagnosis. Feedback received from the family highlighted concerns regarding the clinical management plan during the admission. .	Postoperative paediatric surgical patients will be offered a review by a surgeon at the earliest opportunity. This will support prompt assessment of any concerns and ensure appropriate clinical oversight.
Surgical Specialties	
Delays within the patient's pathway following referral to ENT, resulting in opportunities to strengthen pathway monitoring, tracking and escalation arrangements.	The process for placing patients on the cancer fast-track (CFT) pathway has been reviewed and updated, to support timely review and reduce the risk of delays. A new policy has also been introduced to help ensure that patients requiring urgent care are identified promptly, monitored closely and escalated appropriately where required.

	In addition, a new category is being introduced within the e-outcome system, allowing clinical teams to clearly mark patients as CFT, helping to make the process more straight forward and reducing the risk of delays. The ENT Team are recording their clinic letters and highlighting if patients are urgent, so the Secretarial Team are aware to follow this up and once a week, a MDT meeting is taking place to review patients who have been waiting the longest, so that any concerns can be identified and addressed quickly. An ENT Consultant has sought advice from other teams within the Trust regarding the management of patients on urgent pathways. Changes are being explored to ensure that patients remain clearly identified as requiring urgent care until they are either treated or no longer require this level of priority.
Women's and Children's	
During an induced labour, a patient with pre-existing spinal conditions was unable to receive an epidural. Feedback from the patient indicated concerns regarding pain relief options available during labour. The patient also reported that they did not feel sufficiently informed regarding the induction process, including what to expect at each stage. The patient reported that these factors had a negative impact on their overall experience of care.	The Maternity Team have produced a new induction of labour video for women, which covers the full induction process, what to expect when they arrive in the induction bay, how it works and what happens while waiting for waters to be broken. The Trust are also exploring alternative pain relief options for women who are unable to have an epidural. Remifentanil Patient Controlled Analgesia is being used at other NHS Trusts and is now being formally reviewed by NCM.
Integrated Medicine and Community	
A patient with significant care and support needs, including visual impairment and limited mobility, was discharged without confirmation of community service arrangements and communication with those involved in the patient's ongoing care.	Learning has been shared to the Wider Nursing Team on Ward A9, to reinforce the importance of ensuring referrals are always followed up and documented within patient records to ensure the right care is arranged for patients on their return home. It has also been highlighted to staff that family members must be contacted, where appropriate, to notify them of discharge plans to ensure that they are well prepared and informed in order to support patients.

Medical Care	
A patient was sent home with an end-of-life care package and medication to support their ongoing care. Feedback from the family indicated that there was insufficient information provided regarding the medications administered, the timing of the next doses and the purpose of the medications supplied.	The importance of explaining medications with patients and families has been reiterated to staff, ensuring that they are fully understanding of what medications are required, for what and when they are needed. This was shared as part of daily safety huddles, team discussions and at the Ward Meeting.
Urgent and Emergency Care	
A patient was discharged with a cannula remaining in situ.	The ED Senior Management Team is currently developing a “test of change”, which includes a five step discharge checklist. This checklist is intended to ensure that all required safety steps are consistently followed prior to discharge, including the safe removal of cannulas before a patient leaves the department.
Community and Dental	
A patient attended the Urgent Treatment Centre and was discharged following clinical assessment. The patient subsequently attended another healthcare service the following day, where diagnostic imaging identified a fracture.	A change in process has been agreed and shared with staff which ensures that all patients who are reviewed in triage and deemed not to require an x-ray, will receive a formal assessment from a different practitioner to ensure sufficient review and a second opinion has been sought. Staff have also been reminded that pain relief is to be discussed as part of each consultation to ensure adequate pain relief and pain management.

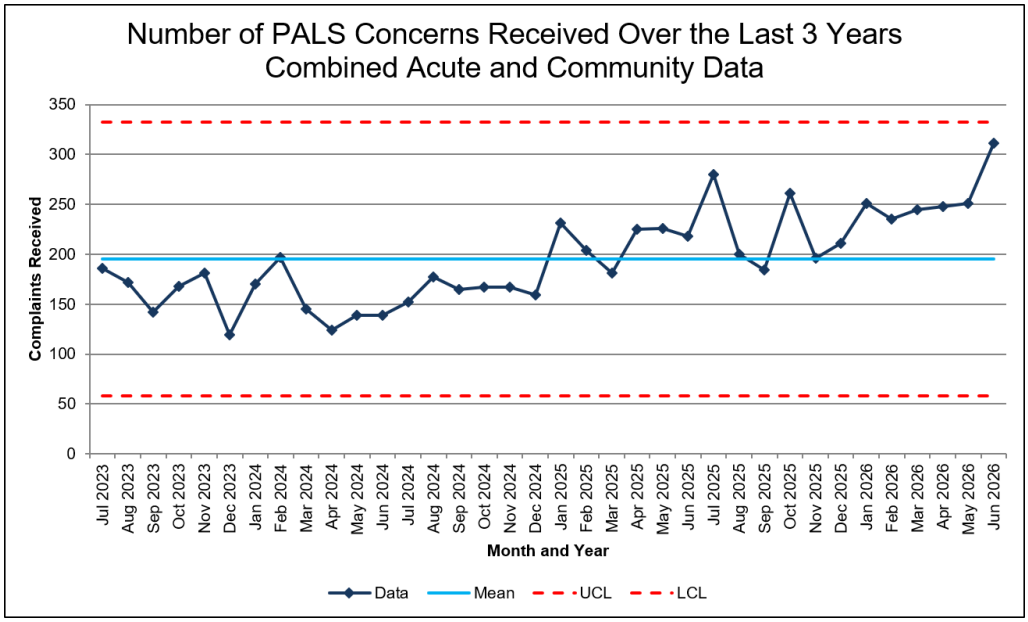
3.2 PALS Concerns

3.2.1 PALS Received Position

Whilst acute and community PALS data has been combined to provide an overall Trust view, interpretation of the SPC chart illustrated in **Graph 7** should consider the sustained increase in PALS activity in acute settings from 2025 previously reported on. This increase is reflected in the combined data and may represent a shift in underlying level of activity in PALS concerns compared to earlier years. Community PALS data prior to the integration has remained stable. A previous review of PALS data, comparing activity in the 2025 and 2024 calendar years was undertaken in Q4. Notable analysis included:

- Surgical Specialties remained the highest reporting CBU and recorded the largest year on year increases in PALS concerns.
- Medical Care also demonstrated a notable rise in concerns when compared to the previous year.
- Clinical Treatment remined the most frequently reported theme with a significant increase in concerns received.
- Other recurring themes included Appointment Delays and Communication (combining oral, written and telephone communication themes).

Graph 7



In Q1, a total of 811 PALS concerns were received, representing a decrease of 58 concerns (6.67%) compared to Q4 where 869 concerns were received. Of these, 758 concerns were reported across the CBUs and the Clinical Support Services Care Group. The remaining 53 concerns were reported under Corporate Support Services (acute) and External Site/Organisation.

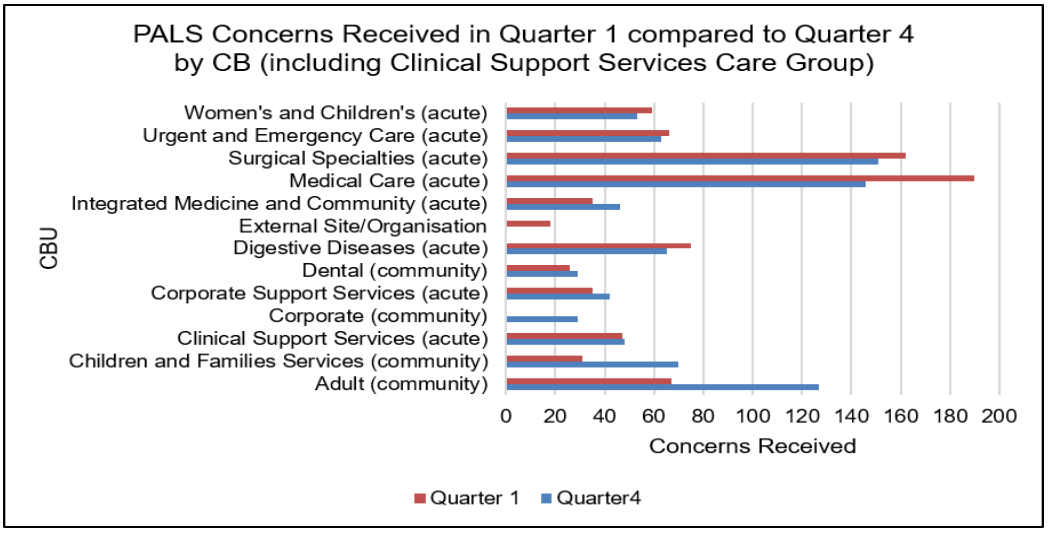
Changes in the volume of concerns received were evenly distributed, with 5 CBUs observing increases and 5 observing decreases. The increases were seen in Digestive Diseases, Medical Care, Surgical Specialties, Urgent and Emergency Care and Women's and Children's. The largest increase was noted in Medical Care (increase of 44, 30.14%).

The decreases were observed in Adult, Children and Families Services, Clinical Support Services, Dental and Integrated Medicine and Community. Children and Families experienced the largest percentage decrease (decrease of 39, 55.71%) and

Adults showed the largest numerical decrease (decrease of 60, 47.24%). Notably, all the community services have shown decreases in PALS concerns received following the integration. This could reflect the recent transition from Ulysses to Datix and any associated changes to recording processes. Further monitoring over the subsequent quarters will be required to determine whether this is representing a sustained improvement in these areas or is attributable to changes in data capturing and reporting practices following the integration.

These CBU comparisons are illustrated in **Graph 8**.

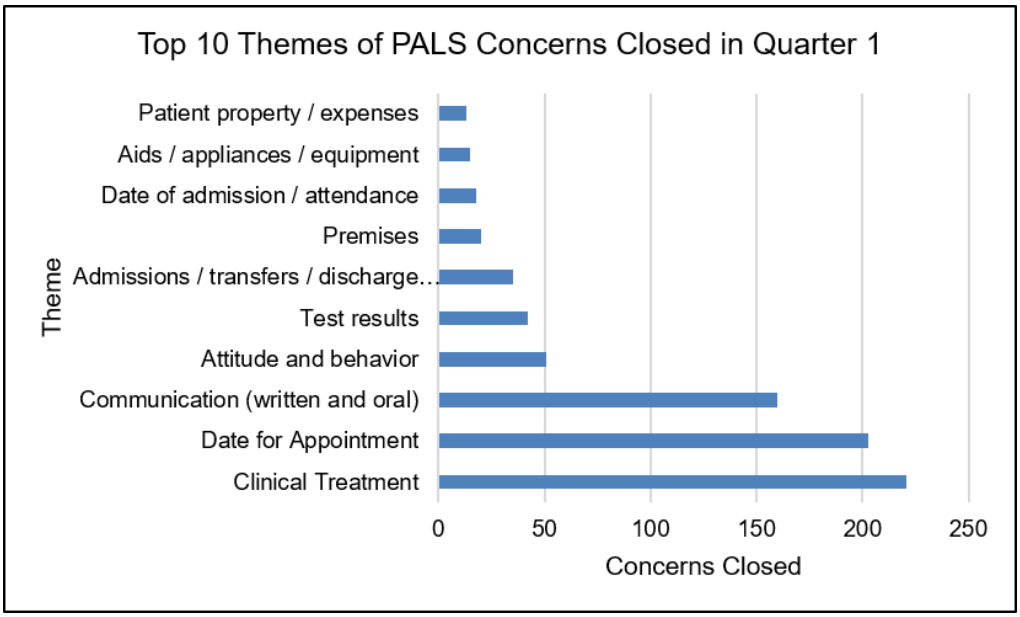
Graph 8



3.2.2 PALS Closed Position

In Q1, there were 809 PALS concerns closed, an increase of 20 concerns (2.53%) compared to Q4 where 789 concerns were closed. Similar to complaints, the themes of historic community concerns recorded in Ulysses were categorised using a different classification framework from Datix. We have mapped the Ulysses data to the most appropriate Datix concern theme for trend analysis. In Q1, the top 3 themes of concerns closed were Clinical Treatment (221), Date for Appointment (203) and Communication (oral and written) (160). This is illustrated in **Graph 9**, note a comparison of the top10 themes between concerns closed in Q1 and Q4 has not been undertaken due to the differences in reporting of themes, however this will be included in the next LFE report.

Graph 9



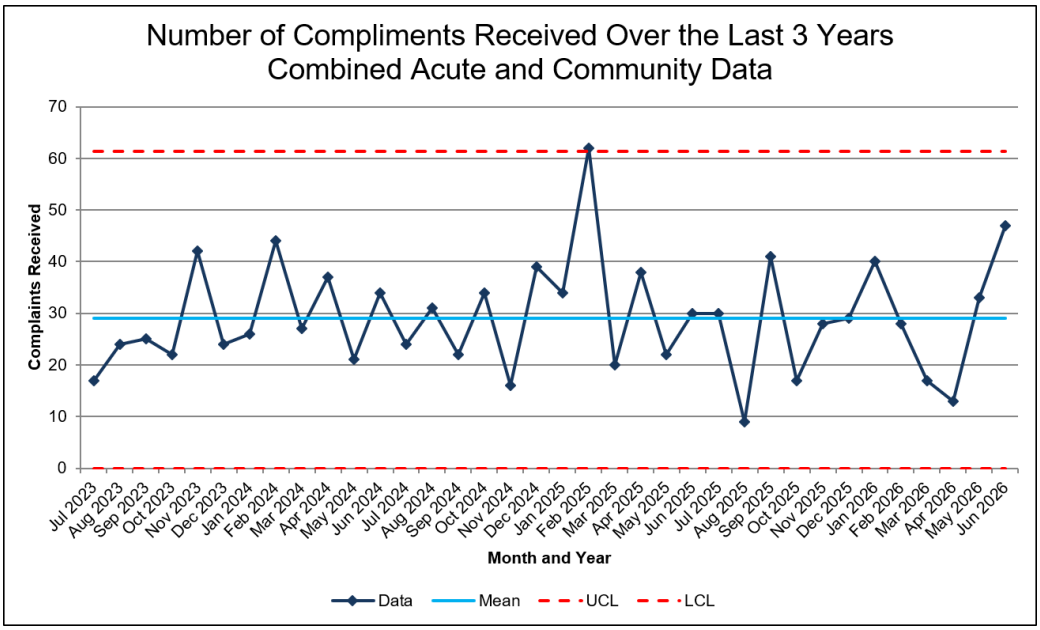
4. Learning from Compliments

Analysis of compliments received across acute and community services demonstrates generally normal variation, with 1 notable increase observed in the community data in February 2025 which appears above the upper control limit. As this was not part of a sustained shift or trend, this potentially reflects a special cause event such as a local initiative, increased patient engagement or enhanced reporting of compliments on Ulysses.

The average number of compliments recorded in community services is around double that of acute services. This should be considered when interpreting the SPC chart illustrated in **Graph 10**. Despite this difference in volume, the combined data continues to demonstrate normal variation, with the exception of February 2025.

There were 93 compliments received in Q1, an increase of 8 compliments (9.41%) compared to Q4 where 85 were received.

Graph 10



5. Learning from Quality Improvement and Knowledge and Experience

5.1 Learning from Registered QI Projects Completed Q1

There were 6 QI projects recorded as complete within Q1. These are highlighted in **Appendix 1** together with their project progress score (based on the scoring method used by the Institute of Healthcare Improvement) and impact statement.

5.2 Learning from the Application of Knowledge and Evidence Service

Fragile Services Support – Chronic Pain Service Clinical Model Workshop

In May the Knowledge and Evidence Service (KES) were one of several facilitators of the Chronic Pain Service Clinical Model Workshop with participants from NCM and community partners including GPs, recovery and mental health charities. The KES delivered a digest of the best available evidence of effective models from across the country and facilitated a dialogue using liberating structure methodology around the key components of an effective service model, which were identified as:

- Pain cafe's – community-led spaces where people living with chronic pain can come together to share experiences, provide peer support and learn self-management strategies.
- MDT Approach

- Increased working with voluntary/third sector
- Community delivery
- One stop shop model
- Spectrum of offers including mental health support
- Joined up working across boundaries

Quality and Productivity – Corridor Care Summit Support

As part of wider Quality Academy support, the KES assisted the Corridor Care summit held in June. This convened clinical, operational and system leaders to agree the priority actions required to reduce corridor care, improve patient flow and strengthen the safety, quality and experience of care across the urgent and emergency care pathway. The summit was designed to secure a shared set of system priorities capable of informing coordinated delivery across organisational boundaries and supporting measurable improvement.

The top 5 system priorities identified were:

1. Discharge lounge
2. Criteria-Led Discharge
3. Discharge planning
4. Consultant support for early ward rounds
5. Increased deflection at the front door

6. Learning from Safety Alerts

The Trust produces a Daily Safety Brief which is distributed Trust wide via email to support the sharing of safety information and learning, including National Patient Safety Alerts. During Q1, there were 61 alerts issued: 17 in April 2026, 23 in May 2026 and 21 in June 2026. To maximise visibility and staff engagement, some alerts were shared over several days.

The Daily Safety Brief is used not only to disseminate national and location safety information, but also to reinforce safe clinical practice, raise awareness of emerging risks and support the implementation of actions to reduce the likelihood of patient harm across the Trust. Several of the alerts issued during Q1 provided valuable opportunities to share learning. Some examples of alerts shared are detailed below.

Instruction Example: Inappropriate Potassium Prescribing in Hyperkalaemia

A recurring patient safety risk was identified where potassium-containing IV fluids were prescribed to patients with hyperkalaemia, including Plasma-Lyte and potassium-containing IV fluids in patients with DKA whose potassium levels remained elevated. The alert highlighted the risk of life-threatening arrhythmias and cardiac arrest associated with inappropriate potassium administration.

Learning Shared

- Clinicians should always check serum potassium levels, renal function and urine output before prescribing IV fluids.
- Prescribers should be aware that Plasma-Lyte contains potassium and is contraindicated with hyperkalaemia.
- Potassium-containing fluids should not be prescribed when serum potassium remains greater than 5.5mmol/L.

Action Taken

- Learning was disseminated Trust wide though the Daily Safety Brief.
- Staff were reminded to verify electrolyte composition before prescribing maintenance or resuscitation fluids.

Safety Alert Example: Risk of Severe Harm from Use of Incorrect Giving (Administration) Set for Blood Transfusion

A national patient safety alert was circulated regarding the risk of IV infusion giving sets being mistaken for blood transfusion giving sets. Use of the wrong equipment can result in under-infusion of blood or haemolysis, causing severe patient harm.

Learning Shared

- Staff must be able to distinguish between blood transfusion and standard IV infusion giving sets.
- Blood transfusion giving sets should always be used when administering blood products.
- Appropriate storage and clear labelling can reduce the risk of selection errors.

Action Taken

- Wards and Departments were reminded to store transfusion equipment separately from standard IV equipment.
- Teams were asked to reinforce awareness and identification of the correct administration sets.

- **Figure 1**



Medicines & Healthcare products Regulatory Agency

DEVICE SAFETY INFORMATION (DSI)

Risk of severe harm from use of incorrect giving (administration) set for blood transfusion
DSI/2026/003

Specialisms: *Anaesthesia and intensive care, Cardiovascular disease and lipidology, Critical care, Ear, nose and throat, Emergency medicine, General surgery, Gastro intestinal Medicine, hepatology and pancreatic disorders, Haematology and oncology, Immunosuppression and transplantation, Infectious disease, Obstetrics, gynaecology and fertility, Orthopaedics, Paediatrics and neonatology, Pathology, Renal medicine, Theatre practitioners, Urology and nephrology, Vascular and cardiac surgery*

DEVICE DETAILS

All IV giving/administration sets used for the transfusion of blood and blood components

Summary

There is a potential for serious harm to patients if an intravenous (IV) infusion giving set is used instead of a blood transfusion giving set to deliver a transfusion of blood or blood components (see Annex 1). Use of an IV infusion giving set instead of a blood transfusion giving set may result in under-infusion of blood or destruction of red blood cells (haemolysis) which can lead to serious patient injury.

Advice for Healthcare Professionals:

Advice for coordinators:

- ensure staff who may carry out IV therapy and transfusions and non-clinical staff who handle the sets can identify the differences between IV infusion and blood transfusion giving sets
- ensure blood transfusion giving sets are stored in clearly labelled containers, in their original packaging, separate from IV infusion giving sets to prevent selection of the wrong type

Advice for individual healthcare professionals:

- always use a blood transfusion giving set for a blood transfusion

Instruction Example: Safe Management of Transdermal Patches – Timely Removal and Documentation

Several incidents were reported where transdermal patches had not been removed before new patched were applied, creating a risk of unintentional overdose, particularly with opioid patches such as Fentanyl and Buprenorphine.

Learning Shared

- A patch left in place remains an active medicine and can continue delivering medication. Failure to remove previous patches can increase the risk of sedation, respiratory depression and overdose.
- Clear documentation and communication between clinical teams is essential.

Action Taken

- Staff were reminded to check for and remove existing patches before applying new ones.
- Guidance was reinforced regarding documentation of removal and application sites, use of body maps and safe disposal procedures.
- Teams were encouraged to highlight transdermal patches during handovers.

7. Learning from Claims

7.1 Clinical Claims

7.1.1 Clinical Claims Received Position

There were 29 Clinical Claims received in Q1. This is a decrease of 19 claims (39.58%) compared to Q4 where 48 were received. When a new claim is received, it is triangulated with incidents and complaints reported on Datix and linked accordingly.

7.1.2 Clinical Claims Closed Position

There were 35 ongoing Clinical Claims closed in Q1; 7 with damages totalling £731,387.46 (including costs of instructing Trust Solicitors), 4 were repudiated and 24 were withdrawn, including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	Number of Claims
Acute Medicine	£2,000.00	1
Cardio-Respiratory	£75,000.00	1
Emergency Medicine	£52,324.00	1
General Medicine	£1,500.00	1
Radiology	£40,669.00	1
Trauma and Orthopaedics	£134,499.46	1
Urology	£425,395.00	1
Total	**£731,387.46**	**7**

7.2 Non-Clinical Claims (Employee/Public Liability)

7.2.1 Non-Clinical Claims Received Position

There were 5 Non-Clinical Claims received in Q1. This is an increase of 1 claim (25%) compared to Q4 where 4 were received.

7.2.2 Non-Clinical Claims Closed Position

There were 2 ongoing Employer Liability Claims closed in Q1, both closed with damages.

Specialty	Damages Paid	Number of Claims
Estates and Facilities	£102,188.36	2
Total	**£102,188.36**	**2**

7.3 Claims Learning and Actions Taken

The review of Claims which have been closed provides an important opportunity to identify themes, understand contributory factors and share learning across the Trust. The below examples illustrate key learning arising from closed Claims during Q1and the actions taken to improve patient safety and quality of care.

Management and treatment in relation to a shoulder reduction in September 2020.	
Lessons Learned	**Actions Taken**
Effective monitoring of patients following procedures undertaken in the ED should always be undertaken by ED staff. Nursing staff should be informed when a procedure involving any level of sedation starts and when it finishes if they are not present for the procedure. If there are any potential injuries that may require specialist input e.g. Orthopaedic input, following initial imaging, the doctor who attends the trauma call on behalf of the specialist team must proactively make themselves available to the ED Team for further advice.	ED clinical leadership staff need to ensure that staff know which clinical pathway should be used in which circumstance. The ED Team will complete a collaborative piece of QI work with the Pharmacy Team to create a 'drug set' for use in ED, which will include the administration of PRN (when required) Morphine. All staff should receive further training on the Trusts Electric Prescribing and Medicines Administration (EPMA) system, which should include how to use 'drug sets' and how to view previously administered PRN and urgent drugs.

The claimant's mobility or ability to transfer was not discussed before asking the patient to get up onto a bed from their wheelchair. The claimant also was not offered any assistance in transferring. The claimant then fell and struck their head on a chair and injured their wrists.	
Lessons Learned	**Actions Taken**
The patient's mobility and ability to transfer was not discussed with them and they were not offered any assistance when transferring from the wheelchair to the bed. The patients visual impairment was not recognised.	Safety alert to be completed containing information on how to reduce the likelihood of similar incidents and the correct action to be taken following a patient fall in the department. The safety alert will also be shared via the Radiology Team Brief. To add an alert on the Radiology Information System (RIS) regarding patient's risk of falls and visual impairment.

Delay in diagnosis of a Peterson's hernia and delay in diagnosis of bowel obstruction, resulting in surgery, scarring and pain.	
Lessons Learned	**Actions Taken**

Patient was an inpatient for 9 days before the diagnosis of an obstructed bowel was made. There were identified opportunities to support earlier specialist surgical involvement where diagnostic uncertainty persists or symptoms continue to evolve Peterson's hernia was an incidental finding at the laparotomy. It is a rare complication following gastric bypass with non-specific signs and symptoms which also includes abdominal pain. When the patient was admitted under the care of the Urology Team, they should have had a daily consultant led ward round. The investigation team recognised that this has already been initiated. Following assessment and investigation of a patient in ED, the patient should be admitted under the appropriate specialty for their presenting complaint. Patients requiring referral to the Surgical Team should be done via the ICE (Integrated Clinical Environment) system and when urgent, a phone call alongside the ICE referral should be carried out. Unexpected findings of the colon identified on x-ray should prompt urgent referral to the appropriate specialty.	Patients admitted under the care of the Urology Team are to have a daily consultant led ward round. To implement a process to accept Urology admissions from ED. This will be linked to the PSCESC plan for Urology. This will be discussed at the Specialty Meeting. To share with staff that patients requiring referral to the Surgical Team should be done via ICE system and when urgent a phone call alongside the ICE referral should be carried out. To develop close working relationship with the General Surgeons and Urology Team in relation to the patient pathway from ED. A meeting to discuss this has been arranged.
Initial Safety Review was carried out: **Patient attended ED for check on an ankle injury after being struck by lightning whilst on holiday. The patient returned and attended ED for a checkup and was diagnosed with strain of Achilles tendon and discharged. The patient then continued to have problems with their ankle, and it was discovered that they had ruptured the tendon and should have been given a ski-boot for support.**	
Lessons Learned	**Actions Taken**
There were opportunities to strengthen adherence to the agreed clinical pathway, including the timely implementation of recommended management interventions.	. The issue was initially raised through the complaints process and was subsequently reviewed as a patient safety incident following identification of concerns regarding

There was also a lack of clarity regarding responsibility for reviewing and acting upon ultrasound findings A referred to the Virtual Fracture Clinic was also clinically indicated.	the follow-up and actioning of an ultrasound result A process mapping exercise is being undertaken in partnership with the Quality Improvement Team

It is alleged that that there was a failure as the Claimant was able to mobilise out of their bed and attempt to go to the bathroom unaided. As a result, the patient fell and fractured their shoulder blade and injured their elbow.	
Lessons Learned	**Actions Taken**
Staff to utilise red flag alerts on Safe Care and escalate concerns. There was limited clarity within the nursing documentation regarding the fall's prevention measures and equipment in place to support the patient. The review noted staffing challenges, which were considered as part of the review.	The Ward Manager and Clinical Governance Manager will regularly encourage staff to use red flag alerts to show when the ward is short-staffed or caring for patients with high needs. At the start of every shift, the Ward Manager and Senior Team will check that any falls prevention equipment used for patients have been properly documented. The Ward Manager has spoken directly to staff about the need to accurately document all falls prevention equipment used.

8. Learning from Inquests

At the time of reporting, there are 24 inquests open. Of these 1 is linked to a claim, 1 inquest has a linked MDT Review, and 2 inquests have legal representation. There were 9 inquests opened in Q1, this is a decrease of 10 inquests (52.63%) compared to Q4 where 19 inquests were opened.

The Trust reviews the findings from closed inquests to identify opportunities for learning and service improvement. Where learning is identified, this is shared with relevant teams to support improvement. The example below highlights learning identified from an inquest closed in Q1.

Example Inquest Closed in Q1

Following an inquest and comprehensive multidisciplinary review, a number of learning opportunities were identified. Actions have since been implemented to strengthen clinical assessment processes, documentation standards and access to

relevant patient information, supporting organisational learning and service improvement.

The review highlighted the importance of considering all available clinical information when undertaking patient assessments, including pre-hospital documentation and risk assessment information. It also reinforced the need for clear documentation of clinical decision-making, particularly where management differs from established guidance or pathways.

