Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 5 February 2026, 10am
Ground Floor Conference Suite, Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
01/26	10.00	(i) Apologies (ii) Quoracy Statement (iii) Declarations of Interest in items on the agenda	1	Assurance
02/26	10.00	Patient Story: Phlebotomy Service	2	Information
03/26	10.25	Minutes of the last meeting held on 4 December 2025	1	Approval
04/26	10.30	Matters Arising from the Action Log	1	Assurance
05/26	10.35	Any urgent items to be taken at the discretion of the Chair		
06/26 Page 19	10.35	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
07/26 Page 32	10.45	Key Corporate Messages – presented by the Chief Executive	1	Information
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
08/26 i) Page 37 ii) Page 48 iii) Page 52	11.00	(i) Finance Report - presented by the Director of Finance (ii) Report from the Audit Committee held on 22 January 2026 - presented by the Committee Chair (iii) Reports from the Finance, Sustainability and Performance Committee in Common held on 22 December 2025 and 26 January 2026 - presented by the BCH Committee Chair	5 1, 5 5	Assurance Assurance Assurance
ACQUISITION TRANSACTION BY WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST				
09/26 Page 63	11.40	North Cheshire and Mersey NHS FT Brand Identity – presented by the Director of Corporate Governance	1-7	Approval

QUALITY: We will deliver quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered				
10/26 i) Page 90 ii) Page 171	12.00	(i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 18 December 2025 presented by the Committee Chair	1 2,3	Assurance 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				
11/26 Page 232	12.35	Reports from the Strategic People Committee in Common held on 17 December 2025 and 21 January 2026 – presented by the BCH Committee Chair	4,6	Assurance
CORPORATE GOVERNANCE ITEMS				
12/26 Page 244	12.50	Quality, Safety and Assurance Committee in Common Terms of Reference and Cycle of Business – presented by the Director of Corporate Governance	1	Approval
CLOSING ITEMS				
13/26	1.00	(i) Review of meeting and Items to be added to the Board Assurance Framework	1	Information
		(ii) 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

Extraordinary Meeting – 12 March 2026, 10am, Ground Floor Conference Suite, 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

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Unapproved Minutes from a Public Board Meeting
Held on Thursday 4 December 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
Paul Fitzsimmons, Medical Director
Nick Gallagher, Director of Finance
Elaine Inglesby, Non-Executive Director
Ali Kennah, Chief Nurse
Dan Moore, Chief Operating Officer
Tina Wilkins, Non-Executive Director
Paula Woods, Director of People and Organisational Development

In Attendance
Lucy Gardner, Chief Strategy and Partnerships Officer (WHH)
Amena Patel, NeXT Director
Thara Raj, Director of Population Health and Inequalities (for item 90/25 only)
Lynda Richardson, Board and Committee Administrator
Sam Scholes, Head of Corporate Governance

Observers/Members of the Public
Andy Carter, Designate WHH Chair

For Patient Story (item 81/25 only)
Matt Bryers, Service Manager, Driveability Service

80/25 (i) APOLOGIES FOR ABSENCE
Lynne Carter, Director of Delivery Unit and Deputy Chief Executive
Bob Chadwick, Non-Executive Director
Jan McCartney, Director of Corporate Governance
Abdul Siddique, Non-Executive Director

(ii) QUORACY STATEMENT

MT confirmed that the meeting was quorate.

(iii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made in respect of the items on the agenda.

81/25 PATIENT STORY - DRIVEABILITY SERVICE

Matt Bryers delivered a presentation on the Driveability Service and a patient story which detailed how the service had supported a patient to recommence driving following a stroke.

MB provided an overview of the service, which offered rehabilitation for individuals whose medical conditions or other factors had affected their ability to drive. The service worked in

partnership with other organisations and partners and was audited through Driving Mobility. Due to its collaborative nature, Driveability worked with various public bodies and was currently undergoing a reorganisation to assess delivery methods and forecast assessment volumes. Notably, when assessment numbers exceeded targets, additional funding was received (an increase of 16% over the previous year had resulted in £35,000 from the Department of Transport to support the service and cost improvement programmes). The service formed new partnerships, including with the Police, who referred individuals where appropriate as an alternative to prosecution (for example, drivers over 70 years of age or those with medical conditions affecting their driving). This was also another income generation route. The service also supported children with disabilities and specialist needs to travel in vehicles, providing information and advice and providing specialist seats and seatbelts/harnesses to ensure safety. The service was also working with Warrington Council supporting with blue badge assessment.

The service's impact was underscored by recent referrals prompted by a coroner's report in Lancashire, highlighting the need for better fitness-to-drive assessments for elderly drivers. The funding model was under review, with a preference for block funding in future. The business case for Driveability had overachieved, exceeding targets and expanding into new areas. Capital investment was utilised for a four-year property lease, with the service repaying the Trust through rent, generating savings. Additional Department of Transport funding supported those efforts. Surpluses were used to repay initial deficits, with the business plan demonstrating prudence and delivery following scrutiny. Risks associated with expansion were monitored.

A case study was shared of a patient, Ellie, who accessed the service in 2023. Following a stroke that caused loss of sensation on her right side, Ellie's driving licence was then revoked by the DVLA. After being referred to Driveability, Ellie underwent a thorough assessment by an occupational therapist and an approved driving instructor and attended the service for weekly tuition. Adaptations, such as a left foot accelerator and a steering wheel spinner, enabled her to drive safely. Ellie received three months of tuition and a full reassessment with a fit to drive opinion given, after which the DVLA agreed with the assessment and opinion and reinstated her licence, restoring her independence.

NK questioned raising awareness of Driveability and exploring further partnership opportunities. The multidisciplinary nature of the service was highlighted as a potential model for other collaborations. MB noted that engagement strategies were developed, including presentations to referrers and staff, and partnerships with organisations like Age UK and Warrington Disability Partnership to support mobility for those unable to drive. MB confirmed to NK that the duration of a client's engagement with Driveability depended on individual needs, such as regular assessments for those diagnosed with dementia.

The Board welcomed the presentation and acknowledged the valuable work of the Driveability service. MT commented on a recent visit to the service that he had attended with Trust Governors which had showcased this.

82/25 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 9 October 2025 were approved as an accurate record.

83/25 MATTERS ARISING FROM THE ACTION LOG

The Board noted the updates against current actions recorded within the action log:

84/25 and 41/25ii Neurodevelopment Service/Reports from Quality and Safety Committee

EI confirmed that the Quality and Safety Committee was receiving updates on Neurodevelopment at each meeting, noting that this was the highest rated risk currently on the Trust risk register. PF advised that discussions were continuing with commissioners, who would be rolling out the Portsmouth model. The service had been asked to provide a clear understanding of the demand and capacity to enable a review of which patients would be able to be seen. **The Board agreed that it required a comprehensive update on the current position with the service to provide assurance on progress. This would be presented to the next meeting.**

61/25 IQPR (action one) – Toyota Benchmark

It was noted that the benchmarking was yet to be considered at the Quality and Safety Committee. An update would be presented to the Board next time.

61/25 IQPR (action two) – timing of IQPR information

The required report timings had now been aligned. The Board agreed that this action could be rated as blue/completed.

75/25vi FTSU Update

AK explained that a task and finish group had been established around FTSU with People Directorate support. This group would take forward actions and learning modules and explore how those could be built into team leaders and managers training plans. FTSU would also be included specifically into particular roles to enable a wider range of support across services. AK reported that she was continuing to meet with staff who had raised FTSU issues to understand those cases. The Board agreed that it was content with the progress that had taken place and that this action could be closed.

76/25iii Finance Report

NG confirmed that establishment, bank, agency and overtime information was now included within the finance report as requested at the last meeting.

The following blue rated items were agreed to be completed and would be removed from the action log:
45/25ii Fit and Proper Annual Review
61/25 IQPR (action one) Pressure Ulcers Benchmarking
61/25 Board Committee Terms of Reference and Business Cycles (updates completed)

84/25 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

MT confirmed that he had not been made aware of any urgent items of business to be taken. He informed the Board that he had agreed that item 90/25 Health Equity Update would be taken out of the agenda order prior to 88/25 Integration Update.

85/25 BOARD ASSURANCE FRAMEWORK (BAF)

The Board received detail of changes made to the BAF over the previous cycle which were approved.

SS confirmed to MT that the risk rating within BAF5 for dermatology had not changed. TW added that this was discussed and queried at the November 2025 meeting of the Finance, Sustainability and Performance Committee in Common (FSPCiC) where it was confirmed that the rating would be reviewed and the scoring reconsidered.

86/25 KEY CORPORATE MESSAGES

The Board received the report presented by NK, outlining a summary of Executive and Non-Executive Director activities for the period as well as key publications. The report also outlined some changes to the senior leadership at the ICB, and confirmed the commencement of Andy Carter, the Chair Designate of the new organisation post acquisition, in an Associate Non-Executive Director role in preparation for 1 April 2025 when he would formally take office as Chair. NK highlighted concerns that had been raised regarding Winter from NHS England, with all Chief Executives to attend a meeting to take place on 8 December. There had been particular concerns on the level of flu cases in under 65s. There was an ask to bring forwards January plans as this was likely to spike during December. In terms of finances, NK commented that the Trust was doubling down on exiting the financial year with the best possible position. Meetings would continue with the ICB and PWC.

MT referred to the number Time to Talk visits that had taken place over the period and commented that he would like to see an increase: he emphasised the need for Executive and Non-Executive Directors to visit teams. He asked Executive colleagues to ensure that visits were being scheduled. PW agreed to raise this with the staff responsible for arranging the visits and would escalate any cases where staff may respond that they could not take part due to time pressures. AK also offered to support the drive for visits to take place to clinical services. PW and AK agreed to link in outside of the meeting. NK agreed that the visits must take place with the exception of any safety issues arising for services which would prevent a visit from happening. EI agreed with the comments made and proposed that the way in which the visits were arranged and conducted could be changed to take pressure away from staff, and that staff could just be advised that Executive and Non-Executive Directors would just attend services and be there to listen to them. **MT asked PW to review this proposal and to consider how the visits were positioned**. Consideration would also be given to improving the way in which visits were coordinated around availability of key attendees and avoiding clashes with the Trust's corporate calendar.

The Board noted that Industrial Action was planned to take place from 17 to 22 December. PF advised that negotiations may take place. He noted that whilst BCH would not be as directly impacted as WHH, however there would be a system impact. MT asked what support BCH may be able to offer to WHH. PF advised that plans were in place at WHH to cover the period and he would not be looking to reallocate community staff to acute services. AK noted that there would be senior decision makers available to review discharges and ED. There would also be patients looking to leave hospital prior to Christmas. NK highlighted that both organisations would be working together over the Christmas period on the Multi Agency Discharge Events (MaDE) which aimed to deliver a focused period of activity to reduce the length of stay for patients. It was anticipated that there would be an estimated £500k impact for five days of industrial action in addition to the run rate.

The Board received the report for note.

87/25 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) FINANCE REPORT

NG presented the report and highlighted the key aspects for month seven:
The Trust was reporting a deficit of £2.61m, in line with plan.
The Trust was reporting a savings achievement of £3.01m against a plan of 2.98m. This related to level one and level two BAU CIP savings.
Income was £58.60m against a plan of £58.55m.

Expenditure was £61.21m against a plan of £61.16m.
Pay was £42.55m against a plan of £42.50m.
Agency spend was £0.19m against a plan of £0.71m
Non pay expenditure was £18.19m against a plan of £17.71m.
Capital charges were above plan by £0.06m.
Capital expenditure was £0.62m at month seven, planned spend is £0.69m.
Cash was reported as £5.44m.
Debtors and creditors: A focus was being retained on retrieving debts. Positive movements had been observed on aged debt. The Trust's BPPC position continued to be positive.
Agency: Currently only two services were reported as using agency: UTC Widnes covering locum GP shifts and Community Paediatrics in both Halton and Warrington covering a career break.
Cash: Temporarily reduced due in month to delayed critical invoicing and subsequent delay in payments from commissioners. Cash was expected to recover in January.
Underlying Deficit: The latest underlying financial position for the Trust was £4.47m deficit.
Dermatology service: NG referred to the £0.5m service adjustment. Ongoing discussions were continuing with commissioners to formalise and bring to a conclusion. Additional funding was being received.
Best, worst, medium and likely case scenarios: The likely case scenario assumed that as no additional savings had been identified to mitigate the additional stretch target to date, with significant risk that this would not be delivered. This scenario also assumed that revenue to capital savings would be reallocated in line with discussions with PWC and the ICB. This would result in a £4.4m deficit, £2.1m adverse to an adjusted plan.

The Board received the report for assurance.

(ii) REPORT FROM THE AUDIT COMMITTEE HELD ON 16 OCTOBER 2025

The Board received a report detailing the key considerations of the Audit Committee from its last meeting. This was presented by TW as Deputy Committee Chair.

(iii) REPORTS FROM THE FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE IN COMMON HELD ON 27 OCTOBER 2025 and 24 NOVEMBER 2025

TW presented detailed reports from the meetings held in October and November 2025.
The October report was taken as read.

TW presented key points from the November meeting: She noted that there had been no assurance on the level three CIP achievement. The Committee in Common had discussed the Performance Council Report and sought further information on areas affected Warrington Adult Services. The Committee in Common had noted the current position on Dermatology which was also being reported via the Quality and Safety Committee. The position was being closely monitored. In terms of Dental services, TW reported that the Committee in Common was concerned in relation to delays, particularly for those awaiting General Anaesthesia with specific needs. Further information was requested to be presented back to the Committee in Common to provide additional assurance. NK asked whether any learning could be obtained from other organisations providing dental services to support the reduction of the waiting list. TW advised that she was seeking a deep dive to be presented back to a future meeting on dental services. It was suggested that benchmarking around any learning could be included as part of that presentation.

The Board noted the considerations of the Committee in Common and received the report.

88/25 ACQUISITION TRANSACTION BY WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

INTEGRATION UPDATE INCLUDING:
(i) Full Business Case
(ii) Board Certification
(iii) Post Transaction Implementation Plan (PTIP)
(iv) Secretary of State for Health documents

LG referred to the circulated documents: Board Certificate, PTIP, Business Case, and SoS documents. These were in draft form the previous month, except for the PTIP. Slides in the pack highlighted key points: context, essential actions, and the integration achieved thus far, serving as a reminder of the timeline.

Strategic Case Review: NHS E reviewed the strategic case, which was subsequently approved by both Boards. On 14 November, the case review outcome was formally received with an amber rating, granting permission to proceed to the next stage. Recommendations in the accompanying letter referenced some issues not fully covered within the letter. The team demonstrated how these matters had been reviewed and detailed plans to address or continue addressing them as part of ongoing work and planning.

Key Document Summary: The summary identified which documents required approval by the Board. Five SoS documents were prepared, with four presented and the fifth serving as a summary of all others. The contents were embedded within the other documents and were scheduled for sharing with the executive team ahead of submission.

Document Submission and Approvals Timeline: Work with NHS E established a draft timeline for the next stages, including when to expect transaction waiting periods, engagement around the new constitution, presentation for approval, development and presentation of the transaction agreement, and submission of the application letter to the CoG. All relevant draft dates were included. To meet these timelines, it appeared likely that an Extraordinary Board would need to be scheduled in the third week of March 2026, with the possibility of standing up an Extraordinary Council of Governors meeting.

Due Diligence: Draft due diligence documents were included within the pack and underwent factual accuracy checks, which were completed and signed off by executive leads. All 151 risks and issues were logged, with actions assigned to recommended leads and timeframes. Risk scoring was implemented, with residual risk scores calculated following mitigation steps, and this detail was captured in the full business case.

Risk Management: MT sought assurance that all identified risks would be managed or mitigated and questioned how these would be escalated to committees. LG explained that the integration tracker was monitored through the delivery tracker, which fed into the Better Care Together delivery group and subsequently into Trust Boards. Risks also needed to be routed through the relevant committee, such as Quality and Safety, until a Quality Committee in Common (CiC) was established. All risks were included in a tracker with designated owners. The highest risks were summarised in the due diligence risk summary.

MT noted that some details in the summary paper were still not factually correct, particularly the clinical and operational harmonisation approach regarding reporting to the CiC. LG clarified this was an outstanding action, due to be implemented in February. EI expressed discomfort with the language used, pointing out the identification of five BCH fragile services. She noted that she was only aware of three services that met these criteria: Neuro, dental and dermatology services. She considered that ‘fragile services’ related to language used within WHH documents which was not used at BCH. EI questioned whether the business

case reflected negatively on the completion status of due diligence, given the challenge of addressing all 120 actions, and suggested focusing on the high-risk items.
MT and EI discussed the distinction between risks inherent to the transaction and those, such as waiting lists, that would be ongoing regardless. NK and LG agreed to reflect further on this and review following this meeting.

Submission and Feedback: LG confirmed that the documents presented would be submitted to NHS E on 5 December 2025.

EI raised concerns about the Court of Protection issue for a dental patient which had been referenced, which was highlighted as resolved and therefore should not have been included.

Updates and Supplementary Documents: The Board Certificate had been updated since the previous month, with further work and progress summarised in the slides. The post-transaction integration plan (PTIP) was recognised as a live document by NHS E and would remain so, despite some repetition within the FBC. Alongside the core documents, an additional 66 supplementary documents had previously gone through Boards, with some review by EMT for executive approval and others scheduled for future Board consideration. This explained the lack of detail in the PTIP compared to other documents.

The Board approved the following documents:
- **Full Business Case (FBC)**
- **Post Transaction Implementation Plan (PTIP)**

The Board received and endorsed the following documents:
- **Board Certification**
- **SoS Duties (NHS Act 2006)**
- **Environmental Principles**
- **Public Sector Equality Duty (PSED)**
- **Family Test**

NK thanked LG and all those involved in this work for their efforts.

89/25 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

DM highlighted several operational metrics, focusing on the impact that dermatology and cancer performance had had within the system. Efforts had been underway to determine when these numbers were expected to recover, with projections having indicated improvements between months 9 and 10 across all specialities. This recovery had been closely aligned with the Cheshire and Merseyside Cancer Alliance, and the expectation had been for a steady upward trajectory, resulting in monthly improvements.

Three new sections had been added to the performance council report. These included:

- Monitoring cancer trajectory performance,
- Tracking the recovery of long waiters on general anaesthetic (GA) dental lists and achieving 80% of the dental threshold,
- Implementing a recovery plan for audiology to monitor progress.

The challenge of long waits in dermatology had continued, with a significant number of patients having waited over 65 weeks for treatment. A successful bid to the C&M elective

fund had been secured to support recovery efforts. The first activities funded by this pot had been scheduled to commence that week, with sessions planned through to the end of the year. This funding was being drawn down in parts, and "Consultant Connect" was utilised to review waiting lists and explore alternative patient pathways. The primary focus had been on ENT and dermatology specialities, with the service going live from 15 December. The aim had been to achieve a 15-20% reduction in waiting list numbers before the year's end, drawing down the initial portion of the funding to make progress. Ongoing engagement with Consultant Connect was expected to further help reduce waiting times, with continuous monitoring via the Finance, Sustainability and Performance Committee in Common.

PF confirmed to EI that the initiative had been consultant-led and focused solely on this area, with no involvement in other services. Reviews had been conducted within existing Standard Operating Procedures to ensure appropriate patient pathways. In response to a query from MT regarding the available funding, DM clarified that the total allocation had been £363,000, based on modelling designed to treat all patients by 31 March, including those waiting over 65 weeks. The plan had been to draw down £200,000 initially to begin booking patients, while holding back £163,000 based on the outcomes achieved with Consultant Connect. This approach aimed to clear the backlog efficiently and avoid accumulating further delays. Criteria for the service and deployment plans had been finalised for implementation at the beginning of January, with ongoing assessment to ensure the correct service capacity and demand. PF confirmed to EI that that locum consultants were already being used in dermatology, with successful precedents having been established at ENT in Chester. The reduction in numbers was expected to present challenges.

An improvement plan for audiology had been underway, aiming for compliance with the diagnostic standard by the end of January (Q4). Early indications had been positive, with an 88% performance rate achieved, suggesting that the plan was beginning to deliver the expected improvements. While risks remained, there had been notable improvements in compliance over recent weeks.

An action plan was being developed to address dental waiting times, particularly for patients requiring general anaesthetic (GA). The primary constraint had been the availability of theatre capacity, with discussions ongoing regarding the number of available sessions. Progress had been made rapidly, with updates to be provided to Finance, Sustainability and Performance Committee in Common in due course. EI questioned whether a review should take place of those long-wait GA list could be considered for inhalation sedation. DM confirmed to EI that work was being undertaken to map long waits across areas including dermatology, dental and neurodevelopment. He explained that an aggregated long wait trajectory would be created before the next meeting of the Finance, Sustainability and Performance Committee in Common meeting, which could identify any key areas of risk.

AK presented highlights in relation to quality. AK reported that there had been a rise in category two pressure ulcers and she had sought further information from teams on drivers for this. She advised that conversations would take place on the categorisation to determine the issues, with reporting to be fed into the Quality and Safety Committee. EI referred to discussions that had taken place on this matter at the Committee, where it was proposed that a retrospective review may beneficial. MT agreed that this should take place. AK also reported on a retrospective review of Duty of Candour incidents and harm grading with 13 historic incidents being changed. This was considered to be related to differences in knowledge and application. GB highlighted that there were small numbers of Duty of Candour incidences within BCH and this was an area where the Trust should not be getting this wrong. It was important to understand responsibilities around this and not only on the Trust's approach but its responses. AK advised that she had discussed this with teams.

An increase was also noted in falls at Padgate House. AK confirmed to MT that work was taking place with the nursing teams. There were currently eight falls reported.
PW presented highlights in relation to workforce. She noted that the Trust currently held its highest ever sickness absence rate. The Trust was aware of the challenges and the reasons for absence. Support for staff was in place. GB noted an increase in stress being reported as a reason for absence and asked if there were different themes being identified from return-to-work interviews. PW advised that there had been no other themes noted other than where work related stress was being compounded with home stress, which was resulting in staff then being unable to cope and becoming unwell. Work was being undertaken to target this such as ensuring that people were being rostered properly and taking lunch breaks and leave. NK commented that if the Trust was taking all the available actions but only achieving the current position, recognising that the Trust had one of the worst absence rates in the region, the Trust should explore actions being taken on sickness absence in other organisations. **PW advised that she could link in with the National Community HR Network and gather data in relation to this to share with the Board**.

MT welcomed the summary report provided with the IQPR presentation; however he asked DM to discuss the content of the main presentation with him outside of the meeting as he considered that this was not providing what the Board required in its current format. He commented that this should be an exception tool and was not providing information around actions being taken on key areas.

(ii) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 30 OCTOBER 2025

The Board received a report from the October meeting of the Quality and Safety Committee presented by EI as Committee Chair.

EI noted that there were a number of amber rated areas within the report as the Committee had not been able to take full assurance in relation to harms from incidents and classification with further detail requested on affected patients and impact.

The Committee also refused a request to reduce the risk rating in relation to the Neurodevelopment service as it considered the proposed consequence score to be too low. It requested that the risk be reevaluated along with the scoring.

Concerns were raised about the operational narrative within the IQPR for pressure ulcers, which sometimes attributed cases to patient immobility or end-of-life status, potentially appearing defensive. It was requested that the narrative must clarify whether care breaches occurred.

The Committee requested more detail on QIA impact indicators and timely reviews, especially for Halton 0-19 Service and Dermatology QIA for next meeting.

A position statement on national policy compliance for clinical holds would be reported to the Committee at its next meeting to provide further assurance.

The PSIRF plan (focusing on pressure ulcers, falls, and equipment) was shared with the ICB for feedback following the October Committee meeting. Following Committee sign off via e-governance on 28 November 2025, the plan was recommended by the Committee to the Board for final ratification and was appended to the Committee Chair report. The Board received and finally ratified the PSIRF plan.

(iii) EPRR ANNUAL REPORT

DM presented the report following the Trust's self-assessment against the national EPRR framework, which for community trusts consisted of 58 core standards split into the functional domains of: governance, duty to assess risk, duty to maintain plans, command and control, training and exercising, response, warning and informing, co-operation, business continuity and Hazmat/CRBNe. Based on the evidence requirements and ICB feedback against the standards, the Trust was reporting a partially compliant score of 83% (full compliance was achieved at 89%). 45 standards had been assessed as fully compliant and 13 standards as partially compliant.

For the non-compliant scores, a proposed action plan was in place and detail was appended to the circulated report. This action plan, together with the proposed work programme would be governed and manged through the established EPRR group.

DM reported that work had commenced between BCH and WHH to review EPRR arrangements collaboratively in preparation for integration, given that for 2026/27 there will be no requirement to submit a separate statement for BCH. All appropriate polices and processes relating to Emergency Planning, Business Continuity and on-call arrangements would need to be reviewed.

