

PUBLIC BOARD MEETING

Thursday 7 August 2025, 10am

Ground Floor Conference Suite, Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
53/25	10.00	Apologies for Absence		Information
54/25	10.00	(i) Quoracy Statement (ii) Declarations of Interest in items on the agenda	1	Assurance
55/25 Page 4	10.00	Minutes of the last meeting: (i) Board meeting held 5 June 2025 (ii) Extraordinary Board meeting held on 25 June 2025	1	Assurance/ Approval
56/25 Page 15	10.05	Matters Arising from the Action Log	1	Assurance
57/25	10.10	Any urgent items to be taken at the discretion of the Chair		
58/25	10.10	Patient Story: GP Connect Collaboration – presentation at the meeting	2,3	Information
59/25 Page 18	10.40	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
60/25 Page 32	10.50	Key Corporate Messages – presented by the Chief Executive	1	Information
QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered				
61/25 (i) Page 40 (ii) Page 111 (iv) Page 120 (vi) Page 134	11.05	(i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 26 June 2025 – presented by the Committee Chair (iii) Learning from Deaths Report - <i>deferred to October 2025</i> (iv) Learning from Deaths Annual Report - presented by the Medical Director (v) Freedom to Speak Up Update Report - <i>deferred to October 2025</i> (vi) Freedom to Speak Up Annual Report - presented by the Chief Nurse	1 2,3 2,3 2,3 1-6 1-6	Assurance Assurance/ Approval Assurance Assurance Assurance Assurance

Ref	Time	Item Title	BAF Ref	Action
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
62/25	11.50	(i) Report from the Finance and Performance Committee held on 23 June 2025 - presented by the Committee Chair	5	Assurance
(i) Page 148		(ii) Report from the Finance, Sustainability and Performance Committee in Common held on 28 July 2025 - presented by the BCH Committee Chair	5	Assurance
(ii) Page 153			5	Approval
(iii) Page 158			1,5	Assurance
(iv) Page 167			1,5	Assurance
(v) Page 176	(v) Annual DIGIT Report including SIRO Report - presented by the Director of Finance			
PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities				
		No items this month	3-8	Assurance
STAFF: We will ensure that the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive				
63/25	12.30	(i) Reports from the Strategic People Committee in Common held on 18 June and 16 July 2025 – presented by the Deputy Committee Chair	4,6	Assurance
Page 214		Including reports for final ratification: a) Annual Workforce Assurance Report b) Facilities Time off Annual Report		
OVERARCHING CORPORATE GOVERNANCE ITEMS				
64/25	12.45	(i) Fit and Proper Persons Report - presented by the Director of Corporate Governance	1	Assurance
(i) Page 276		(ii) Board Committees: Terms of Reference and Business Cycles including Committees in Common and the Joint Executive Committee - presented by the Director of Corporate Governance	1	Approval
(ii) Page 281			1	Approval
(iii) Page 335		(iii) Cheshire and Merseyside Provider Collaborative Leadership Board Terms of Reference - presented by the Director of Corporate Governance		
CLOSING ITEMS				
65/25	1.00	Review of meeting and Items to be added to the Board Assurance Framework	1	Information
66/25		Opportunity for questions to the Board from staff, media or members of the public at the discretion of the Chair	1	Information



DATE AND TIME OF NEXT MEETING

Thursday 9 October 2025, 10am at Spencer House, Dewhurst Road, Birchwood, Warrington

MOTION TO EXCLUDE

(Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960)

The Trust Board reserves the right to exclude, by its resolution, the press and public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the resolution



Unapproved Minutes from a Public Board Meeting

Held on Thursday 5 June 2025, 10.00am

Ground Floor Meeting Room, Spencer House, Dewhurst Road, Birchwood, Warrington

Present

Martyn Taylor, Trust Chair
Nikhil Khashu, Chief Executive
Gail Briers, Non-Executive Director
Bob Chadwick, Non-Executive Director
Tina Wilkins, Non-Executive Director
Elaine Inglesby, Non-Executive Director
Abdul Siddique, Non-Executive Director
Nick Gallagher, Director of Finance
Paula Woods, Director of People and Organisational Development
Dan Moore, Chief Operating Officer
Paul Fitzsimmons, Medical Director

In Attendance

Jan McCartney, Director of Corporate Governance
Jeanette Hogan, Deputy Chief Nurse
Amena Patel, NeXT Director
Karen Pinnington, Executive Assistant

For Patient Story (item 37/25 only)

Sheila Hudson, Health Visitor, 0-19(25) Service – Halton
Michelle Martin, Operational Manager, 0-19 Halton Children's Services Team

32/25 APOLOGIES FOR ABSENCE

Lynne Carter, Chief Nurse.

Observers

Rita Chapman, Public Governor, Rest of England

33/25 (i) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No Declarations of Interest were made in respect of the items on the agenda.

34/25 MINUTES OF THE LAST MEETING

(i) BOARD MEETING HELD 3 APRIL 2025

The minutes were approved as an accurate record.

35/25 MATTERS ARISING FROM THE ACTION LOG

The Board noted that an update on the Neurodevelopment Pathway would be provided at the August Board meeting and that the Board Assurance Framework was included as an item on the agenda.

36/25 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

The Chair confirmed that he had not been made aware of any urgent items of business to be taken.

37/25 PATIENT STORY – CHILDREN’S SERVICES – SEND STAY & PLAY

Sheila Hudson, Health Visitor and Michelle Martin, Operational Manager from the 0-19 Children’s Services in Halton gave a presentation on the SEND Stay and Play Scheme which was implemented in Widnes a few months ago. It has been co-produced with parents who have played an active role in the planning and shaping of the group, which is run collaboratively with staff from the Trust’s Family Hub Early Years Team and Halton 0-19 service. The presentation provided an explanation on how the journey began and videos were shown from both the staff and parent’s perspective on the benefits being provided to parents and their children.

Sheila Hudson advised that the staff listen to the voice of the child and parent and further work is being undertaken to encourage more families to join the group. The next steps were described and it is hoped that parents would eventually run the group with some support from the 0-19 service, and that a similar group could be replicated in Runcorn. There is a succession plan in place to work closely with the local authority and other agencies.

The Non-Executive Directors commented that this was a fantastic service and were pleased with the approach being taken, particularly co-production.

A discussion took place about the Neurodevelopment Pathway and a query was raised as to what support could be provided to both parents and those children who were on the waiting list and awaiting a diagnosis. Michelle Martin explained that families can access the service to seek tips, guidance and coping mechanisms to enable children to reach their full potential, whilst awaiting a diagnosis. By working in partnership with the Family Hub, further resources and offers of support is available. Good news stories were to be published to encourage more families to join the group.

Michelle Martin confirmed that an evaluation of what has been achieved in the first 1001 days will be undertaken and it is hoped that funding will be made available to ensure the service is sustainable. A monthly steering group is meeting to discuss this and the ‘Start for Life Journey’.

The Chair thanked Sheila and Michelle for their informative presentation.

38/25 BOARD ASSURANCE FRAMEWORK (BAF)

The Director of Corporate Governance confirmed that the BAF, along with the risk appetite was discussed at the last Board Time-Out session and that this paper included the agreed changes to be made. Executive Directors have reviewed the assurances and BAF 8, Integration with WHH, has been removed. It was highlighted that the definition of ‘cautious’ was different under BAF 1 and BAF 2. It was explained that this was dependent upon the subject matter. A query was raised as to whether vaccines needed to be added to the risk register. The Director of Corporate Governance advised that this was a management action which would need to go via the relevant Committee for agreement to be placed onto the risk register. A few typos within the document to be corrected.

The Board approved the Board Assurance Framework.

39/25 KEY CORPORATE MESSAGES

The Chief Executive presented the key highlights from the circulated report:

The Chair and Non-Executive Directors had attended numerous meetings since the last reporting period. The vast majority of meetings attended by the Chief Executive and Chair related to operational planning. The NHS 10-Year Plan is due to be published shortly.

Professor Steven Broomhead, Chief Executive of Halton Borough Council is retiring. The Chief Executive stated that it is crucial that the Trust has partner involvement in the recruitment process for the new Chief Executive.

The Council's recent CQC inspection of Adult Social Care Services has been rated as 'Requires Improvement'. The Deputy Chief Nurse confirmed that there were no points within the report which directly impacts on the Trust but were part of the action group looking at the recommendations/actions.

The Chief Executive stated that the Trust needs to be sighted on the financial review of the Council.

The Board received and noted the report.

40/25 TERMS OF REFERENCE

(i) BOARD

The Director of Corporate Governance confirmed that the Terms of Reference had been amended to reflect the changes in relation to one less Non-Executive Director and the joint posts in place for the Chief Operating Officer and the Medical Director.

The Board approved the quoracy of the Board of Directors.

(ii) NOMINATIONS & REMUNERATION COMMITTEE

The Director of Corporate Governance advised that the members were the Chair and Non-Executive Directors. The recommendation within the paper is to reduce quoracy by one (from four to three).

The Board approved the updated quoracy to be reduced by one Non-Executive Director.

At this stage, the Audit Committee Terms of Reference (included under agenda item 42/25iii) was reviewed. Non-Executive Director, Bob Chadwick advised that fewer Executive Directors were needed and that the Chief Nurse & Deputy Chief Executive and the Chief Operating Officer would no longer be required. However, any director may be called upon to attend future meetings where any reports receive 'Limited' or 'Low' Assurance, and time in diaries would be ringfenced. It was confirmed that of the MIAA reports, none had received 'Limited' or 'Low' assurance. Other amendments as outlined within the Terms of Reference were noted.

The Board approved the updated Terms of Reference for the Audit Committee.

41/25 QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered

(i) IQPR

The Board received a comprehensive report on performance areas across operations, quality, finance and people indicators from the Chief Operating Officer. Key points were noted on each section:

Operations:

Warrington Dermatology Cancer 31-day wait from diagnosis to first treatment.

Improvement in UTC performance, impact on system and flow.

A reduction in audiology 6-week diagnostic breaches. An internal review has taken place and there is an ongoing review via the ICS.

Diagnostic recovery was at 51% and is now at 66% compliance and continues to track positively.

There has been an increase in long waits in community paediatrics and dermatology. The Chief Operating Officer referred to the WMDS sitrep and advised that there is no reporting functionality for community services. The 65-week breaches were reported via the national and regional team and the figure on the latest sitrep was 298 which was queried. The Chief Operating Officer confirmed that this has been challenged and guidance/direction on what this means was awaited as there may be other community providers who are reporting via a different route.

A discussion took place regarding the impact on long waits at the time when the two organisations become one. The Chief Operating Officer confirmed that guidance from the regional team is awaited and that this would be reported via the Finance & Performance Committee.

The Chief Operating Officer advised that discussions with other regional providers for mutual aid and support were being progressed and agreed to keep colleagues updated via the Finance & Performance Committee.

Quality:

The Deputy Chief Nurse confirmed that the focus is on moderate incidents.

Falls within the bed-based unit remains a key quality indicator and will be closely monitored, and there has been an increase in pressure ulcers.

Services need to report incidents in a timely manner to ensure these are dealt with as soon as possible.

The Chief Executive raised his concerns about the performance to target for both falls and pressure ulcers. In terms of falls, the Deputy Chief Nurse advised that a piece of work in respect of the categorisation of falls would be undertaken and that the Performance Team had used the NHSE standard calculation, which provides 2-3 years of data. There is a need to use the SPC charts going forward but this needs to be developed, along with an agreement on how it is interpreted. The Deputy Chief Nurse advised that number of pressure ulcers were being closely monitored, with a particular focus on category 3.

People:

The Director of People & OD reported three indicators were red. It was confirmed that the overall sickness rate was at 6.33% against a target of 5.50% and there is a focus on short term absence, which the HR Business Partners were aligned to, by borough.

(ii) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 14 MAY 2025

The Board received a report from the May meeting of the Quality and Safety Committee meeting from Non-Executive Director and Committee Chair, Elaine Inglesby for assurance.

Key points noted from the update were:

Category 3 pressure ulcers will be the focus, with a monthly audit focusing on end of life.

The agreed 'firebreak' for the Community Paediatrics and Neurodevelopment Pathway is ongoing and an update, along with outcomes would be provided to the next Committee meeting. **At the request of the Chair, the Chief Operating Officer to provide an update at the next Committee meeting - action.**

Many of the agreed actions for Padgate House were now complete and an update on the leadership model discussed later in the agenda.

Following the presentation of the QIAs presented at the Vacancy Control Panel meetings, the figures from are to be reflected in future reporting to the Committee.

The Medical Director confirmed that the Trust is fully committed to the Prevention Pledge and this is being worked through in terms of resource and capacity to fulfil what is required.

(iii) LEARNING FROM DEATHS ANNUAL REPORT

This item was deferred to August 2025. The Medical Director confirmed that there would be a more joined up approach to the pathways.

(iv) QUALITY ACCOUNT

The Board received the Quality Accounts for 2024/25, which had been presented to the Quality & Safety Committee and the ICB, who had provided a complimentary response. The Deputy Chief Nurse confirmed that this identifies the progress made on the Trust's priorities and what will be achieved in 2025/26.

It was acknowledged that this is a significant document which has involved a lot of effort. A commitment to next years pledges is crucial.

A query was raised by one of the Non-Executive Directors about the plan for the review of the deteriorating child guidance quality priority. The Deputy Chief Nurse confirmed that contact had been made with the Safety Lead at NHSE and some work will involve raising awareness of Martha's Law and what this means for community services. This would be undertaken in harmonization with the acute trust as part of the integration work. It was noted that General Practice is also key and would be included in this work.

The Chair expressed his thanks to all those involved in the production of this comprehensive document.

The Board approved the report.

42/25 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) REPORTS FROM THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 24 APRIL AND 29 MAY 2025

The Board received reports for assurance from the April and May meetings from Non-Executive Director and Committee Chair, Tina Wilkins. The key points highlighted were:

There were a number of savings on plan, both recurrent and non-recurrent. However, the Committee noted that there were still savings to be fully identified. The underlying deficit is to be included in a future report.

The Delivery Unit was not fully set up at the time of the meeting, but it was confirmed that a full cycle of meetings were completed in May. A formal framework is to be made available which should provide the grip and control going forward.

Greater Manchester Dental Services were not achieving contractual target. A paper has been presented to the Executive Management Team, the Performance Council and will be presented to the next Finance & Performance Committee on 23 June. The Chair raised his concerns and asked if there were any immediate issues to be escalated? The Chief Operating Officer confirmed he would be attending the next Contract meeting and would present a paper to the Executive Management Team on 17 June which would include what actions were to be taken to address the issues. The Director of Finance highlighted the ongoing issues relating to access to GA sessions but confirmed that all other service lines were fairly consistent and static.

In terms of digital, the 2024/25 DSPT standards have been raised in line with Cyber Assessment Framework and affects all the organisation's scores. A submission is to be made at the end of June.

Non-Executive Director, Bob Chadwick referred to CIP and stated that a pipeline of schemes is needed, which goes beyond the required amount. This would allow a degree of flexibility as not all schemes may come to fruition.

(ii) FINANCE REPORT

The Director of Finance presented the Month 1 report:

- The Trust was reporting a deficit in Month 1 of £0.43m, £0.01m favourable to plan.
- Savings requirement, excluding system savings of £5.48m (5.02%) in line with ICB.
- A savings achievement of £0.37m against a plan of £0.37m.
- Income at £8.08m against a plan of £8.28m.
- Pay - £5.96m against a plan of £6.03m
- Agency spend was £0.04m against a plan of £0.11m.
- Non-pay expenditure was £2.48m against a plan of £2.55m.
- Capital charges reported were in line with plan.
- Capital expenditure was £0m at Month 1, planned to spend is £0.
- Cash - £7.49m

The Director of Finance advised that agency continues to be converted to bank, which is cheaper, and for each overspending cost centre, an immediate recovery plan has been requested. All recovery actions identified last year continue to be implemented in 2025/26. There is intense scrutiny and it is crucial that the Trust delivers on CIP. It was confirmed that the formal executive for the Delivery Unit is the Chief Executive.

It was highlighted that there were no capital plans at Month 1 and from a cash flow perspective, a number of outstanding debts with the local authority would be expedited and payment received shortly. The Director of Finance confirmed that the plan is on track for Month 2.

The Board noted the financial position and assurance was provided.

A discussion took place regarding the Comms Plan for savings. The Director of People & Organisational Development confirmed that periodic comms is provided via the Trust's Bulletin and via the Senior Leadership Team and Divisional Leadership Team (DLT) meetings and that a comms plan would be aligned to the Delivery Unit. The day to day managing of the agency spend will go via the DLTs and any issues would be escalated to

the Executive Management Team. The Chief Executive also confirmed that the direct face to face messaging is being undertaken via regular briefings, which is open to all staff and provides an opportunity for questions to be asked. **It was agreed that a staff engagement paragraph, along with examples, would be included in the Comms Plan – action.**

Non-Executive Director, Tina Wilkins made a request for the Comms plan to be presented to the Finance & Performance Committee – action.

(iii) REPORT FROM THE AUDIT COMMITTEE HELD ON 24 APRIL
(including Committee Terms of Reference)

The Board received a report for assurance from the April meeting from Non-Executive Director and Chair of the Audit Committee, Bob Chadwick. The Terms of Reference was covered under agenda item 40/25.

Key points noted were:

- Standing agenda item on integration so members were being sighted on any issues.
- Audit Annual Report was approved.
- Committee fully assured that the Committees of the Board were discharging their duties according to the Terms of Reference.
- No issues highlighted regarding the accounting policies and annual accounts.
- No audits with 'Limited' or 'No' assurance reported.
- Draft Annual Internal Audit Report and Director of Audit Opinion 2024-25 received a 'Substantial' level of assurance overall.
- Anti-Fraud Annual Plan has been approved.

(iv) ANNUAL ANTI-FRAUD / BRIBERY REPORT

The Director of Finance presented the report and confirmed that this was a position statement for the last 12 months. The key message is that the Trust scored 'Green' on all 12 domains.

The Chief Executive queried the number of investigations brought forward from 2023/24 and those carried forward to 2025/26 and asked if any support was needed. It was confirmed that these were progressing and no additional support was needed.

The Board was assured with the content of the report.

43/25 PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities

(i) HEALTH EQUITY UPDATE

The Medical Director presented the update and highlighted the four areas of focus.

Reasonable adjustments digital flag – this is really important to ensure the data is recorded. The work has commenced on SystmOne, with a view to linking it to the NHS Spine and National Care Record Service.

Language interpretation provision – this is being managed and has its challenges due to the lack of face-to-face interpreters available. It was highlighted that there may be opportunities to work with other organisations for this service to be provided. The Chief Executive stated that the system needed to have the functionality for an interpreter to be requested prior to the patient's appointment in order to avoid any delays.

Improving ethnicity coding in patient records – this is being led by the Information Team with support from the Equality Lead. Updates are planned in SystmOne and following this, the learning will be applied to those using EMIS to provide a simplified list of ethnicity categories, mapping codes to Census 2011 definitions, which will include other white ethnic categories.

Embedding the new equality and health inequalities (EHIA) assessment templates – these were approved as part of the integration work and include further detail.

The plans for 2025/26 work were highlighted:

Trust's support to armed forces community in services.

Smoke free policy.

Prevention Pledge which will be built into the clinical pathways.

Making Every Contract Count – the level of inequity across the boroughs is already available and need to work with this to target certain age groups.

Community Health Worker service – this is included on the agenda for the Neighbourhood meeting at the ICB. One of the Non-Executive Director's expressed disappointment that the original scheme piloted by the Trust in 2021 did not continue and that the lessons and evaluation from this needed to be re-visited to inform future neighbourhood schemes.

Improvements to dental health data reporting – review how joint working will strengthen the programme.

The Chair stated that this needed to add value and asked if this would be undertaken in conjunction with the outcomes of the clinical summits. This was agreed.

The Board noted the progress to date.

In order to strengthen its leadership competencies on health inequalities, a future Board to Board meeting may be needed.

44/25 STAFF: We will ensure that the trust is a great place to work by creating an environment for our staff to develop, grow and thrive

REPORTS FROM THE STRATEGIC PEOPLE COMMITTEE IN COMMON HELD ON 16 APRIL AND 21 MAY 2025

Non-Executive Director, Abdul Siddique presented the Chairs Reports from the Joint Strategic People Committee in Common meetings for April and May and referenced the key areas of discussion.

The Board received the report to note.

The Director of People & Organisational Development made reference to the messages received from Mandy Nagra, the ICBs Chief Officer for System Improvement and Delivery in relation to a freeze on recruitment for all non-clinical posts and stopping overtime payment, and highlighted that there may be some exceptions due to critical posts requiring cover/overtime, but wished to assure the Board that there is robust grip and control.

(i) APPROVED KPI PEOPLE INDICATORS

The Board noted the content of the report.

(ii) GENDER PAY GAP

The Director of People & Organisational Development presented the report, which was taken as read. The Board's attention was highlighted to Section 4, Results, and it was confirmed that the Trust had improved year on year. This will be published, as required, nationally. Where possible, collaboration opportunities with Warrington and Halton Teaching Hospitals NHS FT is to be explored.

The Board approved the report.

45/25 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) RISK MANAGEMENT FRAMEWORK

The Deputy Chief Nurse presented the report, which was taken as read. This document identifies the approach to managing risks within the organisation. It was highlighted that no changes from previous iterations had been made, only minor changes in terms of the process.

The Board approved the report.

(ii) FIT PROPER ANNUAL REVIEW

This item was deferred until August.

The Director of Corporate Governance confirmed that the Trust was on course to complete the process by the end of June. **A formal report would be presented to the August Board meeting – action.**

46/25 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

Good discussion and debate on all agenda items.

The Board agreed that there were no items to be reflected within the Board Assurance Framework following the discussions held.

47/25 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

Governor, Rita Chapman welcomed the positive patient story and stated that this was a fantastic service being provided to families.

It was noted that the Board agenda and papers were not received until quite late on Tuesday, 5 June. The Director of Corporate Governance apologised for the lateness in the dispatch of the papers.

DATE AND TIME OF NEXT MEETING

Thursday 7 August, 10am at Spencer House, Dewhurst Road, Birchwood, Warrington

MOTION TO EXCLUDE

(Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960)

The Trust Board reserves the right to exclude, by its resolution, the press and public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the resolution.

Unapproved Minutes from an Extraordinary Public Board Meeting
Held on Wednesday 25 June 2025, 11.30am
Microsoft Teams

Present

Martyn Taylor, Trust Chair
Nik Khashu, Chief Executive
Gail Briers, Non-Executive Director
Bob Chadwick, Non-Executive Director
Elaine Inglesby, Non-Executive Director
Abdul Siddique, Non-Executive Director
Tina Wilkins, Non-Executive Director
Lynne Carter, Chief Nurse
Paul Fitzsimmons, Medical Director
Nick Gallagher, Director of Finance
Dan Moore, Chief Operating Officer
Paula Woods, Director of People and Organisational Development

In Attendance

Jan McCartney, Director of Corporate Governance
Samantha Scholes, Head of Corporate Governance
Lauren Ryan, Executive Assistant

Observers

Kevin Goucher, Public Governor, Warrington

48/25 (i) APOLOGIES FOR ABSENCE

Observers

Rita Chapman, Public Governor, Rest of England

49/25 (i) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

There were no declarations of interest made.

50/25 Annual Report and Annual Accounts 2024-25: Director of Corporate Governance and Director of Finance

The Director of Corporate Governance presented the Annual Report and explained that some minor administrative amendments were required to be completed prior to final sign off and the Extraordinary Audit Committee on 25 June 2025 recommended that the Board approve the Annual Report following these amendments.

The Director of Finance presented the Annual Account and explained that some minor narrative changes and adjustments were also required and would be circulated to Board members prior to final sign off. He added that the accounts detailed a deficit of just under £1.2m, which was in line with the forecast and that the auditors were proposing a clean audit opinion.

The Chair of the Audit Committee confirmed that the external auditors' annual report was unqualified and clean with no significant inconsistencies or concerns and that the Head of Internal Audit Opinion was of substantial assurance.

At the Chair's request, Nikhil Khashu, Chief Executive Officer as the Trust's Accountable Officer, confirmed he was satisfied with the content of the Trust's Annual Report and Annual Accounts for 2024-25.

The Board received and approved the Annual Report and Annual Accounts which had been reviewed and recommended for approval by the Extraordinary Audit Committee on 25 June 2025.

51/25 Letter of Representation – External Auditors: Director of Finance

The Director of Finance provided the standard letter of representation, confirming that there was no unusual or extraordinary content.

The Director of Finance outlined the final steps for submission of both the Annual Report and Annual Accounts to NHS England which would take place by 27 June 2025.

52/25 Review of meeting and items to be added to the Board Assurance Framework

The Chair thanked Kevin Goucher, Public Governor on his observation of the Extraordinary Public Board meeting.

DATE AND TIME OF NEXT MEETING

Thursday 7 August 2025, 10am, Spencer House, Dewhurst Road, Birchwood, Warrington

ACTION LOG

Key

Red	Significantly Delayed and / or of High Risk
Amber	Slightly Delayed and / or of Low Risk
Green	Progressing to timescale
Blue	Completed

Meeting: Bridgewater Community Healthcare NHS Foundation Trust Board – Public Meeting

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
05.12.24	84/24	Patient Story – Neuro-development Service	The Board requested that the Associate Director of Children’s Services discuss closer working with partner organisations to look to resolve some of the issues raised for the future, recognising that the Neurodevelopment/ADHD pathway was complex with many different partners involved at different points and that there was a lack of resources. The story would also be shared with the Trust’s Neuro Development Group for consideration of future learning.	Paul Fitzsimmons/ Dan Moore	GREEN August 2025	February 2025: Update: Halton borough have a multi-agency programme of work underway which will develop an approach to supporting a child / young person’s presenting needs rather than a focus on referral for diagnostic assessment. Halton and Wirral have been identified as pilot sites across cheshire and Merseyside to pilot this approach Warrington are planning to take a “fast follower” approach in due course. For families living in Frodsham and Helsby this is a little more complex in that the trust is commissioned to deliver ASD diagnostic assessment only – all other services are commissioned by Cheshire West Place ICB with providers including, Cheshire West and Chester Council (Family Hubs, Children’s Services etc), Cheshire and Wirral Partnership NHS Foundation Trust (Health services) and Frodsham, Helsby and Elton Primary Care Network. We have however, since the board meeting been able to schedule meetings with cheshire west commissioners and requested a review the wider multi agency neurodevelopmental assessment pathway. Verbal update in August 2025 on initial findings and firebreak.

ACTION LOG				Meeting: Bridgewater Community Healthcare NHS Foundation Trust Board – Public Meeting		
Key						
Red		Significantly Delayed and / or of High Risk				
Amber		Slightly Delayed and / or of Low Risk				
Green		Progressing to timescale				
Blue		Completed				
Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
05.12.24	85/24	Board Assurance Framework	It was agreed that further discussions would take place on capacity and shared posts in view of the journey with WHH going forwards at the next shared Executive Team Meeting.	Jan McCartney	BLUE	February 2025: This will be actioned following decision on integration being made. April 2025: It was agreed that discussions on capacity and shared posts would be taken forwards as part of integration work. Discussion to take place at the May Board Time Out session. June 2025: agreed changes at Board Time-Out session made. Executive Directors have reviewed the assurances and BAF 8, Integration with WHH has been removed. A few typos in the document to be corrected.
05.06.25	41/25ii	Report from Quality & Safety Committee on 14 May	Chief Operating Officer to provide an update on the ‘firebreak’ for the community paediatrics and Neurodevelopment Pathway at the next Quality & Safety Committee meeting	Dan Moore	GREEN	August 2025: This matter is ongoing. A formal action plan will be taken into the Quality and Safety Committee.

ACTION LOG				Meeting: Bridgewater Community Healthcare NHS Foundation Trust Board – Public Meeting		
Key						
Red		Significantly Delayed and / or of High Risk				
Amber		Slightly Delayed and / or of Low Risk				
Green		Progressing to timescale				
Blue		Completed				
Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
05.06.25	42/25ii	Finance Report – Comms Plan for savings	Staff engagement paragraph, with examples, to be included as part of plans for regular communications through various means around savings. This would be aligned to the delivery unit. The above plan was to be presented to the Finance & Performance Committee.	Paula Woods Nick Gallagher/Lynne Carter	BLUE	Approaches to communication provided to NG, including various communication and engagement to date. Information will be provided through the future updates from the Delivery Unit into the Committee/Committee in Common.
05.06.25	45/25ii	Fit Proper Annual Review	Formal report to be presented to the August Board	Jan McCartney	GREEN August 2025	August 2025: Item included on the agenda.

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	59/25		
Report Title	BOARD ASSURANCE FRAMEWORK		
Executive Lead	Nikhil Khashu, Chief Executive Officer		
Report Author	Jan McCartney, Director of Corporate Governance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note
Executive Summary			
The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework. The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.			
Previously considered by:			
☒ Audit Committee ☒ Quality & Safety Committee ☒ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee ☒ Strategic People Committee in Common ☒ EMT			
Strategic Objectives			
☒ Equality, Diversity and Inclusion - We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☒ BAF 2	☒ BAF 3	☒ BAF 4	☒ BAF 5	☒ BAF 6	☒ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☒ Caring	☒ Effective	☒ Responsive	☒ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	59/25		
Report Title	BOARD ASSURANCE FRAMEWORK		
Report Author	Jan McCartney, Director of Corporate Governance		
Purpose	The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.		
1. EXECUTIVE SUMMARY			

- 1.1 The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.
- 1.2 The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.
- 1.3 The Board Assurance Framework is received at the Board, all the Committees of the Board and other key decision-making / operational meetings. It is a working document that is used in Committees and meetings to ensure the meeting agendas remain focused and proactive on strategic objectives. The recommended changes can be found in section 2.
- 1.4 Each BAF has also been updated with their corporate risks rated 12 and above from the risk register produced for the July Risk Management Council.

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

2.1 BAF 1: Governance

The Audit Committee met on 31 July 2025. The BAF has now been amended to reflect the opinions of both External and Internal Audit. The Gaps in Control section has also been updated to reflect the transaction with Warrington and Halton Teaching Hospitals NHS Foundation Trust is an acquisition.

2.2 BAF 2: Quality

The Quality & Safety Committee met on 26 June 2025 where a discussion took place in relation to Paediatric Audiology, therefore it is recorded as an emerging risk.

The BAF was also updated to show the Chief Nurse as the lead director.

The Committee considered the risk scoring and agreed it should remain unchanged. No other updates were recommended.

2.3 BAF 3: Health Equity

The Quality & Safety Committee met on the 26 June 2025. The Committee did not identify any changes to be made to BAF3 and there were no proposed changes to the scoring.

2.4 BAF 4: Staff

The People Committee-in-Common met on 18 June and 16 July 2025. The Committee recognised that there was a potential emerging risk to the system around the forthcoming resident doctors, industrial action.

There was no proposed change to the scoring of the risk ratings.

2.5 BAF 5: Resources

The Finance & Performance Committee met on 23 June 2025 however as this was an extraordinary meeting of this committee the Board Assurance Framework was not considered.

The first Committee-in-Common was held on 28 July 2025. There are no changes or updates to recommend to the Board following this meeting.

No change to the current risk rating is recommended.

2.6 BAF 6: Equality, Diversity & Inclusion

The Strategic People Committee in Common met on 18 June and 16 July 2025, the Committee did not identify any changes to be made and there were no proposed changes to the scoring.

2.7 BAF 7 – Partnerships

There have been no updates to this BAF.

3. RECOMMENDATION

3.1 The Board is asked to approve the changes recommended by the Committees.

Appendix 1: Board Assurance Framework

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 31 July 2025

STRATEGIC OBJECTIVES

- **Quality** – We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
- **Health Equity** – We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
- **Staff** – We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.
- **Resources** – We will ensure that we use our resources in a sustainable and effective way.
- **Equality, Diversity and Inclusion** – We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
- **Partnerships** – We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

BAF 1 Governance	BAF 2 Quality	BAF 3 Health Equity	BAF 4 Staff	BAF 5 Resources	BAF 6 Equality, Diversity & Inclusion	BAF 7 Partnerships / Integration with WHH
Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Failure to deliver quality services and continually improve	Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Failure to create an environment for staff to grow and thrive	Failure to use our resources in a sustainable and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system
Risk Rating Inherent risk rating 4 (C) x 4 (L) = 16 significant Current risk rating 4 (C) x 2 (L) = 8 medium Target risk rating 4 (C) x 2 (L) = 8 medium	Risk Rating Inherent risk rating 5 (C) x 5 (L) = 25 significant Current risk rating 5 (C) x 3 (L) = 15 significant Target risk rating 5 (C) x 2 (L) = 10 high	Risk Rating Inherent risk rating 3 (C) x 5 (L) = 15 significant Current risk rating 3 (C) x 4 (L) = 12 high Target risk rating 3 (C) x 2 (L) = 6 medium	Risk Rating Inherent risk rating 4 (C) x 4 (L) = 16 significant Current risk rating 4 (C) x 4 (L) = 16 significant Target risk rating 4 (C) x 1 (L) = 4 low	Risk Rating Inherent risk rating 4 (C) x 5 (L) = 20 significant Current risk rating 4 (C) x 4 (L) = 16 significant Target risk rating 4 (C) x 2 (L) = 8 medium	Risk Rating Inherent risk rating 4 (C) x 4 (L) = 16 significant Current risk rating 4 (C) x 3 (L) = 12 high Target risk rating 4 (C) x 1 (L) = 4 low	Risk Rating Inherent risk rating 3 (C) x 4 (L) = 12 high Current risk rating 3 (C) x 4 (L) = 12 high Target risk rating 3 (C) x 2 (L) = 6 low
Risk Appetite: Cautious	Risk Appetite: Cautious	Risk Appetite: Open	Risk Appetite: Seek	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Seek

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 1: Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust’s Strategy	RELATED OBJECTIVES: • Quality • Health Equity • Staff • Resources • Equality, Diversity and Inclusion • Partnerships	RISK RATING: Inherent risk rating: 4 (C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 2 (L) = 8 medium Target risk rating: 4 (C) x 2 (L) = 8 medium	RISK APPETITE: CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Audit Committee last review: July 2025 Risk Ratings review: July 2025	If the Trust is unable to put in place and maintain effective corporate governance structures and implement and maintain sound systems of Corporate Governance, then there may be poor oversight of Board level risks and challenges, resulting in failure to deliver the strategy. <u>Risks on register 15 plus</u> No risks at this level	Prevent Controls • Accountability Framework in place • Board Assurance Framework & Risk Register • Board development • Standing Financial Instructions • Scheme of Reservation and Delegation • Operational management structure and policies and procedures are in place • Trust Board scrutiny	Detect Controls • Board development • Board Members working within wider system • Committees receive by exception reports from operations leads, these are reported to the Board • Contributing to work across the system in relation to developing Children’s Services • Council structure, reporting to Committees • Engagement internally / externally with partners • Execs carrying out SRO roles within system • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Joint working on a number of projects with commissioners and local authority • Performance framework – enabling strategies - operation delivery plans • Regular Exec meetings with commissioners and other key stakeholders • Senior Leadership Team meeting monthly • Senior staff involvement with borough based integrated care partnerships visions; ‘Warrington Together’ and ‘One Halton’ • Staff engagement • Targeted action planning on Staff Survey results • Compliance with ICB requirements	Assurances • Annual Review of Effectiveness of Audit Committee • Annual Review of Effectiveness of External Audit Service • Annual Review of Effectiveness of Internal Audit & Anti-Fraud • Annual Reports received from Committees of the Board • Board, Committees (Audit, Quality & Safety, Finance & Performance, and People) • Clean Unmodified Audit Opinion & clean VFM opinion 2024/25 • Substantial Assurance rating from Internal Audit 2024/25 • Daily automated data reporting • Declarations of Interests Register • Emerging integrated governance structures with partners • External independent Well Led review 2023 • Internal Audit Plan agreed for 2025/26 • Anti-fraud plan agreed for 2025/26 • ICB Provider Collaborative member • MIAA governance checklists • MOU in place where services are delivered in conjunction with other partners • PWC Investigation & Intervention Report Audits 2023/24 Risk Management Core Controls – High DSPT – Substantial 2024/25 Risk Management Core Controls – High DSPT – Substantial EPRR – Substantial
Risks on register 12 2428 Data Security Protection 3161 EPRR Training Compliance 3173 EPRR On Call Arrangements	Rationale for current score • Governance structure approved by Board and audited by internal and external auditors. • Substantial Assurance – Heads of Internal Audit opinion 2023/24 • Triangulation with Risk Register, Incidents, items on Committee agendas. • Trust Strategy 2023 ‘Communities Matters’, now approved by Board with enabling strategies • Well Led 2023 report and recommendations accepted and action plan completed and signed off by the Audit Committee April 2024.			
Gaps in controls and assurance: • 2018 CQC rating ‘requires improvement’ remains due to changes to inspections. CQC not due to inspect as no concerns have been raised in relation to the Trust. • Integration / Acquisition programme with WHH in progress		Mitigating actions: • Board oversight		Emerging risks: Ability to resource the integration programme NHS and system financial risks impacting on the Trust. Operational Planning Guidance impact Shift in direction of Trust Strategy

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 2: Quality Failure to deliver quality services and continually improve.	RELATED OBJECTIVES: • Health Equity • Resources • Staff		RISK RATING: Inherent risk rating: 5 (C) x 5 (L) = 25 significant Current risk rating: 5 (C) x 3 (L) = 15 significant Target risk rating: 5 (C) x 2 (L) = 10 high		RISK APPETITE: CAUTIOUS Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent to patient safety and effectiveness.
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Chief Nurse last review: June 2025 Q&S Committee last review: June 2025 Risk Ratings review: June 2025 <i>In collaboration with People</i>	If we fail to deliver safe and effective services, then there may be potential harm to patients and their outcomes. <u>Risks on register 15 plus</u> 1138 Community Paediatric doctor capacity, Warrington (<i>x-ref 3,5,6</i>) 1139 Community Paediatric / NDP waiting times, Halton (<i>x-ref 3,5,6</i>) 3241 Community Paediatrics demand, Warrington & Halton (<i>x-ref 3,4,5,6</i>) 3266 Community Paediatric clinical harm reviews, Warrington & Halton (<i>x-ref 3,5,6</i>) 3271 Community Paediatric ADHD diagnostic reviews, Warrington & Halton (<i>x-ref 3,5</i>) 3341 Failure to provide contracted Dental Services within GM (<i>x-ref 5</i>) Cross-referenced with BAF 5, Resources Rationale for current score • Winter plan • Enabling strategies: • Medicines Management • Safeguarding • Engagement • Risk • People strategy • EDI strategy • Industrial action (BMA) • Number of quality risks • Quality & Safety governance structure in place. • Robust QIA process for service changes • Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. • Waiting list pressures	<u>Prevent Controls</u> • Clinical policies, procedures & pathways • Weekly Senior Safety Huddle • Directorate Team Meetings • Freedom to Speak Up Guardian in place • Quality Impact Assessment Process • Risk Management, Quality, Performance & Transformation Councils in place • Trust Strategy – Communities Matter • Winter Plan • Statutory & Mandatory Training	<u>Detect Controls</u> • Clinical & Internal Audit Programme • Clinical Quality and Performance Groups (CQPGs) in place with all NHS commissioners. • E-roster monitoring • End of Life group • Equality Impact Assessments • Health and Safety group • Increased reporting of incidents, including medication incidents • IQPR & quality dashboards • Learning from Deaths report • Quality Council • Performance Council • Quality & Safety Committee bi-monthly meetings • Quality Impact Assessments • Quality Visits • Trust Transformation Programme (BOOST) • Patient experience scores • Listening to staff voices • Revalidation & registration	<u>Assurances</u> • Regular engagement with CQC • External Well Led review • IQPR & quality dashboards • Consistency of reporting patient safety incidents (measured nationally) • Deep dives at Committee • Clinical Peer Safety Review • Neurodevelopment pathway work commenced <u>Audits</u> 2023/24 Risk Management Core Controls – High Consultant Job Planning – Moderate Dental Network – Moderate Patient Feedback – Moderate Quality Spot Checks – Limited 2024/25 Risk Management Core Controls – High Dermatology – Substantial PSIRF – Substantial Quality Spot Checks – Moderate	
Gaps in controls and assurance: • Paediatric Audiology • Clinical leadership strategy – in development • Recruitment & Retention • CIP 2025/26		Mitigating actions:		Emerging risks: Neurodevelopment pathway – 6 week pause in activity to review service Paediatric Audiology	

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 3: Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients.	RELATED OBJECTIVES: - Equality, Diversity, and Inclusion - Partnerships - Quality		RISK RATING: Inherent risk rating: 3 (C) x 5 (L) = 15 significant Current risk rating: 3 (C) x 4 (L) = 12 high Target risk rating: 3 (C) x 2 (L) = 6 medium		RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Medical Director last review: June 2025 Q&S Committee last review: June 2025 Risk Ratings review: June 2025 In collaboration with F&P and People	If we fail to understand health inequity with our communities, we may fail to deliver services in an equitable way, which could contribute to health inequity and our patient's ability to improve their health. <u>Risks on register 15 plus</u> 1138 Community Paediatric doctor capacity, Warrington (<i>x-ref 2,5,6</i>) 1139 Community Paediatric / NDP waiting times, Halton (<i>x-ref 2,5,6</i>) 3241 Community Paediatrics demand, Warrington & Halton (<i>x-ref 2,4,5,6</i>) 3266 Community Paediatric clinical harm reviews, Warrington & Halton (<i>x-ref 2,5,6</i>) 3271 Community Paediatric ADHD diagnostic reviews, Warrington & Halton (<i>x-ref 2,5</i>)	<u>Prevent Controls</u> - Board development - Chair working within wider system - Contributing to work across the system in relation to developing Children's Services - Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint - Health Inequalities and Prevention Pledge Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones - Performance framework – enabling strategies - operation delivery plans - Embedding an expectation of improving health equity in board, committees and Trust groups.	<u>Detect Controls</u> - Execs carrying out SRO roles within system - Joint working on a number of projects with commissioners and local authority - Patient Satisfaction Surveys - Regular Exec meetings with commissioners and other key stakeholders - Senior staff involvement with borough based integrated care partnerships visions including: 'Warrington Together', 'One Halton' and Dental Networks - Understanding activity and referral data in relation to access to services - Health & Wellbeing Boards - CIPHA - Childrens and Adults safeguarding Boards	<u>Assurances</u> - Emerging integrated governance structures with partners - Engagement internally / externally - Executive Directors hold regular meetings with all key partners and stakeholders - Implementing Dental Strategy with partners - Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff - MOU in place where services are delivered in conjunction with other partners - Programme Director – Collaboration and Integration - Achieving Anchor status - Developing health equity indicators in IQPR	
Risks on register 12 2985 Dental GA Paediatric Access	Rationale for current score - Enabling strategies: - Prevention Pledge - JSNA - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports. - Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. Increased assurance from system relationships and partnerships - Health equity will be influenced by national, regional and local policies. The Trust will influence some elements of health equity but cannot be singularly responsible for improving health equity where we work.				<u>Audits</u> 2023/24 Risk Management Core Controls – High Consultant Job Planning – Moderate Dental Network – Moderate Patient Feedback – Moderate Quality Spot Checks – Limited 2024/25 Risk Management Core Controls – High Dermatology – Substantial PSIRF – Substantial Quality Spot Checks – Moderate
Gaps in controls and assurance: - Health equity improvement is a system responsibility - Mature health equity indicators - Quality Impact Assessment Panels					Mitigating actions:

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 4: Staff Failure to sustain an environment for staff to develop, grow and thrive.	RELATED OBJECTIVES: - Equality, Diversity and Inclusion - Health Equity - Partnerships - Resources - Quality		RISK RATING: Inherent risk rating: 4 (C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 4 (L) = 16 significant Target risk rating: 4 (C) x 1 (L) = 4 low		RISK APPETITE: SEEK - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Director of People & OD last review: July 2025 Strategic People Committee in Common last review: July 2025 Risk Ratings review: July 2025	If we fail to sustain an environment for staff to develop, grow and thrive, in a safe, inclusive environment then it may result in low staff morale, less effective teamwork, reduced compliance with policies and standards; high levels of staff absence; and high staff turnover rates. <u>Risks on register 15 plus</u> 3241 Community Paediatrics demand, Warrington & Halton (<i>x-ref 2,3,5,6</i>)	Prevent Controls - Apprenticeship Programme - Bi-monthly meetings with Staff Side - Freedom to Speak Up & Listening to staff voices - In-house Resilience Training Programme - Local Negotiating Committee, Joint Negotiation & Consultative Committee - North West Person-Centred approach to absence management - Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian - Onboarding surveys - People Committee Organisational and local Staff engagement plan - People Plan, Promises & NHS Long Term Workforce Plan - POD Council - Culture and Leadership - Recruitment & Retention - Health & Wellbeing programme - Education & Professional development - PPDR and Statutory & Mandatory Training compliance report - Talent Management process and Succession Planning Tool (Scope For Growth) - Reward and recognition packages - Exec vacancy control panel - Vacancy Management (standing agenda item DLTs) - Workforce planning and plans - Staff governors - Choose Kindness campaign and initiatives - Sexual safety campaign and initiatives	Detect Controls - Strategic People Committees-in-Common with WHH - Feedback from Quality and Safety Committee on workforce issues - Safer staffing - Monthly Time to Talk including CEO Q&A sessions - Freedom to Speak Up & Listening to staff voices - National Staff Survey - North West Person-Centred approach to absence management (early adopter Trust) - Onboarding surveys - People Indicators / KPIs - POD Council (operational plans) - Culture and Leadership - Recruitment & Retention - Health & Wellbeing programme - Education & Professional development - PPDR and Statutory & Mandatory Training compliance report - Exit interview questionnaire - Staff Friends and Family Test (SFFT) and Staff Engagement Surveys - Staff Networks - Staff Stress Audit Survey	Assurances - Employee Relations Activity Report - Outcome of Staff Survey – sustained score for staff engagement - Responsible Officer’s Board report - Staff Survey and ‘temperature check’ surveys - Triangulation of People Indicators - Improved staff survey scores (2024) - Improved KPI indicators - Bronze accreditation – North West Anti Racist Framework Audits 2023/24 Stress Risk Assessments – Limited 2024/25 Freedom to Speak Up – High Bank & Agency – Moderate	
Risks on register 12 3296 Podiatry waiting lists	Rationale for current score - Enabling strategies: - People - EDI Strategy - Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair’s Reports. - Vacancy management rates				
Gaps in controls and assurance: - Staff morale and resilience (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes - Lack of national system for talent management – Trust has local processes in place		Mitigating actions:		Emerging risks: Ability to resource the integration programme System wide commitment to level playing field on incentives National shortage of key staff groups Proposed pay offer, and nursing & midwifery profiles Apprenticeship levy	

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 5: Resources Failure to use our resources in a sustainable and effective way	RELATED OBJECTIVES: - Equality, Diversity and Inclusion - Health Equity - Quality - Staff	RISK RATING: Inherent risk rating: 4 (C) x 5 (L) = 20 significant Current risk rating: 4 (C) x 4 (L) = 16 significant Target risk rating: 4 (C) x 2 (L) = 8 medium	RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.	
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Director of Finance last review: July 2025 F&P Committee last review: July 2025 Risk Ratings review: July 2025 In collaboration with People	Failure to use our resources in a manner to delivery our operational plan. Failure to achieve the CIP target and the additional system savings required (Resources include workforce, finance, estates and digital) <u>Risks on register 15 plus</u> 1138 Community Paediatric doctor capacity, Warrington (x-ref 2,3,6) 1139 Community Paediatric / NDP waiting times, Halton (x-ref 2,3,6) 3241 Community Paediatrics demand, Warrington & Halton (x-ref 2,3,4,6) 3266 Community Paediatric clinical harm reviews, Warrington & Halton (x-ref 2,3,6) 3271 Community Paediatric ADHD diagnostic reviews, Warrington & Halton (x-ref 2,3) 3341 Failure to provide contracted Dental Services within GM (x-ref 5) Cross-referenced with BAF 2, Quality	Prevent Controls Careful utilisation of our resources will enable us to invest and transform our services to ensure continued sustainability of the services we provide. This will be achieved through: Finance - National and regional financial planning and management arrangements, Trust Financial Plan and planning process, Accountability Framework and Standing Financial Instructions with limits approved by the Board, Agreed medical and nursing revalidation protocols, preparation and remedial processes. People - Agreed recruitment and selection policies and processes (safer recruitment / FPPT). Bi-monthly meetings with staff side between JNCC, HR Policies and working groups, People Strategy & NHS Long Term Workforce Plan, POD Council, DLT discussions including HR Business Partners, Business continuity plans in place, Robust temporary staffing expenditure control and monitoring – MIAA follow up in progress Digital - Trust Digital Strategy, project governance and assurance, DSP Toolkit, GDPR Cyber Security standards, Service Management standards (ITIL, ISO etc) Estates - Capital Plan, Estates Strategy Trust hybrid working Green Plan, Process around Capital and Revenue Business Cases Operations - Transformation Council etc Vacancy approval process in place Increased scrutiny by Committee	Detect Controls - Delivery Unit (Pay, non pay, productivity) - Variable staff/pay reporting (bank, agency & overtime) - Staff sickness reporting - Audit Committee receives reports from internal audit and external audit - Capital Group monthly review - CIP plus QIA/EQIA process - Committees receive Audit Recommendations tracker - F&P Committee review monthly financial performance - People Committee review KPIs - ICB control and reporting (finance, workforce and activity) - NHSE monthly returns - Staff survey / Pulse Survey results - Turnover rate reporting - Vacancy control panels - Digital - Estates	Assurances - Board review of internal audit plan - Board review of external audit plan and annual accounts - Escalation from Quality & Safety Committee - Health Rostering / Safer Staffing Report - Integrated Quality Performance Report includes workforce metrics including training levels and ‘heat map’ - Monthly Finance Report including - Financial position / Forecast Position - Cash & Capital - Working Capital - CIP - Performance report indicating number of lapsed registrations each month - Review of Winter Plans - Workforce approval panel - Vacancy approval process reviews use of variable staff – regular review of staffing levels - Workforce plans developed for all services - Apprenticeship Levy Audits 2023/24 Accounts Payable – High Accounts Receivable – High Treasury Management – High General Ledger – Substantial DSPT – Substantial 2024/25 General Ledger – High Accounts Payable – High Accounts Receivable – High Treasury Management – High EPRR – Substantial Bank & Agency – Moderate
Gaps in controls and assurance: - The 2025/26 Trust challenging CIP as not all programmes have not been finalised and implemented. Contingency schemes not yet identified - Reduction in variable pay spend targets. The Trust is focussing on supporting all teams to deliver the planned savings and spend reductions and support and advice sessions will be included in the Senior Leadership Team meeting.		Mitigating actions: 2024/25 Financial recovery plan actions to continue 2025/26. - Delivery Unit established		
		Emerging risks: - Ability to resource the integration programme - ICB management of system deficit - Review of Trust estate		

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 6: Equality, Diversity & Inclusion Failure to build a culture that champions ED&I for staff	RELATED OBJECTIVES: • Health Equity • Resources • Staff		RISK RATING: Inherent risk rating: 4(C) x 4 (L) = 16 significant Current risk rating: 4 (C) x 3 (L) = 12 high Target risk rating: 4 (C) x 1 (L) = 4 low		RISK APPETITE: OPEN Willing to consider all potential delivery options and choice while also providing and acceptable level of reward
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Director of People & OD last review: July 2025 Strategic People Committee in Common last review: July 2025 Risk Ratings review: July 2025 In collaboration with F&P and Q&S	If we fail to continue to build a culture that champions EDI for staff, (the baseline) then: - we will not meet the diverse needs of our workforce, adversely impacting on the provision of compassionate care to our diverse population, representative of the communities we serve. - staff with protected characteristics may have a poor experience <u>Risks on register 15 plus</u> 1138 Community Paediatric doctor capacity, Warrington (x-ref 2,3,5) 1139 Community Paediatric / NDP waiting times, Halton (x-ref 2,3,5) 3241 Community Paediatrics demand, Warrington & Halton (x-ref 2,3,4,5) 3266 Community Paediatric clinical harm reviews, Warrington & Halton (x-ref 2,3,5)	Prevent Controls • Bronze accreditation – North West Anti-Racist Framework • Bi-monthly meetings with Staff Side with regard to the NHS EDI Improvement Plan • Equality delivery system 2 • Education & Professional development • Health & Wellbeing programme • Local Negotiating Committee and Joint Negotiation & Consultative Committee • North West Person-Centred approach to absence management (one of 4 Trusts piloting this) • People Committee • Organisational and local Staff engagement plan • POD Council • Public Sector Equality Duty • Recruitment & Retention processed (EDI focused) • Talent Management process and Succession Planning Tool (Scope For Growth) • Just Culture • WDES • WRES • Choose Kindness campaign and initiatives • Sexual safety campaign and initiatives	Detect Controls • Feedback from Quality and Safety Committee on workforce issues • Freedom to Speak Up process • Employee relations activity/case loads • Gender Pay Gap Report • HR Policies & Procedures • In-house Resilience Training Programme • Key Operational Delivery Controls • National Staff Survey • NW EDI Group • NW BAME Assembly Support • POD Council • Revised exit interview questionnaire and processes • Staff Friends and Family Test (SFFT) and Staff Engagement Surveys • Staff Stress Audit Survey • Staff survey feedback	Assurances • Outcome of Staff Survey – sustained score for staff engagement • People Operational Delivery Actions Plans • Public Sector Equality Duty • Staff Networks • Staff Survey and ‘temperature check’ surveys • People Indicators and KPIs	
Risks on register 12 2985 Dental GA Paediatric Access	Rationale for current score • Current risk rating reflects that the Board acknowledges that, despite the controls and assurances in place, this will be ongoing: • Organisational restructures, service redesigns and reorganisations • Patient experience may be adversely affected (links to Q&S Committee) • Restoration and recovery programmes / post covid effects • Recovery from Industrial Action • Uncertainty / Impact of national change programmes – Health & Care Act integration and collaboration • Enabling strategies: • Equality, Diversity & Inclusion • People Committee ensure governance and holds to account. • Triangulation with Risk Registers, incidents, employee relations activity, items on Committee agendas, Council Chair's Reports, IQPR People Indicators and KPIs	Audits			
Gaps in controls and assurance: • Engagement with staff groups including BAME and LGBT+ staff (remain until all established and Networks are embedded)		Mitigating actions:		Emerging risks:	

Board Assurance Framework (BAF) August 2025 – FINAL

BAF 7: Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system		RELATED OBJECTIVES: • Quality • Health Equity • Staff • Resources • Equality, Diversity and Inclusion • Partnerships		RISK RATING: Inherent risk rating: 3 (C) x 4 (L) = 12 high Current risk rating: 3 (C) x 3 (L) = 9 medium Target risk rating: 3 (C) x 2 (L) = 6 low	RISK APPETITE: SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances			
Chief Executive last review: May 2025 EMT last review: May 2025 Risk Ratings review: May 2025	If we fail to work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities, then: - we will fail to work with partners to champion patient care, resulting in failure to optimise outcomes and failure to effectively use resources If the Trust fails to successfully integrate services with WHH in a timely manner, there is a risk that: - The system remains clinically and financially unsustainable - We will not make the sustained improvements needed to the local urgent and emergency care system and pathways <u>Risks on register 15 plus</u> No risks at this level	<u>Prevent Controls</u> • Better Care Together programme with WHH • ‘Communities Matter’ Trust Strategy • Contributing to work across the system in relation to developing services • Emerging integrated governance structures with partners • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff • Voluntary and Community Link Workers providing targeted support to contribute to the overall enhancement of well-being • SLA in place with GP Health Connect	<u>Detect Controls</u> • Ongoing Board development • Contributing to work across the system in relation to developing services • Joint working on a number of projects with commissioners and local authorities • Performance framework – enabling strategies - operation delivery plans • Senior staff involvement with borough based integrated care partnerships visions; ‘Warrington Together’, ‘One Halton’ and dental managed clinical networks • Clinical engagement with Dental managed clinical networks • Place-based maturity assessments (Warrington Together and One Halton) • Joint CEO with WHH • Joint Medical Director with WHH • Joint Chief Operating Officer with WHH • Data sharing agreement with WHH • Summary case for change approved	<u>Assurances</u> • Implementation of dental strategy with partners • SLAs and MOUs in place where services are delivered in conjunction with other partners • Programme activity of the Mental Health, Community and Learning Disability Provider Collaborative • Public and community engagement • Place-based leadership and influence • ICB Virtual Ward programme • PCN developments and relationships • Progress on Family Hubs with Halton Council and partners • EDI Strategy in place • Public & Community Engagement Group	
<u>Risks on register 12</u>	Rationale for current score • Better Care Together programme • Enabling strategies: ◦ Dental • Increased assurance from system relationships and partnerships • Triangulation with Risk Register, Staff Survey, reports from Partner organisation, items on all Committee agendas, Council Chair’s Reports and EDI Improvement Plan. • Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. • Current level of investment in Place-based set up • Contribution to Warrington based adaptive reserve fund				
Gaps in controls and assurance: • Lack of integration governance systems • Maturity of place-based relationships • Impact of pressures (inc. finance)		Mitigating actions: • Better Care Together programme • Joint executive roles		Emerging risks:	

Board Assurance Framework (BAF) August 2025 – FINAL

No.	Risk Title	Inherent			Target			Q2			Q3			Q4			Q1			Change	Impact on Objectives					
		Score			Score			Jul-Sep			Oct-Dec			Jan - Mar			Apr-Jun				Quality	Health Equity	Staff	Resources	Equality, Diversity & Inclusion	Partnerships
		C	L	S	C	L	S	C	L	S	C	L	S	C	L	S	C	L	S							
BAF 1	Governance Failure to implement and maintain sound systems of corporate governance	4	4	16	4	2	8	4	2	8	4	2	8	4	2	8	➡	✓	✓	✓	✓	✓	✓			
BAF 2	Quality Failure to deliver quality services and continually improve	5	5	25	5	2	10	5	3	15	5	3	15	5	3	15	➡	✓	✓	✓	✓	✓	✓			
BAF 3	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	2	5	10	2	2	4	3	4	12	3	4	12	3	4	12	➡	✓	✓	✓	✓	✓	✓			
BAF 4	Staff Failure to create an environment for staff to grow and thrive	4	4	16	4	1	4	4	2	8	4	2	8	4	4	16	⬆	✓	✓	✓	✓	✓	✓			
BAF 5	Resources Failure to use our resources in a sustainable and effective way	4	4	16	4	1	4	4	3	12	4	4	16	4	4	16	➡	✓	✓	✓	✓	✓	✓			
BAF 6	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	4	4	16	4	1	4	4	3	12	4	3	12	4	3	12	➡	✓	✓	✓	✓	✓	✓			
BAF 7	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system	3	4	12	3	2	6	3	3	9	3	4	12	4	3	12	➡	✓	✓	✓	✓	✓	✓			

Board Assurance Framework (BAF) August 2025 – FINAL

Appendix 1: Risk grading criteria

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its **Consequence** (the scale of impact on objectives if the risk event occurs) and its **Likelihood** (the probability that the risk event will occur).

The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

	Consequence score & descriptor with examples				
Risk type	Very low 1	Low 2	Moderate 3	High 4	Very high 5
a. Patient harm or b. Staff harm or c. Public harm	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: • Discomfort.	Minor, short term injury or illness, requiring non- urgent clinical intervention (e.g., extra observations, minor treatment or first aid). e.g.: • Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. • Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: • Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. • Grade 2 or3 pressure ulcer. Healthcare associated infection (HCAI). • Noticeable adverse reaction to medication. • RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual, e.g.: • Loss of a limb Permanent disability. • Severe, long-term mental illness. • Grade 4 pressure ulcer. Long-term HCAI. • Retained instruments after surgery. • Severe allergic reaction to medication.	Multiple fatal injuries or terminal illnesses.
d. Services	Minimal disruption to peripheral aspects of service.	Noticeable disruption to essential aspects of service.	Temporary service closure or disruption across one or more divisions.	Extended service closure or prolonged disruption across a division.	Hospital or site closure.
e. Reputation	Minimal reduction in public, commissioner and regulator confidence. e.g.: • Concerns expressed.	Minor, short-term reduction in public, commissioner and regulator confidence. e.g.: • Recommendations for improvement	Significant, medium-term reduction in public, commissioner and regulator confidence e.g.: • Improvement / warning notice • Independent review	Widespread reduction in public, commissioner and regulator confidence. e.g.: • Prohibition notice	Widespread loss of public, commissioner and regulator confidence. e.g.: • Special Administration • Suspension of CQC Registration • Parliamentary intervention
f. Finances	Financial impact on achievement of annual control total of up to £50k	Financial impact on achievement of annual control total of between £50 - 100k	Financial impact on achievement of annual control total of between £100k - £1m	Financial impact on achievement of annual control total of between £1 - 5m	Financial impact on achievement of annual control total of more than £5m

Likelihood score & descriptor with examples				
Very unlikely 1	Unlikely 2	Possible 3	Somewhat likely 4	Very likely 5
Less than 1 chance in 1,000 Statistical probability below 0.1% Very good control	Between 1 chance in 1,000 and 1 in 100 Statistical probability between 0.1% - 1% Good control	Between 1 chance in 100 and 1 in 10 Statistical probability between 1% and 10% Limited effective control	Between 1 chance in 10 and 1 in 2 Statistical probability between 10% and 50% Weak control	Greater than 1 chance in 2 Statistical probability above 50% Ineffective control

Risk scoring matrix						
Consequence	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
Likelihood						

Rating	Very low (1-3)	Low (4-6)	Medium (8-9)	High (10-12)	Significant (15-25)
Oversight	Specialty / Service level annual review		Directorate quarterly review		Board monthly review
Reporting	None			Relevant Board Committee	

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	60/25		
Report Title	KEY CORPORATE MESSAGES		
Executive Lead	Nikhil Khashu, Chief Executive		
Report Author	Jan McCartney, Director of Corporate Governance		
Presented by	Nikhil Khashu, Chief Executive		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			
The Board is asked to note the content of the report			
Previously considered by:			
☐ Audit Committee ☐ Quality & Safety Committee			
☐ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee			
☐ Strategic People Committee in Common ☐ EMT			
Strategic Objectives			
☒ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			



How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☐ Effective	☐ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	60/25		
Report Title	KEY CORPORATE MESSAGES		
Report Author	Jan McCartney, Director of Corporate Governance		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole.		

1. NON-EXECUTIVE DIRECTOR UPDATES

1.1 The Chair attended the following meetings:

30 May – Cheshire and Merseyside Rapid Diagnostic Review meeting with PWC.
 13 June – MIAA Seminar regarding fraud.
 19 June – Warrington and Halton Integration meeting with the ICB.
 25 July – Good Governance Institute Seminar regarding the 10 Year Plan.
 29 July – Council of Governors meeting – welcoming new governors.

The Chair also attended two Time to Shine meetings on 12 June, where presentations were provided from the Halton Wellbeing Team, Enhanced Care Support Team and Halton 0-19 services and on 8 July, a presentation was received from dental services.

Two NHSE meetings took place on 3 July and 8 July which the Chair attended. The focus of the first meeting was the launch of the 10 Year Plan and the following meeting focused on strengthening our NHS for tomorrow.

The Chair held several 1-1 meetings as follows:

- The Medical Director on 30 May
- The Chief Operating Officer on 5 June
- The Company Secretary from Warrington & Halton Teaching Hospitals Foundation Trust on 17 June

The Chair attended a mentor meeting with the Chair of Bristol University NHS Foundation Trust took on 16 July.

On 23 July, the Chair visited the services provided by Bridgewater at Padgate House.

1.2 Non-Executive Director, Bob Chadwick attended two Extra-Ordinary Audit Committee meetings on 12 June and 25 June, a meeting with internal audit on 20 June and on 6 July, a

meeting with Cheshire and Merseyside Chairs of Audit. Bob also had 1-1 meetings with the Chair on 18 and 30 June.

- 1.3 Non-Executive Director, Tina Wilkins attended the Voice of the Child Forum on 10 June. Tina accompanied the Medical Director on his Time to Talk with the Leigh Dental Team on 10 July and on 17 July accompanied the Director of Corporate Governance on the Time to Talk with the Warrington Neurodevelopment/Learning Disability Team

2. EXECUTIVE DIRECTOR UPDATES

- 2.1 On 1 July the following changes were made in relation to Executive members of the Board:

- Lynne Carter became the Director of the Delivery Unit for both Bridgewater and Warrington and Halton Hospitals NHS FT (WHH) but remains as the Deputy CEO for Bridgewater.
- Alison Kennah became the joint Chief Nurse for both Bridgewater and WHH.
- Paul Fitzsimmons, the joint Medical Director, became the Caldicott Guardian for Bridgewater.

- 2.2 The Chief Executive attended the North West System Leaders on 3 June. Key topics discussed were the Regional Performance & Delivery of 2025/26 plans, the next steps for the Future Ready Programme and the 10 Year Plan.

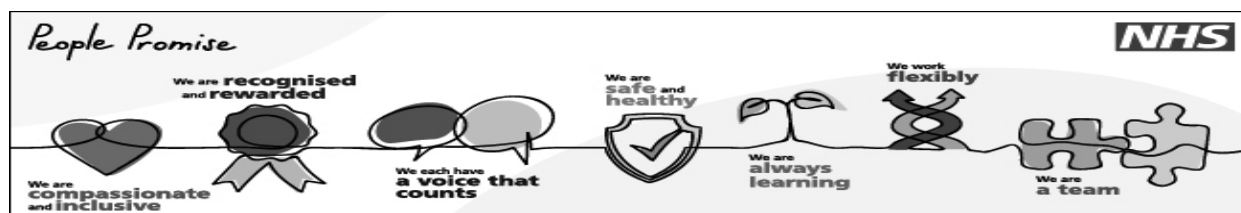
- 2.3 The Chief Executive attended the NHS Confederation/Expo meeting in London on 11 June and on 12 attended the HFMA Conference in Chester.

- 2.4 The Chief Executive visited the Paediatric Bladder and Bowel service based at Sandy Lane, Orford, Warrington on 13 June.

- 2.5 On 10 July, the Chief Executive attended an NHS Leadership event for ICB and Trust Chief Executives.

Executive and Senior Team Engagement

- 2.6 The Trust's Time to Talk process now aligns to the NHS Our People Promises and its seven elements.



- 2.7 These are measured by the Staff Survey and Quarterly Pulse Survey which enables us to further internally assess how we are delivering on these Promises.

2.8 The sessions are set up to allow the Executive Team to update staff on Trust news, ask questions about the teams and service and to take an interest in staff health and wellbeing. It also provides an opportunity for staff to share good news stories and to ask any questions of the executive team.

2.9 The following Time to Talk sessions have taken place:

2.9.1 The Medical Director met with the dental team from Leigh Health Centre on 10 July. Non-Executive Director, Tina Wilkins accompanied the Medical Director on this visit.

2.9.2 On 10 July, the Director of People & Organisational Development held a virtual meeting with the community matrons. Non-Executive Director, Abdul Siddique joined this session.

2.9.3 The Director of Corporate Governance met with the Warrington Neurodevelopment/Learning Disability Nursing Teams on 17 July. Non-Executive Director, Tina Wilkins joined this session.

2.10 Board Sessions/Events

Board to Board Session

On 2 July 2025 the Board was invited to join a session with WHH Board where the CQC attended to provide an overview of the most up to date Well Led Framework. This was followed by a formal Board to Board meeting where the Strategic Case for change was approved, along with the integration milestone plan. The Boards also approved the Joint Committee of the Boards terms of reference.

Altrincham Dental Hub

On 22 July, the new Altrincham Dental Hub was officially opened by Chair and Chief Executive Officer of Bridgewater Community Healthcare NHS Foundation Trust. This hub is a modern, purpose-built facility located within the Altrincham Health and Wellbeing Centre. Designed as a “one stop shop” for specialist community dental care, the clinic offers fully equipped treatment rooms with the latest dental technology, including on-site X-ray equipment. It caters to patients who cannot access standard NHS dental services due to complex needs. The environment has been carefully created to reduce anxiety, especially for children, and aligns with the NHS 10 Year Health Plan’s focus on personalised care.

3. DIRECTORS’ FEEDBACK FROM TIME TO TALK SESSIONS

3.1 Monthly feedback from the Executive Team is collated. An example of the feedback received in respect of the visit to the Warrington Neurodevelopment/Learning Disability Nursing Team included:

“The team was welcoming, passionate and really upbeat. They were keen to share their successes and could articulate easily how they improve the lives of many patients across Warrington”.

4. EXTERNAL PUBLICATIONS, REPORTS & LOCAL NEWS

4.1 NHS Oversight Framework

On 26 June 2025 the NHS Oversight Framework 2025/26 was published, it introduces a unified approach to evaluating the performance of Integrated Care Boards and NHS Trusts, focusing on six domains including access, safety, and health inequalities. Organisations are segmented from 1 (high-performing) to 5 (requiring intensive support), with financial discipline playing a key role—those in deficit are capped at Segment 3. NHS England will tailor support based on segmentation, and a public dashboard will display scores.

Bridgewater Community Healthcare NHS Foundation Trust has been placed in **Segment 3**.
[NHS England » NHS Oversight Framework 2025/26](#)

4.2 Fit for the Future: 10 Year Health Plan for England

The 10 Year Health Plan for England was published on 3 July 2025. This plan The NHS 10 Year Health Plan, titled *Fit for the Future*, sets out a bold transformation of the health system to ensure its sustainability and relevance for future generations. It is built around three strategic shifts: moving care from hospitals to communities, transitioning from analogue to digital systems, and shifting focus from treatment to prevention. The plan aims to personalise care, empower patients, and reduce health inequalities by integrating services locally, expanding digital tools like the NHS App, and investing in public health and early intervention. It also prioritises workforce development, financial sustainability, and a cultural reset to reduce bureaucracy and improve staff morale.

[10 Year Health Plan for England: fit for the future - GOV.UK](#)

Attached at appendix A is letter from, Dr Penny Dash, the Chair of NHS England.

4.3 PWC – Rapid Financial Diagnostic Report (June 2025)

This report, whilst the contents are confidential, assesses the financial position of Bridgewater within the Cheshire and Merseyside Integrated Care System (ICS) for FY25/26. It highlights the ICS's significant financial challenges, including a large system-wide deficit and ambitious efficiency targets. Bridgewater plans for a modest deficit and has identified savings targets, though some are high-risk and depend on broader system changes. The report emphasises the need for collective system-wide action and leadership to deliver financial recovery and long-term resilience.

5. RECOMMENDATIONS

5.1 The Board is asked to note the report.

To: • ICB and NHS trust chairs and
Executive teams

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

cc. • NHS England regional directors

3 July 2025

Dear colleagues

Fit for the Future: 10 Year Health Plan for England

Today sees the publication of Fit for the Future, our 10 Year Health Plan for England: an important milestone in the broader reset of the NHS, which describes the ambitions of the staff, patients, partners and citizens that have contributed to its development over the last year.