Actions implemented include:

- Introduction of a standardised One Response competency checklist for Emergency Department staff, including locum clinicians, with completed records retained for governance assurance.
- Implementation of a revised Emergency Department induction pathway from June 2026.
- Reinforcement of processes to ensure nursing triage information is routinely considered as part of the initial clinical assessment.
- Completion of reflective practice by the clinician involved, focusing on clinical decision-making and contributing factors.
- Delivery of targeted education sessions for medical and nursing staff to support recognition of alternative diagnoses and avoid diagnostic overshadowing in patients with long-term conditions.
- Enhanced accessibility to One Response records through integration with existing clinical systems, supporting timely access to relevant patient information.

9. Learning from Patient Experience and Inclusion

9.1 Patient Stories

Patient stories continue to play an integral role in the Trust's approach to organisational learning, providing first-hand insight into the experiences of patients and families and ensuring the patient voice remains central to quality improvement.

During Q1, two patient stories were presented through the Trust's governance framework, each highlighting different aspects of the patient journey and providing valuable opportunities for organisational learning.

The first story, Mark's Intensive Care Experience, was presented to the Trust Board in June 2026. Mark reflected on two admissions to Warrington Hospital, including a prolonged stay in Intensive Care following a diagnosis of Legionnaires' disease. Mark and his wife described outstanding clinical care, highlighting the professionalism, compassion and personalised support provided by the Intensive Care team. They also identified opportunities to strengthen communication with families, improve

consistency of information, enhance the critical care environment and further develop discharge planning following prolonged admissions.

The second story, Valerie's ED Experience, was presented to the Quality and Safety Assurance Committee in May 2026 by her granddaughter. Valerie, aged 92, was admitted to the ED with sepsis following deterioration at home and sadly died during her admission. Her family shared their experience to help improve care for future patients and families. Whilst recognising the professionalism and compassion of many staff involved in Valerie's care, the story highlighted the significant emotional impact that inconsistent communication can have during periods of uncertainty. The family described opportunities to improve communication regarding diagnosis, prognosis and treatment, the use of plain English, timely updates to relatives, documentation relating to significant clinical events and the management of complaints.

Although the clinical journeys differed considerably, both stories identified communication as a key determinant of patient and family experience. The stories reinforced that whilst delivering safe and effective clinical care remains paramount, the way information is communicated, particularly during periods of uncertainty, deterioration and end-of-life care, has a lasting impact on patients and those closest to them. Learning from these stories has been triangulated with patient feedback, complaints, compliments and observational visits to support service improvement and reinforce the Trust's commitment to compassionate, person-centred care.

Learning Identified

- Compassionate, timely and honest communication is essential, particularly when a patient's condition is deteriorating or end-of-life care is being provided.
- Patients and families require clear explanations using plain English to support informed decision-making and realistic expectations.
- Early involvement of relatives and timely communication about significant changes in a patient's condition can help reduce distress and ensure families have the opportunity to be present where appropriate.
- Accurate documentation and effective communication between clinical teams support safe, compassionate and person-centred care.
- Patient stories continue to provide invaluable organisational learning and, when triangulated with complaints, compliments, Friends and Family Test feedback and observational visits, strengthen continuous quality improvement.

Actions Taken

- Learning has been shared through the Trust Board, Quality and Safety Assurance Committee and Patient Experience and Inclusion Sub-Committee to reinforce organisational learning.

- Communication expectations have been reinforced within Urgent and Emergency Care and Intensive Care services, with particular emphasis on providing timely updates to patients and families.
- Clinical teams have been reminded of the importance of using plain English when discussing diagnoses, treatment plans and prognosis, ensuring patients and relatives fully understand the information being shared.
- Services have been asked to review documentation standards relating to significant clinical events and communication with relatives during deterioration and end-of-life care.
- Patient stories will continue to inform leadership discussions, staff learning and quality improvement programmes across the Trust, ensuring the patient voice remains central to service development and continuous improvement.

9.2 Interpretation Services

The Trust continues to monitor interpretation and translation services through the Patient Experience and Inclusion Sub-Committee to ensure patients requiring communication support can access safe, equitable and person-centred care. Quarterly monitoring provides assurance regarding activity, provider performance and fulfilment rates whilst identifying opportunities to improve accessibility and reduce health inequalities.

During Q1, interpretation services continued to support a diverse patient population, with **Cantonese, Arabic, Polish, Sorani Kurdish and Romanian** remaining the most frequently requested languages. Monitoring of activity continues to support service planning and ensure interpreting provision reflects the needs of the local population.

Performance remained consistently high for The Big Word interpretation and translation Service Provider throughout the quarter.

Month	Face to Face Fulfilment	Telephone Fulfilment
April 2026	100%	100%
May 2026	100%	100%
June 2026	97%	100%

Q1 also saw the implementation of 24-hour British Sign Language (BSL) interpretation through Language Line, complementing the existing face-to-face service provided through the Deafness Resource Centre. This development has significantly improved access to communication support for Deaf patients requiring urgent or out-of-hours care, whilst maintaining face-to-face provision where clinically appropriate.

Monitoring continues through regular contract review meetings, ensuring provider performance, fulfilment rates and patient needs remain under continual review.

Learning Identified

- Demand for interpretation services remains consistently high, reflecting the diverse needs of the local population.
- Timely access to professional interpreters is fundamental to patient safety, informed consent and personalised care.
- Continuous monitoring of language demand enables services to respond proactively to changing population needs.
- Extending BSL provision to a 24-hour service has strengthened equitable access to healthcare and supports compliance with the Accessible Information Standard.

Actions Taken

- Introduced 24-hour remote BSL interpretation via LanguageLine whilst maintaining face-to-face provision through the Deafness Resource Centre.
- Continued monitoring of provider performance and fulfilment rates through the Patient Experience and Inclusion Sub-Committee.
- Ongoing review of language trends to support future commissioning and service development.
- Continued promotion of interpretation and accessible communication services to clinical teams to ensure patients' communication needs are identified and met at the earliest opportunity.

Assurance

Learning from patient stories and interpretation service monitoring continues to influence improvements across the Trust. Learning is routinely triangulated with complaints, compliments, Friends and Family Test feedback, observational visits and quality metrics to identify themes, inform service improvements and strengthen person-centred care. Progress against actions is monitored through the Patient Experience and Inclusion Sub-Committee, providing ongoing assurance that learning is embedded into practice and contributes to continuous improvement in the quality and experience of care.

10. Learning from Clinical Audit

10.1 Learning from National Audits

National Emergency Laparotomy Audit (NELA) Year 10

Summary

The tenth annual report of the NELA examines care received by 23,560 NHS patients in 176 hospitals across England and Wales admitted for emergency laparotomy (emergency bowel surgery, EmLap) between 1 April 2023 and 23 April 2024.

Key Findings

The Trust achieved excellent results in documenting patient risk, consultant involvement in high-risk cases, and the assessment and management of frail older patients. Case ascertainment remained high at 96%, ensuring robust audit participation and data quality.

Areas requiring improvement include timely CT reporting and communication, getting urgent patients to theatre within the recommended timeframe, and the prompt administration of antibiotics for patients with infection or sepsis. The adjusted mortality rate increased slightly to 8.2%, broadly in line with the national rate of 8.1%.

Learning Identified

The focus will be on improving communication of time-critical CT findings, reducing delays to theatre for emergency surgical patients, and increasing compliance with antibiotic administration standards for patients with infection and sepsis.

The audit also highlighted the need for timely completion of NELA documentation and continued multidisciplinary collaboration between surgical, anaesthetic, ED, theatre and radiology teams to support further improvements in patient care and outcomes.

This audit was presented to the PSCESC in June 2026. The outcome was to arrange a meeting regarding developing a Perioperative Older Person Surgery (POPs) service.

Assurance rating (using Trust assurance rating matrix): Moderate assurance

10.2 Learning from Local Audits

Audit of Clinical Documentation Quality in the ED

Summary

This local audit aimed to assess and improve the quality and completeness of clinical documentation in the ED, ensuring compliance with national record-keeping standards and supporting safe, consistent patient care.

Key Findings

This audit has shown that although diagnoses and management plans are generally well documented, the assessment underpinning those decisions is not always clearly recorded, creating a gap in the clinical record. Missing or incomplete documentation of examination findings, observations, and red flags increases the risk of serious conditions being overlooked or deterioration not being recognised early.

Where assessment is not documented, it becomes difficult for other clinicians to understand the reasoning behind decisions, which can impact continuity of care, particularly during handover.

Learning Identified

- Risk documentation is inconsistent and requires reinforcement:
  - Red flags are not reliably recorded, even when clinically relevant.
- Structured documentation improves reliability:
  - Lack of prompts contributes to omission of key elements such as observations and examination.
- Variation in pathways leads to variation in documentation:
  - Minors, ambulatory, and direct specialty pathways reduce consistency in documentation standards.

Assurance rating (using Trust assurance rating matrix): Moderate

11. Learning from Compliance

11.1 Key Improvements Implemented in Q1

During Q1, the Trust has continued to strengthen its approach to regulatory compliance by building on learning from Care Quality Commission (CQC) engagement, organisational integration and routine governance. The focus has been on embedding regulatory compliance within existing governance arrangements, strengthening organisational oversight and supporting continuous improvement across the Trust. Key improvements implemented in Q1 include:

- **Embedding compliance within routine governance** – building on the revised assurance framework introduced in Q4, standalone Compliance Summits have been replaced by attendance at existing Care Group governance meetings by the Head of Compliance and Clinical Effectiveness. This enables regulatory compliance to be discussed alongside routine quality, safety and performance with operational, nursing and medical colleagues. The approach has reduced duplication, strengthened organisational oversight and further embedded regulatory compliance within existing governance arrangements.

- **A single approach to regulatory assurance** – following organisational integration, the Trust has further aligned acute and community services under a consistent approach to regulatory assurance, including the management of CQC enquiries, statutory notifications and inspection preparedness. The Quality Compliance Oversight Group (QCOG) has also expanded to include community services, supporting a single organisational approach to regulatory oversight. This has strengthened governance across the organisation and provided a more consistent approach to regulatory compliance.
- **Development of a Trustwide CQC Staff Guide** – the Trust has developed a CQC Staff Guide for acute, community and corporate services to support staff understanding of regulatory assessments and the role they play in demonstrating the quality of care provided. The guide has been developed with input from subject matter experts to provide clear and practical guidance for all staff groups.
- **Refresh of the CQC Mobilisation Plan** – the Trust has refreshed its CQC Mobilisation Plan to reflect the integrated organisation, providing a consistent approach to coordinating future CQC activity across acute and community services. This has strengthened organisational arrangements by providing greater clarity around roles, responsibilities and communication during regulatory activity.
- **Introduction of Compliance Quality Walk Rounds** – learning from routine compliance assurance identified the benefit of complementing documentary review with visits to clinical services and engagement with frontline teams. During Q1, the Trust introduced a programme of Compliance Quality Walk Rounds, undertaken jointly by the Head of Compliance and Associate Chief Nurses, with the first visits commencing during the quarter. The programme supports the identification of good practice, opportunities for improvement and shared organisational learning.

Collectively, these developments demonstrate the Trust's continued commitment to embedding regulatory compliance within routine governance, strengthening organisational oversight and supporting continuous improvement.

11.2 Planned Work for Q1 to Embrace Learning

The Trust will continue to build on the learning from Q1 by focusing on the following priorities:

- Continue embedding regulatory compliance within routine governance through ongoing attendance at Care Group governance meetings.
- Continue delivery of the Compliance Quality Walk Round programme, embedding feedback and learning within existing governance arrangements to support continuous improvement and organisational oversight.

- Roll out and embed the Trustwide CQC Staff Guide across acute, community and corporate services.
- Embed the refreshed CQC Mobilisation Plan through organisational familiarisation and ongoing review.
- Progress implementation of the Audit Management and Tracking (AMaT) programme, with migration of compliance assurance into the system as part of implementation.
- Continue proactive engagement with the CQC, using learning from regulatory engagement to inform continuous improvement and organisational preparedness.

12. Learning from Research and Development Activity

12.1 Learning from Complaints

One complaint has been received following the complainant's participation in a non-commercial gastroenterology trial. Identifying details will not be disclosed, including the name of the trial. "Participant A" complained about their experience on the trial about a part of a procedure that was not discussed with Participant A prior.

The lead nurse for the trial assisted Participant A with their complaint and notified the trial team immediately. Subsequent discussions found that the subject of the complaint was not included in the training on the trial, had not been raised by the Research Ethics Committee or Public and Patient Involvement groups, and therefore not included on the participant information leaflet (PIL), which is given to potential participants and supports informed consent procedures.

The trial team have implemented enhanced guidelines for the procedure and updated the PIL to update the information on given on the procedure.

The Research and Development Team regret that Participant A did not have the experience that we aim to deliver, however the Team are grateful for their feedback which has allowed for improvements to the trial, both locally and nationally.

12.2 Inclusion in Appraisal

The Allied Health Professional Workforce Lead in Community and Dental and delegate on the NIHR (National Institute for Health and Care Research) Developing Research Leaders programme, has collaborated with the Organisational Development team to incorporate research into the Trust appraisal.

Inclusion in the appraisal is a welcome development and highlights that research is a part of everyone's roles.

Figure 2



Supporting Research

North Cheshire and Mersey NHS Foundation Trust strives to work in partnership on high quality clinical research for the benefit of patients, public and staff.

Please consider how you will be involved in research in your role over the next 12 months, and check the option that applies:

- **Awareness -** recognising that we are a research-active Trust, and the importance of research for improving patient care ☐
- **Engagement -** putting research into practice and implementing evidence-based practice in your area ☐
- **Participation -** being involved in research through educational courses or taking active part in research projects ☐
- **Established -** supporting others to engage in research or leading on research projects ☐

The new section is due for launch in August and will allow the research and Development Team to better understand research engagement across the whole Trust.

12.3 Continuous Improvement – Feasibility

The Research and Development Team have undertaken a process mapping exercise for our feasibility process. The feasibility process was poorly understood, with inconsistent approaches and unknown timeframes for completion. A good quality feasibility should result in faster set up times, which must be completed within 60 days to qualify for performance-based funding.

The new process has now been mapped with the involvement of the whole Research and Development Team and now enters into the monitoring phase, supported by new data points that will enable close monitoring and further understanding of the feasibility process.

13. Recommendations

The members of the Quality and Safety Assurance Committee are asked to note the contents of the report.

North Cheshire and Mersey
NHS Foundation Trust

Appendix 1

Project Aim	Start Date	Completed Date	Project Outcome	Impact
To increase the percentage of patients at risk of delirium who receive 4AT screening within 24 hours of admission by 22% by August 2024.	02/10/2023	01/04/2026	4.5 Sustainable improvement	This quality improvement project demonstrated a sustained improvement in delirium screening, supporting earlier identification of patients at risk and improved patient safety. Use of the COM-B model enabled a structured analysis of behavioural barriers and informed targeted, achievable interventions. SPC monitoring has proven highly effective in enabling real time oversight of performance and supporting meaningful engagement with key stakeholders. The 4AT SPC measure is now embedded as a key performance indicator for delirium care across the organisation.
Improving compliance with 7-day review appointments for 18–25-year-old who commence on antidepressant medication.	15/12/2025	21/05/2026	3.0 Modest Improvement	The project addressed issues of delayed follow up for patients aged 18-25 who commenced anti-depressant medication. It was identified that only 3 out of 33 patients (9%) had their follow-up within the recommended time frame at baseline. This increased to 8 out of 11 patients (73%) following the implementation of training and posters. Further monitoring is required to establish the sustainability of these interventions due to the small number of patients included at follow up.
Improving the timeframe between admission and surgical VTE prophylaxis.	01/04/2025	03/06/2026	3.0 Modest improvement	By redesigning the admission workflow rather than relying on staff memory alone, this project delivered an improvement in VTE prevention processes across the acute surgical pathway. Timely prophylaxis increased from 85% to 92%, documentation compliance rose from 61% to 73%, and VTE prompt

				completion reached 96%. These improvements strengthened compliance with NICE guidance and increased assurance that patients at risk of hospital-acquired thrombosis receive appropriate preventative treatment. Further suggested test cycles involving changes to the IT systems and an automated compliance report will further ensure sustainable change.
To improve patient compliance with Amsler grid monitoring and post-intravitreal injection safety advice among patients attending the Age-related macular degeneration clinic, increasing Amsler grid use from 60% to 70% and recall of post-injection safety.	18/09/2025	23/06/2026	3.5 Improvement	Baseline questionnaires identified poor compliance with Amsler Grid monitoring (60%) and limited understanding of post-injection safety advice and red flag symptoms (both 55%), increasing the risk of delayed complication detection and avoidable vision loss. The team used Quality Improvement methods, including stakeholder engagement, process mapping, a fishbone analysis, a driver diagram, and two PDSA cycles, to test standardised patient education, simplified leaflets, Amsler Grid demonstrations, teach-back techniques, and discharge checklists. As a result, weekly Amsler Grid use increased to 70%, recall of safety advice improved to 65%, and awareness of red flag symptoms reached 65%, supporting safer self-monitoring and earlier recognition of complications.
To improve access to Respiratory Physiotherapy and Pulmonary Rehab for people with a diagnosis lung disease or self-reported symptoms for people who are experiencing addiction by 25% in 6 months.	01/07/2025	29/06/2026	3.0 Modest improvement	This project aimed to improve access to respiratory physiotherapy for people experiencing addiction by delivering clinics within local addiction services and introducing direct referrals. Eleven patients accessed the service, achieving a higher attendance rate than typically reported for this population group, while patient feedback was 100% positive, demonstrating improved engagement, increased access to specialist care, and progress towards reducing health inequalities.
To reduce the number of inappropriate referrals to Pulmonary Rehabilitation at point	01/10/2024	30/06/2026	3.0 Modest improvement	Inappropriate referrals to Pulmonary Rehabilitation were creating unnecessary workload and reducing service capacity. By introducing a referral screening process at the point of

of receipt by 25% by October 2025.				receipt, the team, improved patient understanding of the service so they could make better informed decision on if the service was right for them. This resulted in patients who were unsuitable for the services being identified earlier and therefore prevented unnecessary appointment attendances.

North Cheshire and Mersey
NHS Foundation Trust

Quality and Safety Assurance Committee

Agenda reference:	**QSAC/26/08/133**			
Subject:	**Infection Prevention and Control Report Quarter 1**			
Date of meeting:	11 August 2026			
Action required:	**To note the report**			
Author(s):	Lesley McKay, Associate Chief Nurse, Infection Prevention and Control			
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**
		✓	✓	N/A
	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: Nil			
Executive summary:	This report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2026/27 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators for FY. The annual thresholds are awaited at the time of writing the report. Acute Trust apportioned, mandatory reportable, healthcare associated infection (HCAI) cases to the end of the Q1 are: • *E. coli* bacteraemia 22 cases • *Klebsiella Spp.* bacteraemia 3 cases • *P. aeruginosa* bacteraemia 3 cases • *C. difficile* 21 cases • *MRSA* bacteraemia 0 cases • *MSSA* bacteraemia 6 cases (no threshold).			

	Two wards were affected by norovirus and the IPC Team worked closely with operational teams to safely place patients and minimise bed loss.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Quality and Safety Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.		
Previously considered by:	**Committee**	Infection Prevention and Control Sub-Committee	
	Agenda Ref.		
	Date of meeting	23 July 2026	
	Summary of Outcome	Submit to Quality and Safety Assurance Committee	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***Submit to Trust Board***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

This report provides an overview of infection prevention and control (IPC) activity for Quarter 1 (Q1) of the 2026/27 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds and HCAI events.

All Foundation Trusts are required to minimise rates of *Clostridioides (Clostridium) difficile* (*C. difficile*) and Gram-negative bloodstream infections (GNBSI) and thresholds are set annually by NHS England.

GNBSI include: -

- *Escherichia coli* (*E. coli)*
- *Klebsiella species (Klebsiella spp.)*
- *Pseudomonas aeruginosa (P. aeruginosa)*

The National Action Plan on confronting antimicrobial resistance (2024/29), is part of a 20-year vision and in addition to an ambition to prevent increases in GNBSI aims to optimise antimicrobial stewardship by: -

- Reducing need for and unintentional exposure to antimicrobials
- Optimising the use of antimicrobials

There is a zero-tolerance approach to avoidable *Meticillin-resistant Staphylococcus aureus* (MRSA) bloodstream infections (bacteraemia).

There are no set thresholds for *Meticillin-sensitive Staphylococcus aureus* (MSSA) bloodstream infections.

The thresholds for North Cheshire and Mersey NHS Foundation Trust (NCM) for 2026/27 are awaited.

Table 1 WHH HCAI Thresholds for 2026/27

HCAI	WHH Thresholds 2026/27
C. difficile	Awaited
E. coli	Awaited
Klebsiella spp.	Awaited
P. aeruginosa	Awaited

Bacteraemia case apportionment is as follows: -

- **Hospital-Onset Healthcare Associated** (HOHA) specimen date is ≥ 3 days after current admission date* (where decision to admit date is day 1)

- **Community-Onset Healthcare-Associated** (COHA) is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

- Community-Onset, Community Associated (COCA) is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

C. difficile **case apportionment** is as detailed below:

- **Hospital-Onset, Healthcare Associated** (HOHA) specimen date is ≥3 days after the current admission date* (where decision to admit date is day 1)

- **Community-Onset Healthcare-Associated** (COHA) is not categorised HOHA, and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where date of discharge is day 1)

- Community-Onset, Indeterminate Association (COIA) is not categorised HOHA, and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where date of discharge is day 1)

- Community-Onset, Community Associated (COCA) is not categorised HOHA, and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where date of discharge is day 1)

HOHA and **COHA** cases are apportioned to acute Trusts and count as cases against the NHS England thresholds.

NHSE also set annual thresholds for all NHS Integrated Care Boards (ICB). These thresholds include all cases (comprising of the acute Trust and community cases).

The Cheshire and Merseyside ICB, HCAI thresholds are shown in table 2.

Table 2: NHS Cheshire and Merseyside (C&M) ICB Thresholds for 2026/27

C&M ICB	*C. difficile*	*E. coli*	*Klebsiella spp.*	*P. aeruginosa*
QYG	Awaited	Awaited	Awaited	Awaited

2. Key elements

Healthcare Associated Infection Surveillance Data

Red, Amber, Green (RAG) rating of Trust performance for HCAI by month is shown in table 3, with more detailed information in appendix 1.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	Total	Trajectory position
C. difficile	Awaited	10	4	7	21	TBC
MRSA BSI	Awaited	0	0	0	0	On Trajectory
MSSA BSI	Awaited	3	1	2	6	No threshold
E. coli BSI	Awaited	8	7	7	22	TBC
Klebsiella spp. BSI	Awaited	0	1	2	3	TBC
P. aeruginosa BSI	Awaited	0	1	2	3	TBC

***C. difficile*:** 21 Trust apportioned cases were reported in Q1.

HCAI review meetings are held for hospital onset/healthcare associated *C. difficile* cases and are aligned to the Patient Safety Incident Response Framework (PSIRF) and the Safety Engineering in Patient Systems (SEIPS) model. Local and system learning from these review meetings includes: -

- Missed sampling opportunities and delay in isolating patients
- Gaps in stool chart documentation
- Multiple antibiotic courses with occasional antibiotic prescribing non-compliance

Proactive surveillance of C. difficile cases is in place to detect periods of increased incidence (PII). A PII is defined as two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period on a ward.

C. difficile PII Ward A9

In June, a PII (three toxin positive cases) was detected on Ward A9. These cases are under review and ribotyping results are awaited to determine if the cases are linked. The review highlighted delays in sampling, delays in isolation, improvements required to documentation on stool charts. The review meetings for the cases highlighted additional ward pressures due to 2 boarded patients and staffing challenges.

A plan is in place to carry out HPV decontamination of toilets, bathrooms and sluice/dirty utility and side rooms following patient discharge and provide education updates on the SIGHT mnemonic: Suspect; Isolate; Gloves/Apron; handwashing/

Testing. In addition, ward A9 will be included in the antimicrobial stewardship ward rounds.

MRSA Bacteraemia: Nil Trust apportioned cases in Q1 and for a rolling 15 months.

MSSA Bacteraemia: 6 cases were reported in Q1. There is no set threshold for MSSA cases. There are a mixture of primary sources including skin and soft tissue infection, pneumonia and some cases with source unknown.

GNBSI: cases reported in Q1 are:

- *E. coli* (22 cases)
- *Klebsiella spp.* (3 cases)
- *P. aeruginosa* (3 cases)

Urinary tract infections continue to be the main primary source for GNBSI. Prevention activity is targeted at: -

- Hydration aligned to the Nutrition and Hydration Strategy
- Urinary catheters
    - catheter associated urinary tract infection surveillance
    - catheter prevalence survey
- Timely blood culture sampling in ED aligned to sepsis workstreams
- Oral hygiene to prevent hospital acquired pneumonia
- Education on GNBSI prevention included in Mandatory Training

The GNBSI Prevention Action Group terms of reference has been updated and meetings re-established with improvement activity plans being shared by the clinical teams.

Policy/Guideline/SOP Updates

The IPC Team annual workplan includes a schedule of documents for review in line with the National IPC manual for England. The following documents were updated and approved by the Infection Control Sub-Committee (ICSC) in Q1: -

- Qualitative Fit Testing SOP
- Quantitative Fit Testing SOP
- Blood Culture Policy
- Reusable Personal Protective Equipment Decontamination and Maintenance SOP
- Measles Policy
- Meningitis/Invasive Meningococcal Disease Guidelines
- TB Policy
- Influenza (pandemic and seasonal) guidelines
- Level 1 Mandatory IPC presentation
- Level 2 Mandatory IPC presentation

Audit

During Q1, 40 full Infection Prevention and Control (IPC) ward/department audits were completed. Scores are detailed in appendix 2. The IPC audit tool is aligned to the NHS England National Infection Prevention and Control Manual and includes standard precautions.

A summary of areas for improvement (list is not intended to be exhaustive) are included in table 4.

Table 4: Summary of Audit Findings

Element	Areas for improvement
General Environment	Cluttered environments, dusty IT equipment, dusty vents/fans ceiling tiles stained,
Clean Utility Rooms	Dusty environment, items stored on floors, ANTT tray required cleaning
Cleaners Rooms	Chlorine based solution dilution records missing, signage on colour coding missing, cleaning materials not stored correctly
Ward Kitchens	Fridge temperature monitoring completion intermittent, pest proof containers missing, damaged worksurfaces and cupboards

A programme of ward kitchen upgrades is in progress. Concerns and issues requiring immediate action are reported to the nurse in charge at the time of the audit. Full audit findings are emailed to Ward Managers and an action plan to address findings is requested.

The re-audit schedule is set according to findings. For areas with lower scoring results and areas with outbreaks or clusters of infections, re-audit is completed sooner and/or more frequently. All areas are monitored by an IPC and CBU Matron monthly visit and if concerns about IPC standards are identified, a full IPC audit is completed.

Education and Training

Compliance with level 1 IPC mandatory training has remained above 90% for substantive staff. A slight dip in level 2 Mandatory IPC training was noted in Q1 and action from the CBUs requested at Infection Control Sub-Committee to improve compliance. Training is available via eLearning and face to face.

Table 5 Mandatory Training Compliance

IPC Mandatory Training	A	M	J
Level 1 – Non-Clinical	92%	91%	92%
Level 2 – Clinical	81%	80%	83%

Awareness Raising Events

World Hand Hygiene Day

The Infection Prevention and Control Teams hosted a joint awareness raising event to promote best practice in hand hygiene, which was well attended by staff and patients.





Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring. All areas are scoring 4-star or 5-stars (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories.

Incidents

Norovirus

2 wards in the Trust were affected with Norovirus in April 2026. The IPC Team worked closely with the Operational Teams to safely optimise bed capacity.

Collaboration with Estates

The IPC Team continue to work closely with the Head of Estates Maintenance, Compliance and Risk on water safety and ventilation issues and the Head of Capital Projects on all new builds and upgrade works.