DM confirmed to MT that there were no expected issues for the Trust resulting from the partial compliance scoring. He considered that the current scoring was a fair reflection and assessment of the Trust's current position and corroborated with the work plan.
The Board noted the content of the report and approved the submission of the 2025/26 statement of compliance.

90/25 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

(i) HEALTH EQUITY UPDATE

TR presented the report and highlighted key areas of focus that included: aligning BCH's health equity programme with Warrington and Halton Teaching Hospitals, embedding the joint Health Equity Group, and aligning with the Core20PLUS5 framework. Shared priorities included smoking cessation, respiratory pathways, early cancer diagnosis, and reducing missed appointments, complemented by prevention commitments such as the NHS Prevention Pledge and the MECC Train-the-Trainer programme. The Health Inequalities Dashboard had also now been launched, embedding Core20PLUS5 priorities, and drafting a joint Accessible Information and Communication Policy to strengthen health and digital literacy.

TW referred to the Health Inequalities Dashboard and asked how this would be able to be used to support the work of the Trust in serving its populations. TR confirmed that work would be undertaken with performance teams and LG to consider how this information would be reported. GB added that she would like to have sight of how the information had been utilised, noting that the Board had previously spent some considerable time on this, including sessions on data for each borough and forming strategy. PW welcomed the inclusion of workforce inequalities and offered her support and that of the workforce team if required.

The Board concluded that this work would link into integration and the final business case for acquisition. **It was agreed that all would welcome sight of the dashboard and that this should be a live document.**

91/25 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

(i) REPORTS FROM THE STRATEGIC PEOPLE COMMITTEE IN COMMON HELD ON 15 OCTOBER 2025 AND 19 NOVEMBER 2025

The Board received the Committee Chairs reports, presented by EI on behalf of AS. Following a Deep Dive on the Corporate Services Workstream, the Strategic People Committee in Common (SPCiC) had agreed that further financial analysis was required around model health benchmarking and BCH corporate cost variances. This was agreed to be escalated to the FSPCiC for further analysis. TW clarified that the WHH Chief Finance Officer, Jane Hurst, had provided further information following the meeting and as part of integration work there were plans in place to reduce the costs. It had therefore been agreed that this item no longer required escalation to the FSPCiC.

NK highlighted one error within the report from the November meeting: this referred to a no redundancy policy – NK confirmed that there was no such policy. The report would be amended to correct this error.

PW informed the Board of the current response rate to the NHS Staff Survey. This was at 52%, 10% below the Trust's best ever response rate.

92/25 CORPORATE GOVERNANCE ITEMS

(i) BOARD BUSINESS CYCLE

The Board reviewed and approved its business cycle.

(ii) CORPORATE CALENDAR 2026/27

The Board reviewed and approved a draft corporate calendar which had been produced in the event that the Trust's acquisition may be delayed and business as usual would need to continue for any period of time beyond 1 April 2026.

(iii) APPLICATION OF THE TRUST SEAL

The Board received a report which detailed seven applications of the Trust Seal between 26 March to 28 November 2025.

93/25 (i) REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

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

(ii) OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

No questions raised.

DATE AND TIME OF NEXT MEETING

Thursday 5 February 2026, 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.

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	**BLUE**	December 2025: Please see action below: 41/25i

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
05.06.25	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 and Safety Committee meeting	Dan Moore Paul Fitzsimmons	**BLUE**	December 2025: The Board agreed that it required a comprehensive update on the current position with the service to provide assurance on progress. February 2026: A detailed update position is provided on the agenda within the Committee Chair's report at item 10/26.
07.08.25	61/25	IQPR	Indicators showing no change/usual variation to have Toyota benchmark – this would be taken into the Quality and Safety Committee.	Ali Kennah	**BLUE**	February 2026: Toyota specification is to align with QI work. This is ongoing. Item is due to be picked up at the February Committee meeting.
			Month three IQPR information should have been provided to the August Board – discussion to take place on this at EMT. Report should also include actions being taken to improve areas.	Nik Khashu Dan Moore	**BLUE**	December 2025: The Board agreed that this action could be closed – required detail has been provided and report timings had now been aligned as required.

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
09.10.25	75/25vi	FTSU Update	Following receipt of information detailing staff concerns and detriments that had been reported following staff speaking up, the Board agreed that it must review the opportunities across the Trust to listen to staff and ensure that such instances were dealt with appropriately and did not continue. Ali Kennah agreed to present a report on this to the EMT and assurance would be provided to the Board.	Ali Kennah	**BLUE**	December 2025: Update provided on work in train including the establishment of a FTSU task and finish group and further embedding of FTSU within specific roles – the Board agreed that this action could be closed.
09.10.25	76/25iii	Finance Report	Report to include establishment as well as bank agency and overtime information.	Nick Gallagher	**BLUE**	December 2025: Information now included within the finance report.
04.12.25	86/25	Key Corporate Messages	Time to Talk visits to be reviewed to inform staff of their purpose, to prevent staff feeling pressured by the visits and consider how the visits were positioned. PW would take this forwards with the those responsible for arranging the schedule.	Paula Woods	**BLUE**	January 2026: Documentation and communication systems reviewed. Escalation process also in place for any services advising they cannot accommodate a visit when requested of them.

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
04.12.25	89/25	IQPR	Work to be undertaken to explore actions being taken on sickness absence in other organisations. PW to link in with the National Community HR Network and gather data in relation to this to share with the Board.	Paula Woods	**BLUE**	January 2026: CPO Networks at C&M and North West levels have agendas/cycles of business focussed on sickness absence and absence reduction programmes and initiatives, etc. The national CPO Network has this on the agenda with the meeting cycle for 2026 yet to be confirmed. Absence rates are being benchmarked at a system level. Updates to be routed to SPCiC and featured in IQPR narrative and Chair's Reports to Board.
04.12.25	90/25	Health Equity Update	Board requested sight of the Health Inequalities Dashboard.	Thara Raj	**BLUE**	January 2026: Information will be provided by Thara Raj and shared/circulated to Board members for sightedness and comment.

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**5 FEBRUARY 2026**
Agenda Item	**06/26**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Executive Lead	Nikhil Khashu, Chief Executive Officer		
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 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 and Safety Committee**
☒ **Finance, Sustainability and Performance Committee-in-Common**	☐ **Remuneration and 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** 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**	**5 February 2026**
Agenda Item	**06/26**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Report Author	Samantha Scholes, Head 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 January Risk Management Council.

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

2.1 **BAF 1: Governance**

The Audit Committee met on 22 January 2026 and agreed to add the high assurance outcome of the Fit and Proper Person Test internal audit to the assurances. There were no proposed changes to the scoring.

2.2 **BAF 2: Quality**

The Quality and Safety Committee met on 18 December 2025. The Committee did not identify any changes to be made and there were no proposed changes to the scoring.

2.3 **BAF 3: Health Equity**

The Quality and Safety Committee met on 18 December 2025. The Committee did not identify any changes to be made and there were no proposed changes to the scoring.

2.4 **BAF 4: Staff**

The Strategic People Committee-in-Common met on 17 December 2025 and 21 January 2026. The Committee did not identify any changes to be made and there were no proposed changes to the scoring.

2.5 **BAF 5: Resources**

The Finance, Sustainability and Performance Committee-in-Common met on 22 December 2025 and 26 January 2026.

The Committee agreed to add Level 3 CIP to the Gaps in controls and assurance section.

It also agreed to move the statement '*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'* from Gaps in controls and assurance to the Mitigating actions section.

There were no changes to the scoring.

2.6 **BAF 6: Equality, Diversity & Inclusion**

The Strategic People Committee in Common met on 17 December 2025 and 21 January 2026. 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 28 January 2026

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** **Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy**	**BAF 2** **Quality** **Failure to deliver quality services and continually improve**	**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**	**BAF 4** **Staff** **Failure to create an environment for staff to grow and thrive**	**BAF 5** **Resources** **Failure to use our resources in a sustainable and effective way**	**BAF 6** **Equality, Diversity & Inclusion** **Failure to build a culture that champions equality, diversity and inclusion for patients and staff**	**BAF 7** **Partnerships / Integration with WHH** **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 3 (L) = 9 **medium** 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) February 2026

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: January 2026 Risk Ratings review: January 2026	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. **Risks on register 15 plus** 3429 Community Equipment Stores, Capacity, Halton *(x-ref BAF 1,4,5,7)*	**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, Sustainability & Performance Committee-in-Common, and Strategic People Committees-in-Common) • 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 FPPT - High
Risks on register 12 2428 Data Security Protection 3161 EPRR Training Compliance 3173 EPRR On Call Arrangements 3191 Staff Health & Wellbeing 3209 Incident Recording	**Rationale for current score** • Governance structure approved by Board and audited by internal and external auditors. • Substantial Assurance – Heads of Internal Audit opinion 2024/25 • 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:	**Mitigating actions:**	**Emerging risks:**
• 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	• Board oversight	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) February 2026

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: December 2025 **Q&S Committee** last review: December 2025 Risk Ratings review: December 2025 ***In collaboration with*** • ***Strategic People Committee in Common***	If we fail to deliver safe and effective services, then there may be potential harm to patients and their outcomes. **Risks on register 15 plus** 3376 Community Paediatrics demand, Warrington & Halton *(x-ref BAF 2,3,5,6)* 3377 Community Equipment Stores, Servicing Standards, Halton 3418 Dermatology, performance, Warrington 3419 Dermatology delays, Warrington 3420 Dermatology CHR completion, Warrington 3421 Dermatology delays, Warrington 3429 Community Equipment Stores, Capacity, Halton *(x-ref BAF 1,4,5,7)* **Cross-referenced with BAF 5, Resources**	**Prevent Controls** • 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	**Detect Controls** • 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	**Assurances** • 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 • Quality impact assurance panels • Clinical leadership strategy **Audits** **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

Risks on register 12
2428 Data Security Protection
2985 Dental GA Paediatric Access
3161 EPRR Training Compliance
3360 Community Equipment Stores IPC standards
3404 District Nursing OOH & Evenings
3405 Virtual Ward Staffing
3430 Community Equipment Stores Estate
	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			

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• Paediatric Audiology • Recruitment & Retention • CIP 2025/26		Paediatric Audiology

Board Assurance Framework (BAF) February 2026

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: December 2025 **Q&S Committee** last review: December 2025 Risk Ratings review: December 2025 ***In collaboration with:*** • ***Finance, Sustainability & Performance Committees in Common*** • ***Strategic People Committees in Common***	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. **Risks on register 15 plus** 3376 Community Paediatrics demand, Warrington & Halton *(x-ref BAF 2,3,5,6)*	**Prevent Controls** • 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.	**Detect Controls** • 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	**Assurances** • 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 • Quality impact assessment panels **Audits** **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

Risks on register 12
None
	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.			

Gaps in controls and assurance:	**Mitigating actions:**	**Emerging risks:**
• Health equity improvement is a system responsibility • Mature health equity indicators		

Board Assurance Framework (BAF) February 2026

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: January 2026
 	
Strategic People Committees in Common
last review: January 2026
 	
Risk Ratings review:
January 2026
	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. National regional and system finance and workforce targets to reduce headcount, agency, overtime and sickness.
	
	Risks on register 15 plus
	3376 Community Paediatrics demand, Warrington & Halton *(x-ref BAF 2,3,5,6)*
	3429 Community Equipment Stores, Capacity, Halton *(x-ref BAF 1,4,5,7)*
		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 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
		• Delivery Unit
			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
			• Delivery Unit
			• E.Roster system
			• ESR reporting
				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
				• Finance & Workforce Principles
				• Overtime, bank and agency reports
				
				Audits
				
				2023/24
				Stress Risk Assessments – Limited
				
				2024/25
				Freedom to Speak Up – High
				Bank & Agency – Moderate

Risks on register 12
3191 Staff Health & Wellbeing
3296 Podiatry waiting lists
3372 Wheelchair service – reduced capacity
3404 District Nursing OOH & Evenings
3409 District Nursing sickness
3432 Dental H&S
	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:	Mitigating actions:	Emerging risks:
• 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		Ability to resource the integration programme System wide commitment to level playing field on incentives National shortage of key staff groups Proposed pay offer, RCN Industrial Action

Board Assurance Framework (BAF) February 2026

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: January 2026
 	
Finance, Sustainability & Performance Committees in Common
last review: January 2026
 	
Risk Ratings review:
January 2026
 	
In collaboration with
• ***Strategic People Committee in Common***
	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)
	
	Risks on register 15 plus
	3376 Community Paediatrics demand, Warrington & Halton *(x-ref* BAF *2,3,4,6)*
	3377 Community Equipment Stores, Servicing Standards, Halton
	3418 Dermatology, performance, Warrington
	3419 Dermatology delays, Warrington
	3420 Dermatology CHR completion, Warrington
	3421 Dermatology delays, Warrington
	3429 Community Equipment Stores, Capacity, Halton *(x-ref BAF 1,4,5,7)*
	
	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
			• FS&P Committees-in-Common review monthly financial performance
			• Strategic People Committees-in-Common 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

Risks on register 12
2428: Data Security Protection
3161 EPRR Training Compliance
3173 EPRR On Call Arrangements
3191 Staff Health & Wellbeing
3296 Podiatry waiting lists
3360 Community Equipment Stores IPC standards
3372 Wheelchair service – reduced capacity
3387 – Trust financial plan
3405 Virtual Ward Staffing
3430 Community Equipment Stores Estate
	Rationale for current score
	
	• Triangulation with the various areas of resource including; financial, physical, digital and staff.
	• Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports.
	• Governance arrangements in place
	• Committees of the Board
	• Current forecast is off the original plan but in line with revised outturn agreed with ICB
	• Enabling strategies:
	  • Digital
	  • Finance
	  • Estates & Development
	  • Green Plan
	  • People
	  • EDI
	
	Additional place integration savings ask alongside the CIP challenges
	
	National Oversight Framework – Segment 3			

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• The 2025/26 Trust challenging CIP as not all programmes have not been finalised and implemented. Contingency schemes not yet identified • Level 3 CIP	• 2024/25 Financial recovery plan actions to continue 2025/26. • Delivery Unit established • 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.	• Ability to resource the integration programme • Review of Trust estate

Board Assurance Framework (BAF) February 2026

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: January 2026 **Strategic People Committee in Common** last review: January 2026 Risk Ratings review: January 2026 ***In collaboration with*** • ***Finance, Sustainability & Performance Committees in Common*** • ***Quality & Safety Committee***	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 **Risks on register 15 plus** 3376 Community Paediatrics demand, Warrington & Halton *(x-ref BAF 2,3,4,5)*	**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) • Strategic People Committees-in-Common • 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 **Audits**

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
	• Strategic People Committees-in-Common 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			

Gaps in controls and assurance:	Mitigating actions:	Emerging risks:
• Engagement with staff groups including BAME and LGBT+ staff (remain until all established and Networks are embedded)		

Board Assurance Framework (BAF) February 2026

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 **Executive Management Team** 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 **Risks on register 15 plus** 3429 Community Equipment Stores, Capacity, Halton *(x-ref BAF 1,4,5,7)*	**Prevent Controls** • 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	**Detect Controls** • 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	**Assurances** • 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
Risks on register 12 3405 Virtual Ward Staffing	**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:	Mitigating actions:	Emerging risks:
• Lack of integration governance systems • Maturity of place-based relationships • Impact of pressures (inc. finance)	• Better Care Together programme • Joint executive roles	

Board Assurance Framework (BAF) February 2026

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**	**5 FEBRUARY 2026**
Agenda Item	**07/26**		
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 and Safety Committee**
☐ **Finance, Sustainability and Performance Committee in Common**	☐ **Remuneration and 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**	**5 FEBRUARY 2026**
Agenda Item	**07/26**		
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 Since the last update, the Chair has attended the following meetings during this reporting period:

27 November – meeting with NHSE re: acquisition
3 December – Time to Shine meeting
10 December – Cheshire & Merseyside Chairs meeting
6 January – NHSE National meeting re: acquisition full business case
6 January – Local Governors meeting
13 January – Meeting with PwC and ICB re: finances/productivity
21 January – Cheshire and Merseyside Chairs Providers Collaborative meeting
28 January – Equality, Diversity and Inclusion meeting

The Chair had a 1-1 meeting with the Cheshire and Merseyside ICB Chair on 2 December.
On 11 December, the Chair had an informal meeting with the NED/Chair Designate of Warrington and Halton Teaching Hospitals NHS Foundation Trust, Andy Carter. This was followed by a formal meeting and walkaround Bridgewater Community Healthcare NHS Foundation Trust headquarters on 21 January.

1.2 On 20 January, Non-Executive Director, Bob Chadwick went to Halliwell Jones Stadium to visit the Podiatry and Dermatology services

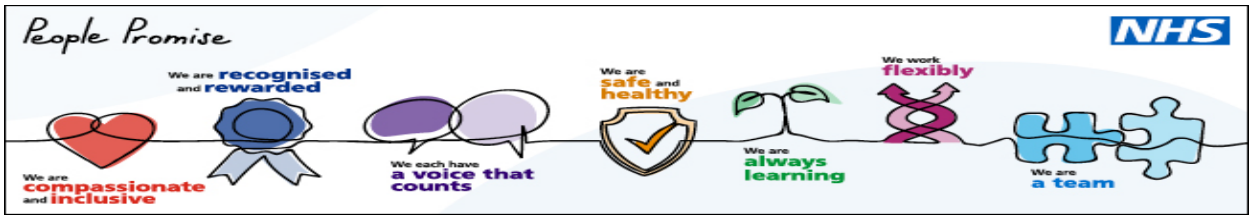
1.3 Non-Executive Director, Tina Wilkins attended The Voice of the Child Forum on 2 December 2026 and had a meeting with the Executive Director of Finance on 10 December.

2. EXECUTIVE DIRECTOR UPDATES

2.1 The Chief Executive was invited to join a Christmas Supervision and Team Morale meeting on 11 December at Spencer House. This was led by Katie Laga, Team Leader for Children's Physiotherapy and Occupational Therapy / Dental Therapist for community dental Trafford. The Chief Executive thanked Katie and the team for the enthusiasm, dedication and passion shown to their work and each other and that this had shone through within the meeting.

Executive and Senior Team Engagement

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



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.

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.

The following Time to Talk sessions have taken place:

On 27 November, The Executive Medical Director met the Halton Adults Wellbeing Team. Non-Executive Director, Elaine Inglesby also joined the session.

3. DIRECTORS' TIME TO TALK FEEDBACK

3.1 From the visit that took place, the member of the Executive Management Team highlighted that the service was very cohesive, with staff showing high regard for each other and for their manager. It was evident that this was a team proud of the work they do, though they are feeling uncertain about the future and the continuation of the gold-standard service they provide.

The service shared that they thoroughly enjoy working at BCHFT but were feeling the pressures of the current finance and workforce requirements. They also expressed a desire for more recognition of Long Service achievements. Additionally, the service requested support for a featured article in the Bridgewater Bulletin, which the Director of People and Organisational Development agreed to action. The article was subsequently included in the 8 December edition of the Bridgewater Bulletin.

4. RECOMMENDATIONS

4.1 The Board is asked to note the report.

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**5 FEBRUARY 2026**
Agenda Item	**08/26i**		
Report Title	**FINANCE REPORT – MONTH NINE (DECEMBER 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

At month nine 2025/26:

- The Trust is reporting a deficit at Month nine of £3.16m, in line with plan.
- The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3).
- The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m
- Income is £75.23m against a plan of £75.23m.
- Expenditure is £78.39m against a plan of £78.39m.
- Pay is £54.30m against a plan of £54.47m.
- Agency spend is £0.21m against a plan of £0.88m.
- Non pay expenditure is £23.47m against a plan of £22.75m.
- Capital charges are above plan by £0.12m.
- Capital expenditure is £0.69m at month nine, planned spend is £1.16m.
- Cash is £3.30m.

Previously considered by:

☐ **Audit Committee**	☐ **Quality and Safety Committee**
☐ **Finance, Sustainability and Performance Committee in Common**	☐ **Remuneration and 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**	**5 FEBRUARY 2026**
Agenda Item	**08/26i**		
Report Title	**FINANCE REPORT MONTH NINE (DECEMBER 2025)**		
Report Author	Nick Gallagher - Executive Director of Finance		
Purpose	To brief the Board on the financial position as at Month Seven		

1. SCOPE

1.1 The purpose of this report is to brief the Board on:

- Financial position as at Month nine
- CIP plans and delivery
- Capital and Cash

2. FINANCIAL POSITION AS AT MONTH FIVE

2.1 The purpose of this paper is to update the Board on the financial position of the Trust at the end of December 2025 (Month 9).

2.2 The key headlines for Month nine 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:

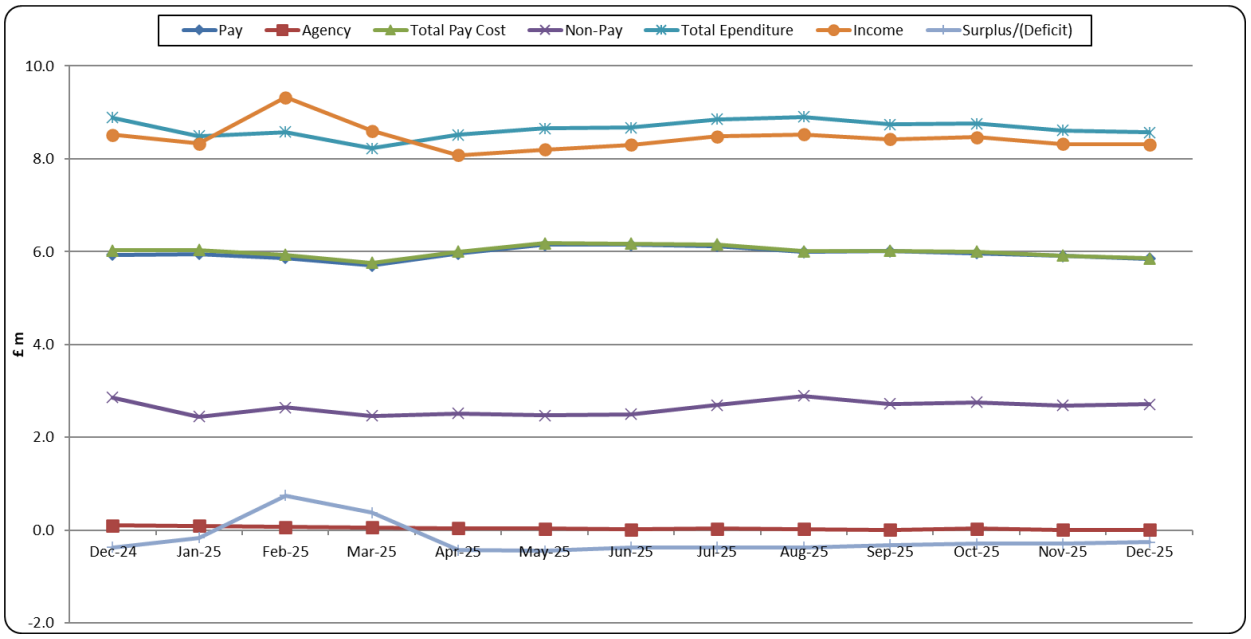
i. Level 1 – Trust BAU CIP – These savings are part of the Trust 5% savings target and are solely the responsibility of the Trust to deliver.
ii. Level 2 – Trust and WHH – These savings are also part of the Trust 5% savings target and are the responsibility of the Trust to deliver, working in partnership with WHH.
iii. Level 3 – System 'stretch' savings – These savings are to be delivered across the system. System workstreams have been formed to support the identification of additional.

Table 1 – Summary of Financial Performance

Summary Performance Month 09 2025-26	Month 9 Plan	Month 9 Actual	Month 9 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.34)	(8.31)	△ (0.04)	(75.23)	(75.23)	△ (0.01)	(100.27)	(100.27)
Expenditure - Pay	5.97	5.85	● 0.12	54.47	54.30	● 0.17	72.37	72.37
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.08	0.01	● 0.07	0.88	0.21	● 0.68	1.10	1.10
Expenditure - Non Pay	2.52	2.63	△ (0.11)	22.75	23.47	△ (0.72)	30.84	30.84
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	(2.90)	(2.90)
EBITDA	0.23	0.19	● 0.05	2.87	2.75	● 0.12	1.14	1.14
Financing	0.03	0.08	△ (0.05)	0.29	0.42	△ (0.12)	0.39	0.39
Normalised (Surplus)/Deficit	0.26	0.26	△ (0.00)	3.16	3.16	△ (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	0.26	0.26	△ (0.00)	3.16	3.16	△ (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	0.26	0.26	△ (0.00)	3.16	3.16	△ (0.00)	1.53	1.53
Savings - CIP Levels 1 & 2	0.50	0.51	● 0.01	3.99	4.03	● 0.04	5.48	5.48
Savings - CIP Level 3	0.00	0.00	● 0.00	0.00	0.00	● 0.00	2.90	2.90
Capital	0.25	0.03	● 0.22	1.16	0.69	● 0.48	2.10	2.10
Cash	6.66	3.30	△ (3.36)	6.66	3.30	△ (3.36)	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 nine are:

Trust is reporting a cumulative deficit of £3.16m, which is in line with the submitted plan.