Throughout our leadership discussions over the last few months, the importance of returning to being more ambitious for our staff and patients has been a consistent theme: Fit for the Future provides the platform for us as a leadership community to inspire our teams to be bold and impatient for change.

It's a pivotal moment. We've talked a lot about the three big shifts over the last 12 months: today's publication sets out a route map on how we can use these to fundamentally change the way we deliver care over the next decade.

That change will only happen if we get the foundations right. So, our continued leadership focus on resetting how we work over the months ahead is crucial to creating the conditions and headspace we need to deliver change. In the short term, prioritising financial discipline, delivery of our commitments and a relentless focus on preparing for winter this year will put us in good shape to push on with the ambitions set out in the 10 Year Health Plan.

For our part, moving us quickly to medium term planning, aligning how the centre and regions work to support you better, and simplifying rules and accountability, remain absolute priorities for the months ahead.

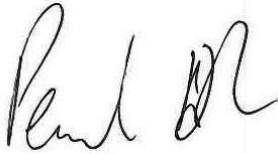
We will work closely with you over the summer to align all of these priorities and agree our collective delivery approach for Fit for the Future – focusing on those elements of the plan that will have the most immediate impact on our staff and patients, while looking ahead at the more medium and long-term changes we need to make.



Alongside the plan, your team will receive a communications pack to support you in cascading its key messages. It would be great if you and your senior team could spend time looking at the plan, so we can talk through next steps in more detail in the coming weeks.

In the meantime, we are all aware of the very real challenges we face getting the NHS back to a place where our staff and public want and need it to be. Today's publication of Fit for the Future gives us all an opportunity to galvanise energy and optimism about the future, and the need for your leadership in this has never been more important.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Penny Dash', with a stylized flourish at the end.

Dr Penny Dash
Chair, NHS England

A handwritten signature in black ink, appearing to read 'James Mackey', with a large, sweeping loop at the end.

Sir James Mackey
Chief Executive, NHS England

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	61/25i		
Report Title	IQPR Month 02		
Executive Lead	Dan Moore, Chief Operating Officer		
Report Author	Melanie McLaughlin, Acting Director of Operations/Deputy Chief Operating Officer		
Presented by	Executive Leads		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			
The IQPR relates to performance across the Trust in Month 02 – May 2025. There are 27 Green and 20 Red Performance indicators, with performance breaches noted in Dermatology, Audiology six-week diagnostic waits, and percentage of patient waiting over 18 and 52 weeks. Activity variance for Halton Adults, Warrington Adults and the Children's Directorate is currently not on target. In the dental service, the numbers of waiters within each time band have remained relatively consistent. There are 26 Green and 6 Red Quality indicators. Breaches have been identified in the following areas: percentage of incidents reported within 48 hrs, percentage of patient safety incidents that are medications incidents, total number of acquired pressure ulcers, and the percentage of category 3 pressure ulcers and category 4 pressure ulcers acquired in Bridgewater. There are 3 Green and 1 Red People indicators, with performance target breaches against actual sickness absence rates. Finance details include reporting a deficit of £0.88m, £0.01m favourable to plan and a year-to-date savings achievement of £0.76m against a plan of £0.76m.			
Previously considered by:			
☐ Audit Committee ☒ Quality & Safety Committee (quality indicators)			
☒ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee			
☒ Strategic People Committee in Common (people indicators) ☐ EMT			
Strategic Objectives			
☐ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			

☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☒ BAF 2	☒ BAF 3	☒ BAF 4	☒ BAF 5	☒ BAF 6	☒ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☒ Caring	☒ Effective	☒ Responsive	☒ Safe	☐ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	61/25i		
Report Title	IQPR Month 02		
Report Author	Melanie McLaughlin, Acting Director of Operations/Deputy COO		
Purpose	To provide Board with an overview of the Month 02 IQPR.		

1. OVERVIEW

Responsive (Operations)

There are 27 Green indicators and 20 Red indicators in month 2.

- Six Red to Green indicators
 - Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment
 - Unplanned re-attendance rate < 5%
 - Referrals to plan - Children's
 - A&E: Total time in A&E (% of pts who have waited <= 4hrs)
 - Total time in A&E - 95th Percentile (Mins)
 - Community Health Services Sitrep - % waiters over 104 weeks (1 month in arrears)
- Two Green to Red indicators:
 - Percentage of children who received a 2 - 2½ - year review, by the age of 2½ years – Halton
 - Percentage of children who received a 2 - 2½ - year review in the quarter, using ASQ 3 - Halton
- 24 indicators have shown an in-month improvement
- 23 indicators have shown an in-month deterioration
- 0 indicator has shown no in-month changes

Safe, High-Quality Care (Quality)

- There are 26 green indicators and 6 red indicators in month 2:
- One Red to Green indicator:
 - BCHFT patients Falls per 1,000 bed days – bed based
- One Green to Red indicator:
 - % of category 4 pressure Ulcers acquired
- 8 indicators have shown an in-month improvement
- 13 indicators have shown an in-month deterioration
- 11 indicators have shown no in-month changes

People

There are 3 green indicators and 1 red indicator in month 2:

- 0 Red to Green indicators
- 0 Green to Red indicators
- 3 indicators have shown an in-month improvement
- 1 indicator has shown an in-month deterioration

Making Good Use of Resources (Finance):

- The Trust is reporting a deficit of £0.88m, £0.01m favourable to plan.
- The Trust is reporting a savings achievement of £0.76m against a plan of £0.76m.

2. OPERATIONS HIGHLIGHTS

Warrington Dermatology Cancer 31 - day 2nd treatment comprising surgery

- This indicator is reported by exception due to performance of 50% against a target of 94%.
- Bridgewater have a very small number of patients relating to this indicator. This was 2 patients out of a total of 4. One breach was due to a specific Consultant being required to complete the surgery. The second breach was delayed due to patient choice but has now been seen.

Percentage referred onto A+E (UTC)

- This indicator is reported by exception due to performance of 12.08% against a target of 3%.
- The service is looking closely at data recording pertaining to patients that are discharged onto A&E. This indicator should reflect patients that have attended UTC inappropriately and were onward streamed to A&E
- Currently, the number also includes patients that were discharged to Hospital for specialist services, such as fracture clinics. The services will request a more appropriate list of discharge reasons to be configured.

Percentage of DNAs/Was not brought – Children's

- This indicator is reported by exception due to performance of 6.45% against a target of 3%.
- Most appointments where children are "not brought" are follow up contacts. Warrington Health visiting, Children's LD Nursing, Continence and Paediatric SLT report the highest numbers. The number of 'Was Not Brought' cases has shown an overall reduction since January 2025. However, a slight increase was noted in month, likely due to the impact of the Easter holidays. Plans to reduce 'Child not brought' include:
 - Develop communication packs for families to explain the importance and impact of visits and appointments
 - Utilise social media and family hubs to engage families
 - Review follow-up needs for SLT and other children's specialist services and consider virtual follow ups
 - Regularly update the services website with DNA statistics and their impact on waiting times

- Collaborate with parents care forums to disseminate consistent messages to families
- Review and discharge patients sooner if safe to do so
- Explore the possibility of text message responses for appointment confirmations

Warrington Audiology - Number of 6 weeks diagnostic breaches

- This indicator is reported by exception due to a performance of 63 against a target of 0.
- The number of breaches increased again in May; this was influenced by the departure of a locum audiologist in April, combined with seasonal annual leave. Both have contributed to an increase in waiting times.
- Interviews for the vacant audiologist post were held on 6th March. The successful candidates commenced in post in June 2025.
- The service is currently developing and implementing a plan aimed at reducing the number of 6-week breaches.

Community Health Services SitRep

- % Under 18 Weeks: 59.59%
- % Over 18 Weeks: 12.31%
- The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's Community Health Services. Community Health Services Sitrep submission does not include Dental or Dermatology waiting times.

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

- % Under 18 Weeks: 57.85%.
- % Over 52 Weeks: 10.44%.

Percentage of children who received a 2 - 2½ - year review, by the age of 2½ years – Halton

- This indicator is reported by exception due to performance of 89.07% against a target of 90%.
- The data has continuously been below the target of 90%, with the exception of quarter 3. However, it has seen an increase in performance in the last 2 quarters.
- The team have improved compliance by offering the health review at 2 years - 2 years 3 months in order to accommodate any change of appointment requests/Child Not Brought

Percentage of children who received a 2 - 2½ - year review in the quarter, using ASQ 3 – Halton

- This indicator is reported by exception due to performance of 82.52% against a target of 90%
- The target has only been met once in the past four quarters
- The ASQ 3 screening tool is not always appropriate for children with identified or suspected Special Educational Needs and Disabilities (SEND)
- The service is however exploring compliance with this KPI with BI colleagues – ASQ3 may have been completed but not accurately recorded in the electronic record.
- ASQ3 refreshers training and the peer review of child health reviews are planned to assess the quality of the assessments which will include the use of ASQ3.

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

- This indicator is reported by exception due to compliance at quarter 4 of 93.68% against a target of 95%
- The target set by Warrington commissioners is 93%
- The data for Q4 shows that 415 families received a face-to-face NBV within 14 days.
- Of the 28 that were not completed within 14 days:
 - 20 babies were on NNU.
 - 2 no access visits to prearranged appointments resulting in the contact taking place after day 14
 - 2 contacts rearranged to after day 14 at parental request.
 - 2 were completed late due to restricted days due to BH
 - 2 declined the contact
- The data has continuously been below the target of 95%.

Dental – Waiters by Time Band

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2025-04-22	4,346	1,257	2,292	239	31	15
2025-04-28	4,470	1,259	2,179	238	30	16
2025-05-06	4,576	1,113	2,190	253	33	16
2025-05-12	4,614	1,075	2,231	244	33	19
2025-05-19	4,734	1,040	2,131	255	32	20
2025-05-27	4,750	1,100	2,137	254	32	23
2025-06-02	4,316	1,168	2,063	257	34	37

- Cheshire & Mersey: currently have no patients waiting over 65 weeks. Patients are proactively managed through early opt-in processes, early assessment appointments and prioritisation based on minimum waiting times for treatment. This targeted approach has contributed to a reduction in patients waiting over 52 weeks, including within the most challenging pathway, Minor Oral Surgery (MOS).
- Greater Manchester: 112 patients waiting over 65 weeks. 100 are for Paediatric General Anaesthetic, 7 are for Inhalation Sedation (due to patients cancelling appointments) and 4 special care (adults) for General Anaesthetic. Managers book assessments in order of receiving referral or clinical priority

3. QUALITY HIGHLIGHTS

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

- This indicator is reported by exception due to performance of 86.99% against a target of 87%.
- This indicator is being monitored each month by the Directorate Incident Review and Learning Groups (DIRLG's). Further analysis of the data is being carried out to determine if there are any specific reasons why incidents have been reported outside of the required timescale. Further work with clinical and operational services is being undertaken to improve performance of the indicator.
- In May 2025, the compliance rate was 86.99%, compared to 84.93% in April 2025. This demonstrated an improved performance, which was 0.01% below target. Performance remained within the upper and lower control limits and was above the mean for the period covered by the SPC. Whilst the level of performance in May 2025, was an improvement and was fractionally below target, there is currently no evidence to indicate that this is due to anything other than common cause variation.

- The data is a mostly consistent trend of data points sitting close to the mean, yet below target. In February 2025 there was a significant improvement, yet the past three months have fallen back below target.

% of BCHFT patient safety incidents that are medications incidents

- This indicator is reported by exception due to performance of 13.01% against a target of 7%.
- A total of 19 medication-related patient safety incidents were reported across the Trust in May 2025. 16 incidents were categorised as causing 'Insignificant or No Harm' with 2 near misses and 1 incident resulting in minor harm.
- Although we saw a notable rise compared to the previous 6 months, overall incident levels remain within expected control limits. No patterns were identified in relation to service, location, drug, or individual clinicians.

IPC assurance audit compliance

- This indicator is reported by exception due to performance of 73.2% against a target of 90%.
- In April, the compliance collection method for hand hygiene and donning/doffing was revised to ensure a more accurate reflection of practice. As a result of this improvement, a reduction in compliance is anticipated, reflecting the increased accuracy of data reporting and enabling the team to be more effective in targeting areas for improvement.
- There was an increase in number of assurances not received in Month 2. 11 teams have not reported data in month. Operational Managers and Directorate Leadership teams have been informed.

Total number of BCHFT acquired pressure ulcers

- This indicator is reported by exception due to a performance of 26 against a target of 15.
- All data points remain within normal variation yet fluctuate around the mean
- During this reporting period there was an increase with 26 acquired pressure ulcers reported. 9 of those reported were in Halton and 15 in Warrington. 22 of the 26 incidents related to category 2 pressure ulcers.

% of Category 4 Pressure Ulcers acquired in Bridgewater

- There has been an inconsistent trend due to the low numbers reported
- This indicator is reported by exception due to a performance of 3.85% against a target of 0%.
- This relates to one incidence, which on clinical review, was subsequently downgraded and therefore compliant with the indicator in month.

% of Category 3 Pressure Ulcer acquired in Bridgewater

- This indicator is reported by exception due to performance of 11.54% against a target of 3%
- All data points are within standard variation
- The inconsistent trend in category three pressure ulcer incidents continue in month and has been recognised in the pressure ulcer priority group as an area for focused improvement on 2025/26

4. PEOPLE HIGHLIGHTS

Sickness absence rate (Actual)

- This indicator is reported by exception due to performance of 6.57% against a target of 5.50%.

5. FINANCE HIGHLIGHTS

The key headlines for Month 2 are as follows:

- The Trust is reporting a deficit at M2 of £0.88m, £0.01m favourable to plan.
- The Trust has a savings requirement, excluding system savings, of £5.48m (5.02%) in line with ICB instruction.
- The Trust is reporting a savings achievement of £0.76m against a plan of £0.76m
- Income is £16.41m against a plan of £16.56m.
- Expenditure is £17.29m against a plan of £17.46m.
- Pay is £12.29m against a plan of £12.06m.
- Agency spend is £0.07m against a plan of £0.22m.
- Non pay expenditure is £4.86M against a plan of £5.11M.
- Capital charges are in line with plan.
- Capital expenditure is £0m at M2, planned spend is £0m.
- Cash is £5.72m.

6. RECOMMENDATION

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

Communities Matter

Creating stronger, healthier, happier communities.



Bridgewater
Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: May 2025 (Month 2)



Contents

- Section 1: Trust Overview
- Section 2: Operations – Responsive
- Section 3: Safe, High-Quality Care
- Section 4: People
- Section 5: Finance - Making Good Use of Resources

Introduction

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

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

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

This month's report describes activity in May 2025.



Within this Report

1. KPI Amendments:

No amendments within Month 2.

2. Recommendations:

The Finance & Performance committee are asked to:

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

Trust Overview

Executive Summary

Responsive (Operations)

There are 27 Green indicators and 20 Red indicators in month 2.

- Six Red to Green indicators
- Two Green to Red indicators:
 - Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton
 - Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton
- 24 indicators have shown an in-month improvement
- 23 indicators have shown an in-month deterioration
- 0 indicators have shown no in-month changes

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 26 green indicators and 6 red indicators in month 2.

- One Green to Red indicators:
 - % of Category 4 Pressure Ulcers acquired in Bridgewater
- One Red to Green indicator:
 - BCHFT patient safety Falls per 1,000 bed days - bed based
- 8 indicators have shown an in-month improvement
- 13 indicators have shown an in-month deterioration
- 11 indicators have shown no in-month changes

Trust Overview

Executive Summary

People

There are 3 green indicators and 1 red indicator in Month 2.

- Zero Red to Green indicators
- Zero Green to Red indicators
- 3 indicators have shown an in-month improvement
- 1 indicator has shown an in-month deterioration

Making Good Use of Resources (Finance)

- The Trust is reporting a deficit at Month 2 of £0.88m, £0.01m favourable to plan.
- The Trust is reporting a savings achievement of £0.76m against a plan of £0.76m

Operations

Executive Summary

Of the 47 Operations indicators which are reported; 20 are red and 27 are green.

The 20 indicators which were red in May are as follows:

- Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery – Deterioration in Month
- Percentage referred onto A+E (UTC) – Deterioration in Month
- Data Quality Maturity Index (DQMI) (monthly internal reporting) – Deterioration in Month
- Data Quality Maturity index (DQMI) Monthly published score (3 months in arrears) – Deterioration in Month
- Percentage of was not brought – Childrens – Improvement in Month
- Audiology - Number of 6 weeks diagnostic breaches – Deterioration in Month
- Referrals to plan - Warrington Adults – Deterioration in Month
- Referrals to plan - Halton Adults – Deterioration in Month
- Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears) – Deterioration in Month
- All waiters - % waiting over 52 weeks (awaiting initial access) – Deterioration in Month
- All waiters - % waiting under 18 weeks (awaiting initial access) – Improvement in Month

Operations

Executive Summary – Continued

Red indicators (continued):

- Warrington Adults Activity Variance
 - Warrington Children's Activity Variance
 - Halton Adults Activity Variance
 - Halton Children's Activity Variance
 - Percentage of births that receive a face to face NBV within 14 days by a Health Visitor – Halton
 - Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton
 - Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton
 - Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington
- Deterioration in Month
 - Improvement in Month
 - Deterioration in Month
 - Improvement in Month
 - Deterioration in Quarter
 - Deterioration in Quarter
 - Deterioration in Quarter
 - Improvement in Quarter

Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		98.96% (▲)	94.52% (▼)	93.31% (▼)	95.07% (▲)	95.72% (▲)	99.35% (▲)	97.86% (▼)	98.47% (▲)	99.17% (▲)	97.29% (▼)	98.92% (▲)	95% (▼)	95.61% (▲)
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (▶)	50% (▼)	100% (▲)	100% (▶)	66.67% (▼)	0% (▼)	83.33% (▲)	100% (▲)	100% (▶)	100% (▶)	100% (▶)	66.67% (▼)	50% (▼)
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		100% (▶)	92.31% (▼)	92.86% (▲)	100% (▲)	100% (▶)	90.91% (▼)	61.54% (▼)	100% (▲)	94.12% (▼)	83.33% (▼)	100% (▲)	94.74% (▼)	100% (▲)
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		100% (▲)	100% (▶)	93.75% (▼)	93.48% (▼)	93.33% (▼)	100% (▲)	82.35% (▼)	92.31% (▲)	88.1% (▼)	89.47% (▲)	90.91% (▲)	93.75% (▲)	91.18% (▼)
28 day faster diagnosis	75%		90.57% (▼)	87.31% (▼)	87.5% (▲)	81.27% (▼)	91.69% (▲)	89.33% (▼)	88.82% (▼)	82.01% (▼)	83.53% (▲)	82.69% (▼)	91.89% (▲)	84.26% (▼)	89.53% (▲)
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		97.81% (▼)	99.49% (▲)	98.67% (▼)	98.84% (▲)	99.14% (▲)	98.92% (▼)	97.72% (▼)	95.06% (▼)	98.68% (▲)	94.5% (▼)	96.88% (▲)	94.49% (▼)	98.56% (▲)
Total time in A&E - 95th Percentile (Mins)	4 Hrs		03:54 (▼)	03:28 (▲)	03:41 (▼)	03:24 (▲)	03:29 (▼)	03:45 (▼)	03:51 (▼)	03:59 (▼)	03:44 (▲)	04:11 (▼)	03:54 (▲)	04:11 (▼)	03:49 (▲)
Total time in A&E - Median (Mins)	4 Hrs		01:41 (▼)	01:34 (▲)	01:30 (▲)	01:13 (▲)	01:22 (▼)	01:24 (▼)	01:27 (▼)	01:36 (▼)	01:28 (▲)	01:37 (▼)	01:19 (▲)	01:38 (▼)	01:26 (▲)
A&E Time to treatment decision (median) <=60 mins (Mins)	60 Mins		00:09 (▼)	00:08 (▲)	00:08 (▼)	00:06 (▲)	00:07 (▼)	00:07 (▼)	00:07 (▲)	00:08 (▼)	00:06 (▲)	00:07 (▼)	00:09 (▼)	00:07 (▲)	00:07 (▲)
A&E Time to treatment decision 95th percentile <=60 mins (Mins)	60 Mins		00:29 (▼)	00:22 (▲)	00:23 (▼)	00:14 (▲)	00:14 (▲)	00:15 (▼)	00:15 (▼)	00:21 (▼)	00:15 (▲)	00:16 (▼)	00:23 (▼)	00:18 (▲)	00:14 (▲)
A&E Unplanned re-attendance rate <=5%	5%		6.74% (▶)	6% (▲)	7.81% (▼)	8.42% (▼)	6.47% (▲)	7.38% (▼)	4.55% (▲)	4.45% (▲)	4.42% (▲)	4.79% (▼)	5.38% (▼)	5.24% (▲)	3.82% (▲)
A&E left without being seen <=5% (left before trx completed)	5%		0.13% (▲)	0.03% (▲)	0.06% (▼)	0% (▲)	0.14% (▼)	0.15% (▼)	0.13% (▲)	0.31% (▼)	0.06% (▲)	0.04% (▲)	0.22% (▼)	0.16% (▲)	0.09% (▲)
Percentage referred onto A+E (UTC)	3%		11.73% (▼)	11.71% (▲)	12.45% (▼)	11.09% (▲)	11.04% (▲)	9.81% (▲)	8.74% (▲)	11.33% (▼)	12.81% (▼)	12.41% (▲)	10.33% (▲)	11.17% (▼)	12.08% (▼)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		88.99% (▲)	89.12% (▲)	89.12% (▼)	88.86% (▼)	90.24% (▲)	90.37% (▲)	90.92% (▲)	90.95% (▲)	91.78% (▲)	91.46% (▼)	90.42% (▼)	92.03% (▲)	91.46% (▼)
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	95%		88.8% (▲)	87.1% (▼)	87% (▼)	86.7% (▼)	87.1% (▲)	85.8% (▼)	27% (▼)	88.9% (▲)	89.1% (▲)	89.8% (▲)	90.1% (▲)	90.5% (▲)	90.2% (▼)

Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
ercentage of was not brought - Childrens	3%		6.47% (▼)	6.35% (▲)	7.31% (▼)	8.79% (▼)	5.83% (▲)	6.31% (▼)	6.36% (▼)	9.15% (▼)	6.96% (▲)	6.46% (▲)	5.87% (▲)	6.8% (▼)	6.45% (▲)
ercentage of DNAs/Was not brought - Warrington Adults	3%		2.82% (▲)	2.82% (▲)	3% (▼)	2.31% (▲)	2.09% (▲)	2.33% (▼)	2.23% (▲)	2.27% (▼)	2.24% (▲)	1.95% (▲)	2.07% (▼)	2.1% (▼)	2.15% (▼)
ercentage of DNAs/Was not brought - Halton Adults	3%		2.19% (▲)	1.97% (▲)	1.36% (▲)	1.11% (▲)	1.28% (▼)	1.25% (▲)	1.37% (▼)	1.06% (▲)	1.14% (▼)	0.89% (▲)	0.91% (▼)	1.02% (▼)	1.06% (▼)
Proportion of Urgent Community Response referrals reached within two hours	70%		88.1% (▼)	86.4% (▼)	85.4% (▼)	90% (▲)	81.3% (▼)	81.5% (▲)	76.5% (▼)	80% (▲)	78.5% (▼)	77% (▼)	81.1% (▲)	87% (▲)	81.3% (▼)
udiology - Number of 6 weeks diagnostic breaches	0		194 (▼)	217 (▼)	192 (▲)	149 (▲)	100 (▲)	88 (▲)	71 (▲)	76 (▼)	53 (▲)	43 (▲)	32 (▲)	57 (▼)	63 (▼)
eferrals to plan - Childrens	95%		108.33% (▼)	108.36% (▼)	109.84% (▼)	104.92% (▲)	105.92% (▼)	106.71% (▼)	106.7% (▲)	105.95% (▲)	107.37% (▼)	107.77% (▼)	107.6% (▲)	105.12% (▲)	104.07% (▲)
eferrals to plan - Warrington Adults	95%		88.35% (▼)	86.53% (▼)	86.74% (▲)	83.34% (▼)	82.15% (▼)	82.21% (▲)	81.32% (▼)	80.87% (▼)	80.74% (▼)	79.91% (▼)	78.36% (▼)	74.33% (▼)	73.57% (▼)
eferrals to plan - Halton Adults	95%		81.85% (▼)	80.47% (▼)	81.48% (▲)	83.25% (▲)	83.19% (▼)	84.25% (▲)	84.04% (▼)	83.69% (▼)	84.76% (▲)	85.08% (▲)	84.62% (▼)	91.54% (▲)	89.6% (▼)
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)	92%		68.11% (▲)	68.95% (▲)	68.42% (▼)	67.32% (▼)	66.05% (▼)	65.63% (▼)	65.1% (▼)	63.4% (▼)	63.84% (▲)	62.84% (▼)	61.39% (▼)	63.53% (▲)	59.56% (▼)
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)	0%		2.68% (▼)	3.24% (▼)	4.51% (▼)	5.57% (▼)	5.19% (▲)	5.96% (▼)	6.58% (▼)	7% (▼)	7.74% (▼)	9.01% (▼)	10.51% (▼)	10.87% (▼)	12.31% (▼)
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.01% (▼)	0.01% (▲)	0% (▲)	0.03% (▼)	0.03% (▲)	0% (▲)
Il waiters - % waiting over 52 weeks (awaiting initial access)	0%		3.47% (▲)	3.99% (▼)	4.3% (▼)	3.43% (▲)	3.09% (▲)	3.67% (▼)	4.65% (▼)	5.26% (▼)	5.69% (▼)	6.51% (▼)	7.42% (▼)	9.52% (▼)	10.43% (▼)
Il waiters - % waiting under 18 weeks (awaiting initial access)	92%		67.31% (▲)	66.98% (▼)	64.78% (▼)	61.87% (▼)	61.46% (▼)	59.01% (▼)	57.31% (▼)	56.86% (▼)	57.46% (▲)	58.19% (▲)	59.56% (▲)	56.87% (▼)	57.84% (▲)
/arrington Adults Activity Variance	3%		-11.65% (▼)	-13.47% (▼)	-13.26% (▲)	-16.66% (▼)	-17.85% (▼)	-17.79% (▲)	-18.68% (▼)	-19.13% (▼)	-19.26% (▼)	-20.09% (▼)	-21.64% (▼)	-25.67% (▼)	-26.43% (▼)
/arrington Childrens Activity Variance	3%		28.9% (▲)	28.48% (▲)	28.67% (▼)	19.23% (▲)	19.89% (▼)	22.49% (▼)	23.76% (▼)	21.87% (▲)	24.01% (▼)	24.43% (▼)	24.38% (▲)	26.94% (▼)	23.24% (▲)
alton Adults Activity Variance	3%		-18.15% (▼)	-19.53% (▼)	-18.52% (▲)	-16.75% (▲)	-16.81% (▼)	-15.75% (▲)	-15.96% (▼)	-16.31% (▼)	-15.24% (▲)	-14.92% (▲)	-15.38% (▼)	-8.46% (▲)	-10.4% (▼)
alton Childrens Activity Variance	3%		-26.75% (▲)	-26.48% (▲)	-24.15% (▲)	-22.22% (▲)	-20.93% (▲)	-22.73% (▼)	-24.35% (▼)	-23.78% (▲)	-23.8% (▼)	-23.69% (▲)	-24.14% (▼)	-30.06% (▼)	-28.63% (▲)

Operations

Trust Scorecard

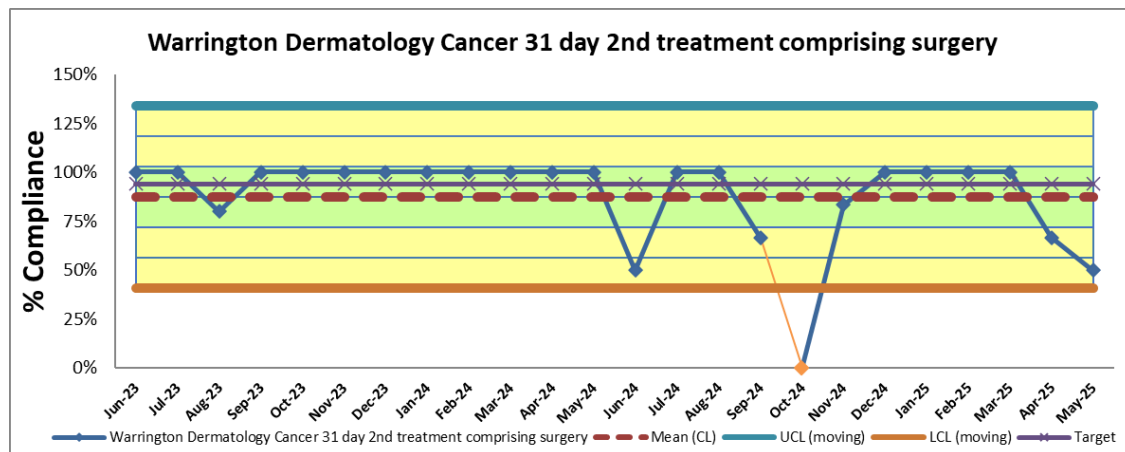
Operations															
KPI Name	Target	Trend Line				May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	May-25
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton						89 (▲)			86 (▼)			104 (▲)			112 (▲)
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%					85.28% (▲)			87.58% (▲)			88.78% (▲)			92.16% (▼)
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Halton	90%					85.95% (▲)			91.44% (▲)			90% (▼)			90.51% (▼)
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Halton	85%					67.93% (▲)			86.33% (▲)			87.59% (▲)			88.7% (▲)
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Halton	85%					87.29% (▲)			89.58% (▲)			91.33% (▲)			91.42% (▲)
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	90%					85.9% (▲)			80.92% (▼)			81.27% (▲)			89.07% (▼)
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	90%					90.62% (▼)			71.67% (▼)			82.2% (▲)			82.52% (▼)
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington						307 (▼)			312 (▲)			346 (▲)			333 (▲)
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%					90.54% (▼)			92.94% (▲)			94.25% (▲)			93.68% (▲)
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Warrington	90%					96.06% (▼)			95.95% (▼)			96.58% (▲)			96.33% (▲)
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Warrington	85%					94.44% (▼)			94.5% (▲)			94.21% (▼)			93.72% (▼)
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Warrington	85%					98.92% (▼)			97.13% (▼)			97.9% (▲)			98.45% (▲)
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	90%					94.82% (▼)			95.34% (▲)			95.64% (▲)			96.58% (▼)
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	90%					96.86% (▼)			94.7% (▼)			93.19% (▼)			94.15% (▼)
available Virtual Ward Capacity per 100,000 head of population						10.15 (▲)	4.82 (▼)	5.25 (▲)	5.97 (▲)	3.94 (▼)	1.05 (▼)	4.17 (▲)	5.18 (▲)	0.83 (▼)	3.95 (▲)

Operations: Exception Reporting

Flagged Indicators

OP12	A&E Unplanned re-attendance rate <=5%		Points below lower control limit
OP39	Referrals to plan - Warrington Adults		Points below lower control limit
OP40	Referrals to plan - Halton Adults		Points below lower control limit
OP67	Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)		Points below lower control limit
OP68	Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)		Points above upper control limit
OP45	All waiters - % waiting over 52 weeks (also include Dental)		Points above upper control limit
OP46	All waiters - % waiting under 18 weeks(also include Dental)		Points below lower control limit
OP48	Warrington Adults Activity Variance		Points below lower control limit
OP50	Halton Adults Activity Variance		Points above upper control limit

Operations: Exception Reporting



Analytical Narrative

The data for this indicator remains mostly consistent within normal variation and intermittent achievement of target, which sits close to the mean.

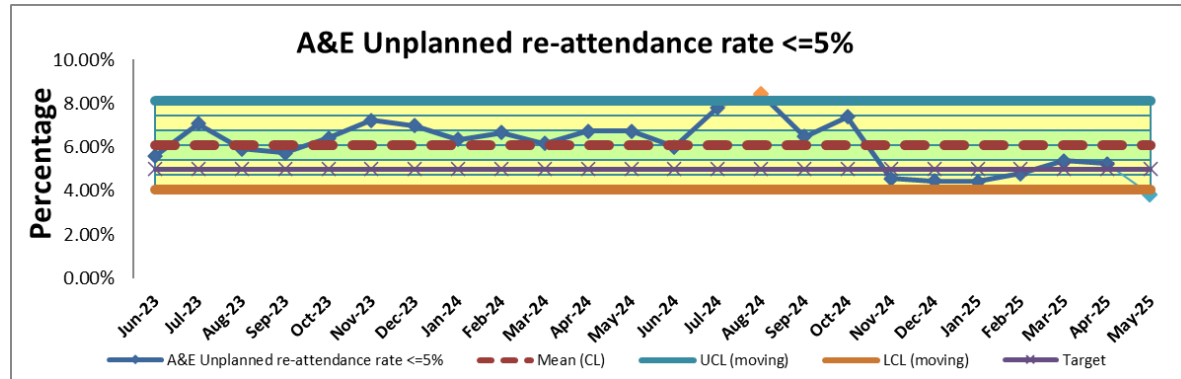
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery

National Target is 94% (April Performance reported in arrears: 50%)

Operational Narrative

Bridgewater have a very small number of patients relating to this indicator. This was 2 patients out a total denominator of 4. One breach was due to a specific Consultant being required to complete the surgery. The second breach was delayed due to patient choice but has now been seen.

Operations: Exception Reporting



A&E Unplanned re-attendance rate <=5%

National Target is 5%

Performance in May – 3.82%

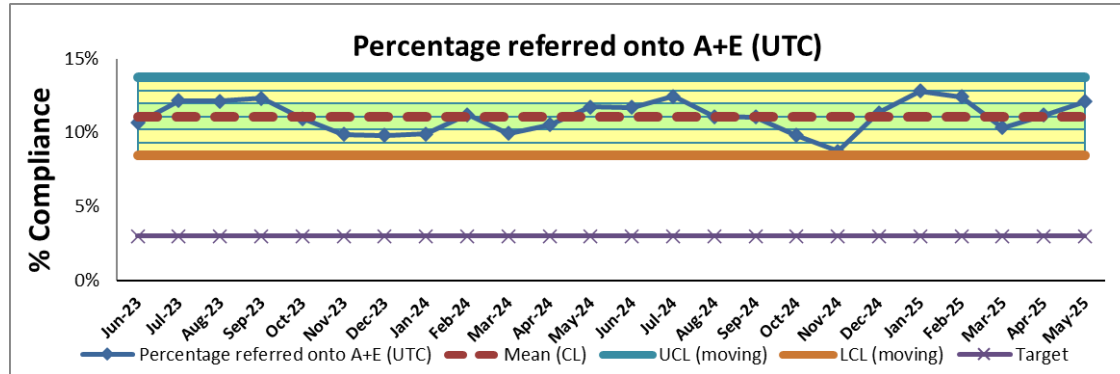
Operational Narrative

Data relating to this KPI is regularly provided by the Information team to enable UTC operational manager to carry out quality assurance. Weekly reattendances are reviewed and ongoing discussions are also held with admin team to ensure the patients are booked in correctly.

Analytical Narrative

This indicator remains within normal variation. The data shows an improving trend with 7 consistent points below the mean. Month 2 saw the performance fall back within target and also outside of control limits. We will continue to monitor this trend.

Operations: Exception Reporting



Percentage referred onto A+E (UTC)

Local target is 3%

Performance in May – 12.08%.

Analytical Narrative

The data for this indicator remains consistently within normal variation. However, the target sits outside of process limits and is unlikely to be achieved without any change in process.

Operational Narrative

The service are looking closely at data recording pertaining to patients that are discharged onto A+E.

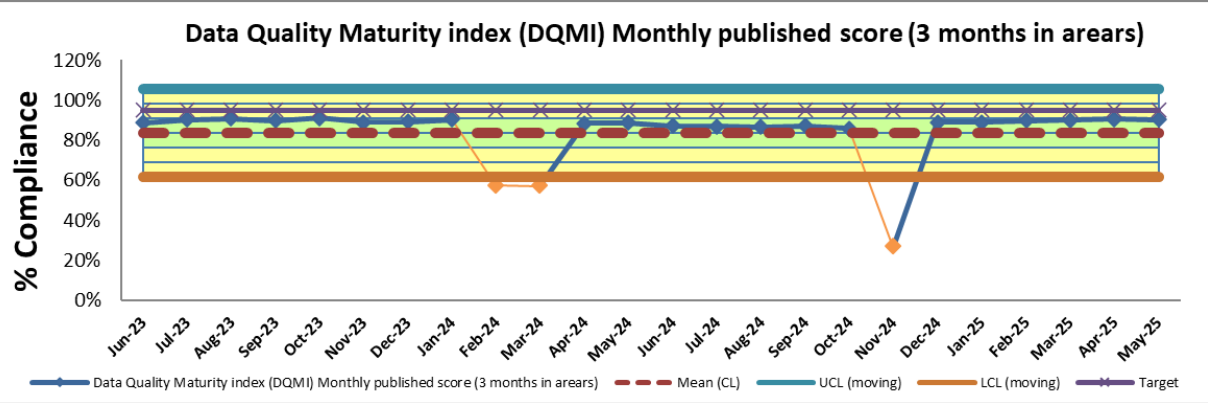
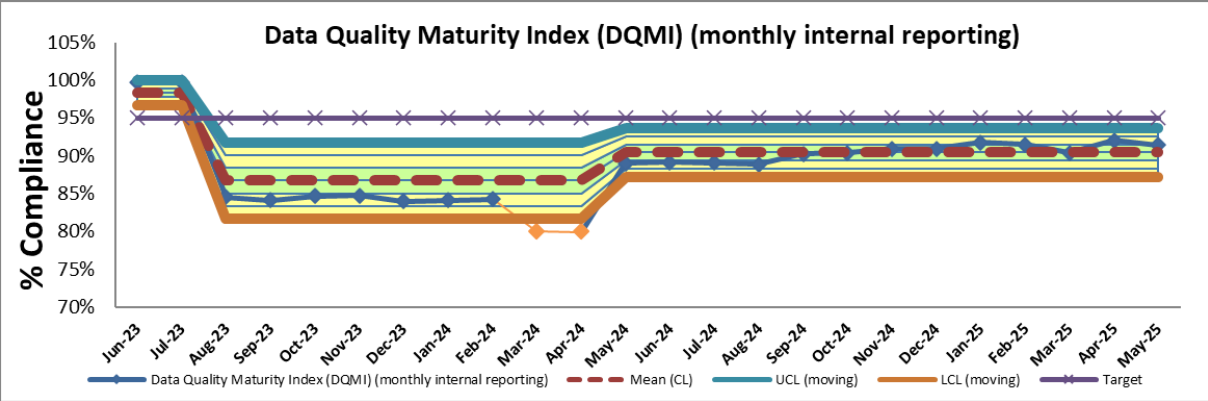
This indicator should reflect patients that have attended UTC inappropriately and were onward streamed to A+E .

Currently, the numerator also includes patients that were discharged to Hospital for specialist services, such as fracture clinics. The service will request a more appropriate list of discharge reasons to be configured.

It may be a few months before we see the full impact of these changes in the data.

Operations: Exception Reporting

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



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



National DQMI Score

71.1

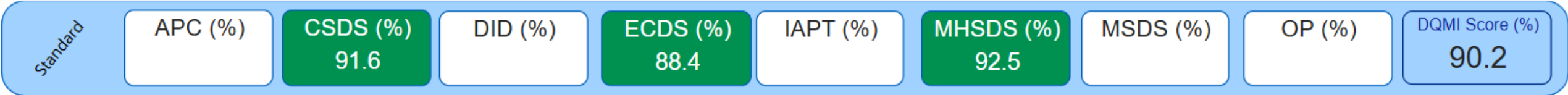
Experimental National DQMI Score

65.3

Data set	National Data Set Score	National Data Set Score Experimental
APC	86.5	86.5
CSDS	73.3	68.6
ECDS	80.8	80.8
IAPT	96.2	86.9
MHSDS	46.3	41.7
MSDS	96.1	96.1
OP	86.6	86.6

Operations: Exception Reporting

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



Analytical Narrative

The process limits for the internal monitoring were reset in August 2023 and again in May 2024 to reflect process changes. There continues to be an upward trend in performance for the internal measurement which is also reflected in the published data that is published 3 months in arears.

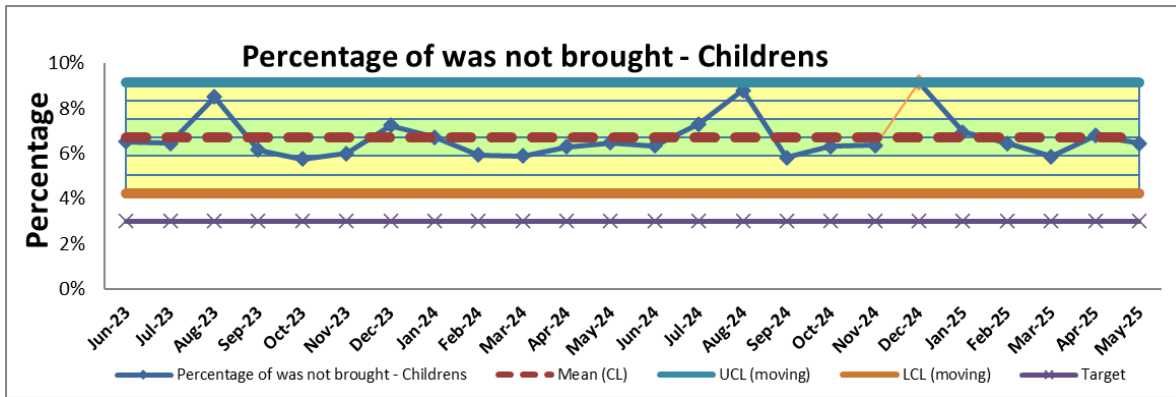
We expect this trend to continue and once we have more data points above the means we will recalculate the mean, which will bring the target inside of control limits.

Operational Narrative

Bridgewater are measured upon the completeness and quality of three national datasets for the DQMI. Of the 3 ECDS (Emergency Care Dataset) is currently scoring the lowest.

The information team are continuing to flag poorly populated indicators within the ECDS and are working with the service to improve them.

Operations: Exception Reporting



Percentage of "Child not brought " Children's Services

Local Target: 3%

May compliance – 6.45%

Analytical Narrative

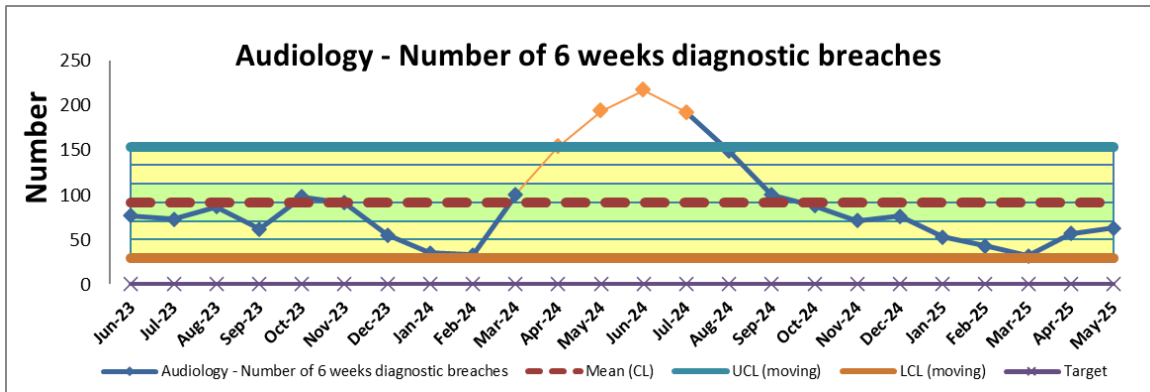
The data for the percentage of child not brought for Children's Directorate shows mainly standard variation with several points of variation that coincide with seasonal times such as summer holidays and Christmas period.

Operational Narrative

Most appointments where children were "not brought" (CNB) are follow up contacts. Warrington Health visiting, Children's LD Nursing, Continence and Paediatric SLT report the highest numbers. Warrington HV has now completed a data quality exercise, and the data is now showing an accurate picture. Following this exercise the child not brought has reduced since January 2025. The slight increase this month is down to Easter holidays. Plans to reduce 'Child not brought' include:

- Develop communication packs for families to explain the importance and impact of visits and appointments.
- Utilise social media and family hubs to engage with families.
- Review follow-up needs for SLT and other children's specialist services and consider virtual follow ups.
- Regularly update the services website with DNA statistics and their impact on waiting times.
- Collaborate with parent care forums to disseminate consistent messages to families.
- Review and discharge patients sooner if safe to do so.
- Explore the possibility of text message responses for appointment confirmations.

Operations: Exception Reporting



Analytical Narrative

The data was consistently below the mean up until March 2024. May, June and July 2024 saw the breaches escalate to outside of normal variation. August onwards has seen an improving position, with the last 7 data points below the mean and the data now close to the lower control limit. However, the number of breaches has increased again in May 2025.

The Target sits outside of normal process limits, the data suggests that it is unlikely to be met within current operational processes.

Warrington Audiology - Number of 6 weeks diagnostic breaches

National Target: 0

May compliance - 63 breaches

Operational Narrative

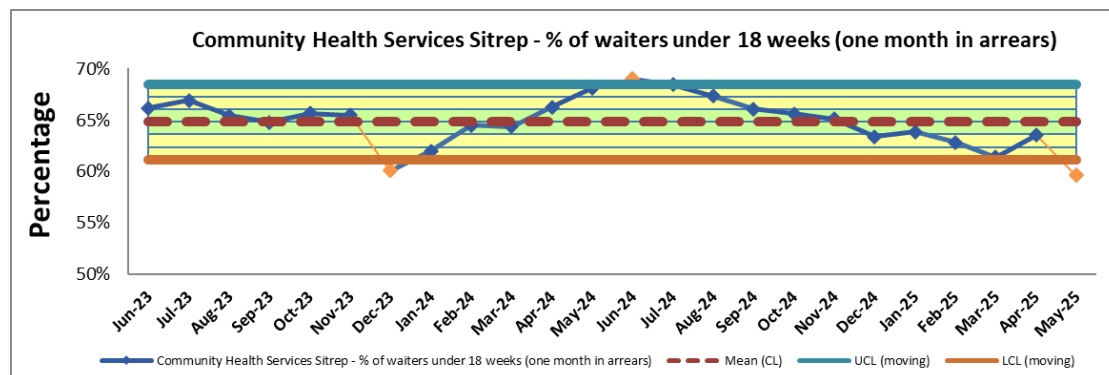
The vacant audiologist post interviews took place on the 6th March; recruitment was successful and pre-employment recruitment checks have taken place and the new member of staff started with the service in June 2025.

The locum audiologist ceased in April, this along with seasonal annual leave has contributed to an increase in waiting times.

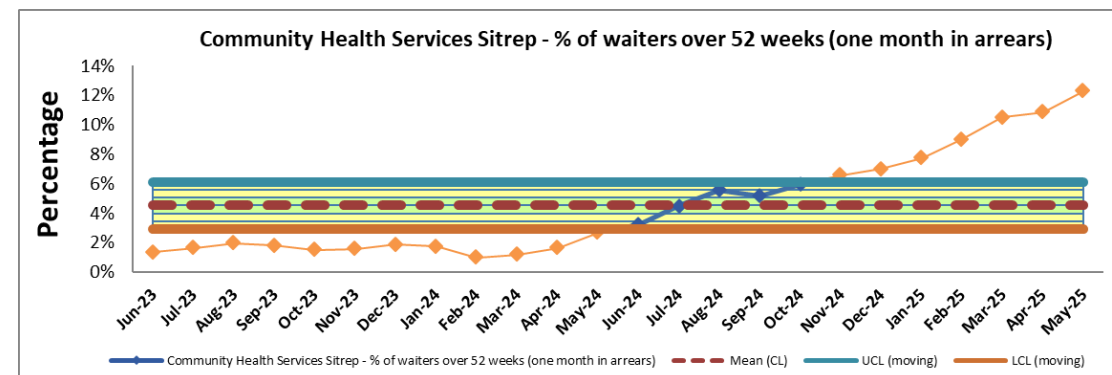
Operations: Exception Reporting

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

April % under 18 weeks – 59.56%



April % over 52 weeks – 12.31%



The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's community health services. Providers submit aggregated information for service lines, irrespective of the number of ICBs or regions they provide services under. The SitRep includes a broad range of NHS commissioned community health services. It may not cover all services in some systems. This publication contains management data which is collected on a rapid turnaround basis, allowing only minimal validation to be undertaken.

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

Operations: Exception Reporting

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

Organisation Name	Total waiting list	Number of patients waiting:							
		0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD									
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	420	11	25	42	316	9	17	0	0
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	447	237	49	40	114	7	0	0	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	161	51	31	24	44	3	8	0	0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST									
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	6,160	949	471	1,254	2,867	395	223	1	0
EAST CHESHIRE NHS TRUST	4,540	579	292	646	1,505	638	839	41	0
COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST									
MERSEY CARE NHS FOUNDATION TRUST	18,748	3,288	1,207	3,596	8,012	1,607	1,038	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	3,524	465	221	518	1,463	539	308	1	9
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	3,519	266	261	560	1,479	186	724	43	0
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	5,378	582	472	761	2,511	840	212	0	0

Analytical Narrative for April 2025 data:

- Total adults reported on Bridgewater waiting lists in April 2025: **3519** (decrease of **6.28%** on March 2025)
- Long waits for adults on Bridgewater waiting lists in March 2025: **186** waiting **>12-18 weeks**, **724** waiting **>18-52 weeks**, **43** waiting **>52-104 weeks**, and **0** waiting over **104 weeks**.
- Adults waiting over **52 weeks** on Bridgewater waiting lists has increased by **5** to **43** from last month.

Operations: Exception Reporting

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

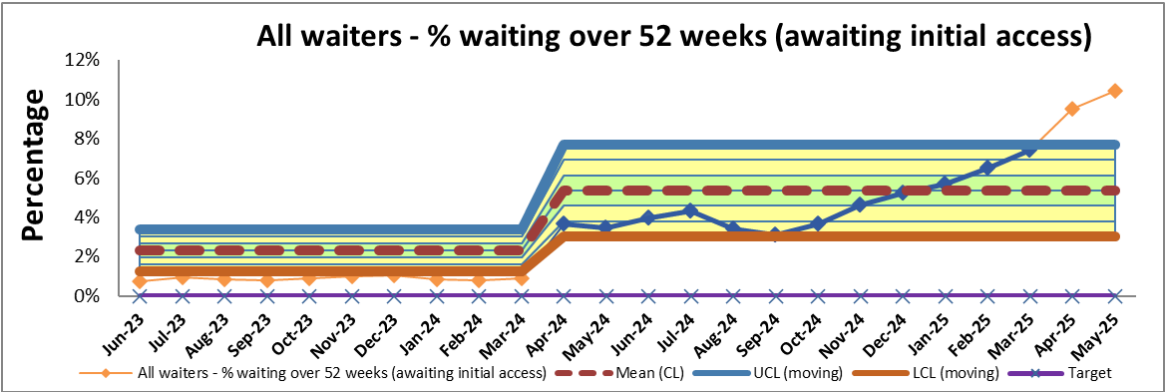
Organisation Name	Total waiting list	Number of patients waiting:							
		0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD									
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	5,140	64	27	228	589	243	1,635	1,819	535
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	928	61	37	66	226	98	394	46	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST									
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5,153	230	139	388	1,880	715	1,765	36	0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	1,527	97	40	141	447	363	429	10	0
EAST CHESHIRE NHS TRUST	846	71	35	105	316	113	204	2	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,268	30	12	69	295	116	644	102	0
MERSEY CARE NHS FOUNDATION TRUST	891	142	35	156	483	60	15	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	173	11	8	10	33	15	76	18	2
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	4,241	125	150	279	923	393	1,459	912	0
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	352	27	36	45	136	50	58	0	0

Analytical Narrative for April 2025 data:

- Total children & young people reported on Bridgewater waiting lists in March 2025: **4241** (increase of **3.41%** on March 2025)
- Long waits for children & young people on Bridgewater waiting lists in March 2025: **393** waiting **>12-18 weeks**, **1459** waiting **>18-52 weeks**, **912** waiting **>52-104 weeks**, and **0** waiting over **104 weeks**.
- Children & young people waiting over **52 weeks** on Bridgewater waiting lists has increased by **96** to **912** from last month.

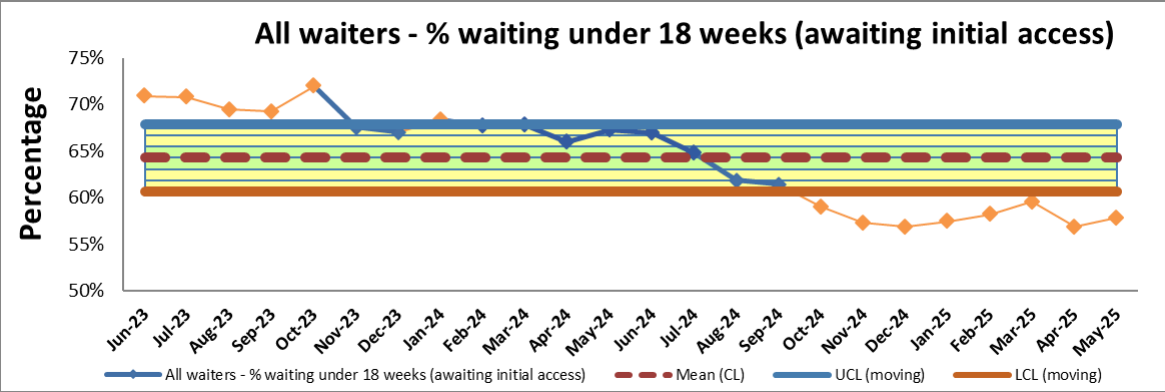
Operations: Exception Reporting

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



Over 52 weeks	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Warrington	208	230	214	248	299	432	517	639	816	1044	1289	1556
Halton	138	180	162	175	192	214	255	285	313	360	409	287
Dental	431	355	220	110	127	140	126	64	29	25	42	31
Total Over 52 weeks	777	765	596	533	618	786	898	988	1158	1429	1740	1874

Percentage of patients waiting over 52 weeks in May is 10.44%.

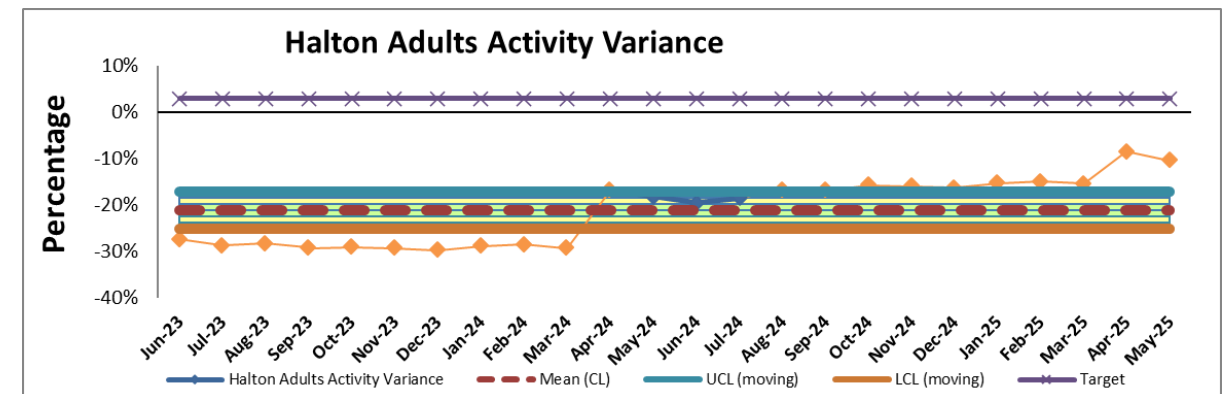
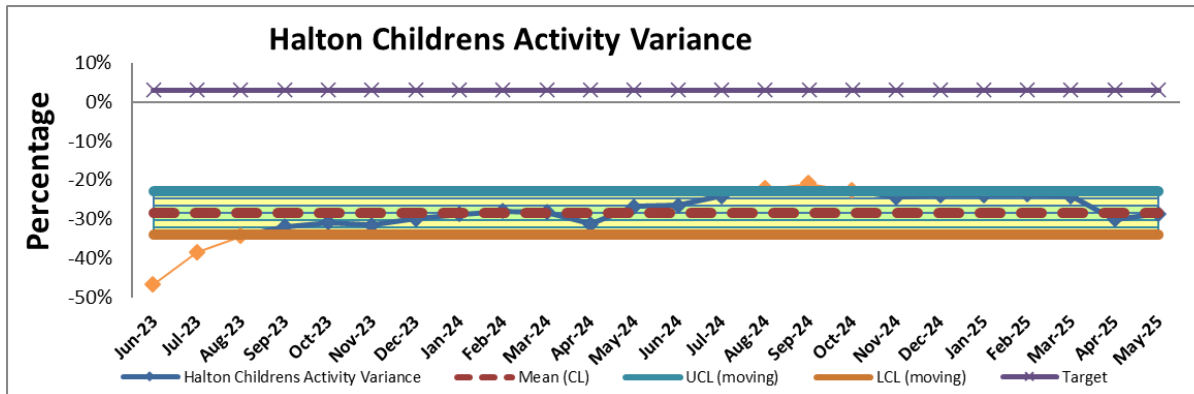
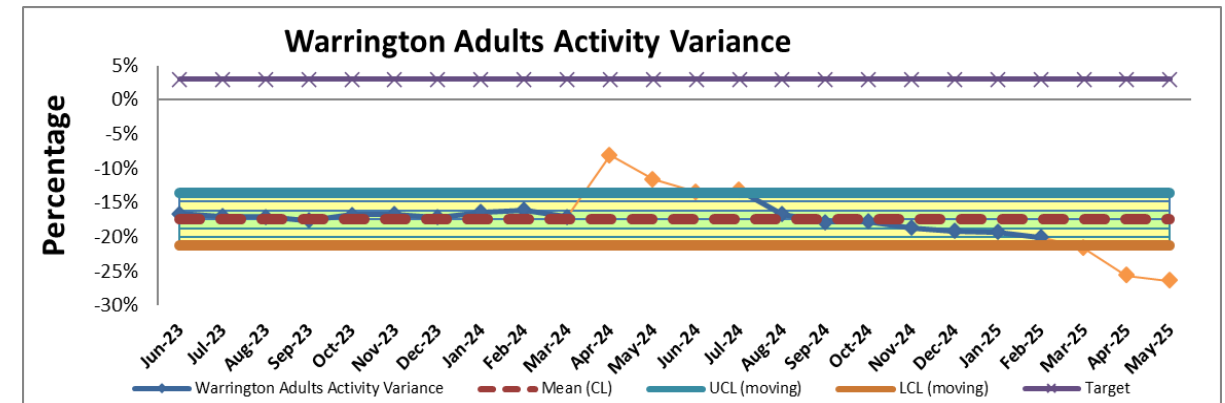
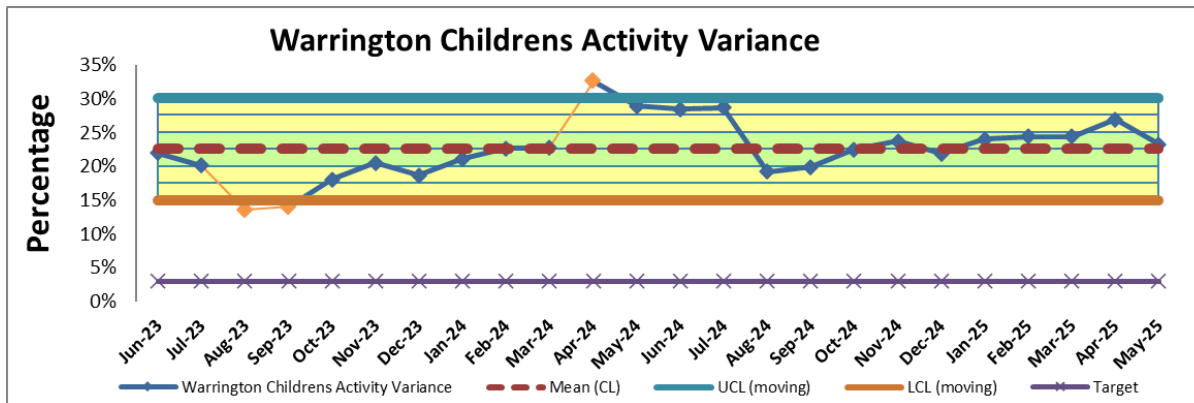


Under 18	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Warrington	6817	5391	5057	4881	4705	4672	4756	4710	4701	5459	4655	4855
Halton	2065	2035	1931	1967	1726	1600	1542	1725	1704	1824	1518	1553
Dental	4150	4096	3774	3755	3498	3416	3407	3548	3943	4185	4221	3979
Total Under 18	13032	11522	10762	10603	9929	9688	9705	9983	10348	11468	10394	10387

Percentage of patients waiting under 18 weeks in May is 57.85%.

Operations: Exception Reporting

Activity Variances Local Target: 3%



Operations: Exception Reporting

Activity Variances Local Target: 3%

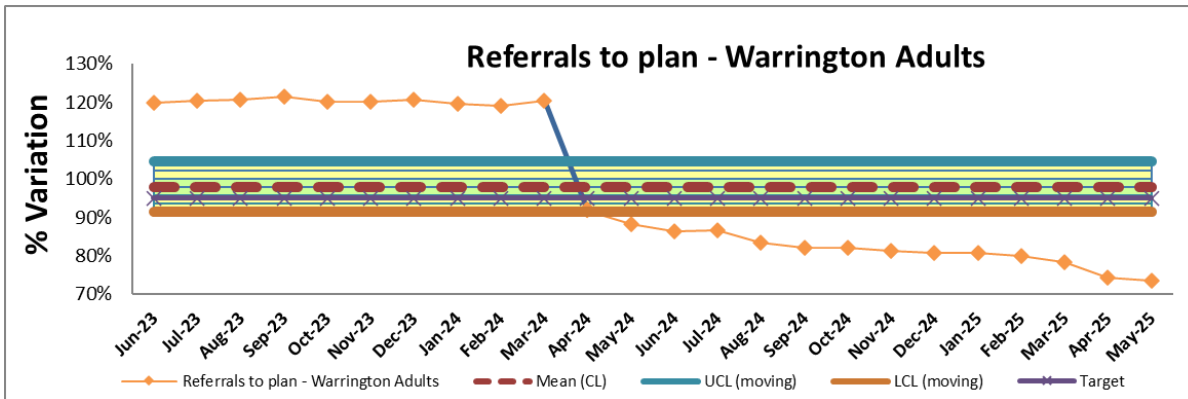
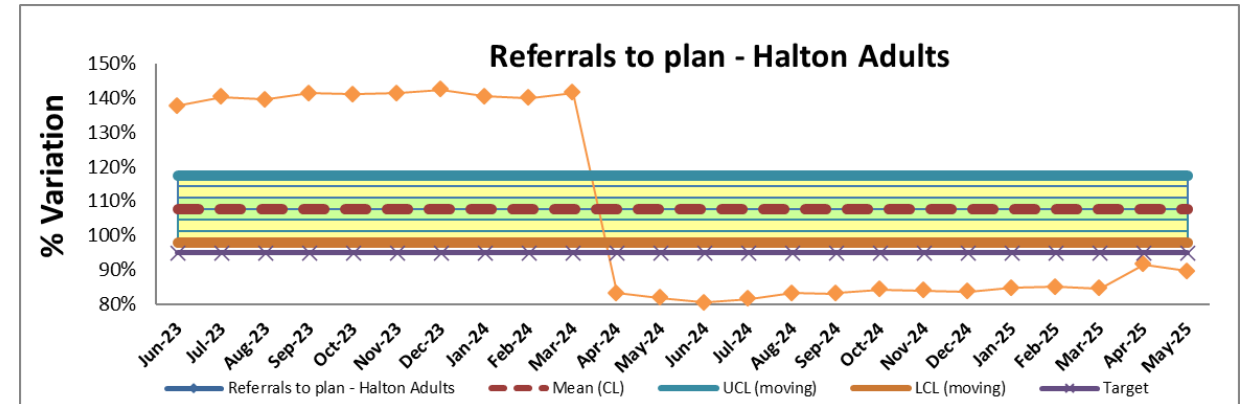
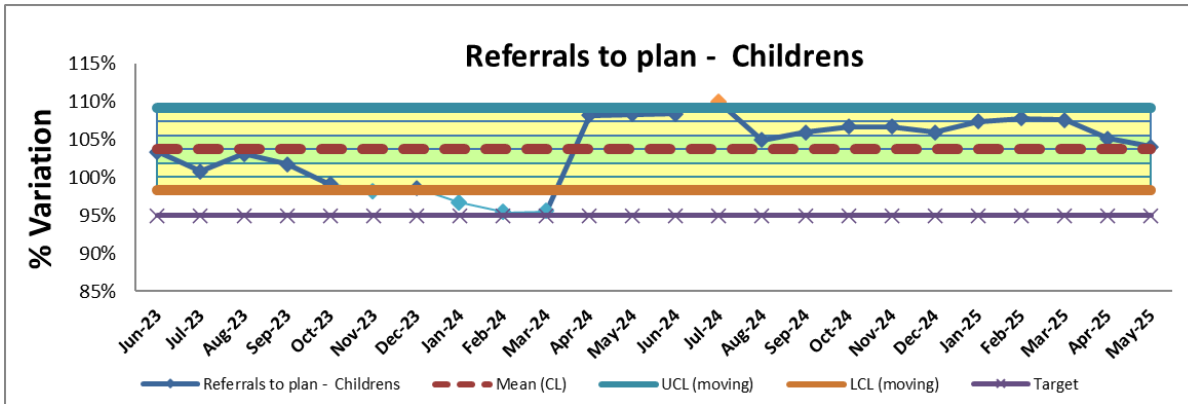
Analytical / Operational Narrative

Activity targets are still based on 2018/19 targets and represent values which were agreed prior to the pandemic. These targets may not represent the levels of activity that we would now expect.

New activity variances need to be socialised and signed off for inclusion in 2025/26 reporting. Once signed off we will backdate compliance for Month 1 onwards.

Operations: Exception Reporting

Referrals to plan Local Target 95%

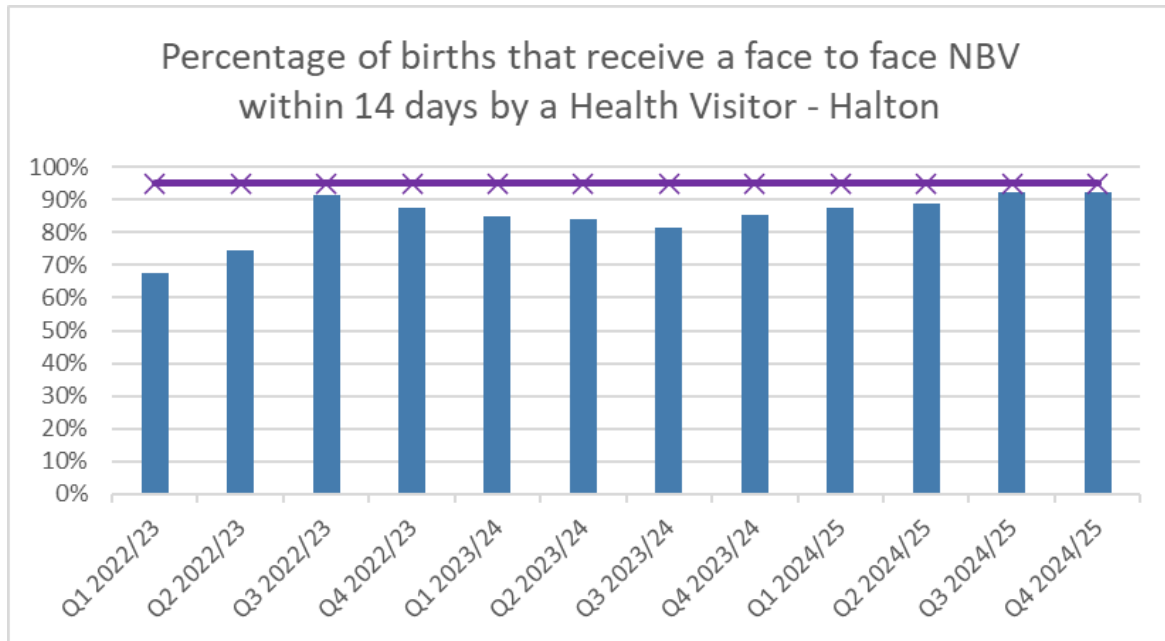


Analytical / Operational Narrative

Referrals to plan is related to the resetting of new activity variances.

New activity variances need to be socialised and signed off for inclusion in 2025/26 reporting. Once signed off we will backdate compliance for Month 1 onwards.

Operations: Exception Reporting



Analytical Narrative

The data has continuously been below the target of 95%, however it has seen an upward trend in the last four quarters.

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

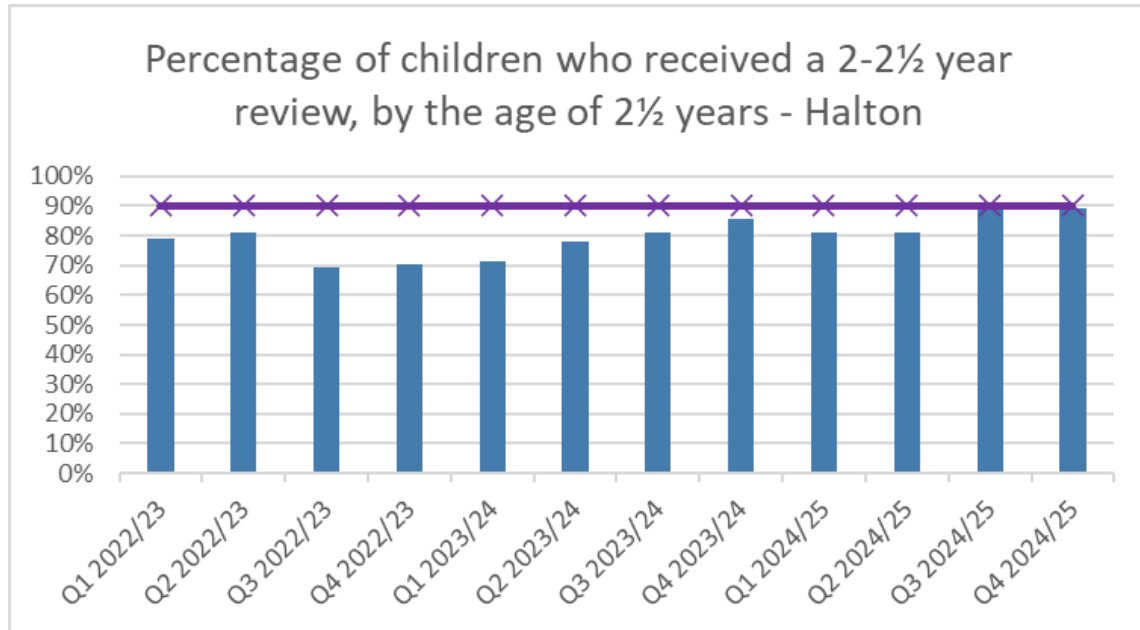
National Target: 95% Quarter 4 Compliance – 92.16%

Operational Narrative

All exceptions that didn't meet the 14-day target for this indicator during quarter 4 were due to infants being in hospital special care / no access visits.