3. Actions required/responsible officer

- Deliver the workplan for the 2026/27 financial year
- Provide expert infection prevention and control advice to colleagues

- Review escalations in infections, jointly with the associated Care Group
- Share learning from infection related incidents with relevant teams and external partners
- Align acute and community-based infection control services

4. Measurements/evaluations

- UKHSA mandatory reportable HCAI
- Local surveillance of HCAI and action implemented in response to increased incidences of HCAI and infection control related incidents
- Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI event aligned to SEIPS/PSIRF reports and audits with agreed actions to support care improvements
- Cleanliness monitoring reports and multi-disciplinary efficacy audits
- Review of Datix reports

5. Trajectories/objectives agreed

- Revise the IPC Strategy in line with the NCM strategy

- Prevention of healthcare associated infections

Table 6 HCAI Thresholds 2026/27

HCAI	WHH Thresholds 2026/27
C. difficile	Awaited
E. coli	Awaited
Klebsiella spp.	Awaited
P. aeruginosa	Awaited

- Antimicrobial Stewardship – Priority actions as per the National Action Plan
    - Switching intravenous to oral antibiotics - <15% of IV antibiotics at 72 hours could have been switched to oral
    - >75% of durations for 3 common infections meet formulary guidelines
    - ED based interventions to promote appropriate use of antibiotics in the 'watch' category

- Improving standards of environmental cleanliness
    - Deep cleaning programme

- Sustainability
    - Implementing actions in line with the NHS Waste Strategy

6. Monitoring/reporting routes

High level briefing papers from the Infection Prevention and Control Sub-Committee are submitted to:

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Sub-Committee

Director of Infection Prevention and Control (DIPC) reports are submitted quarterly to:

- Infection Prevention and Control Sub-Committee
- Quality and Safety Assurance Committee and onwards to Trust Board.

IPC Board Assurance Framework compliance assessment reports are submitted to the Quality and Safety Assurance Committee Biannually.

Verbal updates are provided by the Chief Nurse/DIPC to Trust Board monthly as part of the Integrated Performance Report.

The DIPC Annual Report is submitted to the Quality and Safety Assurance Committee, Trust Board and published on the Trust website.

Monitoring is in place at the Senior Executive Oversight Group.

7. Timelines

- 2026 – 2027 Financial Year

8. Assurance committee (if relevant)

- Infection Prevention and Control Sub-Committee

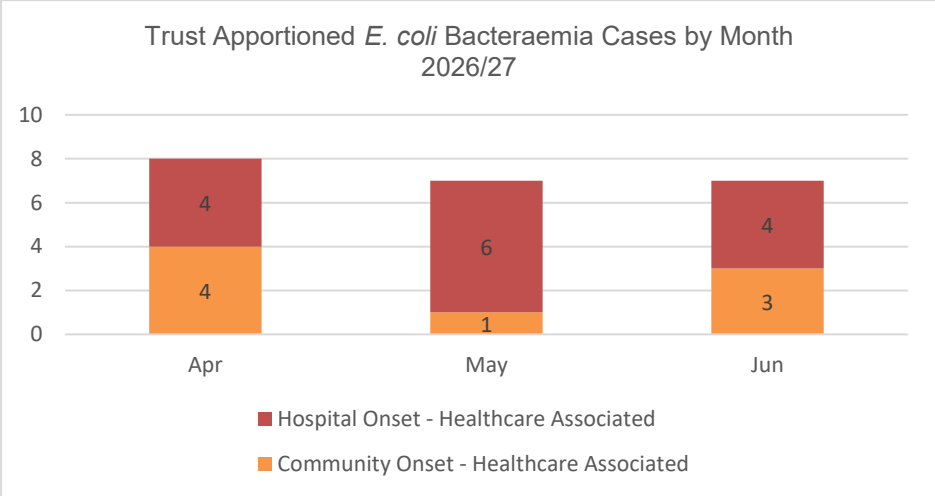
9. Recommendations

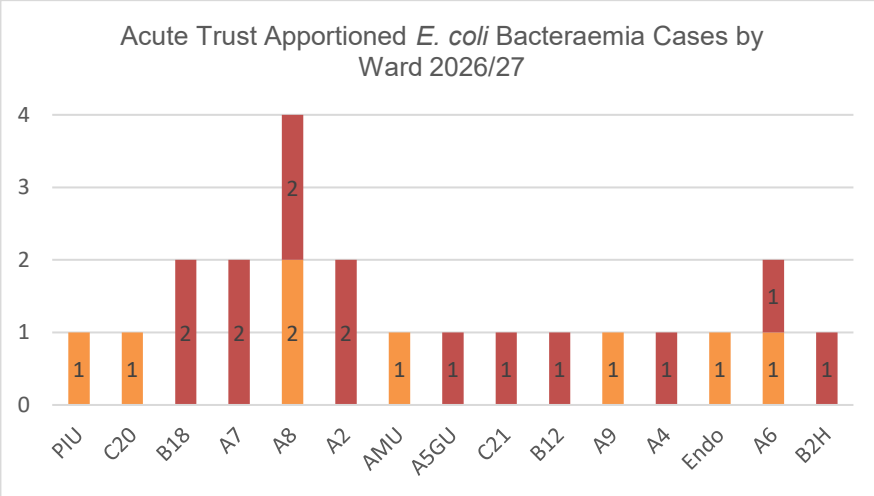
The Quality and Safety Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported, and progress made.

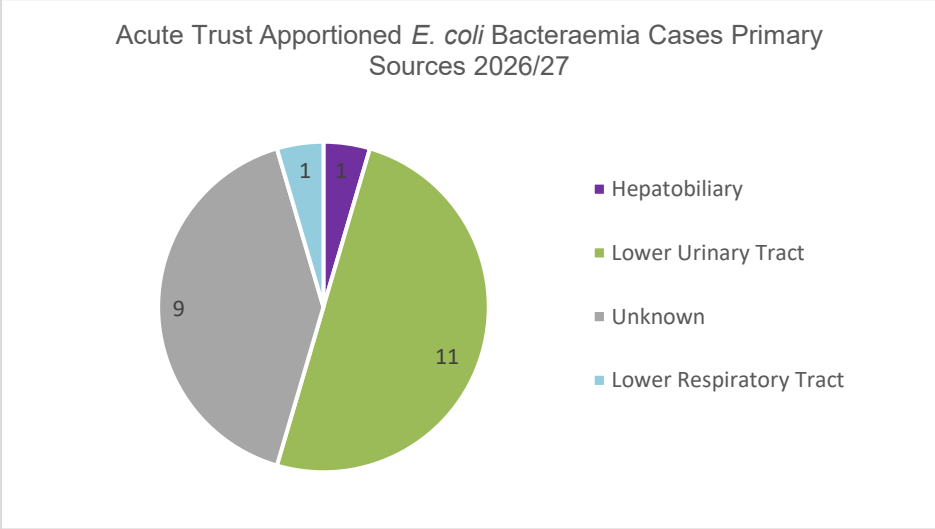
Appendix 1 HCAI DATA

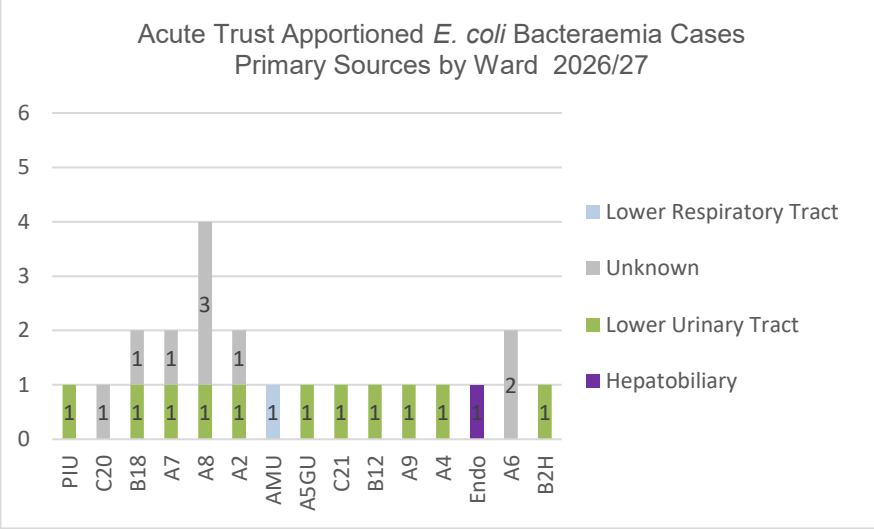
Threshold	TBC
YTD Total	22

Gram Negative Bacteraemia: *E. coli* Apr – Jun 202



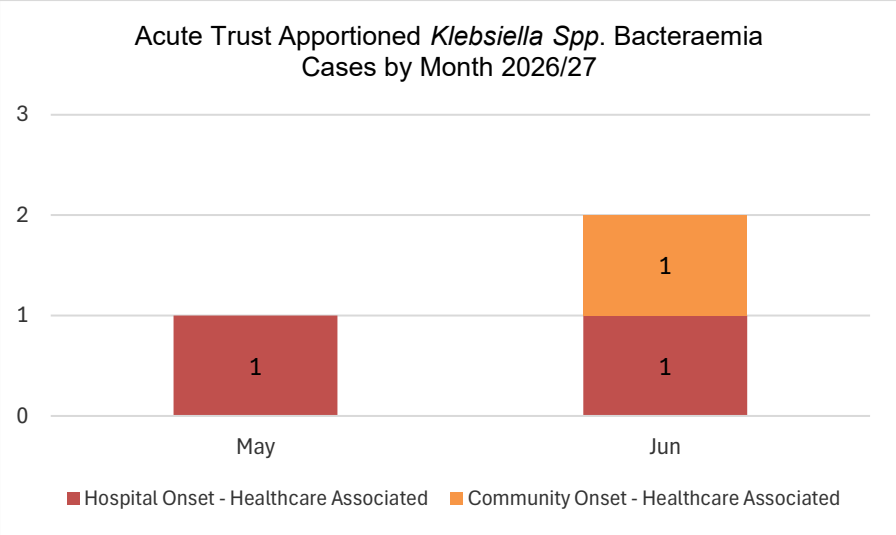


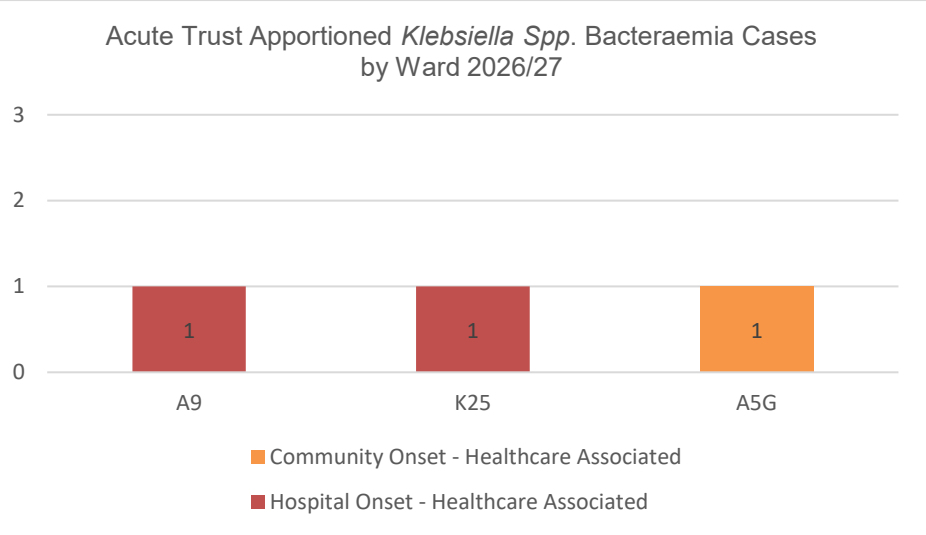


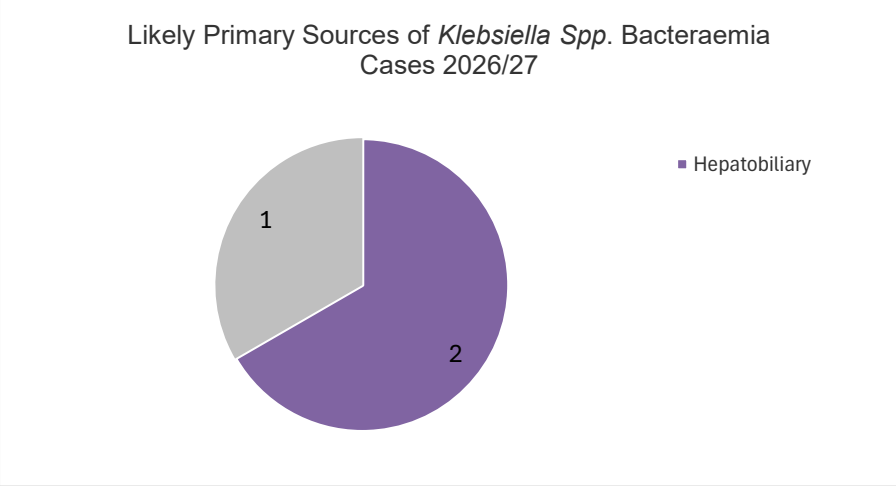


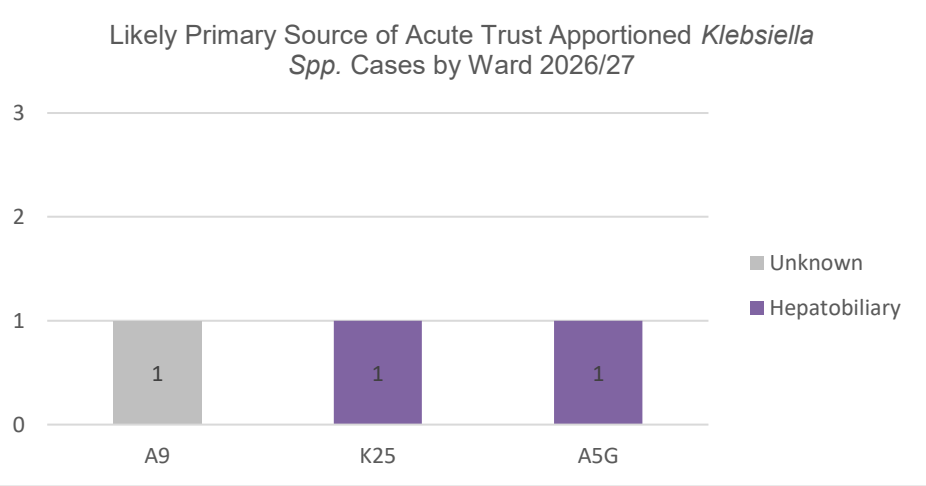
Gram Negative Bacteraemia : *Klebsiella spp*. Apr – Jun 2026

Threshold	TBC
YTD Total	3

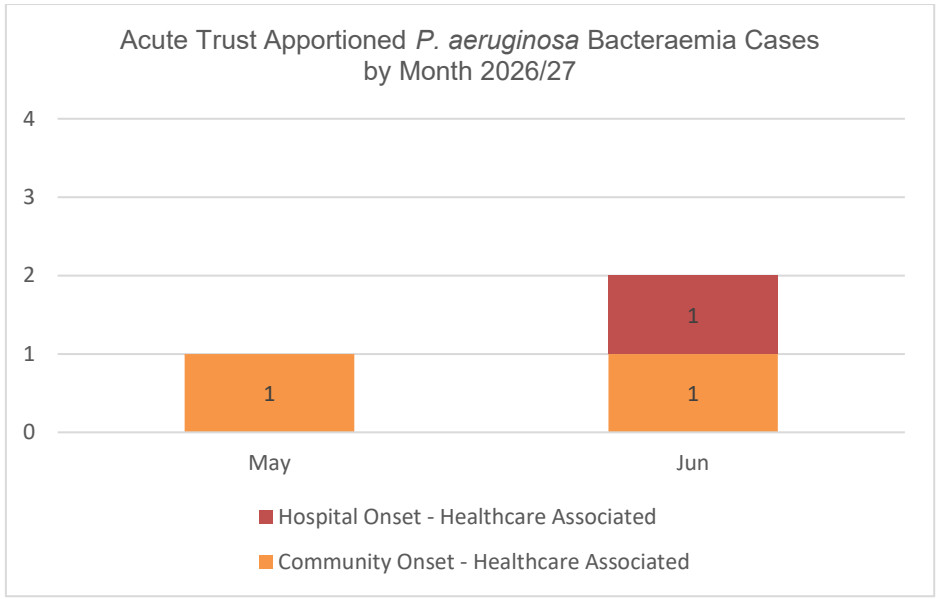


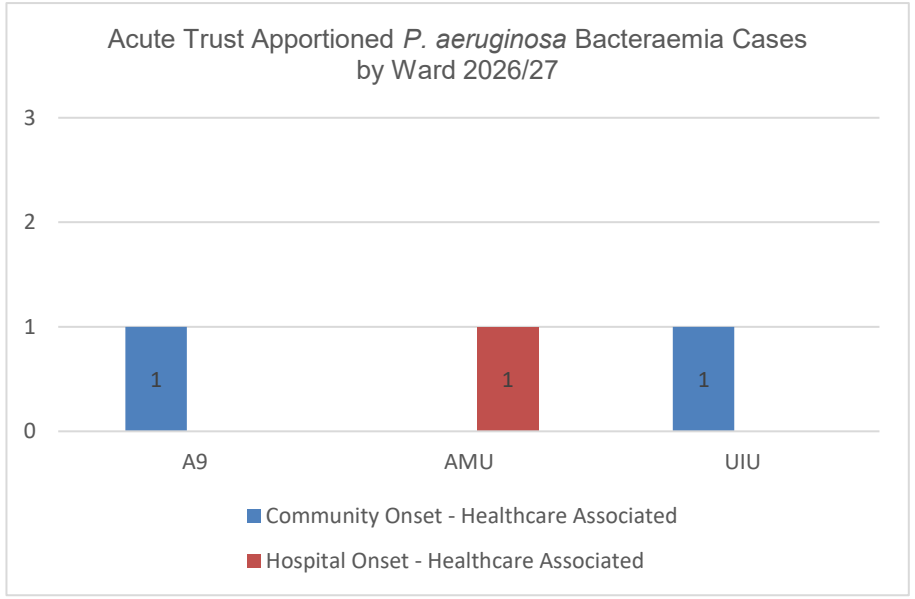


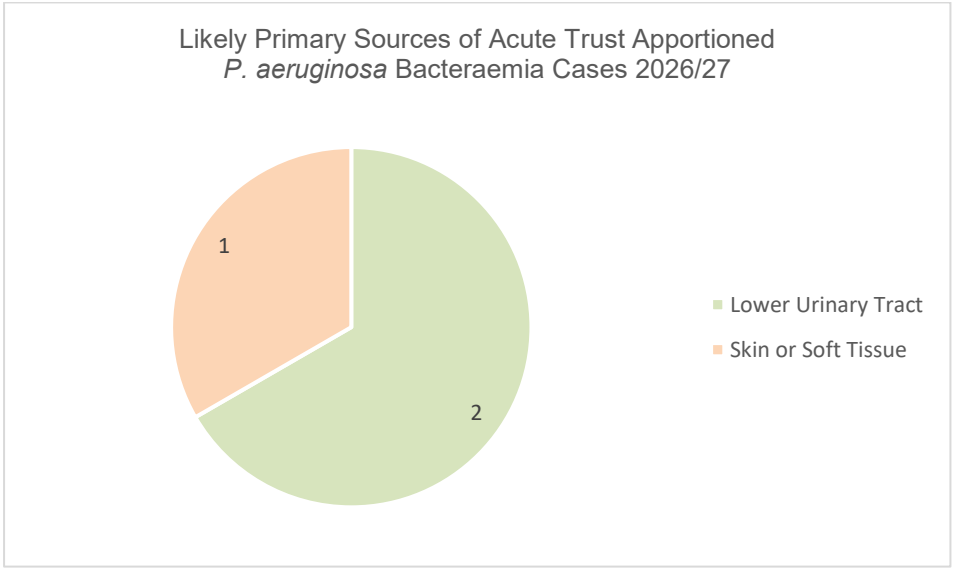


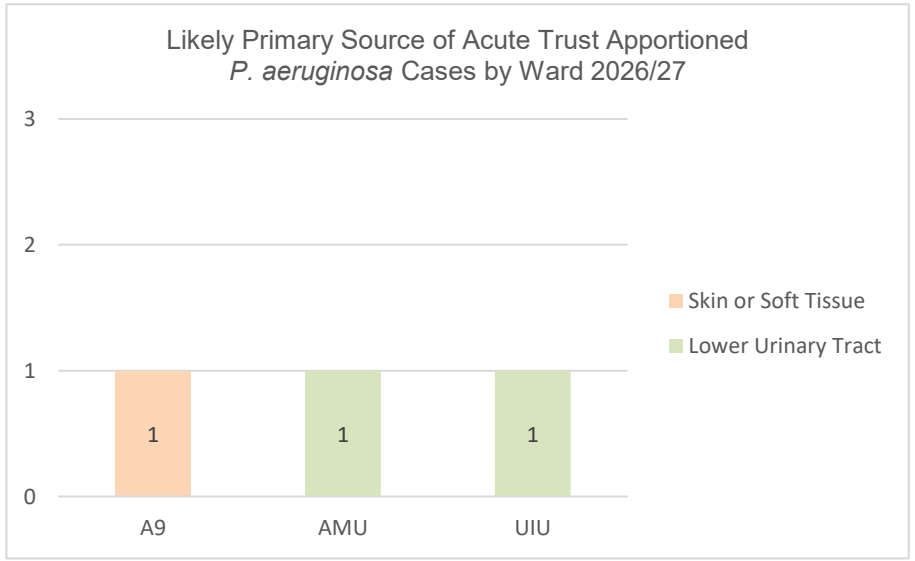


Gram Negative Bacteraemia: *Pseudomonas aeruginosa* (*P. aeruginosa*) Apr – Jun 2026

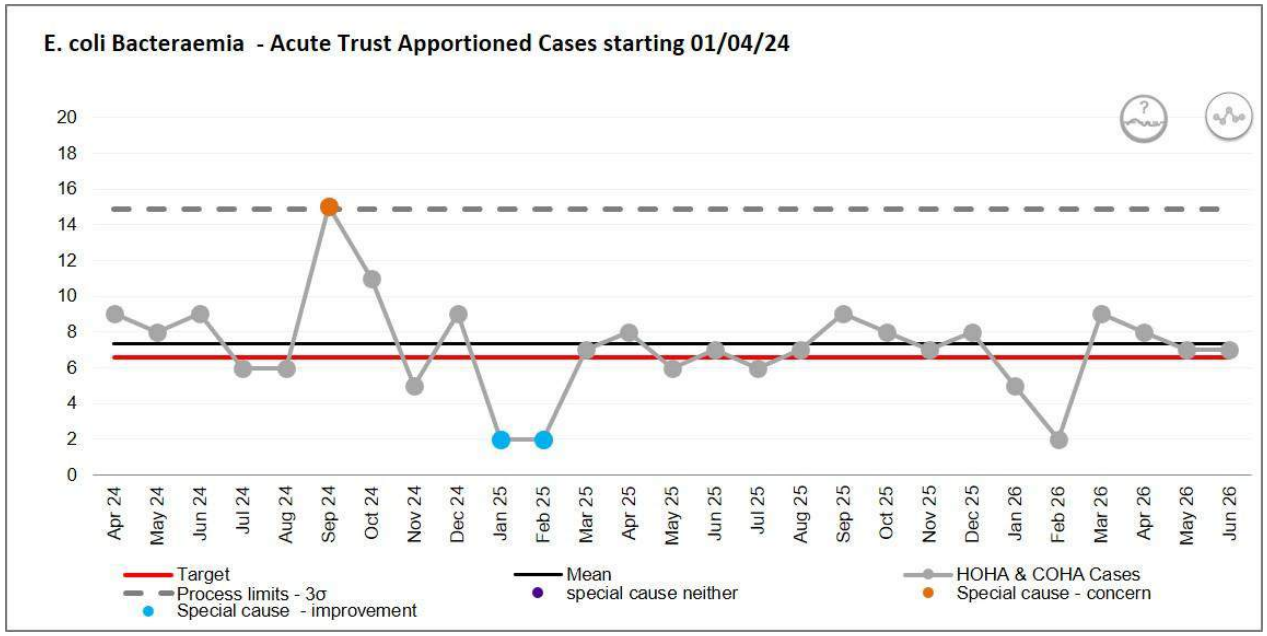


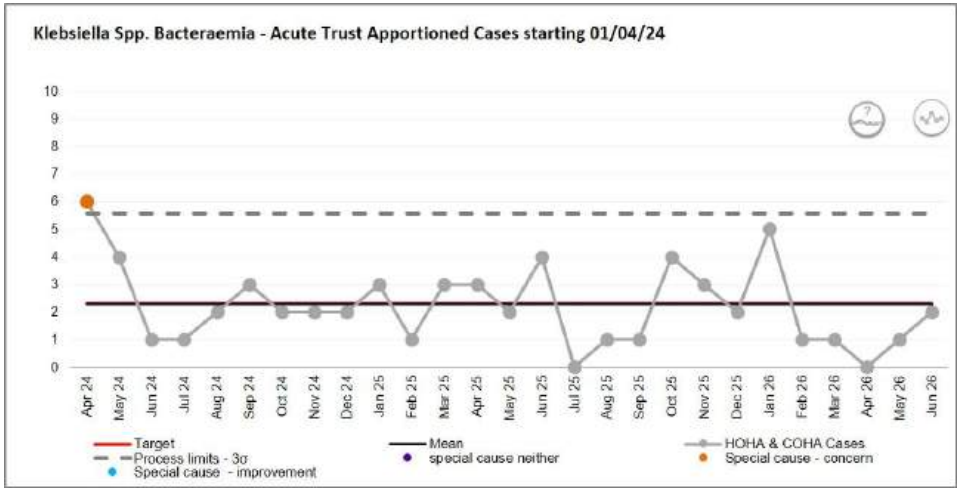


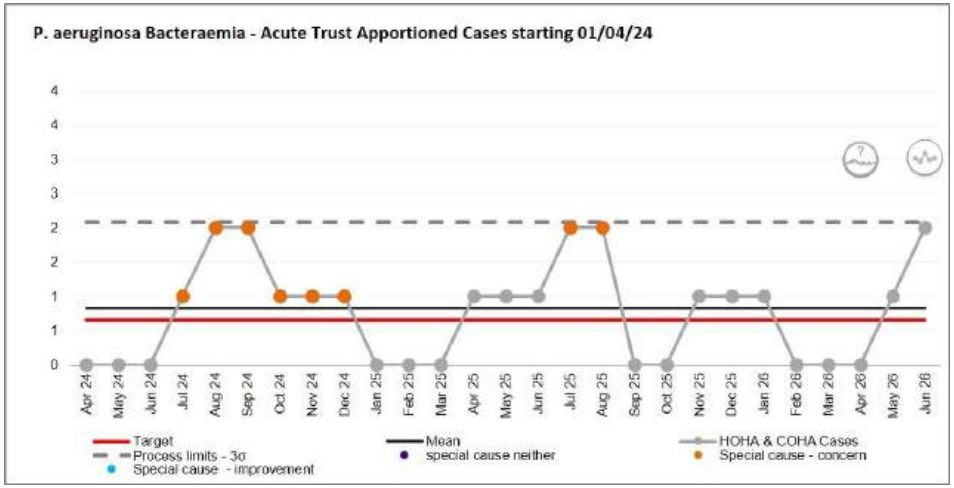




GNBSI SPC Charts Apr 24 – Jun 26





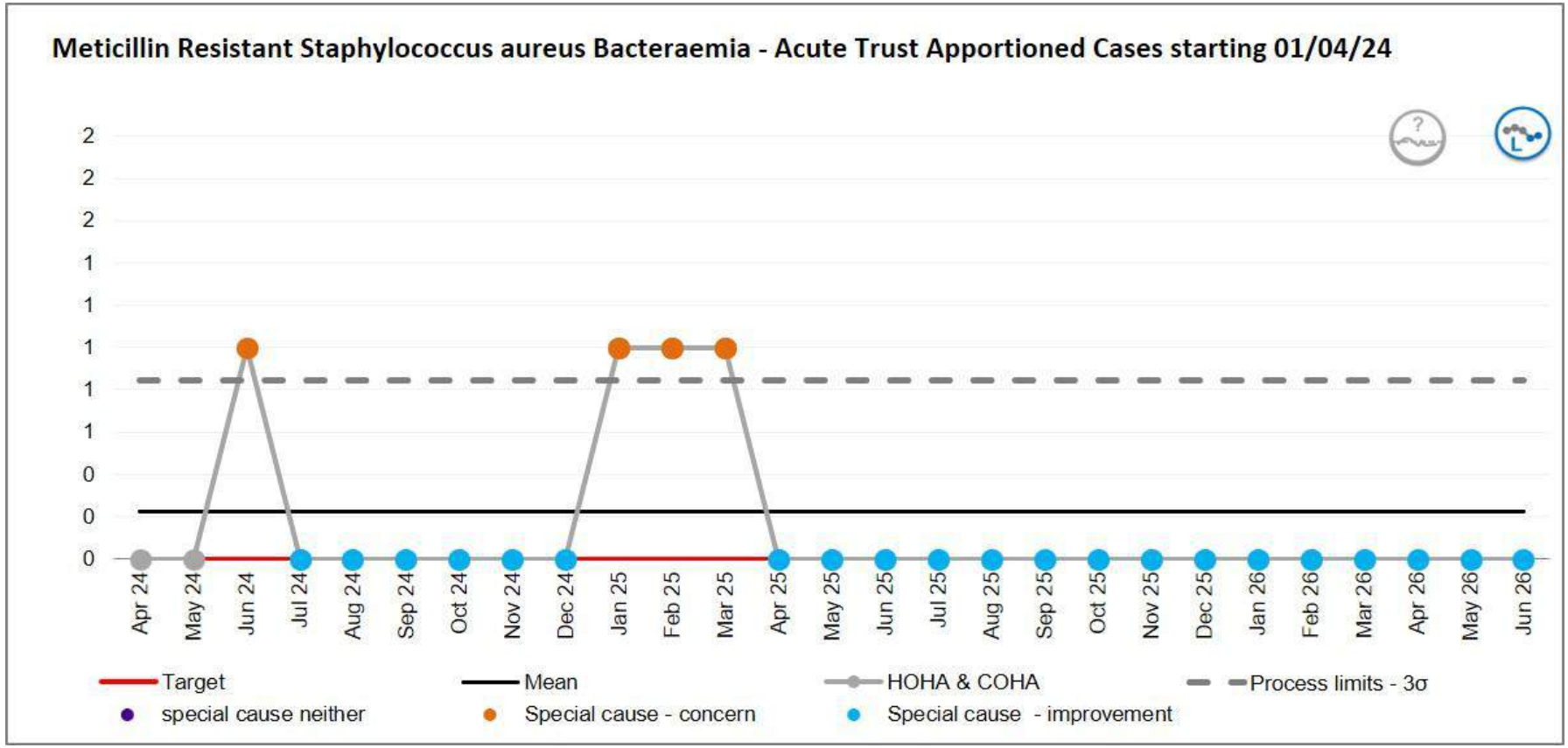


Gram Positive Bloodstream Infection: Meticillin-resistant *Staphylococcus aureus* (*MRSA*) Apr 24 – Jun 26