- **Income**

Cumulative income was on plan at £75.23m.

- **Pay**

Pay costs are below plan by £0.12m in month nine predominantly due to vacancies, cumulative pay costs are £0.17m favourable to plan.

Workforce (WTE)	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	MoM Movement
Substantive (Planned)	1,415	1,410	1,404	1,403	1,403	1,398	1,398	1,398	1,393	1,393	1,393	1,388	(0)
Substantive (Actual)	1,376	1,372	1,364	1,361	1,347	1,327	1,323	1,307	-	-	-	-	(16)
Bank (Planned)	20	20	20	20	20	20	20	20	20	20	20	20	0
Bank (Actual)	19	22	20	21	19	18	21	21	-	-	-	-	(0)
Agency (Planned)	15	14	13	12	11	10	9	8	7	6	5	4	(1)
Agency (Actual)	6	3	1	1	1	1	1	1	-	-	-	-	(0)
Total Planned	1,450	1,444	1,437	1,435	1,434	1,428	1,427	1,426	1,420	1,419	1,418	1,412	(1)
Total Actual	1,401	1,397	1,385	1,383	1,367	1,346	1,345	1,328	-	-	-	-	(17)
Total Variance	(49)	(47)	(52)	(52)	(67)	(82)	(82)	(98)	-	-	-	-	

- **Agency**

Year to date the Trust has incurred costs of £0.21m against the plan of £0.88m. Month on month the Trust has continued to reduce agency spend and spent £0.01m in month nine against a plan of £0.08m.

There is now only one service using agency:

- UTC Widnes – locum GP shifts.

Agency costs incurred in month nine equated to 0.49 WTE staff, all being medical locums.

The Trust has reduced its agency spend substantially over the past 21 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 nine, agency equated to 0.15% of the pay bill in month and 0.38% year-to-date.

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

For month nine, bank costs were £0.10m, in line planned expenditure of £0.10m, and a slight reduction from month eight.

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 graph below:

Table 3 – Agency Spend

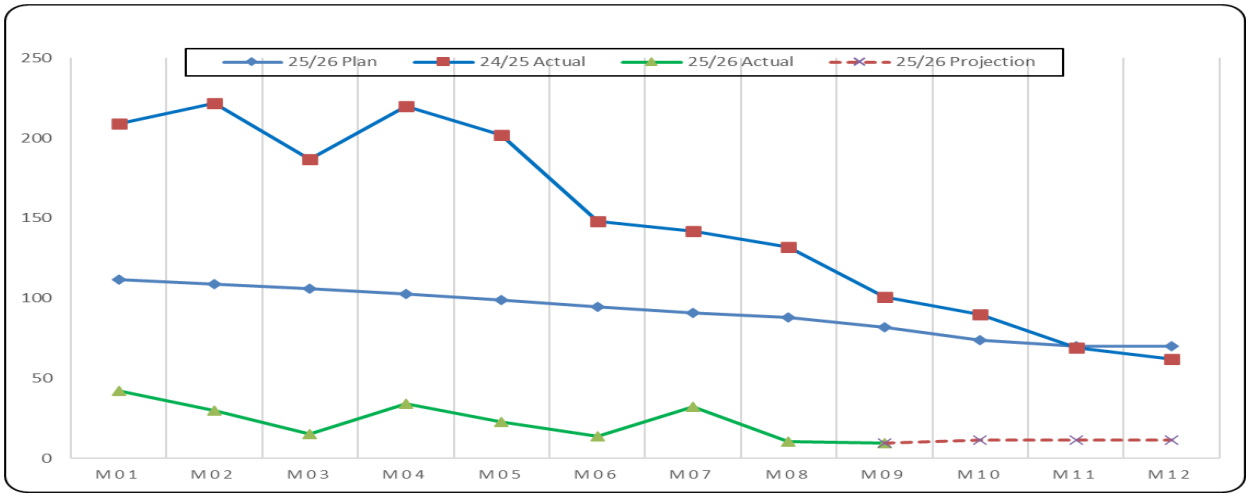
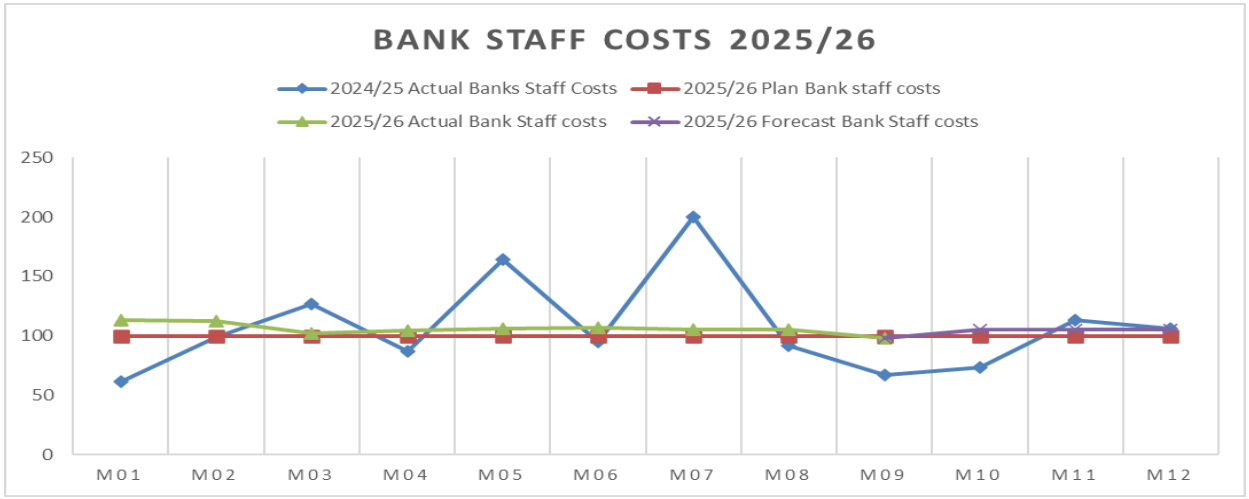


Table 4 - Bank Spend

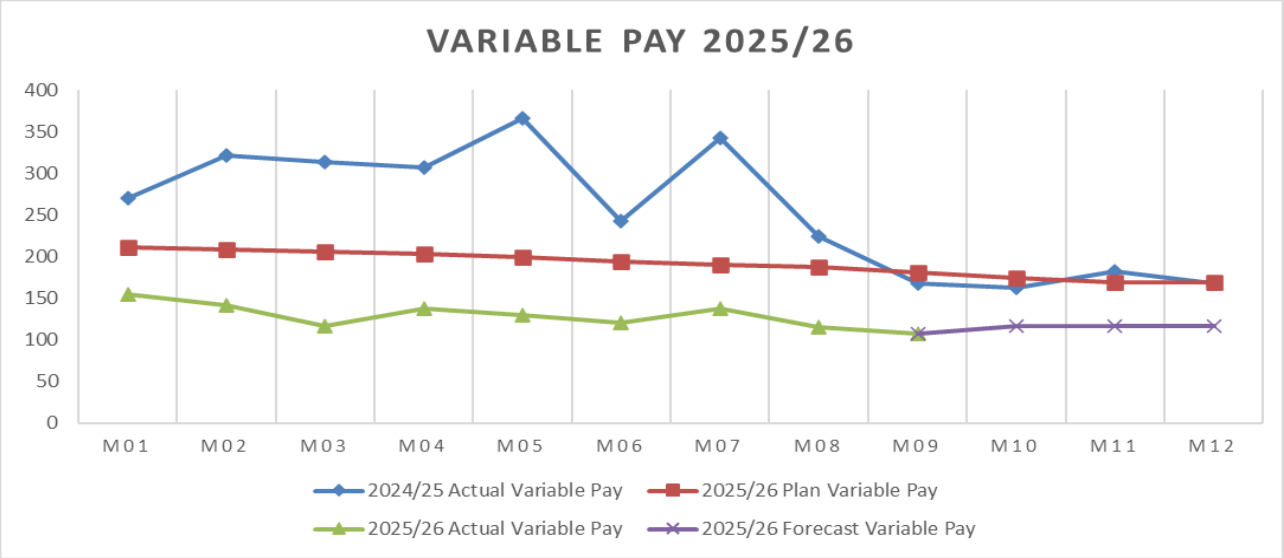


Variable Pay

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	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Rolling 12 Months
Bank staff including on-costs	126	126	125	100	100	100	100	100	100	100	100	100	**1,277**
Agency/contract	70	71	71	112	109	106	103	99	95	95	95	95	**1,121**
Total Variable Plan	196	197	196	212	209	206	203	199	195	195	195	195	**2,398**
Variable Pay £'000	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	Total
Bank	67	73	113	112	112	102	104	106	107	106	105	98	**1,204**
Agency	90	69	62	42	30	15	34	23	14	32	10	9	**430**
Overtime	9	15	6	10	2	2	2	0	0	0	1	0	**48**
Total Variable Pay	**166**	**157**	**181**	**164**	**144**	**119**	**139**	**129**	**121**	**138**	**116**	**108**	**1,681**
Overtime	9	15	6	10	2	2	2	0	0	0	1	1	48

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



- **Non Pay**
  - During month nine the Trust has spent £2.63m on non-pay, £0.11m above plan predominantly due to an increase in biologic drug costs in Dermatology and Continence products (note these are offset by an increase to income), plus equipment costs.

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 five performance reporting.

3.4 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 nine is £3.99m, against which achievement of £4.03m is reported, of which £0.17m is non-recurrent vacancy slippage, this will be replaced by recurrent schemes as the year progresses.

4. FORECAST OUTTURN

4.1 Based on the run rate to month nine, and assuming this run rate continues for the rest of the financial year, the following outturn scenarios are forecast.

4.2

	Best Case £m	Medium Case £m	Worst Case £m	Likely Case £m
Year to date Deficit	(3.16)	(3.16)	(3.16)	(3.16)
Straight Line Forecast deficit	(4.21)	(4.21)	(4.21)	(4.21)
CIP - Level 3 - Rev to Cap	0.80			
CIP - Level 3 - Service Redesign	0.50	0.00		
CIP - Level 3 - System stretch	1.60			
Adj	(0.22)	(0.21)	(0.21)	(0.21)
Adjusted Outturn	(1.53)	(4.42)	(4.42)	(4.42)
Plan deficit	(1.53)	(1.53)	(1.53)	(1.53)
CIP - Level 3 - Realloc Rev to Cap				0.00
Revised Planned Deficit	(1.53)	(1.53)	(1.53)	(1.53)
Variance to Plan	(0.00)	(2.89)	(2.89)	(2.89)

4.3 Best Case – the best case scenario assumes that the Trust can deliver additional savings in line with the full system deficit stretch target included in the original 2025-

26 plan. The Trust will also deliver the additional savings identified for delivery in the second half of the financial year.

4.4 Worst / Medium / Likely Case – these scenarios all assume that the Trust does not deliver any of the additional system stretch target savings. As at month nine the Trust has been unable to implement any savings schemes to support this savings ask.

- Revenue to Capital Opportunities – The Trust has no spending planned in this financial year that would provide opportunities to deliver these savings. The ICB has been made aware of this position. The expected system wide review has not been completed at the time of writing this report.
- Service Redesign – As part of the planning process, the Trust identified an opportunity to reduce spend in dermatology, recognising that any service risks would need to be mitigated with system support. As at month nine, no agreement on these mitigations has been reached. Discussions with Commissioners have continued to secure additional funding which could then release capacity to deliver these savings, however as at month nine Commissioners have indicated that no additional funding is likely in 2025/26.
- General system stretch – As at month nine, the Trust is continuing to explore any opportunities for savings to contribute to this target. To date, all system generated ideas have either already been included in the Trust Level 1 and 2 CIP programmes or have not been relevant to community Trusts. As a system additional ideas and opportunities are continually being developed, and these are all evaluated as they arise.
- This case assumes that the reduced run rates to date will continue in the final quarter of the year.

5. UNDERLYING POSITION

5.1 As at month nine the latest underlying financial position for the Trust is £4.47m deficit. The table below bridges from the 2025/26 plan and adjusts for any non-recurrent items or deviations from the plan.

	2025/26 Plan £m	Non recurrent efficiencies £m	Stretch Target £m	Recurrent efficiencies to mitigate shortfall £m	2025/26 Underlying Position £m
Surplus / (Deficit)	**-1.53**	**-0.20**	**-2.89**	**0.15**	**-4.47**

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

6.1 The Trust spent £0.69m on capital schemes up to month nine, against a plan of £1.16m.

6.2 The latest list of all capital schemes for 2025/26 is presented to the finance committee every month.

6.3 In December 2025 there was a net cash outflow of £1.43m with a closing cash balance of £3.30m. the Trust is expecting cash receipts exceeding £2m in January (month 10).

6.4 Invoiced debt has increased by £0.65m and of that, overdue debt has decreased by £1.67m.

6.5 Total debt has increased by £1.57m compared to prior month and this is primarily due to an increase in invoiced debt.

6.6 Total trade and other payables as at 31st December are £8.60m, of which £5.30m relates to creditors.

6.7 Total payables have decreased by £0.80m compared to the previous month.

6.8 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
Jul-25	95.0	99.0	99.5
Aug-25	95.0	99.3	99.7
Sep-25	95.0	99.5	99.7
Oct-25	95.0	99.6	97.3
Nov-25	95.0	99.6	98.7
Dec-26	95.0	99.2	98.6
Year to date performance	**95.0**	**99.1**	**99.0**

7. RECOMMENDATION(S)

7.1 The Board is asked to:

- Note the contents of this report.
- Note the financial position.
- Note the forecast outturn scenarios.

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	**Audit Committee**		**Report to:**	**Board of Directors**
Date of Meeting:	22 January 2026		Date of next meeting:	TBC
Chair:	Bob Chadwick, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Bob Chadwick, Non-Executive Director, Committee Chair Tina Wilkins, Non-Executive Director, Committee Vice-Chair Gail Briers, Non-Executive Director Abdul Siddique, Non-Executive Director	**In Attendance and Observers:** James Boyle, Director, KPMG Paul Fitzsimmons, Medical Director (to 10:20) Nick Gallagher, Director of Finance (from 10:20) Jeanette Hogan, Deputy Chief Nurse (to 10:15) Rachel Hurst, Deputy Director of Finance Jan McCartney, Director of Corporate Governance Adrian Poll, Senior Audit Manager, MIAA Emma Simpson, Manager, KPMG Andrew Wade, Anti-Fraud Specialist, MIAA Debbie Weir, Financial Controller <u>Observer</u> Rita Chapman, Governor Kevin Goucher, Governor	**Key Members not present**:	**Member:** Elaine Inglesby, Non-Executive Director Ali Kennah, Chief Nurse Dan Moore, Chief Operating Officer **Attendee:** Linda Daisley, Anti-Fraud Specialist, MIAA

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
	1			

	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

Clinical Audit Process Assurance Update	1		The Committee received assurance that the audit process is planned, approved and reviewed in line with national standards. Some local audits were overdue and work to support this was ongoing and preparations were being made for a joint clinical audit plan, post-integration with WHH.	
Review of Board Assurance Framework and Corporate Risk Register	1		BAF 1 was reviewed and it was agreed that the recent high assurance outcome for the Fit and Proper Persons Test process audit would be added to the assurance section. The Corporate Risk Register for October – December 2025 was reviewed. Eight new corporate risks had been identified in the period. Some existing risks had been escalated and one risk, Children's Service and the Neurodevelopmental Pathway had a score of 20 (Significant). Risks with limited assurance related to Dermatology, Dental services, Children's Directorate, and EPRR standards and it was acknowledged that a clearer narrative was needed for future reports.	As information on limited assurance risks presented differed from the report provided, JH committed to recirculating the report.
Trust Registers of Interests including Gifts and Hospitality for the reporting period including updated Directors Register of Interests	1		The Committee noted the 100% compliance from Governors and the Board and an increase to 97.8% compliance among senior managers and equivalent doctors and dentists. Updates to the Board declarations were noted due to joint appointments, with no issues arising. No Gifts and Hospitality declarations were recorded which was acknowledged to be normal in community trusts.	
Review of Losses, Special Payments and Tender Waivers	1		The Committee noted that £8,833.01 of total bad debts had been written off as at the end of December 2025. There had been no special payments made during the last quarter. There were six waiver requests totalling £280,993.49 of which three were over £50,000. The Committee was assured that the arrangements which required the waivers provided the most cost-effective and safe options, however these continued to be reviewed as part of integration.	

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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 Committee Terms of Reference	1		The Committee approved the Terms of Reference which had been updated to reflect the Quality Assurance Committee in Common with WHH and noted that due to the pending integration, no other changes were recommended.	
Annual Self-Assessment of Committee Effectiveness	1		The Committee received the outcome of the annual self-assessment of the Committee, noting that overall satisfaction had increased from last year's assessment which demonstrated that the Committee was well led and in good state for handover to the new organisation.	
Review of Annual Accounts Progress	1		The Committee received the update that planning was underway, and no issues had arisen to date, and noted that the forthcoming integration would likely add complexity to the process.	
Internal Audit - Mersey Internal Audit Agency (MIAA) Items: (i) Internal Audit Progress Report and Sector Updates	1		Planning for 2026-27 would be in the context of integration. The audit plan would be developed and the plan approved at the April 2026 Audit Committee of the new organisation.	
(ii) Annual Review of Effectiveness of Internal Audit	1		The review had not been undertaken in light of the anticipated acquisition of the Trust and cessation of the contract between the Trust and MIAA.	
(iii) Internal Audit Progress Report and Sector Updates	1		The Committee received an update which included high assurance opinion on the Trust's Fit and Proper Person Test audit with good controls in place.	
Internal Audit - Mersey Internal Audit Agency (MIAA) Anti-Fraud Items: (i) Anti-Fraud Progress Report	1		The Committee received the report and noted that fraud risk assessment continued to be rated amber, pending reassessment.	

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

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

Committee Chair's Report

(ii) Annual Review of Effectiveness of Anti-Fraud Services	1		The review had not been undertaken in light of the anticipated acquisition of the Trust and cessation of the contract between the Trust and MIAA.	
(iii) Anti-Fraud, Bribery and Corruption Policy – updated			The Committee approved the updates to the policy which reflected new legislation.	
External Audit – KPMG Items: (i) External Audit Progress Report	1		The Committee received the report which highlighted materiality levels, significant risks (fraudulent expenditure recognition and management override of controls), and the removal of a previous risk related to asset valuation due to increased materiality.	
(ii) Indicative External Audit Plans and Fees	1		In addition, the audit timeline and fees were detailed and the Committee acknowledged KPMG's declaration that it was independent and had the resources and ability to deliver the audit. KPMG explained that reference to the integration in the audit plan would be addressed in the value for money risk assessment and future versions of the plan as integration details were confirmed.	It was confirmed that an Extraordinary Audit Committee to provide a handover from the Trust to the new organisation's Audit Committee would be scheduled and include TW as the Finance, Sustainability & Performance Co-Chair, along with internal and external audit.
Risks Escalated: None from the meeting				

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

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

Name of Committee/Group:	**Finance, Sustainability and Performance Committee in Common**	**Report to:**	Trust Board
Date of Meeting:	22 December 2025	Date of next meeting:	26 January 2026
Chair:	BCH Chair, Tina Wilkins	Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** **BCH**: Tina Wilkins, Non-Executive Director and Committee Chair Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance **BCH and WHH Joint Directors**; Paul Fitzsimmons, Medical Director Daniel Moore, Chief Operating Officer Ali Kennah, Chief Nurse	**Key Members not present (apologies received)**:	Lynne Carter, Director of Delivery Unit Bob Chadwick, Non-Executive Director

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Hot Topic – Medium Term Plan – BCH	5		It was noted that both BCH and WHH finance teams had worked closely to ensure that plans aligned structurally, used the same assumptions, and enabled a consistent approach for the new organisation. Initial draft presented to Board 4/12/25 (included inflation, CNST and CIP assumptions) was a brea-even plan. Revised plan following updated income guidance from ICB, update to 5% CIP plan, and amendments for smoothing and exit run rate improvements brings the deficit to £4.2m. Therefore, to achieve the break-even plan limit, a further **£1.9m** CIP would be required. This brings total improvements required to **£6.3m (c7%).**	The Committee gave significant time to thoroughly examine the issues raised during the discussion. Several key areas of concern were raised. These included: 1. The level of CIP required was significantly higher than what has previously been achieved recurrently. 2. Achieving all the necessary savings is unlikely to be realised through reductions in corporate staffing alone and this could affect clinical staffing, potentially impacting quality and safety.

Committee Chair's Report

			The plan is based upon the following assumptions: 1. 2025/26 CIP plans all achieved recurrently 2. CNST funding received to match premium increase 3. Drugs risk share agreed – shared care prescribing 4. Income reductions matched with expenditure reductions (e.g. Dermatology and VW) 5. System work required to deliver CIP plans	3. The Board needs sufficient information about the schemes and programmes to be confident in the Trust's ability to deliver these savings before approving the assurance statement. 4. Ultimately, accountability for achieving these targets rests with the Board, which will be held responsible if they are not met. The Finance, Sustainability and Performance Committee in Common supported the draft submission of activity, workforce and finance operational plans to ICB and NHSE on 16 December by 5pm
BCH Finance Report – Month 8	5		The key headlines for month eight are as follows: • The Trust is reporting a deficit at Month 8 of £2.90m, in line with plan. • The Trust has a Level 1 and 2 savings requirements, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £3.52m against a plan of £3.49m • Income is £66.92m against a plan of £66.89m. • Expenditure is £69.82m against a plan of £69.79m. • Pay is £48.45m against a plan of £48.50m. • Agency spend is £0.20m against a plan of £0.80m. • Non pay expenditure is £20.83m against a plan of £20.23m. • Capital charges are above plan by £0.08m. • Capital expenditure is £0.66m at month eight, planned spend is £0.92m. • Cash is £4.73m.	It was requested that future finance reports included further detail on non-pay savings from underspends and changes in contracts next month. The finance report was recommended to the Board for approval.

	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

			The Committee highlighted and raised questions about the cash position, underspends in pay and overspends in non-pay. Further a concern was raised that the income generated used to offset the non-pay overspend was only able to offset a relatively small proportion of expenditure and led to a significant overspend in this area.	
BCH Monthly CIP Updates – Month 8	5		At month 8, the Trust reported savings of £3.52m in line with the submitted plan. Of the cumulative savings £0.15m is non recurrent savings relating to vacancies. Under the budget review process, DLT's will review the non-recurrent savings to identify opportunities to make them recurrent once they were taken through the QIA process. If the savings cannot be made recurrent, additional recurrent schemes will need to be identified to mitigate this shortfall, or schemes that did not deliver in line with the original plan will be required to accelerate and deliver the recurrent savings not achieved. There was a need to have a contingency around risks.	Level 3 CIP savings schemes have not yet been identified to meet the required savings target. Hence the Committee RAG rated this as red.

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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

BCH Performance Council Report BCH IQPR	5		Improvement plans were being developed and would be included as part of future reporting. Dental sessions were being delivered in line with contractual expectations. The number of sessions would equate to 80% of the contracted value. Work was continuing to reduce the Dermatology long waiters with a bid having been successful to support additional sessions being in place to reduce those. The sessions had commenced during the final week of November/first week of December 2025. It was expected that the numbers would reduce in accordance with the plan and this would be able to be observed by the next FSPCiC meeting. It was noted that the circulated report had only included the 28 day faster diagnosis standard and there needed to be an improvement trajectory and graph for both the 31 day and 62 day standards following the recent incident with the 181 patients not recorded on Somerset. This information would be included within future reporting. Improvements were on plan, with numbers in line with the reported trajectory. A compliant position was expected by the end of January 2026.	The Committee noted the challenges to performance in both Dentistry and Dermatology.An improved reporting format for both performance Council and IQPR would be presented at the next Committee meeting.
Integration Update	1&7		Report was received and noted.	
BCH Audit Recommendations	5		The report was noted.	
Risks Escalated: None **Items to be escalated:**				

	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

Name of Committee/Group:	**Finance, Sustainability and Performance Committee in Common**	**Report to:**	Trust Board
Date of Meeting:	26 January 2026	Date of next meeting:	23 February 2026
Chair:	BCH Chair, Tina Wilkins (meeting Chaired by WHH Chair, John Somers	Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** **BCH**: Tina Wilkins, Non-Executive Director and Committee Chair Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Lynne Carter, Director of Delivery Unit **BCH and WHH Joint Directors**; Paul Fitzsimmons, Medical Director Daniel Moore, Chief Operating Officer Ali Kennah, Chief Nurse	**Key Members not present (apologies received)**:	

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Deep Dive/Hot Topic – BCH Final Operational Plan	5		The Committee received a presentation setting out current progress with the planning process. The basis for the plan is per the last submission: The 2025/26 exit run rate is £4.4m, with 2026/27 inflation and CNST increase of 8% this becomes a deficit of £6.6m. Initial draft presented to Board 4/12/25 (included inflation, CNST and CIP assumptions) was a break-even plan. Revised plan following updated income guidance from ICB, update to 5% CIP plan, and amendments for smoothing and exit run rate improvements brings the deficit to £4.2m. Therefore, to achieve the break-even plan limit, a further £1.9m CIP would be required.	