The commissioner has lowered this target locally to 90%.

Operations: Exception Reporting



Percentage of children who received a 2-2½ year review, by the age of 2½ years – Halton

National Target: 90% Quarter 4 Compliance – 89.07%

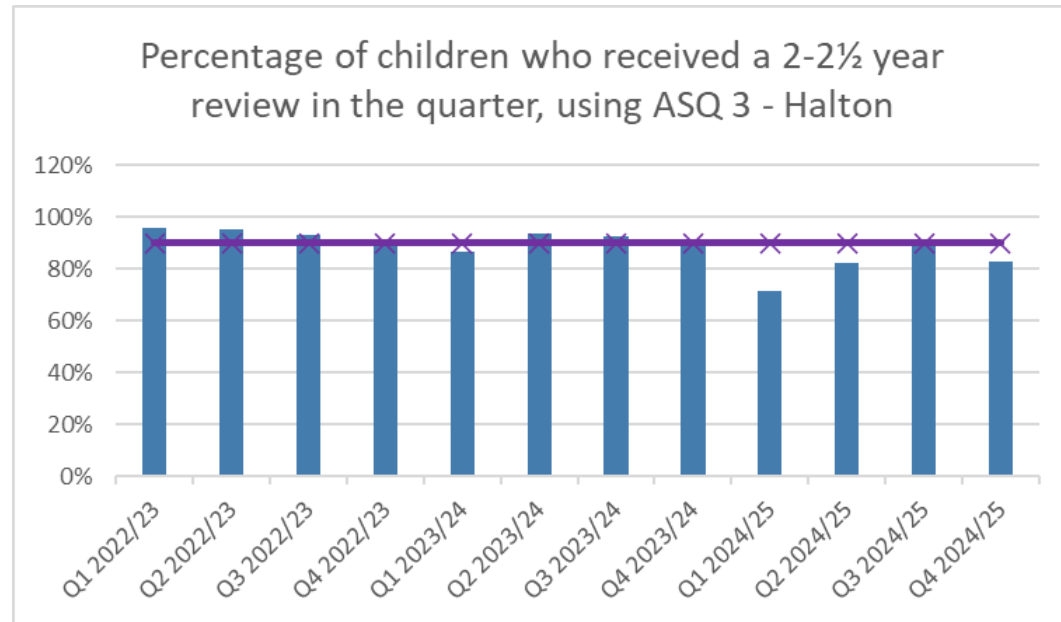
Operational Narrative

The team have improved compliance by offering the child health review at 2 years – 2 years 3 months in order to accommodate any change of appointment requests /Child Not Brought (CNB). Further work is underway to reduce CNB rates as per the Percentage of "Child not brought " Children's Services slide.

Analytical Narrative

The data has continuously been below the target of 90%, with the exception of quarter 3. However, it has seen an increase in performance in the last 2 quarters.

Operations: Exception Reporting



Analytical Narrative

The target has only been met once in the past four quarters.

Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 – Halton

National Target: 90% Quarter 4 Compliance – 82.52%

Operational Narrative

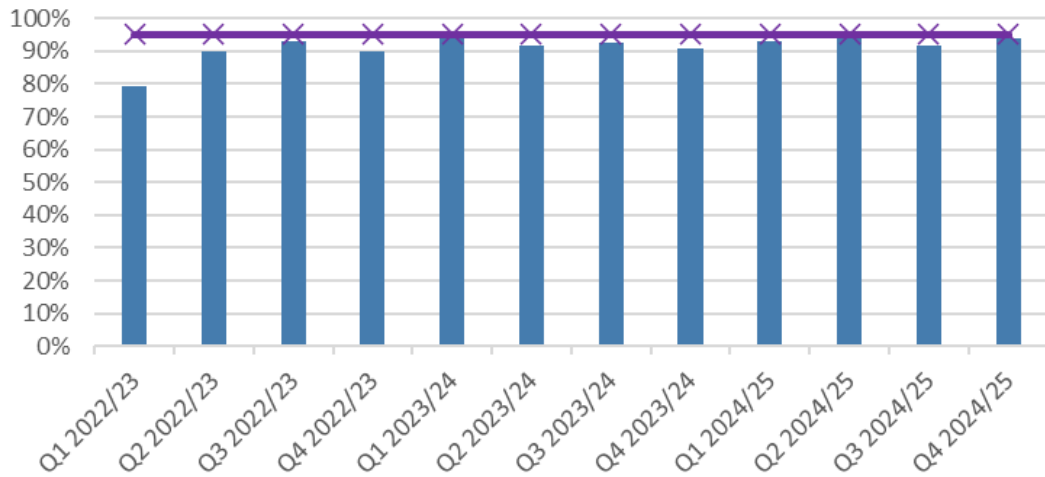
The ASQ3 screening tool is not always appropriate for children with identified or suspected Special Educational Needs and Disabilities (SEND).

The service is however exploring compliance with this KPI with BI colleagues – ASQ3 may have been completed but not accurately recorded in the electronic record.

ASQ3 refresher training and the peer review of child health reviews are planned to assess the quality of the assessments which will include the use of ASQ3.

Operations: Exception Reporting

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



Analytical Narrative

The data has continuously been below the target of 95%.

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

National Target: 95%

Quarter 4 compliance – 93.68%

Operational Narrative

The target set by Warrington commissioners is 93%.

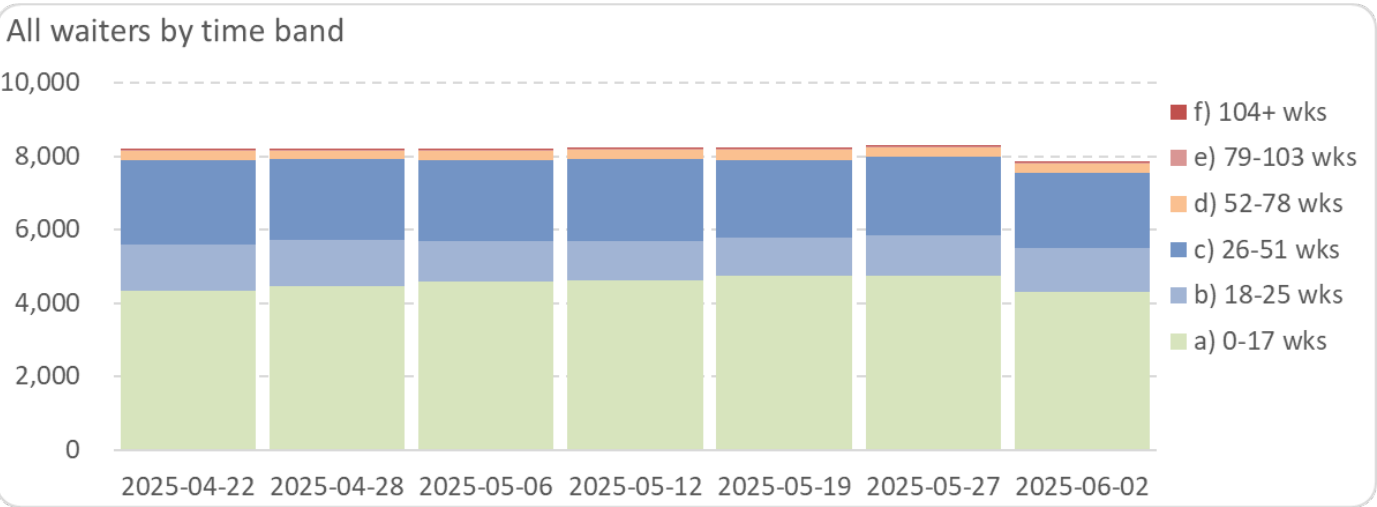
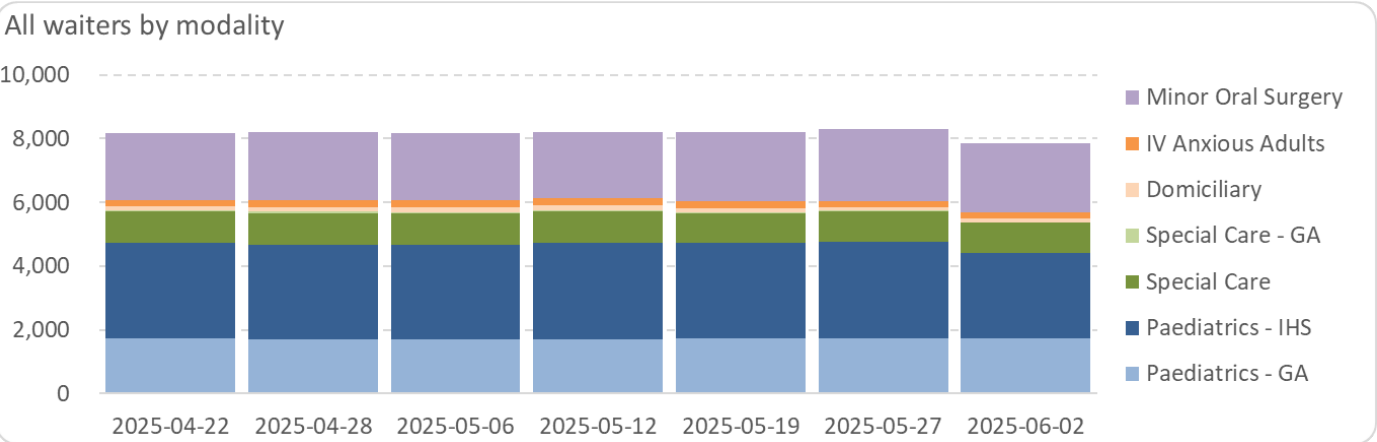
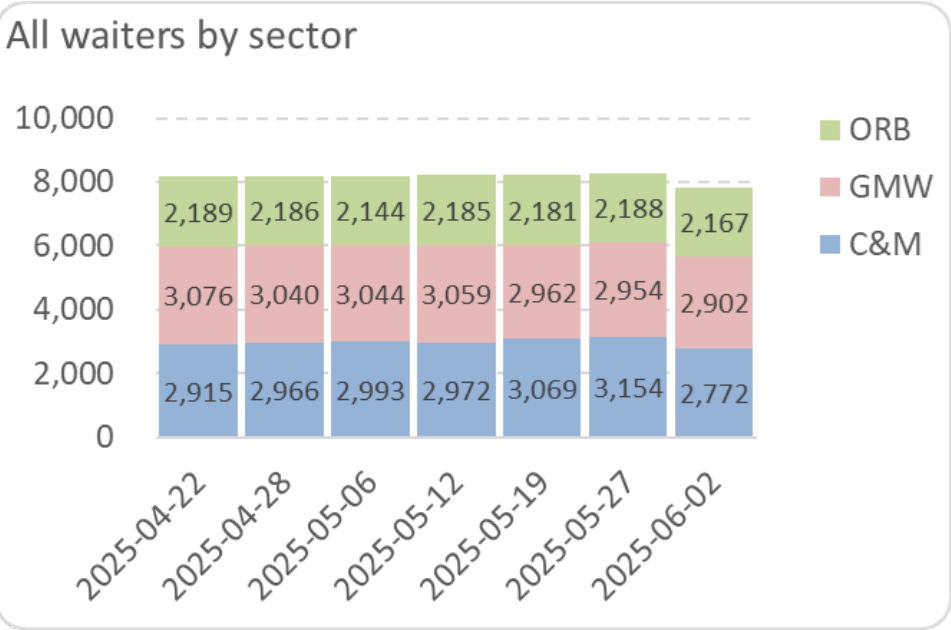
The data for Q4 shows that 415 families received a face-to-face NBV within 14 days.

Of the 28 that were not completed within 14 days:

- 20 babies were on NNU.
- 2 no access visits to prearranged appointments resulting in the contact taking place after day 14
- 2 contacts rearranged to after day 14 at parental request.
- 2 were completed late due to the Xmas holidays (restricted days due to BH)
- 2 declined the contact

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality



Operations: Exception Reporting

Dental – All Waiters by time band

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2025-04-22	4,346	1,257	2,292	239	31	15
2025-04-28	4,470	1,259	2,179	238	30	16
2025-05-06	4,576	1,113	2,190	253	33	16
2025-05-12	4,614	1,075	2,231	244	33	19
2025-05-19	4,734	1,040	2,131	255	32	20
2025-05-27	4,750	1,100	2,137	254	32	23
2025-06-02	4,316	1,168	2,063	257	34	37

Analytical / Data Quality Narrative

The numbers of waiters within each time band has remained consistent, although a decrease in patients waiting 0-17 weeks and a slight increase in 18-25 weeks, decrease in 26-51 weeks, weeks 52-78 and above have remained consistent to last month. The performance team are in the process of visualising this data via SPC's.. The high waiters >104 are for Paeds GA in greater Manchester, due to theatre capacity.

Greater Manchester commissioners have recently asked for additional data relating to activity. It is clear there are data quality issues relating to referral and activity data due to limitations of the Dentally system. We are currently mitigating the impact of this with some manual data collection whilst the Information team explore best options to improve electronic reporting. We are confident that waiting list data is accurately captured and all measures to manage the continued reduction of long waiters are in place for both sectors.

Operations: Exception Reporting

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

Over 65 week waits - Cheshire & Mersey have NO waiters over 65 weeks.

Waiters are targeted via opt ins, early assessment appointments and a minimum wait for treatment. This is evident in a reduction of waiters over 52 weeks being offered treatment , even in the most challenging pathway- Minor Oral Surgery. (MOS)

We currently have just 8 waiters over 52 weeks across all pathways- all with treatment appointments booked.

A session of theatre slots for children has been to GM so their high waiters can be seen, due to a fall in demand from C and M.

An existing session dedicated for children requiring pre -meds now negotiated with Whiston.

The following actions are contributing to performance improvement:

- Performance data contributes to weekly waitlist management meetings with Clinical Director, HOS , Data Analyst and DNTMs. This includes scrutinising discharges/cancellations/DNAs and prioritising patient lists to target/apply resources in key areas.
- Parameters set for assessing MOS referrals is 35 weeks maximum. Offered treatment appointment by 45 weeks.
- Weekly booking efficiency meetings assist managing patient flow and maximising activity- utilisation report being developed.
- Performance Dashboard now in place to monitor activity against contractual targets monthly.
- Operational flexibility enabled allowing targeting of areas where demand is high.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality Greater Manchester Operational Narrative

Over 65 week waits - Greater Manchester (GM) have 112 patients waiting over 65 weeks.

100 are for Paediatric General Anaesthetic, 7 are for Inhalation Sedation (due to patients cancelling appointments) and 4 Special Care GA patients (adults) for General Anaesthetic. 1 SC patient.

Managers book assessments in order of receiving referral or clinical priority.

The following actions are contributing to performance improvement:

- High waiters in GM are being offered other clinics with more capacity if patients are happy to travel.
- Assessments are booked before 45 weeks in all clinics for assessments, to ensure all treatments completed by 52 weeks. Not always possible due to appointments available.
- Monthly calls with Managers including Clinical director and BI team to go through high waiters, cancellations, discharge and to discuss any issues with reports.
- Following acceptance and discharge criteria to reduce waiting lists from 65 weeks to 45 weeks in proving successful. However, the total volume on waiting list continues to increase due to increase in referrals.
- Regular meetings with commissioners and ICB for mutual aid to reduce General Anaesthetic waiters as we do not have much theatre capacity in GM – We are now sending 5 patients per week to Whiston in C&M in June, more sessions available in Whiston if finance approve
- Commissioners focussing on reviewing delivery of contracted number of sessions rather than high waiters. Greater Manchester are not delivering the full number of contracted sessions. Business Case sent for EMT

Quality

Executive Summary

There are 6 Quality indicators reporting as red and 26 green indicators in May 2025.

The 6 indicators which were red in May are as follows:

- % Incidents reported within 48 hrs of discovering an incident has occurred – Improvement in Month
- % of BCHFT patient safety incidents that are medication incidents – Deterioration in Month
- Total number of BCHFT acquired pressure ulcers – Deterioration in Month
- % of Category 4 Pressure Ulcers acquired in Bridgewater – New in Month
- % of Cat 3 Pressure Ulcers acquired in Bridgewater – Improvement in Month
- IPC assurance audit compliance – Deterioration in Month

Quality: Exception Reporting

Trust Scorecard

Quality															
KPI Name	Target	Trend Line	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of Never Events	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
% Incidents reported within 48 hrs of discovering an incident has occurred	87%		87.27% (▲)	84.56% (▼)	83.42% (▼)	84.14% (▲)	84.62% (▲)	86.53% (▲)	82.22% (▼)	83.21% (▲)	85.07% (▲)	90.99% (▲)	85.12% (▼)	84.93% (▼)	86.99% (▲)
% of incidents causing moderate harm (Score 3)	1%		2.42% (▲)	0.74% (▲)	0% (▲)	2.76% (▼)	3.3% (▼)	1.04% (▲)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0.83% (▼)	0.68% (▲)	0% (▲)
% of incidents causing severe/fatal harm (Score 4-5)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
Patient Safety Incident Investigations compliance submitted within 90 days	90%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
DOC (Duty of Candour) for moderate harms and above 10-day compliance	100%		100% (▶)	100% (▶)	0% (▼)	50% (▲)	100% (▲)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
% of BCHFT patient safety incidents that are medication incidents	7%		9.09% (▲)	8.82% (▲)	7.77% (▲)	10.34% (▼)	8.79% (▲)	8.81% (▼)	10.29% (▼)	7.63% (▲)	3.73% (▲)	9.82% (▼)	5% (▲)	7.53% (▼)	13.01% (▼)
% of Patient safety medication incidents causing moderate harm (Score 3)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
% of Patient safety medication incidents causing severe/fatal harm (Score 4-5)	0%		0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
Information Governance Training	95%		95.89% (▼)	95.09% (▼)	93.87% (▼)	95.65% (▲)	96.2% (▲)	95.39% (▼)	95.73% (▲)	95.51% (▼)	94.51% (▼)	94.87% (▲)	95.44% (▲)	95.55% (▲)	95.43% (▼)
Safeguarding Childrens Level 1	95%		98.86% (▼)	98.7% (▼)	98.76% (▲)	98.31% (▼)	98.19% (▼)	98.34% (▲)	98.71% (▲)	98.51% (▼)	98.38% (▼)	98.05% (▼)	98.29% (▲)	98.19% (▼)	98.19% (▲)
Safeguarding Childrens Level 2	95%		99.04% (▼)	99.23% (▲)	99.31% (▲)	98.8% (▼)	98.05% (▼)	98.41% (▲)	98.48% (▲)	98.57% (▲)	98.9% (▲)	98.47% (▼)	98.89% (▲)	98.61% (▼)	98.27% (▼)
Safeguarding Childrens Level 3	95%		99.22% (▲)	99.24% (▲)	98.47% (▼)	98.47% (▼)	96.55% (▼)	98.97% (▲)	99.3% (▲)	98.3% (▼)	98.65% (▲)	98.64% (▼)	98.99% (▲)	99.66% (▲)	99.66% (▲)
Safeguarding Adults Level 1	95%		98.86% (▼)	98.72% (▼)	98.85% (▲)	98.4% (▼)	98.6% (▲)	98.3% (▼)	98.79% (▲)	98.21% (▼)	98.2% (▼)	97.88% (▼)	98.43% (▲)	98.21% (▼)	98.15% (▼)
Safeguarding Adults Level 2	95%		98.57% (▼)	99.23% (▲)	99.49% (▲)	99.14% (▼)	98.38% (▼)	98.32% (▼)	98.72% (▲)	98.89% (▲)	98.97% (▲)	98.88% (▼)	99.05% (▲)	99.04% (▼)	98.87% (▼)
Safeguarding Adults Level 3	95%		98.54% (▲)	98.34% (▼)	97.79% (▼)	98.35% (▲)	97% (▼)	97.05% (▲)	98.12% (▲)	97.64% (▼)	97.93% (▲)	97.64% (▼)	99.22% (▲)	99.48% (▲)	98.96% (▼)
% of BCHFT risks managed in line with policy ie risks with in date reviews	92%		81.25% (▼)	89.95% (▲)	73.33% (▼)	89.94% (▲)	100% (▲)	94.29% (▼)	85.96% (▼)	85.64% (▼)	97.06% (▲)	83.23% (▼)	100% (▲)	96.23% (▼)	96.15% (▼)
Percentage of BCHFT risks identified as 12 or above	11%		13.02% (▼)	13.23% (▼)	15.56% (▼)	13.97% (▲)	15.34% (▼)	16% (▼)	14.61% (▲)	14.92% (▼)	15.29% (▼)	15.57% (▼)	12.1% (▲)	9.43% (▲)	9.62% (▼)

Trust Scorecard

Quality															
KPI Name	Target	Trend Line	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
% of BCHFT patient safety falls identified as serious	0%		0% (▲)	0% (▶)	0% (▶)	5.88% (▼)	11.11% (▼)	12.5% (▼)	0% (▲)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)	0% (▶)
BCHFT patient safety Falls per 1,000 bed days - bed based	8		12.53 (▲)	8.29 (▲)	22.53 (▼)	15.44 (▲)	18.32 (▼)	16.71 (▲)	8.43 (▲)	6.46 (▲)	14.34 (▼)	12.79 (▲)	12.83 (▼)	10.92 (▲)	5.2 (▲)
Total number of BCHFT acquired pressure ulcers	15		22 (▼)	15 (▲)	18 (▼)	13 (▲)	21 (▼)	19 (▲)	12 (▲)	20 (▼)	24 (▼)	13 (▲)	22 (▼)	20 (▲)	26 (▼)
% of Category 4 Pressure Ulcers acquired in Bridgewater	0%		0% (▶)	6.67% (▼)	0% (▲)	0% (▶)	4.76% (▼)	5.26% (▼)	0% (▲)	0% (▶)	4.17% (▼)	0% (▲)	0% (▶)	0% (▶)	3.85% (▼)
% of Cat 3 Pressure Ulcers acquired in Bridgewater	3%		31.82% (▼)	13.33% (▲)	16.67% (▼)	23.08% (▼)	9.52% (▲)	15.79% (▼)	8.33% (▲)	25% (▼)	4.17% (▲)	15.38% (▼)	13.64% (▲)	25% (▼)	11.54% (▲)
MRSA - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
C.Diff - Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
E Coli- Total Number of outbreaks (Community)	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
Bacteraemia - Total Number of outbreaks	0		0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)	0 (▶)
Complaints that are managed within the policy timelines	100%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
National Patient Safety Alerts opened and managed in line with policy timescales	100%		100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)	100% (▶)
% of all policies within review date	90%		88.21% (▲)	89.73% (▲)	92.02% (▲)	92.78% (▲)	95.82% (▲)	95.82% (▶)	95.06% (▼)	95.13% (▲)	97.38% (▲)	95.56% (▼)	96.67% (▲)	97.41% (▲)	98.89% (▲)
IPC assurance audit compliance	90%		88.2% (▲)	78.4% (▼)	88.8% (▲)	89.4% (▲)	77.4% (▼)	79.8% (▲)	87.4% (▲)	80.4% (▼)	83.6% (▲)	82% (▼)	83% (▲)	79% (▼)	73.2% (▼)
Record keeping Audit completion compliance	90%			82.63% (▼)			100% (▲)			100% (▶)			100% (▶)		
Overall CQC rating (Yearly)	Good									Requires Improvement (▶)					
Flu vaccinations for frontline healthcare workers (CQUIN01)	80%		54.6% (▼)												
Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%		78.69% (▼)			81.4% (▲)			83.08% (▲)			61.76% (▼)			93.94% (▲)
Assessment and documentation of pressure ulcer risk (Community Hospital Inpatients) (CQUIN12)	85%		93.33% (▲)												

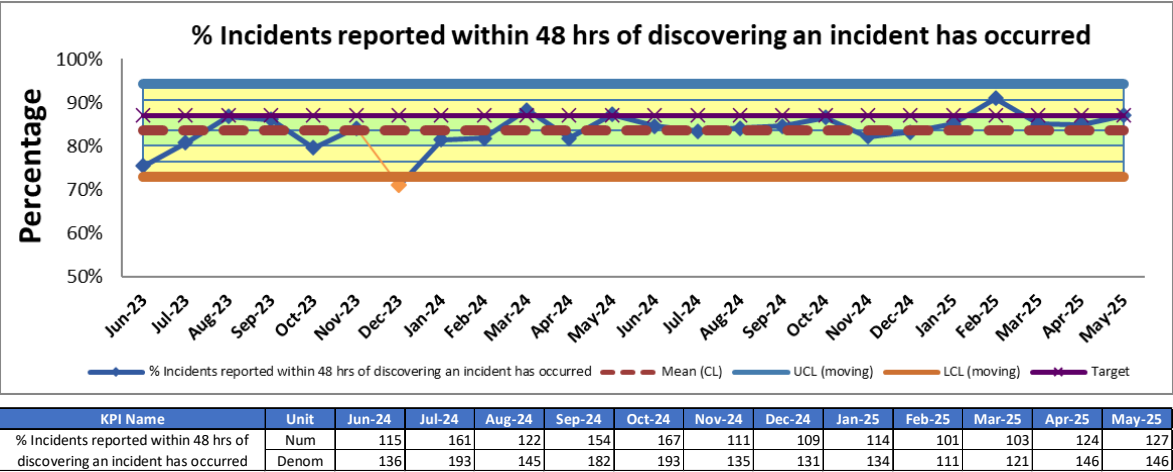
Quality: Exception Reporting

Trust Scorecard

No Quality Indicators are outside of control limits in May 2025.



Quality: Exception Reporting



Analytical Narrative

We were seeing a mostly consistent trend of data points sitting close to the mean, yet below target. In February 2025 there was a significant improvement, yet the past three months have fell back below target.

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

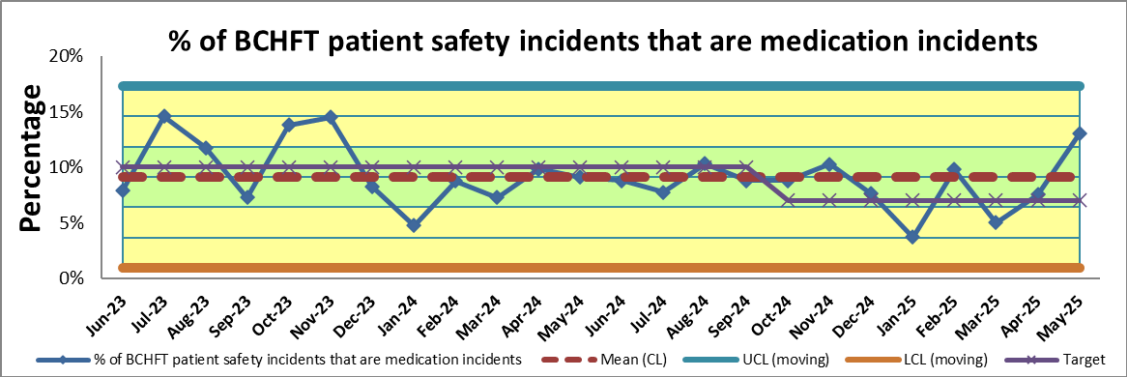
Target: 87% Compliance in May – 86.99%

Operational Narrative

In May 2025, the compliance rate was 86.99%, compared to 84.93% in April 2025. This demonstrated improved performance, which was 0.01% below target. Performance remained within the upper and lower control limits and was above the mean for the period covered by the SPC. While the level of performance in May 2025, was an improvement and was fractionally below target, there is currently no evidence to indicate that this due to anything other than common cause variation.

It is noted that there will occasionally be incidents reported outside of the 48-hour threshold, indeed that is reflected in the target level for this indicator.

Quality: Exception Reporting



KPI Name	Unit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
% of BCHFT patient safety incidents that are medication incidents	Num	12	15	15	16	17	14	10	5	11	6	11	19
	Denom	136	193	145	182	193	136	131	134	112	120	146	146

Analytical Narrative

May 2025 - although we saw a notable rise compared to the previous 6 months, overall incident levels remain within expected control limits. No patterns were identified in relation to service, location, drug, or individual clinicians.

While previous concerns suggested a **possible underreporting trend** due to fear of blame, the increase in May suggests reporting behaviours remain active. The Medicines Management Team continues to monitor trends and support services with shared learning and safety improvements.

% of BCHFT patient safety incidents that are medication incidents
Local Target: 7% Compliance in May – 13.01%

Operational narrative:

A total of **19 medication-related patient safety incidents** were reported across the Trust in May 2025.

- 16 incidents** were categorised as causing “**Insignificant or No Harm**”, with **2 near misses** and **1 incident resulting in minor harm**.
- The minor harm incident involved a **delay in administering morphine and cyclizine** for symptom control in an end-of-life care setting.

The most common cause was **Medication – Administration Errors (12 of 19 incidents)**. These included - **Wrong dose or drug, Early or delayed administration and Missed doses**.

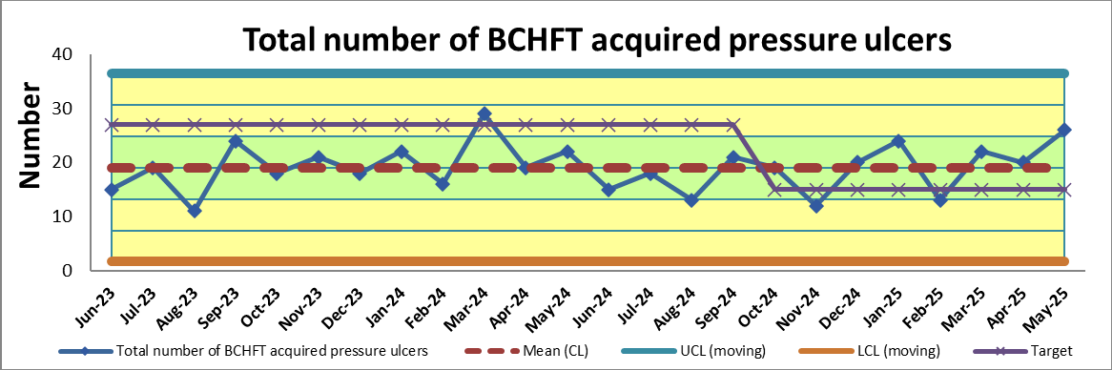
Other reported causes included (7):

- Immunisation-related issues (3)** – including **one wastage** and **two preparation errors** involving **MEN ACWY vaccine**. Initially thought to be user error, the repeated nature has raised concern of a **potential medical device issue**.
- Record-keeping error (1)**
- Prescribing and transcribing errors (2)**
- One incident involved third-party handling**: a family member discarded end-of-life controlled drugs (**morphine, midazolam**). Although recorded as a Trust incident, it occurred outside of service control, emphasising the need for secure medicine return processes.

Frequently involved medicines included:

- Nutrison Energy Multifibre** (2 separate administration errors for the same patient)
- Morphine** (2)
- MEN ACWY vaccine** (3)

Quality: Exception Reporting



KPI Name	Unit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Total number of BCHFT acquired pressure ulcers	Num	15	18	13	21	19	12	20	24	13	22	20	26

Analytical Narrative

All data points remain within normal variation yet fluctuate around the mean. The target is within limits and is achievable.

Total number of BCHFT acquired pressure ulcers

Target: 15 Compliance in May - 26

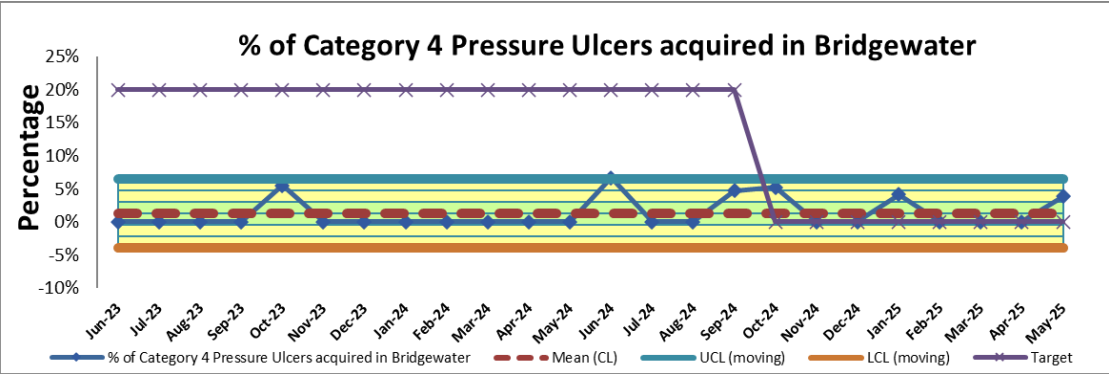
During this reporting period there has been an increase in BCHFT acquired pressure ulcers reported.

9 of those reported were in Halton and 15 in Warrington. 22 of the incidents related to category 2 pressure ulcers

In Halton, all of the cases were within the district nursing service, with equal distribution across the teams.
Within Warrington 10 of the recorded incidents were within District Nursing and 4 in Padgate house.

All appropriate interventions were undertaken; however, work remains ongoing through the pressure ulcer priority group to identify any themes, learning and any areas of improvement.

Quality: Exception Reporting



KPI Name	Unit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
% of Category 4 Pressure Ulcers acquired in Bridgewater	Num	1	0	0	1	1	0	0	1	0	0	0	1
	Denom	15	18	13	21	19	12	20	24	13	22	20	26

Analytical Narrative

There has been an inconsistent trend with numerous data points either side of the mean. However, this could be due to the low numbers reported.

Following the reset of the target in October 2024, this now sits within limits and is achievable.

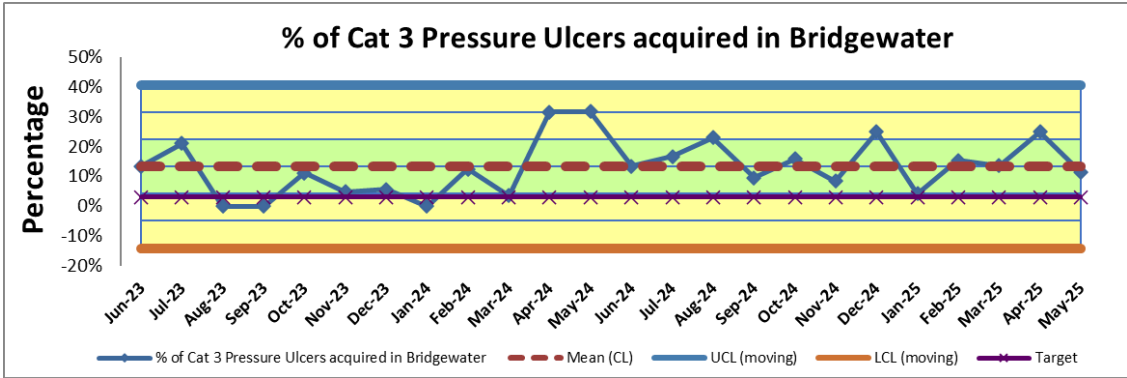
% of Category 4 Pressure Ulcers acquired in Bridgewater

Target: 0% May Compliance – 3.85%

Operational Narrative

This pressure ulcer incidence has now been categorised as a category three pressure ulcer, therefore the target was achieved in month.

Quality: Exception Reporting



KPI Name	Unit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
% of Cat 3 Pressure Ulcers acquired in Bridgewater	Num	2	3	3	2	3	1	5	1	2	3	5	3
	Denom	15	18	13	21	19	12	20	24	13	22	20	26

Analytical Narrative

We are seeing an inconsistent trend due to the low numbers of category 3 pressure ulcers reported. All data points are within standard variation, as is the target.

% of Category 3 Pressure Ulcers acquired in Bridgewater

Local Target: 3% Compliance in May – 11.54%

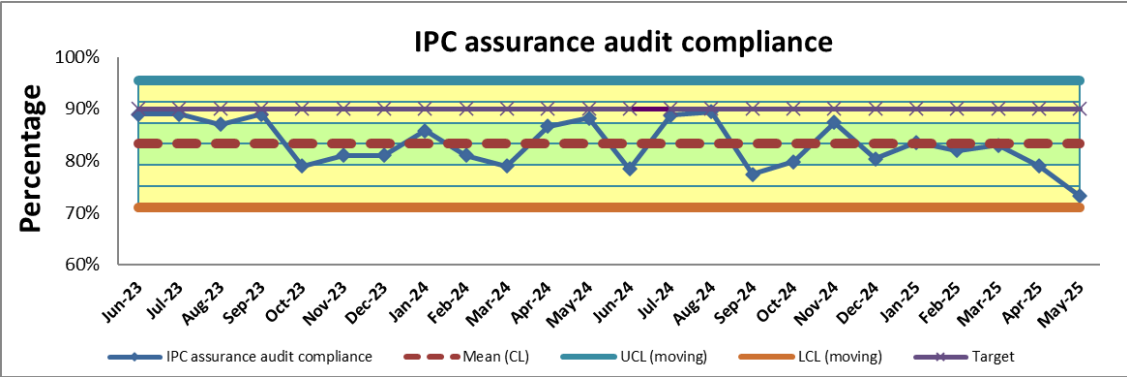
Operational Narrative:

The inconsistent trend in category three pressure ulcer incidence continues in month and has been recognised in the pressure ulcer priority group as an area for focused improvement in 2025/26.

In this reporting period there has been 1 reported category 3 Pressure Ulcers, attributed to Halton Directorate and 0 attributed to the Warrington. The incidents relate to patients with who resides in a care home whose general health had deteriorated and reduced her mobility but spends periods of times sitting out.

All appropriate interventions were undertaken; however, work remains ongoing through the pressure ulcer priority group to identify learning and any areas for improvement.

Quality: Exception Reporting



KPI Name	Unit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
IPC assurance audit compliance	%	78.4%	88.8%	89.4%	77.4%	79.8%	87.4%	80.4%	83.6%	82.0%	83.0%	79.0%	73.2%

Analytical Narrative

We can see a consistent trend with all data points within normal variation. The target sits within limits and is achievable.

IPC assurance audit compliance

Local Target: 90%

Compliance in May – 73.2%

Operational Narrative

In April the compliance collection method was amended for both hand hygiene and donning + doffing to ensure a true reflection of compliance within practice is reported. Due to this improvement a reduction in compliance is expected which reflects the increased scrutiny of the data reported and allow the team to target areas more effectively.

There was also an increase in the number of assurances not received. Eleven teams have not reported data this month, operational managers and Directorate Leadership teams have been informed.

People

Executive Summary

One out of four People indicators are shown as red in May 2025.

The one indicator which was red in May is as follows:

- Sickness absence rate (Actual) – Improvement in Month

People

Trust Scorecard

People															
KPI Name	Target	Trend Line	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Staff turnover (rolling)	12.00%		11.33% (▲)	11% (▲)	10.21% (▲)	10.47% (▼)	10.7% (▼)	10.75% (▼)	10.72% (▲)	10.81% (▼)	11.06% (▼)	11.28% (▼)	11.83% (▼)	11.38% (▲)	11.1% (▲)
Sickness absence rate (Actual)	5.50%		5.71% (▲)	5.63% (▲)	6.65% (▼)	6.19% (▲)	5.76% (▲)	6.49% (▼)	6.81% (▼)	7.32% (▼)	7.97% (▼)	6.23% (▲)	6.33% (▼)	6.91% (▼)	6.57% (▲)
% of staff with a current PDR	85.00%		87.28% (▼)	91.19% (▲)	86.33% (▼)	86.06% (▼)	85.77% (▼)	86.98% (▲)	87.63% (▲)	87.37% (▼)	87.12% (▼)	87.91% (▲)	88.18% (▲)	87.43% (▼)	86.68% (▼)
% Overall Mandatory Training Compliance	85.00%		97.01% (▲)	95.39% (▼)	95.61% (▲)	95.68% (▲)	95.93% (▲)	94.85% (▼)	95.78% (▲)	95.56% (▼)	95.77% (▲)	96.11% (▲)	96.58% (▲)	96.97% (▲)	97.13% (▲)

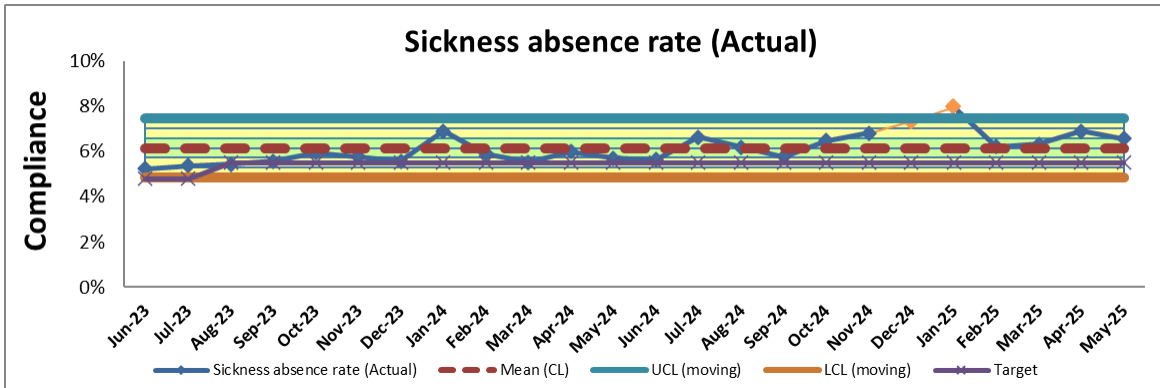
People

Trust Scorecard

No People Indicators are outside of control limits in May 2025.



People: Exception Reporting



Analytical Narrative

We were seeing an increasing trend, but the latest data points are back within control limits, yet still above target. We will continue to monitor this.

Sickness absence rate (Actual)

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

May compliance – 6.57%.

Operational Narrative

In response to higher levels of absence during Q3 2024 a Deep Dive exercise was completed to understand the reasons and contributory factors for absence, comparing 2023 with 2024 data. Findings ultimately confirmed that increases were seasonal, but improvements in early intervention support were identified as learning and are currently being implemented. New policy implemented in May 2024 with the aim of prevention and longer-term improvement in wellbeing levels, impact review planned for early autumn. HR Team are currently considering how we can focus on stress support as our highest reason for absence and an increase in short term absence due to stress.

Finance

Month Two Finance Report

Scope

The purpose of this paper is to update the Committee on the financial position of the Trust at the end of May 2025 (Month Two).

Summary Performance Month 02 2025-26	Month 2 Plan	Month 2 Actual	Month 2 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Fore cast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.28)	(8.20)	▲ (0.08)	(16.56)	(16.41)	▲ (0.16)	(99.20)	(99.20)
Expenditure - Pay	6.04	6.15	▲ (0.11)	12.06	12.29	▲ (0.23)	71.30	71.30
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.11	0.03	● 0.08	0.22	0.07	● 0.15	1.10	1.10
Expenditure - Non Pay	2.56	2.45	● 0.11	5.11	4.86	● 0.25	27.94	27.94
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
EBITDA	0.42	0.42	● 0.01	0.83	0.82	● 0.01	1.14	1.14
Financing	0.03	0.03	● 0.00	0.06	0.06	● 0.00	0.39	0.39
Normalised (Surplus)/Deficit	0.45	0.45	● 0.00	0.89	0.88	● 0.01	1.53	1.53
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.45	0.45	● 0.00	0.89	0.88	● 0.01	1.53	1.53
Other Adjustments	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.45	0.45	● 0.00	0.89	0.88	● 0.01	1.53	1.53

Savings - CIP	0.40	0.40	● 0.00	0.76	0.76	● 0.00	5.48	5.48
Savings - Integration Target	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Capital	0.00	0.00	● 0.00	0.00	0.00	● 0.00	2.10	2.10
Cash	9.96	5.72	▲ (4.24)	9.96	5.72	▲ (4.24)	6.85	6.85
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance ▲ Adverse Variance

Finance

2025-26 Plan

2025-26 Plan

1. The Trust submitted a financial plan for 2025/26 with a deficit position of £4.42m. This plan reflected the underlying financial position and run rate of the Trust and was developed using the income and cost assumptions provided both nationally and by the local ICB. This was included in Cheshire & Merseyside ICB's overall draft plan submitted to NHSE. The ICB has a control total of £178m deficit and the consolidated plans submitted did not meet this value. The ICB plan was not accepted or approved.
2. As a result, the ICB were instructed to revisit all plans and asked all Trusts to include additional savings in their plan. These additional savings were labelled as 'placeholder savings' and allocated based on turnover. The ICB recognised that there would be a system solution required to deliver these savings. The ICB also recognised that the initial allocation may need to be revisited following the system led workstreams identifying additional savings opportunities to ensure equity and to match savings achieved to the additional stretch savings targets within organisations. This may require the reallocation of the savings targets across organisations later during the year.

Finance

2025-26 Plan

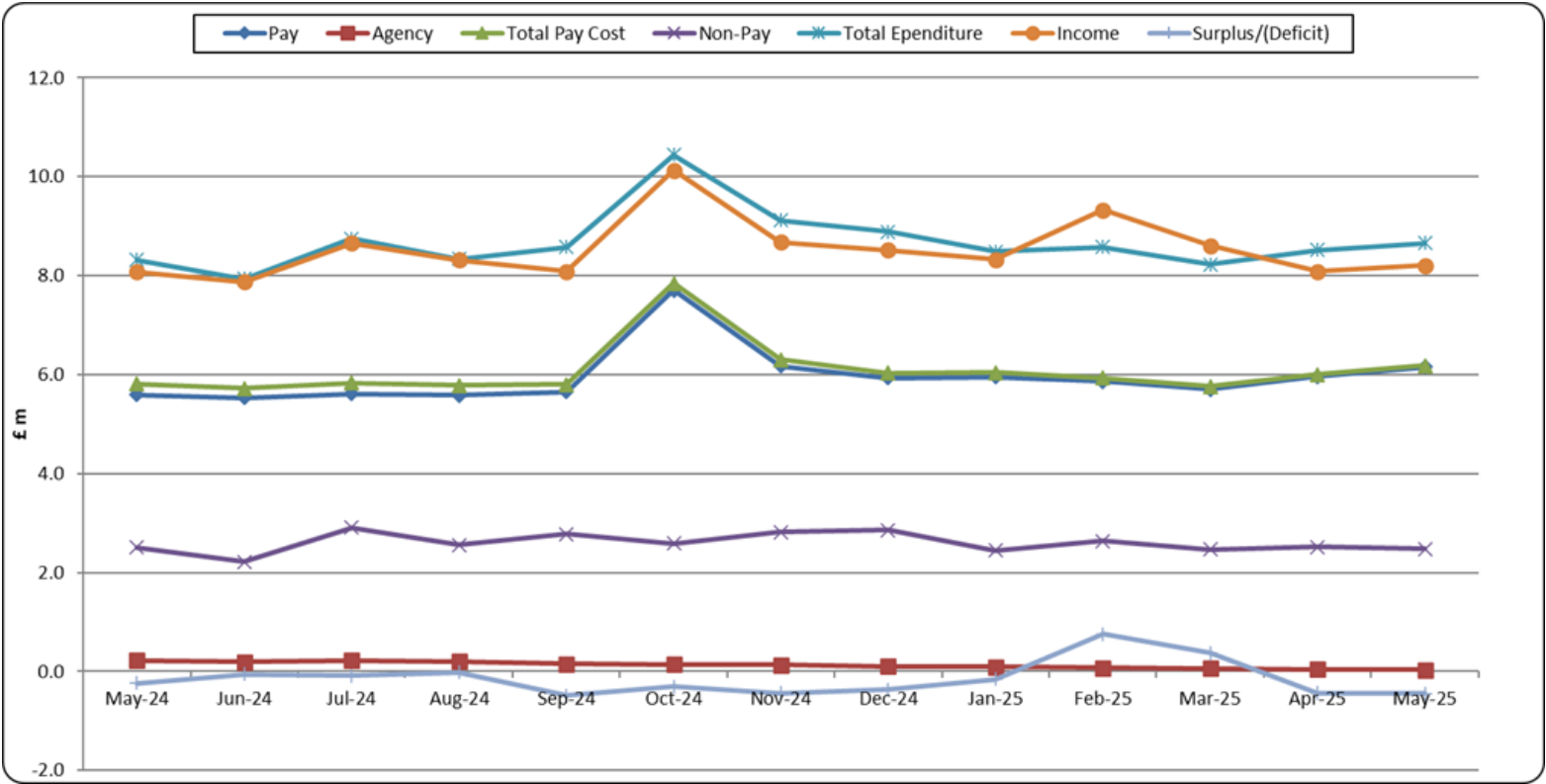
2025-26 Plan (Continued)

3. Following agreement by the Board, a revised plan was developed to include an additional £2.89m savings, £0.5m is associated to service reduction, the remaining £2.39m is the BCH share of system-wide savings. This plan is reflected in the table in 1.7.
4. The Trust has categorised the total savings required in 2025-26 at three levels:
 - i. Level 1 – Trust BAU CIP – These savings are part of the Trust 5% savings target and are solely the responsibility of the Trust to deliver.
 - ii. Level 2 – Trust and WHH – These savings are also part of the Trust 5% savings target and are the responsibility of the Trust to deliver, working in partnership with WHH
 - iii. Level 3 – System ‘stretch’ savings – These savings are to be delivered across the system. System workstreams have been formed to identify opportunities. The system is expected to deliver these savings.

Finance

Key Headlines

Rolling Run Rates 2024/25 to 2025/26



CUMULATIVE PERFORMANCE AGAINST NHSE PLAN

The key headlines for month 1 are as follows:

- The Trust is reporting a deficit at Month 2 of £0.88m, £0.01m favourable to plan.
- The Trust has a savings requirement, excluding system savings, of £5.48m (5.02%) in line with ICB instruction.
- The Trust is reporting a savings achievement of £0.76m against a plan of £0.76m
- Income is £16.41m against a plan of £16.56m.
- Expenditure is £17.29m against a plan of £17.46m.

Finance

CUMULATIVE PERFORMANCE AGAINST NHSE PLAN (continued)

- Pay is £12.29m against a plan of £12.06m.
- Agency spend is £0.07m against a plan of £0.22m.
- Non pay expenditure is £4.86m against a plan of £5.11m.
- Capital charges are in line with plan.
- Capital expenditure is £0m at month two, planned spend is also £0m.
- Cash is £5.72m.

Appendix

Indicator	Detail
Operations	
Diagnostic waiting times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
Four-hour A&E Target	All patients who attend a Walk in Centre or Urgent Care Centre (A&E Type 4) should wait no more 4 hours from arrival to treatment/transfer/discharge. The national target is 95%.
Cancellation by Service	The Trust aspires to ensure that no patient will have their appointment cancelled. In exceptional circumstances, however the service may need to cancel patient appointments. In these instances, patients/carers will be contacted and offered an alternative appointment at their convenience acknowledging the maximum access times target.
Cancellation by patient	A patient cancellation or rescheduling request occurs when the patient contacts the service to cancel their appointment. Short notice cancellations i.e.: within 3 hours of appointment time should also be recorded as cancellation.

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Monthly Clinical Harms Review Report

Information Team

Reporting Period: Month 2



52 + week waits and outstanding clinical harm reviews

Services with patients waiting over 52 weeks (data as at 02/06/2025)

Directorate	Service Line	Total over 52 weeks	Number of outstanding
Warrington Adult	Dermatology Service	830	755
Warrington Adult	Podiatry Service	56	27
Halton Adult	Podiatry (Halton)	9	1
Warrington Child	Paediatric Community Medical Service	50	13
Halton Child	Community Paediatrics (Halton)	388	161
Dental	Dental	28	0

Key

Worse than last month

Better than last month

Same as last month

New to report

Data Quality Issues

Harm reviews completed in month

Number of harm reviews completed in reported month

Directorate	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Warrington Child	33	214	77	79	64	50	41	225
Halton Child	28	112	24	64	80	69	66	71
Warrington Adults	24	15	4	124	69	0	17	1
Halton Adults			9		0	0	0	6
Dental						24	105	28

Harm levels recorded in reported month

Directorate	Low Harm	Moderate	Severe	Fatal	Total
Warrington Child	3	4	0	0	7
Halton Child	3	10	0	0	13
Warrington Adults	0	0	0	0	0
Halton Adults	0	0	0	0	0
Dental	0	0	0	0	0

Harms recorded as PSII's in reported month

Directorate	Low Harm	Moderate	Severe	Fatal	Total
Warrington Child	0	0	0	0	0
Halton Child	0	0	0	0	0
Warrington Adults	0	0	0	0	0
Halton Adults	0	0	0	0	0
Dental	0	0	0	0	0

Dental data for CHR is still in development and not available electronically yet.



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01925 946400



bchft.enquiries@nhs.net



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NHS Oversight Framework

File created on: 16/06/2025



NHS Oversight Framework - Organisation Detail



Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
MHPRV C19 Type BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2025 01	2-Flexible support					
	MH Provider	S035a: Overall CQC rating	Month	2025 01	2-Requires improvement					48/82
	MH Provider	S050a: CQC well-led rating	Month	2025 01	2-Requires improvement					48/82
	MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual: calendar year	2023	6.75%	9.94%		↓		21/88
	MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual: calendar year	2023	10%	17.7%		↓		28/88
	MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users	Annual: calendar year	2023	18.4%	25.1%		↓		5/88
	MH Provider	S067a: Leaver rate	Month	2024 12	6.91%	6.94%		↓		7/87
	MH Provider	S068a: Sickness absence rate	Month	2024 09	6.81%	5.01%		↓		47/87
	MH Provider	S080a: Staff survey engagement theme score	Annual: calendar year	2023	7.28/10	6.89/10		↑		16/88
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual: calendar year	2023	10.7%		12%	↑	↑	28/84
	MH Provider	S071c: Proportion of staff in senior leadership roles who are disabled	Annual: calendar year	2023	7.14%		3.2%	↑		13/84
	MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation	Annual: calendar year	2023	80.3%	56.4%		↓		26/87
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual: calendar year	2023	7.68/10	7.09/10		↑		16/88
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual: calendar year	2023	7.1/10	6.46/10		↑		11/88
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual: calendar year	2023	7.1/10	6.46/10		↑		11/88
	MH Provider	S133a: Staff survey - compassionate and inclusive theme score	Annual: calendar year	2023	7.78/10	7.3/10		↑		13/88
	MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES)	Annual: calendar year	2023	1.4		1	↑		28/84
	MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual: calendar year	2023	1		1	↑		28/84

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile



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bchft.enquiries@nhs.net



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Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		Report to:	Board of Directors
Date of Meeting:	26 June 2025		Date of next meeting:	28 August 2025
Chair:	Elaine Inglesby, Non-Executive Director and Committee Chair		Quorate (Yes/No):	Yes
Attendance:	Present: Elaine Inglesby, Non-Executive Director and Committee Chair Gail Briers, Vice Chair and Non-Executive Director Lynne Carter, Chief Nurse Mark Charman, Acting Director of Operations Paul Fitzsimmons, Medical Director	In attendance: Susan Burton, Associate Chief Nurse Jeanette Hogan, Deputy Chief Nurse Suzanne Mackie, Director of Quality Governance Melanie McLaughlin, Associate Director Warrington Adults Jan McCartney, Director of Corporate Governance Lauren Ryan, Executive Assistant Observers: Christine Stankus, Lead Governor	Key Members not present:	Apologies received from: Abdul Siddique, Non-Executive Director Dan Moore, Chief Operating Officer Tania Strong, Head of Human Resources

Committee Chair's Report

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Serious incidents compliance report and update on any incidents of concern	2		The report reviewed patient safety reporting within the Trust over March and April 2025. Since October 2024 there had been a downward trend in reported incidents, countered by enhanced incident-report training and ongoing monitoring at Directorate Incident Review Groups (DIRGs). The key elements included: - Top incident types remained moisture lesions, pressure ulcers, and falls. One moderate harm incident in March and one in May; no Patient Safety Incident Investigations (PSIIs) requested. Overall number of pressure ulcers sits within upper and lower control limits (common cause variation). - Category 2 ulcers: 18 in March, 15 in April. - Category 3 ulcers: 3 in March, 5 in April (two patients in end-of-life care). - No specific themes or trends identified. - The priority group continued to meet regularly to share learning and drive training. Reported medication-related safety incidents have reduced, though underreporting cannot be ruled out. - No moderate harm attributed to medication incidents this year. - Four near-miss medication incidents reported; staff encouraged to report near misses promptly. - Falls remained within control limits, indicating common cause variation. An audit of fall-safety procedures will be presented in due course. - Thirty-four learning responses completed and approved; detailed lessons in Appendix A. - Two incidents during March–April required duty of candour, both handled in compliance with policy.	Discrepancy noted between PSIRF paper narrative and SPC chart for grade 4 pressure ulcers; teams to improve chart updates and data management outside this meeting. Committee to receive further information on improvement plans for pressure ulcers. The Committee received the report for assurance.

Committee Chair's Report

Risks related to Quality and Safety	2	The report demonstrated no significant movements in risks categorised as scoring 12 or above. Demand and capacity risks remained the most common risk theme for quality and safety related risks within the Corporate Risk Register. In April 2025, there were 10 risks, while in May 2025 there were six risks regarding demand and capacity. For April 2024, eight risks related to the Children's services directorate, whilst two related to the Halton Adults directorate. During May 2025, there were four risks in the Children's services directorate and two risks regarding Halton Adult directorate. In both April and May 2025, there was one risk which scored 20, this related to the cumulative risk around pressures within the Children's services directorate. The Trust maintained oversight of the above risks through review and discussion at the monthly Risk Management Council. Three new risks with a score of 12 had been identified within the reporting period: Lack of administrators to coordinate Neuro Development Pathway, long term sickness within the Tissue Viability Team and risks for patients awaiting minor oral surgery breaching 52 weeks within the Cheshire and Merseyside Dental Service.	The Committee was assured that the risks scoring 12 and above in relation to quality and safety were being identified and managed effectively.
Report from Quality Council	2	The Committee noted the key points from the considerations of the Quality Council: Audit and research activity had increased during the period. Medication incidents have reduced, with improved compliance supporting shared learning. Children's Services update included waiting-time metrics and clinical harm reviews. Rapid intervention in the Neurodevelopment pathway was underway. Communications with referrers and families would be detailed in the next report to the Committee.	The Committee received the report for assurance. Following discussions around Dental Services, an action was agreed for Dental Services to produce a gap analysis against the dental strategy and previous action plans and produce information around emerging risks that could be presented to the Committee for assurance. It was agreed that

Committee Chair's Report

			PASQAT Audiology Audit: June Risk Management Council and Quality Council would receive further updates. The ICB had provided positive feedback on joint working with WHH to provide safe practice and praised the facilities at Bridgewater. It was noted that the final inspection report was delayed until 7 July. Warrington and Halton Adults Service: National Patient Safety Alert has been issued for Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices. There were two outstanding actions from the gap analysis, both related to ongoing maintenance and servicing processes for the equipment. A risk had been added to the risk register and a task and finish group had been established to manage the remaining actions. Dental Services: An update was provided which included an update on Paediatric general anaesthetic commissioning which was under review. The Quality Council had escalated this matter and the risk register entry was being updated. A discussion took place concerning patient information leaflets: Version control gaps had been identified. This would be tracked through directorate nursing groups across both boroughs. The Committee also identified that there were a high number of areas within the report with amber/red ratings – a review of rating criteria and narrative clarity would be undertaken by the Quality Council.	this would be brought forward to October 2025.
IQPR			24 green indicators and seven red indicators documented in month one. There had been two green rated indicators that changed to red: Percentage of incidents causing moderate harm (score of three). Percentage of Category Four Pressure Ulcers acquired in Bridgewater. One red indicator changed to green in-month: percentage of risks identified as 12 or above.	Discrepancies were highlighted in data presented around pressure ulcers and falls – this would be reviewed and updated as required, to ensure accuracy prior to this report being taken into the Board in August.
Community Paediatrics/ Neurodevelopment Action Plan	2		The Committee received a verbal update on current work.	

Committee Chair's Report

Padgate House Update Report	2		The Committee received an update on the current position: work was completed with evidence captured and actions closed. One remaining action was progressing with meetings to take place between Bridgewater and key partners.	Any further updates would be presented to the Committee as required.
CQC Update report (verbal)	2		The Committee were informed that a positive meeting had taken place with the CQC on 20 June which had included the attendance from the Trust Chief Executive and Directors. The CQC were assured from discussions held and comprehensive updates provided by the Trust on key areas of work.	
QIA Report	2		The Committee noted that a total of nine QIAs had been undertaken between March to April 2025 of which five related to Cost Improvement Schemes (CIP). Six QIAs were approved and would return to panel for future review Two QIAs were closed following review as no adverse impact had been identified since implementing the proposal. One QIA was retracted with no need to return to panel. The format of the report has been amended for greater transparency of proposal type, within the following categories: Cost Improvement Service change / redesign Vacancy	The Committee received the report including the detail of the QIAs for the reporting period for assurance.

Committee Chair's Report

Trust Improvement Plan	2		A report was provided to provide an update on the improvement plans: Of the 11 current plans within the programme: Five plans have shown positive progress with an increase in overall Blue and/or Green actions: • Paediatric Audiology Review Action Plan • Paediatric Audiology RCA Action Plan • Padgate House Action Plan • Paediatric Audiology Service Quality Assessment Tool (PASQAT) – Warrington • Voice of the Child Action Plan Four plans have progressed but with no overall changes to progress indicators: • Carers' Strategy • Drive Ability Northwest • Neurodevelopmental Pathway Boost Action Plan • Paediatric Audiology Service Quality Assessment Tool (PASQAT) – Halton Two plans are complete: • Community Nursing Halton and Warrington • Community Equipment Stores Action Plan Three plans have been removed (completed last reporting cycle) Warrington Wolves Improvement Plan • Dental – Development of Quality Assurance Templates • Dental – Standardisation of Radiation Protection An update was provided against the red rated areas with assurances provided on progress against: • Carers strategy – work progressing with WHH • Drive Ability Northwest – pending relocation – action being actively progressed. • Padgate House – actions had been completed and this would be demonstrated within the next cycle. • Neurodevelopment Pathway – progress delayed due to rapid response work.	The Committee received the report for assurance.

Committee Chair's Report

Learning from Deaths Annual Report	2		The report outlined compliance with medical examiner reviews, the scope and outcomes of structured mortality reviews, thematic learning, and planned harmonisation of processes across hospital and community settings. The following key points were highlighted: • 100% compliance achieved with timely medical examiner review of all deaths in Warrington and Halton, covering both community and hospital services. • Figures have been reviewed with the coroner to confirm full adherence to statutory requirements. • 96 deaths underwent structured judgement reviews under the Learning from Deaths framework, with selection criteria detailed in the report. • 10 deaths escalated via the National LEADER process, and 14 child deaths reported as serious incidents. • No concerns reported from LEADER during 2024/25, though some submitted reviews are still pending feedback. • No care delivery failures or causality issues were identified in any of the 96 internal reviews. • Record-keeping inconsistencies across community and hospital sectors—and within multiple internal systems—require resolution via the digital strategy. • This quarter would deliver the final standalone community mortality report; from next quarter onward, reporting will be unified with WHH. • Learning from Deaths leads from both Bridgewater and WHH will establish a single selection criterion and a consolidated mortality review group.	The Committee received the report for assurance. Within roles and responsibilities, an addition would be made to explain that the Trust had been compliant with national reporting guidelines via taking the reports through the Trust Board. This report is also included on the Board agenda for final ratification.
Review of MIAA and Clinical Audits: PSIRF 2024/25 – substantial assurance	2		The Committee received the MIAA report which gave an overall assurance opinion of substantial assurance. The purpose of the Audit had been to evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring and reporting of incidents following the adoption of PSIRF. There was one medium and four minor findings had been identified which were being progressed.	The Committee received the report for assurance – it would receive a further update once all actions were completed.

Committee Chair's Report

Strategies, Annual Reviews and Annual Reports	2		The Committee received the following reports: Pressure Ulcers Annual Report Non-Medical Prescribers Q3 2024-25 Report A number of further reports were deferred to the next meeting: Dental Strategy Clinical Audit Annual Report Medicines Management and Controlled Drugs Annual Report	
Review of Committee Terms of Reference and Business Cycle	1		The Committee reviewed both documents.	Both documents were approved with the caveat that the ToR would be updated to reflect the addition of vacancies, cost improvement plans and service change information to be included as part of the QIA report. The Committee membership would also be updated to ensure it was current.
Assurance Reports	2		The Committee agreed that it did not require any additional assurance reports based on the items and discussions at today's meeting.	
Items to be shared/escalated with the Board or other Committees	1, 2		The Learning from Deaths Annual Report was escalated to the Board.	
Review of meeting	1		The Committee noted that this would be the Chief Nurse, Lynne Carter's final meeting and extended its thanks for her considerable work and contributions.	

Committee Chair’s Report

Risks Escalated: None this month.

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

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

Learning from Deaths

Annual Report 2024-2025

May 2025



Contents

1. Purpose of this Report
2. Background
3. Learning from Roles and Responsibilities
4. Learning from Deaths Process
5. Cumulative Learning from Deaths Review Statistics 2024 – 2025
6. Learning and Improvement
7. Next Steps
8. Conclusion
9. References

Learning from Deaths Annual Report 2024/25

1. Purpose of this Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This annual report covers all four quarters from the 1st of April 2024 and the 31st of March 2025.

This report serves to provide assurance to the Board that the Trust is compliant with the mortality review requirements as set out in the NHSE National Quality Board - National Guidance on Learning from Deaths 2018.

Nationally, most people will be in receipt of care from the NHS in the weeks, months or years leading up to their death. However, for some people, their experience is of poor-quality care for several reasons including system failure.

Learning from Deaths (LfD) within the Trust is supported by two key policies in the Trust, the Learning from Deaths Policy and the Patient Safety Incident Response (PSIRF) Policy. Both these policies guide and inform the organisation about reporting, investigating and learning from deaths.

Between the 1st of April 2024 and the 31st of March 2025 96 deaths were reviewed.

The 96 deaths reviewed, in line with the Trust policy were done so by working with the families/carers of the patients who had died, and the health and social care providers involved in the patients care.

Learning from excellence and from improvement was identified and shared across Bridgewater services and place-based partnerships.

2. Background

In December 2015, the Secretary of State for Health commissioned the Care Quality Commission (CQC) to carry out a review of how acute, community and mental health Trusts across the country investigate incidents and learn from deaths. This was to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed.

The NHS Quality Board national guidance was followed in July 2018 with specific guidance for NHS Trusts on working with families and carers. This was co-produced with families and carers to provide Trusts with advice on how they should support, communicate and engage with families following the death of someone in their care.

Whilst the guidance makes it clear that Trusts should report on inpatient deaths and those that have died within 30 days of leaving hospital, this is not applicable to community Trusts and locally Trusts can determine their own individual approaches to undertaking mortality reviews including definitions of deaths in scope for review. Consequently, qualitative mortality review data is therefore not comparable between Trusts.

3. Roles and Responsibilities within the Trust for Learning from Deaths

The Trust Medical Director is responsible for providing assurance to the Board with respect to mortality governance arrangements. This includes the provision of a quarterly report to the Quality and Safety Committee of the Board on the numbers of deaths of patients who were under the care of the Trust and the Trust's response to these, including any resultant learning.

The Medical Director, together with the Chief Nurse, has responsibility for monitoring and improving the quality of clinical services. They ensure systems are in place to

identify opportunities for service improvement, including as an outcome of investigation of deaths or serious incidents.

The Trust secretary is responsible for providing a quarterly report of coronial inquests that the Trust is involved to the Quality and Safety Committee.

The Safeguarding Team coordinates the Trust's contribution to the Child Death Overview Panel and multi-agency safeguarding reviews including Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

The Directorate Incident Review Group (DIRLG) is responsible for advising operational managers in relation to the need for further investigation and the applicability of duty of candour following the reporting of a death of a patient under the care of the service along with:

- Supporting the identification of any subsequent learning
- Assessing each LfD case note review
- Recommending whether further investigation is required
- Monitoring the status of investigation into deaths and providing intelligence for Trust Patient Safety Incident Response Framework from Learning Panel (PSIRPaLP) in respect of deaths investigations
- Providing updates of LfDs to PSIRPaLP

The PSIRPaL on behalf of the Medical Director oversees all the Trusts reported deaths by providing senior level scrutiny.

4. Learning from Deaths Review Process

As a Trust, in line with the National Quality Board report published in 2017 we carry out a review or investigation of the death of any patient under our direct care.

In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being firstly primary care and

acute care and then ambulances services and acute care and mental health services combined with any of these. We actively involve ourselves in other providers' investigations about patient deaths and involve them in the Trust investigation as and when appropriate.

The Trust LfD Policy sets out how we identify, report, investigate and learn from the death of patients who die under the Trusts management and care. All deaths in scope are reviewed to maximise learning and share best practice.

The method adopted by Trust is based on the Structured Judgement Reviews (SJRs) for Improvement, Royal College of Physicians V1.3 June 2018.

The benefits of utilising this type of methodology are that it provides a structured and reproducible process to reviewing deaths across the Trust. This method examines not only intervention but also looks at the holistic care, giving a rich data set of information.

Using the SJR method, the Trust has established a community-based LfD case note review process. This method allows for the identification and feedback of both good and 'problematic' care, as there is much to be learned from both.

As part of this process, an LfD case note review assessment tool is completed by the lead clinician within a service once it has been identified the patient death has triggered one or more of the reporting criteria.

The Trust LfD policy objective is to set out how the Trust responds to and learns from the deaths specifically; the policy describes how the Trust:

- Determines which patients are under its care for the purpose of responding to deaths
- Determines which deaths to report as incidents for possible investigation and learning

- Reports deaths within the organisation and to other organisations who may have an interest
- Engages meaningfully and compassionately with bereaved families and carers
- Identifies and acts on learning from the investigation of deaths
- Responds to all deaths of patients detailed in the 'criteria for reporting a death'.
- Promotes organisational learning and improvement.

The LfD policy applies to all Trust employees including agency workers, volunteers, contractors, bank staff and learners in practice conducting work on behalf of the Trust.

The criteria applied for reporting a patient death within the Trust for 2024 – 2026 was as follows:

- The deceased patient had a learning disability or Autism
- The deceased patient was a child aged <18 years
- The death was unexpected, and the last service intervention was less than 30 days ago.

And where:

- The bereaved family have expressed a concern about the care their relative received from the Trust or other partner services
- Staff employed by the Trust have expressed a concern about the quality of care received by the deceased e.g., did not die in their preferred place of care
- The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g., through audit or CQC inspection)

Directorate Incident Review Groups (DIRLGs)

All deaths that meet the above criteria are reported as an incident in the Trust's incident reporting system Ulysses within 48 hours and are reviewed/investigated in our weekly DIRLGs.