Nil *MRSA* Bacteraemia Cases Apr – Jun 26

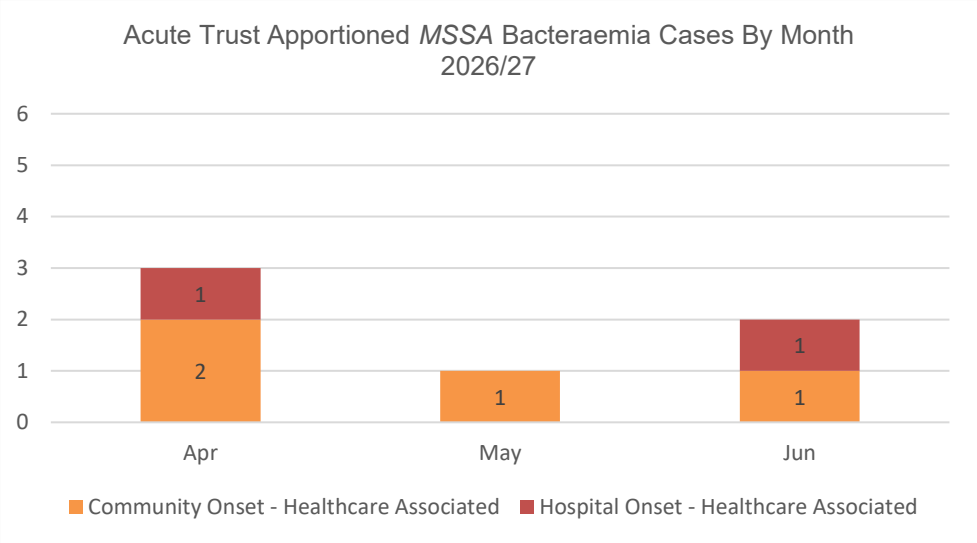
- Last acute Trust apportioned case – 14/03/2025

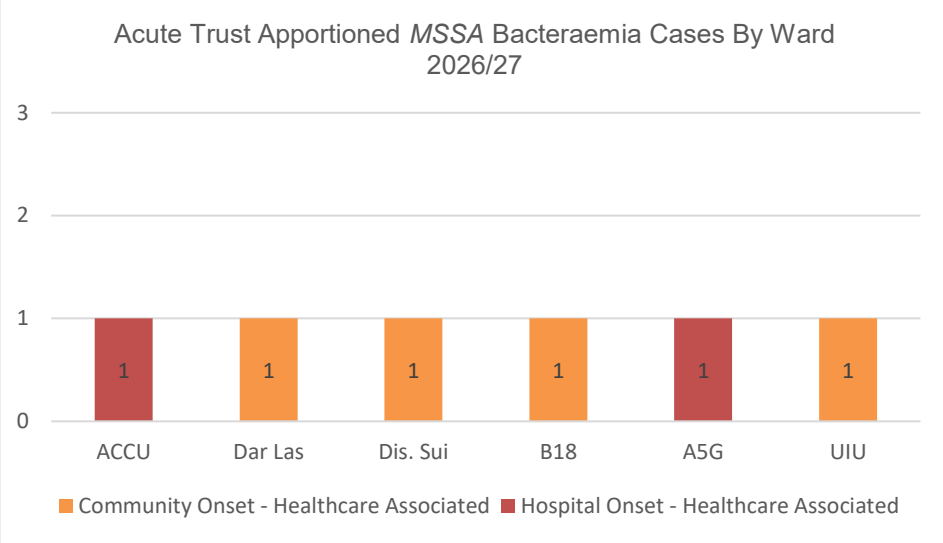
Threshold	Zero
YTD Total	0

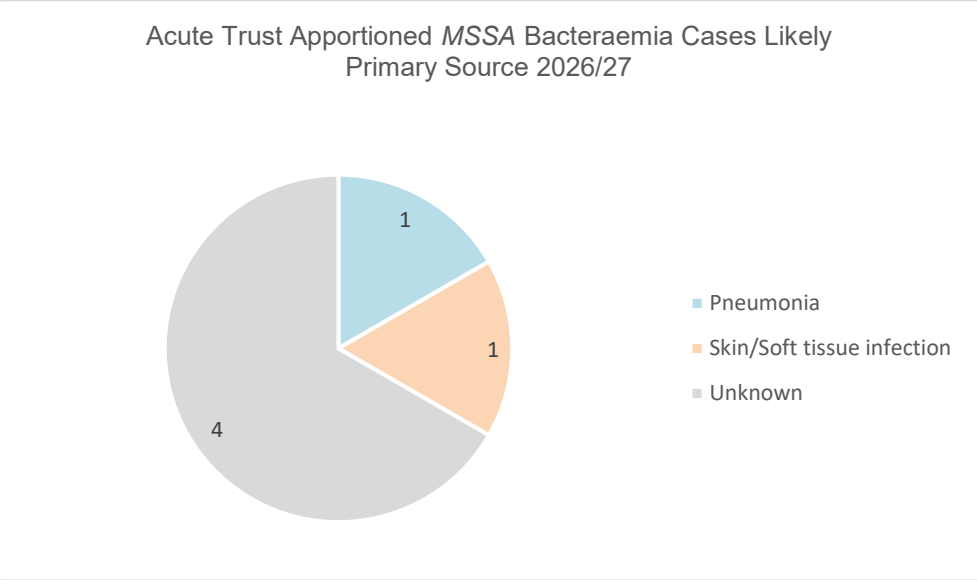


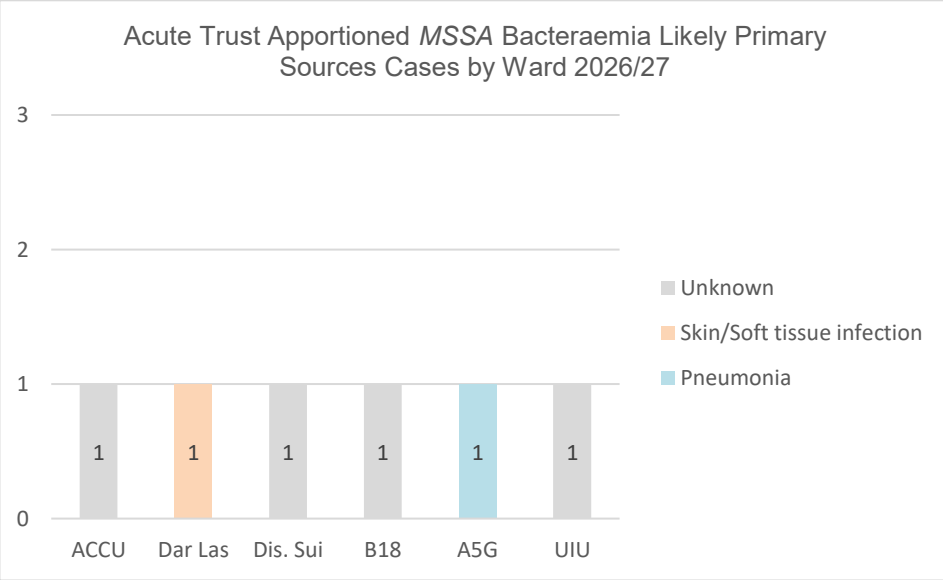
No Threshold	
YTD Total	6

Gram Positive Bloodstream Infection: Meticillin Sensitive *Staphylococcus aureus* (*MSSA*) Apr – Jun 26

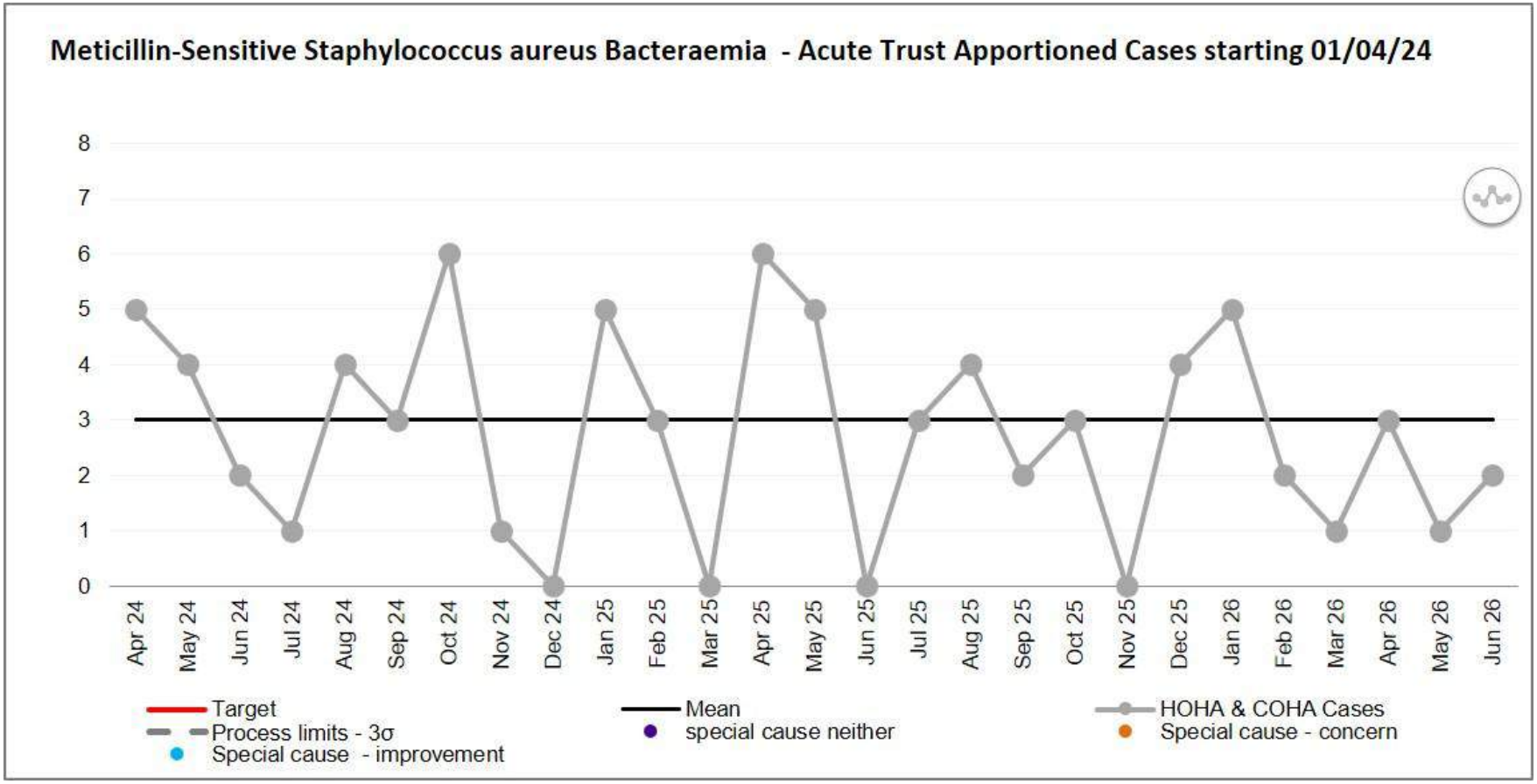






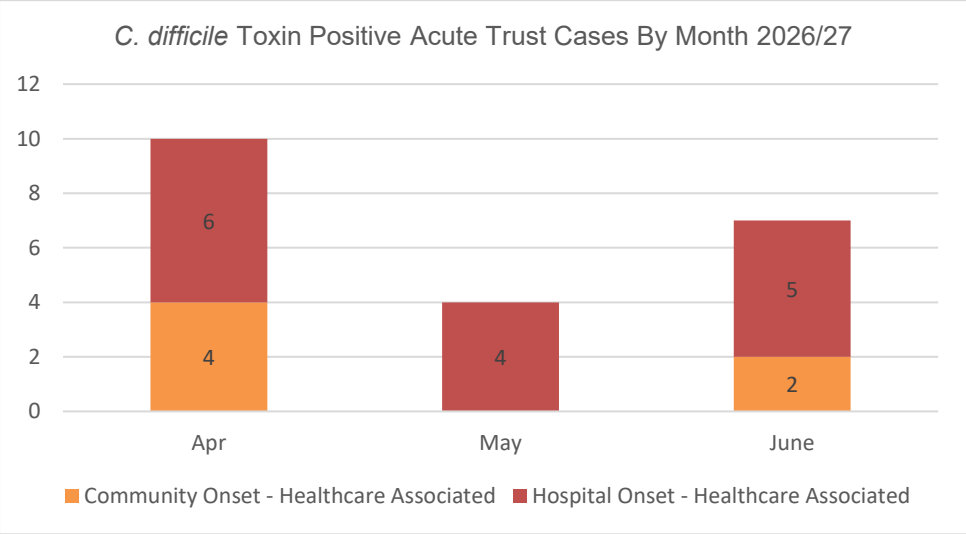


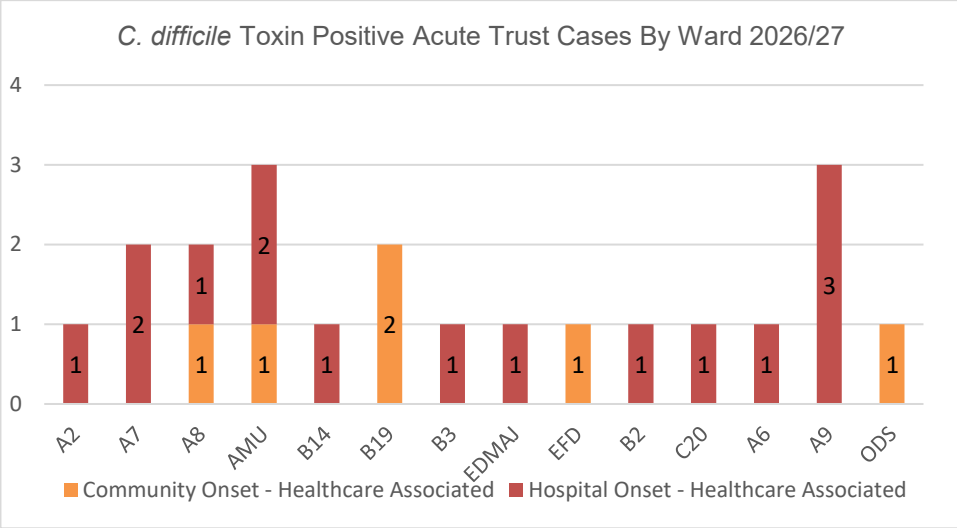
Meticillin Sensitive *Staphylococcus aureus* Bacteraemia Cases Apportioned to Acute Trust SPC Charts Apr 24 – Jun 26

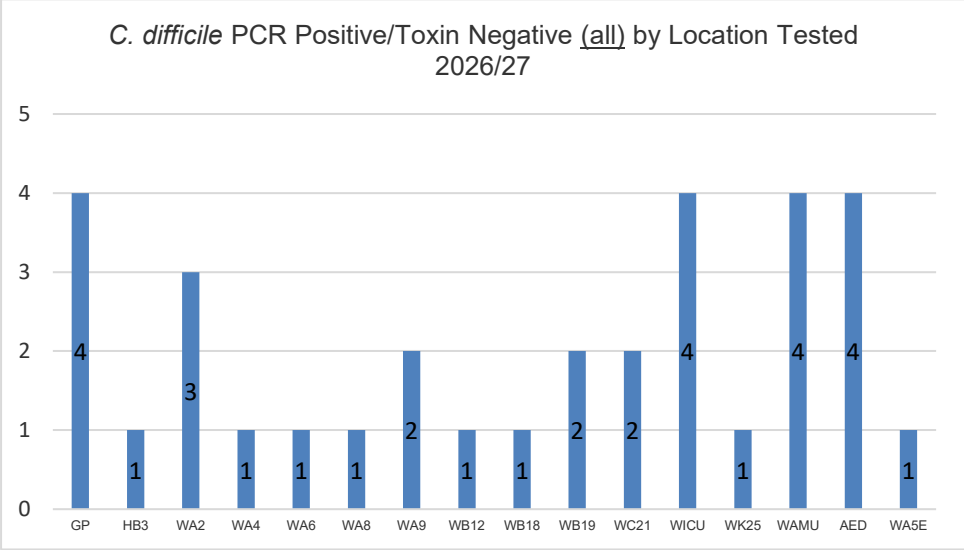


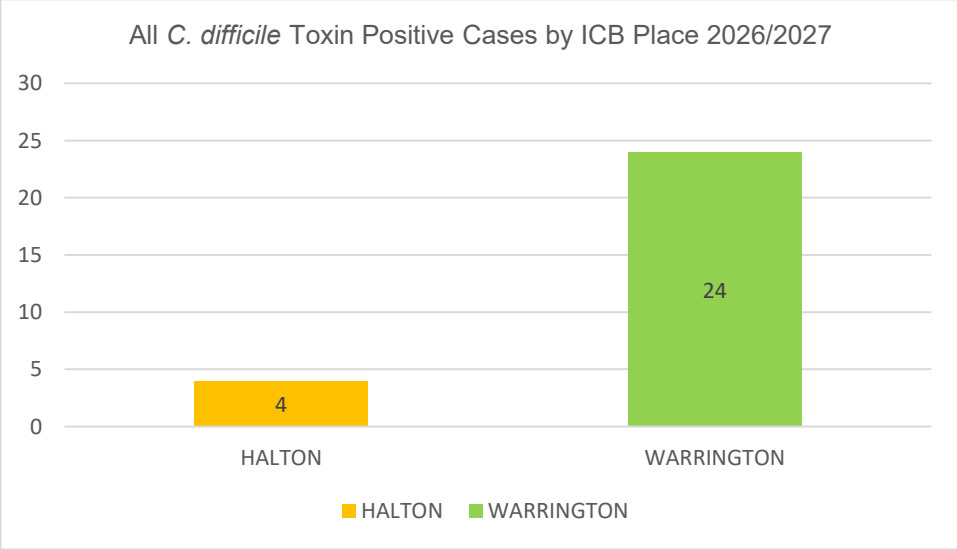
Clostridioides difficile (C. difficile) Toxin Apr – Jun 26

Threshold	TBC
YTD Total	21

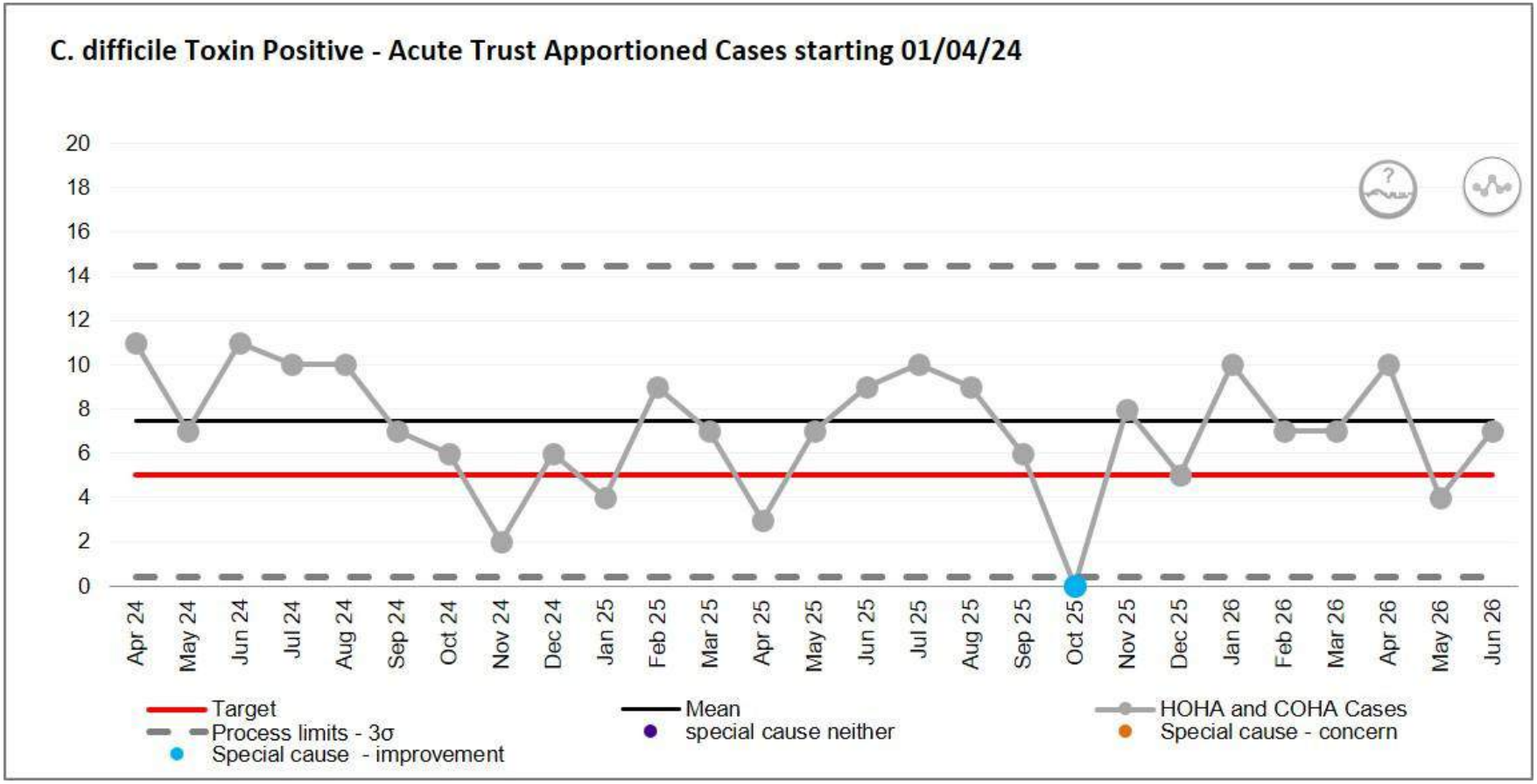




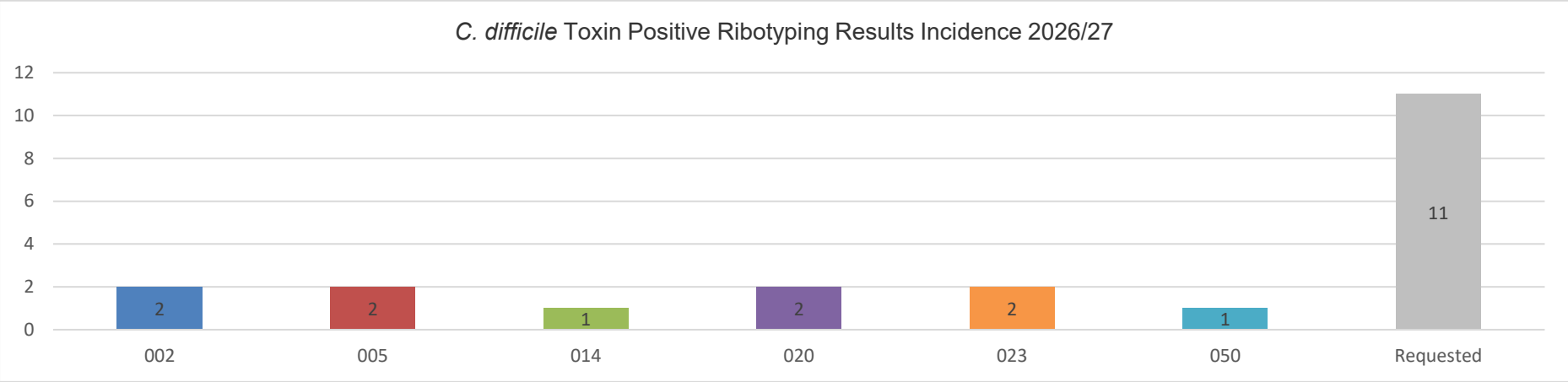




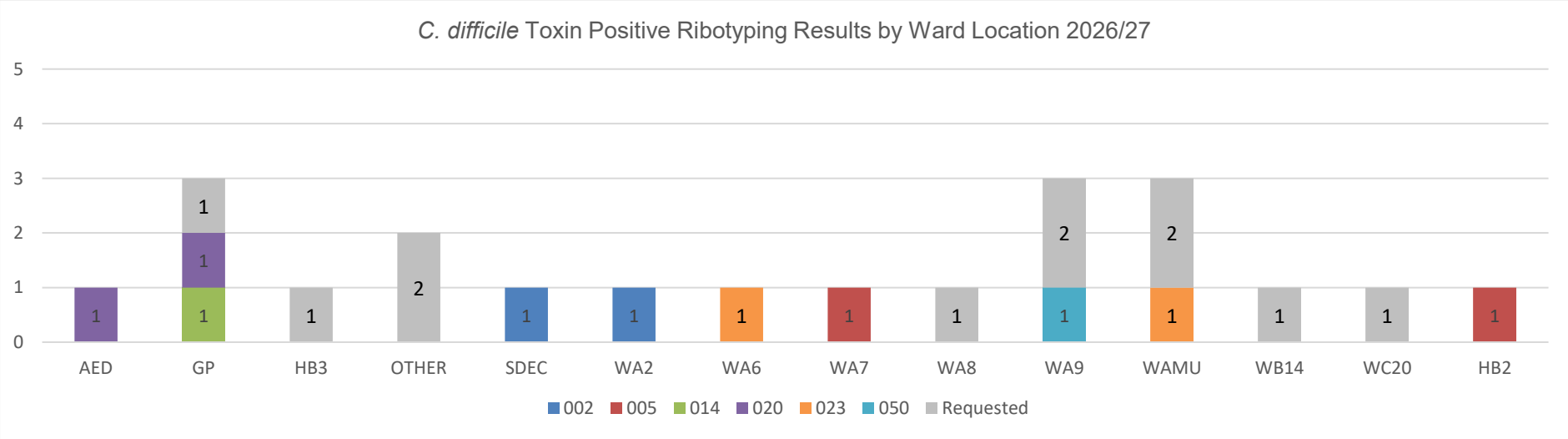
C. diffcile Toxin Positive Cases Apportioned to Acute Trust SPC Chart Apr 24 – Jun 26