Committee Chair's Report

			This brings total improvements required to £6.3m (c7%). The Committee reviewed the current options for the 2026/27 financial plan, noting the requirement for a 7% CIP target. The Committee did not feel confident that this could be achieved within a 1-year financial plan as the Trust had never achieved recurrent CIP at this level. The option to develop a longer term 3-year financial plan to manage the underlying deficit and take the trust to a break-even position was discussed by the Committee and it was felt that this was the way to progress. The Committee also discussed the implication of proposed workforce reductions and their impact on productivity improvements. The updated assurance statement was presented to the Committee.	The Committee stressed the critical importance of robust Board assurance processes. It was agreed that any financial plan ultimately approved must be demonstrably deliverable and maintain the highest standards of safety. To this end, the Committee highlighted the need to triangulate considerations across three key domains: financial sustainability, workforce planning, and quality of service delivery. It was agreed that the assurance statement required careful consideration by the Board prior to sign off. Therefore, the Committee agreed to schedule an extraordinary session to review the assurance framework and finalise recommendations for the Board, ensuring that all risks and assumptions are fully understood before submission.
BCH Finance Report – Month 9	5		• The Trust is reporting a deficit at Month nine of £3.16m, in line with plan. • The Trust has a Level 1 and 2 savings requirements, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). • The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m	The Committee recommends the Finance report to the Board for approval.

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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

			• Income is £75.23m against a plan of £75.23m. • Expenditure is £78.39m against a plan of £78.39m. • Pay is £54.30m against a plan of £54.47m. • Agency spend is £0.21m against a plan of £0.88m. • Non pay expenditure is £23.47m against a plan of £22.75m. • Capital charges are above plan by £0.12m. • Capital expenditure is £0.69m at month nine, planned spend is £1.16m. • Cash is £3.30m. The Committee noted the current position where level 1 and 2 savings were on track. However, there continues to be no achievement of level 3 savings and it is unlikely that there will be any improvement within this financial year. The Committee raised the ongoing deterioration in the cash position which continues to perform well below plan.	
BCH Monthly CIP Updates – Month 9	5		Level 1 and 2 annual CIP savings target is £5.48m (5%). Level 3 stretch savings target is £2.90m. The Trust plan to month nine is £3.99m, against which achievement of £4.03m is reported, of which £0.17m is non-recurrent vacancy slippage, this will be replaced by recurrent schemes as the year progresses. There is still no progress relating to level 3 savings.	The excellent work of all staff in the Trust has contributed to the achievement of the level 1 and 2 CIP. The RAG rating relates to the continued non-achievement of level 3 CIP.
BCH Performance Council Report	5		A presentation with a focus on Dermatology, Audiology and Dental was provided to the Committee: Dermatology: Performance has reduced over the period from 1st December 2025.	The reduced performance in concerning and the Committee and look forward to receiving key remediating actions once the recovery plan is completed.

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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

			• Shortfall of sessions from the 1st December to the 9th of January 96 sessions should be done, 59 sessions have been completed. • A risk to 52ww and 65ww delivery has been communicated by management team because of a shortfall of lists from intersource and booking processes. This now presents a significant delivery risk. • A recovery plan is being drawn up at the time of writing this report. • Required amount per week will increase from 16 previously stated to circa 20. per week. Intersource are forecasting to achieve this position. • The service recognises there is a pivot on the required focus to the routine surgery waiting lists to reduce the longest waiters. These clinic slots are being prioritised for booking w/c the 19/1/26. Audiology: There has been a considerable improvement in Audiology. • The team have undertaken a significant piece of work in relation to • Waiting list management and scheduling • Data cleansing • Understanding and reporting of ECAD (Earliest Clinically Appropriate Date) This has resulted in an improvement in compliance resulting 0 breaches reporting week 12.01.26, therefore, achieving the 6-week diagnostic pathway target. It is imperative the service continue to achieve the target week on week moving forward.	The Committee noted the improvement in Audiology and recognised the work that had been done to achieve this.

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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

			Dentistry – Greater Manchester Contract Capacity issues have meant that the improvement plan has not progressed in line with the target which is due to the following: • With the current staff in post, we are projected to deliver max 1179 sessions • This is below the 80% target of 1352 sessions (green dashed line) • The shortfall is due to vacancies not yet recruited. • Recruitment is underway to fill both vacant posts and staff going on Maternity • Based on these staffing issues, we will have sufficient capacity to hit 80% of sessional target by April 2026 The following set of next steps have been identified to address and improve performance: • The recruitment plan is progressing in line with vacancies to ensure we have all budgeted staff in post in line with expectations. Staff in post will include those on Long Term sickness and not available to service for patient care; and those on Maternity leave • Maternity absences will affect sessional delivery in the remaining part of the quarter, and these have been factored into the staffing projection • Reviewing clinical diaries weekly to ensure maximum available time is used within core patient facing hours	The Committee wants to keep a sharp focus on Dentistry performance and are concerned that the recruitment of the required staff to achieve the contract is not delayed by the recruitment review process.

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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

			• Lead Clinical Director has written to all Dentists to ensure e-learning is undertaken within protected core Admin time; and that any TOIL is approved in advance of it being taken • Providing greater clarity to clinics/clinicians, how time away from patient facing activities is recorded in the diaries e.g. additional clinical admin; staff training (not picked up in core time); RPS duties; etc. Aiming to have greater scope of this time for review and consideration once the reporting of it is consistently captured. • Profile the Annual Leave sessional quantum to calculate the additional staffing requirement	
BCH IQPR	5		Performance continues to be a challenge for the Trust. The report was noted.	
BCH DIGIT Chairs Report	5		Report deferred to February.	
BCH Procurement Report	5		Report deferred to February.	
BCH Audit Recommendations	5		The report was noted.	
Emergency preparedness, resilience and response (EPRR) update	5		The report was noted.	

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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

Integration Report Due Diligence	1&7		Noted 151 initial risks/issues were identified as a result of the due diligence exercise undertaken as part of the development of the full business case for integration. Of these, 106 were identified as requiring further action. 66 of them are finance-related and therefore updates on progress will be reported via Finance, Sustainability and Performance Committee in Common. As at the beginning of January, 105 individual actions have been recorded by workstreams against the 66 finance-related risks/issues. All these actions are reporting as complete or on track.	
Risks Escalated: None **Items to be escalated:**				

	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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**05 FEBRUARY 2026**
Agenda Item	**09/26**		
Report Title	**NORTH CHESHIRE AND MERSEY BRAND IDENTITY**		
Executive Lead	Kate Henry, WHH Director of Communications and Engagement		
Report Author	Hayley Smith, WHH Deputy Director of Communications and Engagement		
Presented by	Jan McCartney, BCH Director of Public Governance		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

- As part of the integration process a new brand identity is required that reflects who we are as North Cheshire and Mersey NHS Foundation Trust (NCM) and supports our shared vision for high-quality, joined up care.
- Our 'home, community, hospital' ethos is closely aligned to the national 10 Year Health Plan for England and will be central to our new brand and how we promote and market NCM to staff, patients, public and stakeholders.
- Branding development and engagement work has been undertaken with staff and public to gain feedback on the proposed visual identity, and the results are included within the accompanying report.
- This feedback has been used to evolve and refine the final visual designs for the new North Cheshire and Mersey brand and its associated values.
- The Board is asked to note the branding development and engagement work undertaken.
- The Board is also asked to approve the new organisational brand for North Cheshire and Mersey NHS Foundation Trust from 1 April 2026 upon completion of the integration transaction, following the recommendation of the Executive Management Team.

Previously considered by:

☐ **Audit Committee**	☐ **Quality and Safety Committee**
☐ **Finance, Sustainability and Performance Committee in Common**	☐ **Remuneration and 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**

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

NCM branding update

WHH Board: Wednesday 4 February
BCH Board: Thursday 5 February

Overview

- Integration offers a unique opportunity to build a shared brand that reflects who we are as North Cheshire and Mersey NHS Foundation Trust (NCM)
- We want a brand that is designed to support our shared vision for high-quality, joined up care
- Our ‘home, community, hospital’ ethos is closely aligned to the national 10 Year Health Plan for England, which aims to reshape the health service and provide more care on people’s doorsteps and in their own homes
- This ‘home, community, hospital’ wording will be central to our new ‘brand’ and how we promote and market NCM to staff, patients, public and stakeholders
- Our four shared values will also reflect what it means to receive care from us and they guide how our staff learn, train and work together every day. Their visual identity will help to ensure they are embedded in everything we do
- Engagement work to obtain feedback on our draft brand identity was undertaken from Monday 12 January to Friday 23 January – the results and recommendations are shared on the following slides
- This work has been undertaken in-house by the communications and engagement teams, with no external costs incurred

Brand survey distributed to:

- Leadership Forum members
- WHH Culture Champions
- BCH People Promise Champions
- Staff network members
- Council of Governors
- Experts by Experience
- Trust Boards

Number of responses:

- Staff: 137 (75.44% female / 18.42% male / 6.14% not specified)
- CoG / EbyE: 46
- In total: **183**

Our brand identity

Survey feedback

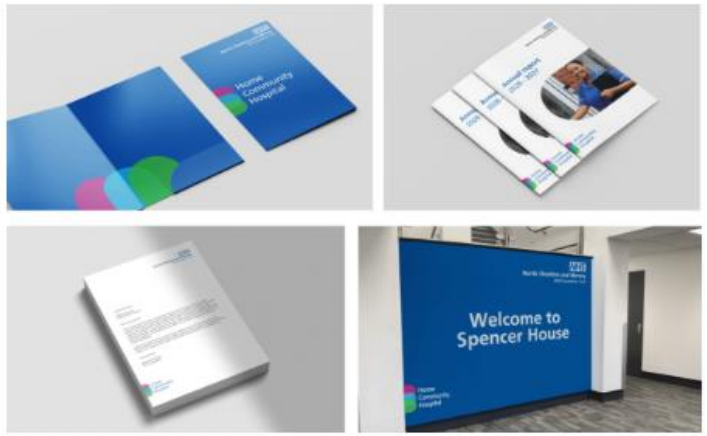
Visual Identity Staff Survey

Our visual identity

As a single organisation we will be committed to tackling health inequalities, supporting older and frail people in the community, and preventing avoidable hospital admissions.

Our 'home, community, hospital' shared vision is closely aligned to the national 10 Year Health Plan for England, which aims to reshape the health service and provide more care on people's doorsteps and in their own homes.

This 'home, community, hospital' wording is central to our new 'brand' and how we promote and market NCM to staff, patients, public and stakeholders.



1. Looking at the overall brand design, what is your first impression?

2. Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

- ○ Yes
- ○ Mostly
- ○ Not sure
- ○ No
- ○ If the answer is no or not sure, please explain why:

Headline findings (Staff):

- Strong positive first impressions – clean, professional
- Colour palette and simplicity widely praised
- ‘Home, community, hospital’ tagline resonates with staff as aligning to clinical and strategic direction
- Staff feel the brand fits a combined trust identity
- Only minor refinements suggested for wording and clarity

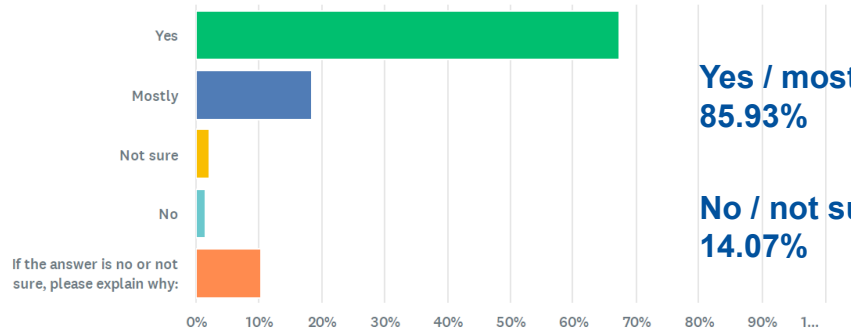
(CoG / EbyE):

- Overall identity clear, recognisable and aligned to NHS values
- Colours and simplicity attractive and easy to understand
- Appreciation given for the straightforward, modern design
- Some clarification in additional wording would strengthen confidence and understanding of the ‘home, community, hospital’ tagline

Visual identity (Staff)

Q2 Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

Answered: 135 Skipped: 0

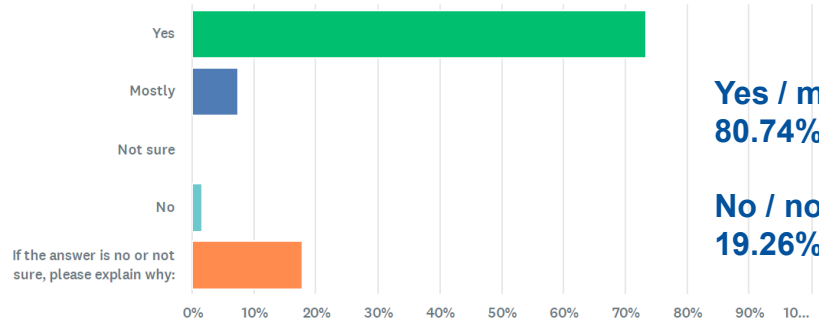


Yes / mostly: 85.93%

No / not sure: 14.07%

Q3 Does the ‘home, community, hospital’ tagline make sense to you? (select one option)

Answered: 135 Skipped: 0



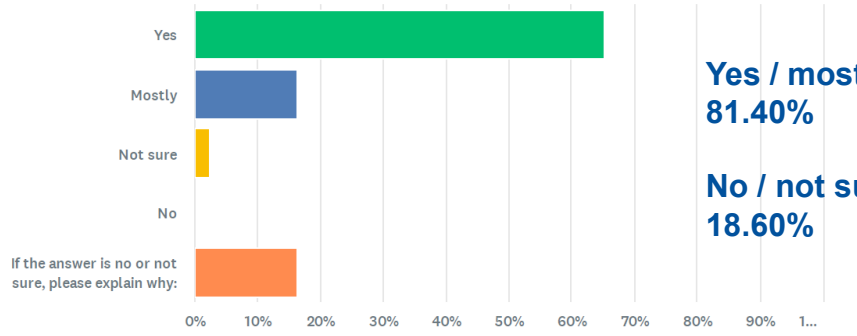
Yes / mostly: 80.74%

No / not sure: 19.26%

Visual identity (Public)

Q2 Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

Answered: 43 Skipped: 1

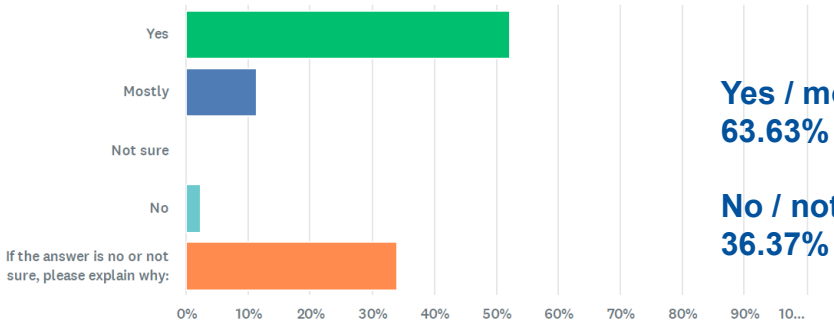


Yes / mostly: 81.40%

No / not sure: 18.60%

Q3 Does the ‘home, community, hospital’ tagline make sense to you? (select one option)

Answered: 44 Skipped: 0

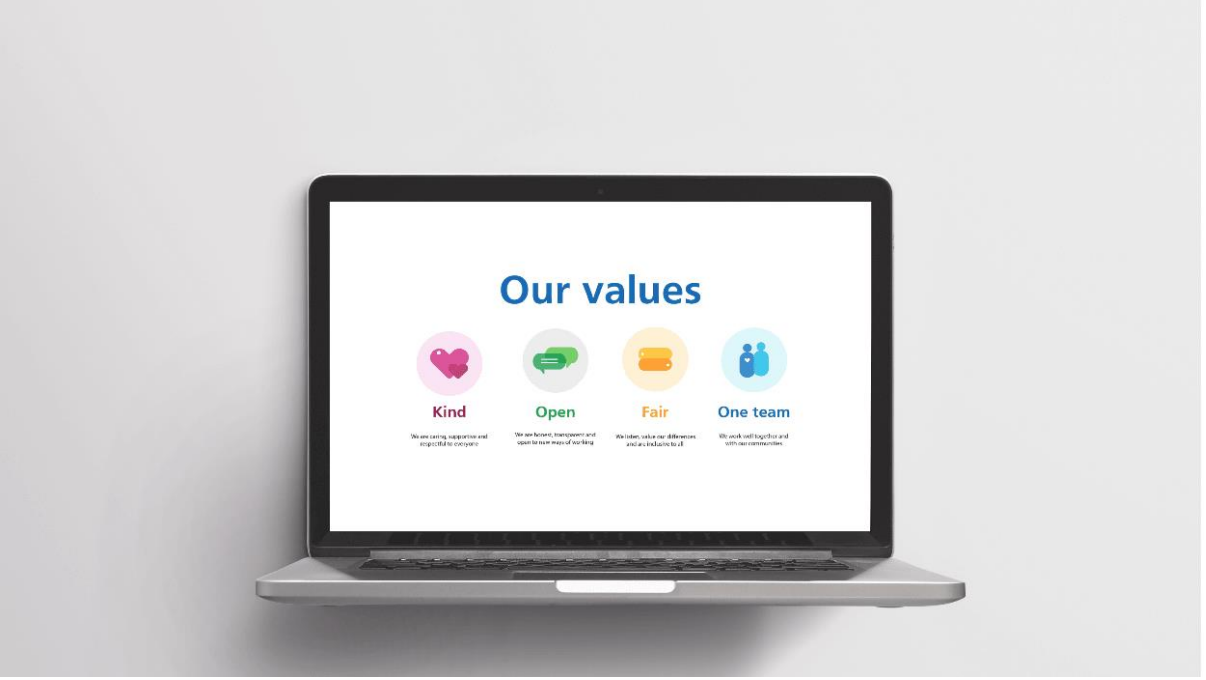


Yes / mostly: 63.63%

No / not sure: 36.37%

Our values

Survey feedback for draft icons
(values and accompanying wording previously approved)



Headline findings (Staff)

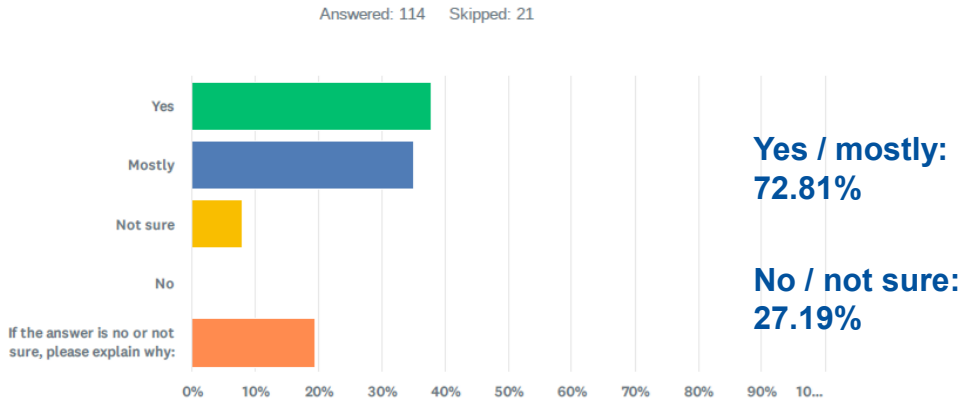
- Icons repeatedly described as simple, friendly, approachable
- Colleagues like the harmony between shapes / styles
- Seen as clear overall, but some further refinement required to strengthen instant recognition
- Small enhancements, e.g. clearer symbolism for ‘fair’, and ‘one team’ would improve interpretation and reinforce the idea of collective working while keeping a clean design

(CoG / EbyE)

- Visually appealing overall, seen as modern, cheerful and memorable
- Positive response to colours and layout
- Simple shapes easy for public to navigate and not too overwhelming
- Colour palette well received – accessibility checks required
- Not all values instantly understood without the accompanying wording – further clarity needed, predominantly for ‘fair’, and also ‘one team’

Our values (Staff)

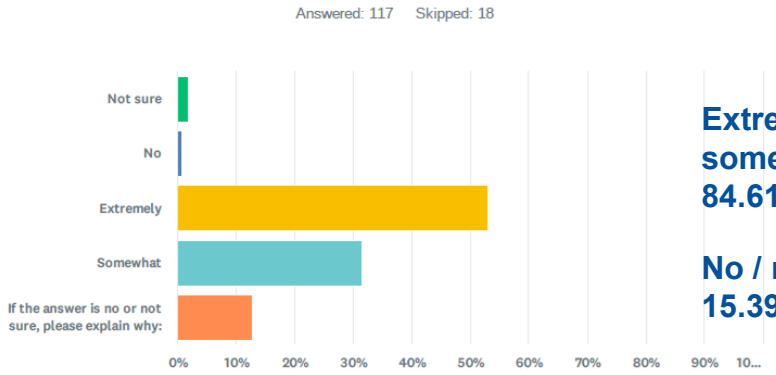
Q8 Are they clear and easy to understand? (select one option)



Yes / mostly: 72.81%

No / not sure: 27.19%

Q11 How well do the values kind, open, fair and one team reflect who we want to be as a single organisation? (select one option)

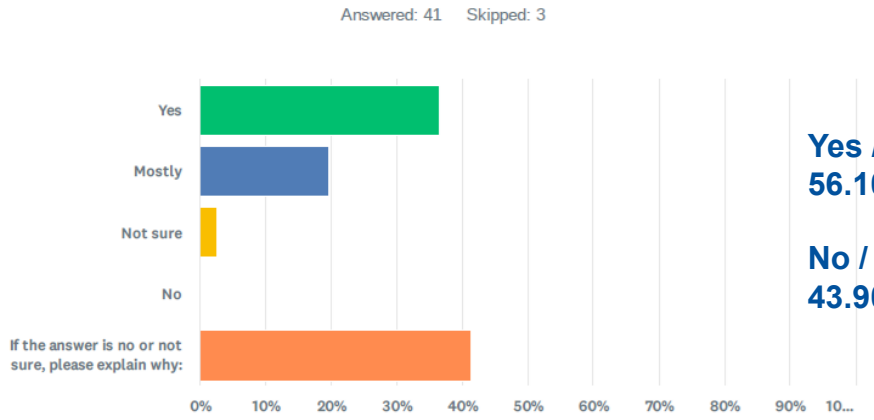


Extremely / somewhat: 84.61%

No / not sure: 15.39%

Our values (Public)

Q8 Are they clear and easy to understand? (select one option)



Yes / mostly: 56.10%

No / not sure: 43.90%

(Q11 was specifically tailored to staff so not included in public survey)

Changes implemented

Changes implemented

EMT supported the overall brand design identity and ‘home, community, hospital’ tagline on 27 January 2026, with the recommendation for it to be approved at Board.