The DIRLGs are made up of:

- Associate Directors
- Heads of Service
- Professional Leads
- Operational Managers
- Named Nurse for Safeguarding
- Team leaders
- Head of Risk Management and Patient Safety

The DIRLG review the weekly LfD incidents with clinical teams and work with services to implement changes to practice if a need is identified.

The group review trends in the LfDs undertaking thematic reviews to identify areas of best practice and of learning. Trends and themes are reported to the PSIRFaLP.

Any SJR of a death that reveals any concerns around care provision, service provision, or identifies issues which may have contributed to the death of a service user or patient are presented to the PSIRFaLP and, where appropriate, are reviewed via a Serious Incident Root Cause Analysis investigation.

All deaths of patients with a Learning Disability or Autism in the Trust are reviewed and reported to Cheshire and Merseyside LeDeR programme.

5. Cumulative Learning from Deaths Review Statistics 2024 – 2025

Service led SJRs, Directorate Incident Review Group (DIRLG) and Safety Incident Response Framework from Learning Panel (PSIRPaLP) (formally Safety Incident Reporting Panel) were applied to 96 deaths.

Total SJRs Completed:

2023-2024	Quarter One	Quarter Two	Quarter Three	Quarter Four
Total Deaths Per Quarter	20	21	26	29
LeDeR Deaths	4	2	2	1
Child Deaths	3	3	3	5
Deaths reported as Serious Incidents	0	0	0	0

Deaths reported to the Learning Disability Mortality Review (LeDeR)

Nine deaths were reported to the Cheshire and Merseyside LeDeR Governance Group where the patient had a learning disability or autism between April 2024 and March 2025. The LeDaR reviews of deaths ensures that broader thematic findings are recognised by health and social care providers across the system and acted upon to prevent premature deaths.

Cheshire and Merseyside LeDaR report back to Trusts if they have concerns regarding a death. No concerns were raised in 2024/25 in relation to the care provided by Bridgewater services.

Themes and Trends

The reviews looked at themes and trends from all the deaths investigated across the Trust.

There were more unexpected than expected deaths. Unexpected deaths were higher in adult services.

Age

The highest mortality rate was in the 65 plus age group. Unsurprisingly the highest number of deaths that occurred was in the Trust adult services.

Gender

Differences in the number of deaths in males and females were noted, and the variation was minimal.

Death by Ethnicity

White British was the highest recorded ethnicity group.

Diagnosis and Cause of Death

Where the cause of death was known the higher number of deaths were from respiratory failure and cardiac arrest.

Place of Death

The higher proportion of deaths occurred in hospital followed by death in the patient's home

6. Learning and Improvement

The Trust takes a proactive approach to learning from deaths and the following summary highlights where good practice and areas identified for improvement have been identified. Learning is used to drive quality and safety improvements across the Trust.

Each of the 96 deaths were analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

None of the 96 deaths investigated were caused by or associated with any direct care delivery concern or harm caused by services provided by the Trust. Duty of Candour was not applicable in any of these cases.

Learning from good practice and learning from improvement in the care delivered prior to the deaths was found and shared with teams and services following the 96 reviews.

Learning Themes

Learning themes identified were:

- Improvements in record keeping
- Learning for communication - with patients, families and carers and other health and social care services and professionals

Learning from Good and Excellent Care

Of the 96 reviews carried out a number concluded good and excellent care had been provided across the Trust community services and teams. Aspects identified are highlighted in the examples below:

- Teams demonstrated integrated working across the system.
- Evidence in patients records suggests that there was excellent multi-disciplinary teamwork with regards to the care of patients within both adult and children services.
- The 'voice of the adult' and the 'voice of the child' was captured throughout the patient's care and recorded.
- Good therapeutic relationships with patients and families.
- Professional curiosity was utilised, and the patients' voice captured when risk concerns were raised regarding safeguarding.

Learning from Improvement

Of the reviews of the 96 deaths learning was identified in some instances where improvements in care could be made.

Examples of the Learning Related to Record Keeping

Of the reviews carried out and patient records reviewed aspect of learning were identified these included:

- Care and support plans to be completed and reviewed regularly
- Shared care plans to be discussed and agreed with patient, family and carers and recording in EPR.
- Incomplete EPR notes.

Learning Related to Communication

From the reviews of deaths, several learning opportunities were identified with regards to deficits in communication for example:

- Improved communication with Hospital Trust with regards to discharge.
- Mental Capacity Assessments with patients who lack capacity and complete a Best Interest Decision with appropriate others need to be completed and recorded.
- Cause of death is often not available to the Trust.

Third Party Learning

Within the reviews learning was identified and shared with third parties involved in patients care for example:

- Ensure that when a DNAR is in place it is clearly visible to all health professionals, family, or any other support services such as care staff and emergency services.

7. Next Steps

The 96 reviews and subsequent learning have led to several developments including:

- Demographic and ethnicity coding data has been added to Ulysses and EPR.
- Work has begun to bring the community and acute policies and process together.

- The Learning from Deaths policy has been reviewed and agreed. The requirement to review all deaths of patients that have died within 30 days of been seen by a Trust service has been removed. The new criteria are:
 - A patient is currently in an intermediate care bed where Trust services are providing care.
 - Patient had a learning disability/autism diagnosis
 - All adult patients with a severe mental illness (SMI) (bipolar disorder, schizophrenia, psychosis and personality disorders)
 - Any death reported to the Trust of a child (under 18 years) where the Trust has an open patient record either expected or unexpected, except in the case of a baby who died in hospital and who's care has been in hospital from the beginning to the end of their life, or who was not born alive
 - The bereaved family have expressed a concern about the care their relative received from the Trust or other partner services
 - Staff employed by the Trust have expressed a concern about the quality of care received by the deceased e.g., did not die in their preferred place of care
 - The death occurred whilst the patient was under the care of a service where concerns have previous been raised (e.g., through audit or CQC inspection)

8. Conclusion

The Board is asked to note the contents of this report and receive assurance that the Trust is compliant with the mortality review requirements as set out in the NHSE National Quality Board - National Guidance on Learning from Deaths 2018.

During the year 96 LfD reviews were concluded and trends identified that have supported service improvements and developments.

None of the 96 deaths investigated were caused by or associated with any direct care delivery concern or harm caused by services provided by the Trust.

The introduction of the PSIRF framework has continued to support the Trust to develop and maintain effective systems and process to learn from deaths. The Trust

has identified learning where improvements can be made and where good practice can be shared and fed into quality improvements across the Trust and the wider system.

Following direction from the respective Trust Quality Committee chairs Warrington and Halton Hospitals and Bridgewater Community Heath will harmonise and combine their Mortality Review / Learning from Deaths processes with the Q2 205/26 reports being the last which will be received as separate reports.

9. References

The 2010-13 Confidential Inquiry into Premature Deaths of People with Learning Disabilities (2014) *NHS England, The Healthcare Quality Improvement Partnership (HQIP) and the University of Bristol.*

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	61/25vi		
Report Title	FREEDOM TO SPEAK UP ANNUAL REPORT 2025		
Executive Lead	Ali Kennah, Chief Nurse		
Report Author	Helen Young, Lead Freedom to Speak Up Guardian		
Presented by	Ali Kennah, Chief Nurse		
Action Required	☐ To Approve	☐ To Assure	☒ To Note
Executive Summary			
The Freedom to Speak Up (FTSU) annual report is a summary of the FTSU activity during the reporting period 1st April 2024 until 31st March 2025. The report details the numbers of concerns reported, themes of concerns, actions taken to resolve concerns, learning for the Trust and progress on the self-assessment action plan. The report also provides an overview of developments including current mechanisms for speaking up, national staff survey results and National Guardians Office (NGO) updates. This report provides: • An update on learning from concerns raised. • Results of the NHS Staff Survey 2024. • FTSU Update. • Update on the self-assessment action plan. • Update from the National Guardians Office. • Awareness raising and promotion. • Conclusion.			
Previously considered by:			
☐ Audit Committee		☐ Quality & Safety Committee	
☐ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common		☐ Remuneration & Nominations Committee	
☐ Strategic People Committee in Common		☐ EMT	
Strategic Objectives			
☐ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			



☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☐ Resources - We will ensure that we use our resources in a sustainable and effective way.
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

How does the paper address the strategic risks identified in the BAF?

☐ BAF 1	☒ BAF 2	☐ BAF 3	☒ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☒ Effective	☐ Responsive	☒ Safe	☐ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	61/25vi		
Report Title	FREEDOM TO SPEAK UP ANNUAL REPORT 2025		
Report Author	Helen Young – Lead Freedom to Speak Up Guardian		
Purpose	The purpose of this Annual Report is to provide assurance regarding Freedom to Speak Up activity and learning during the reporting period 1 st April 2024 – 31 st March 2025.		

1. SCOPE

- 1.1 This Freedom to Speak Up (FTSU) Annual Report is a summary of the FTSU activity between 1st April 2024 and 31st March 2025, and FTSU activity since the last report in July 2024.
- 1.2 This report also provides:
 - An update on learning from concerns raised.
 - Results of the NHS Staff Survey 2024.
 - FTSU Update.
 - Update on the self-assessment action plan.
 - Update from the National Guardians Office.
 - Awareness raising and promotion.
 - Conclusion.

2. INTRODUCTION

- 2.1 All National Health Service (NHS) Trusts are required to have a FTSU Guardian, and the primary purpose of the Guardian is to support staff in speaking up and to ensure that those who speak up are thanked and that the issues raised receive appropriate attention. Guardians make sure that the person who speaks up receives feedback on the actions taken in response to their concerns.
- 2.2 This Annual Report provides an overview of the activity that took place between 1st April 2024 and 31st March 2025 across the Trust to deliver our commitment to Freedom to Speak Up and will include any actions that have been taken to improve speaking up, and an overview of the number and themes of concerns that have been raised and any learning and recommendations.
- 2.3 There is a network of FTSU Champions who support the FTSU Guardians and details for both the Guardian(s) and Champions are on the intranet and on the dedicated FTSU page, see 6.1. Staff can seek support from the FTSU Guardians or Champions, face to face or via

a phone call or email, or via Microsoft Teams. Regular updates are included in the Trust's Bulletin and information cascaded via 'Team Brief' which all staff can attend monthly.

- 2.4 The FTSU Guardians continue to collaborate with their peers across the region and work with the National Guardians' Office (NGO) and will attend regional meetings and relevant seminars and conferences.
- 2.5 Speaking up activity, themes and trends of concerns raised to the FTSU Guardian/s are reported twice a year to the Trust Board, Bi-monthly to the People Committee and quarterly to the National Guardians Office and there is oversight from a named Executive Lead and named Non-Executive Lead.

3. ACTIVITY OVERVIEW

- 3.1 From the 1st April 2024 until the 31st March 2025 in total 28 concerns were raised to the FTSU Guardians, compared to 18 concerns raised for the same reporting period in 2023/24, which represents an increase of 55.56% in the number of concerns being raised.
- 3.2 In accordance with NGO reporting guidance, each individual speaking up through this route should be counted as a separate case, even if they are speaking up about the same issue, together or separately. Therefore, in total 36 members of staff raised a concern, either individually or as a collective during this period.
- 3.3 Staff can continue to raise concerns openly (where the person raising the concern is happy for their identity and nature of the concern to be shared), confidentially (where only the Guardian and identified persons have access to the reporter's identity), or anonymously. No actions are taken without the consent and agreement of the person raising the concern and Table 1 shows how the concerns were raised.

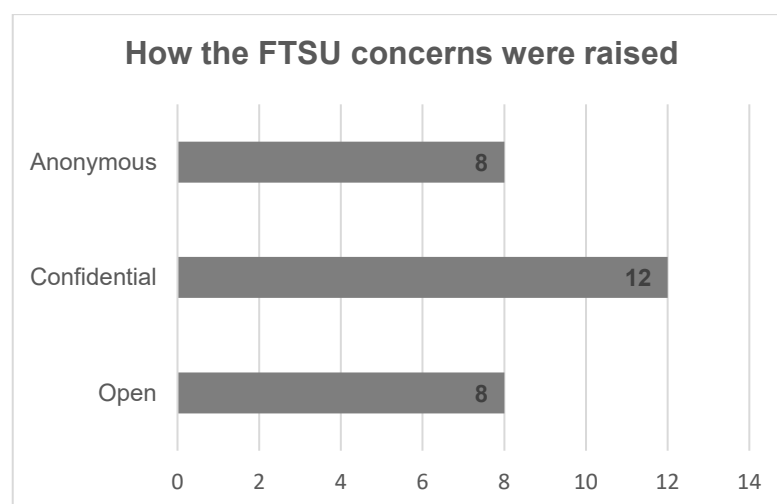
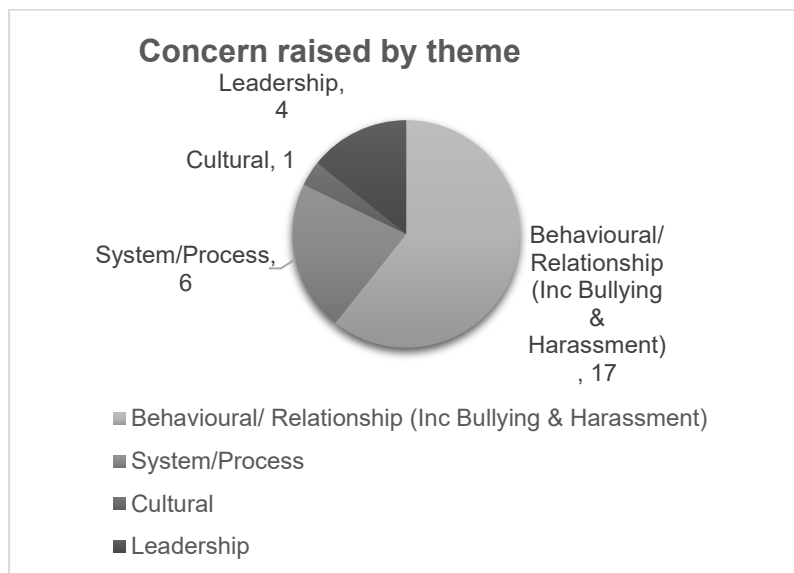


Table 1 – How the concerns were raised.

- 3.4 Following the raising of a concern through FTSU, recommendations might include self-management of next steps or the triggering of review or investigation. More open concerns raised suggest higher psychological safety in the workforce. However, most cases reported in this period were confidential, as shown in Table 1. Additionally, a high number of anonymous concerns could indicate a cause for concern, but not for this reporting period.

3.5 Of those concerns raised, the majority focused on behaviour / relationship themes followed by system / process themes (Table 2), and the concerns were multi factorial in nature, with examples below. Poor Communication continues to be cited as the main concern under the behavioural / relationship theme and feeling not listened too and a hierarchical culture. Under systems and process staff reported a lack of process / not following policy, resulting in mixed messages and unsure of job roles.



An example of the theme leadership:

- Multiple concerns about their role, poor communication and not listened and very top down approach without input or discussion.

An example of Behavioural/Relationship:

- Issues with line manager, feels she is not being treated fairly and is being spoken about.

Table 2 – Concerns raised by theme and please note that individual concerns can have multiple themes.

3.6 For this reporting period, concerns were raised by staff in 4 of our boroughs as seen in Table 3. The most concerns were raised by staff in Warrington.

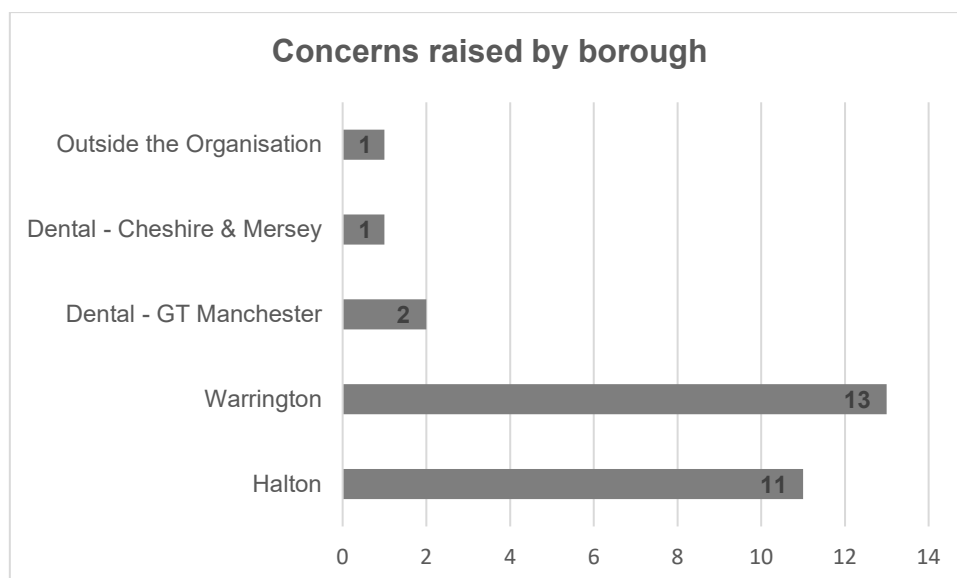


Table 3 – Concerns raised by borough.

3.7 From a worker category perspective, the main professional group reporting concerns are registered nurses (Table 4). This reflects our overall workforce demographic, as nurses

constitute approximately 35.41% of our total staff, making them the largest professional group within our organization.

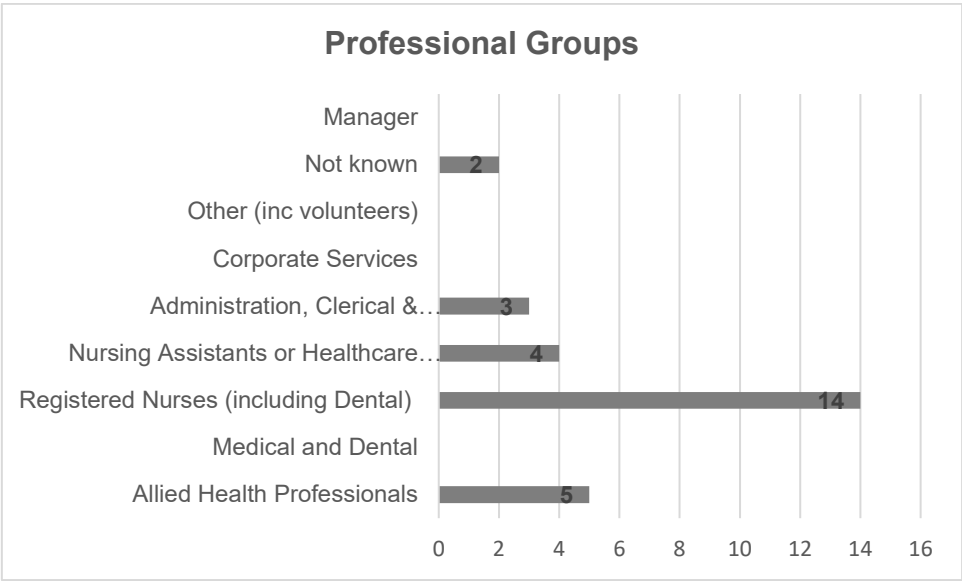


Table 4 – Professional groups raising concerns.

3.8 Comparing the yearly data there has been an increase in concerns being raised but overall, the numbers of concerns being raised remains relatively low. As part of the commitment to staff that they ‘have a voice that counts’, Time to Talk sessions continue to take place. Staff and Teams have the opportunity to talk to one of the Executive team to chat about any good news, ask questions and raise anything that is important to them. This has meant that concerns may have already been raised and dealt with. Also there has been improvements in workplace culture and more confidence in reporting concerns directly to managers may have reduced the number of concerns that need to be reported.

4. LEARNING

- 4.1 When a staff member raises a concern with the FTSU Guardian, several important steps are taken to ensure that their voice is heard and that appropriate actions are taken. Staff can share their concern knowing that their identity will be protected. The Guardian will assess the nature of the concern and determine whether it requires immediate action or further investigation.
- 4.2 After addressing the concern, the Guardian ensures that the staff member receives feedback on the actions taken. This feedback loop is crucial for transparency and accountability and assist in learning and improvements.
- 4.3 **Lessons learnt:** Poor communication is often cited as an issue between staff and managers and improved communication has enabled resolution recently to the concerns being raised. One manager acknowledged that by improving communication, they can better support staff, address issues early, and create a more positive and productive work environment.

- 4.4 After multiple concerns came in about one service when the manager was spoken to, they were already aware of the situation after being approached by a team member. The complexity of the service configuration and management hierarchy contributed to the intricacy of the circumstances. There had been some changes recently and then an isolated incident occurred that had brought things to a head. Proactive measures are underway, with a plan established and Human Resources being fully informed of the situation. This approach is instrumental in providing the necessary support to both the staff and service leaders as they navigate towards a resolution.
- 4.5 A concern was raised about how staff are informed of changes and the tone of emails and limited information and reasons why changes are happening which led to staff feeling anxious, unsure and 'not valued'. This was reported to the relevant managers and as a result, meetings were held with staff and an outcome agreed which was to improve communication within the service.

5. NHS STAFF SURVEY

- 5.1 The 2024 NHS Staff Survey results were released on Thursday, 13th March 2025, and the Trust had a 62% response rate, which matches last year's record participation and aligns with the average for community trusts. The survey evaluated nine areas, encompassing the seven NHS People Promise components, as well as staff engagement and morale.
- 5.2 From a FTSU point of view the overall results were mixed as Question 20a showed a slight increase, while Questions 20b, 25e, and 25f showed a slight decrease. Regarding the 'We each have a voice that counts' element of the People Promise, the Trust scored 7.2, which is consistent with the 2023 score and remains above the Northwest average score.
- 5.3 Question 20a shows a slight increase, similar to the trend observed in 2023. Conversely, Question 20b indicates a slight decrease following the increase seen in 2023, as illustrated in Figure 1.

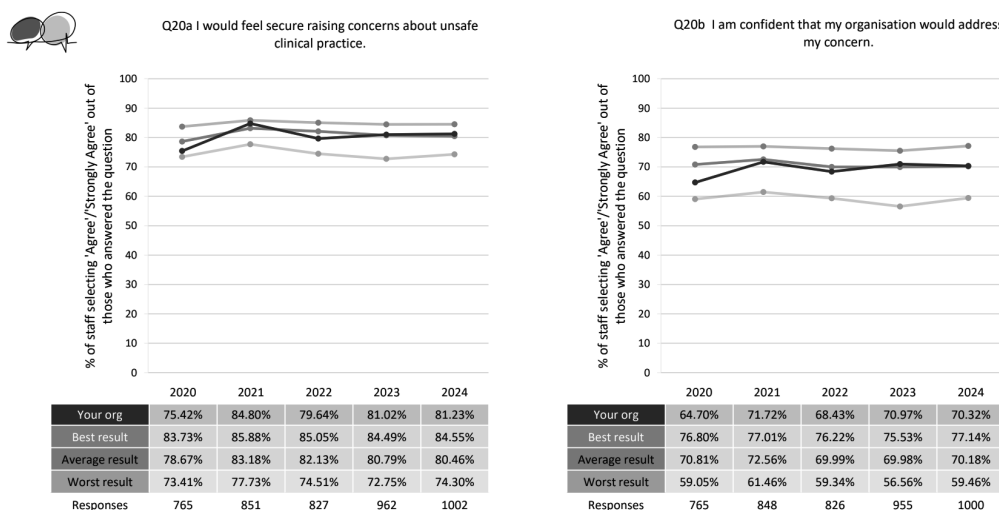


Figure 1: Information taken from the NHS Staff Survey website.

- 5.4 Both Question 25e and Question 25f exhibit a slight decrease, in contrast to the increases observed in 2023, as shown in Figure 2.

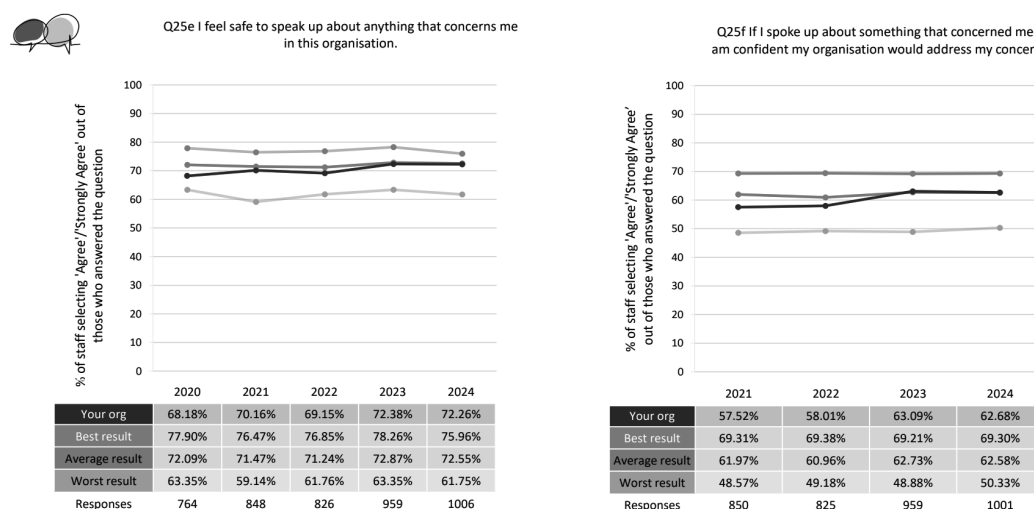


Figure 2: Information taken from the NHS Staff Survey website.

- 5.5 For a second year running there has also been a difference in the experience between disabled and not disabled members of staff and a difference in experience between ethnically diverse/racially minoritised and white members of staff. A negative / red result has been received for both.
- 5.6 For staff from these protected groups the results give a general overview of how they feel and their willingness to speak up and belief they will be heard. Meetings continue to be held with the Equality & Inclusion Manager to discuss what actions can be taken and to identify if more support and information is needed to ensure all staff have the confidence to 'speak up'.
- 5.7 The FTSU Guardian attends regional network meetings, and any shared learning and ideas shared will be considered and taken forward to support staff.
- 5.8 In July 2024, the National Quarterly Pulse Survey (NQPS) was distributed to Trust staff, providing them with an opportunity to share their views on their working experiences. The NQPS focuses on the core set of nine questions which make up the engagement theme from the NHS Staff Survey that provide insight into motivation, involvement and advocacy. In total the NQPS received 214 responses from an approximate total number of 1,724 Trust staff, which represents about 12.42% of staff responding.
- 5.9 A response rate of 12.42% for a staff survey is relatively low, which can affect the reliability and validity of the data, making it challenging to draw accurate conclusions about staff opinions. Nevertheless, valuable insights can still be obtained, providing an indication of staff sentiments that might be representative of the broader staff population. Additionally, comparisons can be made with findings from the PULSE survey and the NHS staff survey that highlight the need that more work needs to be done to improve staff confidence in speaking up.
- 5.10 The PULSE survey asked, 'What did you speak up about?' the higher responses received were for the themes culture, leader / manager behaviour and staff wellbeing. This correlates to what staff are speaking up about today and could indicate broader issues within the

organisation. Due to the low number of respondents however this may give a false picture and would need to be scoped further.

5.11 When staff were asked 'What factors might prevent you from speaking up?' the highest responses were:

- Feeling that nothing would happen if I did speak up - 65.90%
- Feeling there would be negative consequences - 59.10%
- Not trusting the process to keep my concerns secure and confidential - 47.70%

5.12 The Trust wide breakdown of the NHS Staff Survey, we can see how each of the directorates look and there has been a mixed response. The directorates that scored red for 'we each have a voice that counts'

- Corporate Estates – no change as 6.7 in 2023.
- Dental Cheshire & Merseyside – slight increase to 5.9 in 2024 but still red.
- Dental Greater Manchester NE – decrease from 7.1 to 6.5.
- Dental Greater Manchester W&S - decrease from 6.8 to 6.4.
- Warrington Adults – remains the same at 6.8.
- Halton Children – slight decrease from 7.1 to 7.

5.13 The PULSE and NHS Survey results echo previous results from the FTSU internal survey and verbal feedback from staff. Further work is needed to improve staff satisfaction and engagement. Further work is also needed around building trust to reassure staff that their concerns will be kept confidential and to continue to foster a culture of openness and transparency. Additionally, managers are required to also complete the 'Listen Up' training. This will help them handle feedback constructively and help in ensuring there is no retaliation and give staff greater confidence in speaking to them.

5.14 To identify potential areas of concern, ongoing efforts focus on triangulating data from various sources within the organisation, such as HR, risk, and quality and safety information, including patient complaints. This approach helps uncover correlations and patterns, allowing us to pinpoint 'hotspots' that require attention in terms of patient safety, quality, worker well-being, and organisational culture.

6. UPDATES

6.1 **FTSU Champions:** Champions work closely with the FTSU Guardians to help address barriers to speaking up and to promote the speaking up process. Meetings are held on a quarterly basis with the champions with the first meeting for 2025 being held on the 25th February 2025.

6.2 Champions have the opportunity to discuss themes of concerns being brought to them by staff and the meeting serves as a platform for sharing experiences and supporting each other. Additionally, any issues that require further investigation can be addressed. One recurring theme raised at the meeting is that some staff do not believe the FTSU process is confidential or that confidentiality is maintained, which they perceive as a barrier to speaking

up. The group discussed how this can be tackled going forward and more information needs to be available for staff to offer assurance about how confidentiality can be maintained.

- 6.3 There are currently 17 champions, as 2 champions have recently decided to step down temporarily. The target remains at 50 champions in total. The aim is to recruit champions from staff within our network groups to ensure that marginalized staff have the support and confidence to speak up if needed. This will help ensure that everyone's voice counts and make speaking up a regular part of our culture and business as usual.
- 6.4 In October 2024 the FTSU eLearning Training became mandatory for all staff / workers within the Trust. The training is divided into three modules, explaining in a clear and consistent way what speaking up is:
- **Speak Up:** Core training is for all workers including volunteers, students and those in training.
 - **Listen Up:** This training is for all line and middle managers and is focussed more on listening up and the barriers that can get in the way of speaking up.
 - **Follow Up:** This training is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.
- 6.5 At the end of February 2025, the Trust's overall compliance stood at 89.99%. For non-compliant staff, this can be broken down by services, and Trust processes are in place to support these staff members.
- 6.6 **The Freedom to Speak Up Strategy:** has been revised to include the self-assessment action plan. This updated strategy was shared with the Divisional Leadership Teams (DLT) for consultation, with a deadline for comments set for 30th November 2024. Senior Leads were also asked to disseminate the strategy to relevant staff within their teams to gather additional input and feedback. The strategy was approved by the Peoples Committee on the 12th March 2025, and is now available for staff to read on the FTSU webpage.
- 6.7 **The Freedom to Speak Up Concern Escalation Timeframe Flowchart:** was created in response to staff feedback indicating that the response time after raising a concern was too long. The flowchart was distributed for consultation alongside the strategy and was approved by the People Committee on the 12th March 2025. It will be available for staff to read on the FTSU webpage. Additionally, the flowchart will be sent to the relevant person or manager when a concern is raised to ensure they are aware of the timescales.
- 6.8 **The Mersey Internal Audit Agency (MIAA):** are commissioned to evaluate the effectiveness of the internal control systems within the Trust and audited Freedom to Speak Up arrangements.
- 6.9 The audit reviewed several objectives, including Trust Policy, Appropriate Resources, Training, Raising Awareness, Monitoring Arrangements, Provision of Feedback, Case Confidentiality, and Oversight.
- 6.10 The audit resulted in an overall rating of 'High,' with only one recommendation for improvement. The recommendation focused on the Provision of Feedback of FTSU cases between Guardians and people raising concerns. It was identified that there was no feedback form in place for staff to provide feedback to FTSU guardians and champions.

- 6.11 A feedback form was created but was not initially available on the FTSU webpage. Although it was sent to staff, only one member had completed it. Information about the feedback form has now been included in the bulletin and is now accessible on the FTSU webpage. Additionally, the form will be sent to staff when a concern case is closed.

7. SELF ASSESSMENT ACTION PLAN

- 7.1 Progress is being made on the self-assessment action plan, and 76.92% of the action plan has been completed. The initial timeframes set for some actions were optimistic and there is now a better understanding of the time required, and updates on progress will continue to be presented at People Committee and reported to Board.
- 7.2 Action 4 relates to FTSU eLearning and training and once it has been confirmed that all Board members have completed this training this action can be closed.
- 7.3 Actions 9 and 21 focus on detriment and to 'identify a mechanism for evaluation of speaking up experiences, including detriment'. An evaluation form is now available for staff to use that should identify if they have experienced detriment. Understanding the challenges staff face when speaking up can provide valuable insights into areas where we can improve. The NGO have also developed detriment guidance that will be used and to assist in closing actions 9 and 21 (see 8.3).

8. UPDATE FROM THE NATIONAL GUARDIANS' OFFICE (NGO)

- 8.1 The NGO leads, trains and supports the network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector. The NGO have brought to the attention of the Guardians a number of publications and initiatives and news relevant to speaking up.
- 8.2 **The Speaking Up Support Scheme:** was developed to support anyone who had spoken up and experienced an adverse effect from doing so. The scheme provides a range of practical support for NHS workers who have experienced a significant adverse impact following a formal speak up process. The Scheme was independently evaluated and continues to be offered as a support option to NHS staff.
- 8.3 In 2023/24 data submitted by Freedom to Speak Up Guardians, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment as a result of speaking up. Following a collaborative piece of work with Freedom to Speak Up Guardians, a detriment guidance for organisations has been published.
- 8.4 Overall, this guidance serves as a valuable tool to as it offers support and direction, especially in unfamiliar or challenging situations, making it easier to navigate complexities, which can aid Guardians when tackling detriment.
- 8.5 The Guardian and a FTSU Champion via TEAMS attended the National Guardian's Office Freedom to Speak Up Conference 2025, themed "Speaking Up – Changing Organisational Culture," held on the 13th March 2025. The agenda included:
- Empowering a culture of speaking up.

- Does civility save lives?
- Why good teams matter in healthcare.
- Overcoming barriers to speaking up for workers with protected characteristics and temporary workers.
- How to build an open and honest reporting culture.

8.6 This year's Guardian annual mandatory refresher training focused on equity, diversity and belonging, to give all Guardians a better understanding of discrimination. This comprehensive approach ensures that Guardians are well-equipped to handle issues of discrimination and are able to support an inclusive environment.

9. AWARENESS RAISING AND PROMOTION

- 9.1 The month of October is Speak Up Month and the theme for October 2024 was 'Listen Up' focusing on the power of listening, and the important part which listening plays in encouraging people to speak up. The Guardians collaborated with the Communications Team and the FTSU Champions to support this campaign.
- 9.2 Speak Up Month was also an opportunity for leaders at all levels within Bridgewater to show that they are here to listen and that they are commitment to fostering a Speak Up, Listen Up, Follow Up culture within Bridgewater and therefore they were asked to make a 'listen up' pledge. Some of the pledges received:

"I pledge..... to ensure all staff in Halton feel heard. I will continue to encourage staff to speak up and ensure they are supported "

Dr Rachel Hall – Head of Research.

Jilly Wallis - Associate Director of Halton Adult Community Services.

"I pledge.....through my role as FTSU champion, I pledge to raise awareness of freedom to speak up across the Trust and support others to have the confidence to speak up."

"I pledge to.... support others in, building a supportive, empathetic and non-judgemental space where everyone feels valued and feels completely safe to voice their concerns without fear or regret. I commit to active listening prompt action in a Just culture. I am just one, but I am part of something much bigger and together we can build a great workplace".

Louise Pendleton - Professional Lead Adult Services

- 9.3 Information about FTSU month went out in the weekly bulletin and Team Brief and staff were also asked to show their support of 'speaking up' by taking part in 'Wear Green Wednesday'.



Members of staff showing their support for 'Wear green Wednesday'.

- 9.4 During this time information went out to staff about becoming a FTSU Champion to further develop the speaking up networks to raise awareness and promote the value of speaking up, listening up and following up.

10. CONCLUSION

- 10.1 Work will continue to complete the outstanding actions in the self-assessment action plan and an area of focus will be to continue to find out if staff are experiencing detriment and how this can be resolved.
- 10.2 Regular updates on learning from concerns raised and any relevant information will be available to staff on the FTSU page on My Bridgewater and via the FTSU newsletter and other available platforms e.g. Team Brief.

10.3 Work will continue on providing staff with information on confidentiality (please see 6.2) to reassure staff:

- That confidentiality will be maintained when a concern is raised. However confidentiality can be broken under certain circumstances, but this will be made clear if a concern is raised and cannot be kept confidential.
- To ensure that managers and leaders understand the importance of maintaining confidentiality and handling sensitive information appropriately.

Committee Chair's Report

Name of Committee/Group:	Extraordinary Finance and Performance Committee		Report to:	Board of Directors
Date of Meeting:	23 June 2025		Date of next meeting:	24 July 2025 9.30am
Chair:	Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: Tina Wilkins, Non-Executive Director and Committee Chair Gail Briers, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse Dan Moore, COO Jan McCartney, Director of Corporate Governance	In Attendance Debbie Weir, Financial Controller John Morris, Deputy Director of Estates Observers: Christine Stankus, Lead Governor	Key Members not present:	Apologies received from: Bob Chadwick, Non-Executive Director Rachel Hurst, Deputy Director of Finance Gareth Pugh, Assistant Director of Finance Kevin Goucher, Public Governor Rita Chapman, Public Governor

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Finance Report – Month Two	5		The Committee received the report and noted the key headlines. The Trust is reporting a deficit at Month 2 of £0.88m, £0.01m favourable to plan. - The Trust has a savings requirement, excluding system savings, of £5.48m (5.02%) in line with ICB instruction. - The Trust is reporting a savings achievement of £0.76m against a plan of £0.76m - Income is £16.41m against a plan of £16.56m. - Expenditure is £17.29m against a plan of £17.46m.	The Committee noted the financial position for month 2. The identified savings are on plan and include an element of non-recurrent savings. However, this item continues to be rated as amber, as work is ongoing to identify additional savings to ensure shortfalls in agreed savings or delayed schemes are covered. Additionally, the system savings have not yet been fully identified. The committee noted that it was the same four service areas with the highest levels of Agency spend. As the report only highlights the top

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Committee Chair's Report

			• Pay is £12.29m against a plan of £12.06m. • Agency spend is £0.07m against a plan of £0.22m. • Non pay expenditure is £4.86m against a plan of £5.11m. • Capital charges are in line with plan. • Capital expenditure is £0m at month two, planned spend is also £0m. • Cash is £5.72m down £1.77m from month one. Paying invoices subject to BPPC requirements	spending services the committee cannot clearly identify that spend across the services had reduced significantly. It was agreed that more detail would be provided in the next report so that the reduction in spend for each area and the rationale for higher usage in some areas would be more evident. The decline in the month two Cash position was discussed and the Committee noted that the position improved in June because of a significant payment received. The Committee noted the financial position. The Committee noted the report and recommended it for approval to the Board.
CIP Update	5		The Committee received the report. The 2025/26 plan identifies that the Trust has a total savings target of £8.4m. This is made up of the £5.5m business as usual CIP target (5%) and the additional placeholder system stretch savings target of £2.9m. Additional work is in train developing PIDs that will increase the level of identified savings, so that any shortfall in delivery or delay in realisation of schemes will be covered. The stretch savings require system solutions and cannot duplicate schemes already identified as Trust CIP opportunities.	The Committee asked that a session outlining the different RAG ratings and external monitoring requirements be held to ensure they understand the full reporting framework. The Committee noted that a report setting out the governance, reporting framework, metrics, and impacts on performance/productivity for the delivery unit would be circulated towards the end of July.

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Committee Chair's Report

			The additional system stretch target is recorded as separate savings in the plan and does not form part of the CIP return information reported each month. The Trust Report internally, and externally to NHSE and CMICB utilising different RAG ratings which whilst complex is thorough. The allocation of the CIP targets within the Trust have been weighted to require a greater savings requirement from corporate services. This is based on the national benchmarking data that indicates corporate services costs per £100m turnover are greater than the median cost when compared to other Trusts which means there is a greater opportunity for savings from corporate services. Savings targets are allocated to each directorate, however, there is currently a large saving sitting under 'Other Organisational', that needs to be broken down and distributed across the directorates. Quality continues to be a priority and the continued importance of completing PIDs and QIAs was highlighted as part of this process. Delivery Unit meetings have commenced and will follow a cycle, reporting framework has yet to be finalised.	
Annual Accounts	5		The Committee received an update highlighting changes to date.	
Performance Risks and Exceptions	5		None reported.	

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Committee Chair's Report

Review of meeting and items escalated to the Board/other Committees	1		The Chair asked for comments on the meeting. The Lead Governor highlighted that the Annual Audit report referenced a stocktake in Community Equipment Stores. This had been discussed by staff when the Governors conducted a service visit, and it was good to see that their hard work was important.	It was agreed that the committee thanks are passed to the service by the Director of Finance.
Risks Escalated: None Actions delegated/escalated to other Committees:				

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OFFICIAL - Recipients Have Full Control

Name of Committee/Group:	Finance, Sustainability and Performance Committee – Committee in Common:		Report to:	Board of Directors
Date of Meeting:	28 July 2025		Date of next meeting:	
Chair:	John Somers, Non-Executive Director WHH		Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: Tina Wilkins, Non-Executive Director Bob Chadwick, Non-Executive Director Nick Gallager, Director of Finance Lynne Carter, Director of Delivery Unit Melanie McLaughlin, BCH Deputy Chief Operating Officer Paula Woods, Director of People and Organisational Development John Somers, WHH Non-Executive Director (in the Chair) Julie Jarman, WHH Non-Executive Director Ali Kennah, BCH and WHH Chief Nurse Janet Parker, WHH Deputy Director of Finance Zoe Harris, WHH Deputy Chief Operating Officer Paul Fitzsimmons, BCH and WHH Executive Medical Director Lucy Gardner, BCH and WHH Chief Strategy and Partnerships Officer Michell Cloney, WHH Chief People Officer Kate Henry, WHH Director of Communications and Engagement John Culshaw, WHH Company Secretary	In Attendance Alice Forkgen (AF), WHH Finance Sharon Kilkenny (SK) WHH Associate Director – Unplanned Care Observers: Jack Roper (WHH) Governor Kevin Goucher (BCH) Governor	Key Members not present:	Apologies received from: None received

Committee Chair's Report

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Finance Report – Month Three	5		The Committee received the report and noted the key headlines. • The Trust is reporting a deficit at Month 3 of £1.25m, in line with plan. • The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%) in line with ICB instruction. The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £1.16m against a plan of £1.16m • Income is £24.71m against a plan of £24.85m. • Expenditure is £25.82m against a plan of £26.00m. • Pay is £18.44m against a plan of £18.06m. • Agency spend is £0.09m against a plan of £0.33m. • Non pay expenditure is £7.29m against a plan of £7.61m. • Capital charges are above plan by £0.04m. • Capital expenditure is £0.17m at month three, planned spend is £0m. • Cash is £8.40m.	The Committee noted the financial position for month 3. The identified savings are on plan and include an element of non-recurrent savings. However, the impact of cost pressures in Dental and Dermatology has yet to be factored in. Agency spend continues to be well managed. The Cash position improved in July because of a significant payment received. The Committee noted the financial position. The Committee noted the report and recommended it for approval to the Board.
CIP Update	5		The Committee received the report. The 2025/26 plan identifies that the Trust has a total savings target of £8.4m. This is made up of the £5.5m	Although savings are reporting on plan there is still a lack of certainty of deliverability of a large

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Committee Chair's Report

		business as usual CIP target (5%) and the additional placeholder system stretch savings target of £2.9m. As at month 3: The Trust is reporting savings of £1.16m in line with the submitted plan. Of these cumulative savings £0.10m is non recurrent savings relating to vacancies. As part of the budget review process, DLT's will be reviewing these savings to identify opportunities to make these savings recurrent. In total £5.92m worth of recurrent saving opportunities have been identified. The in-year impact of these savings is £5.47m. There is still a large proportion of schemes that have not yet progressed to the 'Blue' delivering rating. Additional recurrent schemes still need to be identified to mitigate potential shortfalls that can arise from lack of delivery, the impact of cost pressures, and schemes that have not yet progressed beyond ideas. The additional system stretch target is recorded as separate savings in the plan and does not form part of the CIP return information reported each month. There is still a large saving sitting under 'Other Organisational', that has yet to be broken down and distributed across the directorates. Quality continues to be a priority and the continued importance of completing PIDs and QIAs is imperative as part of this process.	proportion of identified savings and the delivery unit has yet to commence with formal reports. In addition the system savings plan is still very much in development. Therefore CIP is rated as amber.

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Committee Chair's Report

			Delivery Unit meetings are now embedded and a reporting Framework is anticipated by the next meeting.	
Performance Deep Dive Dermatology	5		The Dermatology Service is failing to achieve the 65 week wait targets and has submitted a plan to improve performance to Executive Management Team (EMT). The proposal (below) aims to clear all patients waiting over 65 weeks by 31/12/25. This will require EMT to approve additional financial resource. 1. A total of 15 sessions dedicated to routine new patient appointments will be required to clear all patients waiting for more than 65 weeks for a routine new Dermatology appointment; 5 sessions allocated to routine new appointments within the existing financial budget and 10 additional sessions 2. 10 sessions per week would need to be funded for approx.14 weeks, costing £112,000 (* Finance to be approved at EMT)	The proposal if approved by EMT will incur a cost pressure to the service, it also doesn't deal with the underlying issue of commissioned capacity not matching quantity of referrals/need and a longer term solution is required.
Performance Deep Dive Dental	5		A deep dive report that had been submitted to EMT was presented to the Committee. The report set out that at a meeting with Greater Manchester Dental Commissioners on 27th February 2025, there was a focus on activity and clinical sessions delivered by the service. Commissioners highlighted that the Greater Manchester service was not achieving the contractual number of clinical sessions and were clear that the service needed to increase activity to meet the target.	The committee appreciated the work that had gone into the report. However, there are still issues regarding the ability of 'Dentally' as a reporting tool and the appropriateness of contractual metrics for showing value for money required from commissioners.

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Committee Chair's Report

			This was escalated to Performance Council who requested a paper be presented to EMT setting out the current position, explaining how the issues have occurred, and provide the options for remediation. EMT were provided with the following 3 options : Option 1 – Recruit to all current vacant posts Option 2 – Recruit to all currently vacant posts and recruit to new posts to create additional capacity uplift. Option 3 – Do Nothing Option 1 was approved by EMT as this would improve contract performance at no additional cost. This option is currently being progressed by the service.	
Review of meeting and items escalated to the Board/other Committees	1		Review of the Meeting This was the first Committee in Common, it was a very large agenda and not unsurprisingly dominated by WHH business. However, there were deep dives on performance across 3 service areas (Urgent and Emergency Care (WHH) Dental and Dermatology (BCH)) which contributed to a cross organisational understanding of priorities. It was difficult for the BCH Governor observer to access the papers which comprised a 760-page document resulting in him receiving it just prior to the weekend leaving only a short time to read all the papers. Work will be done to support this going forward.	Further work is needed to ensure Minutes and Action Logs are dealt with during the meeting.

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Committee Chair’s Report

Risks Escalated: None

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	62/25iii		
Report Title	FINANCE REPORT – MONTH THREE (JUNE 2025)		
Executive Lead	Nick Gallagher - Executive Director of Finance		
Report Author	Nick Gallagher - Executive Director of Finance		
Presented by	Nick Gallagher – Executive Director of Finance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note
Executive Summary			
To brief the Board on financial performance for month three: - The Trust is reporting a deficit at Month 3 of £1.25m, in line with plan. - The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%) in line with ICB instruction. The Trust has an additional system stretch savings target of £2.90m (Level 3). - The Trust is reporting a savings achievement of £1.16m against a plan of £1.16m - Income is £24.71m against a plan of £24.85m. - Expenditure is £25.82m against a plan of £26.00m. - Pay is £18.44m against a plan of £18.06m. - Agency spend is £0.09m against a plan of £0.33m. - Non pay expenditure is £7.29m against a plan of £7.61m. - Capital charges are above plan by £0.04m. - Capital expenditure is £0.17m at month three, planned spend is £0m. - Cash is £8.40m.			
Previously considered by:			
☐ Audit Committee		☐ Quality & Safety Committee	
☒ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common		☐ Remuneration & Nominations Committee	
☐ Strategic People Committee in Common		☐ EMT	
Strategic Objectives			
☐ Equality, Diversity, and Inclusion - We will ensure that equality, diversity, and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☐ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers, and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			



☐ **Staff** - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

How does the paper address the strategic risks identified in the BAF?

☐ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☒ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☒ Effective	☐ Responsive	☐ Safe	☐ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	62/25iii		
Report Title	FINANCE REPORT - MONTH THREE (JUNE 2025)		
Report Author	Nick Gallagher - Executive Director of Finance		
Purpose	To brief the Board on the financial position as at Month three		

1. SCOPE

- 1.1 The purpose of this report is to brief the Board on:
- Financial position as at Month three
 - CIP plans and delivery
 - Capital and Cash

2. FINANCIAL POSITION AS AT MONTH THREE

- 2.1 The purpose of this paper is to update the Board on the financial position of the Trust at the end of June 2025 (Month 3).
- 2.2 The key headlines for Month three are shown in the table 1.
- 2.3 The underlying deficit for the Trust was £5.6m. The Trust submitted a financial plan for 2025/26 with a deficit position of £2.4m. This plan reflected the underlying financial position and run rate of the Trust and was developed using the income and cost assumptions provided both nationally and by the local ICB. The underlying position of £5.6m, amended for changes requested by the ICB adjusted the planned deficit from £5.6 to £2.4m. The £2.4m deficit plan was included in Cheshire & Merseyside ICB's overall draft plan submitted to NHSE. The ICB has a control total of £178m deficit and the consolidated plans submitted did not meet this value. The ICB plan was not accepted or approved.
- 2.4 As a result, the ICB were instructed to revisit all plans and asked all Trusts to include additional savings in their plan. These additional savings were labelled as 'placeholder savings' and allocated based on turnover. The ICB recognised that there would be a system solution required to deliver these savings. The ICB also recognised that the initial allocation may need to be revisited following the system led workstreams identifying additional savings opportunities to ensure equity and to match savings achieved to the additional stretch savings targets within organisations. This may require the reallocation of the savings targets across organisations later during the year.

2.5 Following agreement by the Board, a revised plan was developed to include an additional £2.89m savings, £0.5m is associated to service reduction, the remaining £2.39m is the BCH share of system-wide savings. This plan is reflected in the table below.

2.6 The Trust has categorised the total savings required in 2025-26 at three levels:

- i. Level 1 – Trust BAU CIP – These savings are part of the Trust 5% savings target and are solely the responsibility of the Trust to deliver.
- ii. Level 2 – Trust and WHH – These savings are also part of the Trust 5% savings target and are the responsibility of the Trust to deliver, working in partnership with WHH.
- iii. Level 3 – System ‘stretch’ savings – These savings are to be delivered across the system. System workstreams have been formed to identify opportunities. The system is expected to deliver these savings.

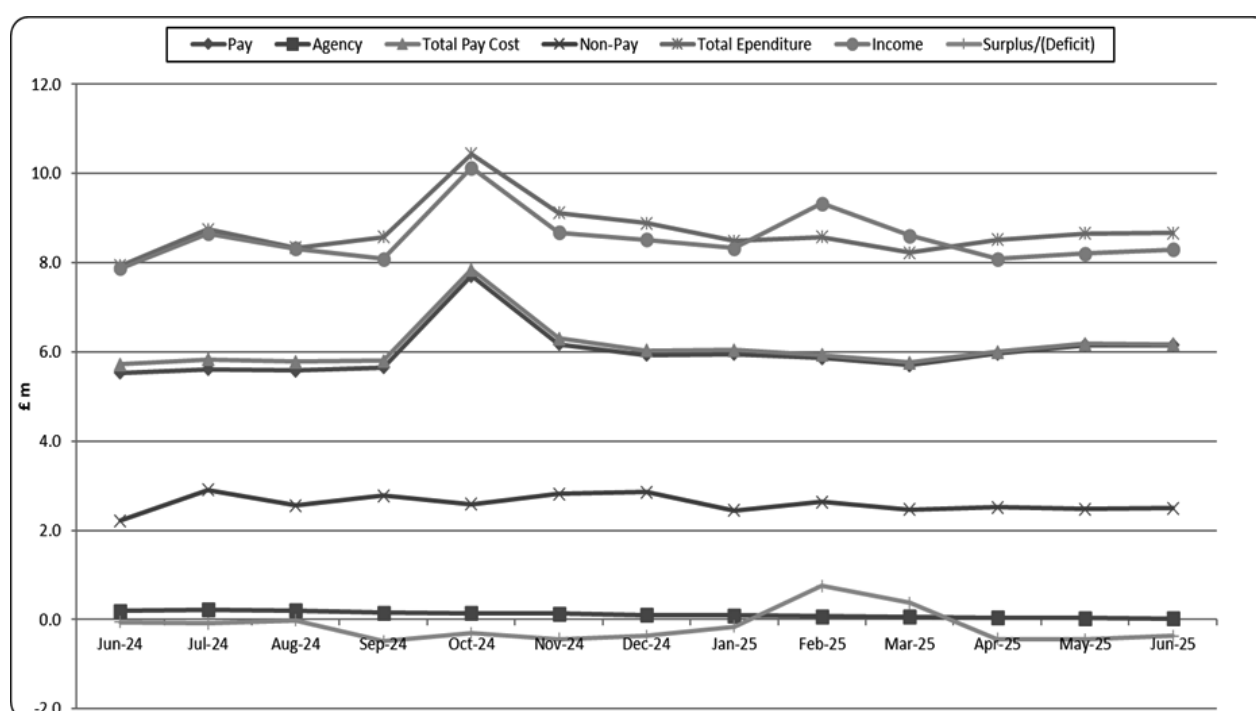
Table 1 – Summary of Financial Performance

Summary Performance Month 03 2025-26	Month 3 Plan	Month 3 Actual	Month 3 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.28)	(8.30)	● 0.01	(24.85)	(24.71)	▲ (0.14)	(99.20)	(99.20)
Expenditure - Pay	5.99	6.15	▲ (0.15)	18.06	18.44	▲ (0.38)	71.30	71.30
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.11	0.02	● 0.09	0.33	0.09	● 0.24	1.10	1.10
Expenditure - Non Pay	2.50	2.43	● 0.08	7.61	7.29	● 0.32	27.94	27.94
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
EBITDA	0.32	0.30	● 0.03	1.15	1.11	● 0.04	1.14	1.14
Financing	0.03	0.07	▲ (0.04)	0.10	0.13	▲ (0.04)	0.39	0.39
Normalised (Surplus)/Deficit	0.35	0.37	▲ (0.01)	1.25	1.25	▲ (0.00)	1.53	1.53
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.35	0.37	▲ (0.01)	1.25	1.25	▲ (0.00)	1.53	1.53
Other Adjustments	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.35	0.37	▲ (0.01)	1.25	1.25	▲ (0.00)	1.53	1.53

Savings - CIP	0.40	0.40	● 0.00	1.16	1.16	● 0.00	5.48	5.48
Savings - Integration Target	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Capital	0.00	0.17	▲ (0.17)	0.00	0.17	▲ (0.17)	2.10	2.10
Cash	9.96	8.40	▲ (1.56)	9.96	8.40	▲ (1.56)	6.85	6.85
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance ▲ Adverse Variance

Table 2 – Rolling Run rates 2024/25 to 2025/26



The key performance headlines as at month three are:

Trust is reporting a cumulative deficit of £1.25m, which is in line with the submitted plan.

- **Income**

Cumulative income was below plan by £0.14m, predominantly due to inflationary uplifts (instructed to be included in plans by the ICB) for Local Authority income included in the plan but not recognised in actuals as they are not yet confirmed, and a lower than planned recharge for biologics (note: off set by lower than planned spend).

- **Pay**

Cumulative pay costs are adverse to plan by £0.38m. This is primarily driven by the phasing of pay savings and is currently off set by increased agency and non pay savings.

- **Agency**

Year to date the Trust has incurred costs of £0.09m against the plan of £0.33m. Month on month the Trust has continued to reduce agency spend and spent £0.02m in month three against a plan of £0.11m.

There are now only two services utilising agency staff, these are:

- UTC Widnes – locum GP shifts.
- Community Paediatrics in both Halton and Warrington.

Agency costs incurred in month three equated to 1.39 whole time equivalent staff, 0.63 of these being medical locums, the balance being late invoices for nursing shifts.

The Trust has reduced its agency spend substantially over the past 15 months, initially by eradicating all off-framework usage towards the end of 2023/24 and the conversion of agency

to bank. This has continued during 2024/25 and into 2025/26 as the Trust works towards the national guideline of agency spend not exceeding 3.2% of the pay bill. At month three, agency equated to 0.24% of the pay bill in month and 0.47% year-to-date.

The impact of converting agency to bank expenditure may result in increased bank spend, but a net saving.

For month three, bank costs were £0.10m, in line with the planned expenditure of £0.10m, and slightly lower than month two.

It should be noted that all agency and bank spend is subject to robust approval processes requiring senior management approval.

This is demonstrated in the graphs below:

Table 3 – Agency Spend

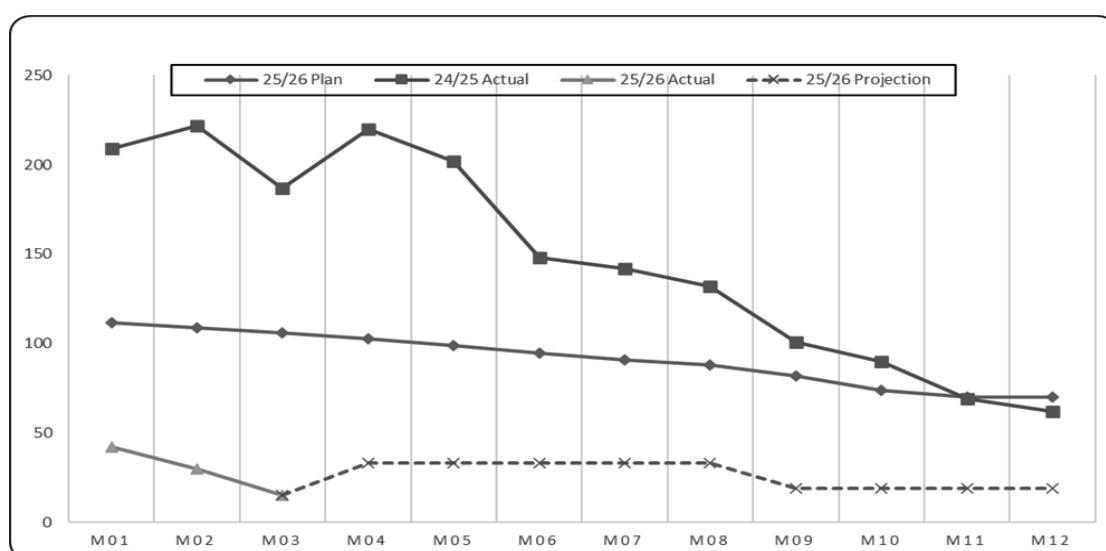


Table 4 - Bank Spend

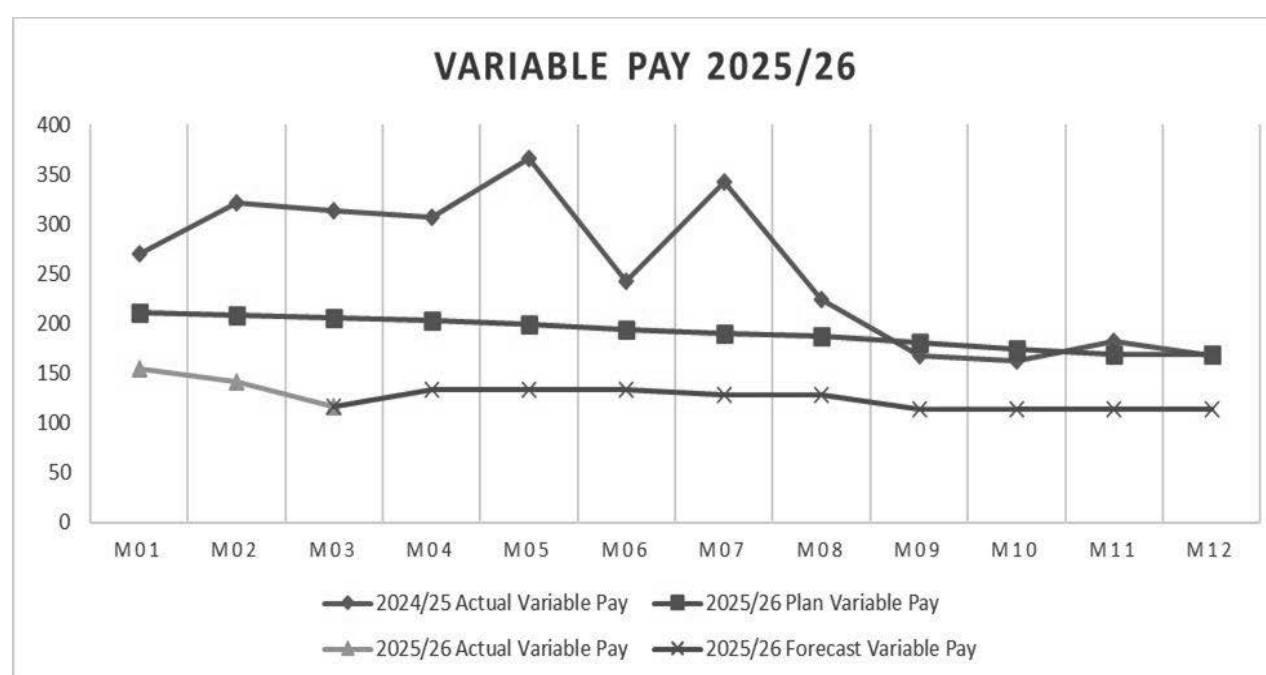


Variable Pay

The Trust has implemented a tight grip and control regime for variable pay, all requests for additional hours now need to be approved by the Deputy Chief Operating Officer. The effects of this grip and control can be seen in the table and graphs below, covering a rolling 12 month period:

Variable Pay Plan	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Rolling 12 Months
Bank staff including on-c costs	105	112	112	126	126	125	126	126	125	100	100	100	1,383
Agency/contract	159	157	146	81	69	69	70	71	71	112	109	106	1,220
Total Variable Plan	264	269	258	207	195	194	196	197	196	212	209	206	2,603
Variable Pay £'000	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Total
Bank	127	87	164	95	200	92	67	73	113	112	112	102	1,344
Agency	220	203	148	142	132	101	90	69	62	42	30	15	1,254
Overtime	32	30	19	31	15	14	9	15	6	10	2	2	185
Total Variable Pay	379	320	331	268	347	207	166	157	181	164	144	119	2,783
Overtime	32	30	19	31	15	14	9	15	6	10	2	2	185

Note: overtime is included within substantive costs in the plan.



• Non Pay

During month three the Trust has spent £2.42m on non-pay, £0.08m below plan predominantly due to lower than budgeted biologic drug costs in Dermatology (note this is offset by a reduction to income).

month one the Trust has spent £2.48m on non pay, £0.08m below plan due to lower than budgeted biologic drug costs in Dermatology (note this is offset by a reduction to income).

3. COST IMPROVEMENT PLAN (CIP)

- 3.1 The Trust's annual BAU CIP target is £5.48m (5%). This relates to levels one and two savings referenced in 2.6 above.
- 3.2 The level three system dependant savings of £2.9m is phased in month 12 of 2025/26 as per Board discussions recognising that at the time of submitting the plan, no system savings or detailed delivery plans were known.
- 3.3 The detailed CIP tracker identifying all the savings schemes planned for 2025/26 was presented to the Finance & Performance Committee as part of month three performance reporting.
- 3.4 In Level 1 and 2 annual CIP savings target is £5.48m (5%). Level 3 stretch savings target is £2.90m.
- 3.5 The Trust plan to month three is £1.16m, against which achievement of £1.16m is reported, of which £0.1m is non-recurrent vacancy slippage, this will be replaced by recurrent schemes as the year progresses.

4. EXTENSION OF SYSTMONE (TPP) EPR CONTRACT

- 4.1 The Trust issued a Voluntary Ex Ante Transparency (VEAT) notice in 2024/25 to publish its intent to extend the current contract with TPP for the provision of the current Systmone EPR system. There were no challenges which therefore allows the Trust to formally sign the extension of the contract.
- 4.2 Recognising the intention to integrate the Trust with Warrington and Halton Hospitals (WHH), the signing of this contract was delayed to ensure that the extension did not impact or compromise the current EPR procurement process being undertaken by WHH.
- 4.3 It is now confirmed that the extension of the Trust's current contract will not impact the WHH procurement and the extension period will allow for a detailed review and procurement process to be undertaken in the next 2 years.
- 4.4 In line with the Trust current Standing Financial Instructions (SFI's), the value of the contract (£986k over three years) does not require formal Board, but as a significant transaction is noted in this report.

5. CAPITAL CASH AND BETTER PAYMENT PRACTICE CODE (BPPC)

- 5.1 The Trust spent £0.17m on capital schemes up to month three, against a plan of zero. This reflects the acceleration of some schemes to avoid delays later in the financial year.
- 5.2 The latest list of all capital schemes for 2025/26 was presented to the finance committee in month three.

- 5.3 In April 2025 there was a net cash inflow of £2.67m with a closing cash balance of £8.40m. The increase in cash is primarily driven by the settlement of a significant debt from a single commissioner.
- 5.4 Invoiced debt has decreased by £1.32m and of that, overdue debt has decreased by £2.01m. During June, the Trust received £3.00m from its largest debtor and a further £2.20m in July.
- 5.5 Total debt has decreased by £2.86m compared to prior month and this is primarily due to a decrease in invoiced debt and accrued income.
- 5.6 Total trade and other payables as at 30th June are £9.65m, of which £5.97m relates to creditors.
- 5.7 Total payables have increased by £0.60m compared to the previous month.
- 5.8 The table shows the percentage (number and value) of invoices paid within BPPC terms.

Month	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-25	95.0	97.9	98.2
May-25	95.0	98.6	99.3
Jun-25	95.0	99.4	99.7
Year to date performance	95.0	98.6	99.0

6. RECOMMENDATION(S)

- 6.1 The Board is asked to:
- Note the contents of this report.
 - Note the financial position.

Committee Chair's Report

Name of Committee/Group:	Extraordinary Audit Committee			Report to:	Board of Directors
Date of Meeting:	12 June 2025			Date of next meeting:	25 June 2025 – Extraordinary meeting 31 July 2025 – regular meeting
Chair:	Bob Chadwick, Non-Executive Director			Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: Bob Chadwick, Non-Executive Director, Committee Chair Gail Briers, Non-Executive Director Elaine Inglesby, Non-Executive Director Abdul Siddique, Non-Executive Director Tina Wilkins, Non-Executive Director, Committee Vice-Chair	In Attendance & Observers: Nikhil Khashu, Chief Executive Nick Gallagher, Director of Finance Debbie Weir, Financial Controller Samantha Scholes, Head of Corporate Governance James Boyle, Director, KPMG Adam Lyon, Manager, KPMG <u>Observer</u> Rita Chapman, Governor Kevin Goucher, Governor		Key Members not present:	Member: None Attendee: Jan McCartney, Director of Corporate Governance Rachel Hurst, Deputy Director of Finance
Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:		Action/decision:
2024-25 Impairment Review of Property, Plant and Equipment (PPE)	1		The Committee received the review, identifying three assets no long in use and 70 fully depreciated assets to be written off. The total value of these assets is £2.3m with a net impact of nil. The report also included an impairment of £12k for certain properties. External Audit requested that an explanation about why the Trust did not believe that the recorded deficits did not pose an increased risk to the Going Concern Assessment		Information received

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

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

Committee Chair's Report

Going Concern Assessment	1		The Committee received the report, highlighting the financial position, future service provision, working capital and cash, borrowings, and future view. The Trust reported a deficit for 2024-25 and 2025-26 however it continued to look for new business opportunities and expected to maintain a healthy cash balance. The assessment concluded that it is appropriate to prepare the accounts on a going concern basis.	Assurance received
Review of draft annual accounts and financial statements to include the Annual Report and Annual Governance Statement	1		The Committee received information relating to: (i) Draft Annual Accounts - verbal There were no significant changes to the earlier draft and the final accounts would be circulated for sign off by 25th June 2025. (ii) Draft Annual Report and Annual Governance Statement The report, including the Annual Governance Statement had been compiled in compliance with the NHS Foundation Trust Annual Reporting Manual and had been reviewed by the Board of Directors and External Audit. The Chief Executive confirmed that he was satisfied with the process and final statement. The final version, including a full list of amendments would be supplied to the Audit Committee for recommendation at its Extraordinary meeting on 25 June 2025 to the Board on the same date.	Information received Information received
KPMG External Audit Progress Update	1		The Audit Committee noted the verbal report on External Audit Progress. Whilst there were a few areas to be finalised, there were no risks to meeting the submission deadline of 27 June 2025.	Assurance received
Review of the meeting	1		There was general agreement that the meeting was effective and the work to produce both the Annual Report and Annual Accounts acknowledged.	
Risks Escalated: None from the meeting				

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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

Committee Chair's Report

Name of Committee/Group:	Extraordinary Audit Committee			Report to:	Board of Directors
Date of Meeting:	25 June 2025			Date of next meeting:	31 July 2025 – regular meeting
Chair:	Bob Chadwick, Non-Executive Director			Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: Bob Chadwick, Non-Executive Director, Committee Chair Gail Briers, Non-Executive Director Elaine Inglesby, Non-Executive Director Abdul Siddique, Non-Executive Director Tina Wilkins, Non-Executive Director, Committee Vice-Chair	In Attendance & Observers: Nikhil Khashu, Chief Executive Nick Gallagher, Director of Finance Jan McCartney, Director of Corporate Governance Debbie Weir, Financial Controller Samantha Scholes, Head of Corporate Governance James Boyle, Director, KPMG Adam Lyon, Manager, KPMG Lauren Ryan, Executive Assistant <u>Observer</u> Rita Chapman, Governor Kevin Goucher, Governor		Key Members not present:	Member: None Attendee: Rachel Hurst, Deputy Director of Finance
Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:		Action/decision:
Annual Internal Audit Report and Head of Internal Audit Opinion 2024-25, MIAA	1 - 7		The Committee received the final version of the draft report. There were no changes to previous versions. The report confirms substantial assurance on the systems of internal control, governance and risk.		Assurance received.