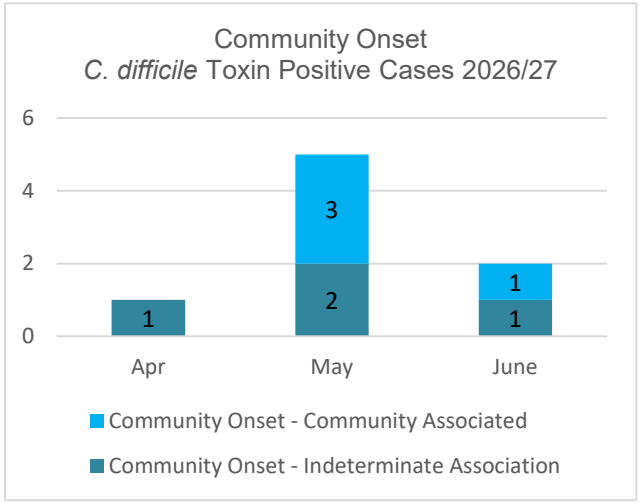
Acute Trust Apportioned *Clostridioides difficile (C. difficile)* Toxin Positive Ribotyping Results Incidence Apr – Jun 26

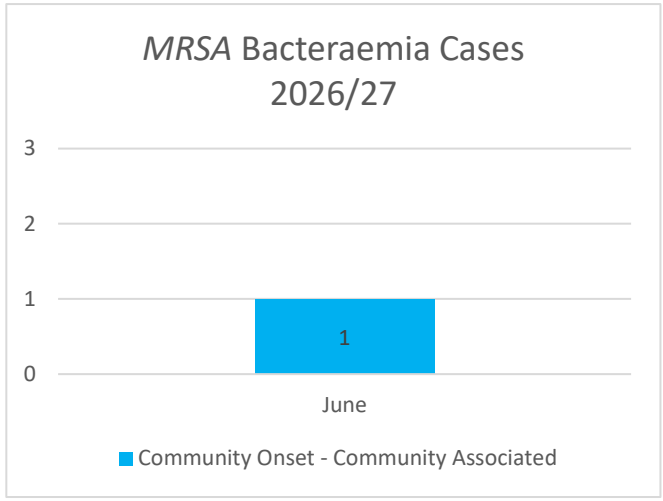


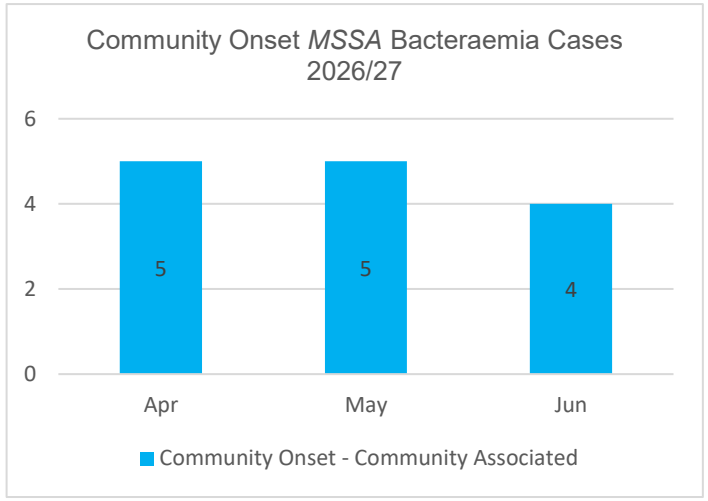
Acute Trust Apportioned *C. difficile* Ribotyping Results by Location Apr - Jun 26

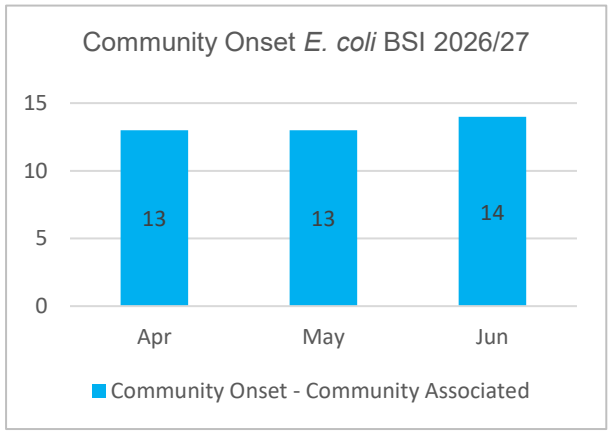


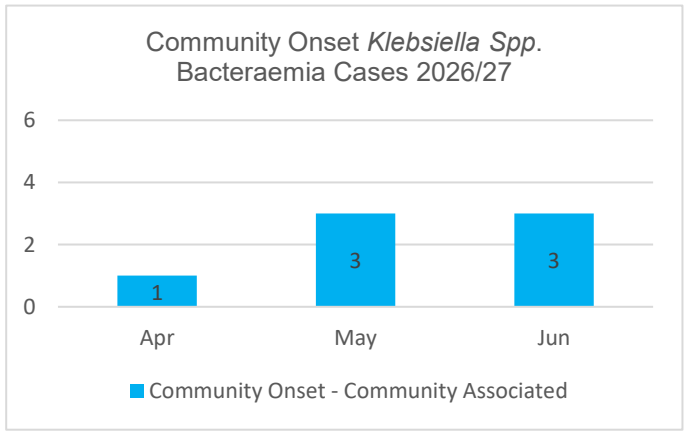
Mandatory Reported Community and Dental HCAI Cases Reported by WHH Apr – Jun 26











Nil *P. aeruginosa* BSI Cases Apr – Jun 26

Appendix 2 IPC Audit Results

Unplanned Care

Assessment	ED TRIAGE	HUB/TT & AC	Resus & Majors	PAEDS ED	ESCALATION	MINORS	SDEC	RESP & HUB2	EFD	AMU	UCC	A2	ACCU	ICU	B18	C21	FAU	B19
Environment - General	67%	91%	71%	80%	79%	94%	95%	91%	86%	86%	90%	86%	95%	91%	91%	100%	95%	95%
Environment - Clean Utility	100%	90%	80%	90%	70%	100%	100%	80%	80%	100%	100%	90%	80%	100%	90%	100%	80%	80%
Environment - Dirty Utility	83%	58%	67%	82%	64%	67%	100%	75%	58%	92%	92%	83%	100%	100%	92%	92%	75%	92%
Environment - Cleaners Room	80%	91%	82%	73%	82%	82%	100%	91%	91%	100%	100%	91%	100%	100%	100%	100%	91%	100%
Environment - Toilets & Bathrooms	80%	100%	100%	100%	100%	100%	80%	100%	93%	93%	100%	93%	86%	100%	100%	86%	100%	100%
Ward Kitchens	89%	70%	78%	43%	81%	81%	96%	78%	89%	89%	96%	89%	100%	96%	100%	100%	100%	100%
Handling/Disposal of Linen	90%	93%	91%	100%	100%	100%	100%	71%	100%	93%	100%	100%	93%	79%	93%	100%	100%	86%
Departmental Waste	83%	100%	92%	100%	85%	100%	92%	77%	83%	85%	100%	92%	92%	100%	92%	92%	100%	85%
Safe Handling Disposal of Sharps	89%	89%	89%	79%	68%	95%	95%	84%	89%	89%	100%	100%	100%	89%	95%	100%	100%	95%
Patient Equipment (General)	100%	100%	92%	89%	78%	100%	96%	88%	96%	92%	100%	96%	95%	95%	96%	92%	96%	100%
Personal Protective Equipment	92%	100%	87%	100%	100%	100%	100%	93%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%
Short Term Catheter Management	100%	100%	100%	100%	90%	N/A	100%	94%	100%	94%	100%	88%	100%	100%	94%	100%	100%	100%
Care of peripheral intravenous lines	100%	91%	91%	100%	100%	100%	100%	100%	91%	100%	100%	73%	100%	100%	82%	91%	100%	100%
Isolation precautions	100%	100%	100%	100%	N/A	N/A	N/A	100%	100%	100%	100%	100%	92%	92%	100%	100%	100%	92%
Hand Hygiene	92%	88%	92%	86%	95%	100%	N/A	92%	92%	96%	100%	92%	96%	88%	92%	100%	96%	84%
Enteral Feeding	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	NA	100%	100%
Central IV Devices	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	NA	100%	100%
Overall Compliance	90%	91%	87%	88%	86%	94%	97%	88%	90%	94%	98%	92%	95%	95%	94%	97%	96%	94%
Date Audit Completed	07/04/26	09/04/26	10/04/26	13/04/26	16/04/26	16/04/26	17/04/26	20/04/26	22/04/26	22/04/26	28/04/26	08/06/26	09/06/26	10/06/26	12/06/26	15/06/26	22/04/26	22/04/26

Planned Care

Assessment	Birth Suite IOL	C23	C20 &GAU	EPAU, Hysto, Colp	NEST MATER NITY TRAIGE	NNU	B10 PAU	B11 B11C	Paediatric OPD	Antenatal clinic and gynae clinic	ANDU	A6	B2	CSTM WARD & PACU	CSTM DCU	UIU	Ophthalmic clinic	Ophthalmic injection theatre
Environment - General	95%	82%	95%	100%	100%	86%	100%	86%	92%	91%	94%	91%	95%	91%	100%	95%	91%	90%
Environment - Clean Utility	80%	90%	90%	100%	80%	90%	100%	90%	100%	100%	90%	90%	100%	90%	100%	100%	100%	100%
Environment - Dirty Utility	83%	100%	67%	100%	67%	100%	100%	92%	100%	100%	N/A	92%	92%	83%	92%	100%	91%	100%
Environment - Cleaners Room	100%	100%	100%	100%	71%	100%	100%	100%	100%	100%	73%	100%	100%	91%	100%	100%	91%	91%
Environment - Toilets & Bathrooms	79%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%	79%	100%	93%	86%	100%
Ward Kitchens	85%	100%	96%	100%	100%	100%	100%	100%	93%	100%	100%	89%	100%	100%	100%	100%	100%	100%
Handling/Disposal of Linen	92%	86%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	79%	93%	100%	93%	100%	N/A	100%
Departmental Waste	85%	92%	85%	92%	100%	92%	100%	100%	100%	92%	100%	92%	100%	85%	92%	100%	92%	100%
Safe Handling Disposal of Sharps	89%	100%	95%	100%	95%	100%	100%	100%	100%	92%	88%	100%	100%	100%	100%	100%	100%	100%
Patient Equipment (General)	100%	95%	92%	100%	96%	92%	95%	92%	100%	87%	100%	96%	96%	100%	100%	100%	100%	100%
Personal Protective Equipment	100%	92%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	93%	100%	100%	100%	100%	100%	100%
Short Term Catheter Management	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	82%	100%	100%	100%	100%	N/A	N/A
Care of peripheral intravenous lines	100%	100%	80%	100%	100%	100%	100%	91%	N/A	N/A	N/A	78%	100%	100%	100%	N/A	N/A	N/A
Isolation precautions	100%	100%	85%	100%	100%	100%	100%	100%	100%	N/A	N/A	92%	N/A	N/A	N/A	N/A	N/A	N/A
Hand Hygiene	100%	92%	100%	100%	100%	96%	94%	88%	100%	100%	100%	96%	92%	88%	100%	100%	94%	94%
Enteral Feeding	100%	N/A	100%	100%	100%	100%	100%	N/A	N/A	N/A	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A
Central IV Devices	100%	N/A	100%	100%	100%	100%	100%	N/A	N/A	N/A	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A
Overall Compliance	93%	95%	92%	99%	94%	97%	99%	96%	99%	96%	95%	91%	98%	93%	98%	99%	95%	98%
CBU	W&C	W&C	W&C	W&C	W&C	W&C	W&C	W&C	W&C	W&C	W&C	SS	SS	SS	SS	SS	SS	SS
Date Audit Completed	24/04/26	28/04/26	29/04/26	01/05/26	05/05/26	06/05/26	08/05/26	11/05/26	12/05/26	14/05/26	15/05/26	16/06/26	17/06/26	22/06/26	23/06/26	24/06/26	29/06/26	30/06/26

Theatres

Assessment Area	Maternity Theatres	Halton Nightingale Theatres	Warrington Theatres	CSTM Theatres
Reception Waiting	91%	100%	100%	100%
Main Theatre Corridor	67%	91%	91%	100%
Theatre Storeroom	88%	100%	100%	88%
Sterile Instrument and P. Packs	100%	100%	100%	100%
Hub Stock	N/A	100%	88%	98%
Operating Room 1	66%	98%	N/A	98%
Operating Room 2	77%	97%	92%	98%
Operating Room 3	N/A	N/A	89%	98%
Operating Room 4	N/A	N/A	89%	98%
Operating Room 5	N/A	N/A	N/A	95%
Operating Room 6	N/A	N/A	86%	N/A
Operating Room 7	N/A	N/A	N/A	N/A
Operating Room 8	N/A	N/A	N/A	N/A
Invasive Device Management	100%	100%	100%	100%
CVC Insertion	N/A	100%	100%	100%
Recovery Room	97%	97%	94%	97%
Staff Rest Room	88%	100%	79%	100%
Staff Changing Room Male	64%	93%	71%	79%
Staff Changing Room Female	64%	93%	79%	86%
Cleaners Room	100%	92%	100%	92%
Surgical Instruments	N/A	100%	100%	100%
Specimen Handling	100%	100%	100%	100%
Overall Compliance	84%	97%	92%	96%
CBU	DD	DD	DD	DD
Date	18/05/26	19/05/26	20/05/26	22/05/26

North Cheshire and Mersey
NHS Foundation Trust

Quality and Safety Assurance Committee

Agenda reference:	**QSAC/26/09/152**			
Subject:	**Learning from Deaths Report Q1 2026-2027**			
Date of meeting:	8 September 2026			
Action required:	**For noting only**			
Author(s):	Dr Lalitha Chinnappan, Consultant Gastroenterology, Associate Medical Director for Patient Safety and Trust Mortality Lead. Dr Judith Raper, Consultant Palliative Medicine and Deputy Trust Mortality Lead Emily Barnett, Clinical Effectiveness Manager			
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:	Paul Fitzsimmons, Executive Medical Director			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further information / comments:			
Executive summary:	This paper provides the Quality and Safety Assurance Committee with the Quarter 1 2026/27 Learning from Deaths report, in line with national requirements for North Cheshire and Mersey NHS Foundation Trust. During the quarter, 285 acute deaths were recorded, 79 met the criteria for a Structured Judgement Review (SJR), and 63 were allocated for review following application of the sampling criteria for DoLS cases. A total of 61 SJRs were completed during the quarter, including 26 allocated in Q1 and 35 carried forward from previous quarters. Assurance is provided that acute SJR allocation remains up to date, with no significant delay currently identified between a patient's death and allocation for review.			

<table>
<tr><td></td><td colspan="3">Overall care ratings were positive, with no completed SJRs rated as poor or very poor for overall care; the majority were rated as good or adequate, with three rated as excellent.

Learning identified through mortality reviews continues to be overseen by the Mortality Review Group and progressed through established workstreams, including DNACPR, patient transfers, specialty input, DoLS/capacity, emergency department documentation and delays, and Medical Certificate of Cause of Death/Medical Examiner processes.

Key learning this quarter related to inpatient diagnostic delays and escalation, timely DNACPR and treatment escalation planning, communication and handover of DNACPR status, and delays in ITU step-down. Actions have been identified and allocated through the appropriate governance routes.

Integration of community and dental mortality processes remains in progress, with Datix mortality forms developed and being reviewed with community colleagues to support consistent recording, review and reporting of community deaths. Mortality indicators continue to be monitored through HED, with HSMR remaining below the national baseline while SHMI has increased in the latest rolling period and requires continued triangulation with internal intelligence.

15 community deaths met the criteria for a Learning from Deaths review during Q1. No deaths were found to be caused from a lack of care provided by North Cheshire and Mersey Community and Dental Services.
The Committee is asked to note the content of the report and the ongoing governance arrangements in place to support learning, improvement and assurance.</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 Committee is asked to note the contents of the paper.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda reference</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of outcome</td><td colspan="2"></td></tr>
</table>

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

1. Background/context

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. Key elements

North Cheshire and Mersey (NCM) use the HED (Healthcare Evaluation Data) system to assess overall acute mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data for Acute deaths, this report includes:

- The total number of deaths of acute patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. Measurements/evaluations

A Structured Judgement Review will be completed if an acute patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a PSII (Patient Safety Incident Investigation) or other Learning Response then an SJR is not undertaken.

MRG – Forward planning

1) Themed workstreams continue to be undertaken ensuring that any common pattern in issues are identified and addressed with the aim to bring about clinical changes and positively impact both patient care and Trust mortality. The current list of workstreams are as follows:
   - DNACPR and DNACPR Palliative Workstream
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee related learnings
   - Good practice- for positive commendation
   - Emergency Department Long Waits and Potential Harm
   - Poor Emergency Department Documentation
   - Primary Care Community Learning
   - Orthopaedic workstream (delays & poor care)
   - Medical Certificate of Cause of Death (MCCD)/Medical Examiner Workstream

2) Annual appraisals continue yearly and are next due November 2026. MRG reviewers are provided with feedback on their role within the MRG and within the wider governance processes. Individualised feedback is sent annually to each reviewer to highlight what is working well and what improvements are required.

3) Reminders continue to be sent out monthly with an aim to ensure that each SJR does not exceed the deadline of 8 weeks. The importance of timely completion is discussed during the monthly MRG meetings including feedback on reviewer appraisal.

May 2026	June 2026	July 2026
8 SJR's are exceeding the 8-week timeframe	6 SJR's are exceeding the 8-week timeframe	12 SJR's are exceeding the 8-week timeframe
23 SJR's withing the 8-week time frame	32 SJR's withing the 8-week time frame	24 SJR's withing the 8-week time frame
Total SJR's outstanding - 31	Total SJR's outstanding - 38	Total SJR's outstanding - 36

4) Quarterly Mortality reports are presented at MRG. The reports which are shared are as follows:
   - Maternal and Perinatal Mortality
   - Trauma Mortality Report
   - Child Death Mortality

5) The Clinical Effectiveness Coordinator liaises with The Trust Learning Disability and or Autism Lead to ensure that all deaths relating to a learning disability and or Autism are captured appropriately.

Community and Dental integration update:

1) Integration of the North Cheshire and Mersey Mortality Services remains in progress. A mortality form has been developed on the datix risk management system, which will enable all community deaths to be recorded without being reported through to LFPSE.
2) A further form has been developed within the mortality module of datix to allow the death to be reviewed and will have embedded drop downs should a review/learning from deaths be required.
3) The developed forms have been shared with the relevant community colleagues to enable a full review to be undertaken of the forms to think about:
   - What fields need to be mandatory on both forms to ensure that we are recording the exact level of detail that is required.
   - What groups will need to be created within the forms to ensure that the relevant staff are receiving notifications when a death is recorded.
   - What reports will be required to be pulled from the data?
   - Is a dashboard required etc.

4) A meeting has been scheduled with the relevant colleagues on Tuesday 11 August 2026, with an aim to finalise the mortality community forms.

Community & Dental Q4 deaths

15 deaths met the criteria for a Learning from Deaths review during Q1. No deaths were found to be caused from a lack of care provided by North Cheshire and Mersey Community and Dental Services.

During Q1, no concerns were raised by the deceased family/carers, and no concerns were raised by staff about the care provided. The table below shows the number of deaths within each service.

Corporate safeguarding concerns (3)	**Adult (10)**	**Child (1)**	**Dental (1)**
Adult = 1	Unexpected = 4	Expected = 1	Unexpected adult = 1
Child = 2	Expected = 6		

Examples of unexpected child deaths

Case Details	**Outcome**
Warrington Safeguarding Community Nursing team received information from Warrington Hospital safeguarding team regarding the sad death of a 17 year old.	LFD completed as per policy for child deaths in community. Learning around professional curiosity in relation to ADHD medication. No further actions for community services.
Notification of child death received from Alder Hey Children's Hospital, reported to be an out of hospital collapse. Incident occurred within the family home.	LFD completed as per policy for all child deaths in community. Learning has been identified and will be captured in an action plan held by the safeguarding partnership. Noted that there had been no failings/missed opportunities from health services for this child and family.
Sad notification received of a parental Death. It is unclear how long mother has been deceased. 3 year old child was found in the property with his deceased mother.	Exceptional completion of an LFD for parental death due to circumstances and explore any learning for community services. No internal learning identified.

Examples of Adult LFD unexpected deaths

Case Details	Outcome
Patient visited for routine flush and redress of PICC line. Patient was on a hospital bed, unresponsive to pain and had very shallow noisy breathing, with a respiratory rate of around 8. Patients mother in attendance asked patient's mum to get the Macmillan nurse back, who had just left. 999, as patient was for resus and did not have a ceiling of care in place. Unable to get sat's reading. Repositioned patient and opened her airway, preparing to do CPR. Ambulance and a paramedic car arrived within approx. 5 mins. A collective decision was made by the paramedics not to resuscitate. Patient's daughter arrived shortly after, and patient passed away with her family around her and the paramedics. GP contacted by Macmillan Nurse.	LFD completed as agreed at DIRLG that it met criteria for further investigation. Learning around greater collaboration and communication in regard to DNACPR and important documentation on transfer from acute to community.
RGN checked on the patient at 9pm and found her unresponsive. Pressed emergency buzzer and started chest compressions. All staff on duty attended emergency buzzer and assisted with the cardiac arrest. 999 called straight away, defibrillator attached and resuscitation continued. Paramedics arrived approximately 10-15 min after emergency buzzer was pressed. All information given to the paramedics about patient's condition and comorbidities. Unfortunately, despite all efforts patient has passed away.	LFD completed as per policy for patient deaths in Padgate House. Deteriorating patient review also completed to check for any missed signs of deterioration. Overall Padgate House staff escalated any concerns appropriately and timely. No gaps in care from PGH staff and no learning identified for NCM staff.

Acute Q4 deaths

During Quarter 1 2026/27 there were between 23-31 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring an SJR per month are 26 which is a decrease of 2 from the last reporting period.

Currently we have 8 Mortality reviewers, with each being allocated up to 5 cases per month, allowing a total monthly allocation of 40 SJRs.

Assurance can be provided that SJR allocation remains up to date, with no significant delay currently identified between a patient's death and allocation for review. This supports timely consideration of learning and enables any concerns to be identified and escalated through the established mortality review governance process.

3.1 Mortality Review Data Q1 2026/27

- During Quarter 1, 79 deaths met the criteria to be subject to a Structured Judgement Review (SJR). However, based on the criteria selection for allocation, only 10% of the DOLs cases were selected meaning a total figure of 63 SJR's requiring review. This is a increase of 9 from Q4.
- During Quarter 1, 63 deaths were allocated to a reviewer for a Structured Judgement Review to be completed.
- 61 SJR's have been completed in Q1, which is a decrease of 14 from Q1.
- Of the 61 SJR's completed, 26 were allocated in Q1 and 35 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q1	Total LD Deaths Q1	PSII's commenced in Q1 relating to patient deaths	Those meeting SJR criteria Q1	Number of SJR reviews completed in Q1	Number of SJR Reviews that were allocated in Q1 2026/27 and completed compared to Q4 2025/26	
285	2	2	79	61	Q4 25/26 Total SJR Completed – 75 Out of 75 SJR's completed, 53 were assigned in Q4 2025/26.	Q1 26/27 Total SJR Completed – 61 Out of 61 SJR's completed, 26 were assigned in Q1 2026/27

Cases rated by reviewers as *1:* ***overall care very poor*** or *2:* ***overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3:* ***Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

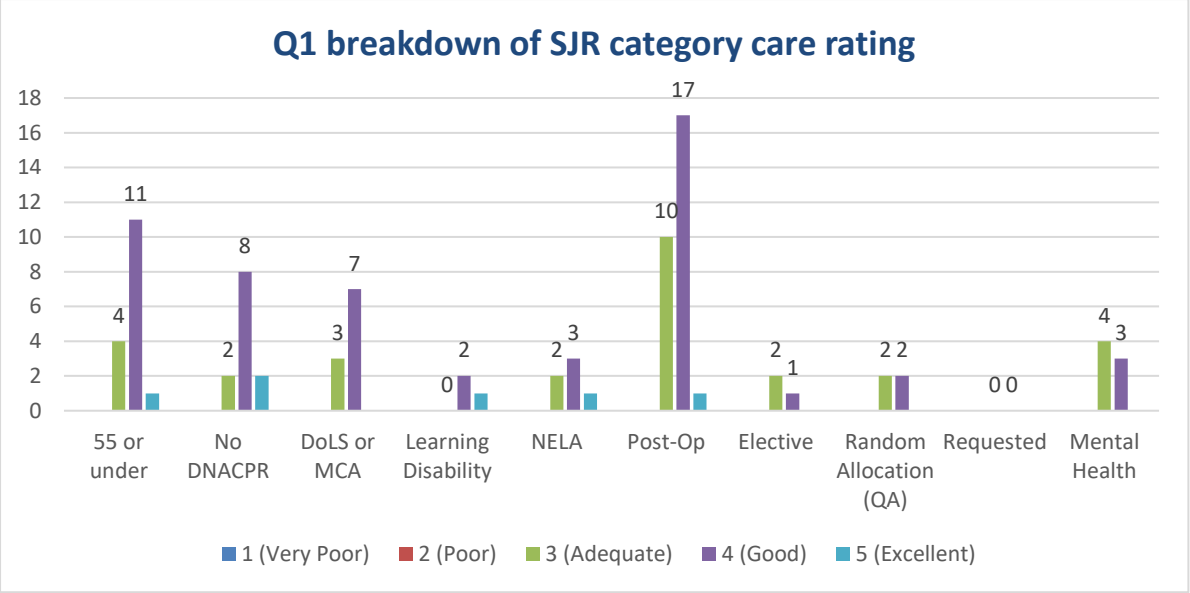
Fig. 2 – Shows the overall and phase of care ratings of the 61 SJRs completed in Quarter 1.

Phase of Care *	**N/A**	**Very Poor**	**Poor**	**Adequate**	**Good**	**Excellent**
First 24 hours/admission	0	0	0	18	38	5
Ongoing care	0	0	0	22	26	1
Care during procedure	0	0	0	9	12	1
End of life care	0	0	2	13	24	2
Patient records/documentation	0	0	0	20	40	1
Overall care	**0**	**0**	**0**	**20**	**38**	**3**

- For the SJRs completed within Quarter 1, there have been 0 'poor' care ratings for the 'Overall Care'.

- All other phases of care and documentation records including overall care had a majority of 'good' ratings with 3 receiving an 'excellent' rating.

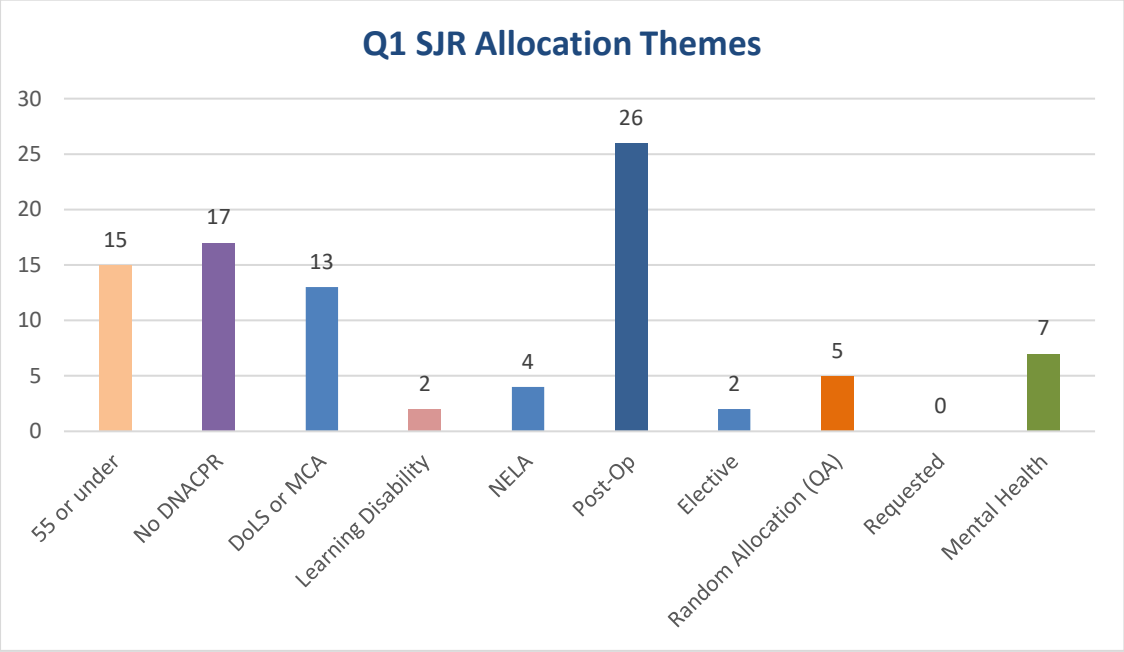
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 1.