It noted the following changes that had been incorporated:

- Reordered the ‘home, community, hospital’ colour to emphasise stages of care i.e. green for home, blue for community, magenta for hospital
- Added a secondary, supporting strapline (caring for you) to emphasise that caring for patients is our priority
- Updated the ‘One team’ values icon to add a third person / hearts to make it more representative of a team
- Slightly updated the ‘Fair’ values icon to try to make it a clearer symbol
- Built upon the option for both the tagline and values to be used as a text-only version as well as a graphic / icon version
- Updated the implementation plan to incorporate feedback

Updated visual identity

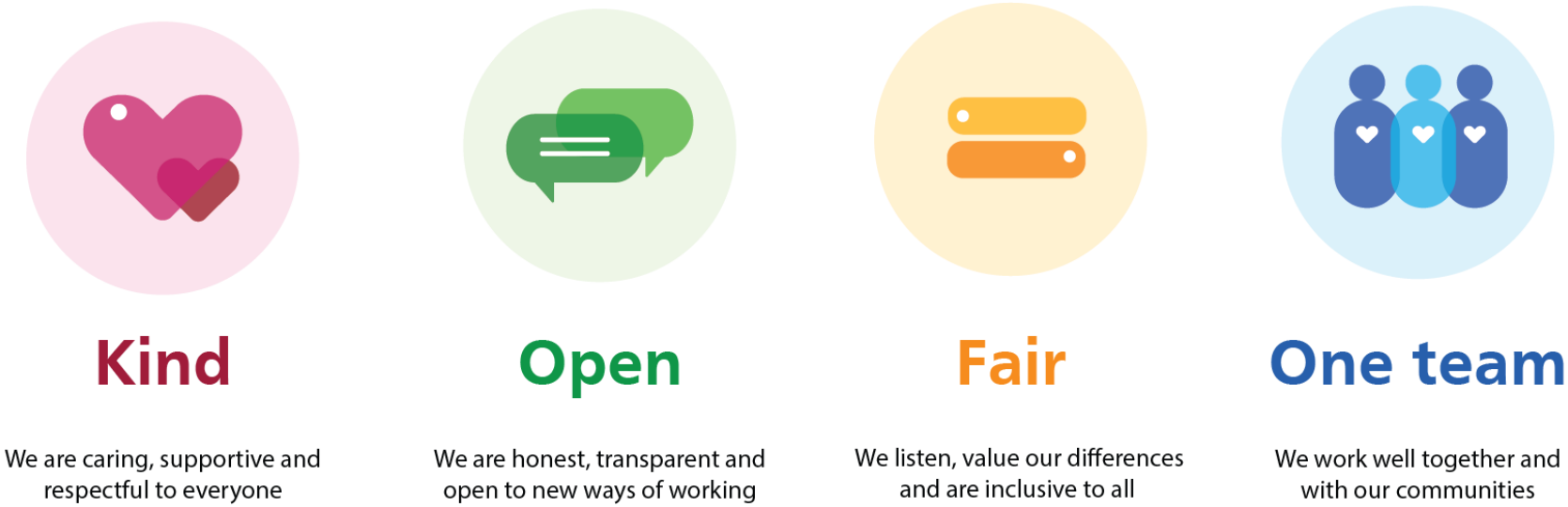
Home
Community
Hospital

•Home•Community•Hospital
Caring for you

We have:

- reordered the colour of the three ‘orbs’ to highlight home first
- introduced a ‘Caring for you’ sub-strapline to emphasise care as the priority
- added coloured dots to break up the tagline wording when used horizontally

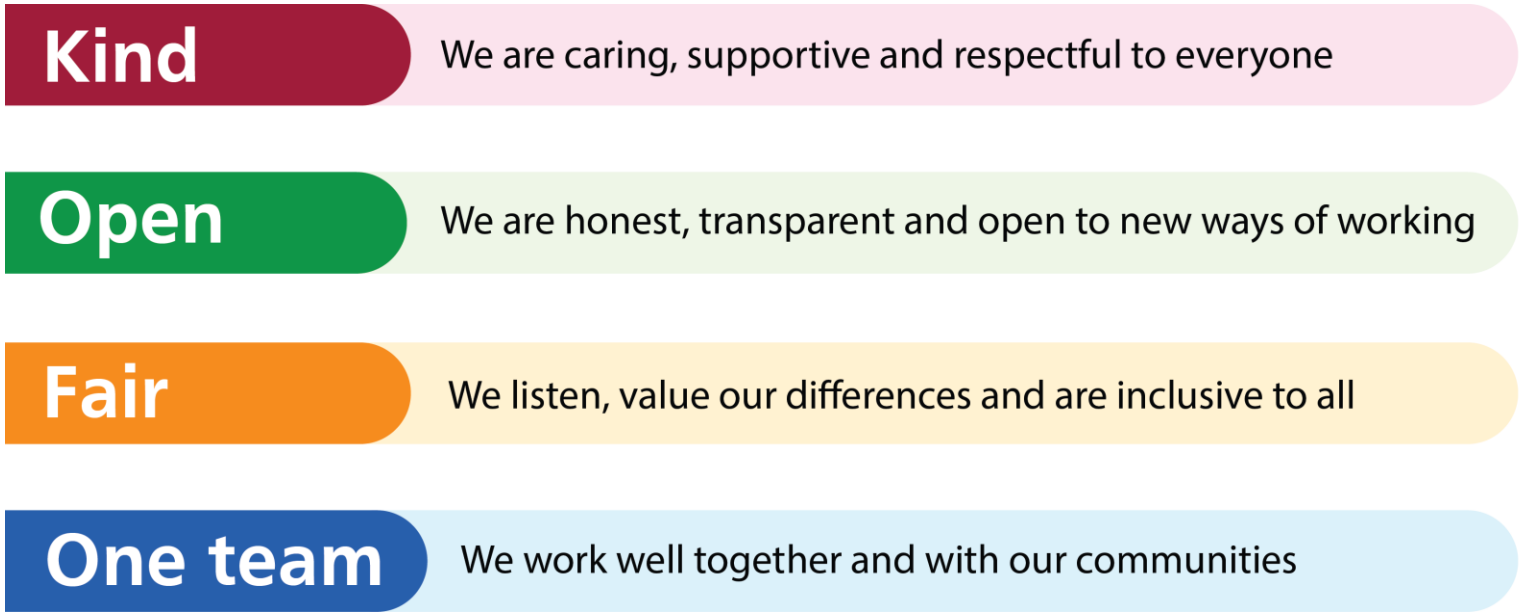
Updated values imagery (icons)



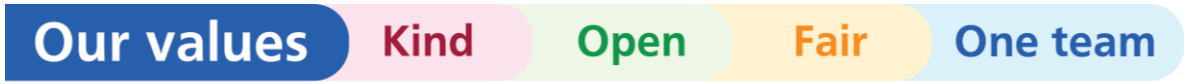
- The initial set of values icons centred around consistent paired, overlapping forms within each icon i.e. two elements per image to represent togetherness. Changing the fair and one team imagery impacts this initial design concept and overall cohesion, but does take on board survey feedback and show a willingness to listen, adapt and improve
- Fair icon – the ‘equals’ sign has now been made more prominent with increased spacing between rules and thicker lines
- One team – an additional figure and hearts have been added to represent team working / two teams joining together as one
- Alternative feedback suggestions for fair e.g. scales of justice were considered but found to be less suitable than the options progressed

Updated values imagery (no icons)

With descriptors:



Without descriptors:



Values may be used with / without icons depending on context or platform (examples to follow in brand guidelines)

Implementation

The following will be actioned as part of the implementation plan:

- Introduce a simple, consistent core narrative to highlight the ‘why’ behind the tagline i.e. providing the right care, in the right place, at the right time
- Develop a comprehensive communications plan for a successful rollout and wider implementation, using multi-channel comms to reinforce key messaging and priorities
- Consistently promote the longer-term benefits for our staff and communities – better outcomes, patient independence, faster recovery, reduced pressure on acute care etc
- Use real examples, everyday scenarios and patient / staff stories to demonstrate what this looks like in practice. e.g. virtual wards, community teams, prevention, targeted support
- Create brand guidelines, templates and accompanying style guide to provide clarity on usage and the where / when / how (ensuring all branding is used appropriately and correctly for specific environments and contexts)
- Ensure the transition to a new organisational name and brand is done as cost-effectively as possible

Recommendation

The Board are asked to:

- note the branding development and engagement work undertaken
- approve the new organisational brand for North Cheshire and Mersey NHS Foundation Trust from 1 April 2026 upon completion of the integration transaction, following the recommendation by the Executive Management Team
- support the implementation plan

Appendices

Qualitative feedback examples

Visual identity: Overall design

What staff like based on first impressions (in their words):

- *The colour scheme is effective and immediately recognisable as NHS branding, reinforcing consistency and trust*
- *The layout guides the viewer's eye naturally, making the key message and tagline easy to understand at a glance*
- *The colours feel cohesive and help reinforce a sense of warmth, care and professionalism, which aligns well with the organisation's purpose*
- *I like the cool toned colours, blue against the white and the accent colours stand out well but look harmonious too. Nice simple, easy to read font. The design successfully communicates the organisation's identity in a way that feels both reassuring and credible*
- *I like the blue colour, it looks professional, modern and fresh. The white looks more clinical*
- *The simplicity of the design is a strength. It keeps the message focused, looks clean, and feels aligned with NHS expectations around clarity and accessibility. Key strengths – subtle, thoughtful messaging. Clean and minimal visual style. Professional and appropriate for an NHS setting. Avoids over complicating the concept*
- *Visual elements e.g. colour, typography and layout work well together, making the brand appear trustworthy and intentional rather than cluttered or inconsistent*
- *It's simple but striking, a definite identity for the new trust that I think can be easily adapted for those additional services that are across a wider footprint, thereby hopefully promoting belonging while sustaining an individual identity and purpose*
- *Really does stand out! I like it more than the current branding at either of the current trusts*
- *It is nice and clean which should give a good impression to our patients who are most important*
- *It looks good. Here's hoping it does the trick!*

Visual identity: Overall design

What our governors / EbyE like based on first impressions (in their words):

- *Eye catching, colourful and simple (so effective)*
- *I like blue / white as the main colours (easily identifiable NHS colours) and having three different colours for 'home, community, hospital'*
- *It looks good and easy to read and identify with*
- *Felt a little bland on initial view until you realise each colour aligns with each strand of the trust vision. This should help users find the area they are looking for if the colour theme follows through to a particular area*
- *Crisp and clean imagery. I think it is brilliant*
- *Excellent work has gone into this branding, in my opinion there's only a few tweaks on the three words 'home, community, hospital' to read a clear message*
- *Quite like the blue background colour and the uncluttered look*
- *I like that it's a simple design and limited colour palette*
- *Looks more professional than usual NHS*
- *Fits very well with our current NHS identity*
- *The colours and text stand out really well and are easily readable and understood*
- *The design is straightforward stating what it is and where*
- *Impressive. Straight to the point. No lengthy reading required*

Home, community, hospital tagline

What staff told us:

- *It gives a clear message of the direction of travel for the future of the NHS*
- *I like the ordering with home listed first, then community and then hospital which is in line with the strategy and 10 Year Plan to keep people well, at home, in the community and hospital admission avoidance*
- *Professional, clean and NHS. With knowledge of the 10 Year Health Plan I think the message is home first then community then hospital*
- *Like the emphasis but it's almost focused on a location as opposed to outcome e.g. stay well, live well, supported well*
- *I think it looks good, unsure of hospital being in green on the bottom as green is usually associated with good – and being in hospital is not the end (good) goal*
- *I think internally it makes sense and is short and snappy. It may take time for this message and principles to gain greater awareness*
- *I can see these being really strong visual identifiers to convey different aspects of our care as we work ever closer*
- *I do like the tagline but I understand that it means home first, then community and hospital is the last resort. That would have to come through more during the promotion aimed at the community*
- *It makes sense to me, but I wonder if it will to the general public. I wonder if there should be a mention of 'care' in these locations?*
- *I like the simpler message, easier to remember and more impactful that a long slogan or summarised vision statement*

Home, community, hospital tagline

What our governors / EbyE told us:

- *Does put the message that the NHS is moving away from hospital as the first port of call*
- *Simple and communicates the key principles well*
- *Perhaps an addition to the tagline in smaller font to explain what it means in broad terms*
- *Why not include: 'Our services' before Home, Community, Hospital, to clarify the integrated and expanded scope of services provided by the new set up*
- *I think the word YOUR should be put in front of every word, otherwise it seems to read as Home Community Hospital*
- *I quite like the home, community, hospital concept since most patients are discharged to their communities early*
- *I feel the 'home' element is conflicting with the community tagline. I would suggest not using home and sticking with community only, it gives a greater sense of belonging*
- *I really like the words Home, Community, Hospital, should we add First at Home, Secondly Community or Hospital Last resort?*
- *Really like the design but it will need further explanation at roll out stage with consistent messaging to embed the vision*
- *I don't think that combination of words is fundamentally healthcare specific – I understand you're aiming for self-care, primary care, secondary care, but home and community do not individually emphasise this*
- *Impressive. Straight to the point. No lengthy reading required. Consistent message of Home, Community, Hospital*
- *I love the clarity and the goals North Cheshire and Mersey are going to achieve*

Areas for development

Collated from both surveys:

- *A recognition programme could be designed around the values embedding their use. Perhaps images could also be developed to further enhance home, community, hospital?*
- *Only minor question is the order of the three coloured 'orbs'. Should it be the opposite way round – green is home, blue is community and red is hospital to indicate that the preferred option (usually denoted by green) is home*
- *Colour alignment if intended should be green for home, blue for community and magenta for hospital*
- *One potential area for improvement is considering whether the strong corporate style could be softened slightly when viewed through a health inequalities lens, e.g. by incorporating more inclusive or accessible design elements, while still retaining clear NHS branding*
- *The 3 coloured oval things that go to the edge of the page might cause issues with creating documents / printing to the edge of paper when printing is necessary. I think circles that don't go to the edge off the page would be better, but still overlapping*
- *Just make it clearer that the three pillars are the trust's priorities*
- *The 'home community hospital' tagline needs commas or something to separate the words when used horizontally*
- *When multiple visual elements are present, simplifying or refining them slightly can help reduce visual competition and keep the focus on the core message, e.g. reducing the number of visuals or simplifying the backgrounds would help the message feel cleaner and more focused. A bit more contrast in terms of value between the accent colours and main blue would help*
- *Would be useful to see the letterhead in black and white also*

Values imagery (Staff)

What staff like based on first impressions (in their words):

- *The icon designs give a strong first impression, modern with a consistent colour scheme. They are easy to understand and the objectives they represent are clear*
- *My first impression is that the icons feel friendly, approachable and values-led. The rounded shapes, soft colour palette and simple forms make them easy to understand and emotionally warm, which suits an organisation focused on care, inclusion, and community. It seems like it is well thought out*
- *The simplicity of the values titles makes them clear and easy to understand, without feeling too corporate or formal*
- *Similar to the brand icon, the value icons are clean and simple. The colours and style jump out well*
- *I love them all apart from the 'fair' icon. They are clear and concise – simplicity is best and the colours are great*
- *The icons successfully balance clarity, warmth, and professionalism. Easy to understand*
- *'Kind' and 'open' convey the right message. I like the emphasis on all working together*
- *The colours are nice and the heart icons in 'kind' and 'one team' are nice. I feel I can buy into them*
- *Simple and colourful images are more impactful than the more traditional person avatars. Will not detract away from important narrative but will support and enhance any message*
- *The wording is good and describes values that I want our organisation to have. I feel I can buy into them*

Values imagery (Staff)

Suggested areas of improvement:

- *I like 'kind' and 'open'. Less keen on 'fair' and 'one team' as they don't necessarily create that association in my mind – but appreciate it's subjective*
- *Mostly good. The 'one team' one looks like a couple not a team. I think we could have something better for 'fair' but it's reasonable*
- *3 out of 4 made sense immediately to me. I am not sure about using a heart image in 2 of the images though*
- *The 'open' one I feel would work better for 'fair'. For the 'open' icon, I personally feel an icon depicting open arms might be better as this is what comes to mind when I think of the word 'open' – welcoming new ideas / ways of working*
- *The icons look fine at first glance, but they feel quite generic. It's unclear what the 'fair' icon is intended to represent, the meaning doesn't come across visually, so this may need clarification or redesign*
- *They align with both organisations – not sure about the fair icon – what does this represent? (I agree with the statement)*
- *Easy on the eye, the colours are good. The 'one team' graphic is a little unclear – thinking if the name and text were not present would it be understood?*
- *I like them, only one I don't feel is clear as an image is 'fair' but I am unsure how else that could be pictorial and the straplines clearly explain them all*

Values imagery (Public)

What our governors / EbyE like based on first impressions (in their words):

- *The icons are bright and draw your eyes to them*
- *Look good and need to mean what they say*
- *Easy to understand and bright colours*
- *Great. Bright, cheerful and with meaning*
- *Simple, clean and consistent imagery. Professional and friendly*
- *I like them, they look modern and are clear*
- *'Love um'*
- *Looks clear and fluent. Not too busy*
- *I like the simplicity of the images and descriptions meaning people will remember them*
- *Colourful. Like the images for 'kind', 'open' and 'one team'*
- *All should work well if people know why the changes are being made*
- *I like the simplicity of the images and descriptions meaning people will remember them*
- *They are relatable and make sense to me. The 'kind' and 'open' icons are particularly easy to understand and effective*
- *Eye catching, make people stop to read*

Values imagery (Public)

Suggested areas of improvement:

- *'Open' could be more clearly conversation. 'Fair' could be a pair of scales for balance. 'One team' needs to be a small group of people of different professions / uniforms. One paler person gives exactly the wrong impression!*
- *Having two of everything seems to accentuate difference rather than being together and united, especially when one is paler than the other*
- *The orange is a challenge for visually impaired people*
- *I like that they're simple but I'm not keen on the 'one team' icon because it reminds me of the old MSN Messenger icon*
- *Patients won't understand them. Why don't we simply use the words as opposed to symbols. If symbols have to be used replace the fairness symbol as it means nothing. Insert it with scales of justice as they are well known as symbols of fairness*
- *Not all the icons work for me as a governor and if I was a patient. Open icon means nothing to me. An open door would represent open better and more people would recognise it.*
- *Fair and open are a bit ambiguous*
- *Like the colours and short explanatory words, but other than kind the other logos don't mean anything to me. Do we actually have to have logos at all?*
- *Finding it difficult to understand the icons / symbols. Is there any way you could let the public know what they stand for? Why should 'We listen, value our differences and are inclusive to all' be just 'fair'?*
- *Didn't understand the 'fair' icon but others ok – team icon needs bigger heads*

Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**5 FEBRUARY 2026**
Agenda Item	**10/26**		
Report Title	**IQPR MONTH 09**		
Executive Lead	Dan Moore, Chief Operating Officer		
Report Author	Melanie McLaughlin Acting Director of Operations/Deputy Chief Operating Officer		
Presented by	Dan Moore, Chief Operating Officer		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary

The Month 09 IQPR reflects a mixed picture of performance across the Trust. While several areas continue to demonstrate sustained compliance, a number of key operational, quality and people metrics remain below target and require continued focus. Financial performance, however, remains aligned to plan for the period.

There are 35 key indicators reported, 10 Green indicators and 25 Red indicators in month 9, with significant performance challenges within Dermatology, including breaches against the 28-day Faster Diagnosis Standard, 31-day and 62-day cancer pathway compliance, alongside breaches in the percentage of patients attending the UTC left without being seen and percentage referred onto A&E, continued breaches in the percentage of patient waiting over 18, 52 and 104 weeks.
Children's services continue to breach performance targets for DNA's/Children not brought and Warrington adults services also demonstrate performance breaches in DNA appointments.
Audiology continues to show a steady month-on-month improvement in six-week diagnostic waits, with further improvement expected to be seen in Month 10.
In the dental service, the numbers of waiters within each time band have remained relatively consistent. although there has been a slight increase in patients waiting 0-17 weeks, slight decrease in 18-25 weeks, with an increase in 26-51 weeks and 52 -78 + have remained consistent with last month.

Quality performance shows 24 Green and 9 Red indicators, with breaches primarily relating to timeliness of incident reporting, moderate harm incidents, Duty of Candour compliance, acquired pressure ulcers (including Category 3 and 4), and the proportion of Trust risks rated 12 or above.

People indicators show 1 Green and 3 Red ratings. Sickness absence remains significantly above target at 9.31%, driven by winter illness and increased stress-related absence. Staff turnover is also above target, influenced in part by the TUPE transfer of School Aged Immunisation teams. PDR compliance continues to fall below expectations at 83.17%, though active monitoring and recovery actions are underway.

Finance details in M9 include reporting a deficit of £3.16m, in line with plan. The Trust is reporting a saving achievement of £4.03m against a plan £3.99m

Previously considered by:

☒ **Audit Committee** ☐ **Quality & Safety Committee**

☒ **Finance, Sustainability and Performance Committee in Common**	☐ **Remuneration and 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	5 FEBRUARY 2026
Agenda Item	10/26		
Report Title	IQPR MONTH 09		
Report Author	Melanie McLaughlin Acting Director of Operations/Deputy Chief Operating Officer		
Purpose	To provide Board with an overview of the Month 09 IQPR.		

1. OVERVIEW

Responsive (Operations)

There are 10 Green indicators and 25 Red indicators in month 9.

- Two Red to Green indicators
  - A&E Unplanned re-attendance rate <=5%
  - Referrals to plan - Children's
- Zero Green to Red indicators:
- 16 indicators have shown an in-month deterioration
- 18 indicators have shown an in-month improvement
- 1 indicator has shown no in-month changes

Safe, High-Quality Care (Quality)

There are 24 green indicators and 9 red indicators in month 9:

- Three Red to Green indicator:
  - % of BCHFT patient safety incidents that are medication incidents
  - Information Governance Training
  - BCHFT patient safety Falls per 1,000 bed days - bed based
- One Green to Red indicator:
  - % of BCHFT risks managed in line with policy, risks within date reviews
- 9 indicators have shown an in-month improvement
- 10 indicators have shown an in-month deterioration
- 14 indicators have shown no in-month changes

People

There are 1 green indicator and 3 red indicators in month 9:

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

Making Good Use of Resources (Finance):

- The Trust is reporting a deficit at month 9 of £3.16m, in line with plan
- The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m

2. OPERATIONS HIGHLIGHTS

Warrington Dermatology Cancer – 28 Day Faster Diagnosis Standard (November performance reported in arrears)

- Current Target: 75%; Actual for Month 8 (month in arrears): 66.87%
- Historically, the service has consistently achieved the 28-day Faster Diagnosis Standard.
- Recent performance decline, due to:
    - Introduction of Skin Analytics
    - Reduced clinical capacity
    - Long term absence of skin cancer nurse specialist
    - Increased demand in the skin cancer pathway
- Performance is improving but remains non-compliant. Additional clinics and temporary adjustments to the Skin Analytics one-stop model are providing more face-to-face capacity. A recovery plan is in place, with compliance expected to be achieved by March 2026.
- Monthly meetings are being held with the Cancer Alliance

Warrington Dermatology Cancer – 31-Day Standards (November, reported in arrears)

- **31-Day 1st Treatment:** Performance was 40% (6/10 breaches): two due to patient choice and four due to limited surgery slots. All patients have now been treated (four discharged, two on follow-up). Capacity pressures were driven by reduced consultant sessions and the impact of Skin Analytics. Recent waiting list initiatives have increased capacity, with improvement expected and targets to be achieved by March 26.

- **31-Day 2nd Treatment:** Target 94% - 5 out of 5 breached the standard (0%).
  All breaches relate to limited surgery capacity, with four of the five compounded by patient choice. Two patients have been discharged; three remain on the pathway. The same capacity pressures applied, and recovery actions are expected to improve performance.

- **New Combined 31-Day Standard:** Compliance stands at 26.67% in month against a target of 96%.

- **Warrington Dermatology Cancer 62 - day for 1st treatment (November performance reported in arrears)**
- Target 85% - 6 of 13 patients breached the 62-day standard (53.85%).
- Three breaches were due to limited Skin Analytics follow-up slots and patient choice; these patients have now been seen and discharged.
- Two breaches were linked to delays to first appointment and subsequent surgery, and the final patient required referral to plastics.
- Reduced consultant sessions and the impact of Skin Analytics have constrained capacity.
- The waiting list initiative implemented in November has increased capacity, a significant improvement in performance is expected in M9 (c.91%).

A&E left without being seen <=5% (left before treatment completed)

- Performance was 5.68% against the 5% target.

- December's performance has breached the target for the second time in three months.

- Patients leave the UTC before being seen for various reasons, including personal choice, opting to access Pharmacy First, their GP, or 111, as well as longer waits caused by increased winter demand. Despite this, there is no associated harm, as all patients are triaged on arrival using the Manchester Triage System, and those assessed as 'Green' are deemed safe to wait.

Percentage referred onto A+E (UTC)

- Performance was 5.84% against the 3% target.

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

- Coding cannot be corrected once the attendance is closed. Performance is observed to be within the control limits. The service lead has reviewed the data with the UTC staff; most codes were recorded in error; staff have been reminded of correct coding practice, and improvement is expected.

Percentage of DNAs - Warrington Adults

- This indicator is reported by exception due to performance of 2.46% against a target of 1.6%.
- DNA rates for Warrington Adults typically range between 2–3% and fluctuate around the mean. The Trust's aspirational goal is to reduce DNA rates, achieving a target of 1.6%.
- Work has been initiated and embedded across all teams to reduce DNA rates, additional efforts are ongoing to address areas with the highest DNA's and identify further actions to drive improvement.
- The highest numbers of DNA's predominantly relate to follow up activity and therapy services.