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Committee Chair's Report

External Audit, KPMG - External Auditors Findings Report / ISA 260 - Auditors Annual Report (AAR) - Management Representation Letter (iv) Financial Statements Opinion	1		The Committee received the reports. The auditors intend to issue an unqualified, unmodified external audit report on the financial statements and value for money arrangements. The Committee noted that the audit was nearly complete, with a small number of elements to be concluded, with the auditors on track to meet the required deadline for submission, 30 June 2025. It had been a rigorous, detailed and informed process, reflecting the continual expansion in requirements and quality standards resulting in increased demands on both teams. The Committee noted the four new recommendations for 2024-25 and the management responses required within the ISA 260.	The Committee was assured that monitoring, review and completion of the recommendations would be undertaken through established governance routes and committees. The Committee was satisfied with all documents presented and would receive the final version of the ISA 260 prior to the deadline.
Annual Accounts and Financial Statements 2024-25	1		The Committee received the Annual Accounts and Financial Statements 2024-25 and the Director of Finance highlighted that the Trust had achieved its financial targets for the year, including the revised out turn plan agreed by the ICB at the end of Q3.	The Committee approved the draft and recommended approval of the final version to the Board.
Annual Report including the Annual Governance Statement 2024-25	1		The Committee considered the current Annual Report and Annual Governance Statement, noting minor amendments may be required following completion of the audit by KPMG and submission to NHS England.	The Committee approved the draft and recommended approval of the final version to the Board.
Review of the meeting	1		There was general agreement that the meeting was effective and the work to produce both the Annual Report and Annual Accounts acknowledged. The Auditors, Finance, Corporate Governance and operational teams were thanked for their work.	Internal and external auditors opinion to be added to BAF 1.

Risks Escalated: None from the meeting

Items escalated to other meetings:

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Assured – no or minor impact on quality, operational or financial performance

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

Committee Chair's Report

- Management responses – monitoring through relevant governance processes and Committees.
- 2024-25 Annual Accounts and 2024-25 Annual Report, including Annual Governance Statement recommended to Board for approval.

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	Assured – no or minor impact on quality, operational or financial performance

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

Name of Committee/Group:	Audit Committee			Report to:	Board of Directors
Date of Meeting:	31 July 2025			Date of next meeting:	16 October 2025
Chair:	Bob Chadwick, Non-Executive Director			Quorate (Yes/No):	Yes
Members present/attendees:	Committee Members Present: Bob Chadwick, Non-Executive Director and Committee Chair Tina Wilkins, Non-Executive Director, Committee Vice-Chair Abdul Siddique, Non-Executive Director	In Attendance & Observers: Nick Gallagher, Director of Finance Jan McCartney, Director of Corporate Governance Alan Lee, Head of Risk Management Gary Baines, Regional Assurance Director Adam Lyon, Manager, KPMG Adrian Poll, Senior Audit Manager, MIAA Andy Wade, Anti-Fraud Specialist MIAA <u>Observer</u> Rita Chapman, Governor Kevin Goucher, Governor		Key Members not present:	Members: Elaine Inglesby, Non-Executive Director Gail Briers, Non-Executive Director Attendees: Ali Kennah, Chief Nurse Linda Daisley, Anti-Fraud Specialist, MIAA Debbie Weir, Financial Controller James Boyle, Director, KPMG Rachel Hurst, Deputy Director of Finance Jeanette Hogan, Deputy Chief Nurse
Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:		Action/decision:
Review of Business Cycle and Terms of Reference	1		The Committee Business Cycle was approved with one minor amendment: KPMG External Audit Progress Report would not be available in October and this item would be deferred to December 2025. The Sector Update would be provided separately in October 2025. The Terms of Reference were approved with one minor amendment: Under Connectivity – titles of the Committees in Common to be updated.		Both documents were approved subject to those minor amendments being made.

Committee Chair's Report

Review of BAF and Corporate Risk Register	1	The Committee received assurances that BAF1 remained at a medium risk rating with no new significant risks identified. The Committee was satisfied that good governance processes were in place within the Trust. Within the assurance section of BAF1 this would reflect the results of the current year audit. Within gaps in control and assurances, it was agreed that the integration programme with WHH should be termed clearly as an acquisition. It was confirmed that any potential risks from ICB restructuring and the wider changes within the NHS, as well any impacts from mergers and acquisitions taking place across the system, were primarily overseen by Boards rather than audit committees. Vigilance would continue to ensure any relevant matters were taken through the Audit Committee as appropriate. The Corporate Risk Register was received. There were no risks overdue for review during the reporting period. Automated reminders were in place via the risk team and monthly monitoring by the Risk Management Council helped to maintain timely risk reviews. The Committee emphasised the importance of continued risk oversight at all Board Committees, including the Committees in Common, to ensure assurances were being provided on those risks scoring 12 and above especially during acquisition-related workload increases, and requested escalation of any emerging concerns.	The Committee received the BAF and Corporate Risk Register for assurance. The Director of Corporate Governance has contacted all Committee Chairs, including the Committee in Common Chairs, to ask that all committees continued to receive regular items on risks scoring 12 or above for Bridgewater. This was a regular item on BCHT committees until recently and the Committee stressed the importance that this must continue to enable assurance to be received.
Trust Registers of Interests including Gifts and Hospitality for the reporting period (Quarter One)	1	100% compliance was noted for all Directors. Governor elections had recently been concluded for the year with work to be undertaken to collect their registers of interest. Staff compliance was reported at 90.5% for quarter one, which was an increase from 65% in the previous quarter. Positive impact was noted from the use of Civica system to now record interests.	Committee received the report for assurance.

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Moderate assurance – potential moderate impact on quality, operational or financial performance
Assured – no or minor impact on quality, operational or financial performance

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

Committee Chair's Report

Review of Losses, Special Payments and Tender Waivers	1		The Committee noted the current position with a £2k write off for staff overpayments from previous years. Two retrospective waivers were noted with context provided around system issues such as ADHD assessments and dermatology contract adjustments. One current waiver was noted around dental services radiology with work being undertaken via procurement to address supplier limitations linked to specific equipment.	Committee received the report for assurance.
Internal Audit Progress Report MIAA	1		The internal audit progress report highlighted positive outcomes from audits on patient safety and incident response frameworks (PSIRF), noting comprehensive policies, training, and governance structures in place. (A report on this was also taken to the June Quality and Safety Committee). The Trust was making good progress in implementing prior audit recommendations, and the audit plan remained under regular review, and would be flexible to developments including around integration.	The Committee received the report for assurance.
Global Briefing	1		The transition to global internal audit standards effective April 2025 was acknowledged. MIAA had completed a self-assessment and was compliant with the standards. Inspections would take place of all audit providers and the Trust would be informed of the timescales and outcomes.	The Committee received the report for note.
Anti-Fraud Progress Report	1, 5		The anti-fraud report detailed ongoing investigation activities, self-assessment returns, and fraud prevention measures including alerts and payslip messages addressing risks such as email hacking and phishing. The National Fraud Initiative was underway, with periodic data matching exercises planned to identify and resolve discrepancies.	The Committee received the report for assurance.

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Committee Chair's Report

			Discussion focused on upcoming legislation introducing a new offence of failure to prevent fraud effective 1 September 2025, emphasising increased accountability for senior leaders and boards. Plans for webinars and presentations to senior staff and particularly board members given accountabilities under the new legislation were agreed to ensure awareness and compliance with the new requirements.	
KPMG	1		There were no reports presented from external auditors this month. Discussion took place concerning the external audit contract and the potential integration timetable. Any extension to the contract would require further consideration once timings for integration were finally confirmed, with the potential for e-governance to be required for any contract extension.	
Review of meeting	1		No items to be added to the BAF other than those discussed. Governor observers welcomed the quality of reports and observed a good level of NED challenge.	
Risks Escalated: None identified.				

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	Assured – no or minor impact on quality, operational or financial performance

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	62/25v		
Report Title	ANNUAL DIGIT REPORT (INCLUDING SIRO REPORT)		
Executive Lead	Nick Gallagher, Director of Finance/Senior Information Risk Owner (SIRO)		
Report Author	Sharon Ormesher, Information Governance Manager		
Presented by	Nick Gallagher, Director of Finance/Senior Information Risk Owner (SIRO)		
Action Required	☐ To Approve	☒ To Assure	☐ To Note
Executive Summary			
This report is the Annual SIRO report to provide the Board with a summary of the activity in 2024/25 and to provide assurance regarding the operation of the systems and processes that facilitate and support digital agenda for the Trust.			
Previously considered by:			
☐ Audit Committee ☐ Quality & Safety Committee ☐ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee ☐ Strategic People Committee in Common ☐ EMT			
Strategic Objectives			
☐ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☐ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☐ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☐ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of	Quality Failure to deliver quality services and	Health Equity Failure to collaborate with partners and	Staff Failure to create an environment	Resources Failure to use our resources in a sustainable	Equality, Diversity & Inclusion	Partnerships / Integration with WHH

Corporate Governance and failure to deliver on the Trust's Strategy	continually improve	communities to improve health equity and build a culture that champions ED&I for patients	for staff to grow and thrive	and effective way	Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☐ Effective	☐ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	62/25v		
Report Title	ANNUAL DIGIT REPORT (INCLUDING SIRO REPORT)		
Report Author	Sharon Ormesher, Information Governance Manager		
Purpose	This report is the Annual SIRO report to provide the Board with a summary of the activity in 2024/25 and to provide assurance regarding the operation of the systems and processes that facilitate and support digital agenda for the Trust.		

1. SCOPE

- 1.1 This report is the Annual SIRO report to provide the Board with a summary of the activity in 2024/25 and to provide assurance regarding the operation of the systems and processes that facilitate and support digital agenda for the Trust.

2. SUMMARY OF KEY EVENTS AND ACTIVITIES IN YEAR

- 2.1 A significant incident involving our third-party supplier was reported through the Data Security and Protection Toolkit (DSPT) within 72 hours. A delivery van was robbed, resulting in the loss of patient delivery details. The police conducted a thorough investigation, and the Trust ensured that the supplier implemented measures to prevent future incidents. The Information Commissioner's Office (ICO) had no comments on the Trust's handling of the situation.
- 2.2 There are currently 10 digital risks on the risk register, 9 IT, 0 Information and Performance and 1 IG. 1 risk is greater than 12 this is the overarching cyber risk and is also reviewed by the Risk management council.
- 2.3 All risks are reviewed each meeting and have all have a mitigating action plan.
- 2.4 The new DSPT represents a significant increase in data security requirements, particularly in protecting against cyber risks. As with many Trust the DSPT has been published with an action plan in place.
- 2.5 To ensure compliance with legal requirements and mitigate risks, eight documents were reviewed before finalisation at the Corporate Clinical Policy Group (CCPG).
- 2.6 There were 37 DPIA undertaken compared to 21 last year. All had recommendations made to ensure information was not compromised. None were deemed high risk if the recommendations were undertaken.
- 2.7 There were 359 access to records/Subject access requests from patients received in between April 2024 – 31st March 2025 compared to 335 last year.

- 2.8 There has been a 20.5% decrease in the number of FOI requests this year compared to last year. However the complexity of the requests has increased, this is mirrored across the Cheshire & Mersey FOI Network.
- 2.9 To ensure that systems are safe for release there were three clinical safety cases and one assurance paper undertaken and approved.
- 2.10 There were 4 investigations into inappropriate access within the clinical systems, all of which were acted upon.
- 2.11 The CABIT group have implemented a new electronic change process to ensure all change risks are mitigated before rolling out. It gives the trust greater assurances on each change with more effective auditing and easier reporting capabilities.
- 2.12 There have been infrastructure developments to improve its cyber defence capabilities throughout the year.
- 2.13 The IT service desk fixed 2,570 issues between April 2024 and March 2025.
- 2.14 Patching remains high with 99% of workstations and 100% of servers being patched within standard time frames.
- 2.15 All systems and devices have firewall and antivirus enabled.
- 2.16 All workstations and servers had antivirus enabled throughout the year.
- 2.17 There were 184 care certificates from April 24 to March 25 of which 14 high were issued but only 2 were applicable to the trust. All were acknowledged within a few minutes, and all were acted upon accordingly.
- 2.18 Cyber vulnerability exposure score within the ICB of 17 other trusts remained low and consistent all year with an average score of 5th lowest for workstations and 4th lowest for servers within the ICB.
- 2.19 P1 calls remained consistent with 155 resolved in 2024/25 compared to the previous year. 97% of all P1 calls were resolved within SLA timeframe. This is supported by 92% of users stated that their issue was fixed “at the time” or “quickly”.
- 2.20 The cyber-attack at Alder Hey and Liverpool Heart and Chest Hospital NHS Foundation Trust did not affect the Trust, but systems were investigated and checked and reported into DIGIT.
- 2.21 There has been a cyber exercise undertaken with more planned.
- 2.22 The digital incident review and learning group (DIRLG) established last year is now up and running and identified trends in incidents that have been addressed.
- 2.23 The Data Quality Steering Group is now in its second year and has identified key themes to address.
- 2.24 The Digital development group is now fully established and prioritised projects directed by DIGIT. There have been seven key projects delivered and reported into DIGIT.

2.25 A formal training session was delivered to digital champions. There is more training session planned to recruit more staff members.

3. ADDITIONAL INFORMATION

3.1 To provide additional information and assurance to the Board, the following additional reports are included as appendices to this report.

- a. Appendix 1 – Detailed DIGIT overview report of in year activity report as presented to the Finance, Sustainability and Performance Committee in Common.
- b. Appendix 2 – Chair of DIGIT summary of key in year highlights
- c. Appendix 3 – Key performance indicators
- d. Appendix 4 – Annual Cyber report

4. RECOMMENDATION(S)

4.1 The Board is asked to note the contents of this report.

Appendix 1

FINANCE & PERFORMANCE COMMITTEE REPORT

Title of Meeting	FINANCE & PERFORMANCE COMMITTEE REPORT	Date	25th July 2025
Report Title	DIGIT OVERVIEW 24/25 (Including SIRO report)		
Report Author	Sharon Ormesher, Information Governance Manager		
Report contributions by	Alan Tweddell, Head of IT Anita Buckley, Head of Information Dave Smith, Assistant Director for Digital Services (CIO) Lucy Brierley, Senior Information Governance Officer Joshua Eckersley, Infrastructure Manager Paul Derryhouse, IT Service Delivery Manager Paula Wright, Chief Nursing Information Officer/Clinical Safety Officer Sandra Alderson, Programme Manager (digital and clinical systems)		
Purpose	To provide an overview of the activity of DIGIT in 24-25 to enable it to review and be assured that appropriate governance and processes are in place for the group to satisfactorily discharge its role and responsibilities.		

1 SCOPE

- 1.1 This report outlines DIGIT's activity for 2024/2025 to provide assurance on its own governance and processes in adhering to and delivering against its Terms of Reference (TOR).
- 1.2 The report is to give assurance of the groups progress in meeting the Trusts Digital Strategy.
- 1.3 Information has been provided for April to June where relevant, and adjustments have been made to reflect the evolving digital landscape. The group is asked to accept this report as assurance.
- 1.4 The DIGIT group reviews compliance with all Digital policies and procedures.
- 1.5 This report has been prepared by the Information Governance Team on behalf of DIGIT and its members.

2 SUMMARY OF DIGIT ACTIVITY 2024-2025

- 2.1 DIGIT meet bi-monthly and met six out of the six meeting session. All meetings were well attended by the multi-disciplinary services and were quorate.
- 2.2 Highlight reports are given to the Finance and Performance by the Chair of DIGIT.
- 2.3 The group received reports from the following reporting groups.
 - 2.3.1 Digital Program Group (DPG) ensures DIGIT has an overview of any potential developments and projects including risks and costs and resources and has input to what development should be a priority.
 - 2.3.2 Change Advisory Board and IT (CABIT) assurance group meet weekly to discuss changes are undertaken with minimum disruption to the Trust systems. They also meet monthly to ensure that metrics and documented process meet digital standards and DSPT requirements.

- 2.3.3 The Data Quality Steering Group the multidisciplinary group will provide assurance and update reports and will identify any areas of learning into training and systems validation processes.
- 2.3.4 The Digital Incident Review & Learning Group (DIRLG) the group meet monthly to review all digital incidents to ascertain if there are any further lessons learned to feedback to services.
- 2.4 The group received reports that have identified, assessed, mitigated, and monitor plans in relation to risks and incidents. The reports also include how the Digital Service are working towards the Trusts Digital Strategy. In the reports are the teams' areas of responsibility these are:
 - 2.4.1 **IT services** included overview on service level agreements, core IT functions, information security aspects and risks associated changes to IT systems.
 - 2.4.2 **Information Governance team** included the Data Security and Protection Toolkit, Data Protection Impact Assessments, agreements, Freedom of information and Subject access request functions. The reports included assurance from the Trusts Information Assets on behalf of the Information Asset Owners (IAO)
 - 2.4.3 **Information Team** included data quality issues, performance information, and an overview of developments in the data warehouse and associated systems.
 - 2.4.4 **IT Clinical systems** including the Caldicott Guardian function that monitors the use of clinical systems, the registration authority that ensures access to the systems is appropriate and monitored.
- 2.5 The multidisciplinary group have ensured that digital services and associated projects are safe, secure, and cost effective and aligned to the Trust strategic objectives.
- 2.6 The DIGIT group have monitored and made recommendations to the prioritisation and implementation of digital projects presented to the group by the Digital Programme Group (DPG).
- 2.7 Agreed, and monitored audit plans and reports, including those from Internal Auditors.
- 2.8 Ensured serious incidents are investigated, actions completed, and lessons learned are rolled out across the Trust.
- 2.9 The group reviewed several policies, procedures, and leaflets, including agreement to develop documents.

3 POLICIES, PROCEDURES AND LEAFLETS

- 3.1 The DIGIT group reviewed and approved 8 policies and procedures before feeding into the Clinical, Corporate Policies Group (CCPG). These were:
 - Prescriptions Electronically Transferred via the Electronic Prescription Service Procedure (full review)
 - Third-Party Supplier Policy (full review)
 - Information Governance Framework Policy (full review)
 - Clinical Photography, Audio/Video Recording and Remote Video Consultation within Healthcare Policy (full review)
 - Data Protection and Confidentiality Policy (full review)
 - Health Records Policy (full review)
 - Subject Access/Access to Health Records Policy (full review)
 - Electronic Patient Record (EPR) System Policy (new)

4 RISKS AND INCIDENTS

4.1 Risks

Low Risk			Moderate Risk			High Risk			High 12 & Extreme				
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	0	0	0	0	2	0	9	0	1	0	0	0	0
0			2			9			1				

4.1.1 Risks are reviewed at each DIGIT meeting. All risks have a mitigating action plan and are now reported into DIGIT in one report.

4.1.2 As at 4/6/25 there are 10 Digital risks on the corporate risk register. 9 for IT, 0 for informatics and 1 for IG. The highest risk is for cyber security and is a standing risk, this risk is also reviewed in the Risk Management Committee.

4.2 Serious Incidents/Data Breach

4.2.1 An incident that is deemed serious must be reported through the Data Security and Protection Toolkit (DSPT) within 72 hours. (DSPT 2023). Reporting through the toolkit automatically reports to the regulator for investigation if the set circumstances or criteria is met.

4.2.2 We reported one significant incident involving our third-party supplier. During this incident, a delivery van was robbed, resulting in the loss of delivery details for our patients. The matter was thoroughly investigated by the police, and the Trust ensured that the supplier implemented a rigorous action plan to prevent future occurrences. The ICO had no comments on the way the Trust had managed the incident.

5 DIGITAL INCIDENT REVIEW AND LEARNING GROUP (DIRLG)

5.1 The group is chaired by the CNIO.

5.2 The DIRLG reviews digital-related incidents covering IT, informatics, and IG systems, to identify trends, extract lessons, and inform improvements. It examines wider Trust incidents for digital insights to contribute to learning circles.

5.3 The group reviewed the TOR in the last year.

5.4 The common themes discussed throughout the year included:

- EMIS outages
- Connectivity issues
- Site-specific problems (e.g. Great Sankey)
- Risk register reviews.

5.5 An example of one incident reviewed showed the need for better data handling and record management practices. It was not classified as a Serious Untoward Incident (SUI), but lessons were documented regarding IG and patient record accuracy.

6 DATA SECURITY AND PROTECTION TOOLKIT (DSPT)

6.1 The DSPT is facilitated by the Information Governance Team. It requests evidence from all services but relies heavily on evidence from the digital services.

6.2 There have been significant changes to the Data Security and Protection Toolkit

(DSPT). The DSPT incorporated the National Cyber Security Centre's Cyber Assessment Framework (CAF) for enhanced cyber security and information governance assurance.

- 6.3 This integration introduced a new interface for NHS Trusts, CSUs, ALBs, and ICBs, aligning requirements with CAF objectives, principles, and outcomes. The 2024-2025 DSPT includes additional cyber and IG requirements compared to the 2023-2024 DSPT.
- 6.4 The DPST has 47 contributing outcomes supported by indicators of good practice, categorised into 'Not Achieved', 'Partially Achieved', or 'Achieved'. To meet the 'Standards Met' criteria, NHS organisations must achieve the expected levels set by NHS England for each outcome. This means if a criterion is set at "partially achieved" and we meet that criterion, we will have achieved the accepted level for this year.
- 6.5 The new DSPT represents a significant increase in data security requirements, particularly in protecting against cyber risks. Which will be a challenge to achieve. The deadline of the: 30th June 2025, is still a requirement.
- 6.6 Last year the Trust achieved the DSPT with significant assurance given from the MIAA audit.
- 6.7 This year as with many other Trusts we need to implement an action plan:
- 6.8 12 outcomes assessed:
 - 9 outcomes met the NHSE minimum achievement level.
 - 3 outcomes not met, resulting in an overall High Risk rating.
- 6.9 High-Risk Areas Identified
 - 6.9.1 Supply Chain (A4.a):
 - Subcontractors not fully documented in DPIAs or supplier records.
 - Accreditation review frequency missing from policy.
 - 6.9.2 Identity Management (B2.a):
 - Lack of formal process for MFA exceptions and remote access controls.
 - 6.9.3 Vulnerability Management (B4.d):
 - Limited scanning beyond annual penetration testing.

7 INFORMATION GOVERNANCE

- 7.1 The IG team has continued to strengthen governance frameworks, manage data protection risks, respond to incidents, and enhance staff awareness and training. The IG team is involved in strategic contributions to regional data initiatives and internal policy improvements, ensuring compliance with national standards and best practices.
- 7.2 Appendix one includes charts and an annual overview of the IG KPIs.
- 7.3 **Data Protection Impact Assessment (DPIA)**
 - 7.3.1 A Data Protection Impact Assessment (DPIA) is required under the UK

General Data Protection Regulation (UKGDPR) any time we begin a new project that is likely to involve “a high risk” to other people's personal information. As we are a health organisation, we always undertaken a DPIA. This includes when procuring a third-party supplier who will process trust personal information or a change to an existing way we process personal information.

7.3.2 The IG team and the Procurement team worked together to ensure that the mandated Digital Technology Assessment Criteria (DTAC) for third party suppliers is embedded in the procurement process. This also links to the DPG group, where both the IG team and the Procurement team are represented. Where a DTAC has been undertaken the DPIA is then built to support the Information Asset Owner and Information Asset Administrator with their responsibilities.

7.3.3 There were 37 DPIA undertaken compared to 21 last year. All had recommendations made to ensure information was not compromised. None were deemed high risk if the recommendations were undertaken.

7.4 Subject access requests (SAR)

7.4.1 The central SAR register is managed by the IG team and is used by all the clinical services as it's deemed not possible to extract information from the information systems despite this being done in other areas.

7.4.2 The chart in Appendix One, shows that there were 359 access to records/Subject access requests from patients received in between April 2024 – 31st March 2025 compared to 335 last year. This year there has been 2 incidents relating to record request being delayed beyond the one-month deadline. Compared to the 5 incidents last year.

7.5 Freedom of information requests (FOI)

7.5.1 There has been a 20.5% decrease in the number of FOI requests this year compared to last year. However the complexity of the requests has increased, this is mirrored across the Cheshire & Mersey FOI Network.

7.5.2 The Trust achieved 68% compliance for supplying information requested within 20 working days out of the 363 FOIs received in 24/25. Last year there was 457 requests with the Trust achieving 69% compliance.

7.5.3 This year there as was 1 internal review undertaken this is the same as last year.

8 HEAD OF INFORMATION TECHNOLOGY/CYBER

8.1 The department has been at the forefront of sustaining and advancing digital infrastructure and cybersecurity during the 2024-2025 period. Significant strides were made to enhance operational efficiency, improve cyber resilience, and align with strategic digital goals. The key achievements are:

8.1.1 An internal audit critical application review on the Trust Ivanti IT Service Management system was undertaken in March 2025. The outcome of the Final Report is TBC.

8.1.2 IT services produce operational activity reports at each DIGIT meeting.

8.1.3 The IT service have continued with infrastructure developments which is tracked against the annual workplan.

8.1.4 The Trust continued its planned digital enabler and infrastructure developments in line with its digital strategy during 2024-25 whilst continuing to improve its cyber defence capabilities.

- 8.1.5 Deployed a new cloud based Privileged Access Management (PAM) solution to centralise elevated privileges internally and from third party support, improving the Trusts cyber protection.
- 8.1.6 Successfully bided and procured 275 replacement laptop devices and ancillary equipment as part of continued lifecycle management and support the impending Windows 11 rollout.
- 8.1.7 Moved all cellular mobile services to a new ICB wide contract attracting significant CIP to the Trust.
- 8.1.8 Continued working with regional teams on 24x7x365 security operations centre provision.
- 8.1.9 Continued to upgrade Trust systems and applications to latest operating systems for security, compliance, and risk mitigation as well as following cloud/internet first programmes of work.
- 8.1.10 Completed the national annual Data Security Protection Toolkit submission (Standards Met) and a range of mandatory internal / external audit reviews.
- 8.1.11 Commenced Digital Integration workstreams covering core IT services of operational, security and compliance from a tactical and strategic reequipment(s).

9 CHANGE ADVISORY BOARD AND INFORMATION TECHNOLOGY (CABIT)

- 9.1 The group is chaired by the Head of Service Delivery
- 9.2 The CABIT and service desk annual report is in [Appendix two](#)
- 9.3 The primary responsibility of this group is to oversee and support the lifecycle of IT changes, ensuring these modifications are advantageous and cause minimal disruption. Its core duties include evaluating, prioritising, and authorising changes to IT services, infrastructure, and documentation, while also ensuring compliance with the Data Security and Protection Toolkit (DSPT) requirements.
- 9.4 The group has weekly meetings as part of the Change management process; they meet monthly with Head of IT and IG to discuss assurance and compliance.
- 9.5 The group have had 34 weekly meeting and 11 longer assurance meetings.
- 9.6 The group reviewed their TOR in October 2024
- 9.7 The change process was successfully migrated to an ITSM (Ivanti) based process from its previous form-based process. This change was completed in Q4 and provides CABIT and the trust with greater assurances on each change with more effective auditing and easier reporting capabilities.
- 9.8 The Group approved 43 changes for the year, a 13% increase from the previous year. CABIT Changes approved, and risk assessed these range from updates to systems or hardware to low level configuration or policy changes.
- 9.9 53 Standard firewall changes have been completed. This process also moved into the Ivanti change model from Q4.
- 9.10 The group refreshed all its KPIs into DIGIT
- 9.11 The CABIT group reviewed and approved 8 process documents supporting our DSPT requirements.
- 9.12 The information below is what the CABIT report in quarterly to DIGIT, these mainly support the DPST. Each of the areas need remediations undertaken to ensure processes are kept up to date.
- 9.13 There were 2570 remediations undertaken from April 24 to March 2025.

9.14 SIEM – Security Intelligence Managed Service

- SIEM is third party system that proactively looks for suspicious activity it raises a security alert to IT services where it has identified suspicious activity.
- SIEM reviewed over 3.8billion logs generated from Bridgewater systems. There were 24 reported incidents from SIEM of which none were deemed high. All incidents were closed.

9.15 Care Certs/cyber alerts.

- NHS Digital notify the Trust of any potential or urgent security exploits that needs to be managed. All alerts are triaged, acknowledged and if applicable a remediation plan is put in place based on the severity.
- There were 184 care certificates from April 24 to March 25 of which 14 highs were issued but only 2 were applicable to the trust. All were acknowledged within a few minutes, and all were acted upon accordingly.

9.16 Patching

- Patching is a process of identifying, testing, deploying, and installing software patches (or updates) to computers or servers. Patching is an automatic process. A manual remediation is only undertaken when the device is seen but has not patched correctly within 90 days for users' workstations, 30 days for servers.
- The number of workstation devices is normally depending on the number of users. There were an average of 1914 workstations with overall patching at 99%. As the Trust is an agile organisation this is an excellent level of compliance.
- There was an average of 66 servers with overall patching rate of 100%.

9.17 Firewalls

- A Firewall is a network security device that monitors and filters incoming and outgoing network traffic.
- All servers and users' devices had firewall enabled.

9.18 Antivirus

- Antivirus software detects anything malicious and will quarantine or remove the file. Workstations or a laptop that has antivirus disabled is immediately acted upon. A user cannot disable a firewall, if a firewall looks like it's been disabled through the reporting systems, it means that there is a problem with workstation or the reporting systems. This means IT must investigate and fix the problem.
- All workstations and serves had antivirus enabled throughout the year.

9.19 Device Exposure Performance

- Computer exposure scores are metrics used to assess the level of risk associated with the use of computer systems and digital infrastructure within an organization. These scores help in evaluating the potential vulnerabilities and threats that could impact the security and functionality of these systems. The higher the score the greater the risk. The IT service continues to focus efforts on reducing our vulnerability score.
- Cyber vulnerability exposure score within the ICB of 17 other trusts remained low and consistent all year with an average score of 5th lowest for workstations and 4th lowest for servers within the ICB.

10 IT SERVICE DESK

- 10.1 There was a 10% year-on-year reduction in the total number of phone calls taken. This reflects both the trusts ever improving technical baseline requiring less break fix interventions as well as moving to a self-service support model giving greater efficiency when logging support calls.
- 10.2 Self-service was the most frequently used method for logging calls, accounting for 52% of all calls raised. This is a slight decrease on last year due to the increase in proactive network calls that were raised.
- 10.3 13% of all calls were proactively generated to address common issues like missing

updates and low disk space, ensuring optimum compliance and performance. The volume of proactive calls has increased 178% on last year and 2600% on two year ago highlighting the focus on delivering optimum performance and compliance on all devices.

- 10.4 The Phone calls that were taken by the service desk were picked up within an average time of just 25 seconds reducing from last year's performance of 49 seconds.
- 10.5 Achieved 97% SLA performance for the full year across all logged support calls, up from 96% in the previous two years.
- 10.6 P1 calls remained consistent with 155 resolved in 2024/25 compared to the previous year. 97% of all P1 calls were resolved within SLA timeframe.
- 10.7 First time fix rate of 51% was achieved for all incidents raised to the service desk.
- 10.8 End user satisfaction is currently at an all-time high with 89% of users rating the service they received as Excellent with a further 9% rating Good.
- 10.9 92% of users stated that their issue was fixed "at the time" or "quickly".

11 INFRASTRUCTURE AND NETWORK TEAM

- 11.1 The infrastructure team reports to CABIT and handles all system modifications. The team have undertaken various projects that have been summarised by the Head of IT.
- 11.2 The Infrastructure Manager is responsible for providing DSPT evidence and serves as the deputy Chair for the weekly Change Advisory Board. The Infrastructure and Network Team also undertakes additional responsibilities. Here is a summary of the key events that they have led on:

11.3 Cyber Event

- 11.3.1 On 29th November, a statement was released by Alder Hey and Liverpool Heart and Chest Hospital NHS Foundation Trust regarding information published online and shared via social media, purportedly obtained illegally from their systems.
- 11.3.2 The CIO network and the Cheshire and Mersey Digital ICB collaborated with the NCSC and made a list of recommendations for each organisation within Cheshire and Mersey.
- 11.3.3 The team acted fast and undertook the necessary audit to ensure continual security. checks.
- 11.3.4 The findings were discussed reported into DIGIT the December meeting.
- 11.3.5 The findings showed:
 - The software infiltration route is not used by the Trust,
 - There was no apparent compromise to BCHFT, but some suspicious IPs were flagged and immediately blocked.
 - There were a few areas for improvement, these were added to the CABIT workplan for action and monitoring.

11.4 Cyber Exercises

- 11.4.1 Cyber-attacks are a significant threat as highlighted in the National Risk Register 2025. Recent incidents like the CrowdStrike-related IT outage in 2024 and the Alder Hey ransomware attack underscore the need for robust cyber awareness and processes.

- 11.4.2 A cyber exercise was organised by C&M ICS, was attended by colleagues from EPRR teams, IT/cyber, IG, and MIAA.
- 11.4.3 The exercise aimed to determine and understand how partner organisations would collaborate to achieve a unified approach in the event of a major system outage.
- 11.4.4 The scenario focused on how our organisations would respond to a Microsoft cloud outage.
- 11.4.5 On the back of this exercise, an exercise was Facilitated by the Infrastructure and IG Manager within the Digital services on the 25th of March 2025.
- 11.4.6 The exercise aimed to summarise the findings of a major system outage within digital services, focusing on the roles and responsibilities during such incidents.
- 11.4.7 To ensure that digital services have the knowledge and procedures to escalate issues during a major system outage. The exercise involved discussions on various scenarios, including cloud access issues, communication strategies, and business continuity plans.
- 11.4.8 There were lessons learned and action plan that will be monitored through CABIT group and team meetings.

12 DATA QUALITY STEERING GROUP

- 12.1 The group is Chaired by the Head of Information
- 12.2 The group have met 10 times in 24/25 and are due to review their TOR in June 2025.
- 12.3 The Data Quality Steering Group has made significant progress in addressing data quality issues within the Trust. Continued focus on these key themes will ensure ongoing improvements and better patient outcomes.

12.4 Key Themes

- 12.4.1 Unfinished Appointments- High volumes of unfinished appoints in some services. The group advised that services need to use Qlik to monitor their own data and improve the process for cancelled and rebooked appointments and ensure accurate status updates.
- 12.4.2 Ethnicity Data Capture - Improvements noted in ethnicity data completeness (e.g., from 38% to 66%). Discussion regarding mandating ethnicity fields in EMIS and System One, addressing system limitations and staff compliance.
- 12.4.3 Dental Data Quality -The new dental analyst has made efforts to integrate dental data into broader reporting to improve referral and waiting list tracking.

12.5 Other Notable Topics

- 12.5.1 Ensuring referrals for deceased patients are closed to avoid distressing families.
- 12.5.2 Inconsistencies in capture across services prompted a review of templates for smoking, alcohol, and exercise data.

13 INFORMATION AND PERFORMANCE TEAM

- 13.1 The Information Team provide DIGIT with assurance of completeness and timeliness of national submissions.
- 13.2 Identify, raise awareness and provide assurance of data improvement work programmes.

- 13.3 Specific project updates such as Qlik Sense and Writeback programme roll out and benefits realisation, New nationally mandated data set builds and delivery progress, Data Improvement events.
- 13.4 New projects were presented to DIGIT for discussion and subject matter expert advice.

14 DIGITAL AND CLINICAL SYSTEMS TEAM

- 14.1 The Digital and Clinical Systems Team provided the Digital Programme Group and DIGIT with visibility of major change requests and projects made by services and assurance on progress and completion of these requests.
- 14.2 Requested DIGIT to advise on strategic direction, prioritisation, and appropriateness of the requests.
- 14.3 Asked DIGIT to prioritise projects due changes in staff and the number of projects ongoing.
- 14.4 Update Digital Programme Group on risks and benefits of each proposed change or development and escalated where appropriate to DIGIT, where the impact has a long-term detrimental impact to the Trust.
- 14.5 Gave assurance that each project deployment includes a roll-back plan to restore the state of the environment if issues arise.
- 14.6 Updated DPG and DIGIT on project closures through sharing of project closure reports.
- 14.7 Agreed and reported back team Key Performance Indicators (KPIs) to DIGIT Group as follows:
- Clinical Systems Service Desk Requests response time/SLA met (5 days).
 - Clinical System Service Desk Incidents response time/SLA met (3 days).
 - Number of projects delivered.
 - Project delivery satisfaction
 - Training delivery satisfaction
- 14.8 Key Projects delivered during the reporting period are:
- Halton Electronic Prescribing service enabled for all prescribing services to send prescriptions to pharmacies.
 - Halton Intermediate Care and Frailty Service – wider deployment of EPR to Therapy and Council staff.
 - Optimisation of SystmOne and EMIS across various services.
 - Urgent Care Direct Booking from GPs to UTC and vice versa.
 - Introduction of SystmOne e-referral functionality between teams and services.
 - Development of digitised referrals forms using Microsoft forms.
 - Digitised communications to patients using tools in SystmOne such as Communication Annexe.

8 DIGITAL PROGRAMME GROUP (DPG)

- 8.3 The DPG is chaired by the Deputy Director of Finance.
- 8.4 The group is managed and facilitated by the Digital and Clinical Systems Team
- 8.5 The TOR is due to be reviewed in June 2025.

- 8.6 The multidisciplinary group meet monthly and have fortnightly 'Check In' calls there have been 7 full meetings, interspersed with check in calls as required.
- 8.7 DPG produced five highlight reports to DIGIT.
- 8.8 The DPG group gave DIGIT an update on the progress against the Digital and Clinical Systems Programme Plan for 2024/25 and associated key risks.
- 8.9 Gave financial assurance for Digital services.

9 CHIEF NURSING INFORMATION OFFICER(CNIO)/CALDICOTT GUARDIAN OFFICER AND DIGITAL SAFETY.

- 9.3 During 24/25 the CNIO presented Q1-Q4 combined reports.
- 9.4 3 Clinical Safety Reports were approved, and 1 assurance paper was also approved.
- 9.5 1 report on a potential project was presented and was approved to discontinue with this project at this time.
- 9.6 A clinical safety Peer review was undertaken with good assurance identified and an action plan to address areas for improvement was approved.
- 9.7 10 digital clinical incident reports were presented.
- 9.8 4 Investigations were undertaken at the behest of Human Resources.
- 9.9 2 high Profile audits were undertaken During 23/24 the CNIO presented 01/Q2/Q3 combined reports and Q4 Caldicott Reports

10 DIGITAL CLINICIAN/DIGITAL CHAMPIONS

10.3 Digital clinician

- 10.3.1 We have hired a digital clinician who has advanced digital innovation for clinical teams. They connect frontline services with the Digital and Clinical Systems Team and ensure safe and effective implementation of digital systems and workflows.

10.4 Digital Champions

- 10.4.1 The Digital Champions initiative has made progress in developing a digitally skilled workforce.
- 10.4.2 The Digital Champions programme aims to:
 - Support staff in enhancing digital literacy and confidence.
 - Foster a culture of digital curiosity and innovation.
 - Serve as a link between frontline teams and digital transformation efforts.
- 10.4.3 The initiative is in line with the Trust's broader digital strategy, which requires "every member of staff to become a digital champion" supported by a network of experts.
- 10.4.4 A formal training session was conducted with 20 attendees. There is more training sessions planned the next being at the end of June 2025. The training included scenario-based learning, breakout sessions, and modules on Teams, Copilot, and digital safety. Feedback was generally positive, though some sessions (e.g., IDF) were seen as less relevant by clinicians.
- 10.4.5 Staff members from various departments (e.g., Child Health, Dental, Estates, Adult DN) attended the training.
- 10.4.6 Champions share resources, updates, and training materials in a dedicated Teams channel.

11 CONCLUSION

- 11.3 This report assures stakeholders of the systems and processes in place to facilitate and support the Trust's digital agenda.

12 RECOMENDATION

- 12.3 This report is presented to the group, so the group may take assurance regarding the operation of the systems and processes that facilitate and support digital agenda for the trust.

Appendix 2

Introduction by Chair of DIGIT

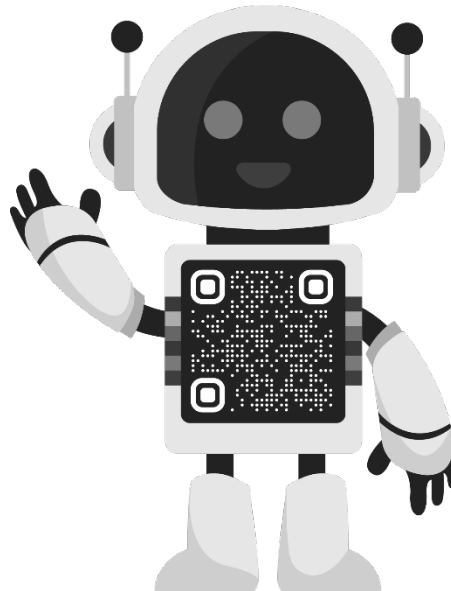
As Chair of DIGIT, it is my privilege to share the substantial progress in fulfilling the objectives outlined in our Digital Strategy. Through a commitment to innovation and concerted teamwork, we have effectively translated strategic goals into measurable outcomes that benefit both our workforce and the communities we serve. By harnessing advanced digital tools and implementing streamlined processes, our initiatives have not only elevated the quality of care but also empowered citizens through enhanced accessibility and inclusivity. These achievements underscore our dedication to fostering a healthier, more connected future while ensuring the optimal use of resources for all stakeholders.

In 2024-25, the digital service progressed its planned developments according to its Digital Strategy. Key accomplishments include:

- Completed the migration of our second legacy dental Electronic Patient Record (EPR) system to our new cloud based dental EPR. All our dental locations now use one common specialist system with comprehensive service reports provided by the Trusts data warehouse and analytics systems.
- Commenced the enablement of the option of patient facing digital services for dental services including self-check in, electronic correspondence and questionnaires.
- Reviewed and optimised clinical records templates with various clinical services.
- Provided access to the Cheshire and Merseyside Connecting Care Record services.
- Completed the rollout of ePrescribing to community pharmacies from Bridgewater services.
- Introduced 2-way appointment booking between GP's and our Widnes Urgent treatment centre along with a range of wider electronic referrals initiatives.
- We procured and deployed 250 new or replacement laptop and desktop devices and ancillary equipment as part of continued lifecycle technology management.
- Completed external legacy telephony replacement in readiness for the revised Public Switched Telephone Network (PSTN) switch off.
- All digital disciplines utilise our online service desk request/reporting portal improving responsiveness and management for Trust staff. 65% of support activity now comes via the portal.
- The Digital services team achieved Level 1 accreditation to the Digital Skills Development Network 'Towards Excellence in Digital Standards' award.
- Continued working with regional teams on 24x7x365 security operations centre and joint cyber security initiatives further improving our cyber posture.
- National annual Data Security Protection Toolkit (DSPT) for 23/24 submission with standards Met and completed a number internal / external audit Digital reviews for assurance.
- Maintained 100% level Password using Multi Factor Authentication (MFA) across our NHS Mail service users, all internet facing applications hosted by Bridgewater now use the same MFA function, improving our cyber protection.
- All Trust systems and applications use fully supported operating systems and software for security, compliance and risk mitigation, with further progress on following cloud / internet first strategic programmes of work.
- Commenced a trial of a range of Microsoft Artificial Intelligence tools as part of National evaluation programme.
- Refreshed Integrated Quality Performance Report (IQPR) indicators and reporting format.

- Migrated to a new improved data warehouse feed from a key EPR supplier improving speed and timeliness of information.
- Implemented successful updates to national submissions to reflect latest version standards and Faster Data Flows requirement.
- Continued with data quality and improvement sessions across all services with the monthly data quality steering group (DQSG) effectively addressing data quality issues.
- Maintained and further developed self-serve Qlik Sense reports to enhance performance data, with write back functionality to facilitate two-way interaction with the data providing actionable insights.
- Provided a range of dashboard and monitoring capabilities which are updateable in real time by our users to drive a data driven/digital first culture.

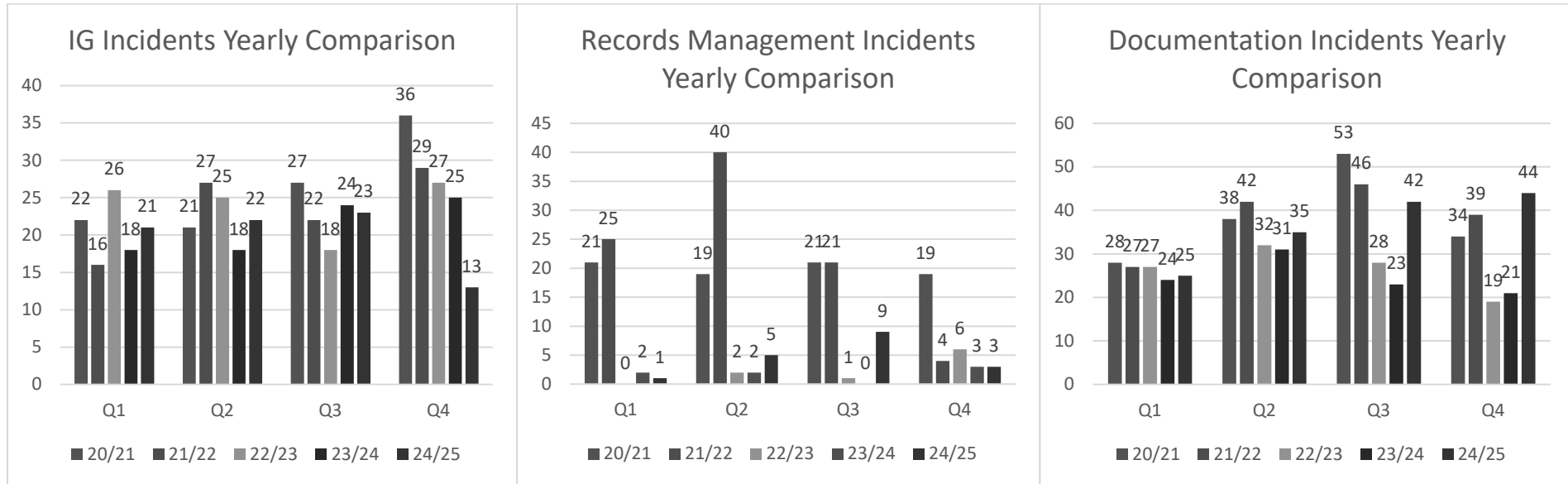
Dave Smith, Assistant Director for Digital Services (CIO)



Appendix 3

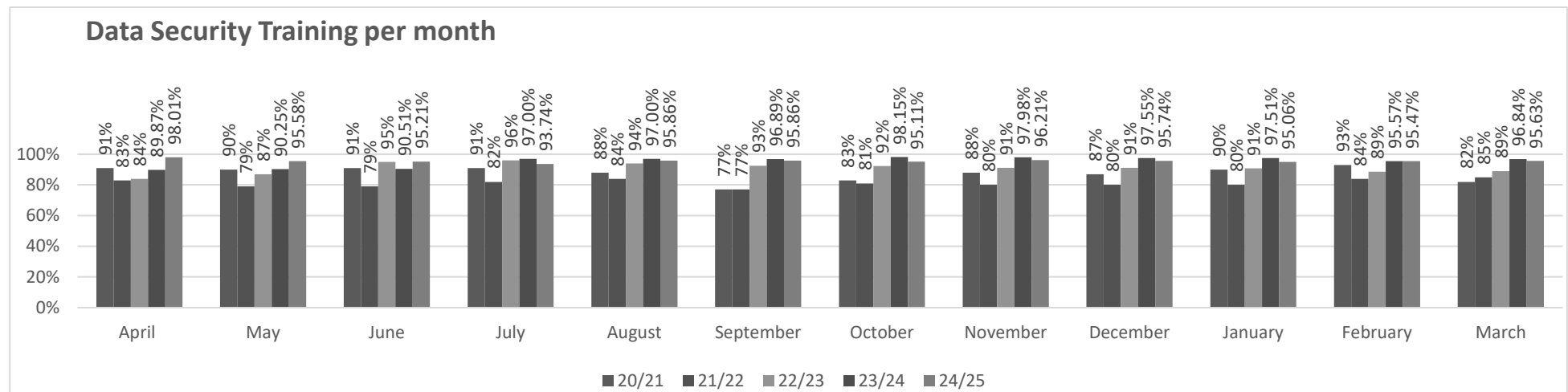
KEY PERFORMANCE INDICATORS (KPI)

Incidents



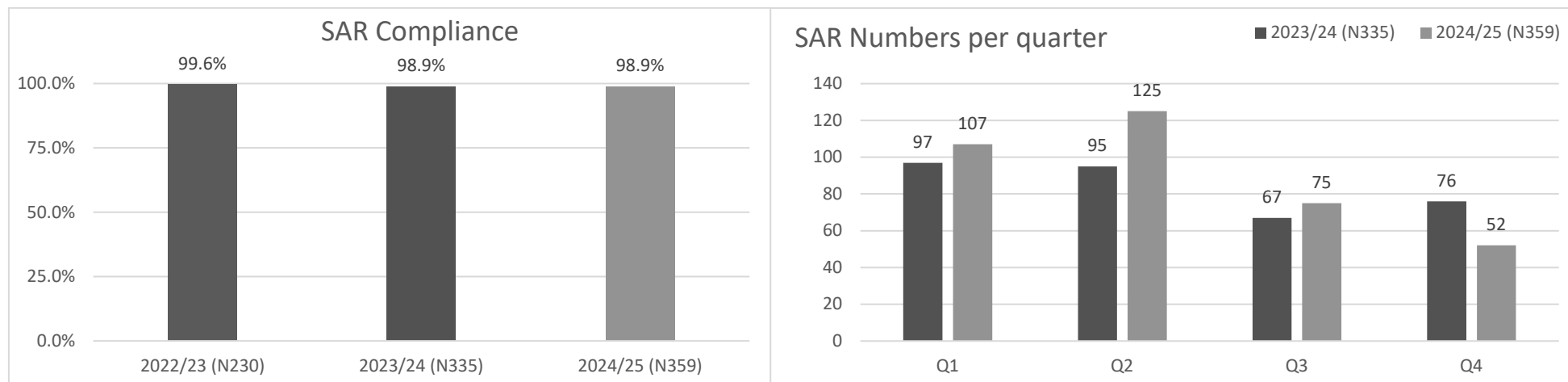
Data security Training

Level one security training remains high with an average of 95.62% throughout the year.

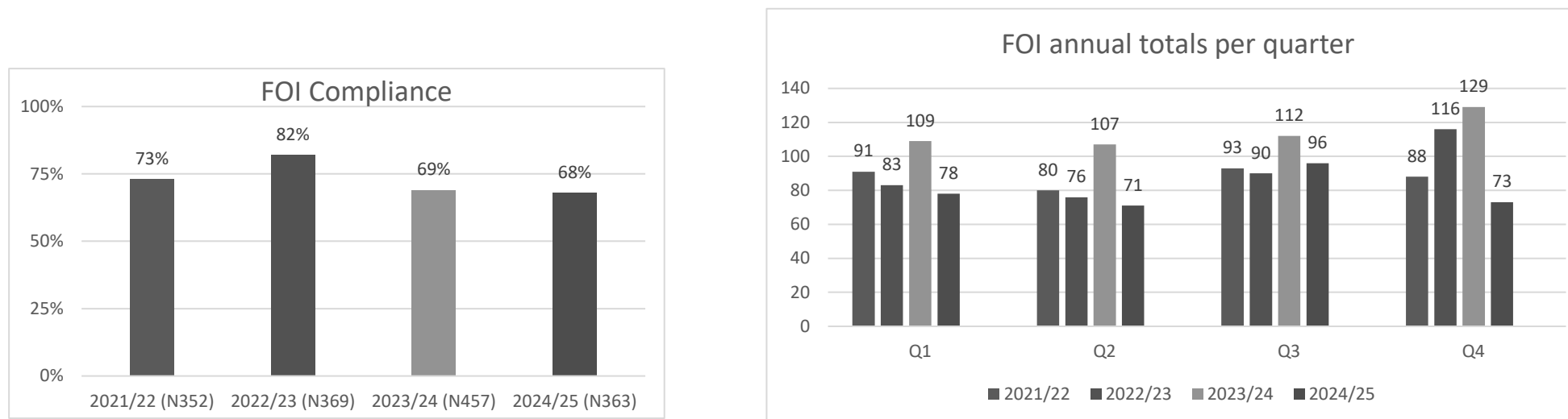


Subject Access Requests (SAR)

- 14% (n43) requests were received by the IG team were not related to our Trust and needed to be re-directed to other organisations.



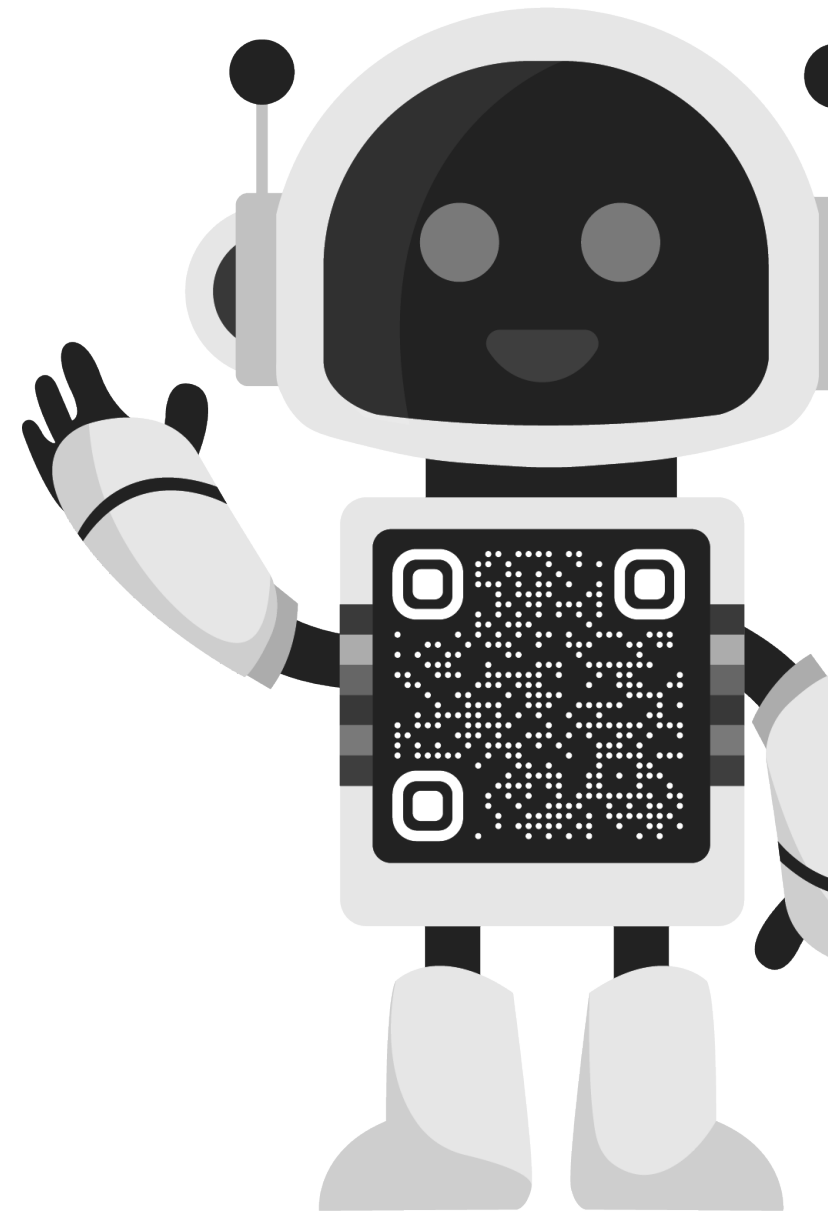
Freedom of Information



Appendix 4

I.T Service - **Cyber Report**

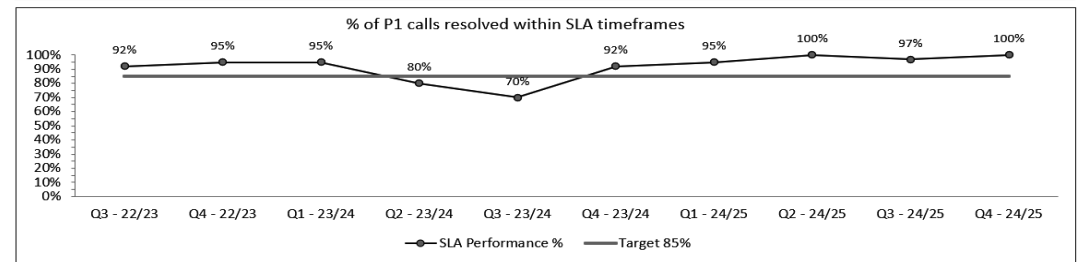
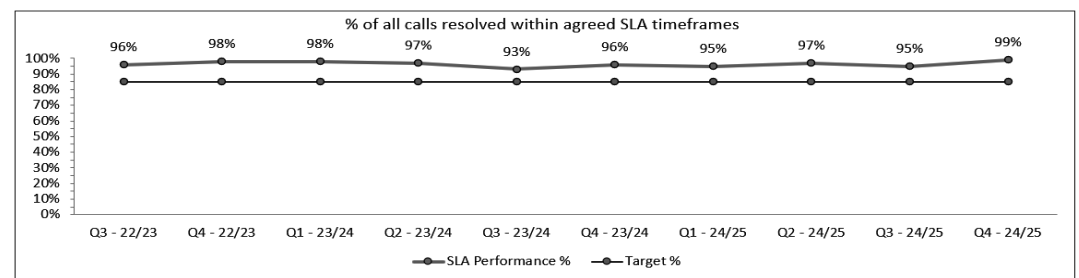
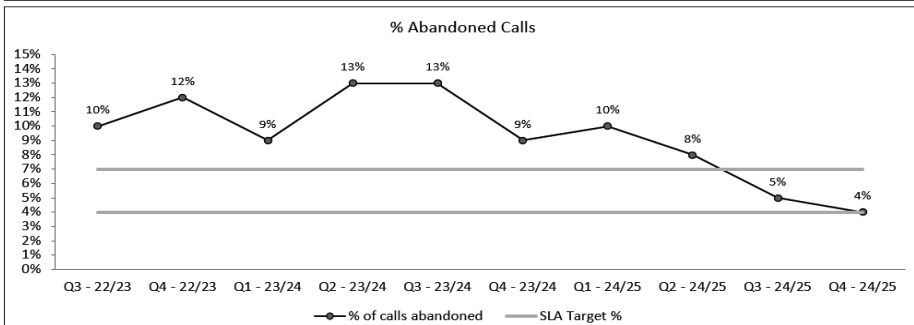
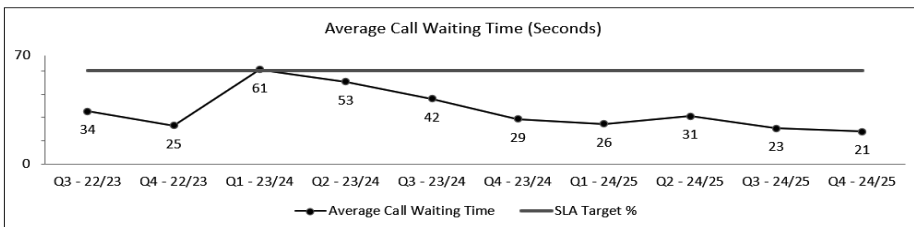
Annual - **2024 - 2025**



Executive Summary - Operational Report

- Exceptional Service Delivery:** Achieved significant service milestones making this year our most successful year to date operationally
- Reduction in Call Volume:** There was a 10% year-on-year reduction in the total number of phone calls taken. This reflects both the trusts ever improving technical baseline requiring less break fix interventions as well as moving to a self-service support model giving greater efficiency when logging support calls.
- Self-Service Utilization:** Self-service was the most frequently used method for logging calls, accounting for **52%** of all calls. This is a slight decrease on last year due to the increase in proactive network calls that were raised.
- Proactive Cyber Compliance:** **13%** of all calls were proactively generated to address common issues like missing updates and low disk space, ensuring optimum compliance and performance. The volume of proactive calls has increased **178%** on last year and **3688%** on two years ago highlighting the focus on delivering optimum performance and compliance on all devices.

Category	Target	Q3 - 22/23	Q4 - 22/23	Q1 - 23/24	Q2 - 23/24	Q3 - 23/24	Q4 - 23/24	Q1 - 24/25	Q2 - 24/25	Q3 - 24/25	Q4 - 24/25			
Average Call Waiting Time	60 Seconds	34	25	61	53	42	29	26	31	23	21			
		Seconds	Seconds	Seconds	Seconds	Seconds	Seconds	Seconds	Seconds	Seconds	Seconds			
% of calls abandoned	4%-7%	10%	12%	9%	13%	13%	9%	10%	8%	5%	4%			
% of P1 calls resolved within SLA timeframes	85%	92%	95%	95%	80%	70%	92%	95%	100%	97%	100%			
% of all calls resolved within agreed SLA timeframes	85%	96%	98%	98%	97%	93%	96%	95%	97%	95%	99%			
% of HIGH patient impact calls resolved within SLA Timeframes	85%	N/A	N/A	N/A	N/A	N/A	N/A	96%	98%	98%	98%			
% of Users satisfied with IT service	85%	99%	97%	98%	96%	97%	95%	97%	97%	99%	97%			

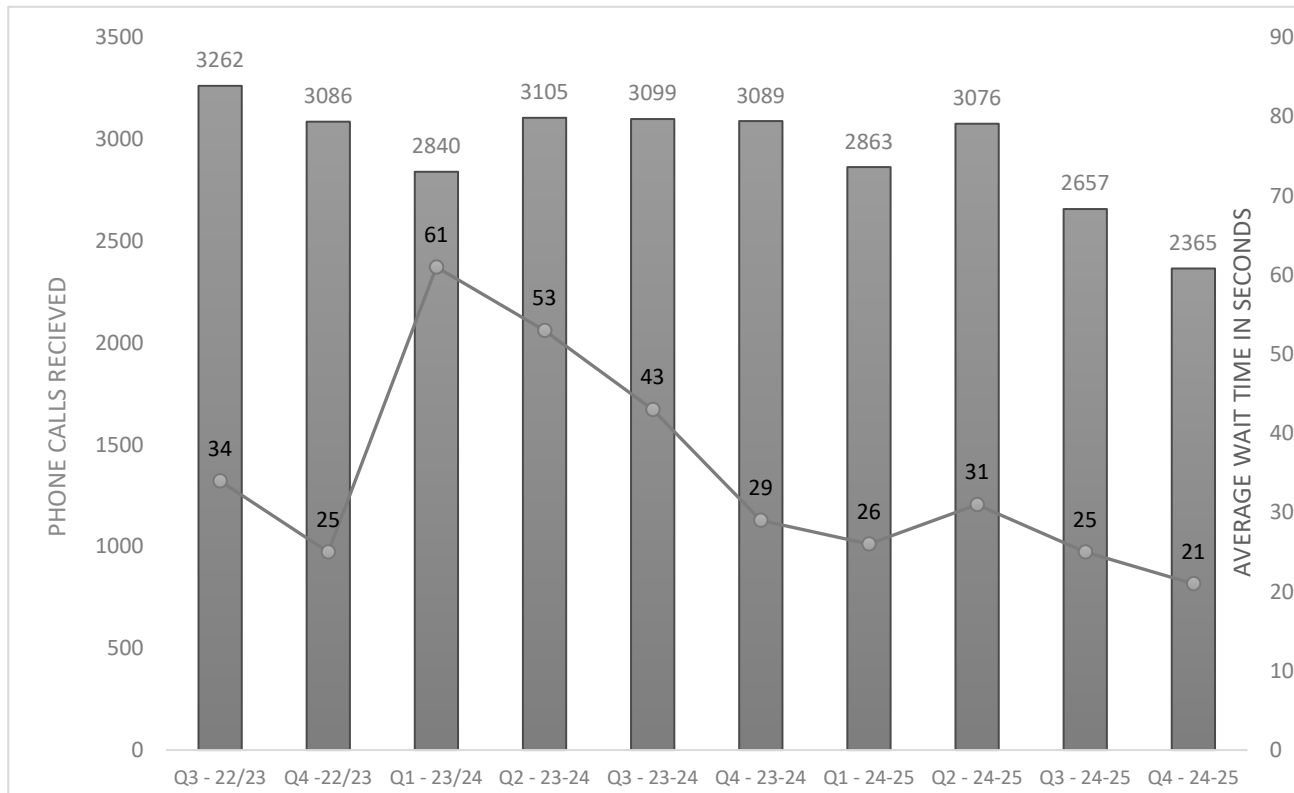


Executive Summary – CABIT Report

- **CAB Meeting Success Rate:** The CABIT group met 45 times out of a possible 49 sessions in 2024/25, achieving a **92%** meeting completion rate
- **Increase in Approved Changes:** CABIT approved 43 changes for the year, a **13% increase** from the previous year with all changes post-reviewed in CABIT
- **Successful Firewall Changes:** Completed 53 firewall changes successfully, with all changes post-reviewed in CABIT
- **Document Review and Approval:** The CABIT group approved the archiving of numerous corporate documents with **8 documents** reviewed and approved by CABIT members in 2024/25.
- **No New Risks Identified:** Risks reviewed in every meeting however the group did not identify any new risks in 2024/25
- **Transition to New ITSM Change Process:** Bridgewater's Change process transitioned from the existing form-based process to an ITSM based method, providing greater governance and assurance offering clearer auditability and greater visibility of approval discussions and votes.

- **Proactive Cyber Remediation Calls:** Saw a **178%** increase in proactive remediations from the previous year, with 2,570 remediations accounting for 17% of the total annual service offering
- **High System Availability:** Maintained **100%** availability for critical systems, including domain services, telephony, backup solutions, and core networks throughout the year
- **Software Patching:** Remained consistently high with an average of **99%** of devices and **100%** of servers were patched within the agreed 90 day window.
- **NHS CareCERTs:** **100%** of national critical Carecerts acknowledged and managed within expected timeframes. Only **2 of 14** issued Critical Carecerts were applicable. This was managed and closed as required
- **SIEM Solution:** Continued to provide critical real time support to Bridgewater. All monthly performance reviews were completed in 204/25
- **Antivirus Software:** **100%** antivirus coverage for workstations and servers as an average across the year
- **Drive Encryption:** **100%** drive encryption was achieved for all devices
- **Regional Exposure Performance:** Our cyber vulnerability exposure score within the ICB of 17 other trusts remained low and consistent all year with an average score of 5th best for Workstations and 4th best for servers within the ICB.

Operational - Incoming Contact Summary

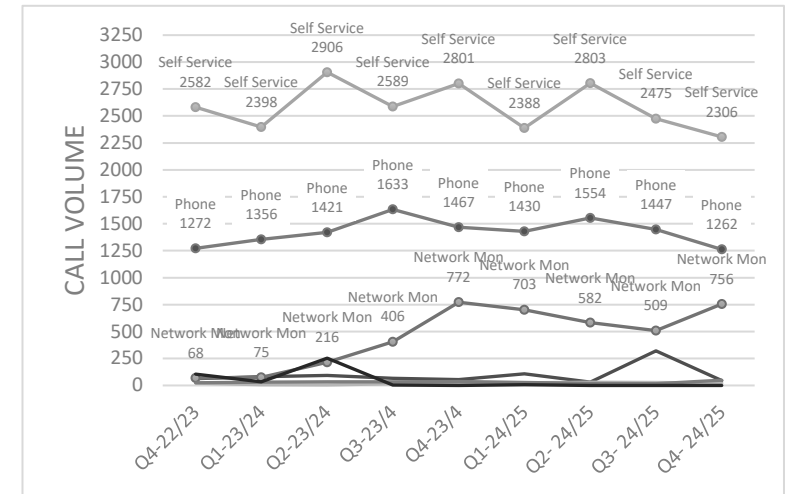


2023/24 – **12133** calls taken

2024/25 – **10961** calls taken Overall reduction of 10% year on year.



Call Origins



Self Service continues to be the most frequently used method of logging calls with **52%** of all calls logged in 2024/25

Telephony accounts for **30%** of all calls logged (down 2% on previous year)

13% of calls were generated proactively linked to cyber compliance. Common issues such as missing updates, devices requiring reboots, low disk space. All proactively managed by the desk to ensure optimum compliance and performance levels.

Just 3% of all calls logged were generated from **emails** as our strategy to move away from this method and to a fully self-service model continues.

Operational – Overall Operational Performance

Bridgewater

2024 - 2025 Operational Statistics

	WE-060424	WE-130424	WE-200424	WE-270424	WE-040524	WE-110524	WE-180524	WE-250524	WE-010624	WE-080624	WE-150624	WE-220624	WE-290624
Resolved	400	398	445	446	371	270	378	364	233	347	304	424	364
SLA %	97%	93%	95%	95%	95%	97%	96%	97%	97%	98%	97%	95%	99%

	WE-060724	WE-130724	WE-200724	WE-270724	WE-030824	WE-100824	WE-170824	WE-240824	WE-310824	WE-070924	WE-140924	WE-210924	WE-280924
Resolved	431	363	354	330	340	374	368	291	268	484	391	334	430
SLA %	97%	97%	98%	98%	94%	98%	98%	97%	94%	98%	99%	94%	98%

	WE-051024	WE-121024	WE-191024	WE-261024	WE-021124	WE-091124	WE-161124	WE-231124	WE-301124	WE-071224	WE-141224	WE-211224	WE-281224
Resolved	564	369	440	501	374	369	399	348	305	296	530	291	83
SLA %	98%	99%	94%	82%	90%	98%	94%	95%	97%	99%	99%	98%	99%

	WE-040125	WE-110125	WE-180125	WE-250125	WE-010325	WE-080225	WE-150225	WE-220225	WE-010325	WE-080325	WE-150325	WE-220325	WE-290325
Resolved	185	343	327	343	341	331	367	267	465	300	300	381	410
SLA %	99%	99%	98%	99%	98%	99%	99%	100%	97%	98%	99%	96%	98%

Quarter 1

4744

96%

Quarter 2

4758

Quarter 3

4869

Quarter 4

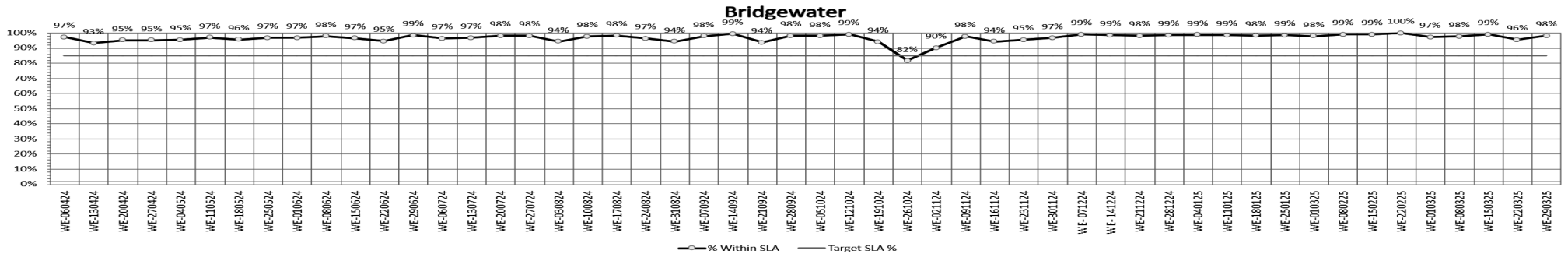
4360

Total Calls Resolved

18731

% Calls Closed Within SLA

97%



An excellent year of support delivery +1% more support calls than last year.