- Most categories are predominantly receiving good/adequate care.
- Random Allocation patients show 'good' and 'adequate' care ratings. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

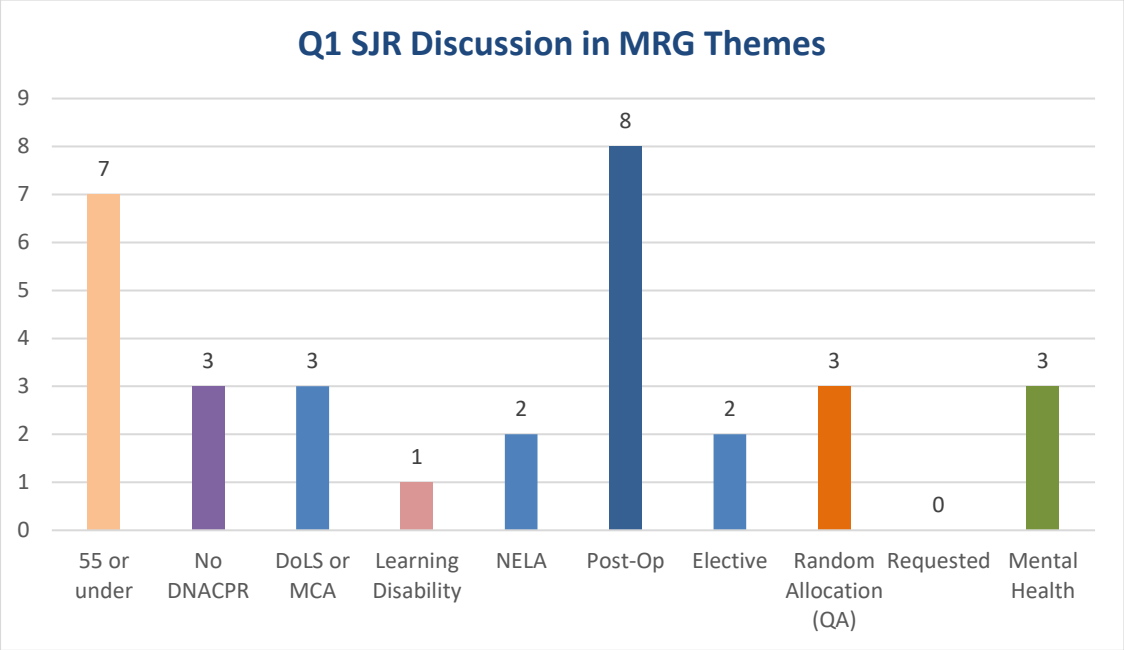
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 1.



- 'Post-Op' was the most frequently allocated category to reviewers in Q1.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP.

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 1.



- The category with the highest number of SJR's requiring further discussion at MRG in Q1 is 'Post-Op'.

Requested allocations are used by the Clinical Effectiveness Coordinator when the death does not meet the SJR criteria, but a review has been requested from another organisation.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
A patient presented with a deteriorating viral-type illness and respiratory symptoms. Initial assessment and ongoing management were considered appropriate, including imaging, ECG and antibiotics. Although there was a delay in completing an echocardiogram despite raised troponin and pericardial fluid, this was considered unlikely to have changed the outcome due to the	• Mortality Chair to raise the query of delays for inpatient echocardiogram – to include what safety netting/risk assessing is in place and if earlier intervention could have made a difference (although noted unlikely to have changed the outcome for the patient)

patient's rapid deterioration and refractory cardiac arrests. The case identified a need to review inpatient echocardiogram delays, associated safety-netting and risk assessment processes. The review identified that while the initial assessment and clinical management were appropriate, there was a delay in completing the inpatient echocardiogram despite clinical indicators including raised troponin and evidence of pericardial fluid. Although this was considered unlikely to have altered the outcome due to the patient's rapid deterioration, the case highlights the need for stronger oversight of delayed inpatient echocardiograms, including clear safety-netting, risk assessment and escalation arrangements for patients with potentially significant cardiac findings. This learning should support improved assurance that delays in diagnostic investigations are actively monitored, clinically prioritised and escalated where deterioration risk is identified.	
A 78-year-old frail patient was admitted following confusion, diarrhoea and a fall at home, with a possible long lie. Investigations and treatment, including CT head, infection management and electrolyte correction, were appropriate, and delirium was diagnosed. However, missed opportunities were identified for earlier DNACPR and treatment escalation planning discussions, despite frailty, multiple comorbidities and clinical deterioration during admission. The patient subsequently suffered a PEA arrest and underwent a resuscitation attempt that was considered futile and likely compromised dignity at end of life. The case highlights the importance of earlier recognition of frailty, comorbidities and clinical deterioration	Clinical Effectiveness Coordinator to add this case to the DNACPR workstream and send to Deputy Mortality Chair – to look at specific feedback to the concerned specialty

as prompts for timely DNACPR and treatment escalation planning discussions. Although clinical assessment and treatment were appropriate, opportunities were missed to consider and document ceilings of care before the patient deteriorated further. The learning is that anticipatory decision-making should be strengthened for frail patients at risk of deterioration, to ensure care remains proportionate, clearly communicated and aligned with maintaining dignity at end of life.	
A 65-year-old patient with multiple comorbidities was admitted with shortness of breath and confusion, with evidence of acute illness including high NEWS, raised CRP, AKI and low blood pressure. A DNACPR discussion took place during the post-take ward round; however, four days later CPR was commenced following a cardiac arrest as staff were unaware that a DNACPR was in place. The case identified poor handover and communication of DNACPR status, resulting in CPR being delivered despite a DNACPR decision being documented. The case highlights the need for reliable communication and handover of DNACPR decisions across ward, ED and out-of-hours teams. Although a DNACPR decision had been documented, this was not clearly recognised at the time of the patient's arrest, resulting in CPR being commenced inappropriately. The learning is that DNACPR status must be clearly visible, consistently handed over and checked during clinical review, escalation and emergency response, to ensure care aligns with documented decisions and avoids inappropriate intervention at end of life.	• Clinical Effectiveness Coordinator to send MRG invite to Associate Chief Nurse for Unplanned Care to support with highlighting ED related issues raised in MRG reviews. • Clinical Effectiveness Coordinator to add case to ED workstream to highlight recurrent theme of documentation/handover issues

A 78-year-old patient was admitted with acute respiratory failure and pulmonary oedema, requiring escalation to ITU, high-flow oxygen and NIV. The patient had a complex admission including pleural effusions with infection, type 2 myocardial infarction, suspected septic arthritis requiring aspiration, a further post-operative ITU admission, VRE infection, low mood with limited engagement in mental health review, and later palliative referral with IPOC commenced. A delay was noted in discharge from ITU back to the ward despite repeated attempts. The case highlights the impact that delayed step-down from ITU can have on patients with complex, multi-factorial needs. Although the patient required appropriate escalation and specialist input during admission, the delay in transfer back to a ward despite repeated attempts suggests a need to strengthen oversight of ITU discharge delays, escalation routes and patient flow processes. The learning is that delayed ward moves should be monitored and escalated where they may affect recovery, rehabilitation, psychological wellbeing, continuity of care or timely transition to end-of-life care.	• Clinical Effectiveness Coordinator to send case to Specialist Nurse Practitioner to look into further and if needed raise the issue with patient flow/ bed managers • Specialist Nurse Practitioner to attend ITU Governance meeting in which data is recorded for delayed discharges • Clinical Effectiveness Coordinator to add this case to the '*Items to escalate to Patient Safety & Effectiveness Sub Committee where there are active/potential risks'* section of the HLBP to highlight ward move delays and the detrimental effect this can have on patients to senior teams
MRG Newsletters **Appendix 1** – MRG Newsletters shared during Q1. (no newsletter was produced in June 2026) **April 2026:** Recognition of Dying in the Hospital Setting- Our Data **May 2026:** Safeguarding Vulnerable Adults	

3.3 Learning from Serious Incident investigations:

2 PSII's were reported during the Quarter 1 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a

100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

The SHMI data is the ratio between the actual number of patients who die within 30 days 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 patients treated there.

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'.

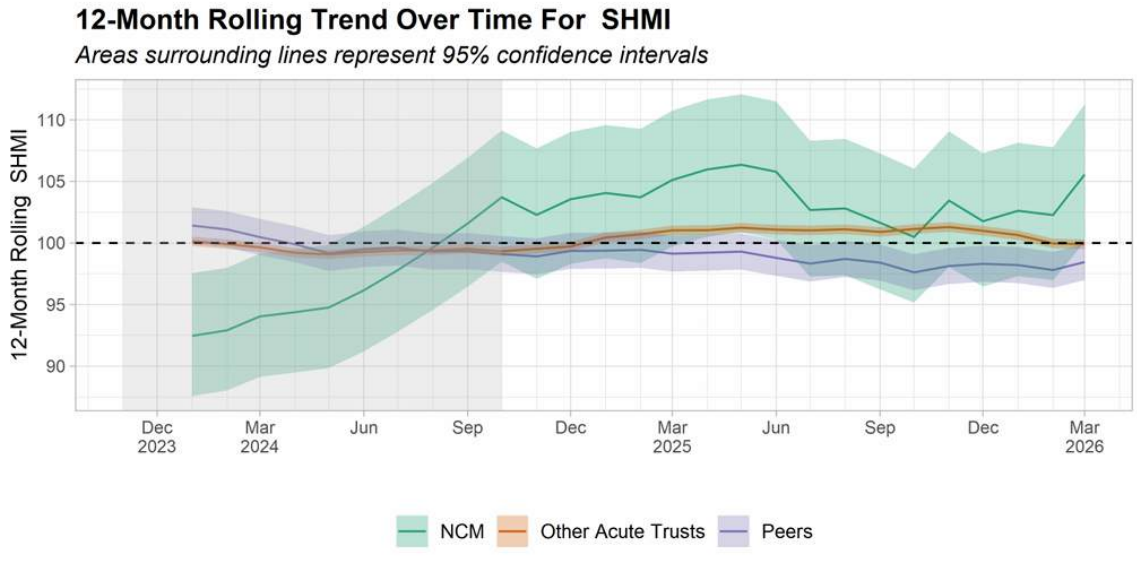
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

3.4 HSMR and SHMI indicators

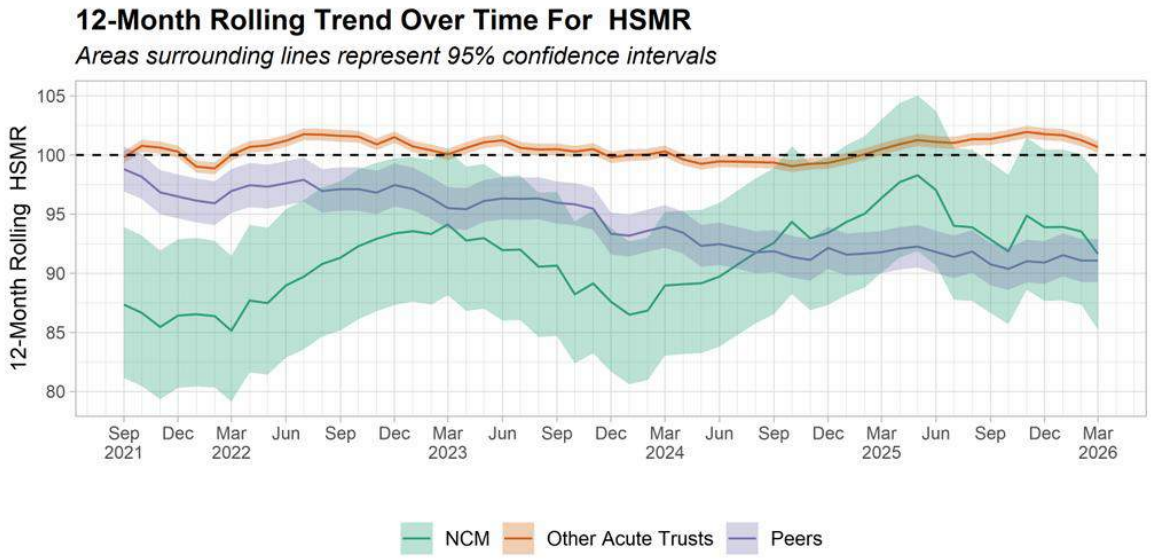
Month	HSMR	SHMI	Total Deaths
February 2026	92.40	101.16	96
March 2026	92.57	101.34	93
April 2026	91.64	105.56	88

HES SHMI for Warrington is 105.56 (April 2025 – March 2026). This result is not an outlier using an over-dispersed funnel plot, but is an outlier based on the stricter Poisson method.



- The SHMI is seen to be increasing in the section of the graph shaded grey (SDEC partially removed).

- NCM's rolling SHMI has recently been very close to the expected value of 100. However, this has risen in the latest 12-month rolling period, which has led to the SHMI becoming statistically significantly high (95% confidence interval is above 100).



4. Monitoring/reporting routes

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee via a high level briefing paper, quarterly to the Quality and Safety Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

5. Timelines

Ongoing - the Mortality Review Group meets monthly (no meeting during August) to review deaths that have been subject to a Structured Judgement Review and require further discussion.

6. Recommendations

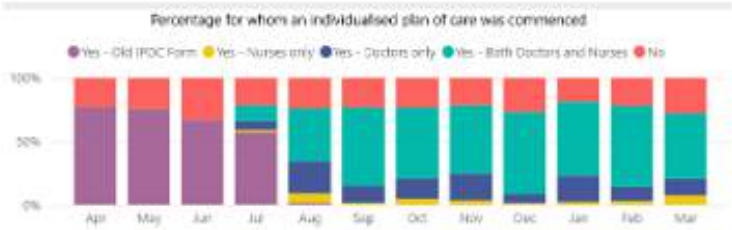
The Committee is asked to note this report.

Appendix One: MRG Newsletters during Q1 (April/May 2026)

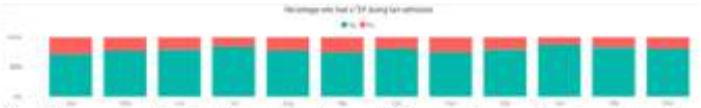
NHS
North Cheshire and Mersey
NHS Foundation Trust

MRG Theme of the month April 2026

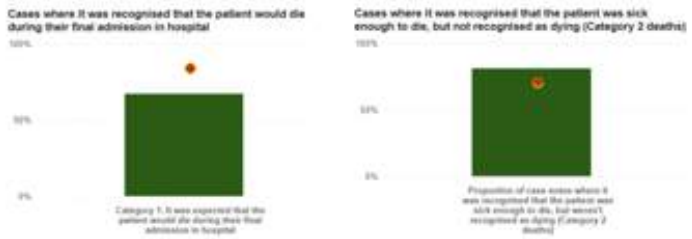
Recognition of Dying in the Hospital Setting- Our Data



In the last fiscal year, local Key Performance Indicators (not including Front Door where sudden deaths occur more frequently, nor ICU when IPOC is not always used once dying is anticipated), dying people were supported by an IPOC between 67%- 81% of the time in Warrington and Halton hospitals. (Breakdowns per specialty and per ward are available.)



For the same cohort, the percentage of those who had had any treatment escalation planning by the time they died (not including CPR Decision Making) ranged from 72% to 88%. (Breakdowns per specialty and per ward are available.)



For the same cohort in 2025, but also excluding those who had sudden, truly unexpected deaths, only 67% of patients in Warrington and Halton hospitals were recognised as dying (bar chart) compared with 84% average in England and Wales and in the Northwest (yellow circle and red diamond). *Interestingly, our hospitals were higher than the national and regional averages at identifying when patients were sick enough that they might die- are we starting AMBER appropriately but then not going through the AMBER ACT daily to identify whether there is improvement or deterioration?*



In 2025, in the survey of bereaved relatives whose loved ones had died in our hospitals, (not including Front Door) only 60% reported that they had been told their loved one was likely to die soon.

Recognition of Dying in the Hospital Setting- Our Learning

What are the disadvantages of not recognising dying early enough, or not at all?

- patient and family left unaware, so their agenda is not met
    - less likely to die in the place they want,
    - spiritual needs less likely to be met,
    - dying people and their families tend to have conversations along the lines of *I love you, I am sorry, Thank you, I forgive you*- they lose this opportunity if you do not tell them they are dying,
- more likely to have unmet symptoms at the end of life and more likely to need anxiolytic or sedating medications
- continuation of burdensome treatments, tests and interventions even when these are no longer providing any benefit
- more likely to be fluid overloaded with all the associated symptoms and risks
- diversion of potentially life prolonging resources away from those who may benefit, e.g. MET Team calls

We miss the opportunity to meet the patient's agenda when we do not tell them they are dying.

What can help?

- At daily team huddles, board rounds and ward rounds;
    - encourage all staff including nurses and resident doctors to make it the norm to raise when someone is clinically deteriorating and **routinely** ask the questions
        - is their recovery uncertain?
        - if they deteriorate despite the current interventions, would they survive escalation, such as intensive care, or is now the right time to ensure appropriate treatment escalation planning?
        - are they deteriorating despite optimal management? Do we know their wishes and what is important to them?

- Use the AMBER Care Bundle appropriately, and not as "IPOC-lite"
    - review daily- if you do not expect them to recover, then AMBER is no longer appropriate as they have moved away from that uncertainty,
    - do not reserve IPOC for when they are no longer able to eat and drink at all, no longer able to articulate at all, but use it when they are dying and likely to be the last weeks or days of life.

- Early specialist palliative care intervention is associated with an increased likelihood of getting that patient out of hospital and to their preferred place of care- refer to hospital specialist palliative care if the patient meets the referral criteria below,
    - any adult patients with a life-limiting diagnosis or for whom recovery is uncertain, and
    - physical, psychological, spiritual, or social needs
    - Reasons for referral include:
        - symptom management
        - challenges facing diagnosis or change in clinical course
        - complex communication issues
        - a need for ongoing specialist palliative care follow-up after discharge
- do not wait until they are dying
- do not wait until potentially life prolonging interventions have been exhausted.

- For patients seen in outpatients likely to be in the last year or so of their life, they will be less likely to die in hospital and less likely to have burdensome interventions which do not benefit them at their end of their life if you;
    - discuss treatment escalation planning and CPR Decision making with them (forms available in outpatients- let them know to bring it in to hospital if ever admitted)
    - gain their consent to be supported by the GP on the Gold Standards Framework (GSF/ palliative care register)
    - add in GP Actions section of letter any treatment escalation decisions made and whether the patient has agreed to be supported by the GSF register- ask GP to commence EPaCCS (Electronic Palliative Care Co-ordination System) and Personalised Care Planning record.

MRG Theme of the Month: Safeguarding Vulnerable Adults - May 2026

Case Study: Out-of-Hospital Cardiac Arrest in a Vulnerable Patient

40-year-old female

Initially, the patient was referred to the Northwest Ambulance Service (NWAS) for a panic attack. After walking out with the crew, the patient collapsed. The patient was found to be in PEA (pulseless electrical activity). A ROSC was achieved, and an iGel was placed pre-hospitally. The patient was intubated in the Emergency Department and subsequently admitted to the Intensive Treatment Unit (ITU).

The patient had a complex medical history, including:
- Excessive alcohol use
- Epilepsy
- Anxiety and depression

Emergency Department Insights:
Interestingly, she had a previous visit to the ED, where she suffered from seizure-related shoulder pain. At that time, she had not been adhering to her prescribed medications. After her discharge with antiepileptic medications, her chaotic lifestyle was noted, highlighting a concerning lack of organisation in her daily life.

Inpatient Journey:
As her hospital stay progressed, a CT scan of her abdomen revealed alarming signs of ischemic bowel. A surgical review sparked discussions about high-risk and palliative surgery with her family. Under ITU care and with input from multiple specialties, further diagnostics revealed:
- A transoesophageal echocardiogram (TOE) showed a mitral valve lesion, marked stenosis, and severe regurgitation.
- Blood cultures identified Staph gallolyticus
- Repeat imaging indicated global hypoxic-ischemic brain injury, confirmed by EEG findings.

Despite receiving maximum medical support, she showed no meaningful neurological recovery after sedation was lifted. Following heartfelt discussions with her family, a mutual decision was made to withdraw care.

Identified Safeguarding Concerns:
During her time in the ED, the Adult Safeguarding Team was notified due to several key observations:
- An unkempt appearance
- Documentation from NWAS outlining poor living conditions

This led to the initiation of a Section 42 safeguarding enquiry, focusing on:
- Self-neglect
- Potential modern slavery concerns

Key Learning Points:

1. Early Safeguarding Considerations: Early safeguarding considerations are essential, including the prompt reporting of concerns and safeguarding notifications for vulnerable individuals with care and support needs.

2. Look Beyond Presenting Complaints: Non-specific symptoms, such as panic attacks, may conceal deeper medical and social risks. Ambulance service information can provide valuable context.

3. Recognise Self-Neglect as a Safeguarding Issue: Issues with medication, living conditions, and frequent ED visits should prompt further investigation.

4. Shared Responsibility in Safeguarding: Early engagement with safeguarding teams allows for comprehensive multi-agency reviews to support vulnerable adults.

For assistance, please get in touch with our Safeguarding Team:

Safeguarding Office: Ext 5153 or 01925 275 553
Safeguarding Email: whh.safeguardingadults@nhs.net
Safeguarding Bleep: 218
The safeguarding team's working hours are between 08.30 and 16.30, Monday to Friday (except on bank holidays).

Let's remember, safeguarding vulnerable adults is not just a duty; it's a shared commitment to their well-being.

North Cheshire and Mersey
NHS Foundation Trust

Strategic People Committee

Agenda reference:	**SPC/26/08/093**			
Subject:	**Guardian of Safe Working Hours Q1 report**			
Date of meeting:	19 August 2026			
Action required:	**To Note**			
Author(s):	Zinnirah Zainodin, Guardian of Safe Working Hours			
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:	Paul Fitzsimmons, Executive Medical Director			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	The Guardian of Safe Working Hours (GoSWH) provides oversight for approximately 253 doctors across North Cheshire and Mersey NHS Foundation Trust, comprising 208 resident doctors and approximately 45 locally employed doctors. During Quarter 1 (April to June 2026), 166 Exception Reports were submitted, of which 150 (90.4%) were approved. Reporting levels remained broadly consistent with Quarter 4 2025/26 and continue to reflect the impact of workload pressures, staffing challenges and increasing patient acuity across acute services. Medicine and Surgery accounted for the majority of reporting activity, with Obstetrics & Gynaecology demonstrating increased reporting compared with the previous quarter. Unscheduled late finishes remained the predominant reason for Exception Reporting, accounting for 94.7% of approved reports. Most approved reports resulted in either Time Off in Lieu or payment, demonstrating			

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.

	effective local resolution of concerns raised through the Exception Reporting process. Twenty-three reports identified a potential impact on patient safety; however, no immediate or unmitigated patient safety concerns requiring formal escalation were identified. Two validated contractual breaches were recorded during the quarter, both within Obstetrics & Gynaecology, resulting in total fines of £606.27. Quarter 1 was the first full reporting period following the Trust's transition to Patchwork. Whilst some data quality issues required local validation and correction, the findings continue to indicate that exception reporting is primarily driven by service pressures rather than widespread contractual non-compliance. No single recurrent or unmitigated specialty-specific risk was identified. Medicine, Surgery and Obstetrics & Gynaecology will remain areas of continued monitoring through the Guardian of Safe Working Hours process.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Strategic People Committee is requested to: 1. Note the contents of the Quarter 1 Guardian of Safe Working Hours Report. 2. Note that 166 Exception Reports were submitted during Quarter 1 and that 150 were approved. 3. Note that two validated contractual fines occurred during the reporting period, both within Obstetrics & Gynaecology. 4. Note the recurring themes of staffing pressures, workload intensity, inadequate clinical support and unscheduled late finishes identified through Exception Reporting. 5. Support continued monitoring and escalation of recurrent issues through the Guardian of Safe Working Hours process.		
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	***None***		

or requires additional monitoring	
Freedom of information status (foia):	Release document in full
Freedom of information exemptions applied: ***(if relevant)***	None

1. Background/context

The 2016 Junior Doctor (now Doctors in Training) Contract is well established at NCM. Rotas for medical trainees are designed to comply with contractual requirements, and systems are in place to facilitate work schedule reviews when persistent problems arise with individual rotas. Most trainees engage directly with the Guardian of Safe Working Hours (GoSWH) and the medical workforce teams when new issues arise. Issues can also be highlighted through the Resident Doctors Forum, held bimonthly, attended by the Director of Medical Education, the Executive Medical Director, HR colleagues, and rota managers, and chaired by the GoSWH.

The GoSWH attends the Regional Guardian Forum to ensure the Trust performs in line with its peers and participates in both the regional and national Guardian of Safe Working networks.

Additionally, through the national Guardian network, the GoSWH participates in consultations with national employers and the BMA to negotiate changes arising from the agreement reached after the 2024 industrial action. These changes were implemented in February 2026.

Most resident doctors (employed by the Lead Employer) have now moved to the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of monitoring the 2016 Contract for Doctors in Training, the GoSWH is also required to submit data on trainees hosted by NCM to the Lead Employer Guardian of Safe Working Hours, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. Key elements

Overall Activity

During Quarter 1, a total of 166 Exception Reports were submitted.

Outcome	Number
Approved	150
Rejected	10
Withdrawn	4
Pending	2
Total	**166**

Table 1 Q1 Exception Reports

Approval rate: 90.4%, demonstrating good engagement with the Exception Reporting process and timely review through the Guardian of Safe Working Hours and Medical Workforce processes.

During Quarter 1 2026/27, 166 Exception Reports (ERs) were submitted, of which 150 were approved. Reporting activity has remained broadly consistent with Quarter 4

following the implementation of national exception reporting reforms in February 2026, although direct comparison between quarters should be interpreted with caution due to changes in reporting processes and the Trust's transition to Patchwork on 1 April 2026.

The majority of reports related to additional hours worked and unscheduled late finishes, reflecting ongoing service pressures rather than widespread contractual non-compliance. Medicine and Surgery remained the highest reporting specialties, with workload intensity, staffing pressures and high patient acuity continuing to be the predominant themes. Obstetrics & Gynaecology also demonstrated increased reporting activity during the quarter.

It is recognised that resident doctors are disproportionately affected by operational pressures, including workforce shortages, patient flow challenges and increasing clinical complexity, mirroring pressures experienced across the wider NHS. The Guardian of Safe Working Hours will continue to monitor reporting trends, identify emerging concerns and work with specialties to address recurring themes and support safe working practices.

Data Quality and System Changes
Quarter 1 was the first full reporting period following the Trust's transition to Patchwork on 1 April 2026. During data validation, several discrepancies were identified relating to doctor grades, employment categories (Lead Employer versus Locally Employed Doctor) and specialty allocation. These records were reviewed and corrected locally to ensure accurate reporting, and feedback has been provided to the Patchwork team.

In addition, Quarter 1 follows the national exception reporting reforms introduced in February 2026, which may have influenced reporting behaviour and reporting volumes. Comparisons with previous quarters should therefore be interpreted with caution.

The transition to Patchwork has also highlighted limitations in specialty-level reporting. In some instances, rota and specialty information can be difficult to distinguish, particularly between Acute Medicine and General Medicine, requiring local validation and manual review to ensure accurate categorisation. The Guardian of Safe Working Hours will continue to work with the Patchwork team to improve data quality, reporting accuracy and specialty attribution. Figures presented within this report reflect locally validated data and will contribute to establishing a reliable post-reform and post-Patchwork baseline for future reporting.

Please see Figure 1 for exception reporting trends in previous years.