Percentage of DNAs/Was not brought – Children's

- This indicator is reported by exception due to performance of 6.71% against a target of 1.6%.
- Children's Services reported an increase in children not brought in Month 9 this is due to Christmas and is a seasonal trend.
- Teams with the highest CNB rates have been identified and are implementing agreed actions, including repeat text reminders, improved appointment letters, ensuring adequate notice for families, consistent application of the Patient Access Policy, and prompt checking of calls and messages.
- The highest numbers of CNBs relate to follow-up appointments.
- Targeted work continues, including a focused meeting with the Associate Directorate of Transformation to support further reduction in CNB rates

Warrington Audiology - Number of 6 weeks diagnostic breaches

- This indicator is reported by exception due to a performance of 50 against a target of 0.
- Breaches continue to decrease, supported by weekly performance reviews and forward planning of clinics, 6 weeks in advance. The service expects to be compliant with the national target by January 2026.
- The team are reviewing child not brought rates and internal processes relating to waiting list management to ensure most efficient use of resources.
- Bridgewater are working with the regional diagnostic analytical team to monitor Audiology diagnostic pathways.

Community Health Services SitRep (one month in arrears)

- % Under 18 Weeks: 50.79%

- % Over 52 Weeks: 15.68%
- % Over 104 weeks: 0.16%
- The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's Community Health Services. Community Health Services Sitrep submission does not include Dental or Dermatology waiting times.
- CHS Sitrep performance has been deteriorating since Summer 2024. The variation can be expected to range between 59% and 69% for 18 week waits and 5% to 16% for over 52 weeks.
- Bridgewater is one of 15 trusts working with the national team to develop waits directly from daily Faster Data Flows submissions.
- Not all services are required to flow via CHS - Dermatology and Dental as an example are excluded from this submission.
- Bridgewater score quite poorly in relation to the percentage of patients waiting above 52 weeks. (NOF Access domain score)
- Focused actions are underway to reduce the number of patient waiting above 52 weeks

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

- % Under 18 Weeks: 55.95%.
- % Over 52 Weeks: 11.88%
- % Over 65 weeks: 7.23%

Operational narrative - Services with over 65 week waits

- **Community Paediatrics and Paediatric Neurodevelopment Services** - in Warrington and Halton continue to experience demand exceeding capacity. Both services are prioritising the highest-risk cohort within the stratified caseload, with trajectory modelling underway and the position being reviewed with commissioners due to current capacity constraints. In the Paediatric Neurodevelopment pathway, the number of children waiting for an initial Autism and ADHD assessment continues to rise. Weekly performance and allocation meetings remain in place to ensure those with the highest clinical need, identified through the risk-stratification tool, are prioritised for the appointments available.

- **Dermatology** – The service is progressing at pace to reduce long waits, with targeted trajectories initially focused on 65-week waits before moving to 52-week compliance. A waiting list initiative introduced at the end of November 2025 is delivering reductions in waiters and will continue through to the end of the financial year to support achievement of a position below 52-week waits.

- **Podiatry Warrington** – All vacancies have now been recruited to, with all posts in place from early January. Plans are being implemented to bring waiting times below 52 weeks by the end of the financial year

- **Halton Podiatry –** The volume of waits has reduced due to a change in service criteria. Plans are in place to move to a below 52-week position by the end of March 2026.

- **Dental - Greater Manchester** - Greater Manchester (GM) have 111 patients waiting over 65 weeks. This has increased slightly since last month due to GA theatre capacity. Urgent referrals being given priority over high waiters. We continue to experience challenges with our theatre access for children with additional needs. We have very limited capacity which has led to 12 children experiencing waits in excess of 104 weeks.

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
2025-11-24	4,911	1,425	1,395	123	40	16
2025-12-01	4,953	1,368	1,359	123	41	18
2025-12-08	5,005	1,428	1,405	124	39	17
2025-12-15	5,129	1,386	1,420	116	44	16
2025-12-22	5,257	1,375	1,367	109	46	14
2025-12-29	5,212	1,309	1,506	104	50	14
2026-01-05	5,224	1,368	1,553	111	53	12

Cheshire & Mersey:

- Have no patients waiting over 65 weeks in M9. Patients are proactively managed through early opt-in processes, early assessment appointments and prioritisation based on minimum waiting times for treatment.

- There are 8 waiters over 52 weeks across all pathways - both with treatment appointments booked and ready to bring forward into cancellation slots.

- Allocated appointments are now in place across all sites to ensure KPIs are consistently achieved and contractual obligations delivered equitably, with particular focus on special care new patients and children.

The following actions are contributing to performance improvement:

- Performance data contributes to weekly waitlist management meetings with Head of Service, Dental Nurse Team Managers, Dental Nurse Team Leaders, and the Data analyst. This includes scrutinising discharges/cancellations/DNAs and prioritising patient lists to target/apply resources in key areas.

- Weekly booking efficiency meetings assist managing patient flow and maximising activity proving successful - target is 0 gaps for week ahead each Friday.

- Performance Dashboard now in place to monitor activity against contractual targets monthly.

- Operational flexibility enabled allowing targeting of areas where demand is high/staff booking at alternative sites to reduce waits/ fulfil KPIs.

Greater Manchester:

- There are currently 111 children waiting over 65 weeks, a slight increase from last month due to limited GA theatre capacity and the need to prioritise urgent referrals over long waiters. Ongoing challenges with theatre access for children with additional needs continue to constrain activity, resulting in 12 children now waiting over 104 weeks.

- The RBH neurodiverse theatre capacity remains significantly constrained, with an allocation of only six patients every six weeks and the longest waiting times concentrated at this site. A paper exercise has been completed to identify children who can be transferred to other Greater Manchester lists with increased capacity. There are currently 164 neurodiverse children on the RBH waiting list.

- Work is ongoing to increase the number of available lists at RBH, subject to theatre capacity, with early discussions underway with WHH to scope additional capacity to support waiting list reduction.

3. QUALITY HIGHLIGHTS

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

- This indicator is reported by exception due to performance of 85.78% against a target of 87%.

- The performance for this target in December 2025, increased to 85.78% compared to 84.78 in November 2025, however this is below the target level of 87%. While this remains within the upper and lower control limits, it is also consistent with the mean level of reporting for this indicator. The time taken to report incidents continues to be reviewed via the Directorate Incident Review and Learning Groups (DIRLG) and monitored at PSIRFaLP with delays being challenged to understand the delays and to promote learning.

- The need to report incidents within 48 hours of discovery, is a key element of the Trust's Incident Reporting Policy and is covered in the Trust's in house training offer.
  To improve access to the training, in addition to existing face to face delivery, several sessions will be delivered virtually during February and March 2026.

% of incidents causing moderate harm (Score 3)

- This indicator is reported by exception due to performance of 2.94% against a target of 1%.

- The performance for this indicator has remained above target for the last seven data points, which are not due to any specific factors and suggest common cause variation. The most frequently reported moderate harms in December 2025 were pressure ulcers, with four reported incidents.

- Three Category 3 and one Category 4 pressure ulcers were reported. Two further moderate harm incidents related to a patient collapse and complications following catheter insertion requiring hospital treatment. All incidents will be reviewed through Directorate DIRLGs to identify learning.

- Targeted work is continuing with specific teams in line with the Pressure Ulcer QI Learning Plan. Workstreams progress is monitored at the Pressure Ulcer Priority Group with reporting into PSIRFaLP.

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

- This indicator is reported by exception due to performance compliance of 85.71% against a target of 100%.

- During December 2025, there were 7 incidents that required part 1 Duty of Candour. In six cases this was completed within the Trust's 10-day threshold. One case was completed outside of the Trust's 10-day target, which meant that the Trust discharged its legal obligation in relation duty of candour in this case. All cases in December 2025, were therefore compliant with legal requirements for notifying patients about incidents.

- The correct application and recording of duty of candour is included in the role specific training for band 7 staff. Compliance is reviewed at DIRLG meetings with monitoring at PSIRFaLP.

% of BCHFT risks managed in line with policy, risks within date reviews

- This indicator is reported by exception due to performance compliance of 91.72% against a target of 92%.

- For the last 2 data points, there have been reductions in compliance, in December 2025, the compliance was 91.72% against a target of 92%, while in November 2025, the Trust achieved 93.75% compliance which exceeded the target of 92%.

- Compliance is monitored at the Risk Management Council. Risk owners are required to report to the Risk Management Council any risks that have passed their review dates. Further targeted work with Corporate and Operational services leads to provide assurance that the risks are being managed in line with Trust policy has been undertaken.

Percentage of BCHFT risks identified as 12 or above

- The compliance for December 2025, was 15.17% against a target of 11%. This was above the mean level of reporting for this indicator, however it is within the upper control limit. It should be noted that several new risks relating to Dermatology were reported during December 2025 and were the main factor in this increase.

- The Trust takes assurance regarding the scoring of it's risks from the risk review process that is carried out at the meetings of the Risk Management Council.

Total number of BCHFT acquired pressure ulcers

- This indicator is reported by exception due to a performance of 16 against a target of 15.

- There has been a further in month fall in pressure ulcers for December following the significant rise seen in October. The highest number of reported ulcers remains category two.

- Following a rapid review of the data in November actions were initiated within the boroughs to address issues identified with greater scrutiny on the accuracy of the quality of data reported particularly of category 2 pressure ulcers. Borough specific meetings have been initiated with District Nurse Co-ordinators and TVN to identify any underlying causal factors that require actioning.

- The findings of the rapid review will be escalated to the Pressure Ulcer Priority Group, and cross referenced against the Pressure Ulcer QI Learning Plan workstream actions and reporting into PSIRFalp for monitoring.

% of Category 4 Pressure Ulcers acquired in Bridgewater

- This indicator is reported by exception due to a performance of 6.25% against a target of 0%.

- The patient has complex health needs and has regular Tissue Viability Nurse monitoring and support. Despite all interventions the patient's ulcer did deteriorate from a category 3 (72007) to a category 4 pressure ulcer.

- A rapid review has been completed and shared with the pressure ulcer priority group to identify any new learning.

% of Category 3 Pressure Ulcer acquired in Bridgewater

- This indicator is reported by exception due to performance of 18.75% against a target of 3%

- The inconsistent trend in category three pressure ulcer incidence remains within standard variation, although a reduction in month. There was 1 incident in the Halton Borough and 2 in the Warrington borough across different teams.

- The three incidents will be benchmarked against the Pressure Ulcer QI Learning Plan to identify any themes and actions identified for improvement.

4. PEOPLE HIGHLIGHTS

Sickness absence rate (Actual)

- This indicator is reported by exception due to performance of 9.31% against a target of 5.50%, this is an increase on M8 8.15%.

- Sickness absence due to anxiety, stress and depression, cold/flu, and gastrointestinal illness increased in December 2025

- A full review of sickness absence has been completed by the HRBPs and Managers and learning and improvements have been identified to provide further support to managers as part of earlier interventions. Actions are in progress including updating opening and closing sickness in a timely manner and HR surgeries with supporting managers on use of the attendance management decision making guides after every second absence.

- The top 10 services have been identified within each borough and weekly intervention support will be in place to support the teams.

Staff turnover (rolling)

- This indicator is reported by exception due to performance of 13.87% against a target of 12.0%.

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

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

% of staff with a current PDR

- This indicator is reported by exception due to performance of 83.17% against a target of 85%.

- PDR rates are being monitored via the DLTs and Performance Council with weekly reporting available via the Qlik system.

- Planned dates for completion are being requested by DLTs and HR. Reasons for non-compliance are being scrutinised. Proactive monitoring is taking place via the HR Team on future expiry dates to limit further non-compliance. Guidance on creative solutions is being developed including team objective setting where staffing levels have had an impact on compliance rates.

5. FINANCE HIGHLIGHTS

- The Trust is reporting a deficit at Month 9 of £3.16m, in line with plan.
- The Trust has a Level 1 and 2 savings requirements, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3).
- The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m
- Income is £75.23m against a plan of £75.23m.
- Expenditure is £78.39m against a plan of £78.39m.
- Pay is £54.30m against a plan of £54.47m.
- Agency spend is £0.21m against a plan of £0.88m.
- Non pay expenditure is £23.47m against a plan of £22.75m.
- Capital charges are above plan by £0.12m.
- Capital expenditure is £0.69m at month nine, planned spend is £1.16m.
- Cash is £3.30m.

6. RECOMMENDATIONS

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

Communities Matter

Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: December 2025 (Month 9)

Contents

Introduction

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

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

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

This month's report describes activity in December 2025.

Within this Report

1. KPI Amendments:

No amendments within Month 9.

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 10 Green indicators and 25 Red indicators in month 9.

- Two Red to Green indicators:
  - A&E Unplanned re-attendance rate <=5%
  - Referrals to plan - Childrens
- Zero Green to Red indicators
- 16 indicators have shown an in-month deterioration
- 18 indicators have shown an in-month improvement
- 1 indicator has shown no in-month changes

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 24 green indicators and 9 red indicators in month 9.

- One Green to Red indicator:
  - % of BCHFT risks managed in line with policy ie risks with in date reviews
- Three Red to Green indicators
  - % of BCHFT patient safety incidents that are medication incidents
  - Information Governance Training
  - BCHFT patient safety Falls per 1,000 bed days - bed based
- 9 indicators have shown an in-month improvement
- 10 indicators have shown an in-month deterioration
- 14 indicators have shown no in-month changes

Trust Overview

Executive Summary

People

There is 1 green indicator and 3 red indicators in Month 9.

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

Making Good Use of Resources (Finance)

- The Trust is reporting a deficit at Month nine of £3.16m, in line with plan.
- The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m.

Operations

Executive Summary

Of the 35 Operations indicators which are reported; 25 are red and 10 are green.

The 25 indicators which were red in December are as follows:

- Warrington Dermatology Cancer 2 week referrals (urgent GP) – Improvement in Month
- Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery – No Change in Month
- Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment – Improvement in Month
- Warrington Dermatology Cancer Combined 31 day General Standard – Improvement in Month
- Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral) – Deterioration in Month
- 28 day Faster Diagnosis Standard – Improvement in Month
- A&E left without being seen <=5% (left before trx completed) – Deterioration in Month
- Percentage referred onto A+E (UTC) – Improvement 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) – Improvement in Month
- Percentage of was not brought – Childrens – Deterioration in Month
- Percentage of DNAs/Was not brought - Warrington Adults – Deterioration in Month
- Audiology - Number of 6 weeks diagnostic breaches – Deterioration in Month
- Referrals to plan - Warrington Adults – Improvement in Month
- Referrals to plan - Halton Adults – Deterioration in Month

Operations

Executive Summary – Continued

Red indicators (continued):

- Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears) – Improvement in Month
- All waiters - % waiting over 65 weeks (awaiting initial access) – Improvement in Month
- All waiters - % waiting over 52 weeks (awaiting initial access) – Improvement in Month
- All waiters - % waiting under 18 weeks (awaiting initial access) – Deterioration in Month
- Warrington Adults Activity Variance – Improvement in Month
- Warrington Children's Activity Variance – Improvement in Month
- Halton Adults Activity Variance – Improvement in Month
- Halton Children's Activity Variance – Improvement in Month

Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		99.17% (▲)	97.29% (▼)	98.92% (▲)	95% (▼)	95.61% (▲)	95.32% (▼)	88.32% (▼)	57.37% (▼)	5.87% (▼)	7% (▲)	11.56% (▲)	72.75% (▲)	
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (►)	100% (►)	100% (►)	66.67% (▼)	50% (▼)	85.71% (▲)	75% (▼)	28.57% (▼)	100% (▲)	0% (▼)	0% (►)	0% (►)	
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		94.12% (▼)	83.33% (▼)	100% (▲)	94.74% (▼)	100% (▲)	56.25% (▼)	89.47% (▲)	95.45% (▲)	86.67% (▼)	33.33% (▼)	25% (▼)	40% (▲)	
Warrington Dermatology Cancer Combined 31 day General Standard	96%		94.44% (▼)	87.5% (▼)	100% (▲)	88% (▼)	87.5% (▼)	65.22% (▼)	86.96% (▲)	79.31% (▼)	88.24% (▲)	23.08% (▼)	12.5% (▼)	26.67% (▲)	
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		88.1% (▼)	89.47% (▲)	90.91% (▲)	93.75% (▲)	91.18% (▼)	90.48% (▼)	94.74% (▲)	66.67% (▼)	86.36% (▲)	79.17% (▼)	71.43% (▼)	53.85% (▼)	
28 day Faster Diagnosis Standard	75%		83.53% (▲)	82.69% (▼)	91.89% (▲)	84.26% (▼)	89.53% (▲)	85.94% (▼)	83.19% (▼)	79.88% (▼)	75.6% (▼)	65.14% (▼)	49.34% (▼)	66.87% (▲)	
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		95.06% (▼)	98.68% (▲)	94.5% (▼)	96.88% (▲)	94.49% (▼)	98.5% (▲)	98.97% (▲)	98.08% (▼)	98.62% (▲)	98.2% (▼)	98.36% (▲)	96.01% (▼)	95.95% (▼)
Total time in A&E - 95th Percentile (Mins)	4 Hrs		03:59 (▼)	03:44 (▲)	04:11 (▼)	03:54 (▲)	04:11 (▼)	03:49 (▲)	03:38 (▲)	03:46 (▼)	03:42 (▲)	03:39 (▲)	03:46 (▼)	03:57 (▼)	03:59 (▼)
Total time in A&E - Median (Mins)	4 Hrs		01:36 (▼)	01:28 (▲)	01:37 (▼)	01:19 (▲)	01:38 (▼)	01:27 (▲)	01:27 (▲)	01:18 (▲)	01:27 (▼)	01:17 (▲)	01:29 (▼)	01:33 (▼)	01:28 (▲)
A&E Time to treatment decision (median) <=60 mins (Mins)	60 Mins		00:08 (▼)	00:06 (▲)	00:07 (▼)	00:09 (▼)	00:07 (▲)	00:07 (▲)	00:07 (▼)	00:07 (▼)	00:07 (▲)	00:07 (▼)	00:07 (▲)	00:07 (▼)	00:08 (▼)
A&E Time to treatment decision 95th percentile <=60 mins (Mins)	60 Mins		00:21 (▼)	00:15 (▲)	00:16 (▼)	00:23 (▼)	00:18 (▲)	00:14 (▲)	00:14 (▲)	00:15 (▼)	00:16 (▼)	00:14 (▲)	00:18 (▼)	00:21 (▼)	00:22 (▼)
A&E Unplanned re-attendance rate <=5%	5%		4.45% (▲)	4.42% (▲)	4.79% (▼)	5.38% (▼)	5.24% (▲)	3.92% (▲)	4.1% (▼)	4.73% (▼)	3.69% (▲)	4.39% (▼)	4.24% (▲)	5.3% (▼)	4.58% (▲)
A&E left without being seen <=5% (left before trx completed)	5%		0.31% (▼)	0.06% (▲)	0.04% (▲)	0.22% (▼)	0.16% (▲)	3.63% (▼)	2.87% (▲)	2.87% (►)	4.61% (▼)	5.7% (▼)	4.8% (▲)	5.46% (▼)	5.68% (▼)
Percentage referred onto A+E (UTC)	3%		11.33% (▼)	12.81% (▼)	12.41% (▲)	10.33% (▲)	11.17% (▼)	6.13% (▲)	5.61% (▲)	5.98% (▼)	5.08% (▲)	5.19% (▼)	4.02% (▲)	5.96% (▼)	5.84% (▲)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		90.95% (▲)	91.78% (▲)	91.46% (▼)	90.42% (▼)	92.03% (▲)	91.46% (▼)	91.65% (▲)	91.31% (▼)	91.95% (▲)	92.21% (▲)	92.66% (▲)	92.8% (▲)	92.11% (▼)
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	95%		90.1% (▲)	90.5% (▲)	90.2% (▼)	89.1% (▼)	88.1% (▼)	87.6% (▼)	88.3% (▲)	87.5% (▼)	87.6% (▲)	88.9% (▲)			

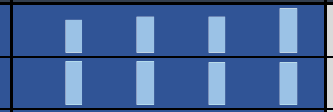
Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Percentage of was not brought - Childrens	1.6%		9.15% (▼)	6.96% (▲)	6.46% (▲)	5.87% (▲)	6.8% (▼)	6.45% (▲)	6.85% (▼)	8.67% (▼)	10.05% (▼)	7.07% (▲)	7.33% (▼)	5.83% (▲)	6.71% (▼)
Percentage of DNAs/Was not brought - Warrington Adults	1.6%		2.27% (▼)	2.24% (▲)	1.95% (▲)	2.07% (▼)	2.1% (▼)	2.13% (▼)	2.36% (▼)	2.09% (▲)	1.91% (▲)	2.13% (▼)	2.36% (▼)	2.29% (▲)	2.46% (▼)
Percentage of DNAs/Was not brought - Halton Adults	1.6%		1.06% (▲)	1.14% (▼)	0.89% (▲)	0.91% (▼)	1.02% (▼)	1.06% (▼)	0.86% (▲)	1.01% (▼)	0.85% (▲)	0.91% (▼)	0.92% (▼)	0.75% (▲)	0.87% (▼)
Proportion of Urgent Community Response referrals reached within two hours	70%		80% (▲)	78.5% (▼)	77% (▼)	81.1% (▲)	87% (▲)	91.5% (▲)	91.1% (▼)	93.9% (▲)	96.7% (▲)	92.6% (▼)	92.2% (▼)	98.2% (▲)	97.8% (▼)
Audiology - Number of 6 weeks diagnostic breaches	0		76 (▼)	53 (▲)	43 (▲)	32 (▲)	57 (▼)	63 (▼)	98 (▼)	93 (▲)	71 (▲)	50 (▲)	16 (▲)	41 (▼)	50 (▼)
Referrals to plan - Childrens	95%		105.95% (▲)	107.37% (▼)	107.77% (▼)	107.6% (▲)	105.12% (▲)	104.07% (▲)	107.45% (▼)	109.6% (▼)	103.67% (▲)	105.16% (▼)	105.53% (▼)	105.34% (▲)	104.95% (▲)
Referrals to plan - Warrington Adults	95%		80.87% (▼)	80.74% (▼)	79.91% (▼)	78.36% (▼)	74.33% (▼)	74.02% (▼)	74.53% (▲)	75.33% (▲)	73.24% (▼)	72.83% (▼)	73.18% (▲)	72.41% (▼)	72.63% (▲)
Referrals to plan - Halton Adults	95%		83.69% (▼)	84.76% (▲)	85.08% (▲)	84.62% (▼)	91.54% (▲)	89.6% (▼)	88.92% (▼)	88.9% (▼)	88.62% (▼)	87.25% (▼)	86.61% (▼)	85.36% (▼)	84.31% (▼)
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)	92%		63.84% (▲)	62.84% (▼)	61.39% (▼)	63.53% (▲)	59.56% (▼)	60.62% (▲)	58.99% (▼)	60.08% (▲)	58.36% (▼)	55.62% (▼)	54.74% (▼)	50.79% (▼)	
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)	0%		7.74% (▼)	9.01% (▼)	10.51% (▼)	10.87% (▼)	12.31% (▼)	12.36% (▼)	16.3% (▼)	13.74% (▲)	13.83% (▼)	14.55% (▼)	14.57% (▼)	15.68% (▼)	
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)	0%		0.01% (▲)	0% (▲)	0.03% (▼)	0.03% (▲)	0% (▲)	0% (►)	1.13% (▼)	0.16% (▲)	0.1% (▲)	0.22% (▼)	0.16% (▲)	0.16% (▲)	
All waiters - % waiting over 65 weeks (awaiting initial access)	0%		1.52% (▼)	1.79% (▼)	2.22% (▼)	2.81% (▼)	4.25% (▼)	2.49% (▲)	6.25% (▼)	7.32% (▼)	8.63% (▼)	9.57% (▼)	7.44% (▲)	7.85% (▼)	7.23% (▲)
All waiters - % waiting over 52 weeks (awaiting initial access)	0%		5.26% (▼)	5.69% (▼)	6.51% (▼)	7.42% (▼)	9.52% (▼)	10.43% (▼)	11.86% (▼)	12.9% (▼)	13.85% (▼)	14.53% (▼)	11.54% (▲)	12.26% (▼)	11.88% (▲)
All waiters - % waiting under 18 weeks (awaiting initial access)	92%		56.86% (▼)	57.46% (▲)	58.19% (▲)	59.56% (▲)	56.87% (▼)	57.84% (▲)	57.08% (▼)	55.89% (▼)	55.33% (▼)	54.57% (▼)	56.5% (▲)	56.04% (▼)	55.95% (▼)
Warrington Adults Activity Variance	3%		-19.13% (▼)	-19.26% (▼)	-20.09% (▼)	-21.64% (▼)	-25.67% (▼)	-25.98% (▼)	-25.47% (▲)	-24.67% (▲)	-26.76% (▼)	-27.17% (▼)	-26.82% (▲)	-27.59% (▼)	-27.37% (▲)
Warrington Childrens Activity Variance	3%		21.87% (▲)	24.01% (▼)	24.43% (▼)	24.38% (▲)	26.94% (▼)	23.24% (▲)	26.87% (▼)	26.52% (▲)	15.6% (▲)	16.47% (▼)	18.43% (▼)	19.37% (▼)	18.03% (▲)
Halton Adults Activity Variance	3%		-16.31% (▼)	-15.24% (▲)	-14.92% (▲)	-15.38% (▼)	-8.46% (▲)	-10.4% (▼)	-11.08% (▼)	-11.1% (▼)	-11.38% (▼)	-12.75% (▼)	-13.39% (▼)	-14.64% (▲)	-15.69% (▲)
Halton Childrens Activity Variance	3%		-23.78% (▲)	-23.8% (▼)	-23.69% (▲)	-24.14% (▼)	-30.06% (▼)	-28.63% (▲)	-26.17% (▲)	-20.94% (▲)	-18.94% (▲)	-16.56% (▲)	-18.55% (▼)	-20.19% (▼)	-19.48% (▲)

Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton					101 (▼)			112 (▲)			114 (▲)			139 (▲)	
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%				92.2% (▲)			92.16% (▼)			89.3% (▼)			90.07% (▲)	
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Halton	90%				92.23% (▲)			90.51% (▼)			84.23% (▼)			83.33% (▼)	
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Halton	85%				85.99% (▼)			88.7% (▲)			84.67% (▼)			87.15% (▲)	
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Halton	85%				90.94% (▼)			91.42% (▲)			94.77% (▲)			95.39% (▲)	
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	90%				90.78% (▲)			89.07% (▼)			91.18% (▲)			91.78% (▲)	
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	90%				90.71% (▲)			82.52% (▼)			94.28% (▲)			90.55% (▼)	
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington					319 (▼)			333 (▲)			338 (▲)			365 (▲)	
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%				91.81% (▼)			93.68% (▲)			90.82% (▼)			93.16% (▲)	
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Warrington	90%				95.47% (▼)			96.33% (▲)			91.69% (▼)			91.01% (▼)	
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Warrington	85%				96.16% (▲)			93.72% (▼)			93.11% (▼)			91.3% (▼)	
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Warrington	85%				97.37% (▼)			98.45% (▲)			97.1% (▼)			97.76% (▲)	
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	90%				97.07% (▲)			96.58% (▼)			92.9% (▼)			93.75% (▲)	
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	90%				100% (▲)			94.15% (▼)			96.77% (▲)			95.48% (▼)	
Available Virtual Ward Capacity per 100,000 head of population			5.18 (▲)	0.83 (▼)	4.18 (▲)	2.67 (▼)	3.85 (▲)	3.95 (▲)	5.66 (▲)	3.4 (▼)	4.51 (▲)	4.36 (▼)	4.31 (▼)	0.04 (▼)	2.32 (▲)

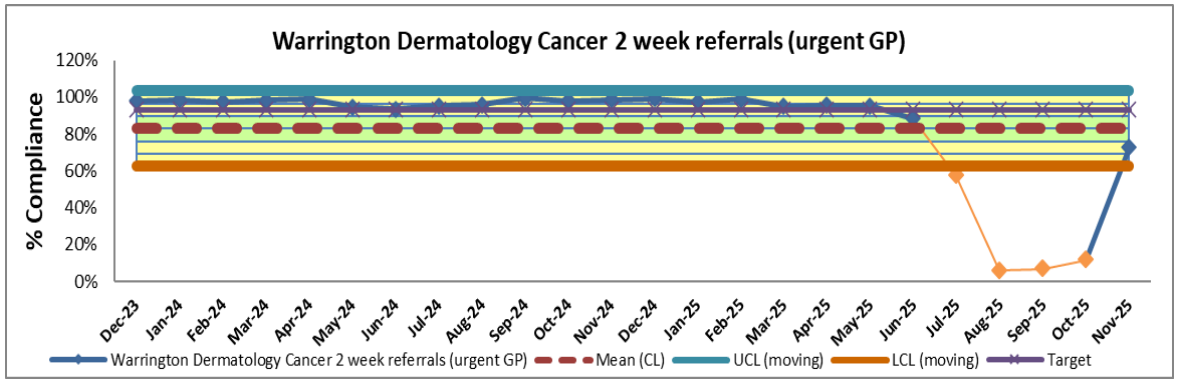
Operations: Exception Reporting

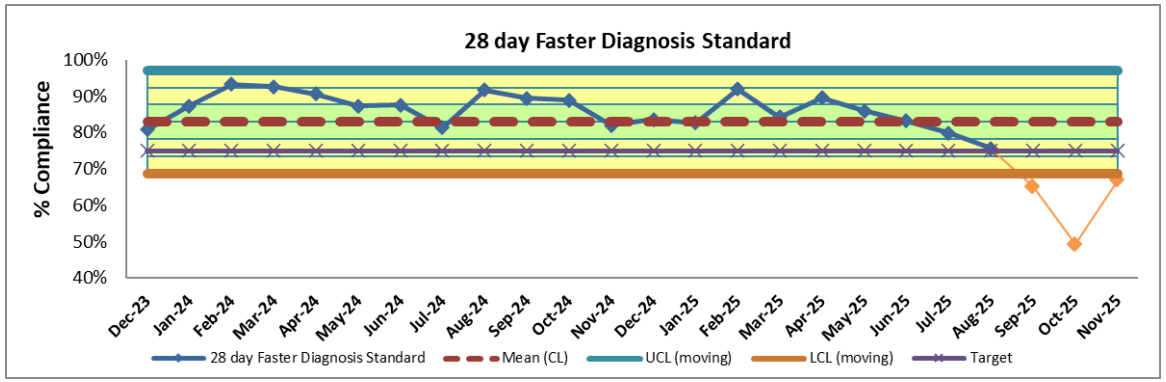
Flagged Indicators

Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery		Points below lower control limit
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment		Points below lower control limit
Warrington Dermatology Cancer Combined 31 day General Standard		Points below lower control limit
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)		Points below lower control limit
28 day faster diagnosis		Points below lower control limit
Referrals to plan - Warrington Adults		Points below lower control limit
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)		Points below lower control limit
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)		Points above upper control limit
All waiters - % waiting over 52 weeks (also include Dental)		Points above upper control limit
All waiters - % waiting under 18 weeks(also include Dental)		Points below lower control limit
All waiters - % waiting over 65 weeks (awaiting initial access)		Points above upper control limit
Warrington Adults Activity Variance		Points below lower control limit

Operations: Exception Reporting

Warrington Dermatology Cancer – (November performance reported in arrears)



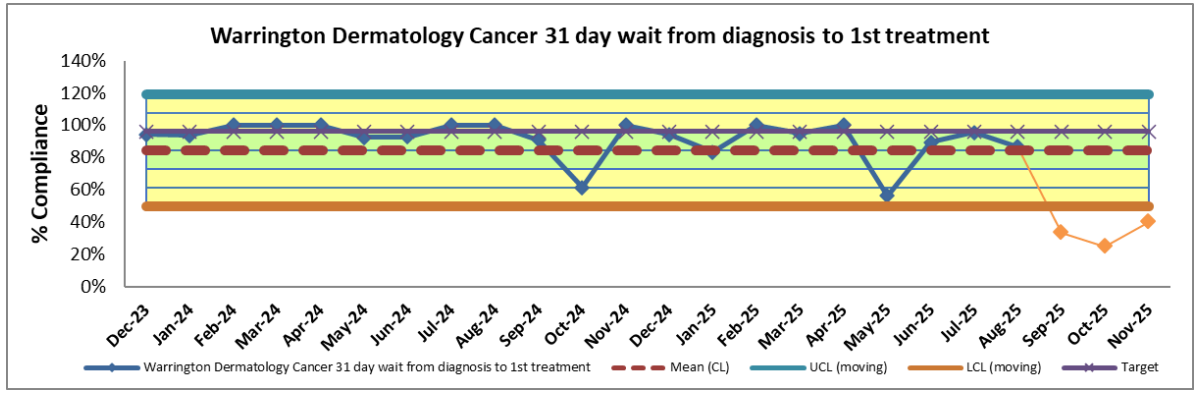


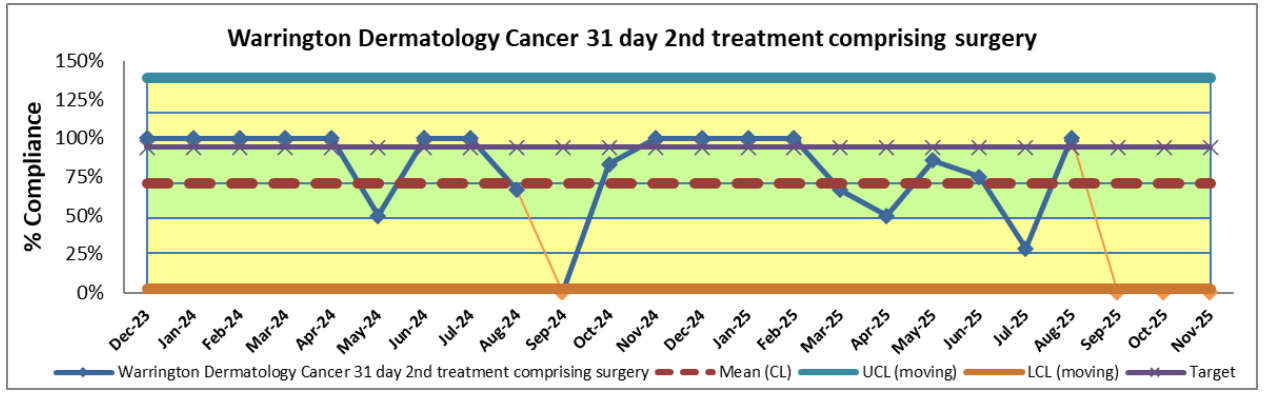
2 Week wait for first appointment – (Old target 93%) Within the month of November Bridgewater saw 356 patients for a first appointment with an urgent referral of suspected cancer. We would normally expect to see variation between 88% and 99%. We have seen an improvement with performance back within control limits in November with a compliance of 72.75% this was as a result of adding additional clinic capacity and adapting the one stop shop model for skin analytics to provide more face to face slots temporarily.. (This indicator no longer forms part of the cancer standards but can be a useful heads up of how well we may perform in relation to the 28 day faster diagnosis standard). The increased demand relates to an increase of referrals into the skin cancer pathway and the introduction of Skin Analytics, accumulatively this has created significant pressures within the skin cancer pathway. The 181 patients have now been cleared which removes the distortion in performance.

28 day Faster Diagnosis Standard - Target 75% (66.87% Month 8) Historically, the service has consistently achieved the 28-day Faster Diagnosis Standard. Performance has improved through additional clinic capacity and temporarily adapting the Skin Analytics one-stop model to create more face-to-face slots.
A previous reduction in capacity, increased referrals into the skin cancer pathway and the introduction of Skin Analytics, accumulatively created significant pressures within the skin cancer pathway, breaches are expected to continue into Month 10, however the percentage compliance will increase following the implementation of a waiting list initiative throughout December. This has allowed for capacity to be released to see new two week wait patients.
The 181 patients have now been cleared which removes the distortion in performance.

Operations: Exception Reporting

Warrington Dermatology Cancer – (November performance reported in arrears)





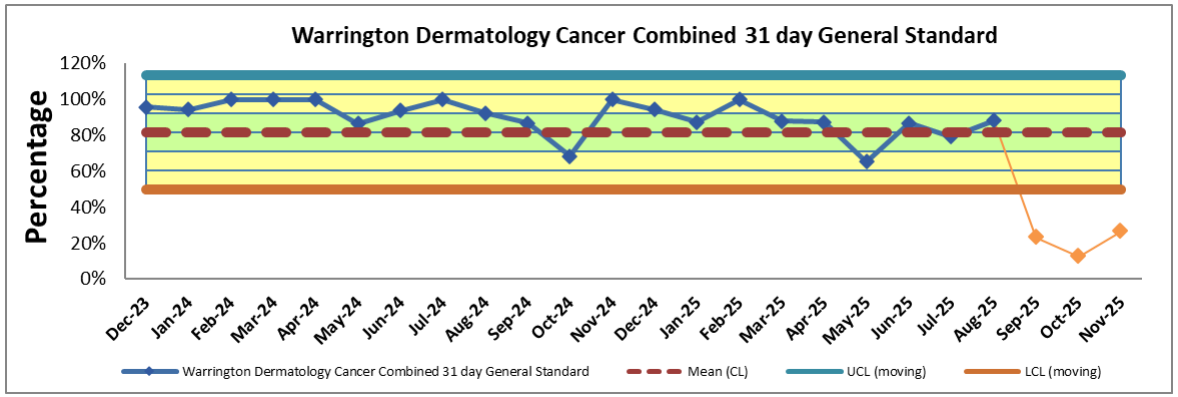
The two 31 day standards are now reported as a combined metric on the next slide. (As per national cancer standards)

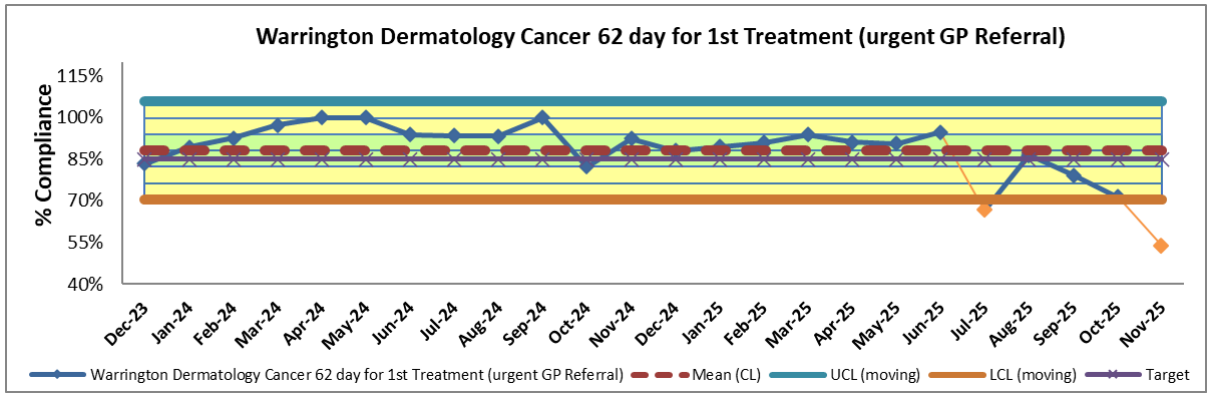
31 Day 1st treatment (old target 96%) - 31-day 1st treatment performance was 40% (6/10 breaches). Two breaches were due to patient choice and four to limited surgery slots, with some further patient-choice delays. All patients have now been seen; four discharged post-surgery and two on follow-up pathways. Reduced consultant sessions and the impact of Skin Analytics have contributed to capacity pressures. The waiting list initiative has increased capacity and clearing the 181-patient backlog has removed previous distortion, so performance is expected to improve.

31 Day 2nd treatment (old target 94%) - Five out of five patients breached the 31-day subsequent treatment standard, all five were due to limited surgery capacity and 4 were further impacted by patient choice. Two patients have been discharged and three remain on the pathway. Reduced consultant sessions and the impact of Skin Analytics have contributed to capacity pressures. The waiting list initiative has increased capacity and clearing the 181-patient backlog has removed previous distortion, so performance is expected to improve.

Operations: Exception Reporting

Warrington Dermatology Cancer – (November performance reported in arrears)

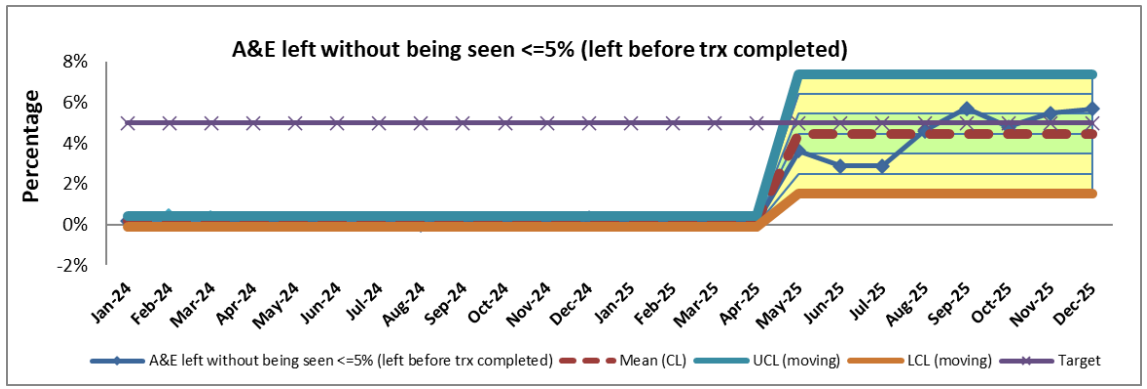




Combined 31-day general standard - (Target 96%) – Bridgewater's compliance with the combined standard is 26.67%. Month 8 challenges were driven by Skin Analytics bottlenecks and reduced clinical capacity, but the backlog has now been cleared in Month 9. Breaches related to both patient choice and limited capacity were expected. Reduced consultant sessions and the impact of Skin Analytics contributed to pressures, but the waiting list initiative has created additional capacity. Clearing the 181-patient backlog has removed previous distortion, and performance is expected to improve.

62 Day 1st treatment (Target 85%) 6 of 13 patients breached the 62-day standard (53.85%).
Three breaches were due to limited Skin Analytics follow-up slots and patient choice; these patients have now been seen and discharged.
Two breaches were linked to delays to first appointment and subsequent surgery, and the final patient required referral to plastics.
The service is working with the Cancer Alliance and expects improvement in December (c.91%), with the 85% target extended to March 2026.
Reduced consultant sessions and the impact of Skin Analytics have constrained capacity.
The waiting list initiative has increased capacity and clearing the 181-patient backlog has removed previous distortion, supporting improved performance going forward.

Operations: Exception Reporting



A&E left without being seen <=5% (left before treatment completed)

Local target is 5%

Performance in December – 5.68%.

Analytical Narrative

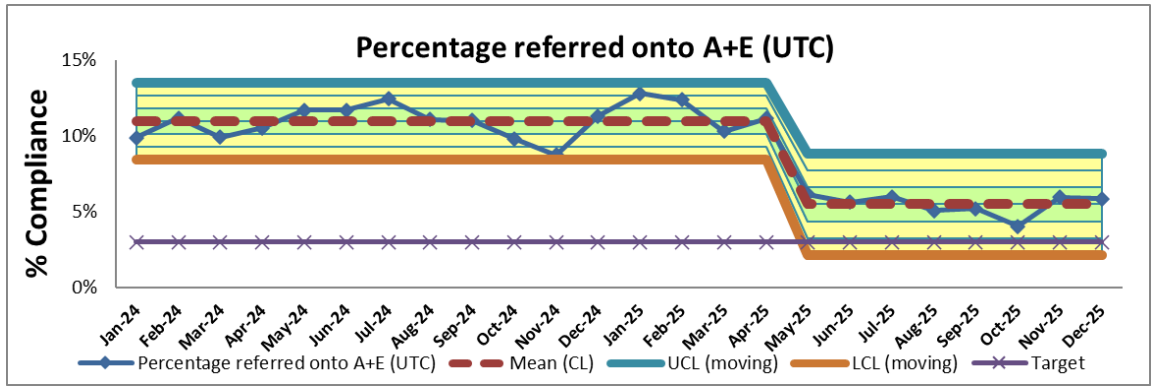
Work to align local and ICB calculation is visible from the significant change in variation from the month of May 25. We have re-baselined the data and expect to see the control limits draw closer. The target is now within control limits yet the performance in December is breaching target for the second time in three months.

Operational Narrative:

There are a variety of reason patients choose to leave the UTC department before being seen, this can be patient choice, the ability to access pharmacy first, their own GP or 111, whilst waiting within the department, is also a common reason. We have seen an increase in demand over the winter months, which has meant on some occasions waiting times have been longer than usual and therefore can lead to patients leaving before being seen.

There is no harm caused during this time as all patients are triaged using Manchester triage system and those who have been triaged as ‘Green’ are safe to wait at that time.

Operations: Exception Reporting



Percentage referred onto A+E (UTC)

Local target is 3%

Performance in December – 5.84%.

Analytical Narrative

Work to align local and ICB calculation is visible from the significant change in variation from the month of May 25. We have re-baselined the data and expect to see the control limits draw closer. The target is now within control limits.

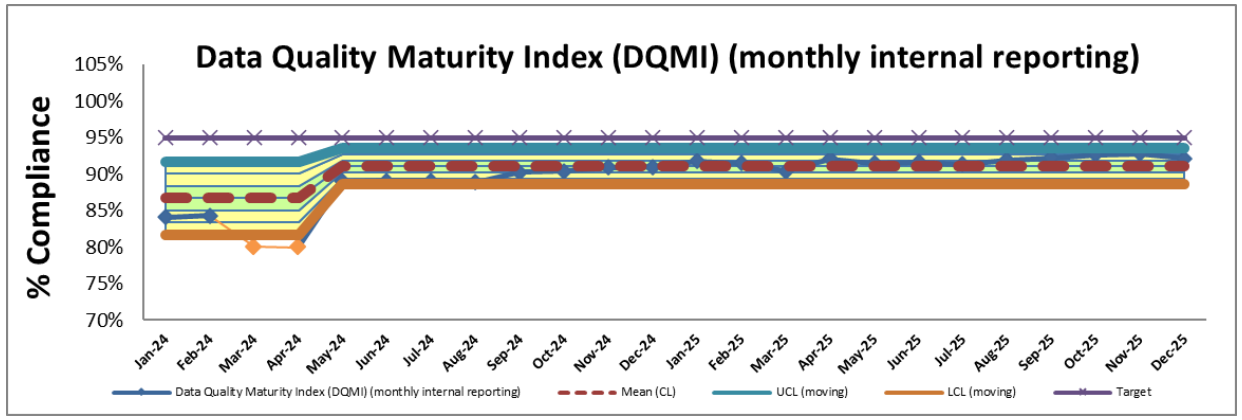
Operational Narrative

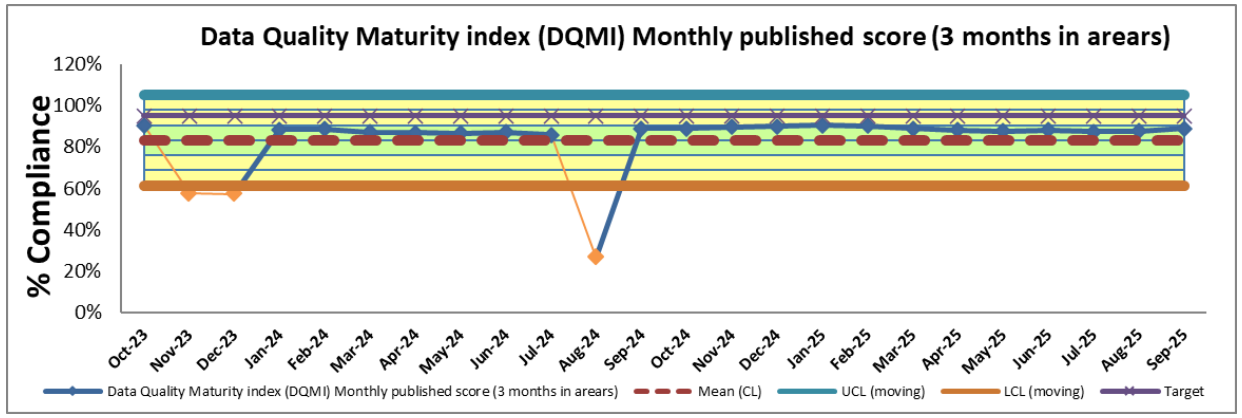
This indicator relates to patients coded as ‘streamed to emergency department following initial assessment (situation)’. The 3% target is achievable; these situations should be a rare occurrence.