51 of 52 weeks achieved +85% SLA performance with the only drop below being

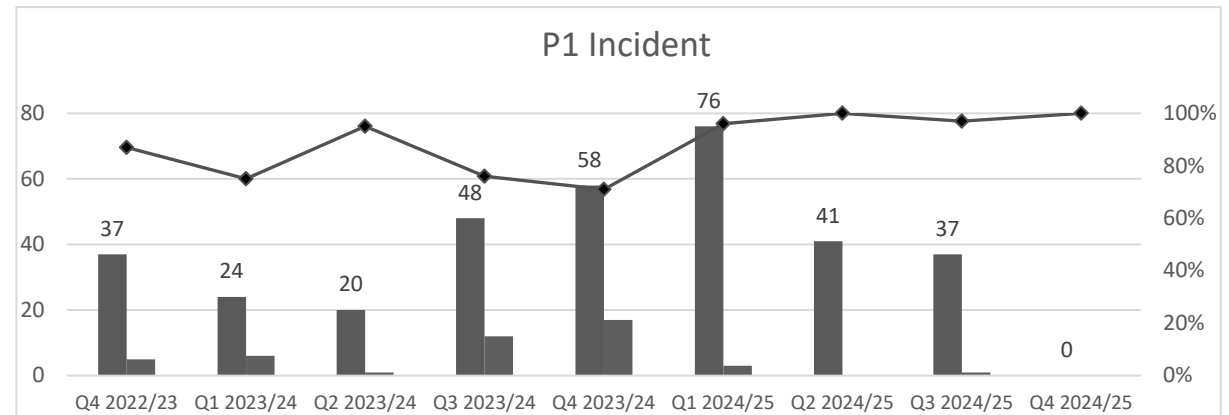
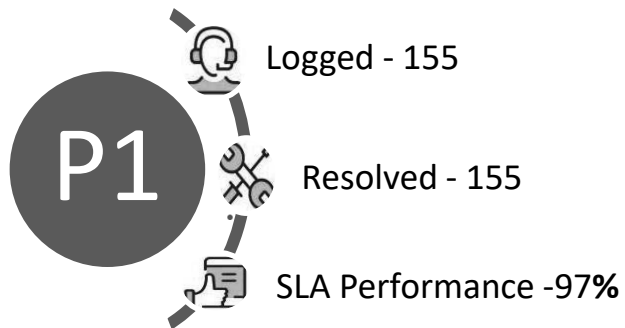
Caused by legacy calls being actioned by the clinical config team.

Our performance of 97% against SLA for the full year is up from 96% which was

Achieved each of the last two years.

2021 - 2022	2022 - 2023	2023 - 2024	2024 - 2025
Total Calls Resolved	Total Calls Resolved	Total Calls Resolved	Total Calls Resolved
17830	15873	18588	18731
% Calls Closed Within SLA	% Calls Closed Within SLA	% Calls Closed Within SLA	% Calls Closed Within SLA
97%	96%	96%	97%

Critical Issues (Priority 1 Support Calls)



P1 Calls have remained consistent in **24/25 – 155** resolved to last year **152** however we have implemented a change to how we recognise and report critical issues.

In Q3 of 2024/2025 an audit was undertaken by Phoenix to complete a full CIS assessment against the 18 CIS Critical Security Controls.

Following this audit, it was noted that the service was potentially over actioning P1 tickets with a misalignment of priorities. Following a review we have updated our service process that supports the identification and management of P1 incidents (IT-SOP022 – P1 Guide)

The definition given to a P1 call is.

“A P1 incident is defined as being an issue causing significant disruption to the organisation. Impacting large volumes of users and causing delays or halting the delivery of patient care or other business critical systems.”

Using this updated process, we have seen a significant drop in the number of P1 calls that are being reported whilst witnessing no changes to the service levels and reaction times offered to end users.

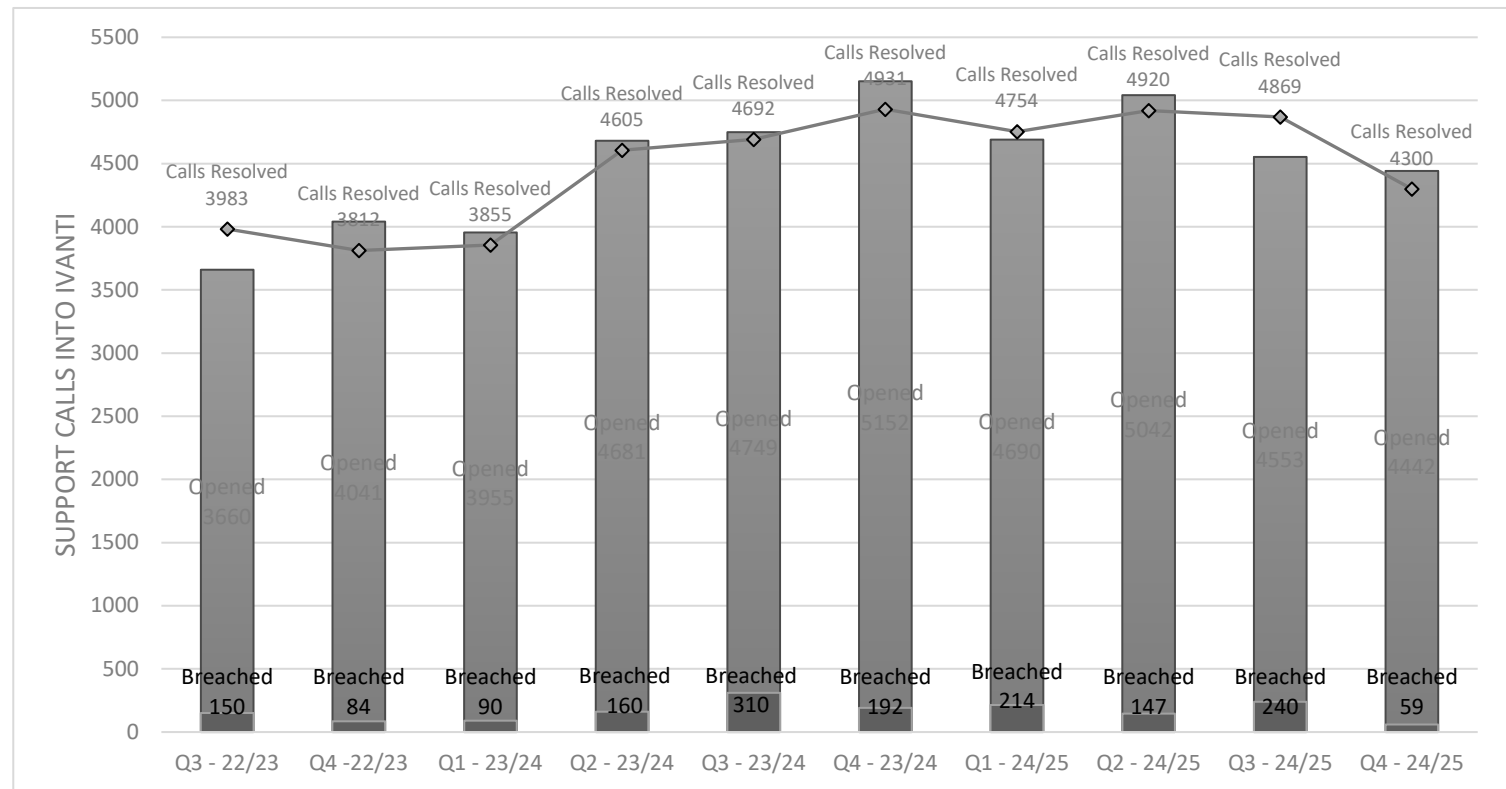


Incident and Request Summary

The number of resolved calls has remained relatively consistent with last year increasing by just **1%**

In 2024/25 we saw a massive increase of **55%** in proactive remediations from the previous year. These are critical interventions carried out by the team to ensure machines remain in optimal condition and cyber vulnerabilities are minimised.

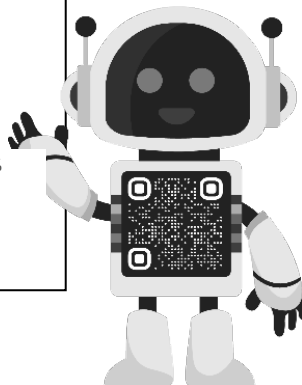
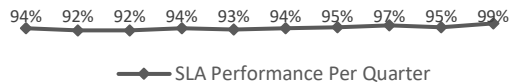
2039 Remediations took place last year accounting for **11%** of our total service offering. (up from 7% the previous year)



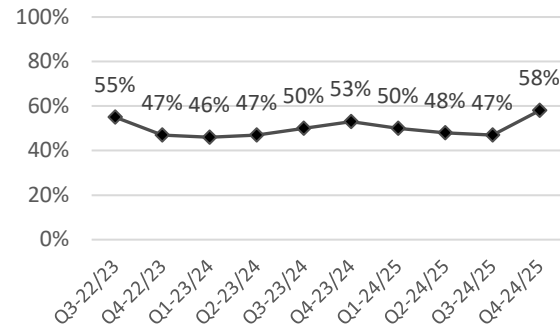
Annual Performance against SLA

97%

Below is the quarterly performance



First Time Fix Rate



First Time Fix rate for the year sat at **51%** of all incidents raised to the service desk being resolved at the first point of contact



End User Satisfaction – Annual Results

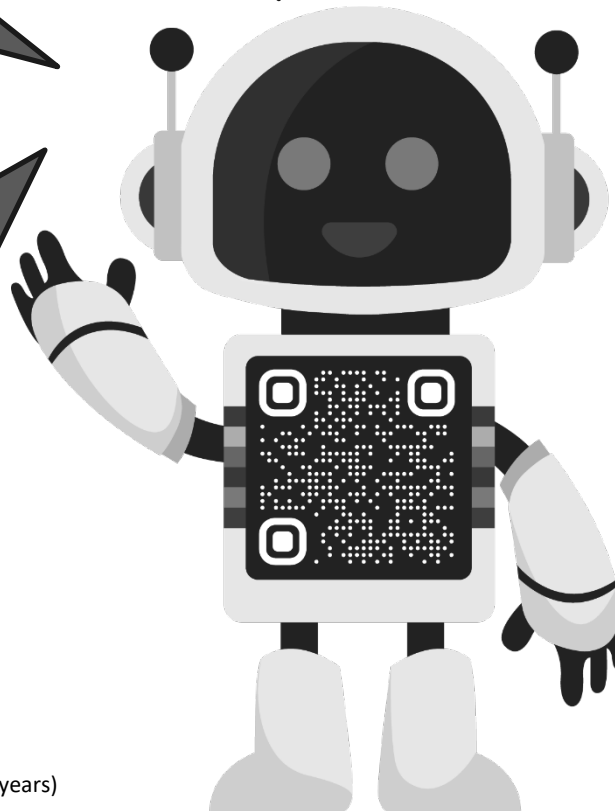
In 2024/25 we saw 1531 survey responses. This is a response of **8%** which is consistent with the previous 2 years response rate of 8% also

88% of users said we answered their phone call quickly with 0.3% user stating it took too long.

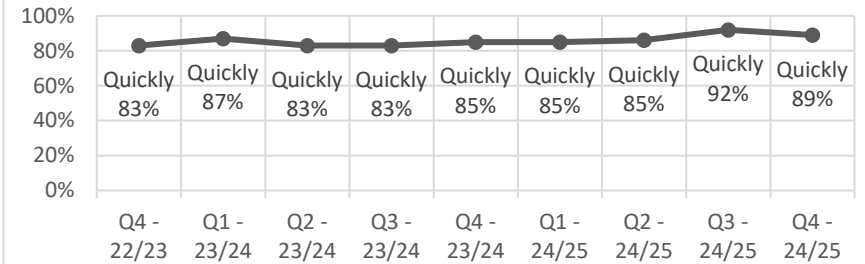
92% of users said we resolved their call at the time of calling or quickly with only **1.3%** saying we took too long

89% of users rated the service they received as Excellent with a further **9%** rating good.

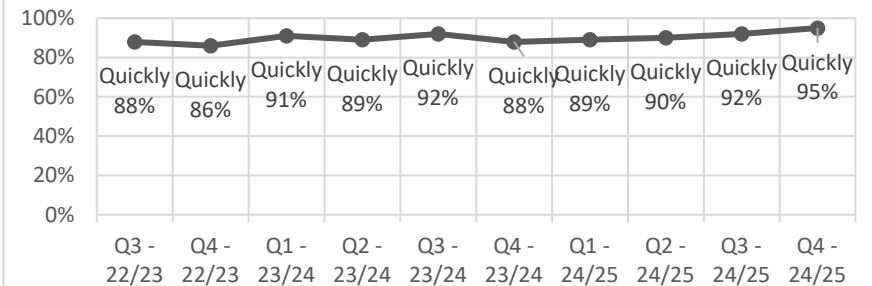
0.5% rated poor. (1 User)
Surveys are anonymous however if identifying feedback is left in the comments section, we do follow up with users to provide additional support or ensure lessons are learnt.



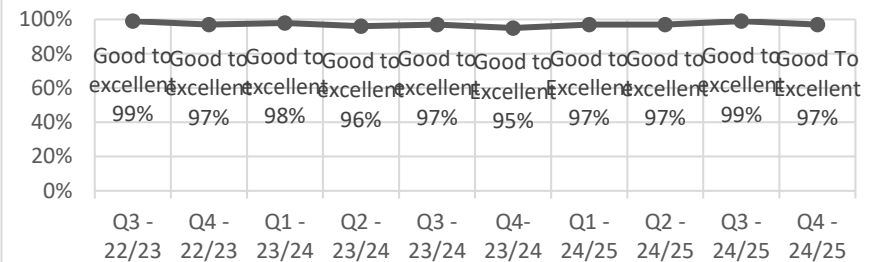
How Fast Did We Answer The Call ?



How Fast Did We Resolve The Issue/Request ?



How Would You Rate The IT Service ?

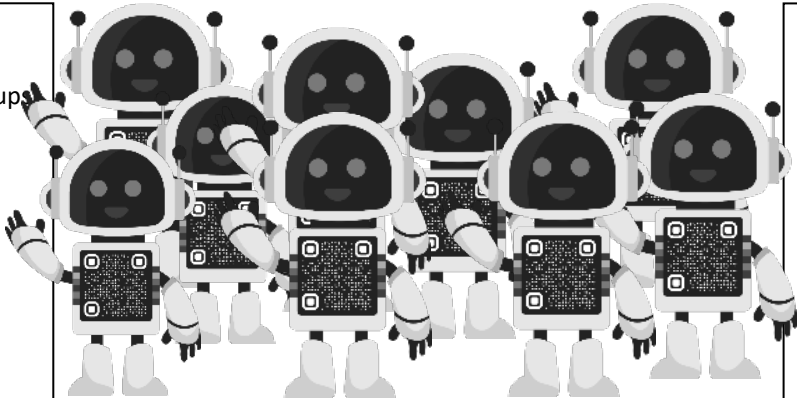


Annual CABIT Group Report

The group meet weekly for the change advisory board discussion. The full month sessions involve reviewing the groups workplan and activity reports.

In 2024/2025 the group met 45 times from a possible 49 (reduced due to change window)

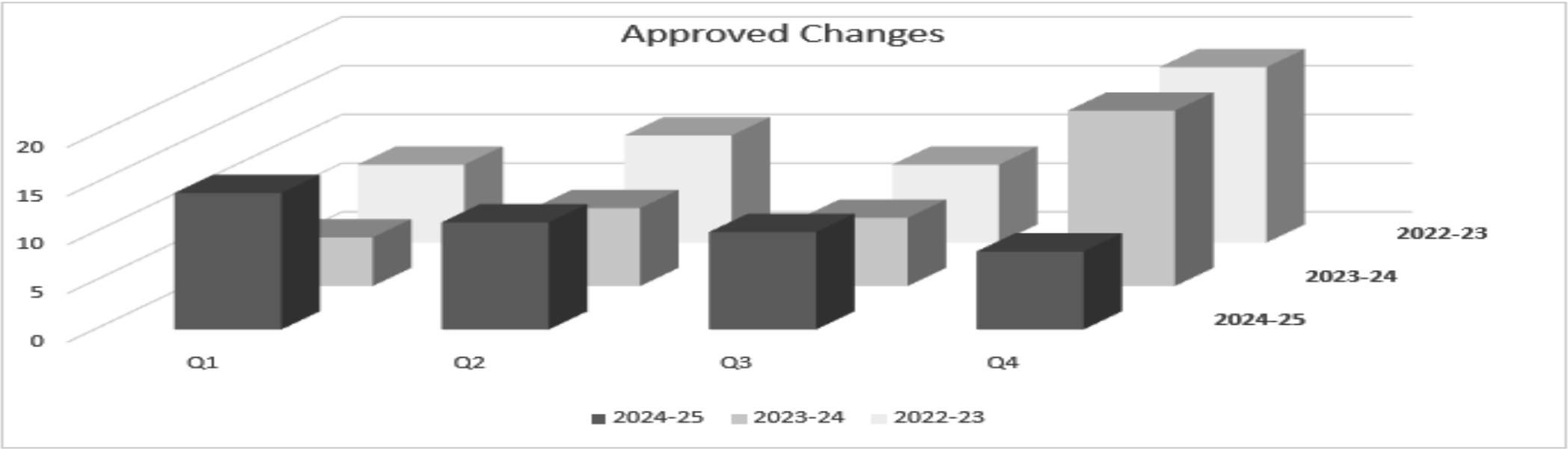
This is a **92%** success rate for CAB meetings.



CAB Approved **43** changes for the year; this is a **13%** increase on last year.

There was a total of **53** Firewall changes completed.

All changes were completed Successfully and post reviewed in CABIT.



CABIT Group Report

Processes Approved/Reviewed

Process Number	Process Name	Process Action
IT-SOP016	Gold Build Management	Created, Reviewed and Published
IT-SOP017	Build ISO Creation	Created, Reviewed and Published
IT-SOP018	SIEM Management Process	Created, Reviewed and Published
IT-SOP019	Remediating Software and Hardware Vulnerabilities	Created, Reviewed and Published
IT-SOP020	Voicemail Unlock	Created, Reviewed and Published
IT-SOP021	AD Reset Password	Created, Reviewed and Published
IT-SOP022	Priority 1 Guide	Created, Reviewed and Published
IT-SOP023	Change Management Process	Created, Reviewed and Published

The DIGIT group approved the archiving of numerous corporate documents that were only for IT staff to implement and monitor. The main IT policies have been reviewed and capture the overview of what is required, these documents are processes to support these requirements.

There were **8 documents** reviewed and approved by CABIT members in 2024/2025

The CABIT group did not identify any new risks in 2024/25

Following a period of configuration and development Bridgewater's Change process transitioned from the existing form-based process to an ITSM based method.

Changes are now logged and managed within Ivanti. This change went live Mid-March 2025

The implementation of this change will provide a greatly level of governance and assurance around changes with clearer auditability and greater visibility of approval discussions and votes.



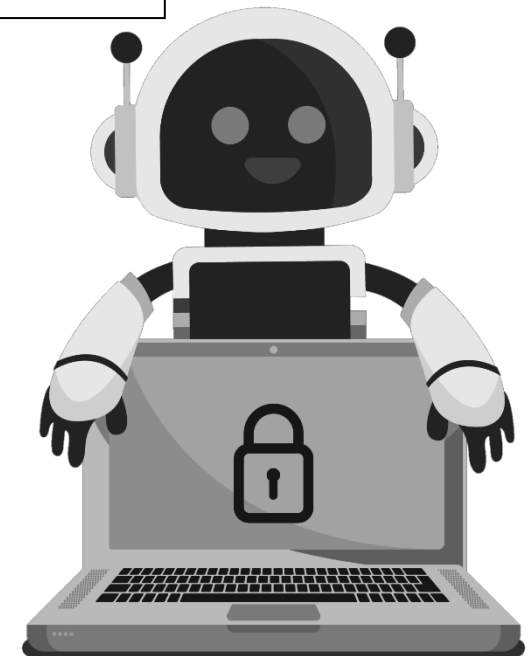
Cyber Report - Security

Software patching is the process of applying updates, or patches, to software and operating systems to fix security vulnerabilities, improve functionality, and address other issues. These patches are crucial for maintaining the security and performance of IT systems.

Software patching is essential for the NHS to safeguard patient data, ensure compliance, maintain operational efficiency, and protect against cyber threats.

NHS CareCERTs (Care Computer Emergency Response Team) are a set of cybersecurity alerts and guidance issued by NHS Digital to help healthcare organizations respond to and mitigate cyber threats. These alerts provide timely information about vulnerabilities, threats, and recommended actions to protect NHS systems and data.

NHS Carecerts are crucial for safeguarding the NHS's digital infrastructure, ensuring compliance, and maintaining uninterrupted healthcare service.



Carecert				
2024-2025	Q1	Q2	Q3	Q4
Number Issued	54	39	48	43
Critical Issued	1	0	4	6
Critical Applicable	1	0	0	0
Critical Resolved	1	0	0	0
Number Applicable	9	4	6	10
High	1	0	0	0
Medium	31	7	6	10
Low	3	0	0	0
Number Outstanding (At start of month)	117	124	31	36

Cyber Report - Security

SIEM (Security Information and Event Management) is a cybersecurity solution that collects, analyses, and manages security data from various sources within Bridgewater's IT infrastructure. It combines Security Information Management (SIM) and Security Event Management (SEM) to provide centralized visibility into security events and log data. This enables Bridgewater to detect, analyse, and respond to potential threats in real-time.

Bridgewater procures its SIEM solution from SOFTCAT and conducts monthly operational reviews.

All account reviews for the reported period have been conducted.



SIEM Statistics				
2024-2025	Q1	Q2	Q3	Q4
Number of P1 & P2	3	6	1	0
High Vulnerabilities	0	0	0	0
Medium Vulnerabilities	0	0	0	0
Malware Alerts	0	0	0	0
Number Of Incidents	7	10	5	2
Number Of Incidents Closed	3	9	5	2
SIEM Outages	0	0	0	0
% SIEM Uptime	100%	100%	100%	100%

Antivirus software is a program designed to detect, prevent, and remove malicious software (malware) from computers and other devices. Malware includes viruses, worms, trojans, ransomware, and spyware, which can harm systems and compromise data. Software patching is essential for the NHS to safeguard patient data, ensure compliance, maintain operational efficiency, and protect against cyber threats.

Antivirus software is essential for the NHS to protect patient data, ensure regulatory compliance, maintain operational continuity, and mitigate cyber threats.

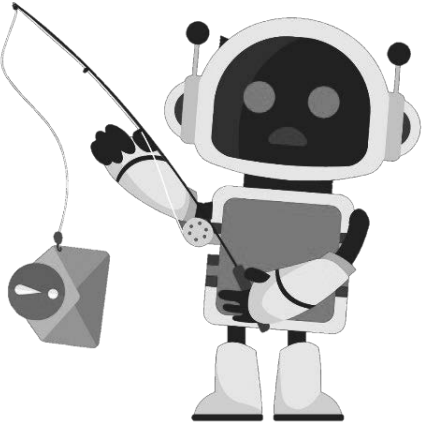
Anti-Virus Status				
Type	Q1	Q2	Q3	Q4
Workstations	100%	100%	100%	100%
Servers	100%	100%	100%	100%

Drive encryption is a security measure that converts data on a storage device into a format that cannot be read without proper authorization. This process uses encryption algorithms to protect data at rest, ensuring that even if the device is lost or stolen, the data remains inaccessible to unauthorized users.

Drive encryption is essential for the NHS to protect patient data, ensure regulatory compliance, maintain operational security, and mitigate risks associated with data breaches.

Encryption Status				
Type	Q1	Q2	Q3	Q4
Encryption %	100%	100%	100%	100%
Manual Remediations Completed	15	17	29	21

Cyber Report - Security



Phishing is a type of cyberattack where attackers use fraudulent emails, text messages, phone calls, or websites to trick individuals into sharing sensitive information or downloading malware. These attacks often appear to come from legitimate sources, making them particularly deceptive.

Understanding and preventing phishing is essential for the NHS to protect patient data, maintain operational security, ensure regulatory compliance, and foster a security-aware workforce.

Phishing Statistics				
Type	Q1	Q2	Q3	Q4
Ivanti Calls Reported	4	1	7	5
MIAA & External Sources	3	0	1	2

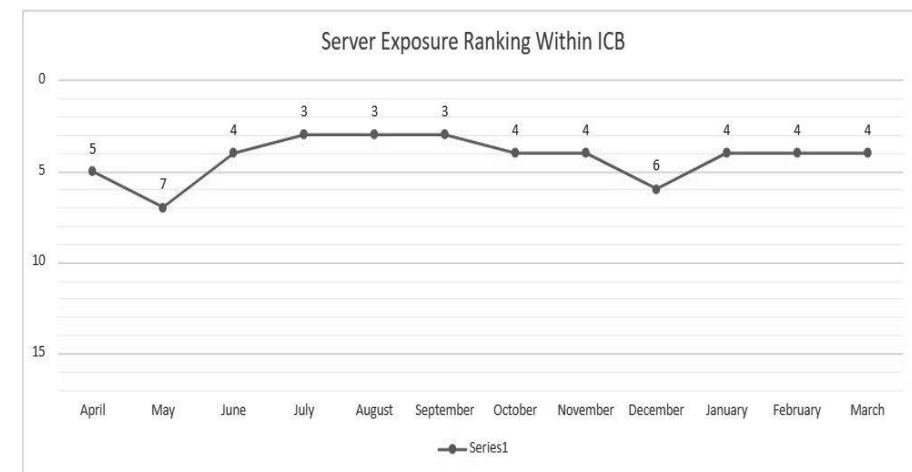
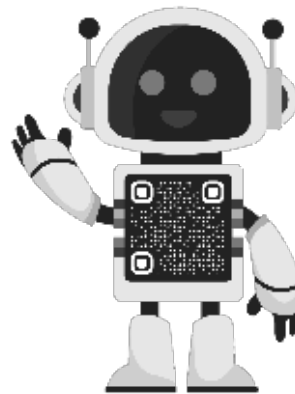
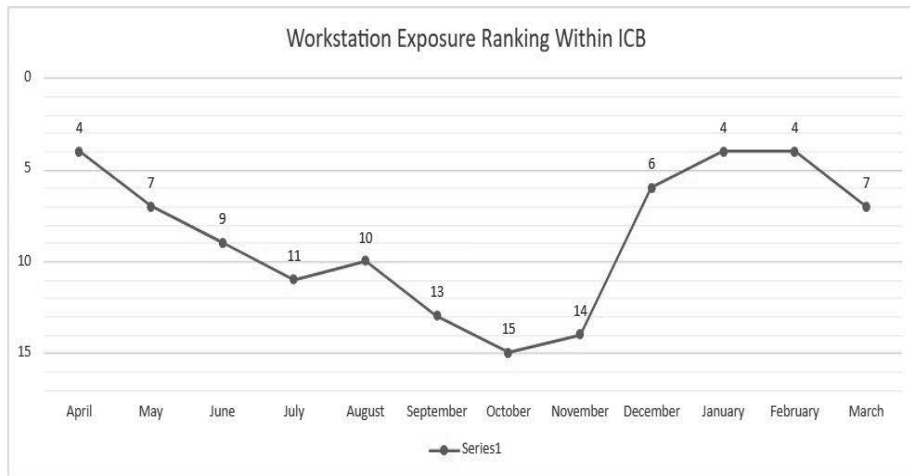
Managing **out-of-support software** in the NHS poses significant risks. Outdated software can lead to security vulnerabilities, making systems susceptible to cyberattacks and data breaches. This can compromise patient data and disrupt essential healthcare services. Additionally, unsupported software often lacks compatibility with newer technologies, leading to inefficiencies and delays in patient care.

Updating software ensures that the NHS can maintain robust security measures, improve system performance, and enhance interoperability between different healthcare systems. This is crucial for delivering high-quality, timely patient care and safeguarding sensitive health information.

Cyber Report - Security

Workstation and Server Exposure scores are metrics used to assess the level of cybersecurity risk associated with workstation and servers within an organisation. These scores help identify vulnerabilities that could be exploited by cyber attackers, allowing the organisation to prioritise and address these risks.

The below data provides our monthly exposure scores and our respective rank within our local ICB.



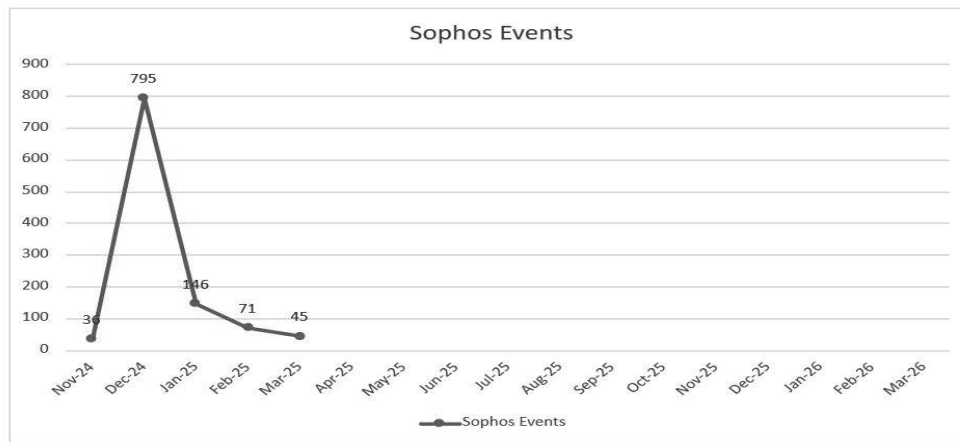
Cyber Report - Security

Sophos Events

Antivirus is essential for NHS systems as it provides robust protection against a wide range of threats, including viruses, malware, and ransomware. It ensures the safety and integrity of patient data by detecting and neutralizing these threats before they can cause harm.

Intercept X, on the other hand, offers advanced endpoint protection that combines deep learning malware detection and exploit prevention. It safeguards NHS devices from sophisticated attacks, ensuring that critical healthcare services remain uninterrupted.

Together, these solutions deliver comprehensive protection for end user devices.



December saw a significant rise in Sophos alerts. Increasing by 2200% due directly to a sequence of work completed by the infrastructure team to update a batch of legacy teams' software.

The work required the use of an approved Microsoft script that despite its approval still alerted within Sophos due to the nature of the changes the script was making.

These alerts were all acknowledged and dismissed.

All remaining events were proactively managed by Sophos and remediated in real time by the system.

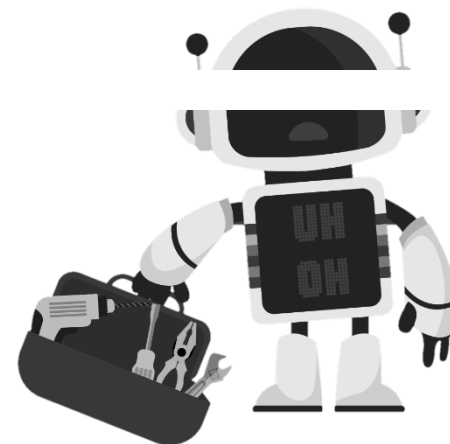
Cyber Report – Infrastructure

Critical system availability refers to the uninterrupted operation and accessibility of essential IT systems and applications. In Bridgewater, these systems include domain services, telephony, backup solutions, and communication networks that Bridgewater rely on to deliver timely and effective patient care as well as its critical corporate functions.

Why is it important?

- **Patient Safety:** Uninterrupted access to critical systems ensures that clinical staff have real-time access to vital patient information, reducing the risk of medical errors.
- **Efficient Operations:** Reliable systems support smooth workflow, allowing all staff to focus on their work without disruptions.
- **Data Integrity:** Continuous system availability helps in maintaining the accuracy and security of records, protecting sensitive information from loss or corruption.

Ensuring the high availability of these systems is essential for maintaining the quality of care and safeguarding patient health and data.



Committee Chair's Report

Name of Committee/Group:	Joint Strategic People Committee		Report to:	Board of Directors
Date of Meeting:	18 June 2025		Date of next meeting:	16 July 2025
Chair:	Abdul Siddique, Non-Executive Director		Parent Committee:	Board of Directors
Members present/attendees:	<u>Membership of the BCHT Committee</u> Abdul Siddique, Non-Executive Director Elaine Inglesby, Non-Executive Director Lynne Carter, Chief Nurse and Deputy Chief Executive (virtually via Microsoft Teams) Nick Gallagher, Director of Finance (virtually via Microsoft Teams) Paula Woods, Director of People and Organisational Development Jo Waldron, Deputy Director of People and Organisational Development <u>Membership of the WHH Committee</u> Julie Jarman, Non-Executive Director (in the Chair) Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director (virtually via Microsoft Teams – from item SPCIC/25/06/050) Ali Kennah, Chief Nurse Jennie Dwerryhouse, Deputy Chief People Officer Jane Hurst, Chief Finance Officer Adam Harrison Moran, Head of Strategic Workforce Development John Culshaw, Company Secretary Kate Henry, Director of Communications and Engagement <u>For WHH and BCH (Joint Directors)</u> Dan Moore (DM) Chief Operating Officer and WHH Deputy Chief Executive Paul Fitzsimmons (PF) Executive Medical Director (from item SPCIC/25/06/048) <u>Observers</u>	<u>Attendees</u> Lynda Richardson, Interim Committee Administrator	Quorate (Yes/No):	Yes
			Key Members not present:	Committee Member: Lucy Gardner (LG) WHH Chief Strategy and Partnerships Officer Jan McCartney (JMC) BCH Director of Corporate Governance Cliff Richards (CR) WHH NED and HWB Guardian (for item SPCIC/25/06/056)

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

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

	Carol Ann Kelly Public Governor, Warrington and Halton			

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
BCHT DIRECTOR OF PEOPLE AND OD REPORT	BAF 4 and 6		The report was presented by Paula Woods for information purposes and provided details on the following: - Staff Survey 2024 – Benchmarking with Cambridgeshire - Community Trust Meeting with Anita Pisani, Chief People Officer and Deputy Chief Executive at Cambridgeshire Community Trust went ahead on the 30th of May. - Alignment of Provider Collaboratives - The alignment of the two provider collaboratives in Cheshire and Merseyside has provided an opportunity to review the ‘community’ programme of work to ensure the continued success of the partnership. - Chartered Institute of Personnel & Development People Management Awards (CIPD) - We are delighted to share with the Committee that Helen Aghanian, OD Practitioner in the People Directorate has made the shortlist for the CIPD People Management Awards in the Michael Kelly Outstanding Student Award Advanced Category. - Warrington Together Workforce & OD Enabling Group (the “WEG”) A meeting will take place on the 23rd of June with Linda Edwards, BI Manager at the ICB to discuss the possibility of hosting the workforce data dashboard. The two Workstream Leads will be in attendance. The contract with Interdigitate has ceased with a handover taking place on the 9th June. Discussion took place around the future and value of WEG and the Committee asked for a deep dive for a future meeting.	The Committee noted the report. Deep dive in relation to future and value of the WEG.
WORKFORCE BRIEF ON NATIONAL, REGIONAL, ICB OR LOCAL WORKFORCE ISSUES (JOINT REPORT)	BAF 4 and 6		This joint report was for noting and provided comprehensive details on the following for information and assurance: - On 15 May 2025, NHS England published the ‘NHS Very Senior Managers Pay Framework’ which applies to all Integrated Care Boards (ICBs) and NHS provider trusts.	The Committee noted the report.

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

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

Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- NHS England Publishes National Recruitment Policy Framework - The changes will impact the whole immigration system including illegal and legal migration routes of work, study, and family. Immigration Changes Announced by Government. While there is currently no set timetable of when these changes will be implemented, they will impact recruitment to the NHS - Agenda for Change Nursing Profiles Review – update provided on joint work across WHH an Bridgewater. - Agenda for Change Mileage Reimbursement Rates Review - no changes to the nationally set mileage reimbursement rates. Deep dive agreed around the progress for August meeting.	Deep dive around Nursing Profiles in August.
BETTER CARE TOGETHER INTEGRATION UPDATE (WORKFORCE AND CORPORATE SERVICES)	BAF 4 and 6		Lucy Gardner presented for information and assurance highlight report for the overall programme of work in addition to the highlight reports for both the Workforce and Corporate Services Workstream was tabled. Key updates included the acceleration of the transaction, staff sharing agreement, the progress with Networks in Common and the draft Culture Plan.	The Committee noted the report.
HEALTH AND WELLBEING UPDATE (INCLUDING HEALTH AND WELLBEING GUARDIAN REPORT)	BAF 4 and 6		Jo Waldron presented the report for information and assurance purposes. The report outlined the Health and Wellbeing activity across the Trust, attendance and evaluation information and future plans. The report also detailed the role of the Health and Wellbeing Guardian who is the Committee Joint Chair for Bridgewater, Abdul Siddique and the valuable contributions made to this agenda.	The Committee noted the report.
IMPROVING PEOPLE PRACTICES BI-ANNUAL REPORT (INCLUDING EMPLOYEE RELATIONS DATA)	BAF 4 and 6		Jo Waldron presented the report for information and assurance purposes. The report provided the Committee with details of current employee relations cases and to provide assurance on the management of these. It provided an overview of the 12-month rolling activity between June 2024 and May 2025. The report provided an overview of the level of employee relations activity, areas of risks, suspensions and wider actions to improve employee relations case management performance.	The Committee noted the report.

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

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 4 and 6		- None	
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK	BAF 4 and 6		- None	
Risks Escalated			None.	

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

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

Committee Chair's Report

Name of Committee/Group:	Joint Strategic People Committee		Report to:	Board of Directors
Date of Meeting:	16 July 2025		Date of next meeting:	20 August 2025
Chair:	Abdul Siddique, Non-Executive Director		Parent Committee:	Board of Directors
Members present/attendees:	<u>Membership of the BCHT Committee</u> Abdul Siddique, Non-Executive Director (in the Chair) Elaine Inglesby, Non-Executive Director Nick Gallagher, Director of Finance (virtually via Microsoft Teams) Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Jo Waldron, Deputy Director of People and Organisational Development <u>Membership of the WHH Committee</u> Julie Jarman, Non-Executive Director Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director (virtually via Microsoft Teams) Jennie Dwerryhouse, Deputy Chief People Officer Adam Harrison Moran, Head of Strategic Workforce Development John Culshaw, Company Secretary Kate Henry, Director of Communications and Engagement <u>For WHH and BCH (Joint Directors)</u> Dan Moore, Chief Operating Officer and WHH Deputy Chief Executive (virtually via Microsoft Teams) Paul Fitzsimmons, Executive Medical Director (virtually via Microsoft Teams) Ali Kennah, Chief Nurse	<u>Attendees</u> Sarah Power, Careers and Apprenticeship Lead Stephanie Carruthers, Nursing Apprentice Rachel Wallis, Guardian of Safe Working Hours (virtually via Microsoft Teams) Laura James, CBU Manager (virtually via Microsoft Teams) Lynda Richardson, Interim Committee Administrator	Quorate (Yes/No):	Yes
			Key Members not present:	Committee Member: Lucy Gardner, WHH Chief Strategy and Partnerships Officer Jane Hurst, Chief Finance Officer Paula Woods, Director of People and Organisational Development Jan McCartney, BCH Director of Corporate Governance

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	Observers Carol Ann Kelly, Public Governor, Warrington and Halton (virtually via Microsoft Teams)			
Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
BCH – STAFF STORY. DEGREE NURSE APPRENTICE – APPRENTICESHIP JOURNEY	BAF 4 and 6		Stefanie Carruthers, Degree Nurse Apprentice shared her Apprenticeship Story with the Committee. Stefanie started as a Healthcare Support Worker with no NHS background having worked in Customer Services and Estate Agency in the past. Stef shared how she never imagined being given the opportunity to begin a career in Nursing whilst being paid to do a job she loves and her perception that Apprenticeships were for young workers only. Stef shared her positive experience of joining with a cohort of 15 other Apprentices, sharing experiences and the positive support she received from members of the Apprenticeships Team, Practice Education Facilitators and of course the operational teams on the ground.	The Committee noted the update and welcomed hearing about such a positive experience.
DEEP DIVE – BCH WELLBEING AND SICKNESS ABSENCE POLICY			Tania Strong, Head of HR presented on BCH's journey as an Early Adopter of the North West (NW) Wellbeing Policy following an agreement to prioritise by the NW HRD Network: - A completely new way of working for the Trust, with a move away from traditional triggers in favour of working to support the whole workforce by keeping those who are in work, well. - Sickness rates in the Northwest have been the highest in the country for some time and current/previous approaches and employer policies have not changed this. - Impact on Productivity due to presenteeism, patient safety issues due to staff struggling with wellbeing etc, time spent on absence and not on keeping staff well. - Stronger focus on informal stages and wellbeing action plans	The Committee noted the report.

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- Steps to implementation, including a Board commitment to the new way of working. - Impact: Initial rises in absence which were anticipated having taken learning from other locals Trusts who had moved away from triggers. Not a significant outlier across Cheshire and Merseyside. - Consideration that austerity on the rise, integration potentially playing a part, previous policy put pressure on staff to return unwell – presenteeism. - Overall staff felt the policy was more supportive of their wellbeing - Overall 88% of managers were comfortable with the Policy but some did express uncertainty in its application, particularly the setting of improvement targets – the HR Team are working with managers to address this. - WHH NED's and Execs expressed their concerns about the removal of triggers and the impact on managers.	
BOARD ASSURANCE FRAMEWORK	BAF 4 and 6		Jo Waldron presented the BAF. No suggestions for amendments at this time. Potentially an emerging risk around Resident Doctors Industrial action. Bridgewater don't have Resident Doctors, however consideration of the system impact.	The Committee noted the report.
BCHT DIRECTOR OF PEOPLE AND OD REPORT	BAF 4 and 6		The report was presented by Jo Waldron on behalf of Paula Woods for information purposes and provided details on the following: - Update on WEG progress. Committee expecting a deep dive into the WEG and whether it's sustainable given the current climate and lack of engagement. - Paula is the CPO aligned to the Standardising of Medical & Dental Bank Rates Workstream – Cheshire & Merseyside. - On behalf of NHS England, the NHS North West Leadership Academy are inviting contributions to the development of the national NHS Leadership and Management Framework – Paula has put forward her interest.	The Committee noted the report.
WORKFORCE BRIEF ON NATIONAL, REGIONAL, ICB OR			This joint report was for noting and provided comprehensive details on the following:	The Committee noted the report.

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
LOCAL WORKFORCE ISSUES (JOINT REPORT)			- The BMA will be asking members if they are willing to take part in industrial action with the indicative ballot starting on 21 July and closing on 1 September. - The government has published its employment rights bill (ERB) roadmap, giving clarity to employers and workers on the timescale for these changes to employment law. - The 10-year Health Plan for England was published on 3rd July 2025 with a supporting workforce plan expected later this year. - National WRES and WDES Reports Published	
WORKFORCE INTEGRATED PERFORMANCE REPORT	BAF 4 and 6		Jo Waldron presented the paper for information and assurance purposes. Indicators are presented in the form of SPC's. All indicators, but one, are within the control limits and are making improvements, the exception being absence. The deep dive presented earlier highlighted the progress and plans identified to continue to try to address this.	The Committee noted the report.
BCH PEOPLE STRATEGY – BI-ANNUAL UPDATE	BAF 4 and 6		The report was presented by Jo Waldron for information and assurance purposes. It provided the Committee with a high-level summary on the Trust's progress in the delivery of the NHS People Plan, People Promises and the Trust's People Strategy. The report highlighted the operational delivery of the Strategy via the People Operational Delivery Council, the focus on reviewing the data via the People Dashboard, the details of workstreams delivered over the last 6 months and how it has impacted on the People Indicators and Staff Survey results.	The Committee noted the report.
BETTER CARE TOGETHER UPDATE (WORKFORCE AND CORPORATE SERVICES)	BAF 4 and 6		Adam Harrison-Moran provided an update to the Committee on the recent progress within the Workforce and Corporate Services Workstream. The Better Care Together highlight reports were presented which detail achievements in this period and next steps.	The Committee noted the report.
BCH ANNUAL WORKFORCE ASSURANCE REPORT	BAF 4 and 6		The report was presented by Jeanette Hogan for approval purposes before escalation to Board.	The Committee noted the report and approved for

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
				escalation to Board.
FACILITIES TIME OFF ANNUAL REPORT	BAF 4 and 6		The report was presented by Jo Waldron for approval purpose before escalation to Board. Data for 2024/25 shows a minor increase of 1.29 wte in TU representative numbers, a move away from 0% activity towards the 0-50% bracket of activity which is now the largest bracket of activity rates for the Trust. There has also been some increase in trade union activities, which may be attributed to national pay disputes and associated industrial action during 2023/24. The overall proportion of the pay bill has reduced from 0.08 to 0.07%. This has remained relatively static over the last 4 years.	The Committee noted the report and approved for escalation to Board.
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 4 and 6		- BCH Annual Workforce Assurance Report - Facilities Time off Annual Report	
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			Emerging risk in relation to the potential system impact of pending Resident Doctor Industrial Action.	
Risks Escalated			None.	

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STRATEGIC PEOPLE COMMITTEE IN COMMON

AGENDA REFERENCE:	SPCIC/25/07/079			
SUBJECT:	BCH Annual Workforce Assurance Report			
DATE OF MEETING:	16 July 2025			
ACTION REQUIRED:	For information			
AUTHOR(S):	Jeanette Hogan Deputy Chief Nurse Kathryn Sharkey Head of Workforce			
EXECUTIVE DIRECTOR SPONSOR:	Lynne Carter			
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 provides an annual summary of the clinical workforce for 2024/25 and assurance of the systems in place for monitoring of the impact of future workforce planning.			
	Due to the complex and the different range of services that Bridgewater delivers, the service lines within the report have been aggregated only where applicable to enable meaningful and transparent interpretation. The report provides a triangulation of workforce data and service level operational commentary on the actions in place to support staff and service delivery. The commentary details –			
	• Establishments vs Actual FTE • Sickness/Turnover • Risks over 12 • Workforce Initiatives • Apprenticeships/Skill mix • Any mitigating actions • Service Pressures			
	There are a limited number of safer staffing tools for use in Community services, the Community Nursing Safer Staffing tool (CNSST) and the Safer Nursing Care Tool (SNCT) are being implemented in 2025 in District Nursing / Matron services and Padgate House Intermediate Care unit respectively. The results to inform establishment setting will be available in Q2 25/26.			
Future annual workforce assurance reports will capture professional judgements and red flag information. Work is continuing to monitor the daily core staffing daily core staffing				

	reporting using the e roster system has commenced across all clinical services with reporting access via Qlik. Quarterly Workforce Assurance meetings will be establishment in 2025/2026 with Borough Leads, Deputy Chief Nurse, Deputy Chief Operating Officer, Head of Workforce, Assistant Director of Finance and Head of Information to examine skill mix, service pressures, risks, reported professional judgements/red flags and workforce initiatives. To support future reports, the Deputy Chief Nurse and Head of Workforce are working with the Performance Team to build dashboards for triangulation of quality, workforce and financial data.		
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision
RECOMMENDATION:	The Strategic People Committee in Common is asked to note the workforce Assurance Report prior to being reported at the BCH Trust Board.		
PREVIOUSLY CONSIDERED BY:	Committee	Not Applicable	
	Agenda Ref.	N/A	
	Date of meeting	N/A	
	Summary of Outcome	N/A	
NEXT STEPS: <i>State whether this report needs to be referred to at another meeting or requires additional monitoring</i>	Submit to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
	None		

STRATEGIC PEOPLE COMMITTEE IN COMMON

SUBJECT	Annual Workforce Report	AGENDA REF:	SPCIC/25/07/079

1. BACKGROUND/CONTEXT

- 1.1** The report provides an annual summary of the clinical workforce for 2024/25 and assurance of the systems in place for monitoring of the impact of future workforce planning.
- 1.2** The NQB (2016) and Developing Workforce Safeguards (NHSI, 2018) recommendations support NHS providers to deliver ‘the right staff, with the right skills, in the right place at the right time’. Whilst the NQB guidance was developed to support nursing safer staffing in hospitals, the principles and recommendations are acknowledged as best practice. NQB recommends that Trusts should provide an annual workforce assurance report to the organisations Trust Board.
- 1.3** Due to the complex and the different range of services that Bridgewater delivers, the service lines within the report have been aggregated only where applicable to enable meaningful and transparent interpretation. The report provides a triangulation of workforce data and service level operational commentary on the actions in place to support staff and service delivery.

2. Annual Workforce Report by Borough/ Service

2.1 Adult Services – Halton

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)2024/2025	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Infection Control Assurance – Dept	6.80	6.80	8.20	7.75%	0.00%	0.80	0.00	0

Establishment v's Actual FTE - The service has an established staffing of 6.8 wte, as of the 31st of March the service has in post 8.2 wte. The increase on FTE is due to funding for TB services.

Sickness / Turnover - Rolling sickness absence stands at 7.75% this is higher than the trust target. The service has had 2 staff both go on long term sickness absence. The Long Tern Sickness absence episodes ended in December 2024 and January 2025. Low staff turnover (0%) is reported within the team with no leavers reported within this period from the clinical team.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - This team has undergone consultation to combine with the Bridgewater IPC team to improve resilience, develop skill mix, improve career opportunities and will release efficiencies.

Apprenticeships / Skill Mix - Good Skill mix with emphasis on both specialist and highly specialist nurses. This will be supported with the integration of the IPC service within Bridgewater. Admin support completing Apprenticeship in Data Essentials

Any Mitigating Actions - Organisational Change Consultation complete with new working model established.

Service Pressures – This is a small team covering 3 boroughs.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Virtual Wards – Dept	8.88	7.88	7.88	6.59%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - When originally modelled this service had in establishment 8.88 wte staff. As of 31st March 2025, the service is reporting 7.88 wte staff.

Sickness / Turnover - Rolling sickness remains above the trust and sickness/absence is proactively managed at 6.5%. Turnover for the year stands at 0%

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - Work is underway to standardise and consolidate Halton and Warrington VW teams. This will explore an integrated approach to delivery.

Apprenticeships / Skill Mix - Skill mix heavily focused on B7 and 8a roles due to patient complexity and autonomous nature of out of hospital care. Skill mix will be reviewed as part of the review of both Virtual wards across both boroughs within Bridgewater. New model being explored to deliver safe, high quality Virtual ward provision within targeted financial envelope.

Any Mitigating Actions - Work has commenced to look at the options for closer partnership working of the virtual wards. This aims to minimise any identified risks, maximise efficiency and support continued effective delivery of patient care.

Service Pressures – The service operates as part of an integrated approach with Halton Integrated Care and Frailty Service, this necessitates a 2-hour response time during high outturn in a hospital services. The financial changes to the funding stream has resulted in a proposal for a decrease in funding across virtual wards. This will create a stranded cost within the team. This is to be explored as part of the partnership working meetings. Further discussions to be undertaken with Mersey and West Lancashire NHS Trust who host the funding.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Comm Neuro Rehab Service – Dept	4.68	3.75	3.75	5.58%	14.13%	0.00	0.53	0

Establishment v's Actual FTE - The services establishment was 4.68 staff. At month 12 the service reported 3.75 staff in post.

Sickness / Turnover - Sickness is being managed but remains above target at 5.58%. This is a small team so any absences/leave adversely impact on the sickness position.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - In January 2025 the service recruited to a shared funded post with Warrington Neuro for a Neuropsychologist (Band 8D).

Apprenticeships / Skill Mix – Limited opportunities for skill mix in a small team. Following the Integration clinical summit, discussions are underway to explore opportunities with the hospital and Warrington neuro teams.

Any Mitigating Actions - Joint post recruited to within Neuropsychology to manage issues with recruitment. This has reduced resource across both boroughs, but has secured some permanent cover, negating the need for costly agency/bank.

Service Pressures – Due to being a small service- easily impacted by sickness /absence. Service has a restricted specification, and delivers to a very different cohort than its Warrington counterparts, making cross cover difficult.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community Matrons Halton -Dept	10.20	10.20	10.00	4.60%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - The service has 10.20 staff in the establishment and 10 in post as at 31st March 2025.

Sickness / Turnover - Rolling sickness remains below target and all sickness is proactively managed. The service has a 0% turnover rate and has had no leavers in the last 12 months.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives – An internal quality improvement initiative is being led across Halton and Warrington Matron services to review the clinical model of delivery and optimise outcomes.

The Community Nursing Safer Staffing Tool (CNSST) is being introduced in June 2025, this will provide information to inform establishment setting in the service.

Apprenticeships / Skill Mix -1 staff are due to complete master's module, Advance Clinical Practitioner programme, with 2 continuing the pathway.

Any Mitigating Actions – (see workforce initiative)

Service Pressures – Caseload management practices are being explored as part of the quality improvement workstream.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community Palliative Care – Dept	8.20	7.80	7.93	6.45%	7.63%	1.00	0.60	0

Establishment v's Actual FTE - Service shows 8.2 in the establishment and 7.93 in post on 31st March 2025.

Sickness / Turnover - Sickness for the team is above the trust target- this is due to short term sickness.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - The service is under review with Warrington to look at opportunities for further integrated working to add resilience to the palliative offer for both boroughs. A medical Consultant already covers both boroughs within their existing role.

Apprenticeships / Skill Mix –Skill-mix appropriate to meet service need

Any Mitigating Actions – Service is under review with Warrington to look at opportunities for further integrated working to add resilience to the palliative offer for both boroughs.

Service Pressures – Previous high overtime costs within the service, high acuity and increased demand for patients requiring end of life care.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Continence - Dept	6.20	5.31	5.31	0.40%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - The Continence service has in its establishment 6.20wte. As of 31st March, there are 5.3wte in post

Sickness / Turnover - Service has a rolling sickness absence percentage of 0.4% this is well below the trust target; The service has retained staff and has a 0% turnover reported in 2024-2025.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - The service is working with the Warrington in relation to joint working to increase resilience and sustainability.

Apprenticeships / Skill Mix - Skill-mix appropriate to meet service need

Any Mitigating Actions – Cross working to be explored ahead of planned maternity leave to ensure safe coverage of the service.

Service Pressures Service has a staff member due to go on maternity leave- this will have an impact on this already small service. Option for cross cover support is currently being explored ahead of leave

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
District Nursing Halton	81.39	72.59	80.10	6.17%	11.64%	16.50	8.89	0

Establishment v's Actual FTE - In 2024-25 the District Nurse service had an establishment of 81.39, in post on 31st March were 80.10 wte.

Sickness / Turnover - Rolling sickness absence stands at 6.17 % which is above the trust target. All sickness is managed within the teams effectively .

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - The service has supported 2 x SPQ students to undertake their studies in 2024-25 and is about to take on another 2 . The service has successfully supported Health Care Assistant staff to undertake their Trainee Nurse Associate training. In 2024-25 the service has a legacy mentor in post funded non recurrently by NHSE to support new preceptees-

Clinical quality and mentorship is provided by the Clinical Practice Educator and a Clinical Lead. The senior community nurse roles were introduced to support career development in the service.

The Community Nursing Safer Staffing Tool (CNSST) is being introduced in June 2025, this will provide information to inform establishment setting in the service.

Apprenticeships / Skill Mix – The service continues to develop band 5 Community Nurse via the SPQ qualification. A further 2wte B6 (SPQ) are expected to be out of practice in year. Three staff have recently completed the Trainee Nurse Associate Apprenticeship, two of which leave to start Nurse training later on in the year which the service will look to replace. Two members of the team are completing HCA apprenticeships.

Any Mitigating Actions – Work underway between the Quality team and Associate Directors to deliver a new model of community nursing that is fit for the future and supports staff retention. This work is referred to as the 'We are one community Nursing' programme.

Service Pressures - Patient demand and demands of the organisation with changes to service delivery. High levels of Maternity Leave throughout the year.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
DN OOH Halton - Dept	12.76	10.95	10.91	3.97%	20.73%	1.49	2.27	0

Establishment v's Actual FTE - 12.76 wte showing the established budget and 10.91 wte in post as at 31st March 2025.

Sickness / Turnover - Rolling sickness below target within the team. Turnover high at 20.73% service has had 2.7 % leavers and 1.49 % starters in this reporting period.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - Service working to change service delivery to accommodate breaks with the night shift. This is supported by HR. Service are trialing new triage system to improve response and create efficiencies.

Apprenticeships / Skill Mix - Skill mix has been reviewed and no changes identified at this time.

Any Mitigating Actions – Use of bank and agency to cover turnover and the gaps in vacancies to support service delivery.

Service Pressures - Covering transition time between 5pm-6pm with Halton DNs day shifts.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Heart Failure Halton - Dept	6.40	6.40	6.40	4.14%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - The service has 6.4 wte staff in posting month 12 and 6.4 wte staff in the establishment.

Sickness / Turnover - Low sickness and 0% turnover. The service is below the trust target for their sickness. The service has had no leavers or starters within a rolling 12

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives – No workforce initiative required for the service.

Apprenticeships / Skill Mix - No current vacancies. Skill mix is weighted towards B7 practitioner due to complexity of care.

Any Mitigating Actions – No mitigating actions required.

Service Pressures - Service have commenced joint working with Widnes PCN and the local hospital to focus on a heart failure community hub project. This will change the way services are delivered, increasing partnership working and seamless care.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Podiatry & Biomechanics - Dept	13.81	12.05	12.65	2.13%	8.09%	0.60	1.00	0

Establishment v's Actual FTE - The service is reporting 13.81 wte staff in their establishment, with 12.65 in post as at 31st March 2025.

Sickness / Turnover - The rolling sickness absence figure remains below target and the rolling turnover stands at 8.09% The service has had 1 x 0.6 wte staff member leave and 1 wte join in this reporting period

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - The service has reviewed their skill mix to ensure a career pathway from band 4 to band 7. The service requires higher banded posts due to the nature of the client group. The service has recently undergone a workstream looking at changing the eligibility criteria for the service. This will result in a higher acuity of patients accessing the service. This has been approved with commissioners and via quality impact assessment process.

Apprenticeships / Skill Mix - Skill-mix appropriate to meet service need

Any Mitigating Actions – Review of SLA to concentrate on medium to high-risk patients

Service Pressures - High waiting lists due to volume of referrals into this service Podiatry nationally hard to recruit.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Speech & Language Therapy Service – Dept	8.87	8.87	8.67	2.18%	9.01%	0.60	0.80	0

Establishment v's Actual FTE - 8.87 wte in the establishment and as at 31st March 2025 there was 8.67 in post.

Sickness / Turnover - Sickness levels remain below target at 2.18%, staff turnover is highlighted at 9%, In the year the service has had 0.8 wte leavers and 0.6 wte starters.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - New system of triaging introduced at the end of 2024 which ensures that the recorded figures for the waiting list is a true representation of patients who are appropriate for the service.

Apprenticeships / Skill Mix – The service is reviewing the skill mix due to increased patient complexity.

Any Mitigating Actions – New system of triaging introduced at the end of 2024 which ensures that the recorded figures for the waiting list is a true representation of patients who are appropriate for the service.

Service Pressures - Capacity and demand issues. Difficulty to ensure Priority 1 patients are seen within 10 days as per service spec. Difficulties locally and nationally in recruitment. Small team-easily impacted by sickness/absence.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Stroke Service – Dept	1.48	1.48	1.48	0.74%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - The stroke service has 1.48 wte staff in the established budget and 1.48 wte in post.

Sickness / Turnover - Rolling sickness absence is low , below target at 0.74%. There has been no turnover in the team.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - This is a small service with limited opportunities for workforce initiatives.

Apprenticeships / Skill Mix – Skill mix appropriate to meet service needs.

Any Mitigating Actions – Options to integrate this team are being considered to increase resilience.

Service Pressures - Service is small so is easily impacted by sickness/absence.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Treatment Room - Dept	9.30	10.17	9.83	14.91%	14.00%	2.40	1.40	0

Establishment v's Actual FTE - Service has 9.30 wte staff in its established funding.

Sickness / Turnover - Rolling sickness has been high for the service: 14.91% this can be attributed to a number of long-term sickness absences. The turnover % for the service appears also high at 14% however this can be attributed to 2.4 starters and 1.4 wte leavers.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives – Staff training and development plan in place.

Apprenticeships / Skill Mix - Skill mix has been reviewed

Any Mitigating Actions – The service has in place an action plan to support the review and development of the treatment rooms, ensuring efficient management of capacity and demand.

Service Pressures - Demand within community. Capacity and demand, increased expectations of deliverables (injectable medication e.g. B12) Availability of appts for those leaving secondary care.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Urgent Care Centre Halton - Dept	28.80	24.00	22.00	12.69%	20.00%	5.40	4.60	0

Establishment v's Actual FTE - 28.20 wte in the establishment and 22 wte in post on 31st March 2025.

Sickness / Turnover - High sickness (12.69%) in month 12, this is above the Trust target. Turnover level high also at 20%. Service has seen 5.4 wte starters and 4.6 wte leavers

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives - Staff have transferred to NHSP to reduce agency expenditure.

Apprenticeships / Skill Mix - Skill mix is reviewed at regular intervals to ensure high standards of patient care is delivered, one member of the team currently on Msc Advanced Clinical Practitioner programme. Staff due to commence clinical examination and diagnostics and V300 NMP throughout the year to advanced level of skill.

Any Mitigating Actions – Use of NHSP and Agency.

Service Pressures - High demand service. Unexpected, complex arrivals can push waits over 4-hour threshold. Service has a high turnover which is common for UTCs. Reduced staffing levels has an impact on safe service delivery.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Wheelchair Spec Seating - Dept	7.10	5.61	7.21	6.74%	15.60%	3.21	1.00	0

Establishment v's Actual FTE - Service has 7.1 wte staff in its established budget and 7.21 wte contracted in month 12.

Sickness / Turnover - High staff sickness (6.74%) means the service is above the trust. Turnover stands at 15.6%. The service currently has one band 7 vacancy.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - The service now has in post a band 5 rotational therapist – this is a new addition to the service.

Apprenticeships / Skill Mix – Skill mix is appropriate for service need.

Any Mitigating Actions – The service and operational manager have been working with the ICB to look at a new service criteria that will support more effectively delivery and cease element of the service.

Service Pressures - Increasing demand for the service.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community Intravenous Therapy (IV) Service Halton - Dept	2.80	2.80	3.00	4.33%	0.00%	0.00	0.00	0

Establishment v's Actual FTE - The service has in their established budget 2.8 wte staff, currently the service has 3 wte staff.

Sickness / Turnover - Sickness has remained within target and turnover stands at 0%. This is a small team so any absences/leave adversely impact on the sickness position.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives - This is a small team which already operates as part of an integrated team with Warrington.

Apprenticeships / Skill Mix - Small team with limited opportunities for skill mix- service already integrated with Warrington IV team.

Any Mitigating Actions – Working with the Warrington team to support service delivery.

Service Pressures - Small team- but integrated working with Warrington supports the team and vice versa.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Intermediate Care & Frailty - Dept	18.28	16.16	17.16	8.61%	11.28%	1.00	1.88	0

Establishment v's Actual FTE - The service has 18.28 wte staff in the establishment and as at 31st March 2025 the staff in post was 17.16.

Sickness / Turnover - The service has an above average sickness rate; this is higher than the trust target (8.61%). The rolling turnover of the service is 11.28% with one staff starting and 1.8 leaving in this time period.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives – Working in collaboration with Halton Virtual Ward Team for staff resilience and service delivery.

Apprenticeships / Skill Mix - Skill mix is appropriate for service need.

Any Mitigating Actions – Service currently works in collaboration with the Halton Virtual ward Team.

Service Pressures - The HIACF service is pressure to meet 2-hour response times. Sickness has been high which has impacted on the team. Funding streams for both elements of the service differ with HICAF aligned to WHHFT and the virtual ward funded by Mersey and West Lancs NHS Trust.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Driving Assessment Service - Dept	11.48	8.76	11.47	1.13%	33.63%	7.09	3.40	0

Establishment v's Actual FTE - Service has 11.48wte in the establishment. At month 12 the service had 11.47 wte staff in post.

Sickness / Turnover - The rolling sickness for the service is below target at 1.13%. Turnover is reported at 33.63% with 7.09 new starters and 3.4 leavers.

Risks over 12 - The service is currently reporting no risks 12 or above

Workforce Initiatives – No workforce initiatives in place for service

Apprenticeships / Skill Mix - Service now has a band 5 rotational post for therapies to support growing our own and upskilling new AHPs.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures - Balance of assessments undertaken against income from DfT. Move to new premises has increased pressure on the service.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Wellbeing Service - Dept	3.19	3.19	2.40	0.43%	57.34%	0.60	1.60	0

Establishment v's Actual FTE - Service has in their established budget 3.19 wte staff, currently they have in post 2.4 wte. Staff. The service has one band 6 part time vacancy.

Sickness / Turnover - Sickness for the service is reported at 0.43% this is below the trust target. Turnover appears high as this is such a small team. This is a small team so any absences/leave adversely impact on the sickness position.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - No workforce initiatives in place for service.

Apprenticeships / Skill Mix – Skill mix appropriate for service need.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

2.2 Adult Services – Warrington

Service	01 April 2024 - 31 March 2025							
	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Wheelchair & Spec Seating Team – Dept	12.00	11.80	10.20	6.74%	14.54%	0.00	1.60	0

Establishment v's Actual FTE – The difference in establishment and actual is due to a reduction in 1 day from B6 OT. It was agreed at the time that this would be kept in the budget to fund a progressive post from B5 to 6.

Sickness / Turnover - The service experiences sporadic long-term sickness. The service currently has a 0.4 WTE on LTS. This LTS is being managed in accordance with trust policy. The service has had 2 leavers. 1x 1.0 WTE B3 1x 0.6 B2. The service has been able to absorb the workload within each role effectively.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - No workforce initiatives in place for service.

Apprenticeships / Skill Mix - The service has no apprenticeships. 1x progressive post from B5 to 6 – has been in post for 18 months.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – The service criteria has been changed with stopping provision for social usage from April 2025, with commissioners approval. A QIA has been completed. The service is communicating the change with service users,

Establishment v's Actual FTE - The service has 1.0wte band 7 vacancy following the team leader leaving for development opportunities, this has not been recruited into due to funding not being decreased over the year.

Sickness / Turnover – low turnover.

Risks over 12 - The service is currently reporting no risks 12 or above.

Workforce Initiatives - Workforce model is an overall collaborative approach with WHH who provide the medical cover. The service is exploring several PDSA cycle pieces of work to improve efficiency. To ensure bed numbers remain high and increase where possible, the usage of Matrons and ECHST is utilised as required to support business continuity.

Apprenticeships / Skill Mix - There is currently one admin apprentice within the service.

Any Mitigating Actions – Capacity and demand work underway.

Acuity and dependency tool being piloted to support utilisation and productivity.

Service Pressures – Due to high acuity levels of patient's bed capacity numbers have remained at 14 for the last quarter. Due to the workforce model exceeding the income for virtual wards's, vacant posts haven't been recruited to and currently are removed from the workforce model. Due to vacancies, the matron and ECHST have supported the service in times of escalation. Staff have and remain on external training coursed. New staff to the organisation have had to be onboarded in the last 6 months.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
OCATS Warrington – Dept	24.39	23.76	20.35	2.56%	19.11%	0.64	4.30	0

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Virtual Wards - Dept	9.00	4.88	8.56	2.08%	14.88%	3.88	1.00	0

Establishment v's Actual FTE – The budgeted establishment was 24.39 and the staff in post was 20.35 as at 31st March 2025. The team had vacancies and was seeking to appoint a band 7 position on a permanent contract.

Sickness / Turnover – Sickness within this service is reported as a high percentage against the trust target, this is a mixture of long- and short-term sickness. All sickness is managed as per trust policy.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – Current recruitment of B7 physio contract on permanent contract

Apprenticeships / Skill Mix – The service currently has 3 clinical and 1 admin apprenticeships ongoing .

Any Mitigating Actions – Recruitment for Band 7 physio to improve capacity and capability. Flexible use of existing team members to manage peaks in demand. Monitoring of DNA rates with mitigation plans to follow. Continued support of apprentices as a long-term investment in workforce development.

Service Pressures – A reduction in Band 6 staffing has limited the number of available rehabilitation gym class slots. This has led to longer waiting times for both initial appointments and follow-up sessions. As a result, service users are experiencing extended gaps between sessions, which is contributing to a rising rate of non-attendance (DNAs) for gym appointments. Increased waiting times for both initial assessments and follow-up gym sessions, Higher DNA rates, linked to longer gaps between B6 led gym sessions.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community Intermediate Care Team - Dept	28.20	30.25	27.39	6.94%	12.21%	0.80	3.52	0

Establishment v's Actual FTE - The service was over established at the start of 2024. Staff headcount is now running slightly below establishment due to 1 staff member retiring and 2 staff leaving posts for other opportunities.

Sickness / Turnover – Sickness absence has been impacted by 1 staff member being LTS.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – The service is currently supporting three apprentices: one OT pathway (Band 3 Therapy Assistant to Band 5 OT), one physio pathway (Band 3 AP to Band 5 physio), and one therapy assistant pathway (Band 2 AP to Band 4 AP).

Apprenticeships / Skill Mix – The service is currently supporting 3 apprentices to develop. 1 OT pathway 1 physio pathway and 1 therapy assistant pathway.

Any Mitigating Actions – No mitigating actions required for the service.

Service Pressures – While the service itself is not under immediate pressure, there is currently a 3-week waiting list for patients to be seen due to long-term staff sickness.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
D2A - Dept	9.70	6.60	2.60	7.52%	65.21%	0.00	3.00	0

Establishment v's Actual FTE - The Discharge to Assess (D2A) budget line is a funding stream managed by Warrington Borough Council, which includes staffing allocations distributed between the Intermediate Care (IMC) tier and the Urgent Community Response (UCR) team.

Sickness / Turnover – Sickness within this service is reported as a high percentage against the trust target however this is due to the small headcount within this team, all sickness is managed as per trust policy.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – No workforce initiatives required for service

Apprenticeships / Skill Mix – Skill - mix appropriate for service need.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Intermediate Care Bed Based Team - Dept	19.32	18.36	19.92	12.86%	28.84%	4.52	5.52	0

Establishment v's Actual FTE - Measures have been taken to ensure that both the qualified nursing and HCA staff are kept within the financial envelope for the service. However, the service is currently without a band 7 nurse. The recruitment process is ongoing to fill this role.

Sickness / Turnover – Absence is high across the nursing service all staff are being supported back to work and an organisation development programme bespoke for the staff at Padgate has been designed and is being delivered. It is hoped that this will improve resilience of the team and in turn improve sickness absence levels. Staff turnover has been high in the period 24/25 with several staff retiring or moving on to alternative positions outside of the organisation. These posts have all been recruited to.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – Introduction of new roles such as Nurse Associate roles and Band 3 Healthcare Assistants within the service to support service delivery.

Apprenticeships / Skill Mix – Two of the three TNA staff members have qualified and moved into substantive band 4 Nursing associate posts, with the final TNA expected to qualify in September 2025.

Any Mitigating Actions – Monthly safe staffing report completed to monitor staffing levels and triangulate any impact on quality and safety. Annual staff staffing report undertaken in May 2025. Safer Nursing Care Tool (SNCT) to inform establishment setting completed in May 2025 – awaiting outcome report. When staffing levels are below the safer staffing level, bank and agency staff are requested to maintain the provision of safe and effective care.