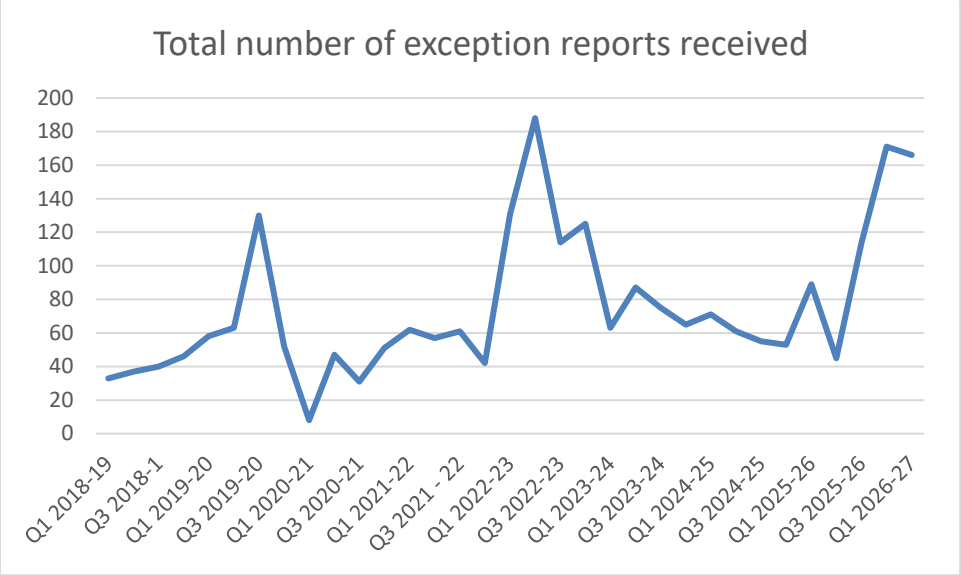


Figure 1 Total Exception Reports by Quarter (2018/19 to 2026/27 Q1)

Fines

The GoSWH is responsible for protecting the safeguards set out in the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.
As per the TCS above, any of the following breaches will incur a financial penalty.

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13-hour shift length; or
- A breach of a maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours of rest in 24 hours has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non resident on-call shift have not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

Grade	No of ERs	Reason	Total (£)
ST3+	2	>13 hours	606.27

Table 2 Fines for Q1

Although small in number, these breaches are significant as they represent occasions where doctors worked beyond contractual safe working limits. Review of Exception Reporting data indicates that reporting activity continues to be driven primarily by workload pressures, staffing shortages, high patient acuity and unscheduled late finishes. No recurrent or unmitigated specialty-specific risks requiring further escalation were identified during the quarter, although reporting patterns will continue to be monitored through the Guardian of Safe Working Hours process.

Financial penalties arising from contractual breaches are managed in accordance with NHS England guidance. A proportion of the fine is paid directly to the reporting doctor,

with the remaining balance retained within a ring-fenced Guardian of Safe Working Hours fund to support resident doctor wellbeing, training and working-life improvement initiatives through the Resident Doctors Forum.

Patient Safety

During Quarter 1, 23 approved Exception Reports identified a potential impact on patient safety, representing 15.3% of all approved reports. These reports were reviewed through the Guardian of Safe Working Hours process and were predominantly associated with staffing pressures, high patient acuity, workload intensity and unscheduled late finishes.

No immediate or unmitigated patient safety risks requiring formal escalation were identified during the reporting period. However, the number of reports highlighting potential patient safety concerns reinforces the importance of Exception Reporting as an early warning mechanism for identifying operational pressures within clinical services.

The GoSWH will continue to monitor patient safety themes, particularly within Medicine and Surgery, where the majority of Exception Reports originated, and will work with specialties to address recurring concerns through existing governance processes.

Detriment survey

Detriment Survey Metric	Q1 2026/27
Response Rate	25/253 (9.9%)
Experienced Actual Detriment	3/25 (12.0%)
Not Discouraged from Reporting	21/25 (84.0%)

Table 3 Detriment Survey report

A detriment survey was undertaken during Quarter 1 to assess doctors' experiences of Exception Reporting and any perceived detriment associated with raising concerns. Twenty-five responses were received from a workforce of approximately 253 doctors under Guardian of Safe Working Hours oversight, representing a response rate of 9.9%. Three respondents (12.0%) reported experiencing actual detriment following Exception Reporting activity, whilst 21 respondents (84.0%) reported that they had not experienced discouragement from raising concerns. Although survey response rates remain low and results should be interpreted with caution, the findings differ from Quarter 4 and will continue to be monitored through future survey cycles to determine whether this reflects emerging concerns or normal survey variation. Findings will continue to be monitored through the Guardian of Safe Working Hours process to promote a positive reporting culture and ensure concerns can be raised without fear of adverse consequences.

Themes for Q1 (1 April 2026 – 30 June 2026)

Grade Breakdown

The highest reporting groups during Q1 were:

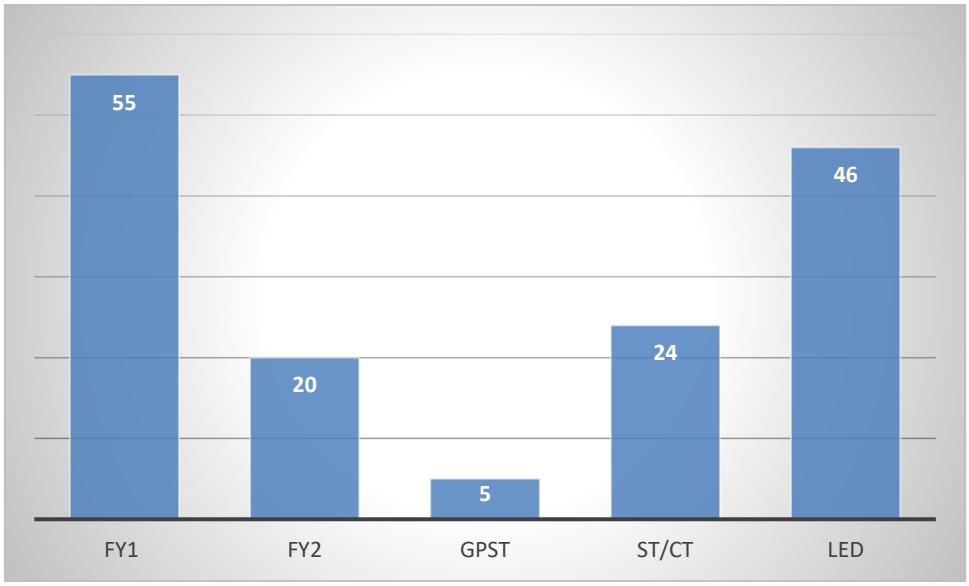


*Figure 2 Grade of doctors. *LED (Locally Employed Doctors)*

FY1 doctors continue to represent the largest reporting group, accounting for approximately one third of all exception reports submitted.

Exception Report Categories

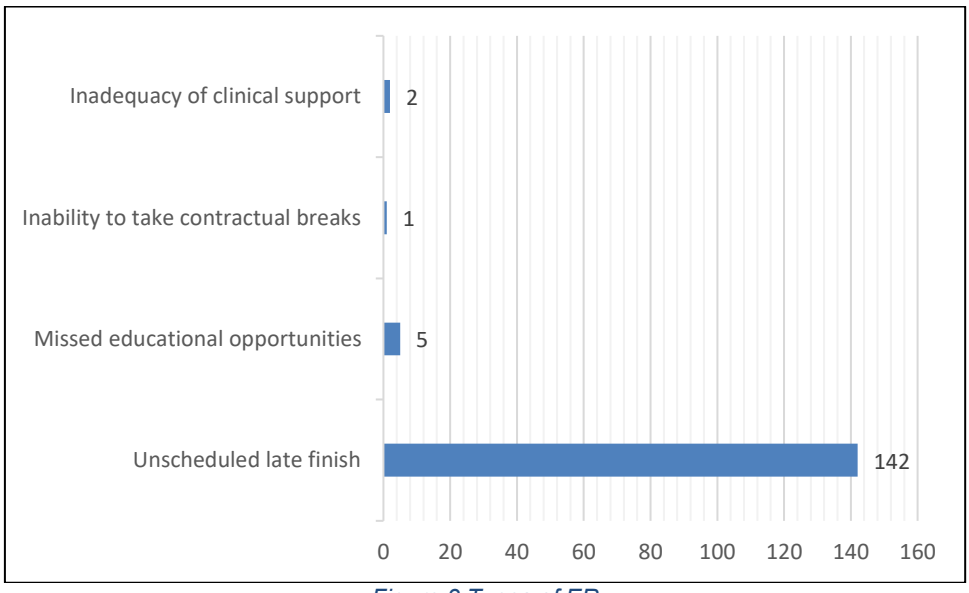


Figure 3 Types of ER

The vast majority of approved reports related to unscheduled late finishes (94.7%).

Specialty Breakdown

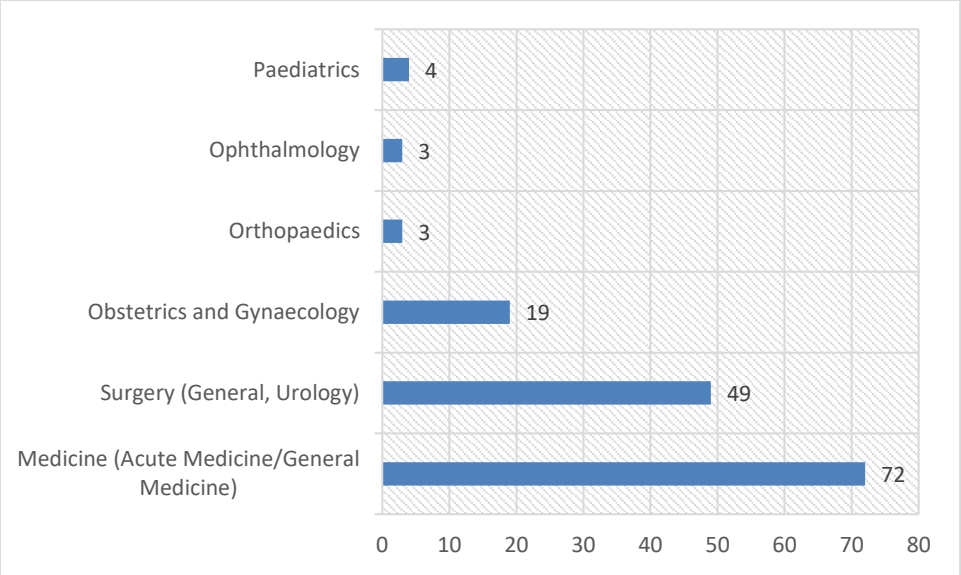


Figure 4 ER as per specialties

Medicine and Surgery accounted for 121 of 150 approved reports (80.7%), demonstrating that Exception Reporting activity remains largely concentrated within the Trust's busiest acute specialties.

The majority of reports from Medicine and Surgery related to unscheduled late finishes caused by workload pressures, staffing shortages, discharge activity, patient acuity and completion of urgent clinical tasks. Obstetrics & Gynaecology accounted for 19 reports and was the only specialty to generate contractual fines during the reporting period. Paediatrics, Orthopaedics and Ophthalmology generated comparatively low levels of reporting activity.

Key Themes Identified

The most common reasons for Exception Reporting during Q1 were:

- Unscheduled late finishes.
- Staffing shortages.
- Increased patient acuity.
- Excessive workload.
- Inadequate clinical support.
- Missed educational opportunities.

Recurring reports from Medicine, Surgery and Obstetrics & Gynaecology suggest ongoing workforce pressures within these services.

Reports Not Progressing to Approval

Sixteen Exception Reports did not progress to approval during Quarter 1, comprising 10 rejected reports, 4 withdrawn reports and 2 reports pending review.

The majority of rejected reports were due to administrative or procedural reasons, including late submission outside contractual timescales, insufficient supporting evidence, GP placement reporting requirements and reports relating to locum shifts requiring alternative payment arrangements.

Overall, the concerns described within non-approved reports were consistent with those identified in approved Exception Reports; however, most did not progress due to procedural or evidential factors rather than the nature of the concern itself.

Themes by Specialty

Medicine (Acute Medicine / General Medicine) – 72 Reports
Medicine remained the highest reporting specialty during Quarter 1, accounting for 72 approved Exception Reports (48%). Although this is lower than the 91 reports in General Medicine during Q4, Medicine continues to generate the largest volume of Exception Reports across the organisation. The predominant themes remained staffing pressures, workload intensity, high patient acuity and unscheduled late finishes. These findings suggest that underlying service pressures remain broadly consistent with those identified in Q4.

Surgery (General Surgery / Urology) – 49 Reports
Surgery generated 49 approved Exception Reports during Quarter 1, similar to Q4 (50 reports). Reports continued to be associated with busy on-call periods, high patient volumes, discharge activity and delays in completing clinical tasks. The consistency of reporting between quarters suggests ongoing operational pressures within surgical services rather than a new or emerging concern.

Obstetrics & Gynaecology – 19 Reports
Obstetrics & Gynaecology demonstrated a notable increase in reporting activity compared with Q4, when only a small number of reports were recorded. Quarter 1 reports primarily related to workload pressures, emergency clinical activity and unscheduled late finishes. The specialty also accounted for both validated contractual fines during the reporting period. Feedback from the Resident Doctors Forum highlighted concerns regarding staffing, supervision and clinical workspace, which will continue to be monitored through local governance arrangements.

Overall Themes Summary
Medicine and Surgery remained the predominant sources of Exception Reporting during Quarter 1, consistent with Quarter 4 findings and reflecting continued pressure across core acute services. Obstetrics & Gynaecology demonstrated increased reporting activity compared with the previous quarter and was the only specialty associated with contractual fines. Across all specialties, the recurring themes remained staffing pressures, high patient acuity, workload intensity and unscheduled late finishes. No single recurrent specialty-specific risk requiring immediate escalation was identified; however, Medicine, Surgery and Obstetrics & Gynaecology will remain areas of focused monitoring by the Guardian of Safe Working Hours.

Resident Doctors' Forum
The Resident Doctors Forum met on 7 July 2026 and discussed themes consistent with Exception Reporting data, including staffing pressures, workload intensity, educational opportunities and rota management. Particular concerns were raised regarding staffing and clinical workspace within Obstetrics & Gynaecology, as well as workload pressures within Medicine. Issues relating to annual leave management and Patchwork implementation were also discussed and escalated through the appropriate governance processes.

Rota Gaps
As part of the overview of resident doctors' wellbeing and work pressures, the GoSWH is expected to oversee rota gaps in training programmes. As with all trusts, both regionally and nationally, NCM has noted an increase in LTFT resident doctors and rota gaps, with the lead employer not allocating sufficient doctors to fill all training programme slots. LTFT posts compound pressure on rotas, as the lead employer does not backfill them and often leaves 20–40% uncovered. This, in turn, increases the pressure on FT doctors working those rotas. Although not within the remit of the GoSWH, this contributes to locum expenditure, and specialties seek to mitigate this by recruiting locally employed doctors where possible and by consultants/SAS acting down, which increases cost pressures.

3. Actions required/responsible officer

The Guardian of Safe Working Hours will continue to:

- Monitor recurrent reports relating to staffing pressures and unscheduled late finishes.
- Escalate recurring themes to Divisional and Specialty Leads.
- Continue targeted oversight of Medicine, Surgery and Obstetrics & Gynaecology.
- Support doctors and supervisors to ensure timely submission and review of Exception Reports.
- Monitor compliance breaches and contractual fines through quarterly reporting arrangements.

Responsible Officer: Guardian of Safe Working Hours.

4. Measurements/evaluations

Compensation Outcomes

Of the 150 approved Exception Reports:

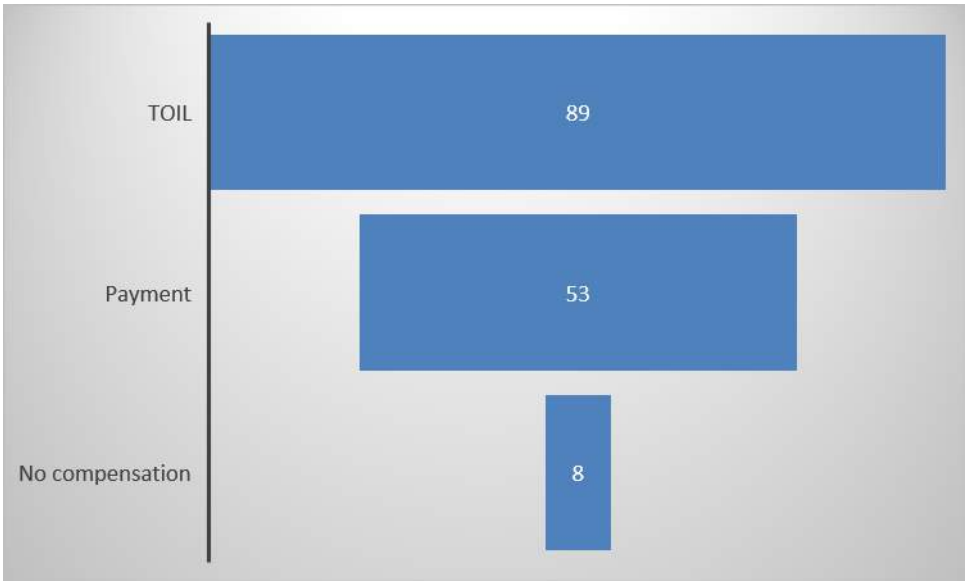


Figure 5 Outcomes of ER

Time Off in Lieu remained the most common outcome following approval of Exception Reports. Overall, **94.7% of approved reports resulted in either TOIL or payment**, demonstrating effective local resolution of concerns raised through the Exception Reporting process.

Performance indicators monitored through the GoSWH process include:

- Number of Exception Reports submitted.
- Approval rates.
- Compensation outcomes.
- Contractual breaches and fines.
- Specialty-specific reporting trends.
- Patient safety concerns.
- Educational exception reports.

5. Trajectories/objectives agreed

Objectives for Quarter 2 include:

- Maintaining timely review and closure of Exception Reports.
- Improving awareness of Exception Reporting processes and contractual submission requirements.
- Monitoring recurring staffing pressures identified within Medicine, Surgery and Obstetrics & Gynaecology.
- Reducing avoidable late finishes where operationally possible.
- Continuing proactive review of contractual breaches and compliance concerns.
- Supporting trainees to report missed educational opportunities where training is impacted.

6. Monitoring/reporting routes

Exception Reporting activity is monitored through:

- Guardian of Safe Working Hours oversight.

- Medical Workforce Team review.
- Divisional governance structures.
- Resident Doctors Forum.
- Quarterly reporting to the Strategic People Committee.

7. Timelines

- Monthly review of Exception Reports and contractual breaches.
- Quarterly reporting to Strategic People Committee.
- Immediate escalation of significant patient safety concerns through existing governance processes.
- Ongoing review of recurring themes to support local improvement actions.

8. Assurance committee (if relevant)

This report provides assurance to the Strategic People Committee regarding compliance with safe working arrangements for doctors in training and supports organisational oversight of workforce risks associated with medical staffing, workload pressures and contractual compliance.

9. Recommendations

The Strategic People Committee is asked to:

6. Note the contents of the Quarter 1 Guardian of Safe Working Hours Report.
7. Note that 166 Exception Reports were submitted during Quarter 1 and that 150 were approved.
8. Note that two validated contractual fines occurred during the reporting period, both within Obstetrics & Gynaecology.
9. Note the recurring themes of staffing pressures, workload intensity, inadequate clinical support and unscheduled late finishes identified through Exception Reporting.
10. Support continued monitoring and escalation of recurrent issues through the Guardian of Safe Working Hours process.

North Cheshire and Mersey
NHS Foundation Trust

Finance, Sustainability and Performance Committee

Agenda reference:	**FSPC/26/09/110**			
Subject:	**Senior Information Risk Owner (SIRO) Report 2025/26**			
Date of meeting:	28 September 2026			
Action required:	The committee is asked to note the contents of the report.			
Author(s):	Mark Ashton with contributions from Stephen Deacon, Sharon Ormesher and Lucy Brierley.			
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:	Paul Fitzsimmons, Executive Medical Director			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	This report provides assurance to the Committee on the management of information governance, data security and cyber security risk across North Cheshire and Mersey NHS Foundation Trust during 2025/26, including performance against the Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT). The Trust continues to maintain established governance, monitoring and control arrangements. During the reporting period, applicable high-level NHS England cyber alerts were addressed within required timescales, critical security patching remained up to date, and further progress was made in reducing legacy infrastructure risk. There remain areas requiring continued management attention, including legacy infrastructure, outstanding CAF-aligned DSPT requirements, third-party access and			

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.

<table>
<tr><td></td><td colspan="3">information governance risks. These have identified owners and mitigating actions and are subject to ongoing monitoring and escalation through established governance arrangements.

The SIRO is reasonably assured that appropriate governance, controls and monitoring arrangements are in place to manage information governance, data security and cyber security risks. The key assurance priority for 2026/27 will be completion of outstanding CAF-aligned DSPT actions and continued alignment of Acute and Community information governance and cyber security arrangements as a single NCM organisation.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Finance, Sustainability and Performance Committee is asked to:
Note the assurance provided by the SIRO regarding the effectiveness of the Trust’s information governance, data security and cyber security arrangements during 2025/26.
Note the residual information and cyber security risks identified within the report and the mitigating actions and governance arrangements in place to manage and escalate these risks.
Note the outstanding CAF-aligned DSPT improvement actions and the ongoing programme of work to meet the Trust’s future submission requirements.
Note the continued work to align Acute and Community information governance, cyber security and information risk management arrangements as part of the development of a single NCM approach.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Partial FOIA exempt</td></tr>
<tr><td>Freedom of information exemptions applied: (if relevant)</td><td colspan="3">Section 31-Law Enforcement</td></tr>
</table>

1. Background/context

The objective of this SIRO report is to inform the board of progress against the Information Governance/Data Security and Protection work programme for the period of the 2025/26 financial year. It contains a quantitative and qualitative analysis using information obtained from the Datix risk and incident system, Cyber Alert Portal, ITHealth Assurance Dashboard, the Cyber Assessment Framework-aligned Data Security and Protection Toolkit, MIAA audit reports, and the minutes of the Information Governance and Records Sub-Committee.

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The report includes a summary of key outstanding issues and clarifies the planned actions to resolve these.

The purpose of the report is to ensure that the board understands how the strategic business goals of the organisation may be impacted by information risks and the steps being taken to mitigate those risks. The Trust's Senior Information Risk Owner position is currently held by the Chief Information Officer. The SIRO is responsible for the provision of assurance to the Board that information risks are adequately managed.

NHS organisations must have a Senior Information Risk Owner (SIRO) to provide high-level strategic oversight and accountability for information risks, ensuring compliance with the legal and ethical framework for protecting the information that the trust processes. This framework includes UK Data Protection laws (UK GDPR and the Data Protection Act 2018), the common law duty of confidentiality, and NHS data security policies for the protection of sensitive data. The trust also uses frameworks such as the Cyber Assessment Framework aligned Data Security and Protection Toolkit to assess compliance on an annual basis.

SIRO Assurance Statement:
Based on the assurance and evidence presented within this report, the SIRO is reasonably assured that appropriate governance, controls and monitoring arrangements are in place to manage information governance, data security and cyber security risks across the Trust.

Assurance is not absolute, and residual risks remain, particularly in relation to legacy infrastructure, delivery of outstanding CAF-aligned DSPT requirements, third-party access and information governance controls. These risks have identified owners and mitigating actions and are subject to ongoing monitoring and escalation through established governance arrangements.

As North Cheshire and Mersey continues to integrate Acute and Community services, a key assurance priority for 2026/27 will be the continued alignment of information governance, cyber security and information risk management arrangements across the organisation.

Assurance Dashboard

Assurance Area	Position	SIRO Assurance
IG governance & oversight	Established IGRSC, SIRO/CG Oversight	**Substantial**
Cyber alerts & response	Applicable alerts resolved within timescale	**Substantial**
Pathing/vulnerability	Critical patching current	**Substantial**
Legacy infrastructure	Server migration progressing residual risk	**Moderate**
CAF/DSPT	Important actions remain	**Moderate**
Information incidents	10 reported to ICO; no further regulatory action	**Moderate**

2. Key elements

The assurance section of the report is divided into six distinct areas. The relevance of each section is described below.

- **Information Governance Framework**

In line with objective A of the Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) the trust must demonstrate that appropriate organisational structures, policies and processes are in place to understand, assess and systematically manage risks to the security and governance of information, systems and networks supporting essential functions.

The Information Governance (IG) Framework describes the structure in place to manage the burgeoning data security agenda and the key staff involved in that process.

- **Information Risk Analysis**

The trust must demonstrate that robust processes are in place to understand and manage identified and significant risks to sensitive information and services. The information risk analysis element of this report describes the arrangements in place to manage such risks.

- **Data Security and Protection Toolkit Performance**

The CAF-aligned Data Security and Protection Toolkit is an updated self-assessment tool for health and social care organisations in the UK which aligns with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF).

The Trust must submit a twice annual assessment of its performance against the standards within the 5 objectives within the toolkit which focus on:

- Managing Risk
- Protecting against cyber-attacks and data breaches
- Detecting cyber security events

- Minimising the impact of incidents
- Using and sharing information appropriately

The DSPT performance section of this report articulates the current compliance position, areas of weakness, and the June 2025 DSPT submission.

- **Cyber Security Arrangements**

The cyber threat landscape continues to evolve rapidly and remains one of the most significant risks facing the NHS. Healthcare organisations are increasingly targeted by a broad range of threat actors, including organised cyber-criminal groups, state-sponsored actors, hacktivist, and opportunistic attackers seeking to exploit vulnerabilities in critical systems and supply chains. Recent geopolitical tensions and international conflicts have contributed to heightened cyber activity directed towards organisations delivering critical public services, including healthcare. The National Cyber Security Centre (NCSC) continues to warn that organisations providing essential services should expect sustained attempts to compromise systems, disrupt operations, and access sensitive information.

Cyber security is therefore no longer solely an information technology concern, it is a patient safety, operational resilience, and organisational governance issue. The increasing reliance on digital systems to support clinical and corporate services means that cyber incidents have the potential to impact service delivery, access to information, and the trust's ability to provide safe and effective care.

The trust works closely with NHS England, the NHS Cyber Security Operations Centre (CSOC), and the National Cyber Security Centre (NCSC) to strengthen cyber resilience, manage cyber risk, and respond effectively to emerging threats. The trust maintains formal arrangements for receiving, assessing, and acting upon national cyber alerts and continues to develop its cyber security capability through proactive monitoring, vulnerability management, cyber incident response planning, workforce awareness, and alignment with the Cyber Assessment Framework (CAF) through the Data Security and Protection Toolkit (DSPT).

- **Externally Reported Data Security Incidents**

In line with Objective D of the DSP Toolkit the trust must have a procedure in place to ensure that data security and protection incidents are managed and reported appropriately and that lessons are learned.

This section of the report contains detail related to 2024/25 data security incidents deemed of the requisite severity for reporting via the DSP Toolkit incident reporting tool. In some cases, incidents will have been escalated to the Information Commissioner’s Office, the Department of Health and Social Care and NHS England

- **The role of the SIRO and the trust's Caldicott Guardian**

In line with DSP Toolkit Objective A the Trust must have effective organisational information assurance management led at Board level. Key to satisfying this objective is an active and engaged Senior Information Risk Owner that takes ownership of the trust's information risks. This individual is known as the Senior Information Risk Owner.

In addition to the SIRO all NHS organisations must have a Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of health and care information and making sure it is used properly.

This section of the report explains how both the SIRO and Caldicott Guardian fulfil their roles and demonstrates that they are active and participating in the trust's data security and protection agenda.

2.1 Information Governance Framework

The trust's DSP annual work plan (cycle of business) details the standing agenda items which are included at each meeting of the Information Governance and Records Sub-Committee (IGRSC). The cycle of business for 2025/26 was reviewed and approved in February 2026.

The (IGRSC) meets on a bi-monthly basis and is chaired by the trust's Chief Information Officer (SIRO) and is attended by the Caldicott Guardian (Executive Medical Director).