Service Pressures - Temporary staff shortages due to unforeseen illnesses have resulted in unsafe staffing levels.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Rapid Community response Service - Dept	21.93	19.33	19.21	10.01%	8.30%	1.00	1.60	0

Establishment v's Actual FTE - The funding stream for UCR has proved challenging for the period of 24/25 with further uncertainty around funding as we move into 25/26.

Sickness / Turnover – 10.01% rolling sickness. No specific patterns or trends in sickness absence have been identified.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – No workforce initiatives in place for service

Apprenticeships / Skill Mix – The service has supported a number of apprentices in the past year. One OT apprentice has now qualified and secured a substantive role within the community neuro team. One Physio apprentice has been supported for a period of 2 years and has now transferred over to the OCATs service where she will be moved into a substantive band 5 post qualification. The team are currently supporting 2 trainee ACPs, 1 of which is on the apprentice programme. These staff members are due to qualify in the autumn of 25 with a further 1 apprentice trainee ACP commencing the course in September.

Any Mitigating Actions – When staffing levels are below the planned levels, bank staff are requested to maintain service delivery

Service Pressures - Staffing levels due to short term sickness within the nursing and therapy teams this is being mitigated by use of NHSP.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
ABI Acquired Brain Injury Team - Dept	2.61	0.61	2.61	0.00%	0.00%	2.00	0.00	0

Establishment v's Actual FTE - The team now have a permanent B8D in post (this is a split post with Halton).

Sickness / Turnover – There is a high turnover as they are a small team, two B3 members of the team left during 2024/25. The reasons for leaving were career progression and caring responsibilities.

Risks over 12 – The service is currently reporting no risks 12 or above

Workforce Initiatives – The team have regular workforce planning meetings.

Apprenticeships / Skill Mix – Currently the team has one B2 apprentice rehab assistant, and one B3 apprentice physio. Also, the team are participating the B5 OT rotation pilot.

Any Mitigating Actions – In place for the team are regular team meetings, robust triage system in post, regular safeguarding supervision

Service Pressures - Waiting times increased due to recent sickness in the small team and B5 OT leaving the service. The Parkinson Disease nurse is on maternity leave - this post is covered by a 12mth fixed term post

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Neuro Community Team - Dept	12.21	11.33	12.23	1.93%	11.12%	1.00	1.31	0

Establishment v's Actual – The team have no vacancies as at 31st March 2025.

Sickness / Turnover – There is a high turnover as they are a small team, two B3 members of the team left during 2024/25. The reasons for leave were career progression and caring responsibilities.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – Currently the team has 1 B2 apprentice rehab assistant, and one B3 apprentice physio. Also, the team are participating the B5 OT rotation pilot.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Bladder and Bowel Service - Dept	5.16	5.23	5.23	4.00%	0.00%	1.00	0.00	0

Establishment v's Actual – The team have no vacancies. This team has had a change in FTE from 2024/25 due to a conversion of B5 to B3 hours to increase capacity to follow-up patients and complete product reviews.

Sickness / Turnover – Sickness within the team is below the trust target.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The OD team have conducted several sessions with the team as part of the kinder culture training.

Apprenticeships / Skill Mix – Skill mix appropriate to meet service needs.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – Financial pressures due to continence product spend.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Care Home Support Team - Dept	15.02	12.91	14.60	3.30%	5.81%	1.00	0.80	0

Establishment v's Actual – As at 31st March 2025 the service had a vacancy for a Band 7 nursing post which has been approved via the vacancy Approval panel.

Sickness / Turnover – Both absence and turnover within the team is low.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No initiatives currently planned.

Apprenticeships / Skill Mix – The service has one apprentice in post. This has gone well, and further apprenticeships will be considered dependant on vacancies.

Any Mitigating Actions – No mitigating actions required for service

Service Pressures – Proactive visits sometimes have to be reduced dependent on need. Primary Care heavily scrutinise activity and movement of staff to support wider borough pressures and requirements for business continuity.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Catheter Care - Dept	7.40	7.40	7.20	2.59%	10.95%	0.00	0.80	0

Establishment v's Actual – All vacancies have been recruited to and the team is now fully staffed.

Sickness / Turnover – The team's sickness and turnover is currently below the trust's target.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The service has a joint band 5 RN post with the district nursing team to allow complex and routine patients to be seen without any additional pressure on either team.

Apprenticeships / Skill Mix – The skill mix is appropriate to meet service needs.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community IV Therapy Team - Dept	9.40	9.40	8.40	10.72%	0.00%	0.00	0.00	0

Establishment v's Actual – All vacancies are now recruited.

Sickness / Turnover – Short term absence is within expected parameters. Vacant posts aren't difficult to fill however staff members find development opportunities within the team limited due to staff retention.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Potential integration with WHH to support patient journey. Plan to have an IV Hub at Woolston Brook is currently on hold. Team is very proactive and keen to expand both from a staffing but also service offer perspective.

Apprenticeships / Skill Mix – skill mix appropriate to meet service need.

Any Mitigating Actions – No mitigating actions required for service

Service Pressures – Due to the ongoing staff management, this has left a 1.6wte shortfall within the service. As a result, NHSP has had to be utilised as has reducing opening times of the service and deferring referrals when appropriate. This is in line with the services Business Continuity Plans.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Community Matrons Warrington - Dept	7.91	7.01	7.89	6.41%	13.42%	0.00	1.00	0

Establishment v's Actual – Service is just below establishment at 7.89wte. Vacancies recruited to in 2024; however, this took the service 1wte over establishment. 1wte left the service which brought the cost centre back in line with budget.

Sickness / Turnover – Rolling sickness slightly above Trust target due to long term bereavement leave. Staff turnover high as small team with 1wte leaver.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Community Matron Model work ongoing to improve service provision and standardise care offer across Warrington and Halton.

Apprenticeships / Skill Mix – No apprenticeships in place. Skill mix appropriate to service requirement.

Any Mitigating Actions – Service continues to work alongside Virtual Ward with community bed-based patients to ensure appropriate staff to meet patient need.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Dermatology Team - Dept	16.80	13.60	14.60	8.11%	0.00%	1.00	0.00	0

Establishment v's Actual – : As at 31st March 2025 the budgeted establishment was 16.80 and staff in post was 14.60. This is a service where there are a number of hard to recruit to posts i.e. Dermatology Consultants, band 8b posts.

Sickness / Turnover – Low absence rate and no turnover in year.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Service relies heavily on an external insourcing model for all the medical workforce. The service has used apprenticeships via the Nursing Associate roles. New roles have been sourced utilising monies from income generation (AI) and external Cancer Alliance Funding.

Apprenticeships / Skill Mix – Advance Clinical Practitioner and Nurse Associates apprenticeship roles.

Any Mitigating Actions – Workforce model continues to be a work in progress.

Service Pressures – Service requires significant financial top up funding to make the service financially viable. The service is attempting to transition towards an increase in a nurse led model. Requirements for patient care have increased year on year beyond the capacity of the service. As a result, waiting times increase.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Discharge Facilitation War - Dept	2.60	1.60	2.60	8.46%	0.00%	1.00	0.00	0

Establishment v's Actual – The discharge facilitation team is based within WHH transfer of care hub. There were no vacancies within the service as at 31st March 2025.

Sickness / Turnover – Sickness absence percentages are above the target due to the small size of the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – The service is supporting a band 2 apprentice administrator to develop.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
DN OO Warrington - Dept	11.27	11.29	12.23	11.82%	0.00%	1.00	0.00	0

Establishment v's Actual - Service was over established due to 0.8wte B7 commencing in post. This money was transferred from Directorate Reserve which was 0.8wte. The FTE will reduce moving into 2025 due to B3 reduction in hours. This supports service need as B3 staff not required as much within OOH period since we now require x2 trained staff on overnight in line with syringe pump policy.

Sickness / Turnover – Staff turnover identifies nil staff have left the service. Rolling sickness high due to long term sickness which is typical of an OOH Service.

Risks over 12 – – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Workforce plan to increase resilience within the service due to staff working OOH period with only the on-call manager to approach for support.

Apprenticeships / Skill Mix – No apprenticeships within OOH. Skill mix to be improved with one staff member currently completing V300 and a further 2 staff members requiring clinical exam and diagnostics to improve patient outcomes and experience.

Any Mitigating Actions – Extra B5 support required to promote resilience in the OOH period.

Service Pressures – Ongoing challenges with complex patients requiring intervention overnight often palliative patients requiring complex review and assessment.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
District Nursing Warrington	91.23	79.40	85.13	7.44%	7.19%	15.00	5.92	0

Establishment v's Actual - The current staffing level is below the established due to existing vacancies, all of which are actively being recruited.

Sickness / Turnover – Staff turnover improved in 2024-2025. Sickness absence is higher than trust target due to both short-term and long-term absence. Sickness absence is being managed via the Trust policies and procedures.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – SPQ, Trainee Nurse Associates, and Nurse Degree top-up students are supported within the service to contribute to workforce capacity and ongoing service development.

Apprenticeships / Skill Mix – SPQ, Trainee Nurse Associates, and Nurse Degree top-up students are supported within the service to contribute to workforce capacity and ongoing service. Introduction of new band 6 role within service to support career development and service need.

Any Mitigating Actions – Continue to use NHSP which is within budget to meet clinical requirement. A Warrington adult community nursing capacity call takes place daily to support workload pressures across the directorate.

Service Pressures – Service experiencing ongoing challenges with workload, visits are being deferred once prioritised.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Falls & Rehabilitation Team - Dept	5.40	5.40	5.40	1.76%	0.00%	0.00	0.00	0

Establishment v's Actual - The community falls, and rehab team is fully recruited to.

Sickness / Turnover – Low absence rate and no turnover in year.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – Skill mix appropriate for service need.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
GPC Palliative Care Med Staff - Dept	1.90	1.90	1.90	3.58%	0.00%	0.00	0.00	0

Establishment v's Actual – The service is fully recruited to – 2 medics work across Warrington and Halton service. 1 additional medic has an honorary contract and works at St Rocco's Hospice.

Sickness / Turnover – Low sickness absence and no turnover in year.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – Skill mix appropriate for service. Requirement for all medical roles.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
ICES Community Equipment Stores - Dept (inc Halton and St Helens)	46.50	45.10	45.90	13.14%	28.57%	6.00	13.00	0

Establishment v's Actual – The current staffing level is below the established due to existing vacancies, all of which are actively being recruited.

Sickness / Turnover – Sickness levels remain elevated within the service, attributable to both long-term and short-term absences.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Decontamination staffing has decreased by 6.0 WTE, with 3.0 WTE positions replaced according to the CIP and workforce plan.

Apprenticeships / Skill Mix – Skill mix appropriate for service need.

Any Mitigating Actions – consolidating van routes to increase vehicle capacity utilisation and enhance productivity during travel when in times of BCP due to sickness. Vehicles may be removed from operation if their capacity is covered by other vans. In addition, collection vans are withdrawn on Fridays to facilitate the decontamination team's weekly close-down activities and IPC deep cleaning requirements.

Service Pressures – The ability to react effectively to urgent/priority (same day breakdowns, 24 hour urgent) requests that come into the service when in Business Continuity due to short term sickness.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Palliative Care Clinical Nurse Specialist - Dept	7.60	7.60	6.80	9.22%	11.11%	0.00	0.80	0

Establishment v's Actual – As at 31st March 2025 the budgeted establishment was 7.60 and staff in post was 6.80.

Sickness / Turnover – Sickness absence is above trust target, and all sickness is being managed in line with policy, this is a mixture of short term and long-term sickness, there has been no turnover of staff within this year.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – 1.0 WTE band 7 currently undertaking apprenticeship in advanced clinical practice and is due to complete in September 2025.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Podiatry & Biomechanics - Dept	14.91	12.53	12.40	3.84%	8.98%	1.00	1.12	0

Establishment v's Actual – The current staffing level is below the established due to existing vacancies, all of which are actively being recruited.

Sickness / Turnover – Sickness Absence is low within the team. Turnover high and expected to increase, this is due to having difficult to recruit to posts within the service. National movement of podiatry staff moving to private practice.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Plans in place to develop the support workforce and to retain staff within the service.

Apprenticeships / Skill Mix – Service has worked very successfully supporting the apprentice levy. Three posts have been filled with a further 1 expected within the next financial year. The service is exploring the current skill mix in more detail and looking at a grow your own model.

Any Mitigating Actions – The team is very proactive and as a result score positively on compliments and complaints. Incidents within the service are low. Minimal red flags raised from a patient perspective.

Service Pressures – Demand exceeding capacity and Service has 52 week plus waits. The Service are required to prioritise diabetic foot clinic SLA with WHH.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Single Point of Access Team - Dept	2.20	2.20	2.20	41.84%	0.00%	0.00	0.00	0

Establishment v's Actual – Service is fully recruited to.

Sickness / Turnover - Sickness within this service is reported as a high percentage against the trust target however this is due to the small headcount within this team, all sickness is managed as per trust policy.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – A need for a workforce review has been identified and will commence when appropriate as ongoing challenges with sickness.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – In the event of staff absences within the service, District nurses will assume responsibility to ensure the continuation of service delivery.

Service Pressures – The service has identified that the high level of sickness is causing pressure within the SPA as well as the DN services.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Stoma Care - Dept	2.80	2.60	2.60	1.05%	0.00%	0.00	0.00	0

Establishment v's Actual – As at 31st March 2025 the budgeted establishment was 2.80 and staff in post was 2.60.

Sickness / Turnover – This team has had no turnover of staff within the year and is below the trust target for sickness, any sickness is managed in line with policy.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures – No current service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Tissue Viability - Dept	2.00	2.00	2.00	18.03%	50.00%	1.00	1.00	0

Establishment v's Actual – Following service redesign, Halton and Warrington Teams have merged into one team. The service is fully recruited to.

Sickness / Turnover - Sickness within this service is reported as a high percentage against the trust target however this is due to the small headcount within this team, all sickness is managed as per trust policy.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Integration of the Halton and Warrington TVN service to improve resilience.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Due to reduced service provision risk has been mitigated by Senior Nursing staff reviewing complex wounds to ensure appropriately categorised.

Service Pressures – The service has identified that the high level of sickness is causing pressure within the TVN service for both Halton and Warrington.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Treatment Rooms- Dept	12.00	12.60	11.60	10.24%	6.61%	0.00	0.80	1

Establishment v's Actual – At the beginning of the year the service was over recruited, however our recent 0.8wte leaver has brought us below establishment.

Sickness / Turnover - Rolling sickness is above trust target all sickness is being managed via trust policy this is a mixture of short- and long-term sickness.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for service.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. Further development in the Team could be supported with B6 and B7 completing clinical skills and diagnostics and V300 which would potentially reduce hospital admissions secondary to infection and improve patient journey.

Any Mitigating Actions – District Nursing Team supporting short term sickness absence.

Service Pressures – Ongoing challenges as minimal scope for staff training and service often requires support from DN Service to ensure clinics remain open and patients are seen. Resilience required within the service as this is impacting DNs. Reviewed clinic offer with a view to reduce, however we are funded to provide this number of clinics.

2.3 Children's Services – Halton

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Schools Vacs & Imms - Dept	5.30	4.53	5.67	1.75%	0.00%	1.91	0.00	0

Establishment v's Actual – The service where over establishment as at 31st March 2025 but this will be brought into line for the next financial year due to reduction in hours.

Sickness / Turnover - Turnover low for last 2 quarters. Sickness rate improving.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working offered and taken up by majority of workforce. First Registered Nursing Associate in post now.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – The team are reported as highly performing across C&M partnerships and consistently score positively on patient experience.

Service Pressures – The trust currently delivers the school aged immunisation service across Halton and Warrington Boroughs. The Halton Service will TUPE transfer to Mersey Care NHS Foundation Trust and the Warrington Service will TUPE transfer to IntraHealth on 1st September 2025. The service has established a demobilisation group in order to manage the transition however this continues to be unsettling for staff. Uptake of immunisations has decreased locally and nationally post COVID pandemic and work continues to increase rates.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Development Centre Halton - Dept	5.10	4.05	3.25	1.52%	50.68%	0.60	1.85	2

Establishment v's Actual – As at 31st March 2025 the service was carrying 1.85 vacancies and out to advert for a Band 4 NDP Coordinator.

Sickness / Turnover – High levels of turnover within a small team. 2 members of staff left the team due to retirement and career progression. Low sickness absence rates but due to long term sickness which is currently being supported.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The service is to undergo a rapid intervention, and this will then streamline the MDT with the Community Paediatrics to provide a Neurodevelopmental Pathway to improve service delivery and experience for families and their children and will support a more cohesive team.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Future recruitment of a band 4 NDP Administrator to support the clinicians under the NDNT pathway.

Service Pressures – The NDP experiences a high demand for service with a lack of capacity to meet demand. The service at present does not have enough administrative capacity to be able to put referrals on in a timely manner, to process the referrals and to communicate with parents and carers outcomes of panel meetings relating to diagnosis for their children nor to speak with parents and carers about any concerns they have.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paed Occupational Therapy - Dept	8.39	8.21	8.21	14.25%	12.18%	0.68	1.00	0

Establishment v's Actual – As at 31st March 2025 the service was carrying a band 6 vacancy and was progressing with recruitment.

Sickness / Turnover – High sickness absence and turnover. Long Term sickness within the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working requests approved as appropriate.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. Within the service there is an OT Degree Registered Apprentice.

Any Mitigating Actions – Working with Warrington Team to support the service when required.

Service Pressures – Long-term waits are impacted due staff sickness and difficult to recruitment to roles.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Physiotherapy - Dept	5.38	4.70	5.38	3.90%	19.84%	0.00	1.00	0

Establishment v's Actual – As at 31st March 2025 the service was fully recruited to.

Sickness / Turnover – Sickness absence below Trust target and is being managed via Trust policy and procedures. One member of the team left in 2024/2025.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working requests approved as appropriate.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need across bands 2,3,5,6 and 7.

Any Mitigating Actions – Across working support with Warrington Service.

Service Pressures – Service demand continues to be high and the team are currently supported by Warrington physiotherapy, whilst recruitment underway.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Community Medical Serv - Dept	9.82	8.81	9.25	2.07%	22.14%	2.43	2.00	6

Establishment v's Actual – As at 31st March 2025 the service was carrying an Administration post.

Sickness / Turnover – Turnover due to staff leaving due to retirement. Low sickness absence within the service.

Risks over 12 – This service carries a joint accumulative risk of 20 with Warrington Community Paediatric Service due to the impact of the increased demand for neurodevelopmental diagnostic assessment.

Workforce Initiatives – The team are currently working through a rapid intervention programme in order to apply the C&M stratification tool to all referrals which will facilitate the appropriate prioritisation of appointments. The team have recently received additional funding from ICB to address the long waits for ASD Speech and Language assessments (currently delivered by independent provider).

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need however team are reviewing clinical pathways to ensure best use of total resources.

Any Mitigating Actions – The creation of new NDP Speech and Language Team.

Service Pressures – Demand for service continues to exceed capacity for assessments for Autism and for ADHD for children and young people. The service continues to receive a high number of complaints from families, mostly relating to the long waiting times and a perceived lack of communication from the service.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Spec Disability Nursing Team Halton - Dept	7.85	5.51	7.31	12.38%	0.00%	2.60	0.00	0

Establishment v's Actual – 7.31wte in post at month 12.

Sickness / Turnover – No Turnover within the team. High sickness absence in the team due to long term sickness which is currently being managed.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The team have successfully developed nurse prescribing roles and health care support staff roles over the last few years.

Apprenticeships / Skill Mix – The skill mix within the team needs to be reviewed to support the completion of ADHA reviews, medications and diagnosis.

Any Mitigating Actions – The team liaise with the Warrington specialist nursing team for peer support and clinical supervision.

Service Pressures – Continued high demand for the service has resulted in over 18 week waiting times. The team have developed and are offering new diagnosis workshops within the 18-week RTT timeframe. The team are supporting medical colleagues in undertaking specific assessments (Qb tests), repeat prescribing of medication and undertaking annual reviews / height and weight measurements.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Breastfeeding Support Services Halton - Dept	0.50	1.00	1.00	1.64%	0.00%	0.00	0.00	0

Establishment v's Actual – The team are utilising Family Hubs Funding to manage the 0.5wte hours over establishment.

Sickness / Turnover – Low Turnover and Sickness Absence within the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The Halton Family Hib Programme has allowed the service to test new roles / new ways of working.

Apprenticeships / Skill Mix – The team are working closely with Halton Borough Council and partners to develop staff roles.

Any Mitigating Actions – Family Hubs funding will continue to facilitate additional capacity into the team.

Service Pressures – UNICEF accreditation process preparation underway.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Health Visiting Teams Halton	48.99	42.24	47.60	7.50%	10.95%	8.00	4.96	0

Establishment v's Actual – As at 31st March 2025 the service had 1.39 vacancies. The trust recently secured the 0-19 Halton contract and are progressing towards the new staffing model required within the financial envelope attached to the contract.

Sickness / Turnover – Long term and short-term sickness due to external factors for staff.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Working closely with Family Hubs the service is testing a number of workforce / service delivery initiatives including infant feeding and infant mental health.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. Four Apprentice Specialist Community Public Health Nursing – Health Visiting opportunities supported from October 2025.

Any Mitigating Actions – Working within the Family Hub Partnership to develop multi agency pathways.

Service Pressures – The reduced budget aligned to the service from 1.4.25 will be challenging to manage, new model in development which will be reviewed with a quality impact assessment.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child School Nursing Halton - Dept	26.03	24.79	26.46	8.38%	6.24%	4.81	1.60	0

Establishment v's Actual – The trust recently secured the 0-19 Halton contract and are progressing towards the new staffing model required within the financial envelope attached to the contract.

Sickness / Turnover – Low Turnover and Sickness Absence within the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working to support staff.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. Two Apprentice Specialist Community Public Health Nursing – School Nurse opportunities supported from October 2025.

Any Mitigating Actions – No mitigating actions required for the service.

Service Pressures – The reduced budget aligned to the service from 1.4.25 will be challenging to manage. QIA of the new model will be completed once model is finalised.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
CHILD FAMILY HUBS - DEPT	4.44	4.44	4.04	0.52%	0.00%	2.00	0.00	0

Establishment v's Actual – Fixed term funding received from Halton Borough Council to support the development of new roles / innovation in service delivery.

Sickness / Turnover – Low sickness absence and turnover within the service.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working to support staff.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Family Hubs multi agency steering group exploring opportunities to retain service developments which are able to evidence they are improving outcomes for children.

Service Pressures – Funding likely to cease March 2026 subject to ongoing evaluation of initiatives.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Audiology Services STH - Dept	11.39	10.39	11.39	3.40%	0.00%	1.00	0.00	1

Establishment v's Actual – As at 31st March 2025 the service was fully recruited to.

Sickness / Turnover – Low turnover and sickness absence within the service.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Service redesign took place in 2023 to ensure appropriate leadership and skill mix in place.

Apprenticeships / Skill Mix – Skill mix is limited to Band 5 and above, but the team are exploring a Band 3 apprenticeship.

Any Mitigating Actions – The team are reviewing new and follow up appointments to ensure best use of total resources.

Service Pressures – Vacancies and maternity leave have created some additional pressure and as a consequence the service has seen an increase in the numbers of children waiting, specifically for review appointments. The team have a post funded at 1.0wte band 5 which is a development post and once all competencies are met the post holder will move to band 6 – this will create a financial pressure

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Newborn Screening STH - Dept	6.20	5.00	5.60	5.16%	0.00%	0.60	0.00	0

Establishment v's Actual – As at 31st March 2025 the budgeted establishment was 6.20 and the staff in post was 5.60. 0.60 vacancy was processing through the recruitment process.

Sickness / Turnover – Low staff sickness and turn over within the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The team are to move out of the Whiston Hospital as a base and into The Bridges with the Audiology team. This will improve team building and better patient experience.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Team able to meet demand through offering clinics in variety of areas across Halton, St Helens and Knowsley.

Service Pressures – A number of staff work unsocial hours during weekends which has not been budgeted for at budget setting.

2.4 Children's Services – Warrington

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Breastfeeding - Dept	1.60	1.00	1.60	3.36%	0.00%	0.60	0.00	0

Establishment v's Actual – The service was fully staffed as at 31st March 2025.

Sickness / Turnover – Low sickness and turnover rates within the service.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – New BF support worker posts offer opportunities for staff to learn new skills.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Wider 0-19 team also support infant feeding.

Service Pressures – UNICEF accreditation preparation process underway.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Oral Health Promotion Warr - Dept	1.32	1.32	1.32	5.03%	0.00%	0.00	0.00	0

Establishment v's Actual – The service is fully staffed as at 31st March 2025.

Sickness / Turnover – The team is a small team made up of two members of staff, therefore any sickness absence causes the team to be impacted.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives - New funding to extend supervised tooth brushing programme received. Additional funding will facilitate a growth in the team for a 12-month fixed term basis.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – No mitigation required.

Service Pressures – No Service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Children's LTC Team – Dept	13.23	13.03	13.31	8.62%	13.66%	2.00	1.80	0

Establishment v's Actual – The service is fully staffed as at 31st March 2025.

Sickness / Turnover – Leave reasons due to band 5 nurses seeking career progression as there is limited opportunities with the service due to retention of band 6 roles. Sickness absence within the service remains challenging however the long-term sickness is being actioned.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Band 5,6 and 7 staff are trained and working across all aspects of the service. The band 4 Community Nursery Nurse is being trained to the needs of individual children on the caseload as well as in the phlebotomy service to support the delivery of service.

Apprenticeships / Skill Mix – Skill mix appropriate to meet service needs.

Any Mitigating Actions – No mitigation actions required.

Service Pressures – No service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Family Nurse Partnership – Dept	3.00	3.00	3.00	4.02%	0.00%	0.00	0.00	0

Establishment v's Actual – The service is fully staffed as at 31st March 2025.

Sickness / Turnover – Turnover and absence low during year.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives - FNP local programme is part of a licenced national programme.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. Commissioned as a prescriptive program with defined set posts.

Any Mitigating Actions – No mitigation required.

Service Pressures – No Service pressures.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Health Visiting Teams Warrington	55.19	53.97	52.38	9.70%	8.65%	3.00	4.60	0

Establishment v's Actual – Service reviewing staffing model to ensure it does not exceed contract value.

Sickness / Turnover – Sickness absence is above Trust target and remains challenging however the long-term sickness is being actioned via Trust policies and procedures. Turnover also was challenging, and this was due to promotions and work life balance. The service has worked with the team to introduce flexible working options.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working arrangements in place for the majority of the team.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need. First Registered Nurse Associate in post.

Any Mitigating Actions – No mitigation required.

Service Pressures –Warrington Borough Council seeking assurance that 0-19 contract will not be affected by cost reduction initiatives.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
School Health Advisors Warrington	16.88	14.90	17.45	1.39%	9.89%	4.60	1.60	0

Establishment v's Actual – Service reviewing staffing model to ensure it does not exceed contract value.

Sickness / Turnover – Absence rates low.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Flexible working arrangements in place for the majority of the team.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – No mitigation required.

Service Pressures –Recruitment to band 6 SCPHN post as there is a shortage nationally, therefore importance placed on growing our own SCPHN of the future. WBC seeking assurance that 0-19 contract will not be affected by cost reduction initiatives.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Vaccinations & Immunisation Team - Dept	9.07	6.51	8.63	1.13%	0.00%	1.18	0.00	0

Establishment v's Actual – As at 31st March 2025 service had a 0.44 vacancy.

Sickness / Turnover – Low turnover and absence rates.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Service will TUPE to Intra Health in September 2025.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – No mitigation required.

Service Pressures –The trust currently delivers the school aged immunisation service across Halton and Warrington Boroughs. The Halton Service will TUPE transfer to Mersey Care NHS Foundation Trust and the Warrington Service will TUPE transfer to IntraHealth on 1st September 2025. The service has established a demobilisation group in order to manage the transition however this continues to be unsettling for staff. Uptake of immunisations has decreased locally and nationally post COVID pandemic and work continues to increase rates.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Audiology Services - Dept	3.63	2.63	2.57	0.27%	0.00%	0.00	0.00	0

Establishment v's Actual – As at 31st March 2025 service had a 1.06 vacancy.

Sickness / Turnover – Low sickness absence and turnover.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Skilled mix within the team and internal promotion to the Band 7 role. Recruitment to a Band 5 vacancy is required to support reducing the waiting lists.

Apprenticeships / Skill Mix – A Band 4 hearing screener completing assistant audiologist training. This will enable her to help more in clinics allowing more clinics and reduce waiting lists.

Any Mitigating Actions – Currently using agency within the service and using hearing screening staff who work in school in audiology clinics instead. Band 7 working clinically instead of prioritising team leader tasks.

Service Pressures – DMO1 6-week RTT breaches for initial appointments and long waiting times for review appointments. Demand exceeds capacity.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Community Learning Disabilities Nursing Team - Dept	7.69	8.39	7.20	1.78%	19.12%	0.00	1.49	0

Establishment v's Actual – As at 31st March 2025 the service had a Band 6 vacancy which will be recruited to support increased demand and capacity.

Sickness / Turnover – Low sickness absence rates.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – Skill mix well established within the team. Flexible working requests approved as appropriate.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions – Regular 1-1's with staff, supporting staff emotional wellbeing, peer supervision, constantly looking for ways to develop and adapt the service in line with demands.

Service Pressures -Volume of referrals outweighing capacity in the team. Team also supporting NDP / Community paediatricians via for example undertaking Qb assessments, completing Annual reviews and height and weight measurements.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child community Neuro Developmental Pathway - Dept	6.90	5.20	4.90	6.26%	0.00%	1.00	0.00	0

Establishment v's Actual – New team/ budget line. As at 31st March 2025 the service had 2.00 vacancies progressing through the recruitment process.

Sickness / Turnover – Sickness absence within the service remains challenging however the long-term sickness is being actioned.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The service has developed a new pathway for Autism and has been testing this via SLTs completing Autism Diagnostic Interview. This will be implemented within this next year.

Apprenticeships / Skill Mix – Skill-mix appropriate to meet service need.

Any Mitigating Actions –Speech and Language Therapists within the service have been trained to complete Autism Diagnostic Interviews, which frees up Paediatrician appointments for ADHD, making the service more cost effective. SLT's have also been trained to complete ASD/ADHD triage. Also, prioritisation of admin duties has supported clinicians. The stratification / date transformation of the caseload to identify need and risk. (Seeing children based on risk level rather than wait order).

Service Pressures - Service pressure such as increased numbers of referrals. There are Increased waits within the service and reduced staffing due to maternity / sick leave. The service are completing Clinical Harm reviews.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Comm Med Serv Team - Dept	5.11	5.11	4.80	4.06%	24.44%	1.00	1.21	4

Establishment v's Actual – 0.30wte specialty doctor vacancy. Locum covering consultant paediatrician career break.

Sickness / Turnover – Low sickness absence within the service. Turnover due to retirements.

Risks over 12 – There are 4 risks over 12 that cover the NDP pathway and Community paediatricians. There are long waits across the pathway. The risks are capacity and demand, increased referrals, Clinical harm reviews not being completed and the harm whilst waiting.

Workforce Initiatives – The service has developed a new pathway for Autism and has been testing this via SLTs completing Autism Diagnostic Interview. This will be implemented within this next year.

Apprenticeships/Skill Mix – Current skill mix appropriate to meet service need however workforce plans has identified that an Advance Clinical Practitioner role is required to support the service.

Any Mitigating Actions – Speech and Language Therapists within the service have been trained to complete Autism Diagnostic Interviews, which frees up Paediatrician appointments for ADHD, making the service more cost effective. SLT's have also been trained to complete ASD/ADHD triage. Also, prioritisation of admin duties has supported clinicians. The stratification / date transformation of the caseload to identify need and risk. (Seeing children based on risk level rather than wait order).

Service Pressures - Increased numbers of referrals and not enough new and review patient slots, prescribing, waits within the service and completion of Clinical Harm reviews.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Continence - Dept	3.73	3.73	3.73	0.04%	0.00%	0.00	0.00	0

Establishment v's Actual – As at 31st March 2025 the service is fully staffed.

Sickness / Turnover – Low sickness and turnover.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – School toilet project in partnership with Aqua, ERIC and Healthwatch. Looking to develop a nurse lead service. One member of staff undertaking non-medical prescribing.

Apprenticeships / Skill Mix – Current skill mix appropriate to meet service need.

Service Pressures - Issues with prescriptions. Awaiting ICE access to be able to directly order bladder scans for patients. There is a consistent level of referrals which is increasing size of caseload.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric OT Team - Dept	9.00	9.40	8.40	3.68%	6.74%	0.60	0.60	0

Establishment v's Actual – 0.60 Band 5 vacancy as at 31st March 2025

Sickness / Turnover – Low sickness absence which is due to Long Term sickness which is currently being managed.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – we are working with local special education needs leads on how they can now direct refer. Increased the number of telephone appointments where appropriate to ensure communication with patients.

Apprenticeships / Skill Mix – We are looking into opportunities for a possible band 4 TA post in the future to improve the progression aspects and skill mix for the future, sensory and upper limb training.

Any Mitigating Actions – No mitigating actions required for service.

Service Pressures - Rapidly increasing new referral demands. Not all staff are SENSORY trained.

Limited capacity with current caseloads even after Analysis of each section. Additional assistance to Halton when required to reduce their WL times, this means our capacity to see new patients is reduced during the same period. Additional 1.0wte band 6 funded by ICB to be invoiced.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Physio Team - Dept	10.40	10.20	8.40	2.39%	17.20%	0.00	1.60	0

Establishment v's Actual – 2.00 vacancies as at 31st March 2025.

Sickness / Turnover – Turnover due to career progression and relocation. Low sickness absence rate within the team.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – The service has increased telephone appointments where appropriate to ensure communication with patients. We are working hard to develop a clear and effective framework for our respiratory therapist along with developing our skill mix as demand increases.

Apprenticeships / Skill Mix – Creating opportunities for a possible band 4 TA post in the future to improve the progression aspects and skill mix for the future.

Any Mitigating Actions – No mitigating actions required.

Service Pressures – Rapidly increasing new referral demands and limited capacity with current caseloads. An additional 1.0wte Band 6 funded by ICB to be invoiced.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Child Paediatric Speech & Language Therapy - Dept	28.61	26.41	27.01	2.28%	3.74%	1.00	1.00	0

Establishment v's Actual. As at 31st March 2025 the service had a Band 5 vacancy.

Sickness / Turnover – Low Sickness Absence and Turnover rates within the team. Majority of absence within the team is short term absence.

Risks over 12 – The service is currently reporting no risks 12 or above.

Workforce Initiatives – No workforce initiatives required for the service.

Apprenticeships / Skill Mix – Current skill mix appropriate to meet service need.

Any Mitigating Actions – No mitigating actions required.

Service Pressures - High level of referrals and approx. 3000 children who need regular follow ups of which over 900 have an EHCP. Increase to waiting times for assessments. Additional funding from ICB for 1.0wte band 6 to be invoiced.

2.5 Dental Service

Service	01 April 2024 - 31 March 2025							
	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Dental Cheshire & Merseyside	61.86	61.63	60.27	6.42%	6.89%	4.20	5.40	1

Establishment v's Actual – As at 31st March 2025 the budgeted establishment was 61.86 and staff in post 60.57. 1.40 vacancies are going through the recruitment process.

Sickness / Turnover – Both short term and long -term absence is being managed with wellbeing training for all managers and a final year-end short-term absence figure of 1.54% and long-term absence of 0.77%. 41% of absence is stress related and the team stress risk assessments as well as those for individuals are being revisited. MSK issues causing 21% of absence and are referred to Occupational Health as needed and ensuring workplace risk assessments and reasonable adjustments are applied to staff as appropriate to address and prevent further deterioration.

With 6 leavers in year and a rolling 6.42% turnover (actual turnover 1.2% in March 25) it is not a concern due to the nature of movement within Dentistry.

Risks over 12 – 1 risk at 12- this relates to 52 week wait (recently reduced from 65 weeks) breaches for Minor Oral Surgery patients.

Workforce Initiatives – Visibility of Head of Service and Clinical Director at all sites to promote trust/open dialogue. Trial of online booking via Dentally Portal to ease pressure for administrators/promote automation /patient choice. All staff attend clinic meetings monthly to ensure they are receiving Trust messages as well as discussing relevant Dental information.

Apprenticeships / Skill Mix – Increase of Dental Therapists would support assessments and recall patients.

Any Mitigating Actions – Clinicians /staff work in an agile manner according to patient demand across the sector as directed by HOS/Clinical Director. Waitlists are reviewed /booking efficiency monitored weekly. Reception staff receive specific training for waitlist reduction initiatives.

Service Pressures – Recruitment challenges for Dental Officers. The correct skill mix being available each shift to run clinics and GA sessions.

	01 April 2024 - 31 March 2025							
Service	Establishment (FTE)	FTE as at 1st April 2024	FTE as at 31st March 2025	Rolling Sickness Absence %	Rolling Turnover %	Number of Starters	Number of Leavers	Risks over 12
Dental Greater Manchester	120.40	112.91	106.23	6.76%	8.39%	9.20	14.06	2

Establishment v's Actual – As of 31st March 2025 the dental services across the Greater Manchester footprint where reporting 14.17 vacancies. There have been recruitment challenges recruiting Dental Officers due to the competitive rates of pay within high street dental practices. A number of vacancies are going through the recruitment process.

Sickness / Turnover – The service currently has high sickness absence across the teams based in GM. The main reasons for absence are stress and anxiety (29.2%), tumours (13.6%) and eye problems at 13.6%. Long term sickness is being managed with the support of Human Resources and reviewing stress risk assessments. Short term sickness is also being reviewed. Turnover is also high which is mainly due to Dentists and Therapists leaving for various reasons. Post leavers questionnaire being reviewed to identify any trends.

Risks over 12 – Inadequate hospital theatre access for paediatrics who require general anaesthetic for children with additional needs. This has been escalated to commissioners.

Waiting List Pressures -Volume of patients since 2020 has doubled although GM are managing waiters by reducing weeks waiting for assessment, we have reduced this from 103 weeks to 53 weeks and intend to decrease to 45 weeks in quarter 2.

Workforce Initiatives – Staff work agile in some clinics across the GM footprint and focusing on clinics with waiting list pressures. New clinic in Altrincham with movement of staff from 3 clinics with Trafford.

Apprenticeships / Skill Mix – Increase of Dental Therapists would support assessments and recall patients.

Any Mitigating Actions – Contract meeting with GM commissioners to identify how to support the waiting list pressures and a business case is to be produced to support funding for additional foundation dentists. Training dental nurses in IV to support in clinics.

Service Pressures – Recruitment challenges for Dental Officers. Geographical footprint across the GM patch can prove difficult for an agile workforce.

3. CONCLUSION

There are a limited number of safer staffing tools for use in Community services, the Community Nursing Safer Staffing tool (CNSST) and the Safer Nursing Care Tool (SNCT) are being implemented in 2025 in District Nursing / Matron services and Padgate House Intermediate Care unit respectively. The results to inform establishment setting will be available in Q2 25/26.

Through 2024 / 25 the Trust has used the e roster and SafeCare systems to develop a 'Core Staffing' functionality and reporting system based on services clinical judgement of the staffing requirements each day. This replaces the current sit rep daily reporting with limited and subjective functionality and will be used in conjunction with existing governance systems in place to provide assurance of escalation processes to maintain safe service delivery.

Future annual workforce assurance reports will capture professional judgements and red flag information. Work is continuing to monitor the daily core staffing daily core staffing reporting using the e roster system has commenced across all clinical services with reporting access via Qlik. All

clinical services are required to complete a daily status review of current staffing against core planned staffing. The system has been fully implemented from July 2025. A RAG based system with SafeCare professional judgements and red flags have been incorporated into the reports to provide organisational assurance and oversight of any areas of staffing concern and mitigating actions for escalation on a daily basis. This approach ensures connectivity and transparency at all levels of the organisation to service pressures, from team leaders to operational managers and quality leads. An escalation process and accompanying policy is being developed that details the roles and responsibility for escalation and assurance of actions undertaken to manage emerging issues.

Quarterly Workforce Assurance meetings will be established in 2025/2026 with Borough Leads, Deputy Chief Nurse, Deputy Chief Operating Officer, Head of Workforce, Assistant Director of Finance and Head of Information to examine skill mix, service pressures, risks, reported professional judgements/red flags and workforce initiatives.

To support future reports, the Deputy Chief Nurse and Head of Workforce are working with the Performance Team to build dashboards for triangulation of quality, workforce and financial data.

The Safer Staffing Group continue to meet on a monthly basis to coordinate and monitor implementation and outputs of the evidence based safer staffing tools that are currently being introduced within the Trust. The group is also developing reporting systems using existing performance data that will provide an analysis of demand and capacity that will inform workforce planning.

All vacancies continue to go through a rigorous process and are approved via the Executive Vacancy Panel.

Temporary staffing is continued to be monitored and all requests are signed off by the Deputy Chief Operating Officer. All temporary workforce is recorded on the E Roster system and are reported on a monthly basis through external and internal processes. As a Trust we are currently on plan in the reduction of temporary staffing costs.

Mandatory Training and PDRs are a Trust priority and compliance remains above target on a monthly basis. Compliance is monitored via Educational Governance and Strategic People Committee.

4. RECOMMENDATIONS

The Strategic People Committee in Common notes the Workforce Assurance Report prior to being reported at the BCH Trust Board.

17. SPCIC/25/07/080 FACILITIES TIME OFF ANNUAL REPORTS

● Decision Item

👤 BCH Deputy Director of People and Organisational Development/WHH Chief People Officer

- i) BCH Report
- ii) WHH Report

17.1 SPCIC/25/07/080i BCH FACILITIES TIME OFF ANNUAL REPORT

 Deputy Director of People

REFERENCES

Only PDFs are attached

 SPCIC2507080i BCH Trade Union Facilities Time off Report July 2025.pdf

STRATEGIC PEOPLE COMMITTEE IN COMMON

AGENDA REFERENCE:	SPCIC/25/07/080i			
SUBJECT:	FACILITES TIME OFF ANNUAL REPORT - TRADE UNION FACILITIES TIME STATUTORY RETURN 2024/25			
DATE OF MEETING:	16 July 2025			
ACTION REQUIRED:	To note the contents of the report			
AUTHOR(S):	Tania Strong, Head of Human Resources			
EXECUTIVE DIRECTOR SPONSOR:	Paula Woods, Director of People and OD			
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:	Facility time is paid time-off during working hours for trade union representatives to carry out trade union duties. This report provides assurance to the Committee that the statutory submission for 2024/25 has been made, and to note the current levels of Trade Union facilities time. The statutory submission applies to the period April 2024 to March 2025 as per the Trade Union (Facility Time Publication Requirements) Regulations 2017. All public-sector organisations that employ more than 49 full-time employees are required to submit data relating to the use of facility time in their organisation with submissions due by 31 July each year. The report provides comparison data for the preceding 5 years, so that a longer-term picture can be reviewed and if there are any action areas required. Data for 2024/25 shows a minor increase of 1.29 wte in TU representative numbers, a move away from 0% activity towards the 0-50% bracket of activity which is now the largest bracket of activity rates for the Trust. There has also been some increase in trade union activities, which may be attributed to national pay disputes and associated industrial action during 2023/24.			
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision	
RECOMMENDATION:	It is recommended that the Strategic People Committee note the submission of the statutory return associated with Trade Union facilities time and the accompanying narrative and the			

	ongoing requirement to collect data on a rolling basis for 2025/2026 in readiness for the 2026 statutory submission.	
PREVIOUSLY CONSIDERED BY:	Committee	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: <i>State whether this report needs to be referred to at another meeting or requires additional monitoring</i>	None	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
	None	

STRATEGIC PEOPLE COMMITTEE IN COMMON

SUBJECT	FACILITES TIME OFF ANNUAL REPORT - TRADE UNION FACILITIES TIME STATUTORY RETURN 2024/25	AGENDA REF:	SPCIC/25/07/080i

1. BACKGROUND/CONTEXT

- 1.1 This paper details the statutory submission for the period April 2023 to March 2024 as per the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017.
- 1.2 All public sector organisations are normally required to report their facility time data by 31st July each year.
- 1.3 All public sector data will be published on the gov.uk website following quality assurance of returns, so this can be benchmarked.
- 1.4 The Trust is required to publish this information within its annual report and on the Trust external website.
- 1.5 Comparison and analysis of data for the preceding 4 years is provided as part of this report.
- 1.6 The purpose of these regulations is to promote transparency and allow for public scrutiny of facility time.
- 1.7 Facility Time data is data that the Trust is required to collect, report and publish under the Trade Union Facility Time Publication Requirements Regulations 2017.
- 1.8 Facility time can be broken down as follows:

Examples of trade union duties

- duties connected with collective bargaining – for example, on terms and conditions of employment, redundancy, allocation of work
- taking part in a negotiation or consultation process – including meeting and corresponding with managers, and informing union members of progress and outcomes
- attending a disciplinary or grievance hearing, with trade unions, including allowing reasonable time to prepare
- attending training for the trade union representative role

Examples of trade union activities

- discussing internal union matters
 - dealing with internal administration of the union – for example, answering union correspondence meetings other than as part of the negotiating or consultation process
- 1.9 Public sector organisations are required to submit:

- total number of trade union representatives the organisation employed - include employees who were not representatives for the full 12 months
- total full time equivalent number of representatives
- total amount of time representatives spent on facility time
- percentage of working hours each representative spent on facility time in the bandings – of 0%, 1 to 50%, 51 to 99%, or 100%
- total amount of time representatives spent on paid facility time – paid union duties and activities
- total amount of time representatives spent on paid union activities
- total amount of time representatives spent on unpaid union activities
- total pay bill – for all employees not just union representatives
- total cost of facility time

The published data output in the prescribed format is detailed within Appendix 1, which will also been uploaded onto the Trust's external website and the data will be included will feature in the Trust's Annual Report.

2. KEY ELEMENTS

Relevant Union Officials

- 2.1 In response to the question 'What was the total number of your employees who were relevant union officials?' The Trust has reported 16 TU officials during 2025/26 – this has increased by three from the previous reporting year. Conversations have been had with local and regional representatives about opportunities to recruit and promote the steward role, and trade unions are offered a forum for recruitment at the Trust's corporate induction. However, whilst the annual number of officials active during all or part of the year has increased, subsequent movement will likely lead to a reduction in overall numbers for 25/26. This included the retirement of both of the Trust's Staff Side Chairs during quarters 3 and 4 of 2024/25 and a further three officials standing down during the year offset against one new additional recruit.

Table 1

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Number of employees who were relevant trade union officials	20	20	12	12	13	16
Total full-time equivalent of trade union officials	15.87	16.87	9.86	9.46	10.75	12.53

2.2 Percentage of Time Spent on Facility Time

In response to the question, 'How many of your employees who were relevant union officials spent a) 0%, b) 1% - 50%, c) 51% - 99%, or d) 100% of their working hours on facility time?' The Trust has reported that two trade union officials spent no time on facility time during 2024/25 which remains static from the previous years' data. The majority of officials spent up to 50% of their working time on facility time. The two officials performing 100% of their time on facility time are afforded time release to undertake these duties, one of these being an aforementioned Staff Side Chair.

- 2.3 Looking back to 2023/24 and in comparison with 2024/25, representative activity levels in the 0-50% bracket activity have grown in line with greater representative numbers (Table 2). Representative numbers had been in decline since 2019 but over the past two years these have seen an increase. The local picture in relation to trade union facilities time includes reducing levels of formal employee relations activity in line with our Just Culture principles but also increased activities during 2023/24 relating to national pay disputes and industrial action. Staff also have a variety of support and advocacy mechanisms in place including Just Culture, Freedom to Speak Up Guardians, Leadership and Organisational Development, Professional Nurse Advocates and Listening to Staff Voices to name some of these, with a greater focus on wider avenues for engagement alongside Trade Union representation.

Table 2

Percentage of time	Number of employees 2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
0%	4	10	4	4	2	2
1 – 50%	15	8	6	6	9	12
51% - 99%	0	0	0	0	0	0
100%	1	2	2	2	2	2

2.4 Percentage of Pay Bill Spent on Facility Time

In response to the request for information relating to the cost of facility time, detail of the cost of facility time as a percentage of total pay bill is detailed in Table 3. Total cost for 24/25 has reduced by 11% in contrast to a higher total pay bill overall – this may be linked to the number of officials standing down during the reporting year. The overall proportion of the pay bill has reduced from 0.08 to 0.07%. This has remained relatively static over the last 4 years.

Table 3

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Provide the total cost of facility time	£46,863.21	£34,625.54	£51,164.09	£49,073.63	£54,703.89	£48,841.97
Provide the total pay bill	£66,994,878	£63,682,517	£69,718,000	£63,279,000	£67,834,000	£74,598,000
Provide the percentage	0.07%	0.05%	0.07%	0.08%	0.08%	0.07%

of the total pay bill spent on facility time:						

2.5 **Paid Trade Union Activities**

Trade union 'activities' typically include discussing internal union matters and dealing with internal administration of the union, whereas 'duties' may typically involve employee relation matters, joint negotiations or training.

- 2.6 In response to the question 'As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?' The Trust information below shows that the total number of hours spent on paid trade union activities has diminished during 24/25 compared to the previous year's industrial relations activity. In recent years, there has been a noticeable increase in tension between national negotiating bodies and trade unions, largely fuelled by unresolved bargaining disputes centred on pay and working conditions and a heightened level of activity among union officials seeking to represent their members' interests. Industrial relations locally have always remained positive against this national backdrop. This activity may be set to rise given indicative ballots currently being run by the BMA and the RCN consulting with their members on the 25/26 pay award.

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Provide the total hours spent on paid trade union activities	331.35	173.5	294.65	369.45	398.85	268.65
Provide the total paid facility time hours	2323.40	2411.8	1859.90	3068.05	2915.75	2692.7
Time spent on trade union activities as a percentage of total paid facility time	14.26%	7.19%	15.84%	12.04%	13.68%	9.98%

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Responsible Officer for Trade Union Facilities Time Statutory Return is the Director of People and Organisational Development.

4. MEASUREMENTS/EVALUATIONS

As per section 2.

5. TRAJECTORIES/OBJECTIVES AGREED

N/A

6. MONITORING/REPORTING ROUTES

To continue to provide details of the statutory submission to SPC and JNCC.

7. TIMELINES

N/A

8. ASSURANCE COMMITTEE (IF RELEVANT)

N/A

9. RECOMMENDATIONS

It is recommended that the Strategic People Committee note the submission of the statutory return associated with Trade Union facilities time and the accompanying narrative and the ongoing requirement to collect data on a rolling basis for 2025/2026 in readiness for the 2026 statutory submission.

Table 1 – Relevant Union Officials

Appendix 1

What was the total number of your employees who were relevant union officials during 2024/25?

<i>Number of employees who were relevant trade union officials during the relevant period</i>	<i>Total full-time equivalent of trade union officials</i>
16	12.53

1. Table 2 - Percentage of Time Spent on Facility Time

How many of your employees who were relevant union officials employed during 2023/24 spent a) 0%, b) 1% - 50%, c) 51% - 99%, or d) 100% of their working hours on facility time?

<i>Percentage of time</i>	<i>Number of employees</i>
0%	2
1 – 50%	12
51% - 99%	0
100%	2

2. Table 3 – Percentage of Pay Bill Spent on Facility Time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during 2024/25.

	<i>Figures</i>
Provide the total cost of facility time	£48,841.97
Provide the total pay bill	£74,598,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.07%

3. Table 4 – Paid Trade Union Activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

	<i>Figures</i>
Provide the total hours spent on paid trade union activities	268.65
Provide the total paid facility time hours	2692.7
Time spent on trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during 2024/25/ total paid facility time hours) x 100	9.98%

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	64/25i		
Report Title	FIT AND PROPER PERSONS ANNUAL REVIEW		
Executive Lead	Martyn Taylor, Chair		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☐ To Approve	☒ To Assure	☐ To Note
Executive Summary			
The Trust is required to undertake Fit and Proper Person Tests on an annual basis for all Board members and for those who advise the Board. For both Bridgewater Community Healthcare NHS FT (BCH) Board members and advisor and three shared posts with Warrington and Halton Hospitals NHS FT (WHH), tests were undertaken in June 2025. The outcome was that each person is considered to be a Fit and Proper Person. The outcomes of both organisations tests were reported to the NHSE Regional Director in June 2025.			
Previously considered by:			
☐ Audit Committee ☐ Quality & Safety Committee ☐ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee ☐ Strategic People Committee in Common ☐ EMT			
Strategic Objectives			
☒ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.			
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.			
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.			
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.			



How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☐ Effective	☐ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	64/25i		
Report Title	FIT AND PROPER PERSONS ANNUAL REVIEW		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	To provide assurance that the annual Fit and Proper Person Test (FPPT) has been undertaken for all Board members and those who advise the Board.		

1. INTRODUCTION

- 1.1 A review of Fit and Proper Person Test (FPPT) compliance for all Board members and those who regularly attend and advise the Board is undertaken annually and reviewed by the Chair.
- 1.2 In June 2025, there were a total of 13 Board members, three of whom were shared posts with WHH and one person who regularly attended Board meetings and advised the Board.
- 1.3 FPPT for the three shared posts was undertaken by WHH as the employing organisation.

2. PROCESS

- 2.1 Following receipt of FPPT self-attestations, and in conjunction with received Declarations of Interest, the following tests were undertaken for the ten BCH Board members / advisor, and the outcomes recorded.
 - a. Last appraisal date
 - b. Training & Development – mandatory training
 - c. Disciplinary findings
 - d. Grievance against the Board member
 - e. Whistleblowing claims against the Board member
 - f. Behaviour not in accordance with organisational values and behaviours or related local policies
 - g. DBS disclosure information
 - h. Companies House Register check
 - i. Bankruptcy & Insolvency Registers
 - j. Disqualified Directors Registers
 - k. Disqualification from being a Charity Trustee
 - l. Employment Tribunal Judgement
 - m. Web and social media checks for news reports plus all social media platforms including;

- i. X
- ii. Facebook
- iii. LinkedIn
- iv. Instagram
- v. Threads
- vi. YouTube
- vii. Tik Tok
- viii. Google

n. Professional Register check – where applicable.

2.2 For the three shared posts with WHH, evidence and assurance was received from WHH that they met the criteria for a Fit and Proper Person.

3. OUTCOME

- 3.1 Of the 10 BCH Board members / advisors whose self-attestations and declarations were tested, the Chair was satisfied that they all met the criteria for a Fit and Proper Person.
- 3.2 Of the three shared Board members whose self-attestations and declarations were tested, the Chair was satisfied with the assurance received from WHH.

4. RECOMMENDATION

- 4.1 The Board is asked to accept the assurance that the Fit and Proper Persons Test has been undertaken for all Board members and advisors and that all meet the criteria.

Appendix 1: 2025 Board FPPT

Appendix 1: 2025 Board FPPT

Name	FPPT Annual self- attestation received	DOI received	Training & Development - all mandatory completed as at 09 June 25	Last Appraisal Date	Companies House Register check	Bankruptcy & Insolvency Register check	Disqualified Director Register check	Disqualification from being a Charity Trustee check	Employment Tribunal Judgement check	Web & Social Media searches	Professional registration check	Body	Professional registration expiry
Gail Briers	05/06/25	06/02/25	Fire Safety & Resus	15/08/24	09/06/25	09/06/25	09/06/25	09/06/25	09/06/25	19/06/25	09/06/25	NMC	31/07/25
Lynne Carter	19/06/25	19/03/25	Yes	30/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	NMC	31/03/26
Bob Chadwick	05/06/25	06/02/25	Resus	27/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	N/A		24/04/25
Nick Gallagher	05/06/25	06/02/25	Yes	09/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	CIMA	31/12/25
Elaine Inglesby	05/06/25	06/02/25	Resus	15/08/24	25/06/25	26/06/25	25/06/25	25/06/25	25/06/25	25/06/25	25/06/25	NMC	31/10/2025
Jan McCartney	05/06/25	06/02/25	Yes	14/08/24	12/06/25	12/06/25	12/06/25	12/06/25	12/06/25	12/06/25	N/A		N/A
Abdul Siddique	05/06/25	06/02/25	Yes	28/08/24	18/06/25	18/06/25	18/06/25	18/06/25	18/06/25	18/06/25	N/A		N/A
Martyn Taylor	05/06/25	06/03/25	Yes	28/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	N/A		N/A
Tina Wilkins	05/06/25	06/02/25	Yes	13/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	N/A		N/A
Paula Woods	05/06/25	06/02/25	Yes	05/08/24	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	19/06/25	FCIPD	01/07/2025

Audit Committee Terms of Reference

Name	Audit Committee	
Purpose	The Board of Directors has established an Audit Committee for the purpose of providing the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Annual Governance Statement. The Board of Directors is responsible for ensuring effective internal control including: a) Management of the Trust’s activities in accordance with statute and regulations. b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought. In addition, the Audit Committee shall: c) Provide assurance of independence for external and internal audit; d) Ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Audit Committee; and e) Monitor corporate governance (e.g., compliance with codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).	
Basis of Authority	The Board of Directors has provided delegated authority to the Audit Committee to seek assurance in accordance with these terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	Members	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director



	Members	All other Non-Executive Directors
	Management Lead (but not a member of the Committee)	Director of Finance
	The Audit Committee members shall be afforded the opportunity to meet at least once per year with no others present. Attendees Only the members of the Committee have the right to attend meetings however, the following shall generally be invited to attend routine meetings: • Deputy Director of Finance • Director of Corporate Governance • Financial Controller • Head of Internal Audit • Anti-Fraud Specialist • External Audit representative Observers Council of Governors' Representatives. Any other person with prior permission of the Chair. Invited as required The Trust Chair. Executive Director (to respond to Audit Reports of no or limited assurance and any other items as determined by the Chair of the Committee) Other staff will be invited as required by the Chair of the Committee, in particular to agenda items in relation to operations, contractual matters, estates or information technology. The Chief Executive will attend at least once a year to provide assurance on the annual governance statement, or as required. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.	
Connectivity	The Audit Committee connects with: • Board of Directors • Finance, Sustainability & Performance Committee in Common • Nominations & Remuneration Committee • Strategic People Committee in Common • Quality & Safety Committee The Director of Corporate Governance or their Deputy attends all Committees of the Board and provides operational connectivity.	
Frequency of Meetings and Location	Meetings will take place quarterly. No less than four meetings are to be held within a calendar year. An additional meeting may be held to consider the draft Financial Statements, Annual Governance Statement and Annual report if required.	

	Each member is to attend at least 75% of the diarised meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Audit Committee will be quorate when at least three Non-Executive Directors, including the Chair or Vice-Chair are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Committee are: Governance, Internal Control and Risk Management a) To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements, (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board. b) Ensuring the provision and maintenance of an effective system of financial and corporate risk identification and associated controls, reporting and governance. c) To review any governance items relating to changes resulting from the Trust's integration with Warrington & Halton Hospitals NHS Foundation Trust d) To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern. e) To review the adequacy by way of the Board Assurance Framework of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. f) To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. g) To maintain oversight of the compliance report received from Q&S Committee on the delivery of the Clinical Audit programme. h) To review the Trust's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test. Internal Audit i) To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation. j) To oversee on an ongoing basis the effective operation of internal audit in respect of adequate resourcing, its co-ordination with external audit, meeting mandatory NHS Internal Audit Standards, providing adequate independence assurances, having appropriate standing within the Trust; and meeting the internal audit needs of the Trust. k) To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

- l) To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- m) To conduct an annual review of the internal audit function.
- n) To oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years.

Anti-Fraud

- o) To review and approve the anti-fraud annual workplan, ensuring that it is consistent with the needs of the organisation.
- p) To oversee on an ongoing basis the effective operation of the Trust's anti-fraud service in respect of adequate resourcing, its co-ordination with internal and external audit, meeting NHS Counter Fraud Authority Standards, having appropriate standing within the Trust; and meeting the anti-fraud needs of the Trust; and recommend the annual Anti-Fraud Report to the Board.
- q) To consider the major findings of anti-fraud investigations and detection work, management's response and their implications and monitor progress on the implementation of any such recommendations.
- r) To consider the provision of the anti-fraud service, the cost of the service and any questions of resignation and dismissal.
- s) To conduct an annual review of the Anti-Fraud Service.
- t) To oversee the conduct of a market testing exercise for the appointment of an anti-fraud service at least once every five years.

External Audit

- u) To ensure that the Council of Governors are fully involved in the selection process for the appointment, reappointment or removal of the external auditors.
- v) To provide the Council of Governors with the necessary information and to enable them to make a recommendation in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the Annual Report, along with the reasons that the recommendation was not adopted.
- w) To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Trust associated impact on the audit fee.
- x) To assess the external auditor's work and fees on an annual basis and based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.
- y) To review external audit reports, including the annual audit letter and the Value for Money (VFM) Risk Assessment, together with the management response, and to monitor progress on the implementation of recommendations.
- z) To develop and implement a policy on the engagement of the external auditor to supply non-audit services.
- aa) To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

Annual Reporting

- bb) To review and approve the annual statutory accounts for recommendation to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:
- the meaning and significance of the figures, notes and significant changes;
 - areas where judgment has been exercised;
 - adherence to accounting policies and practices;
 - explanation of estimates or provisions having material effect;
 - the schedule of losses and special payments;
 - any unadjusted statements; and
 - any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- cc) To review and approve the annual report and Annual Governance Statement for recommendation to the Board, to determine completeness, objectivity, integrity and accuracy.
- dd) To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

- ee) To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of Business conduct, including maintenance of registers.
- ff) To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.
- gg) To review the scheme of delegation.

Other

- hh) To review the Annual Self-Assessment relevant to the remit of the Audit Committee.
- ii) To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.
- jj) To develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.
- kk) To review the work of all other Trust committees in connection with the Audit Committee's assurance function. In particular the respective roles and performance of the Audit Committee and the Quality and Safety Committee will be regularly reviewed to ensure that the Audit Committee primarily focuses in on the robustness of sources of assurance whereas the Quality and Safety Committee focuses in on the adequacy of the resulting assurances offered.
- ll) Review the process for any significant transaction.

Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item. • Reports and plans as per agreed Committees work plan • Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Exception reports • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees.
Outputs	• Minutes • Action log • Committee Chair's report to the Board • Annual report to the Board on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors
Closed Session	On specific occasions it may be necessary for the Audit Committee to meet in closed sessions. Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	• Attendees are authorised to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation) • Review of each meeting by Members and Governor Observers.
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	August 2025
Review Date	August 2026

Appendix A

Monitoring Compliance with the Terms of Reference for Audit Committee

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / Committee which will receive the findings / monitoring report	Group / Committee / individual responsible for ensuring that the actions are completed
Duties of the Group	Review of agenda items	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Membership, including nominated Deputy	Annual report	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Frequency of attendance by Members	Annual report	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Requirements for a quorum	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Audit Committee
Frequency of meetings	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Audit Committee

The monitoring of compliance for the Committee will be undertaken on behalf of the Trust by the Director of Corporate Governance

ISSUE DATE	August 2025
REVIEW DATE	August 2026

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Audit Committee	Full review of format Membership Medical Director moved from Attendees to Invited as Required Connectivity The addition of the Chief Operating Officer or their deputy as an operational link between Committees Frequency of Meetings and Location Members required to attend 75% of diarised meetings per year Quoracy Chairman replaced with Chair Inputs Provision of agenda and supporting papers Outputs Committee Chair's Assurance report to the Board, replaces Exception reports to the Board. Other Matters Review of each meeting by Members and Governor Observers
2.1	August 2022	Board of Directors	Connectivity Connection with all other Board Committees Duties and Responsibilities Anti-Fraud Committee to recommend the annual Anti-Fraud report to the Board
2.2	June 2023	Audit Committee	Duties and Responsibilities Added: e) To maintain oversight of the compliance report received from Q&S Committee on the delivery of the Clinical Audit programme

			v) Value for Money (VFM) assessment to the review of external audit reports p) Title-cased anti-fraud ee) Replaced performance indicators with Annual Self-Assessment relevant to the remit of the Audit Committee gg) Title-cased audit committee Connectivity Added the Board of Directors Other Matters Removed 'Deputies have no voting rights'
2.3	August 2023	Board of Directors	Approved
2.4	June 2024	Head of Corporate Governance	Review and following proposed amendments: Attendees Trust Secretary replaced with Director of Corporate Governance Anti-Fraud Manager replaced with Anti-Fraud Specialist Invited as required Medical Director replaced with Executive Director Governance, Internal Control and Risk Management – added “Governance” to the heading and addition of following items in the section: a) To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements, (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board. g)To review the Trust's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test. External Audit Points t) and u) Replaced Governor's Auditors Appointment Group/ Committee with Council of Governors

			Monitoring Compliance with the Terms of Reference for Audit Committee Trust Secretary replaced with Director of Corporate Governance
2.5	April 2025	Audit Committee	Attendees Removal of Deputy Chief Executive Officer and Chief Operating Officer Invited as required Removal of 'may be invited to attend the Committee' from The Trust Chair Removal of 'depending on agenda items' from Executive Directors Connectivity Amendment of People Committee to Strategic People Committee in Common Amendment of Chief Operating Officer to Director of Corporate Governance Duties & Responsibilities Addition of c) To review any governance items relating to changes resulting from the Trust's integration with Warrington & Halton Hospitals NHS Foundation Trust
2.6	July 2025	Audit Committee	Connectivity Amendment of Finance & Performance Committee to Strategic Finance Committee in Common
2.7	Aug 2025	Board	Approval of revised Terms of Reference

AUDIT COMMITTEE BUSINESS CYCLE 2025/26	ToR Clause	Lead	Action	24 Apr 2025	22 May 2025 Extraordinary (Draft Annual Report & Accounts review)	25 Jun 2025 Extraordinary (Final Annual Report & Accounts review)	17 Jul 2025	16 Oct 2025	22 Jan 2026
Welcome, Apologies and Previous Meetings									
Apologies	Membership	Chair	Information	✓	✓	✓	✓	✓	✓
Declarations of Interest in items on the agenda	Membership	Chair	Information	✓	✓	✓	✓	✓	✓
Minutes from the previous meeting	Membership & Inputs	Chair	Information	✓			✓	✓	✓
Action Log	Outputs	Chair	Information	✓			✓	✓	✓
Urgent Items with the agreement of the Chair	Outputs	Chair	Approve	✓	✓	✓	✓	✓	✓
Items for escalation to Board / other Committees	All	Chair	Information	✓	✓	✓	✓	✓	✓
Review of meeting	Other Matters	Committee		✓	✓	✓	✓	✓	✓
Governance									
Annual Report from each Committee to be received by April AC (governance, how many times met, quorate, TOR reviewed, workplan on track etc.)	D&R jj	DoCG	Assurance	✓					
Clinical Audit review (October & April)	D&R f	Chief Nurse	Assurance	✓				✓	
Fit and Proper Persons Test process	D&R g	DoCG	Assurance					✓	
NHS Provider Licence compliance process	D&R g	DoCG	Assurance					✓	
Oversight of conducting a market testing exercise for the appointment of internal audit and anti fraud services * *Required every 5 years, Q2 or Q3 - last review in 2021	D&R m & s	DOF	Approval or Information						
Produce Annual Audit Committee report	Outputs	Chair	Approve	✓					
Review of audited annual accounts and financial statements to include the Annual Governance Report	D&R aa-bb	DOF	Recommend to Board for approval		✓	✓			
Review Board Assurance Framework and Corporate Risk Register	Duties & Responsibilities (D&R) a-d	DoCG	Assurance	✓			✓	✓	✓
Review Committee Business Cycle (review in January for the upcoming year and interim in July alongside ToR)	Appendix A	Committee	Approve				✓		✓
Review of Committee Terms of Reference	Appendix A	DoCG	Recommend to Board				✓		
Review of Freedom to Speak Up / Raising Concerns policy (next review January 2026)	D&R c	Chief Nurse	Assurance						
Review process for significant transactions (as identified by the Board)	D&R kk	DoCG	Assurance						
Self-assessment of Committee's effectiveness	D&R gg & Outputs	DoCG	Information						✓
External Audit									
Agreement of External Audit plans and fees (recommendation to Council of Governors - only if needed e.g., for additional fees) Jan: Indicative Audit Plan. Apr: Final Audit Plan	D&R t-z	External Audit	Approve	✓ *					✓
Annual Review of Effectiveness of External Audit	D&R t-z	DoCG	Information					✓	
External Auditors Findings Report / ISA260	D&R t-z	External Audit	Recommend to Board			✓			
External Auditors Letter of Representation	D&R t-z	External Audit	Recommend to Board			✓			
External Audit Progress report and sector update	D&R t-z	External Audit	Information	✓				✓	✓
External Audit Sector Update	D&R t-z	External Audit	Information					✓	
Private discussions with External Audit (takes place as required but as a minimum once per year)	D&R t-z	Chair	Assurance	✓			✓		
VFM Risk Assessment (included in the Audit Plan)	D&R t-z	External Audit	Assurance	✓					



AUDIT COMMITTEE BUSINESS CYCLE 2025/26	ToR Clause	Lead	Action	24 Apr 2025	22 May 2025 Extraordinary (Draft Annual Report & Accounts review)	25 Jun 2025 Extraordinary (Final Annual Report & Accounts review)	17 Jul 2025	16 Oct 2025	22 Jan 2026
Internal Audit									
Annual Internal Audit Plan	D&R h	Internal Audit	Approve	✓					✓
Annual Internal Audit Report and Director of Audit Opinion	D&R i-j	Internal Audit	Approve	✓		✓			
Annual Review of Effectiveness of Internal Audit	D&R l	DoCG	Information						✓
Internal Audit Progress Reports and Sector Updates	D&R i-j	Internal Audit	Information	✓			✓	✓	✓
Internal Audit Charter	D&R h	Internal Audit	Assurance	✓					
Private discussions with Internal Audit (held as a pre meet as required but a minimum of once per year)	D&R h-j	Chair	Assurance						✓
Review of Audits with limited or no assurance	D&R j	Internal Audit	Approve	✓			✓	✓	✓
Anti-Fraud									
Anti-Fraud Annual Plan	D&R n	Anti-Fraud	Approval	✓					
Anti-Fraud Annual Report	D&R o,p	Anti-Fraud	Recommend to Board	✓					
Anti-Fraud Progress Update	D&R o,p	Anti-Fraud	Information				✓	✓	✓
Annual Review of Effectiveness of Anti-Fraud services	D&R r	Committee	Information					✓	
Private discussions with Anti-Fraud Services (held as required but as a minimum once per year)	D&R n-s	Chair	Assurance						✓
Registers									
Annual Review of Register of Interests	D&R dd	DoCG	Assurance	✓					
Hospitality Register for reporting period	D&R dd	DoCG	Assurance	✓			✓	✓	✓
Register of Declarations of Interests for reporting period	D&R dd	DoCG	Assurance	✓			✓	✓	✓
Review of losses, write offs and special payments	D&R dd	DOF	Information	✓			✓	✓	✓
Financial Reporting									
Annual review of Scheme of Reservation & Delegation	D&R dd - ff	DoCG	Information					✓	
Annual review of Standing Financial Instructions	D&R dd - ff	DOF	Information					✓	
Review of annual accounts progress	D&R aa	DOF	Information	✓	✓	✓			✓
Review of other reports and policies as appropriate e.g. changes to Standing Orders, changes to accounting policies, Standing Order Waiver Reports.	D&R dd - ff	DOF	Information	✓			✓	✓	✓

Key:

DoCG: Director of Corporate Governance

DOF: Director of Finance

Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals Executive Management Team Meeting

Name

Executive Management Team

Purpose

The Executive Management Team (EMT) is here to ensure our Trusts' strategies are implemented and the organisations run smoothly every day. We do this by:

- Managing clinical and non-clinical services to ensure they are safe and effective for patients.
- Addressing operational performance issues to keep the Trusts running safely and efficiently.
- Reviewing and approving financial requests according to our Trusts' guidelines.
- Assisting the Trust Boards in developing our vision and strategic direction.
- Supporting each Executive Team Director in their roles.
- Providing clear leadership and direction for our staff.
- Managing and mitigating risks that could affect our objectives.