Key Information Governance staff members are:

Acute Based Team

- SIRO (Chief Information Officer)
- Caldicott Guardian (Executive Medical Director)
- Head of Digital Compliance - Stephen Deacon
- Information Governance and Corporate Records Manager/DPO - Mark Ashton

Community Based Team

- Deputy Director of Corporate Governance/DPO-Jan McCartney
- Information Governance Manager-Sharon Ormesher
- Senior Information Governance Officer-Lucy Brierley

The Information Governance and Records Sub-Committee reports directly to the Quality and Safety Assurance Committee and its core members include:

- SIRO (CIO)
- Caldicott Guardian (Medical Director)
- Deputy CIO
- Head of Digital Compliance
- Information Governance and Corporate Records Manager
- Medical Records Manager
- Head of Digital Analytics
- Associate Director of Information
- Key system Information Asset Owners (co-opted as appropriate)

In addition to the IGRSC's reporting obligations to the Quality and Safety Assurance Committee the Audit Committee will be provided with Information Governance related audits conducted by Mersey Internal Audit Agency. Most notably this will include the annual Data Security and Protection Toolkit Assurance Review.

Assurance conclusion: The SIRO is reasonably assured that appropriate governance arrangements are established for oversight of information governance and information risk, with defined SIRO, Caldicott Guardian and IGRSC responsibilities and established escalation routes.

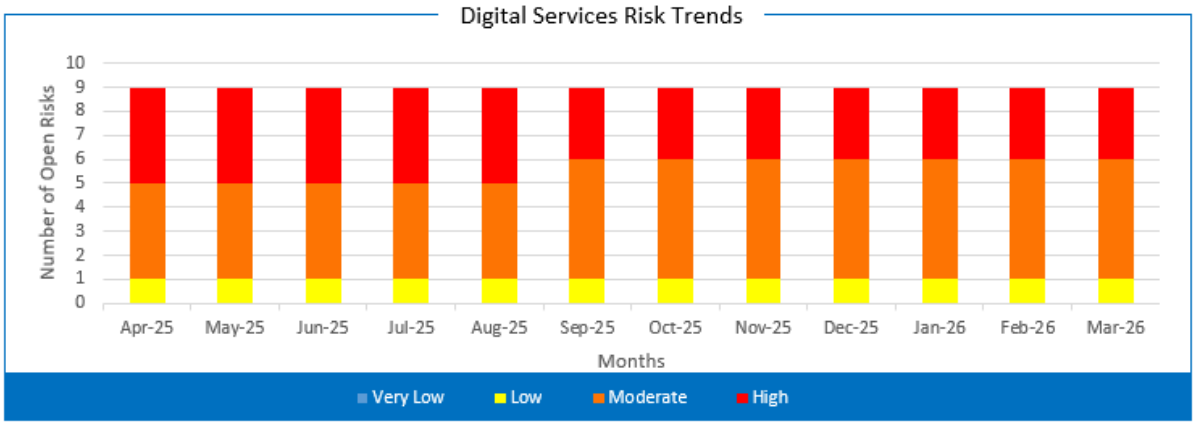
2.2 Information Risk Analysis

Acute Setting

The Head of Digital Compliance manages Digital Services risks for the acute setting, including data security-related risks within the Datix system. Digital Services follow trust policy through monthly risk assessments at Risk Review meetings and quarterly reviews by the trust's Risk Review Group.

Risks and mitigation actions are reviewed by the trust's Risk Review Group. Information Governance and Cyber risks are covered in the agendas of the Information Governance Records Sub-Committee and Digital Service Delivery Group meetings. Risk updates are then escalated to the Quality Assurance Committee (QAC) and Finance and Sustainability Committee (FSC).

The graph shows that the total Digital Services risk score stayed stable in 2025/26, with one risk mitigated (unsupported operating server risk) and one new risk regarding scanned documents into Lorenzo added.



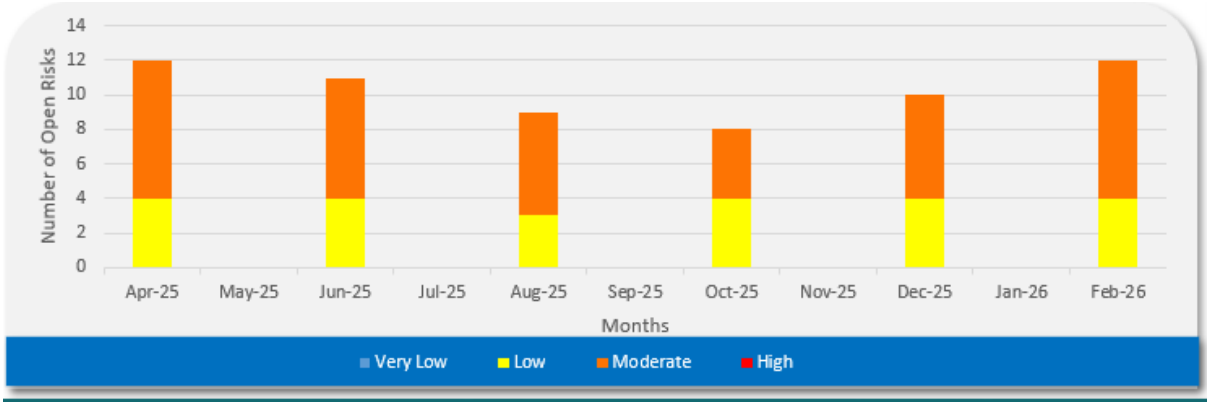
Acute Setting Data Security/Cyber Risks

Risk ID	Risk Description	Outstanding Actions	Rating
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations	• Migrate/decommission Server 2016 Servers. • Multifactor authorisation (MFA/PAM) review of Trust critical systems. • Migrate Windows 10 to Windows 11. • Removal of generic Window accounts.	16
2258	If clinical documents are scanned to incorrect records on Lorenzo (or other clinical systems) then this will result in data quality errors, data loss incidents and potential clinical incidents resulting in detriment to patient treatment, potential fines for data loss, compromised integrity of data in clinical systems and reputational damage	• Review and update SOP to include checks to ensure scanned documents match the right patient. • Approval of and proceed with a scanning bureau creating a full electronic record	12
220	If Digital Services does not have the necessary resources and/or infrastructure resilience, then Digital Services will be unable to implement the requisite NIS Directive (Networks and Information Systems) policies, procedures, and processes resulting in potential unplanned downtime for systems, possible income losses, and regulatory fines of up to 4% of the Trust's annual turnover.	• Data workflow to be remapped - This will improve visibility of how data flows between systems and enable the Trust to more effectively assess the impact of a system outage by identifying which services, processes, and data sets may be affected.	12
202	If smartcard and password sharing occurs, then unauthorised access to electronic personal identifiable data (PID) will be unable to be prevented which could cause inappropriate access to PID and information governance (IG) / data protection breach.	• Perform ward audits post to maintain improved standards 26/27 – Physical security checks will be undertaken to ensure paper-based records are stored securely in locked cabinets and that smartcards are not left in workstations. Workstations must	9

		be locked when unattended to prevent unauthorised access to Trust systems and information.	
208	If the Trust is non-compliant with its information governance (IG) and clear desktop policy, then we will be unable to secure paper medical records in clinical areas which could cause potential breaches of confidentiality.	• Perform ward audits post to maintain improved standards 26/27– Physical security checks will be undertaken to ensure paper-based records are stored securely in locked cabinets and that smartcards are not left in workstations. Workstations must be locked when unattended to prevent unauthorised access to Trust systems and information.	6

Community Setting

During 2025/26, the community team monitored 13 active risks comprising 12 Information Technology risks and one Information Governance risk. Key risk areas included cyber security, digital infrastructure, Electronic Patient Record systems, business continuity, supplier access and records management. One risk scored 12 or above and was escalated to the Risk Management Council. All risks were supported by mitigation plans and subject to regular review. All risk were managed and reported from Ulyssess.



Acute Setting Data Security/Cyber Risks

Risk ID	Risk Description	Outstanding Actions	Rating
2428	Data Security and Protection Toolkit (DSPT) and cyber threats	• Interconnect with WHH completed. • National Cyber Security capital funding (£115K received) for solutions upgrades in conjunction with WHH team/solutions	12
3433	Closure of MLCSU network support arrangements	• Regular meeting with MLCSU • Scoping new provider	12
3439	Cisco telephony cyber vulnerability	• Options appraisal underway, this also looks at the impact on WHH and the strategic future direction for the service in the new NCM organisation. Capital funding being sought.	9
2815	Information systems business continuity and disaster recovery	• Plan in place to deploy a Microsoft Express Route solution at our	9

		Aimes datacentre and this connection will be via our CheckPoint firewalls.	
2948	Capacity and demand for digital developments and optimisation	• Proposed structure in IT services to support functionalities is underway, being reviewed in line with integration.	9
3164	Electronic Patient Record (EPR) governance and contracting arrangements	• Reprocurement of community EPR subject to WHH EPR	9
3249	Management of historical records held in offsite storage	• This risk will remain until records are destroyed. • Iron mountain and Deepstore have had records identified for destruction. • Records management policy has been updated following SI	9
3309	Third-party digital access and supplier security controls	• System procured, roll out planned in line with WHH integration.	9
2572	EPR hazard management and clinical safety	• Updated by CNIO, in line with hazard logs.	6
3262	Internet-facing systems without multi-factor authentication	• IG are working with Information Owners/systems regarding their third party suppliers.	6
3362	Unsupported software within the IT estate	• Plan made to risk assess each software unsupported with the relevant IAO. • Dental have the highest number of unsupported systems.	6

Assurance conclusion: The SIRO is reasonably assured that information and cyber risks are identified, recorded and subject to regular review and escalation. Material residual risks remain across Acute and Community services and will continue to be monitored through established risk.

2.3 Data Security and Protection Toolkit (DSPT) Performance

June 2025 DSPT Submission

Acute setting

The final submission of the 2024/25 DSPT assessment to NHS England took place on June 30th, 2025. Following submission and audit/assurance processes, each trust is awarded an overall DSPT status category as follows:

- Not Published
- Standards Not Met

- Approaching Standards
- Standards Met
- Standards Exceeded

Final publication assessment scores reported by organisations are used by the Care Quality Commission for use as part of the Well Led inspection.

In September 2024 the DSPT adopted the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

The goals of moving to the CAF-aligned DSPT are to:

- Emphasise good decision-making over compliance, with better understanding and ownership of information risks at the local organisation level where those risks can most effectively be managed.

- Support a culture of evaluation and improvement, as organisations will need to understand the effectiveness of their practices at meeting the desired outcomes – and expend effort on what works, not what ticks a compliance box.

- Create opportunities for better practice, by prompting and enabling organisations to remain current with new security measures to meet new threats and risks

The DSPT standards that the acute trust were unable to comply with on making the 2025/26 submission are shown in the table below.

DSPT Evidence Item	Action Required	Owner(s)	Date for Completion
A2.a	To retrospectively to complete DTACs for Critical Systems	S. Deacon/M. Ashton	31/03/2026
A2.b	Need to focus on the lifetime of the a solution	S. Deacon/M. Ashton	31/03/2026
B2.c	Installed a PAM solution (BeyondTrust) configuring for 3rd party vendors to log on and for system/domain admin	Stephen Deacon / IT Service	31/03/2026
B3.a	ROPA documentation to be completed	S. Deacon/M. Ashton	31/03/2026
C1.a	To add firewall logs and DC logs into a SIEM	Stephen Deacon / IT Service	31/03/2026

The DSPT standards that the acute trust were unable to comply with on making the 2025/26 submission are shown in the table below.

DSPT Evidence Item	Action Required	Owner(s)	Date for Completion
A4.a	A review of subcontractors already planned in line with annual review of the IAR. A	Sharon Ormsher	30/06/2026

	digital solution is underway to make the contracts register digital with the IAR to follow including subcontractors. Update the Third-party supplier policy to state review of accreditation as a minimum annually.		30/08/2025
B2.a	A documented process will be completed alongside PAM implementation to support the new system including remote access and exceptions.	Alan Tweddel	30/04/2026

Assurance conclusion: The SIRO is moderately assured regarding CAF-aligned DSPT compliance. Improvement actions have been identified with responsible owners and completion dates; delivery of these actions will remain subject to oversight through the established governance arrangements

2.4 Cyber Security Arrangements

2.4.1 NHS England Cyber Alerts (formerly NHS Digital CareCERTs)

All NHS trusts are required to act upon any critical and high security cyber alerts which are issued by NHS England. Such Cyber Security Bulletins are called Cyber Alerts and organisations are required to confirm that they have taken the requisite action to mitigate cyber threat, or have sought support from NHS England, if they are unable to do so. Any issues are escalated to the trust's SIRO.

The trust continues to use the ITHealth Assurance Dashboard Solution this year which consolidates all areas of the Trusts cyber security into a single, real-time view including our status in respect of the trust's responses to the NHS England issued security Cyber Alerts. The ITHealth Assurance Dashboard gives complete visibility of the status of the trust's network. The dashboard significantly increases our understanding of the security risks we face, and levels of compliance at both a local and national level. Most importantly it provides Digital Services with confidence in the assurance provided to the Board on the security of our IT infrastructure and any risks identified. 81% of mandatory cyber-related requirements contained on the Data Security and Protection Toolkit (DSPT) can be satisfied by the use of the IT Health Assurance Dashboard.

Alongside the ITHealth Assurance Dashboard, the trust has also implemented the Cynerio Medical Device and Internet of Things (IoT) system. This system passively monitors the trust's network to detect and identify medical devices and the Internet of Things, outlining any vulnerabilities and prioritising them based on risk rating.

NHS England issues cyber alerts, ranking them by severity. Upon receiving a high-level cyber alert, the trust must acknowledge it within 48 hours and resolve it within 14 days.

Acute setting

From April 2025 to March 2026, NHS England issued 22 high-level cyber alerts. 4 of the alerts issued directly affected the acute trust all 4 alerts were resolved through appropriate mitigations, with none exceeding the required 14-day resolution period.

The 4 cyber alerts effecting the acute trust were:
CC-4702 - Active Exploitation of Zero-Day Vulnerability CVE-2025-20352 in Cisco IOS and IOS XE
CC-4711 - Microsoft Releases Out-of-Band Security Update for Windows Server Update Service (WSUS)
CC-4738 - Cisco Releases Critical Security Update for Unified Communications Products
CC-474 - BeyondTrust Releases Security Advisory for Remote Support and Privileged Remote Access

Month	High Cyber Alerts Issued by NHS England	Acknowledged with 24 hours	Completed High Cyber Alerts within 14 Days
April 25	1	1	1
May 25	1	1	1
June 25	2	2	2
July 25	1	1	1
August 25	2	2	2
September 25	2	2	2
October 25	5	5	5
November 25	0	0	0
December 25	1	1	1
January 26	2	2	2
February 26	2	2	2
March 26	3	3	3
	22	**22**	**22**

Community Setting
From April 2025 to March 2026, NHS England issued 22 high-level cyber alerts. 2 of the alerts issued directly affected the acute trust all 2 alerts were resolved through appropriate mitigations, with none exceeding the required 14-day resolution period.

The 2 cyber alerts effecting the acute trust were:
CC-4711 - Microsoft Releases Out-of-Band Security Update for Windows Server Update Service (WSUS)
CC-4738 - Cisco Releases Critical Security Update for Unified Communications Products

Month	High Cyber Alerts Issued by NHS England	Acknowledged with 24 hours	Completed High Cyber Alerts within 14 Days
April 25	1	1	1
May 25	1	1	1

June 25	2	2	2
July 25	1	1	1
August 25	2	2	2
September 25	2	2	2
October 25	5	5	5
November 25	0	0	0
December 25	1	1	1
January 26	2	2	2
February 26	2	2	2
March 26	3	3	3
	22	**22**	**22**

2.4.2 Desktop and Server Operating System Patching

Windows updates allow for fixes to known flaws in Microsoft products and operating systems. The fixes, known as patches, are modifications to software and hardware to help improve performance, reliability, and security. There is a patching regime operated routinely on a monthly basis. The patching for both desktop and servers is automated by the use of automated patching software. All critical security patching is up to date.

2.4.3 Migration from Unsupported Operating Systems and Applications

All software will eventually become out of date, after which point, ideally, it should not be used. Using obsolete software compounds two related problems:

- Software will no longer receive security updates from its developers, increasing the likelihood that exploitable vulnerabilities will become known by attackers.
- Latest security mitigations are not present in older software, increasing the impact of vulnerabilities, making exploitation more likely to succeed, and making detection of any exploitation more difficult.

The Windows 11 migration programme is nearing completion, with only five desktop/laptop devices remaining to be upgraded. These devices are currently protected through Microsoft's Extended Security Updates (ESU) offering while are completed.

The trust has also migrated all but nine of its Windows Server 2016 estate ahead of end-of-support, demonstrating significant progress in reducing legacy technology risk.

The trust is within NHS England’s 95% target of using operating systems receiving critical security patches support as no servers or desktops operating systems is currently out of support.

2.4.4 Server Migration Status

Total	Completed	% Complete	Migration Completion Due Date
69	60	87%	October 26

*2016 servers support finishes in October 2026 and after this date they would no longer receiving security patches.

Servers awaiting migration fall into the category of being more problematic to migrate for several reasons. This can be attributed to systems held on servers requiring often complex data migration work to migrate data into new versions of systems which are compatible with newer server operating systems, often requiring additional funding.

The trust is within NHS England's 95% target of using operating systems receiving critical security patches support.

Community Setting

There is a patching regime operated routinely on a monthly basis. The patching for both desktop and servers is automated by the use of automated patching software. All critical security patching is up to date

2.4.5 External Security Rating (Bitsight)

The Digital Services has representation at the regional Cyber Security Group and the Core Cyber Group. This group is a collaboration between the NHS organisations operating within the Cheshire and Merseyside Health ICB. It aims to improve the collective protection from, response to, and recovery from, cyber-attack, to assure the secure delivery of digital systems both within and between the individual organisations. The regional ICB cyber groups are currently developing a ICB wide cyber strategy and looking at the art of the possible with a regional Cyber Security Operations Centre (R-CSOC) and a centralised security dashboard, help provide early warning and a levelling up process for all Trusts.

In conjunction with the regional Cyber Security Groups, Digital Services also have representation at the Cyber Associates Network (CAN). Being a member of the CAN provides enhanced knowledge-sharing, professional development, and networking with peers in health and care. Members also have the chance to influence national cyber security across the system by supporting NHS England's Cyber Security Operations Centre (CSOC) and in developing new national products, services, policies, and strategies.

The Trust uses an external NHS England approved system which calculates a security score and benchmarks the Trust against other organisations within the Healthcare/Wellness industry in 20 major security risk categories. The below graphic

details our security rating trend over the last year. The acute setting is in the upper range of the security score with a rating of 770 (Advanced) which places the Trust within the top 25% of benchmarked healthcare organisations. Alongside signing up with the National Cyber Security Centre (NCSC) early warning system, notifying us of a potential cyber-attack.



2.4.6 Monthly Network Vulnerability Tests

NHS England conduct monthly external network vulnerability assessments on the acute setting trust's network. These tests allow the Trust to detect security weaknesses and flaws that are exposed to the external world on our network, thereby enabling the Trust to gauge the level of security risk and prioritise mitigation plans to address these vulnerabilities and flaws.

Vulnerabilities discovered in network penetration tests are reported to both the Digital Service Delivery Group and the Information Governance and Records Sub-Committee. The reports on these vulnerabilities include a severity score and recommended actions for resolution. The acute setting did not encounter any new vulnerabilities during the 25/26.

Alongside the vulnerability network tests, the trust has applied for NHS England to provide a Cyber Assurance Service test on the following IT Infrastructure areas:

- Network protection assessment.
- Security review for PAS
- File testing.
- Active directory, central security and mobile device review
- Asset security review
- Wireless security review

2.4.7 NHS Secure Boundary

The NHS Secure Boundary provides additional firewall security which effectively allows the Trust to control what passes in and out of our digital estate. This augments the security already deployed by the Trust.

In January 2021, the trust extended the NHS Secure Boundary service to our Internet connection. This strengthens the Trust's cyber-security defences. Use of the NHS Secure Boundary enables NHS England to scan for potential threats in real time,

detecting and neutralising them to help the Trust increase their security protection against cyber-related attacks. The trust is looking at migrating over to NHS Secure Boundary version 2 in the near future which will offer enhanced security features.

Since the installation of the NHS Secure Boundary service, we had several queries regarding the legitimacy of some of the Trust's network traffic. However, all traffic queried has been confirmed as legitimate activity from approved Trust-based systems.

2.4.8 NCSC Early Warning System

The NCSC's Early Warning service processes several UK-focused threat intelligence feeds from trusted public, commercial and closed sources, which includes several privileged feeds not available elsewhere.

Early Warning delivers feeds of the following types of threat information:

- Incident Notifications - Activity that suggests an active compromise of our system.
- Network Abuse Events - Indicators that our devices have been associated with malicious activity.
- Vulnerability Alerts - Indications of vulnerable services running on our devices.

The Early Warning complements the Trusts existing threat intelligence services including Microsoft MDE (formally known as Microsoft's Advanced Threat Protection - ATP) and NHS England's Secure Boundary Service.

Assurance conclusion: The SIRO is reasonably assured that appropriate cyber security monitoring, vulnerability management, patching and incident response controls are operating. Residual risk remains, particularly in relation to legacy infrastructure, and completion of identified

2.5 Externally Reported Data Security Incidents 2025/26

The SIRO is assured that appropriate escalation and external reporting arrangements operated during the period. All ten incidents were appropriately reported and investigated, with the ICO determining that no further regulatory action was required. Themes and lessons arising from incidents continue to be monitored through IGRSC.

NHS England reference	Date reported	Detail	Information Commissioner's Office decision
41816	01/04/2025	Letters sent in error by the Occupational Health team to the wrong consultant's secretary.	The ICO concluded that the incident was not of the requisite severity to

			warrant further action.
43127	06/07/2025	A child's discharge summary was sent to the parents of the wrong child.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
43326	17/07/2025	Email with an attached VFC assessment was sent to the incorrect patient.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
43800	19/08/2025	Patient records shared with incorrect data subject via email.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
44432	01/10/2025	Demographic details of patient A sent by email to patient B in error.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
44839	24/10/2025	Confidential correspondence issued to an incorrect address. System error affected linked communications across multiple organisations.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
45379	26/11/2025	Letter intended for patient A was sent to patient B.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
45853	30/12/2025	A letter generated in the Paediatric team was sent to the wrong patient.	The ICO concluded that the incident was not of the requisite severity to warrant further action.

46179	21/01/2026	A spreadsheet shared with 90 students contained visible details related to other students.	The ICO concluded that the incident was not of the requisite severity to warrant further action.
46951	05/03/2026	Member of staff accessed records for non-business purposes.	The ICO concluded that the incident was not of the requisite severity to warrant further action.

Assurance conclusion: The SIRO is reasonably assured that appropriate incident identification, escalation and external reporting arrangements are operating. Ten incidents were reported and investigated during 2025/26, with the ICO determining that no further regulatory action was required in each case. Learning and themes arising from incidents will continue to be monitored through IGRSC.

2.6 The Role of the Trust's Caldicott Guardian and SIRO

Data Protection Impact Assessments are completed for new / amended processing use cases of Personal Information and signed off	• SIRO and CG actively involved in approving Data Protection Impact Assessments (DPIAs) for new systems and processes. The progress of DPIAs is routinely reported at the Information Governance and Records Sub-Committee.
The Board is informed of confidentiality concerns	• SIRO and CG attend the IGRSC and scrutinise reports provided to the Quality and Safety Assurance Committee . The confidentiality incidents report is a standing agenda item at the Information Governance and Records Sub-Committee. • SIRO and CG are routinely informed of incidents escalated via the DSP Toolkit incident reporting system and of incidents escalated to the ICO.
Arrangements for confidentiality and data protection are monitored	• Confidentiality audits conducted are provided to IGRSC attended by SIRO and CG. • Confidentiality audits performed in clinical areas to support CQC evidence provided to SIRO and CG. • Approval of Information Sharing Agreements entered is sought from CG and records kept of approved ISAs.
Staff are provided with clear guidelines and procedures	• Alerts, guidance, and policies issued are approved by SIRO and CG as core members of the IGRSC.
Identified improvements to confidentiality processes are implemented	• Lessons learned from IG incidents scrutinised by CG and SIRO and escalated to Quality and Safety Assurance Committee. • Actions identified to improve confidentiality processes in audits undertaken approved by CG.

Assurance conclusion: The SIRO is reasonably assured that SIRO, Caldicott Guardian and Information Asset Owner arrangements provide appropriate senior oversight and accountability for information risk, confidentiality and information assets. Continued strengthening of IAO assurance, including data-flow and system-security documentation, remains an ongoing priority.

2.6.1 The Role of the trust's Information Asset Owners

The Trust's key critical digital information assets all have identified Information Asset Owners (IAOs) and Administrators (IAAs). Individuals appointed as Information Asset Owners for critical systems are responsible for ensuring that such assets are handled and managed appropriately. IAOs must make sure that assets are properly protected and that any risks to such assets are mitigated.

In order to strengthen our Data Security and Information Governance processes, and to comply with the Data Security and Protection Toolkit (DSPT) standards, the Trust requires comprehensive documentation of our data flow (electronic and paper-based) and system security measures.

Digital Services has created two documents to simplify this process:

- Data work-flow mapping spreadsheet (department-based): Captures your departments specific data work-flows processes.
- System Level Security Policy word document (system-based): Defines the security measures in place for each system.

We have developed internal training material to guide Information Asset Owners through completion of these documents. In addition to this guidance a new training package has been made available to Information Asset Owners via the E Learning for Healthcare hub and ESR.

3. Actions required/responsible officer

All actions identified at the trust's Information Governance and Records Sub-Committee meeting are assigned to appropriate owners and progress made against the actions is monitored at subsequent meetings. Progress is reported to the trust's Quality and Safety Assurance Committee.

4. Measurements/evaluations

The monitoring of compliance with NHS England Data Security and Protection policy takes place as part of the annual Data Security and Protection Toolkit assessment

conducted by Mersey Internal Audit Agency. The DSPT audit forms part of the trust's annual internal audit cycle.

Plans to improve compliance with data and cyber security standards are scrutinised at the Information Governance and Records Sub-Committee which is attended by the Senior Information Risk Owner (Chief Information Officer) and Caldicott Guardian (Medical Director). Where necessary, data security improvement plans are submitted to NHS England.

Data security risks are managed within the Datix risk/incident system for Digital Services. The Digital Services risk management process ensures that risk management is structured according to trust policy and risks are regularly reviewed at the Digital Services Risk Review meeting.

The trust utilises the ITHealth Assurance Dashboard Solution to measure its cyber security resilience . The dashboard consolidates all areas of the Trusts cyber security into a single, real-time view and includes the status of the trust's responses to the NHS England issued security Cyber Alerts.

5. Trajectories/objectives agreed

Submission of final DSPT assessment to NHSE for the second time as a single entity to reflect the acute and community DSPT position is due by 30th June 2027.

6. Monitoring/reporting routes

- The Information Governance and Records Sub-Committee reports to the Quality Assurance and Safety Committee.
- The annual Data Security and Protection Assessment produced by Mersey Internal Audit Agency is provided to the trust's Audit Committee.
- Data Security and Protection content is included in both the trusts Annual Report and Quality Account.

7. Timelines

All IGRSC actions will be reviewed at the next meeting of the sub-committee which takes place on October 13th, 2026.

The next baseline submission of the trust's DSPT assessment status is due to be completed and submitted to NHSE by December 31st, 2026. This submission will be a baseline against the standards in the CAF aligned DSPT.

8. Assurance committee (if relevant)

Overall SIRO Assurance Conclusion: Based on the evidence presented in this report, the SIRO is reasonably assured that appropriate governance, controls and monitoring arrangements are in place to manage information governance, data security and cyber security risk. Residual risks and areas of partial compliance have been identified and are subject to defined mitigating actions, monitoring and escalation. The principal assurance priorities for 2026/27 are completion of outstanding CAF-aligned DSPT actions, continued reduction of legacy technology risk and further alignment of Acute and Community information governance and cyber security arrangements.

9. Recommendations

The Finance, Sustainability and Performance Committee is asked to:

- Note the assurance provided by the SIRO regarding the effectiveness of the Trust's information governance, data security and cyber security arrangements during 2025/26.
- Note the residual information and cyber security risks identified within the report and the mitigating actions and governance arrangements in place to manage and escalate these risks.
- Note the outstanding CAF-aligned DSPT improvement actions and the ongoing programme of work to meet the Trust's future submission requirements.
- Note the continued work to align Acute and Community information governance, cyber security and information risk management arrangements as part of the development of a single NCM approach.