The Strategic Executive Oversight Group (SEOG) handles the Trust's incident management response and becomes the EMT during such times. SEOG meetings are adjusted based on the NHS England Emergency Preparedness and Resilience Response (EPRR) level or at the Chief Executive's discretion. Strategy Meetings focus on long-term strategy across the executive portfolio.

Basis of Authority

Our authority comes from the two organisations' Board of Directors and Constitutions.

Accountable to

We are accountable to the two Board of Directors and have the delegated authority to manage the day-to-day operations of the organisation.

Membership

Members:

- **Chair:** Chief Executive Officer
- **Vice Chair:** Deputy Chief Executives
- **Members:**
 - Executive Medical Director*
 - Director of Finance*
 - Chief Finance Officer*
 - Chief Operating Officer*
 - Chief Nurse*
 - Director of People and Organisational Development*
 - Chief People Officer*
 - Chief Strategy and Partnerships Officer*
 - Director of Communications & Engagement*
 - Director of Corporate Governance

- Company Secretary

Minute Taker

- Executive Assistant (minute taker)

*Note: Members marked with an asterisk * must send a deputy if they cannot attend.*

Attendees:

- Observers can join with the Chair's consent.
- Other staff may be invited as needed for specific agenda items.

Frequency of Meetings

Types of Meetings and Locations:

- **Regular Meetings:** Weekly, with flexibility based on the Trusts' needs.
- **Extraordinary Meetings:** Can be called at short notice for urgent matters.
- **Virtual Meetings:** Available, if necessary, at the Chair's discretion.

Quoracy

At least one-third of the members, including deputies, must be present.

Duties and Responsibilities

The EMT's key responsibilities include:

- Leading and managing the Trust according to our mission and strategy.
- Planning and implementing strategies, objectives, and policies.
- Ensuring we meet our performance targets.
- Overseeing and mitigating risks.
- Allocating resources within the budget.
- Advising the Trust Boards on strategic and operational matters.
- Ensuring effective communication and stakeholder engagement.
- Setting and maintaining our organisational culture.

Decision Making

- Approving performance-related actions and business cases.
- Authorising revenue funding.
- Reviewing capital schemes over £500k.
- Considering vacancy control recommendations.

Advisory

- Advising the Trust Boards on strategic and operational matters.
- Developing overall strategy for Board approval.
- Keeping staff informed on Trust-wide issues.

Monitoring

- Implementing the strategic vision and key policies.
- Embedding a performance management culture.

- Reviewing patient-focused reports and corporate risks.
- Ensuring the Capital plan is on track.

Inputs

- **Agenda and Papers:** Sent electronically on Friday before the meeting on Tuesday.
- **Minutes:** Recorded and shared, with action items highlighted.

Outputs

- **Minutes:** Formally recorded and shared.
- **Reports:** Provided to the Boards and other committees as needed.

Other Matters

- Executive members should appoint deputies if they cannot attend meetings.

Nominations and Remuneration Committee

Terms of Reference

Name	Nominations and Remuneration Committee	
Purpose	The Board of Directors has established a Nominations and Remuneration Committee to be responsible for considering and making recommendations on changes to the structure, size and composition required of the Board. The Committee is to satisfy itself that its recommendations fulfil the Trust's needs in terms of skills and experience. The Committee will determine the remuneration for Very Senior Managers (VSMs) and Board Executives and other conditions of service and will decide upon the continuation in office of any Board Executive as an employee of the Trust.	
Basis of Authority	The Board of Directors has provided delegated authority to the Nominations and Remuneration Committee to seek assurance in accordance with these terms of reference.	
Reports to	Trust Board	
Membership	Members	
	Chair	Chair (Non-Executive Director)
	Vice Chair	Non-Executive Director
	Members	All other Non-Executive Directors
	Attendees Meeting of the Nominations and Remuneration Committee may be attended by the: • Chief Executive • Director of People and Organisational Development • Director of Corporate Governance	
	Invited as required Any other person who has been invited by the Chair to attend a meeting of the Committee so as to assist in deliberation. The Director of Corporate Governance will be responsible for the taking of minutes and will provide appropriate support to the Chair and Committee members.	



Connectivity	Sub-committees reporting to this Committee • None
Frequency of Meetings and Location	Meetings will take place at least once during a calendar year and ad-hoc as required. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Nominations and Remuneration Committee will be quorate when a minimum of three Non-Executive Directors (one of whom should be the Chair or Vice Chair) are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Committee are: Nominations - Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes. - Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the Board in future. - Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise, in accordance with relevant Department of Health and Social Care guidance. Such appointments would normally be confined to the Chief Executive and Executive Director posts but the remit of the Committee can be extended to other specified posts with the agreement of the Chair. - Be responsible for identifying and nominating a candidate to fill the position of Chief Executive. The appointment will be subject to approval by the Council of Governors. - Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the Committee shall; • use open advertising or the services of external advisers to facilitate the search; • consider candidates from a wide range of backgrounds; • consider candidates on merit against objective criteria. - Consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust. - To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities. Remuneration - To decide and review the terms and conditions of office of the Trust's Executive Directors [and Very Senior Managers on locally determined pay] in accordance

	with all relevant Trust policies and relevant Department of Health and Social Care guidance, including: (i) Salary, including any performance-related pay or bonus; (ii) Provisions for other benefits, including pensions and cars and; (iii) Allowances. i) To monitor and consider the performance of individual Executive Directors. j) To adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective. k) To advise upon and oversee contractual arrangements for Executive Directors, including, but not limited to, termination payments. Special Payments The Committee shall consider proposals from Executive Directors to seek approval for special payments including potential Employment Tribunal cases or redundancy from the appropriate body e.g., Treasury.
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item.
Outputs	• Annual report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its work plan. • The minutes of all meetings of the Committee shall be formally recorded by the Director of Corporate Governance's office and will be retained confidentially by the same. • The Committee shall ensure that Board of Directors emoluments are accurately reported in the required format for the Trust's Annual Report.
Closed Session	The Committee meets in private.
Process for monitoring compliance with Terms of Reference	The Terms of Reference shall be reviewed by the Board of Directors at least annually.
Issue Date	June 2025
Review Date	June 2026

Version Control Sheet

Version	Date	Reviewed By	Comment
2.1	August 2022	Board of Directors	Full review
2.2	August 2025	Board of Directors	Quoracy Amendment of four Non-Executive Directors to three Throughout Amendment of Trust Secretary to Director of Corporate Governance Amendment of issue and review dates and version

DRAFT



NOMINATIONS & REMUNERATION COMMITTEE BUSINESS CYCLE 2025/26			00 Sep 2025	29 Jan 2025
Welcome, Apologies and Previous Meetings				
Apologies			✓	✓
Declarations of Interest in items on the agenda			✓	✓
Minutes from the previous meeting			✓	✓
Action Log			✓	✓
Urgent Items with the agreement of the Chair			✓	✓
Items of business				
Annual review of salaries, bonuses or changes, terms of office / terms and conditions for Board Directors & Very Senior Managers				✓
Annual review of Executive performance / appraisal			✓	
Approval to apply VSM 2025/26 Pay Award - based on NOF segmentation				
Review of the size, structure and composition of the Board			✓	
Review of Terms of Reference				✓
Succession planning for Executive and Non-Executive Directors				✓
Ad hoc items				
Approval of Joint Board Director appointments				
Compromise agreements / special payments				

Quality and Safety Committee

Terms of Reference

Name	Quality and Safety Committee	
Purpose	The Board of Directors has established a Quality and Safety Committee for the purpose of: a) Advocating an active role in keeping the Trust’s services safe b) Seeking assurance on safe and effective clinical governance in the Trust c) Ensuring that the Trust is compliant with relevant national standards and statutory legislation d) Ensuring continuous quality improvement in patient safety, clinical effectiveness and patient experience, including the wellbeing and safety of Trust employees e) Identifying risks and concerns to be escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure referenced within the Board Assurance Framework f) To oversee and scrutinise the implementation of the Trust’s Quality Governance framework	
Basis of Authority	The Board of Directors has provided delegated authority to the Quality and Safety Committee to seek assurance in accordance with this terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	Members:	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director
	Management Lead	Chief Nurse*
		



	In addition: • Two other Non-Executive Directors • Medical Director* • Chief Operating Officer* Attendees Operational Leads as requested: • Deputy Chief Nurse • Associate Chief Nurse • Director of Quality Governance • Director of Corporate Governance • Workforce Representative <i>Individuals flagged with * are required to send a deputy in the event of non-attendance.</i> Observers The Committee is open to all Board members to attend as observers Council of Governors' Representatives Any other person with prior permission of the Chair Invited as required The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee, in particular for agenda items in relation to safeguarding, infection prevention and control, patient experience, risk management, medicines management, clinical audit. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.
Connectivity	Groups reporting to this Committee • Quality Council • Risk Management Council Groups reporting to the Quality Council • Corporate & Clinical Policy Group • Education Governance • Infection Prevention & Control • Medical Devices • Medicines Management • Patient Safety Incident Review Group • Research & Clinical Audit • Resus Advisory Group • Safeguarding & Risk Assurance – by exception and the Annual Report • Serious Incident Review Panel • Time to Shine

	There is an operational link between this Committee and the Finance and Performance Committee and an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures. The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.
Frequency of Meetings and Location	Meetings will take place bi-monthly. No fewer than five meetings are to be held within a calendar year. Each member is to attend at least 75% of the meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Quality and Safety Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Quality and Safety Committee are: - To oversee and scrutinise the effectiveness of the risks escalated in relation to Quality & Safety - To oversee and scrutinise the effectiveness of the Patient Safety Group via the Quality Council, specifically in relation to serious incidents, patient experience and learning lessons - To scrutinise the performance, adequacy and effectiveness of the Trust's clinical governance processes including patient safety, clinical effectiveness and patient experience and compliance with relevant national standards and statutory legislation, by way of receipt of the IQPR and quality indicators. To scrutinise and challenge the quality indicators in the IQPR - To ensure that the Trust scrutinise and benchmark in relation to information by way of available information on quality, safety and patient experience, or other indicators, outcomes of Time to Talk and Quality Visits, serious untoward incidents, complaints, and reports from external bodies - Receive and approve clinical audit and research programme and maintain oversight of it - Where appropriate, to escalate to the Board, themes, trends and risks including those from Serious Incidents and the Trust's capacity to learn lessons - To review and monitor the quality impact of cost improvement plans, service change and vacancies to ensure the processes are robust and effective and that risks to quality and safety are understood, considered, mitigated and monitored - To refer activities and tasks to appropriate Board level Committees or Executive management as deemed appropriate by the Committee, having due consideration of the remit of those Committees and their business cycles - To receive and accept delegated activities and tasks from the Board or other Board Committees by agreement - To hold executive directors to account for the quality and safety of the Trust's clinical services and clinical risk management outcomes

	k) To have oversight and again assurance on the delivery of the Trust's Improvement Plan l) Ensure delivery and management of the agreed Committee business cycle, building in at least an annual review giving consideration to the business cycles of other Board level Committees m) To approve and monitor the delivery of strategies in relation to Quality & Safety n) To receive assurance on compliance with NICE guidance o) Have oversight on the delivery in relation to quality and safety related MIAA audits p) To have oversight and be the responsible committee on the Board Assurance Framework for BAF 2& 3 q) Receive an annual report on safeguarding for assurance r) Receive Infection Prevention Control assurance reports s) To approve the Quality Account process t) Receive the Learning From Deaths report twice yearly
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item • Reports and plans as per agreed Committee's business cycle • IQPR report • Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Quality Impact Assessments of Cost Improvement Programmes • Exception reports from designated sub-groups • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and / or Board level Committees
Outputs	• Minutes • Action log • Committee Chair's reports to the Board • Annual Report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its business cycle • Report to Council of Governors • Report to the Audit Committee on progress against Internal Audit recommendations
Closed Session	On specific occasions it may be necessary for the Quality and Safety Committee to meet in closed sessions (for example where there is a quality or safety issue relating to a specific individual or group). Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.

Other Matters	- Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no voting rights - Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit - Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.)
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	August 2025
Review Date	August 2026

Appendix A

Monitoring Compliance with the Terms of Reference for Quality and Safety Committee

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / Committee which will receive the findings / monitoring report	Group / Committee / individual responsible for ensuring that the actions are completed
Duties of the Committee	Review of agenda items	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Membership, including nominated Deputy	Annual report	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Frequency of attendance by Members	Annual report	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Requirements for a quorum	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee
Frequency of meetings	Review of minutes	Director of Corporate Governance	Annually	Board of Directors	Quality & Safety Committee

The monitoring of compliance for the Committee will be undertaken on behalf of the Trust by the Trust Secretary.

ISSUE DATE	August 2025
REVIEW DATE	August 2026

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Quality & Safety Committee	Full review of format Connectivity Operational link between this Committee and the Finance & Performance Committee Addition of the Chief Operating Officer or their deputy as an operational link between Committees Duties and Responsibilities Removal of oversight of quality aspects of the safer staffing reports Frequency of Meetings and Location Frequency of members attendance specified including reference to 75% of diarised meetings. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting Inputs Provision of agenda and supporting papers Outputs Addition of assurance in relation to Committee Chair's report to the Board Appendix A Monitoring by the Trust Secretary
2.1	June 2023	Quality & Safety Committee	Purpose Removal of 'and Escalation' from the Board Assurance Framework Connectivity Addition of Transformation Council Amendment of Resus Advisory Council to Group Duties and Responsibilities c) amendment of indications to indicators d) amendment of Board visits to Time to Talk and Quality Visits e) addition of research f) addition of 'including those...' h) amendment of work plans to business cycles

			l) amendment of work plan to business cycle m) removal as duplicate of f) Inputs Amendment of work plan to business cycle Outputs Removal of Assurance from Committee Chair's Report
2.2	August 2023	Board of Directors	Approved
2.3	July 2024	Chair's Approval	Membership Addition of Associate Chief Nurse Amendment of Trust Secretary to Director of Corporate Governance Connectivity Removal of Transformation Council in conjunction with Finance & Performance Committee Addition of <i>Group</i>, to Corporate & Clinical Policy Addition of <i>Incident Review Group</i> to Patient Safety Duties and Responsibilities p. Removal of BAF 6 s. Addition of approval of the Quality Account process t. Addition of receipt of the Learning From Deaths report, received twice yearly Appendix A Amendment of Trust Secretary to Director of Corporate Governance
2.4	August 2025	Board of Directors	Membership Deputy Chief Executive / Chief Nurse replaced with Chief Nurse Duties and Responsibilities g) Amendment of point <i>'To review and monitor the quality impact of Cost Improvement Plans, via Quality Impact Assessments, to ensure that processes are robust and effective and that risks to quality and safety are understood, considered, mitigated and monitored'</i> with <i>To review and monitor the quality impact of cost improvement plans, service change and vacancies to ensure the processes are robust and effective and that risks to quality and safety are understood, considered, mitigated and monitored</i>

QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2025-26	ToR Clause	Lead	Action	30 Apr 2025	26 Jun 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026
Welcome, Apologies and Previous Meetings									
Apologies	Membership	Chair	Information	✓	✓	✓	✓	✓	✓
Declarations of Interest in items on the agenda	Membership	Chair	Information	✓	✓	✓	✓	✓	✓
Minutes from the previous meeting	Inputs	Chair	Approval	✓	✓	✓	✓	✓	✓
Action Log	Outputs	Chair	Action	✓	✓	✓	✓	✓	✓
Urgent Items with the agreement of the Chair	Outputs	Chair	Information	✓	✓	✓	✓	✓	✓
Duties and Responsibilities									
BAF 2 & 3	D&Rp	DoCG	Approval/assurance	✓	✓	✓	✓	✓	✓
Clinical Audit Plan and Research Assurance	Connectivity. D&Re	HoR	Assurance					✓	
Improvement Plans: Paediatric, Dermatology, Dental, Children's Transformation:part of Trust Improvement Plan report	Purpose. D&Rg&k	HoT	Assurance	✓	✓	✓	✓	✓	✓
Infection Prevention & Control Assurance: included in Quality Council report	Connectivity. D&Rf. Inputs	HoIPC	Assurance	✓		✓		✓	
IQPR	D&Rc. Inputs	COO	Assurance	✓	✓	✓	✓	✓	✓
Learning from Deaths Report (six monthly)	D&Rt	MD	Assurance	✓	✓	✓		✓	
QIA Report	D&R	CN	Assurance	✓	✓	✓	✓	✓	✓
Quality Account - approval of process	D&Rs. Inputs	CN	Approval	✓	✓				
Quality Council Report, including Effectiveness of Patient Safety Group and NICE Guidance Compliance	Connectivity. D&Rb. Inputs	QC Chair	Assurance	✓	✓	✓	✓	✓	✓
Quality Priorities - included in the Quality Account	D&Rs	DoQG	Approval			✓			
Quality, Safety and Patient Experience	Purpose. D&R. Inputs	HoPE	Assurance	✓		✓		✓	
Review of MIAA Audits within the remit of Q&S Committee	Connectivity. D&Re	DCN	Assurance	✓	✓	✓	✓	✓	✓
Risk Management Council Report	Connectivity. D&Ra, f, g,j	RMC Chair	Assurance	✓	✓	✓	✓	✓	✓
Serious Incidents Oversight	Connectivity. D&R b,d,f	DoQG	Assurance	✓	✓	✓	✓	✓	✓

QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2025-26	ToR Clause	Lead	Action	30 Apr 2025	26 Jun 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026
Terms of Reference Review	All Clauses	DoCG	Recommendation to Board		✓				
Trust Improvement Plan	D&R g&k. Inputs	ADT	Assurance		✓		✓		✓
Deep Dive Programme									
Consideration of future deep dive reports		Chair		✓	✓	✓	✓	✓	✓
Strategy Approval and Annual Review Programme									
Dental 2022-25 - for June 2025	D&Rm	ADD	Approval/Assurance		✓				
Engagement Strategy 2024-27	D&Rm	CN	Approval/Assurance						✓
Controlled Drugs	D&Rm	CDAO	Approval/Assurance				✓		
Prevention Pledge - for April 2025	D&Rm	MD	Approval/Assurance	✓					
Risk Management Framework (Strategy) 2022-25	D&Rm	RMC Chair	Approval/Assurance					✓	
Safeguarding Strategy 2022-25	D&Rm	DoSG	Approval/Assurance			✓			
Annual Reports									
Clinical Audit Annual Report	Connectivity. D&R	HoR	Approval		✓				
Infection Prevention & Control	Connectivity. D&R	HoIPC	Approval				✓		
Medicines Management/Controlled Drugs Annual Report	Connectivity. D&R	HoMM	Approval		✓				
PALS	Connectivity. D&R	HoPE	Approval						✓
Pressure Ulcers	Connectivity. D&R	DCN	Approval	✓					
Safeguarding	Connectivity. D&R	DoSG	Approval			✓			
Serious Incidents Compliance Report including non-medical prescribing	Connectivity. D&R	HoMM / DoQG	Approval		✓				
Corporate Governance									
Committee Annual Report	Appendix A	DoCG	Approval						✓
Committee Effectiveness Review - annual	Outputs	DoCG	Approval						✓
Committee Business Cycle Review - six monthly	D&Rh. Inputs. Outputs	DoCG	Approval		✓			✓	

QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2025-26	ToR Clause	Lead	Action	30 Apr 2025	26 Jun 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026
Items for Escalation to other Committees or Board	Purpose	DoCG	Information	<	<	<	<	<	<



QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2025-26	ToR Clause	Lead	Action	30 Apr 2025	26 Jun 2025	28 Aug 2025	30 Oct 2025	18 Dec 2025	26 Feb 2026

- Key:**
ADD - Associate Director, Dental
ADT - Associate Director, Transformation
CDAO - Controlled Drugs Accountable Officer
CN - Chief Nurse
COO - Chief Operating Officer
DCN - Deputy Chief Nurse
DoCG - Director of Corporate Governance
DoSG - Director of Safeguarding
DoQG - Director of Quality Governance
HoIPC - Head of Infection Prevention & Control
HoPE - Head of Patient Experience
HoR - Head of Research
HoT - Head of Transformation
MD - Medical Director
QC Chair - Quality Council Chair
RMC Chair - Risk Management Council Chair

TERMS OF REFERENCE STRATEGIC PEOPLE COMMITTEE IN COMMON

1. PURPOSE

The Strategic People Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the Trusts' people and organisational development strategies to enhance patient care, operational efficiency, and resource use, aligning with NHS regulations and local priorities.

The Committee Supports:

WHH's Strategic Objective 2:

- *We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

BCHT's Strategic Objective 3, 5 and 6:

- *We will... Ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.*
- *We will... Ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.*
- *We will... Work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.*

The Committee provides assurance to both sovereign Trust Boards that people strategies align with quality aims, overseeing the development and implementation of a joint People Strategy, Workforce Equality, Diversity and Inclusion Strategy, and Culture Plan as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

3.1. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Warrington)
- Chief People Officer (WHH)
- Deputy Chief People Officer (WHH)
- Chief Finance Officer (WHH)
- Chief Nurse (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director

- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Head of Strategic Workforce Development & Culture

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of People and Organisational Development (BCHT)
- Deputy Director of People and Organisational Development
- Director of Finance (BCHT)
- Chief Nurse and (Deputy Chief Executive BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Director of Corporate Governance (BCH)

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief People Officer/ Director of People and Organisational Development (or nominated Deputy) If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided they hold a related in common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Committee by the Trust Boards.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Boards.
- To provide overview and scrutiny to the development of the WHH and BCHT People Strategies.
- To ensure the WHH and BCHT People Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure the WHH and BCHT Workforce Equality, Diversity and Inclusion Strategies are designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the WHH and BCHT People Strategies are provided.
- To receive, agree and monitor progress on the WHH and BCHT People Strategies through receipt of exception reports and updates.
- To ensure that the Trusts attract and retain their workforce using the principles of Model Employer to become the employers of choice.
- To review the consultation, negotiation and approval of all employment policies on an annual basis, including:

- Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy,
- Details of any employee relations negotiations delaying policy approval,
- Details of extensions to policy dates,
- Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
- Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Survey results and to provide a set of recommendations for action by the Trusts.
- To receive, agree and monitor the staff engagement activity at both Trusts, including reward and recognition programmes. Ensuring the effectiveness of these activities on improved morale, increased Quarterly People Pulse scores and subsequent impact on patient experience.
- To ensure that all statutory and regulatory obligations are met in relation to equality, diversity and inclusion. The Committee holds the delegated responsibility on behalf of the Trust Board at BCHT and WHH for the approval of all equality, diversity and inclusion regulated reporting where the Committee is quorate.
- To receive, agree and monitor the Health and Wellbeing activity in both Trusts to be assured of the effectiveness of these activities on improving staff experience.

Duties – advisory:

- Consider any relevant ‘people’ risks within both Board Assurance Frameworks and corporate level risk registers as they relate to the remit of the Committee, as part of the reporting requirements,
- To ensure that there is a framework in place for Education Governance to support the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor both Trusts’ performance against national standards so far as they relate to employment.
- To monitor the effectiveness of both Trusts’ workforce performance reporting systems ensuring that the Trust Boards are assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Committee.
- To report any areas of significant concern to the Trust Boards as appropriate via the Committee Assurance Report.
- To monitor the implementation of Improving People Practices principles for WHH and BCHT through the adoption of a Just and Restorative Culture, including
 - Details of Employee Relations Cases in respect of numbers,
 - Summary of workforce demographics,
 - Analysis and impact assessment of emerging themes,
 - Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
 - Overview of lessons learned and actions taken to address these,
 - Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.
- To monitor the progress with Internal Audit recommendations where there is limited or no assurance identified.

- To monitor the delivery of staff engagement reports, including the NHS Staff Survey results and action plans.
- Monitor ward and maternity staffing data.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

The following Sub-Committees/ Groups will report directly to the Committee:

WHH:

- Operational People Sub Committee
- Workforce Inclusion and Culture Sub-Committee
- Workforce Review Group

BCHT:

- People Organisational Delivery Council (the “POD”)
- Medical and Dental Professional Governance
- Flu Group

Each Sub-Committee will submit a Chair Log Report to their respective Boards detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm one week preceding the Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate and equality and diversity considerations included
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / People Professional Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting unless otherwise agreed with the Chair of the Committee
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair(s) of the Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed

annually by the Committee. From April 2025, these Terms of Reference will be reviewed within three months.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Strategic People Committee in Common
Version:	V1
Implementation Date:	April 2025
Review Date:	March 2026
Approved by:	TBC
Approval Date:	TBC – April 2025

REVISIONS			
Date	Section	Reason on Change	Approved
February 2025	Terms of Reference	Revised Terms of Reference developed to create a Strategic People Committee in Common	TBC – April 2025

TERMS OF REFERENCE OBSOLETE		
Date	Reason	Approved by:
April 2025	WHH v7.1 Strategic People Committee to be replaced by v1 Strategic People Committee in Common	TBC – April 2025
April 2025	BCHT v2.3 People Committee to be replaced by v1 Strategic People Committee in Common	TBC – April 2025

Internal Audit Action Plans	As required	Assurance	DCPO/ DDoP	√	√	√	√	√	√	√	√	√	√	√	√
NATIONAL/ STATUTORY REPORTS															
Midwifery Staffing Report	Quarterly	Assurance	CN/ DoM			Deferred	√ Q4	√ Q1			√ Q2			√ Q3	
Health Education England (HEE) Monitoring Visit (Annual Assessment Visit)	Annually	Assurance	EMD						√						
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 Respnsible Officer Annual Report	Annually	Assurance	EMD						√						
NHSE Self Assessment Report for Education and Training	Annually	Assurance	CN								√				
National Education and Training Survey (NETS) Report	Annually	Assurance	CN	√											
Guardian of Safe Working Hours Report (WHH only)	Quarterly	Assurance	EMD		√ Q4			√ Q1			√ Q2			√ Q3	
Guardian of Safe Working Annual Report (WHH only)	Annually	Assurance	EMD				√								
Facilities Time Off Annual Report	Annually	Assurance	DCPO/ DDoP			Deferred	√ WHH and BCH								
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/ DDoP											√	
Equality Delivery System (EDS) 2025/26	Annually	Approval	DCPO/ DDoP										√		
Gender Pay Report	Annually	Approval	DCPO/ DDoP		√										
Workforce Race Equality Standard (WRES) including Bank and Medical Workforce Race Equality Standard (as required)	Annually	Approval	DCPO/ DDoP					√							
Workforce Disability Equality Standard (WDES)	Annually	Approval	DCPO/ DDoP					√							
GOVERNANCE															
Terms of Reference	Annually	Approval	CS/ DoCG					√ Review							√
Annual Cycle of Business	Annually	Approval	CS/ DoCG												√
Committee Chairs Annual Report to Trust Board to include Annual Review of BAF Risks	Annually	Approval	Chair/ CS/ DoCG			√									
Committee Effectiveness – Annual survey (on hold until Committee in Common Established)	Annually	Assurance/ Approval	CS/ DoCG												
SUB-COMMITTEE CHAIR'S LOGS															
WHH Workforce Inclusion and Culture Sub-Committee	Bi-Monthly	Noting	CPO	√		√		√		√		√		√	
WHH Operational People Committee	Bi-Monthly	Noting	CPO		√		√		√		√		√		√
WHH Workforce Review Group	Monthly	Noting	CN	√	√	√	√	√	√	√	√	√	√	√	√
BCHT POD Council	Quarterly	Noting	DDoP				√				√				√
BCHT Medical and Dental Professional Governance Meeting	Bi-Annually	Noting	EMD						√						√
CLOSING MATTERS															

[illegible]

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	07 AUGUST 2025
Agenda Item	64/25ii		
Report Title	FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE IN COMMON TERMS OF REFERENCE AND BUSINESS CYCLE		
Executive Lead	Nick Gallagher, Director of Finance		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note
Executive Summary			
In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Terms of Reference (ToR) and Cycle of Business on an annual basis to ensure the discharge of duties before presenting to the Trust Board for formal ratification. This report seeks approval from the Board for the establishment of the Finance, Sustainability and Performance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective July 2025). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration, while ensuring compliance with NHS regulations and local priorities. The proposed Cycle of Business is also included. The Trust Board is asked to: 1. Approve the Terms of Reference for the Finance, Sustainability & Productivity Committee in Common (Version 1), effective April 2025. 2. Note the Committee's review schedule, with the next review due by March 2026.			
Previously considered by:			
☐ Audit Committee ☐ Quality & Safety Committee ☒ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Remuneration & Nominations Committee ☐ Strategic People Committee in Common ☐ EMT			
Strategic Objectives			
☐ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.			
☐ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			



☐ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☐ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.
☐ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☐ BAF 2	☐ BAF 3	☐ BAF 4	☒ BAF 5	☐ BAF 6	☒ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☐ Caring	☐ Effective	☐ Responsive	☐ Safe	☐ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	00 Month 2025
Agenda Item	64/25ii		
Report Title	FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE IN COMMON TERMS OF REFERENCE AND BUSINESS CYCLE		
Purpose	One line summary		

1. BACKGROUND

In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Terms of Reference (ToR) and Cycle of Business on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification.

This report seeks approval from the Board for the establishment of the Finance, Sustainability and Performance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective July 2025). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration, while ensuring compliance with NHS regulations and local priorities.

The proposed Cycle of Business is also included.

2. KEY ELEMENTS

What is a Committee in Common?

A Committee in Common (CiC) is a governance arrangement where two or more statutory NHS organisations establish aligned committees that meet together to coordinate decision-making and strategic oversight. Unlike a Joint Committee, which can make binding decisions on behalf of multiple organisations through delegated authority, a CiC retains the sovereignty of each participating body. Each Trust's committee operates under its own terms of reference, albeit shared/aligned, making decisions that are synchronised but separately ratified by its respective Trust Board. This structure facilitates collaboration without compromising the legal independence of each organisation, making it an effective mechanism for partnerships progressing toward integration, as is the case with Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH).

In practice, the CiC enables efficient discussion and alignment on shared objectives such as workforce strategies while allowing each Trust to address unilateral matters pertinent to its own operations. Decisions requiring joint action are agreed in principle during CiC meetings, with formal approval resting with each sovereign Trust Board.

Context and Rationale

The Finance, Sustainability and Performance Committee in Common is established to oversee financial and operational planning, operational performance, strategic and business development,

estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

The Committee will provide assurance to both sovereign Trust Boards that financial strategies align with quality aims as the Trusts progress toward integration.

The CiC replaces the existing WHH Finance and Sustainability Committee (v10) and BCH Finance and Performance Committee (v2.4), consolidating efforts to streamline governance and reduce duplication. Monthly meetings, alternating between Warrington Hospital and Spencer House, will ensure regular collaboration, with in-person attendance encouraged to maximise engagement.

Key Features of the Committee

Membership: Comprises senior representatives from both Trusts, including Non-Executive Directors (one serving as Chair per meeting location), Chief Finance Officer/Director of Finance, and joint roles such as the Chief Operating Officer, Executive Medical Director, and Chief Nurse ensuring cross-Trust representation.

Quorum: Requires four members (two per Trust, including one Non-Executive Director and the Chief Finance Officer/Director of Finance/equivalent or deputy), maintaining flexibility for unilateral decisions if needed.

Authority: Authorised to investigate matters within its remit, request information, and escalate issues to the Audit Committees, while adhering to each Trust's Schemes of Reservation & Delegations.

Duties: Provides strategic oversight and assurance on finance, performance, and operational planning, including scrutiny of financial performance, review of budgets and service lines, monitoring of efficiency savings and pay policies and advises on strategic risks and investments.

Reporting: Provides bi-monthly assurance reports to the Boards and an annual performance review, ensuring transparency and accountability.

Benefits and Alignment

The CiC will:

- Enhance collaboration on financial planning and performance ahead of integration.
- Provide a unified oversight mechanism for finance-related risks and performance indicators.
- Ensure statutory obligations are met efficiently across both Trusts.

This aligns with the broader NHS context of moving from localised to system-wide approaches, as seen in Integrated Care Systems and provider collaboratives, while preserving each Trust's autonomy.

3. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the Terms of Reference for the Finance, Sustainability and Performance Committee in Common (Version 1), effective April 2025.
2. Note the Committee's review schedule, with the next review due by March 2026.

TERMS OF REFERENCE FINANCE, SUSTAINABILITY & PERFORMANCE COMMITTEE IN COMMON

1. PURPOSE

The Finance, Sustainability & Performance Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees financial and operational planning, operational performance, strategic and business development, estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

The Committee provides assurance to both sovereign Trust Boards that financial strategies align with quality aims as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

3.1. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Warrington)
- Chief Finance Officer (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Joint Chief Nurse
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Chief People Officer
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Deputy Chief Finance Officer (WHH)
- Company Secretary
- Associate Director of Estates and Facilities Management
- Chief Information Officer

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of Finance (BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director

- Joint Chief Nurse
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Director of People and Organisational Development (BCHT)
- Deputy Director of Finance (BCHT)
- Financial Controller

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief Finance Officer/ Director of Finance (or nominated Deputy). If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided they hold a related common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It is a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Finance and Performance

- Provide overview and scrutiny of financial performance referred by the Trust Board, especially regarding NHS Provider License breaches.
- Receive and consider financial and operational plans; make recommendations to the Board.
- Monitor effectiveness of financial performance reporting systems; ensure Board assurance via annual and exception reporting.
- Review Trusts' performance against annual financial plan and budgets.
- Review service line reports and seek assurance on service improvements.
- Review operational performance against annual plan; monitor corrective actions.
- Oversee development and monitoring of operational plan (activity, workforce, finance, budget, capital programme, cashflow).
- Ensure triangulation across portfolios in medium and long-term financial models.
- Monitor in-year delivery of annual efficiency savings programmes.
- Monitor compliance with NHSE pay policy requirements.
- Review and monitor Trusts' overall pay bill.
- Benchmark financial and operational performance within ICS, regionally and nationally.
- Approve capital expenditure up to £5m on behalf of the Trust Board. (WHH only)
- Oversee Emergency Preparedness and Response (EPRR) Framework.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

Risk Management and Internal Control

- Receive relevant elements of Board Assurance Framework and Corporate Risk Register; escalate concerns to Audit Committee or Board.
- Receive reports and assurance from Directors on:
 - Significant risks for inclusion in Board Assurance Framework.
 - Divisional action plans to mitigate risks and close assurance gaps.
 - Escalation of significant finance and performance risks.
- Work with Directors to assess and advise on financial/operational aspects of Risk Management Strategy.

Revenue Requests/ Business Cases

- In accordance with the Trusts' Standing Financial Instructions and Scheme of Reservation & Delegation, the Committee will consider revenue requests/ business cases in excess of £500,000, prior to presenting the request to the Trust Board for final approval.

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trusts' operation.

Estates and Assets

- Consider proposals for Estates and Assets.
- Seek assurance on delivery of Estates Strategy.
- Review and recommend Health and Safety Strategy to the Board (BCHT only)
- Receive assurance on compliance with estate and health/safety guidance/legislation.

Quality

- Refer finance-related matters with significant quality implications to the Quality and Safety Committee.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting; and/or
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have; and/or
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

WHH:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

BCHT:

- Capital Council
- Boosting Efficiency Council
- DIGIT
- Estates Sub Committee
- Health & Safety Sub Committee
- Performance Council

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Boards
- A Cycle of Business will be established

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed annually by the Committee.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

**TERMS OF REFERENCE
REVISION TRACKER**

Name of Committee:	Finance, Sustainability & Performance Committee in Common
Version:	V1
Implementation Date:	July 2025
Review Date:	March 2026
Approved by:	TBC
Approval Date:	TBC

REVISIONS			
Date	Section	Reason on Change	Approved

TERMS OF REFERENCE OBSOLETE		
Date	Reason	Approved by:

FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE IN COMMON CYCLE OF BUSINESS 2025/26															
CALENDAR YEAR (APRIL 2025 - MARCH 2026)				2025									2026		
	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				√ WHH	√ BCH	√ WHH	√ BCH	√ WHH	√ BCH	√ WHH	√ BCH	√ WHH
Declarations of Interest	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Business Cycle	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Rolling Attendance Log	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Minutes of the last meeting and Action Log	Standing Item	Approval	Chair				√	√	√	√	√	√	√	√	√
Matters Arising	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
STANDING ITEMS															
Deep Dive	Monthly	Assurance	Chair/CFO				√	√	√	√	√	√	√	√	√
Hot Topic	Monthly	Assurance	Chair/CFO				√	√	√	√	√	√	√	√	√
Integration Update	Monthly	Information	CS&PO				√	√	√	√	√	√	√	√	√
FINANCIAL ASSURANCE															
Finance Report ▪ WHH - including Finance and Resources Group Minutes and Capital Planning Group Minutes ▪ BCH	Monthly	Assurance	CFO/Dir of Finance				√	√	√	√	√	√	√	√	√
CIP Report	Monthly	Assurance	CFO/Dir of Finance				√Separate	√ ? Joint Report	√	√	√	√	√	√	√
Reports/minutes from the Delivery Unit - escalation committee, pay, non-pay and performance	Monthly	Assurance					√	√	√	√	√	√	√	√	√
Capital Expenditure (including schemes above £500K)	Monthly	Assurance	CFO/Dir of Finance				√ Joint	√	√	√	√	√	√	√	√
Cost Pressures (WHH)	Monthly	Assurance	CFO				√	√	√	√	√	√	√	√	√
Pay Assurance Report (WHH)	Bi-Monthly ?tbc	Assurance	CPO					√		√		√		√	
Cash Support Update (WHH)	Monthly	Assurance	CFO				√	√	√	√	√	√	√	√	√
Costing Update Joint report (including National Cost Collection and Service Line Reporting BCH)	Quarterly	Assurance	CFO/Dir of Finance				Q4					Q1 & Q2 Bi Annual			Q3
Benefits Realisation Quarterly Report (WHH only)	Quarterly	Assurance	CFO					Q1			Q2			Q3	
Procurement Report (BCH)	Bi-Annual	Assurance	Dir of Finance						√				√		
Annual Report and Accounts WHH and BCH ? Remove?	Annual	Approval	CFO/Dir of Finance												
Annual Budget Setting Reports ▪ WHH ▪ BCH	Bi- Annual	Approval	CFO/Dir of Finance						√						√
Annual Financial Plan (for recommendation to the Board) ▪ WHH ▪ BCH	Annual	Approval	CFO/Dir of Finance												√
Indicative Financial Cost of Harm Joint Report	Annual	Assurance	CFO/Dir of Finance												
Capital Planning Group Annual Report (WHH)	Annual	Assurance	CFO				√								
Performance Assurance Framework (PAF) Review and Refresh of Trust KPIs ▪ WHH ▪ BCH	Annual	Assurance	CFO/Dir of Finance												√
PERFORMANCE															

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	64/25iii		
Report Title	CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT AND COMMITTEE IN COMMON TERMS OF REFERENCE		
Executive Lead	Nikhil Khashu, Chief Executive		
Report Author	Lucy Gardner, Chief Strategy and Partnerships Officer		
Presented by	Jan McCartney, Director of Corporate Governance		
Action Required	☒ To Approve	☐ To Assure	☐ To Note

Executive Summary

Cheshire and Merseyside (C&M) providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. CMPC has come about through a process borne from bringing together its two forerunners, Cheshire and Merseyside Acute & Specialist Trust Alliance (CMAS) and the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC) to focus on work of shared provider delivery: acute, specialist and community services. Working together has achieved real and tangible benefits since the pandemic and been consolidated since. All providers consider this next step will provide further opportunities and opportunities for at scale working where this makes sense.

Following a review requested by the system leaders and sponsored by Trust CEOs, Trust Company Secretaries have engaged in a process of seeking to build upon the established and available collaboration mechanisms within C&M that have been shown to work and support a track record of collaboration.

In identifying, promoting and championing the benefits of collaboration, NHS England have encouraged all providers to build on local successes through provider collaborative structures where these can be shown to work.

C&M Company Secretaries have worked together and drawn upon the expertise and advice of Hill Dickinson to support the redrafting and reframing of a CMPC Joint working agreement and Committees in Common terms of reference. This approach continues the chosen route of governing collaborative delivery and ongoing potential within the system.

The CMPC Leadership Board recommends the attached appendices for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration.

The Board is asked to:

1. To endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed.
2. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership.

To explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making.



Previously considered by:	
☐ Audit Committee ☐ Finance & Performance Committee/Finance, Sustainability and Performance Committee in Common ☐ Strategic People Committee in Common	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ EMT
Strategic Objectives	
☒ Equality, Diversity and Inclusion - We will ensure that equality, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.	
☒ Health Equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.	
☒ Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.	
☒ Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.	
☒ Resources - We will ensure that we use our resources in a sustainable and effective way.	
☒ Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.	

How does the paper address the strategic risks identified in the BAF?						
☒ BAF 1	☒ BAF 2	☒ BAF 3	☒ BAF 4	☒ BAF 5	☒ BAF 6	☒ BAF 7
Governance Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	Quality Failure to deliver quality services and continually improve	Health Equity Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	Staff Failure to create an environment for staff to grow and thrive	Resources Failure to use our resources in a sustainable and effective way	Equality, Diversity & Inclusion Failure to build a culture that champions equality, diversity and inclusion for patients and staff	Partnerships / Integration with WHH Failure to work in close collaboration with partners and staff in place and across the system

CQC Domains:	☒ Caring	☒ Effective	☒ Responsive	☒ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 AUGUST 2025
Agenda Item	64/25iii		
Report Title	CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT AND COMMITTEE IN COMMON TERMS OF REFERENCE		
Report Author	Lucy Gardner, Chief Strategy and Partnerships Officer		
Purpose	The CMPC Leadership Board recommends the attached appendices for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration		

1. SCOPE

- 1.1 All providers within C&M have some familiarity and individual experiences of differing means of the proposed way of working. This report therefore seeks to briefly orientate an approach and structure of the two documents and then goes on to highlight, at a headline level, changes and areas of development as proposed by Hill Dickinson or Trust company secretaries to aid clarity, understanding and to respond to the current and changed environment.

2. KEY ELEMENTS

- 2.1 **Joint Working Agreement (JWA)**, further detail, and to be read in conjunction with CiC ToR:

- Covers: vision; function; priorities and headline areas of focus
- Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
- Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

- 2.2 **Committee in Common - Terms of Reference (CiC ToR)**, further detail, and to be read in conjunction with JWA:

- Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
- Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
- Sets aims and objectives of CiC
- Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
- Quorum
- Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
- To note: NWAS is proposed as a participant of the meeting rather than as a Member

Changes and variation from previous documentation (or familiar approaches): further detail, and to be read in conjunction with JWA and draft CiC:

Terms of References:

- Updates of names and terminology – organisations, CMPC etc
- Added definitions – to reflect content of documents at request of company secretaries
- Refer to the full breadth of CMPC responsibilities – including community – but also not seek to restrict nor curtail future Trust Board choices
- Additional words without altering meaning of sentences to support clarity
- Reframing of section 2.1 (ToR) to reorder theme stated aims and objectives.
- Add to ICB reference ‘and regulator or those charged with performance management’
- Specifying MS Teams or equivalent as an option for a CiC meeting

Joint working agreement:

- Provide further clarity on the route for determining any costs arising from collaborative arrangements (section 6)
- Provide further clarity on the route for calculating any exist costs or transition arrangements arising from a cessation of collaborative arrangements (section 6)
- Additional parameters on timescales for stages of any dispute resolution (section 10)

A request was also made from one Trust for definition and adoption of an information sharing agreement (something explored on numerous occasions in the past by Leadership Boards). If the will exists for this it is proposed that this is developed by Trust Company Secretaries (with legal support and input) and proposed to Leadership Board for adoption.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M’s preferred way of operating.

The document delivers both a foundation and framework for CMPC development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMPC develops and the ask of the system, for it, expands, varies or diminishes.

3. RECOMMENDATION

- 3.1 To endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed.
- 3.2 To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership.
- 3.3 To explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making.

Appendix A: CMPC Leadership Board Terms of Reference

Appendix B: CMAST Joint Working Agreement

**~~CMAS~~CMPC LEADERSHIP BOARD
TERMS OF REFERENCE FOR A
COMMITTEE OF THE BOARD TO MEET
IN COMMON WITH COMMITTEES OF
OTHER ~~CMAS~~CMPC TRUSTS**

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside ~~Acute and Specialist~~ Trusts Provider Collaborative or <u>CMAS~~T~~CMPC</u>	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
<u>CMAS~~T~~CMPC</u> Agreement	the ~~J~~ oint ~~w~~ orking ~~a~~ greement signed by each of the Trusts in relation to their provider collaborative working and the operation of the [TRUST] CiC together with the other <u>CMAS~~T~~CMPC</u> CiCs;
<u>CMAS~~T~~CMPC</u> CiCs	the <u>Trust CiC and the other respective</u> committees established by each of the Trusts to work alongside ~~the committees established by the other Trusts~~ <u>each other</u> and “ <u>CMAS~~T~~CMPC</u> CiC ” shall be interpreted accordingly;
<u>CMPC Leadership Board</u>	<u>The Leadership Board is a regular meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC</u> <u>Leadership Board can also be used as the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference.</u>
<u>CMAS~~T~~CMPC</u> Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
<u>CMAS~~T~~CMPC</u> Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to <u>CMAS~~T~~CMPC</u> ;
<u>CMAS~~T~~CMPC</u> Programme Support	Administrative infrastructure supporting <u>CMAS~~T~~CMPC</u> ;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the <u>CMAS~~T~~CMPC</u> CiC meetings when they meet in common;
Member	a person nominated as a member of an <u>CMAS~~T~~CMPC</u> CiC in accordance with their Trust's

	Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or “C&M ICS”	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
<u>NHS Cheshire & Merseyside Integrated Care Board or “C&M ICB”</u>	<u>the Integrated Care Board (ICB) for Cheshire and Merseyside. An NHS organisation established on July 1, 2022, that leads an Integrated Care System (ICS). ICBs are responsible for planning and funding most NHS services in their area, managing the NHS budget, and ensuring services are in place to meet the health needs of the local population.</u>
[TRUST] CiC	the committee established by [TRUST] NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other ~~CMAS~~ ~~CMPC~~ CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	[TRUST] NHS Foundation Trust of [Address];
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women’s NHS FT, Alder Hey Children’s Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT, <u>Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust</u> and “ Trust ” shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

- 1.2 The [Trust] NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in ~~CMAS~~~~CMPC~~ to implement change.
- 1.3 Each Trust has agreed to establish a committee which shall work in common with the other ~~CMAS~~~~CMPC~~ CiCs, but which will each take its decisions independently on

behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in ~~CMAS~~CMPC but is not forming its own ~~CMAS~~CMPC CiC and will be in attendance at meetings of the ~~CMAS~~CMPC CiC's but not a member Trust.

- 1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each respective individual ~~CMAS~~CMPC CiC will be different.
- 1.5 Each Trust has entered into the ~~CMAS~~CMPC Agreement on **[DATE]** and agrees to operate its ~~CMAS~~CMPC CiC in accordance with the ~~CMAS~~CMPC Agreement.

2 Aims and Objectives of the [TRUST] CiC

- 2.1 The aims and objectives of the [Trust] CiC are to work with the other ~~CMAS~~CMPC CiCs on system work or matters of significance as delegated to the [Trust] CiC under Appendix A to these Terms of Reference to:

2.1.1 Leadership

Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams.

Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.2 Delivery

Consider different employment models for service line specialities including contractual outcomes and governance arrangements;

Review the key deliverables and hold the Trusts to account for progress against agreed decisions;

Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

Establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

Improve the quality of care, safety and the patient experience delivered by the Trusts;

Deliver equality of access to the Trusts service users; and

Ensure the Trusts deliver services which are clinically and financially sustainable.

2.1.3 Collaborate

Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance;

Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board and regulator or those charged with performance management;

Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC;

Ensure compliance and due process with regulating authorities regarding service changes;

Oversee the creation of joint ventures or new corporate vehicles where appropriate;

- 2.2 Review the CMPC Agreement and Terms of Reference for CMPC CiCs on at least a biennial basis;

3 Establishment

- 3.1 The **[TRUST]** NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the **[TRUST] CMAP** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the **[TRUST]** CiC.
- 3.2 The **[TRUST]** CiC shall work cooperatively with the other ~~CMAS~~**CMPC** CiCs and in accordance with the terms of the ~~CMAS~~**CMPC** Agreement.
- 3.3 The **[TRUST]** CiC is a committee of **[TRUST]** NHS Foundation Trust's board of directors and therefore can only make decisions binding **[TRUST]** NHS Foundation Trust. None of the Trusts other than **[TRUST]** NHS Foundation Trust can be bound by a decision taken by **[TRUST]** CiC.
- 3.4 The **[TRUST]** CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The **[TRUST]** CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

- 4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in **[TRUST]** NHS Foundation Trust's Constitution.
- 4.2 **[TRUST]** CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the [TRUST] CiC in paragraph 4 of these Terms of Reference shall be retained by [TRUST] NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of [TRUST] NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

- 6.1 On receipt of the papers detailed in paragraph 13.1.2, the [TRUST] CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to [TRUST] NHS Foundation Trust's Board for inclusion on the private agenda of [TRUST] NHS Foundation Trust's next Board meeting in order that [TRUST] NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.
- 6.2 The [TRUST] CiC shall send the minutes of [TRUST] CiC meetings to [TRUST] NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of [TRUST] NHS Foundation Trust's Board meeting.
- 6.3 [TRUST] CiC shall provide such reports and communications briefings as requested by [TRUST] NHS Foundation Trust's Board for inclusion on the agenda of [TRUST] NHS Foundation Trust's Board meeting.

7 Membership

- 7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".
- 7.2 Each [TRUST] CiC Member shall nominate a deputy to attend [TRUST] CiC meetings on their behalf when necessary ("**Nominated Deputy**").
- 7.3 The Nominated Deputy for [TRUST] NHS Foundation Trust's Chief Executive shall be an Executive Director of [TRUST] NHS Foundation Trust.
- 7.4 In the absence of the [TRUST] CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:
 - 7.4.1 attend [TRUST] CiC's meetings;
 - 7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and
 - 7.4.3 exercise Member voting rights,and when a Nominated Deputy is attending a [TRUST] CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".
- 7.5 The chair of the [TRUST] CiC shall be nominated by the [TRUST] CiC.

- 7.6 When the ~~CMAS~~CMPC CiCs meet in common, one person nominated from the Members of the ~~CMAS~~CMPC CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

- 8.1 The Members of the other ~~CMAS~~CMPC CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of [TRUST] CiC. The [TRUST] 's Chair shall be invited to meetings of the ~~CMAS~~CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see ~~CMAS~~CMPC JWA) as a non-voting attendee.
- 8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of [TRUST] CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the ~~CMAS~~CMPC CiCs.
- 8.3 The ~~CMAS~~CMPC Programme Lead shall have the right to attend the meetings of [TRUST] CiC.
- 8.4 Without prejudice to paragraphs 8.1 to 8.3~~Error! Reference source not found.~~, inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the ~~CMAS~~CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the ~~CMAS~~CMPC CiCs shall not count towards the quorum or have the right to vote at such meetings.
- 8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of [TRUST] CiC.

9 Meetings

- 9.1 Subject to paragraph ~~9.39.39.2~~ below, [TRUST] CiC meetings shall take place monthly.
- 9.2 The [TRUST] CiC shall meet with the other ~~CMAS~~CMPC CiCs as the ~~CMAS~~CMPC Leadership Board in accordance with the ~~CMAS~~CMPC Agreement (as set out in clause 4 of the ~~CMAS~~CMPC Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.
- 9.3 Any Trust CiC Member may request an extraordinary meeting of the ~~CMAS~~CMPC CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the ~~CMAS~~CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [TRUST] CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the ~~CMAS~~CMPC Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [TRUST] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the [TRUST] CiC shall have one vote. The [TRUST] CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the ~~CMAS~~CMPC Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [TRUST] CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) i.e MS Teams or equivalent to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

- 13.1 Administrative support for the [TRUST] CiC will be provided by ~~CMAS~~CMPC Programme Support (or such other route as the Trusts may agree in writing). The ~~CMAS~~CMPC Programme Support will:
 - 13.1.1 draw up an annual schedule of ~~CMAS~~CMPC CiC meeting dates and circulate it to the ~~CMAS~~CMPC CiCs;
 - 13.1.2 circulate the agenda and papers three (3) Working Days prior to ~~CMAS~~CMPC CiC meetings; and
 - 13.1.3 take minutes of each [TRUST] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant [TRUST] CiC meeting.
- 13.2 The agenda for the [TRUST] CiC meetings shall be determined by the ~~CMAS~~CMPC Programme Lead and agreed by the Meeting Lead prior to circulation.
- 13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the ~~CMAS~~CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CiC

The Board of each Trust within CMAS~~T~~CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAS~~T~~CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the “Services” refer to the services that form part of the CMAS~~T~~CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAS~~T~~CMPC Agreement and which may be supplemented or further defined by an annual CMAS~~T~~CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the <u>CMAS~~T~~CMPC</u> programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the [TRUST] CiC referred to it by the <u>CMAS~~T~~CMPC</u> Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to <u>CMAS~~T~~CMPC</u> Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of <u>CMAS~~T~~CMPC</u> Programmes;

	Decisions delegated to [TRUST] CiC
6.	In relation to services preparing business cases to support or describe delivery of agreed <u>GMASTCMPC</u> priorities or programmes (including as required by any agreed <u>GMASTCMPC</u> annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises;

	Decisions delegated to [TRUST] CiC
	f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and ~~CMAS~~ <u>CMPC</u> Joint Working Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

Draft No: 24
Date of Draft: June 2025 September
2024

Dated 20254

**CHESHIRE & MERSEYSIDE ACUTE AND
SPECIALIST TRUSTS PROVIDER
COLLABORATIVE (CMPCAST)
JOINT WORKING AGREEMENT**

Between

(1) BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

(2) CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

(4)(3) COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

(2)(4) LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

(3)(5) WARRINGTON AND HALTON TEACHING HOSPITALS NHS
FOUNDATION TRUST

(4)(6) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

(5)(7) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

(6)(8) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

(7)(9) THE WALTON CENTRE NHS FOUNDATION TRUST

(8)(10) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

(9)(11) ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

(12) MERSEY CARE NHS FOUNDATION TRUST

(10)(13) EAST CHESHIRE NHS TRUST

(14)(14) MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS
TRUST

WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST

(15) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

(16) WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST

and

(12)(17) NORTH WEST AMBULANCE SERVICE NHS TRUST

Commented [A1]: UPDATE FOR MERSEY CARE /
C&W BW and WC

Draft No:
Date of Draft:
2024

24
June 2025 September

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1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the <u>CMAS~~T~~CMPC</u> CiCs;
<u>CMAS~~T~~CMPC</u> CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and " <u>CMAS~~T~~CMPC</u> CiC " shall be interpreted accordingly.
<u>CMAS~~T~~CMPC</u> Leadership Board	the <u>CMAS~~T~~CMPC</u> CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the <u>CMAS~~T~~CMPC</u> CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the <u>CMAS~~T~~CMPC</u> CiC meetings when they meet in common;
Member	a person nominated as a member of a <u>CMAS~~T~~CMPC</u> CiC in accordance with their Trust's Terms of Reference and " Members " shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	~~the Countess Of Chester Hospital NHS FT,~~ Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "Trust" shall be interpreted accordingly.

- 1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMASTCMPC as a provider collaborative.
- 1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMASTCMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMASTCMPC but is not forming a CMASTCMPC CiC and will be in attendance at meetings of the CMASTCMPC CiC's but not a member Trust.
- 1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMASTCMPC CiC will be different.
- 1.5 The CMASTCMPC Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMASTCMPC Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

- 2.1 Our vision did span a range of time horizons. However as we have become more confident, clear and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

- 2.2 The key functions of CMASTCMPC are to:
 - 2.2.1 Deliver the CMASTCMPC vision;
 - 2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;
 - 2.2.3 Align priorities across the member Trusts,
 - 2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration
 - 2.2.5 Direct operational resources across Trust members to improve service provision;
 - 2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 ~~CMAS~~~~CMPC~~'s stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the ~~CMAS~~~~CMPC~~ CiCs acting through the ~~CMAS~~~~CMPC~~ Leadership Board.

2.5 More specifically the ~~CMAS~~~~CMPC~~ CiCs and the ~~CMAS~~~~CMPC~~ Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of ~~CMAS~~~~CMPC~~ development:

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Delivery and co-ordination of the community programme to support alignment with other programmes;

2.5.3 Further development of community based alternatives to hospital admission and standardisation of the community services offer in Cheshire and Merseyside as per the Neighbourhood health guidance;

2.5.22.5.4 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.32.5.5 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.42.5.6 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.52.5.7 Coordinating and enabling ~~CMAS~~~~CMPC~~ members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.62.5.8 Coordinating and enabling ~~CMAS~~~~CMPC~~ members contribution and response to system wide financial decision making, pressures and financial governance;

~~2.5.7~~2.5.9 Responding to and coordinating ~~CMAS~~CMPC action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

~~2.5.8~~2.5.10 The ~~CMAS~~CMPC Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this ~~CMAS~~CMPC will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate ~~CMAS~~CMPC may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the ~~CMAS~~CMPC Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended through variation, by Trust Board resolutions or agreement of the annual ~~CMAS~~CMPC workplan.

- 2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for ~~CMAS~~CMPC will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

- 3.1 The Trusts have agreed to adopt this Agreement and agree to operate the ~~CMAS~~CMPC CiCs as the ~~CMAS~~CMPC **Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within ~~CMAS~~CMPC openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

~~3.1.7~~ Recognising the relationship between acute, mental health, community and specialist providers ensuring that information is shared where this impacts on other sectors;

~~3.4.7~~3.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

~~3.4.8~~3.1.9 Recognising and respecting the collective view and keeping to any agreements made between the ~~CMAS~~CMPC CiC's;

~~3.4.9~~3.1.10 Maintain ~~CMAS~~CMPC collective agreed position on shared decisions in all relevant communications;

~~3.4.10~~3.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

~~3.1.11~~~~3.1.12~~ Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The ~~CMAS~~~~CMPC~~ CiCs shall meet together as the ~~CMAS~~~~CMPC~~ Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14~~8~~).

4.1.1 Meetings of the ~~CMAS~~~~CMPC~~ Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

- A. ~~CMAS~~~~CMPC~~ Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure;¹
- B. ~~CMAS~~~~CMPC~~ Leadership Board – Decisions to be made under the ~~CMAS~~~~CMPC~~ CiC delegations - CiC CEOs;
- C. ~~CMAS~~~~CMPC~~ Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The ~~CMAS~~~~CMPC~~ CiCs shall work collaboratively with each other as the ~~CMAS~~~~CMPC~~ Leadership Board in relation to the committees in common model.

4.3 Each ~~CMAS~~~~CMPC~~ CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any ~~CMAS~~~~CMPC~~ CiC or its duty to act in the best interests of its Trust, each ~~CMAS~~~~CMPC~~ CiC shall seek to reach agreement with the other ~~CMAS~~~~CMPC~~ CiCs in the ~~CMAS~~~~CMPC~~ Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the ~~CMAS~~~~CMPC~~ CiCs meet in common, as the ~~CMAS~~~~CMPC~~ Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2025~~6~~.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the ~~CMAS~~~~CMPC~~ Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	Approach to decision
Matter under discussion has no involvement or impact on other ~~CMAS~~ ~~CMPC~~ Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the ~~CMAS~~ ~~CMPC~~ Leadership Board if appropriate.
Matter only involves or impacts a smaller group of ~~CMAS~~ ~~CMPC~~ Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The ~~CMAS~~ ~~CMPC~~ CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference.

¹ Chairs will be invited to ~~CMAS~~~~CMPC~~ Leadership Board meetings, at least quarterly.

	Notify the <u>CMAS~~T~~CMPC</u> Leadership Board.
Matter involves or impacts all <u>CMAS~~T~~CMPC</u> Trusts and comes within the delegation under the <u>CMAS~~T~~CMPC</u> CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the <u>CMAS~~T~~CMPC</u> CiCs at the <u>CMAS~~T~~CMPC</u> Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAS~~T~~CMPC Trust will report back to its own Board and the CMAS~~T~~CMPC Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAS~~T~~CMPC Trust Board meetings. The CMAS~~T~~CMPC Trust chairs ~~will~~ may (as well as their quarterly CMAS~~T~~CMPC meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAS~~T~~CMPC on an informal basis. In addition, the CMAS~~T~~CMPC Leadership Board will seek to ensure that each CMAS~~T~~CMPC programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAS~~T~~CMPC CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAS~~T~~CMPC (or if relevant, section of the meeting), ~~will~~ may be held in public except where a resolution is agreed by the CMAS~~T~~CMPC Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAS~~T~~CMPC meetings held in public will be published.

5 Future Involvement and Addition of Parties

- 5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.
- 5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 ~~Any exit plan, when required or proposed by a Trust, will be drafted for consideration by the Leadership Board with support by the CMPC DoFs. Within three (3) months of the date of this Agreement the Trusts shall develop and, it is a necessity that an agreed an exit plan which shall deals~~ with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

~~6.1.3~~ 6.1.3 the Meeting Lead and the CMAS~~T~~CMPC CiC Chairs varying the Agreement under clause 10.6.2.

~~6.1.36.1.4~~ 6.1.4 ~~cost apportionment, where appropriate, will be applied on a proportionate fair shares basis~~

6.2 ~~Once agreed by all of the Trusts, the An exit plan approach is drafted shall be inserted into this Agreement at Appendix 1589 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.~~

7 Termination

- 7.1 If any Trust wishes to revoke the delegation of functions to the relevant ~~CMAS~~CMPC CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:
- 7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the ~~CMAS~~CMPC Leadership Board of their intention to do so; and
 - 7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.
- 7.2 If:
- 7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or
 - 7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,
- then the Exiting Trust may (subject to the terms of the exit plan at Appendix 159) exit this Agreement.
- 7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its ~~CMAS~~CMPC CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:
- 7.3.1 Revoke their delegations and terminate this Agreement; or
 - 7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

- 8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.
- 8.2 Where appropriate the ~~CMAS~~CMPC Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.
- 8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The ~~CMAS~~CMPC Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.
- 8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this cClause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired from other Trusts in connection with this Agreement which concerns:

- 8.4.1 any matter of commercial interest contained or referred to in this Agreement;
- 8.4.2 Trusts' manner of operations, staff or procedures;
- 8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMASTCMPC is committed to clear, consistent and transparent communication across the CMASTCMPC Trusts and with system partners' where appropriate. It is specifically recognised that CMASTCMPC Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMASTCMPC and the CMASTCMPC Trusts may be asked to represent both their own organisations and CMASTCMPC in such local place-based discussions.

- 8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.
- 8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.
- 8.7 The Trusts undertake for themselves and their respective Boards and employees that:
 - 8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';
 - 8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;
 - 8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and
 - 8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.
- 8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMASTCMPC Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMASTCMPC activities.
- 8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

- 8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the further operation or development of CMAS~~T~~CMPC across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 19~~6~~ and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement².

9 Conflicts of Interest

- 9.1 Members of each of the CMAS~~T~~CMPC CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAS~~T~~CMPC Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAS~~T~~CMPC's decision-making processes.
- 9.2 The CMAS~~T~~CMPC Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAS~~T~~CMPC website. It is proposed that such policies will either be CMAS~~T~~CMPC developed or CMAS~~T~~CMPC will support the adoption and application of the policy of the CMAS~~T~~CMPC Chair and/or Meeting Lead.
- 9.3 All CMAS~~T~~CMPC Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAS~~T~~CMPC, will comply with the CMAS~~T~~CMPC policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAS~~T~~CMPC. Reuse / resubmission of host employer or home trust data, where applicable, will be supported
- 9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAS~~T~~CMPC Leadership Board.
- 9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAS~~T~~CMPC Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAS~~T~~CMPC Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAS~~T~~CMPC Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

- 10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.
- 10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.
- 10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAS~~T~~CMPC CiCs at the CMAS~~T~~CMPC Leadership Board the appropriate course of action to take.
- 10.4 If the Meeting Lead and the CMAS~~T~~CMPC Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by

² To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

written notice. Any decision of the Meeting Lead and the ~~CMAS~~CMPC Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the ~~CMAS~~CMPC Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the ~~CMAS~~CMPC Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

- 10.5.1 appointment of a panel of ~~CMAS~~CMPC Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;
- 10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or
- 10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the ~~CMAS~~CMPC Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and ~~CMAS~~CMPC Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and ~~CMAS~~CMPC Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 The above process (10.5) will seek to be addressed within one calendar month and no longer than 6 weeks unless, in such circumstances, as all parties agree to a longer time frame

~~10.6~~10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and ~~CMAS~~CMPC Leadership Board may decide to recommend their Trust's Board of Directors to:

~~10.6-1~~10.7.1 terminate the Agreement;

~~10.6-2~~10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

~~10.6-3~~10.7.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

- 12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.
- 12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.
- 12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

.....
For and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **CHESHIRE AND WIRRAL PARTNERSHIP NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of MERSEY CARE NHS FT

This Agreement is executed on the date stated above by

.....
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

.....
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

.....
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **WIRRAL COMMUNITY HEALTH AND CARE NHS FT**

This Agreement is executed on the date stated above by

.....
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

**APPENDIX 1– TERMS OF REFERENCE FOR BRIDGEWATER COMMUNITY HEALTHCARE NHS
FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Bridgewater Community Healthcare NHS
Foundation Trust CIC]**

**APPENDIX 2 – TERMS OF REFERENCE FOR CHESHIRE AND WIRRAL PARTNERSHIP NHS
FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Cheshire and Wirral Partnership NHS
Foundation Trust CIC]**

~~Appendix 4~~ **APPENDIX 3– TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER
HOSPITAL NHS FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Countess of Chester Hospital NHS
Foundation Trust CiC]**

~~Appendix 2~~ **APPENDIX 4 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY
HOSPITALS NHS FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Liverpool University Hospitals NHS
Foundation Trust CiC]**

**Appendix 3 APPENDIX 5– TERMS OF REFERENCE FOR WARRINGTON AND HALTON
TEACHING HOSPITALS NHS FOUNDATION TRUST CIC**

**[Insert Terms of Reference for Warrington and Halton Teaching Hospitals
NHS Foundation Trust CiC]**

Appendix 4**APPENDIX 6** – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING
HOSPITAL NHS FOUNDATION TRUST CIC

**[Insert Terms of Reference for the Wirral University Teaching Hospital NHS
Foundation Trust CiC]**

~~Appendix 5~~ **APPENDIX 7 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER
CENTRE NHS FOUNDATION TRUST CIC**

**[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS
Foundation Trust CiC]**

**Appendix 6 APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST
HOSPITALS NHS FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS
Foundation Trust CiC]**

~~Appendix 7~~ **APPENDIX 9 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS
FOUNDATION TRUST CIC**

**[Insert Terms of Reference for The Walton Centre NHS Foundation Trust
CiC]**

~~Appendix 8~~**APPENDIX 10 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS
FOUNDATION TRUST CIC**

**[Insert Terms of Reference for the Liverpool Women's NHS Foundation
Trust CiC]**

Appendix 9 APPENDIX 11 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN’S HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children’s Hospital NHS Foundation Trust CiC]

APPENDIX 12– TERMS OF REFERENCE FOR MERSEY CARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey Care NHS Foundation Trust CiC]

~~Appendix 10~~ **APPENDIX 13 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST
CIC**

[Insert Terms of Reference for the East Cheshire NHS Trust CIC]

Appendix 11
APPENDIX 14 – TERMS OF REFERENCE FOR THE MERSEY AND WEST
LANMCASHIRE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION
TRUST CIC

**[Insert Terms of Reference for the Mersey and West Lancashire Teaching
Hospitals NHS Foundation Trust CIC]**

~~Appendix 12~~**APPENDIX 15 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS
NHS TRUST CIC**

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 16– TERMS OF REFERENCE FOR WIRRAL COMMUNITY HEALTH AND CARE NHS
FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral Community Health and Care NHS
Foundation Trust CiC]

~~Appendix 13~~**APPENDIX 17 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE
SERVICE NHS TRUST CIC**

[Not applicable]

~~Appendix 14~~**APPENDIX 18 - EXIT PLAN**

- 1 In the event of termination of this Agreement by all parties, the Trusts agree that:
- 1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;
- 1.2 upon reasonable written notice, each Trust will be liable for one ~~thirteenth~~ seventeenth of any professional advisers' fees incurred by and on behalf of ~~CMAS~~CMPC in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;
- 1.3 each Trust will revoke its delegation to its ~~CMAS~~CMPC Committee in Common (CiC) on termination of this Agreement;
- 1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and
- 1.5 there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.
- 2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:
- 2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from ~~CMAS~~CMPC and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the ~~CMAS~~CMPC CiC;
- 2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurred by and on behalf of ~~CMAS~~CMPC as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;
- 2.3 the Exiting Trusts will revoke its delegation to its ~~CMAS~~CMPC CiC on its exit from this Agreement;
- 2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;
- 2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

~~Appendix 15~~**APPENDIX 19 - INFORMATION SHARING PROTOCOL**

[to be inserted once deemed necessary and agreed]

SUGGESTION from one Trust that - Competition-sensitive information needs inclusions: How will the CMPC ensure compliance with competition law, especially in the absence of a finalised Information Sharing Protocol (Appendix 19)?

Is there a boiler plate ISA that could be provided? The CEOs (while there has been some change within the group) were mainly of the view that this was not a necessity nor deal breaker however the comment suggests to me we may be entering territory where ISA could be used as a reason not to as vs to do something

FURTHER safeguards are in place to ensure that shared data (especially financial or workforce-related) is handled in compliance with GDPR and FOIA obligations? Should a breach of data submitted by a Trust to CMPC occur who is liable. I think my response to this is the hosts of CMPC functions have to declare the breach but costs associated with CMPC activities are not borne by the host alone but by all members as this is a shared / membership endeavour? Fyi – we have 3 host employers atm