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

Operations: Exception Reporting

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





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

National DQMI Score

69.3

Experimental National DQMI Score

62.7

Data set	National Data Set Score	National Data Set Score Experimental
APC	91.6	91.6
CSDS	72.9	68.4
ECDS	79.5	79.5
IAPT	92.4	83.9
MHSDS	41.6	37.1
MSDS	97.4	97.4
OP	88.5	88.5

Operations: Exception Reporting

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

Standard	APC (%)	CSDS (%)	DID (%)	ECDS (%)	IAPT (%)	MHSDS (%)	MSDS (%)	OP (%)	DQMI Score (%)
		91.1		86.1		92.6			88.9

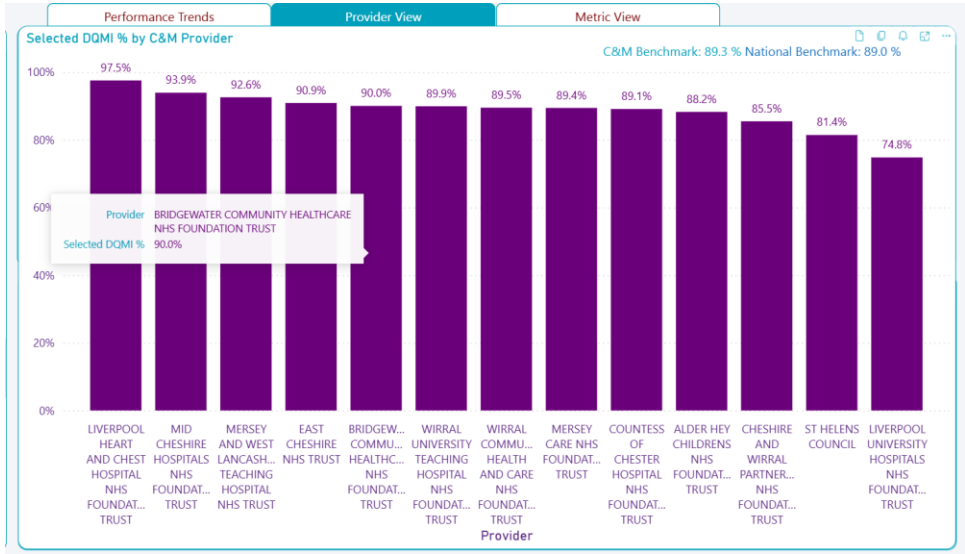
Analytical Narrative / Operational Narrative

The DQMI for Bridgewater is based upon completeness, validity and timeliness of 3 datasets: ECDS, CSDS, MHSDS.

With the exception of Nov 24, variation can be expected between 85% and 90% for Bridgewaters overall published DQMI score.

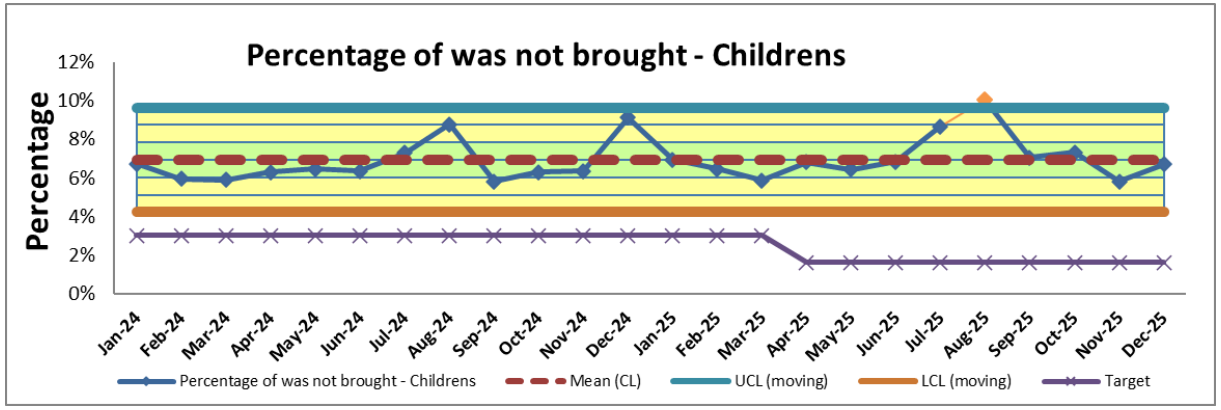
Of the three datasets, ECDS offers most scope for improvement and the information team continue to work alongside the service lead to drive improvements.

It is still proving challenging to achieve the 95% target



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

Operations: Exception Reporting



Percentage of "Child not brought " Children's Services

Local Target: 1.6% December compliance – 6.71%

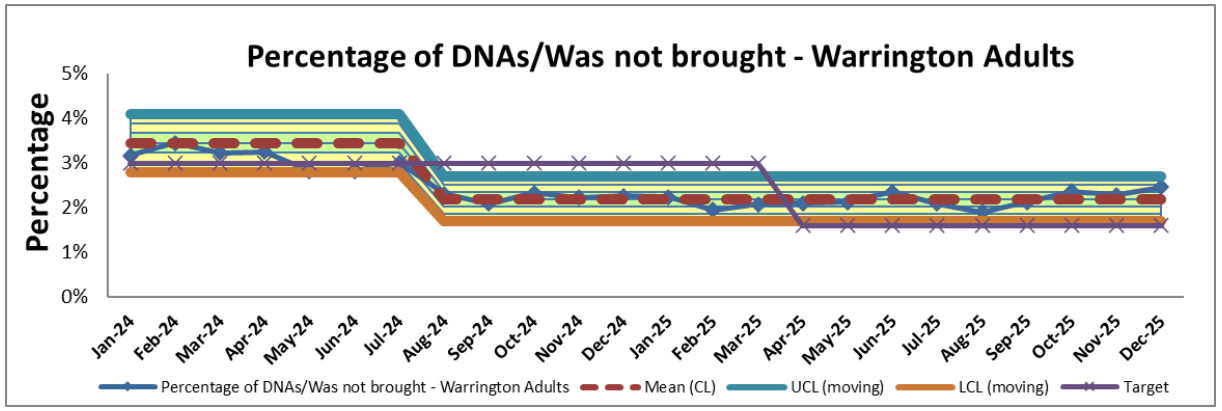
Analytical Narrative

The number of children not brought to their appointment has increased in December to 6.71%. Outside of school holidays we would expect variation to be between 5% and 7%.
The trusts aspirational target is to achieve 1.6% DNA / Child Not Brought.

Operational Narrative / Actions / Risks

Children's Services reported an increase in children not brought in Month 9 this is due to Christmas and is a seasonal trend. Teams with highest CNB rates identified and rates monitored as they continue to implement actions agreed within team action plans. These include actions such as repeat text reminders, reviewing appointment letters, ensuring families have sufficient notice of appointments, ensuring the Trusts Patient Access Policy implemented well within teams and ensuring telephone calls/messages are checked promptly. The highest number of Children not brought relate to follow-up appointments

Operations: Exception Reporting



Percentage of DNAs/Was not brought - Warrington Adults

Local Target: 1.6%

December compliance – 2.46%

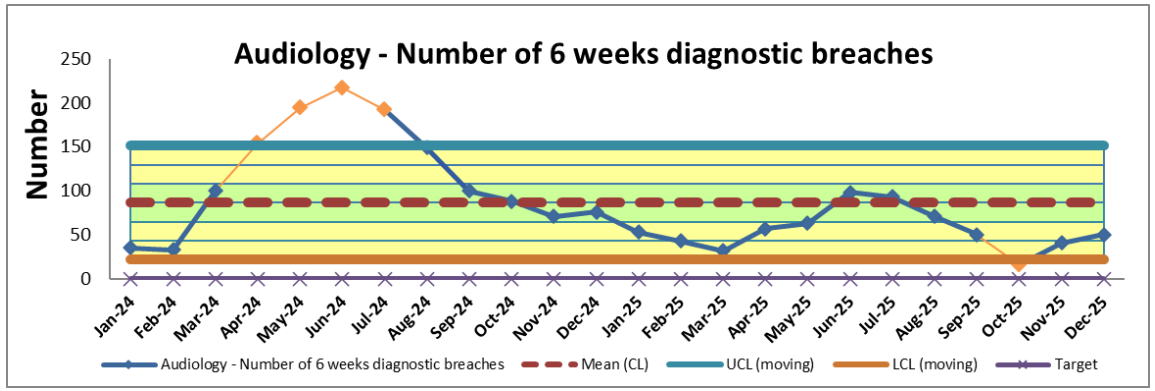
Analytical Narrative

DNA rates for Warrington Adults typically range between 2–3% and fluctuate around the mean. The current target sits just below the lower control limit. The Trust's aspirational goal is to reduce DNA rates further and achieve 1.6%.

Operational Narrative / Actions / Risks

DNA rates fluctuate throughout the year, we expect an increase throughout December due to Christmas. Work has been initiated and embedded across all teams to reduce these rates, with a target of achieving 1.6%. Additional efforts are ongoing to address areas with the highest DNA rates and identify further actions to drive improvement.
The highest numbers of DNA's predominantly relate to follow up activity and therapy services.

Operations: Exception Reporting



Analytical Narrative

Performance had been steadily improving yet has increased again in month 9. We would expect normal variation to range between 30 and 100 breaches.

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

Warrington Audiology - Number of 6 weeks diagnostic breaches

National Target: 0

December compliance - 50 breaches

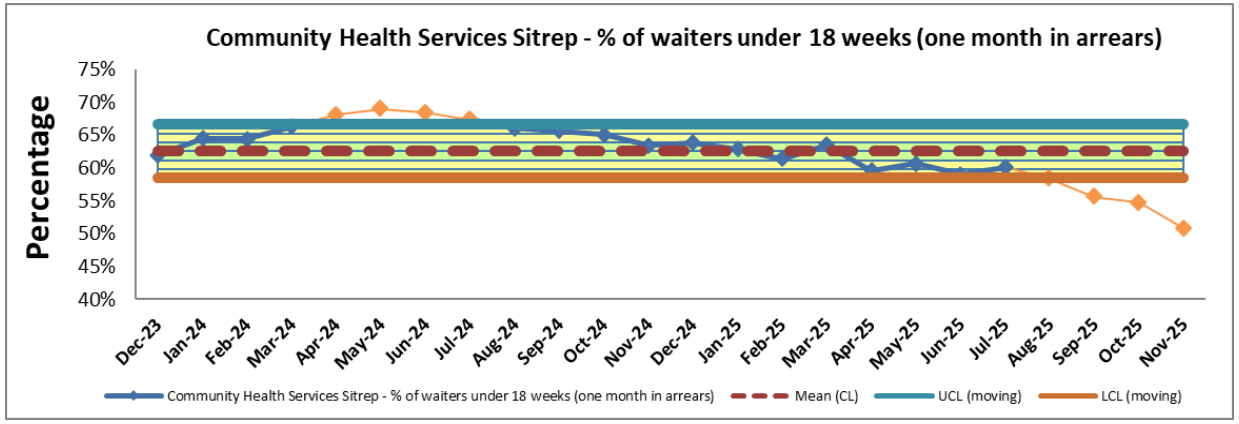
Operational Narrative / Actions / Risks

Weekly performance meetings are now in place with Head of Service to review actual and potential breeches, ensuring robust oversight of waiting list and its management. Training has been given to ensure clock stops are applied.
The team are reviewing child not brought rates and internal processes relating to waiting list management to ensure most efficient use of resources
Plans to meet the national 6-week DM01 target in January 2026 are underway.
Recruitment to 0.6wte vacancy has taken place and they start in February 2026
Data anomalies identified in M8 and M9 as children with a later "Earliest Clinically Appropriate Date" were being included in the data return in error and clock stops were not being applied.
There have been no incidents reported with moderate harm or above. There have been no complaints.

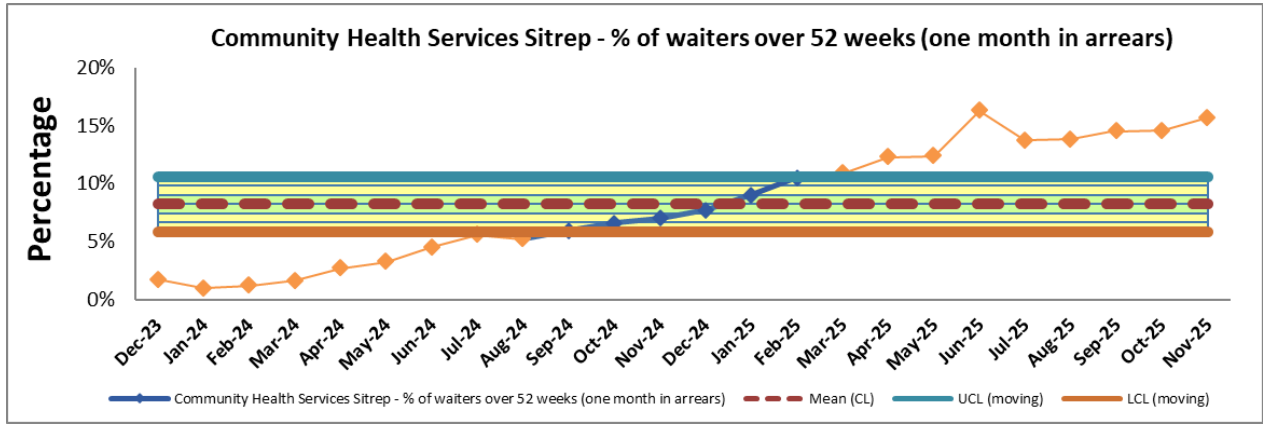
Operations: Exception Reporting

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

November % under 18 weeks – 50.79%



November % over 52 weeks –15.68%



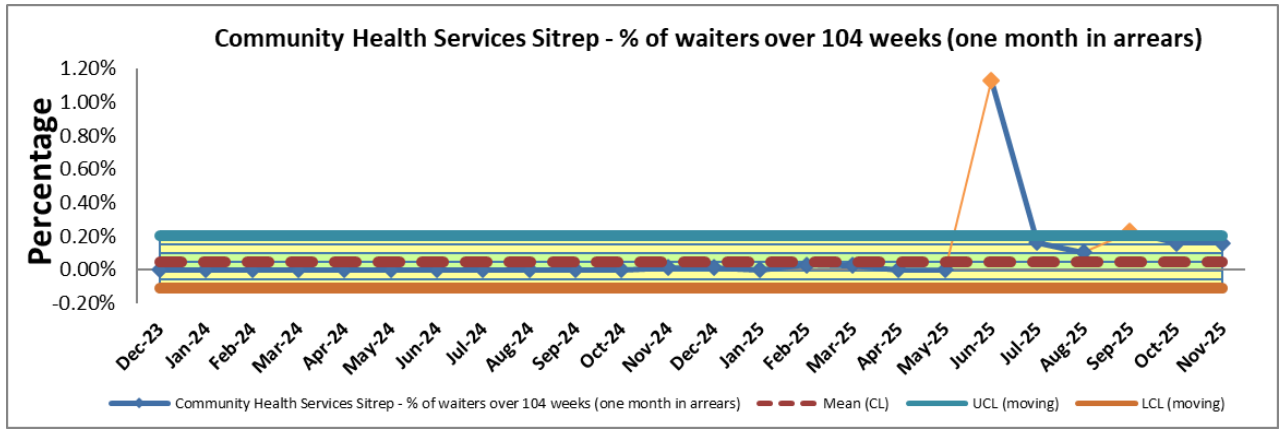
The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's community health services. Providers submit aggregated information for service lines, irrespective of the number of ICBs or regions they provide services 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)

November % over 104 weeks – 0.16%



CHS Sitrep overall performance has been deteriorating since Summer 2024. The variation can be expected to range between 59% and 69% for 18 week waits and 5% to 16% for over 52 weeks.

Bridgewater is one of 15 trusts working with the national team to develop waits directly from daily Faster Data Flows submissions. Not all services are required to flow via CHS - Dermatology and Dental as an example are excluded from this submission.

Bridgewater continue to score quite poorly in relation to the percentage of patients waiting above 52 weeks. (NOF Access domain score) Carrying out the actions described in the indicator (all waiters %under 18 weeks / % above 52 weeks) will improve this score.

The CHS scores are attributed to the National Oversight Framework Access domain scores. Changes to how community waits are calculated may directly affect this score.

Operations: Exception Reporting

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

		Number of patients waiting:							
Organisation Name	Total waiting list	0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	16,403	2,409	1,747	2,543	5,975	1,820	1,770	110	29
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST									
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	295	60	44	95	71	16	8	0	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	148	42	22	37	45	2	0	0	0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST									
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	5,923	685	603	1,132	2,786	608	109	0	0
EAST CHESHIRE NHS TRUST	3,962	468	370	705	1,373	519	523	4	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST									
MERSEY CARE NHS FOUNDATION TRUST	19,277	2,986	2,160	3,378	6,817	2,230	1,706	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	3,723	256	311	477	1,236	440	915	88	0
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	5,570	599	416	792	2,172	879	712	0	0

Analytical Narrative for November 2025 data:

- Total adults reported on Bridgewater waiting lists in November 2025: **3723** (decrease of **5.27%** on October 2025)
- Long waits for adults on Bridgewater waiting lists in November 2025: **440** waiting **>12-18 weeks**, **915** waiting **>18-52 weeks**, **88** waiting **>52-104 weeks**, and **0** waiting over **104 weeks**.
- Adults waiting over **52 weeks on** Bridgewater waiting lists has decreased by 4 this month.

Operations: Exception Reporting

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

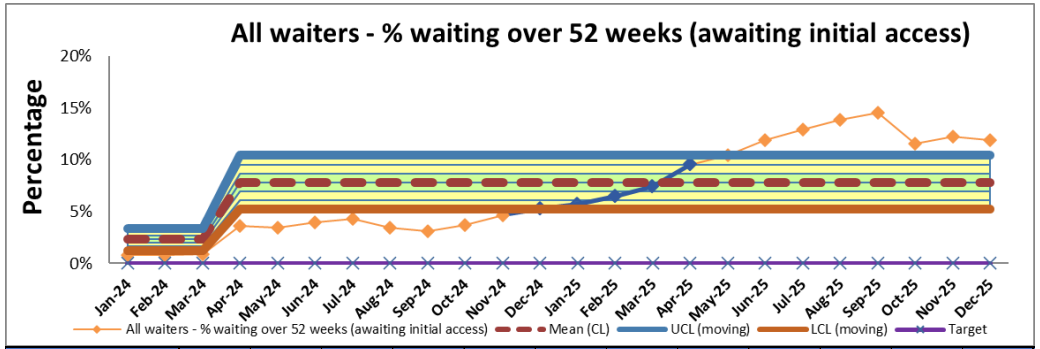
		Number of patients waiting:							
Organisation Name	Total waiting list	0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	1,982	73	92	191	643	188	745	44	6
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST									
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	607	36	25	55	124	88	245	34	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST									
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,764	355	247	578	1,261	475	1,822	25	1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3,003	133	167	291	756	234	793	629	0
EAST CHESHIRE NHS TRUST	526	44	35	63	173	53	158	0	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,473	36	48	70	275	85	778	181	0
MERSEY CARE NHS FOUNDATION TRUST	878	104	109	149	416	59	41	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	5,027	152	230	332	756	254	2,019	1,270	14
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	287	45	35	66	115	13	13	0	0

Analytical Narrative for November 2025 data:

- Total children & young people reported on Bridgewater waiting lists in November 2025: **5027** (increase of **4.40%** on October 2025)
- Long waits for children & young people on Bridgewater waiting lists in November 2025: **254** waiting **>12-18 weeks**, **2019** waiting **>18-52 weeks**, **1270** waiting **>52-104 weeks**, and **14** waiting over **104 weeks**.
- Children & young people waiting over **52 weeks on** Bridgewater waiting lists has increased by **102** to **1284** from last month.

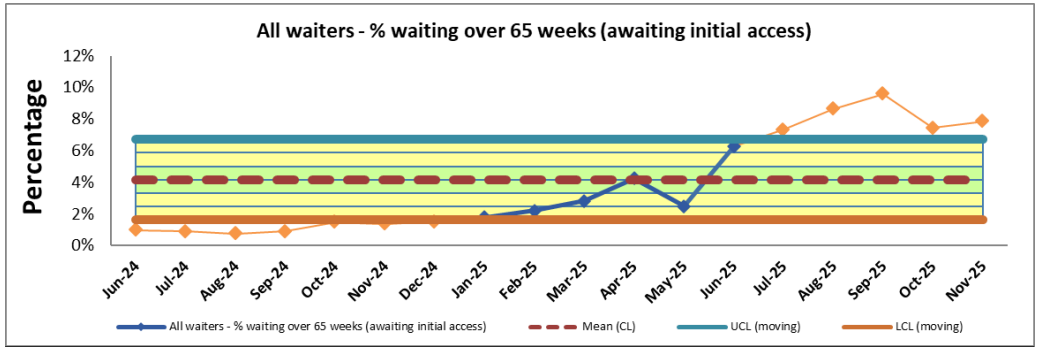
Operations: Exception Reporting

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



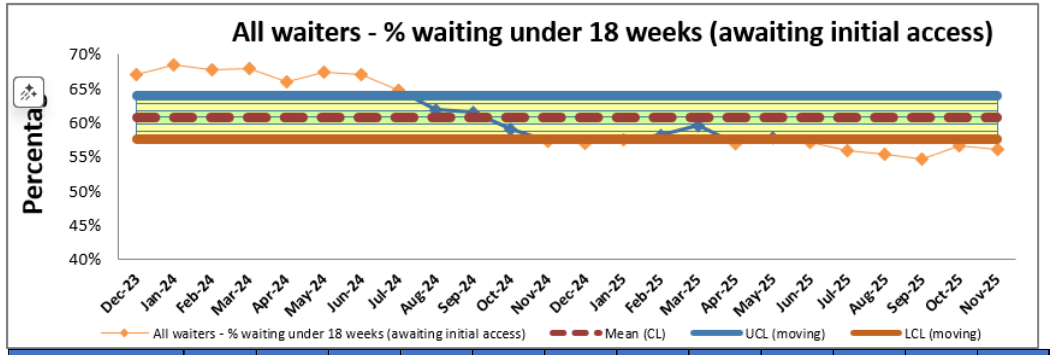
Over 52 weeks	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Warrington	639	816	1044	1289	1556	1676	1738	1852	1881	1502	1598	1433
Halton	285	313	360	409	287	606	794	918	932	707	748	809
Dental	64	29	25	42	31	15	13	10	7	6	3	3
Total Over 52 weeks	988	1158	1429	1740	1874	2297	2545	2780	2820	2215	2349	2245

Percentage of patients waiting over 52 weeks in December is 11.88%.



Over 65 weeks	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Warrington	190	226	344	539	348	857	956	1109	1182	906	995	816
Halton	118	166	195	238	100	354	488	620	675	518	510	548
Dental	102	93	95	100	195	105	96	117	124	4	0	2
Total Over 65	410	485	634	877	643	1316	1540	1846	1981	1428	1505	1366

Percentage of patients waiting over 65 weeks in December is 7.23%.



Under 18	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Warrington	4710	4701	5459	4655	4855	5042	5276	5400	5141	5076	4783	4401
Halton	1725	1704	1824	1518	1553	1645	1746	1586	1300	1442	1403	1375
Dental	3548	3943	4185	4221	3979	4365	4004	4118	4062	4326	4551	4797
Total Under 18	9983	10348	11468	10394	10387	11052	11026	11104	10503	10844	10737	10573

Percentage of patients waiting under 18 weeks in December is 55.95%.

Operations: Exception Reporting

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

Halton	**548**
Community Paediatrics (Halton)	46
Halton Paediatric Neurodevelopment	497
Podiatry (Halton)	5
Warrington	**816**
Dermatology Service	338
Paediatric Community Medical Service	25
Podiatry Service	21
Warrington Paediatric Neurodevelopment	432
Grand Total	**1364**

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

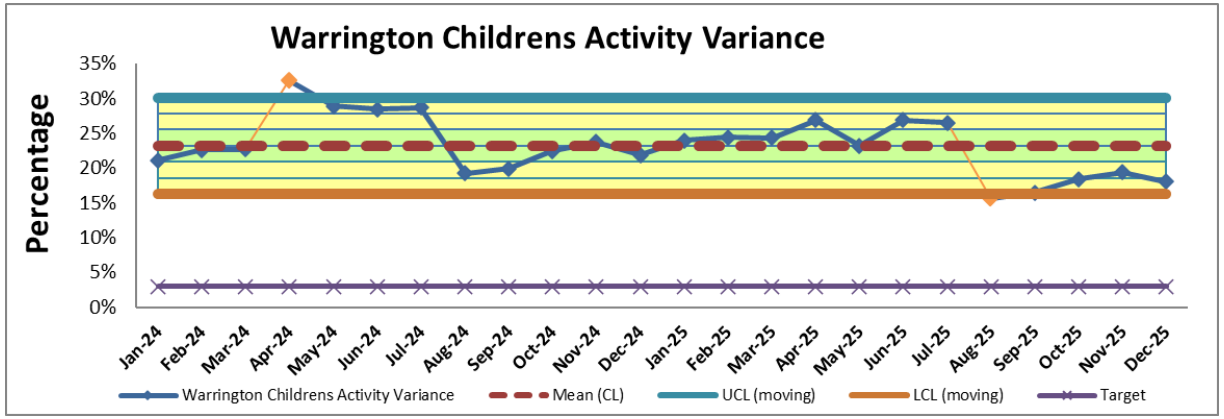
If we aspire to align with elective targets, we would need to achieve 65% of patients waiting less than 18 weeks by March 2026.

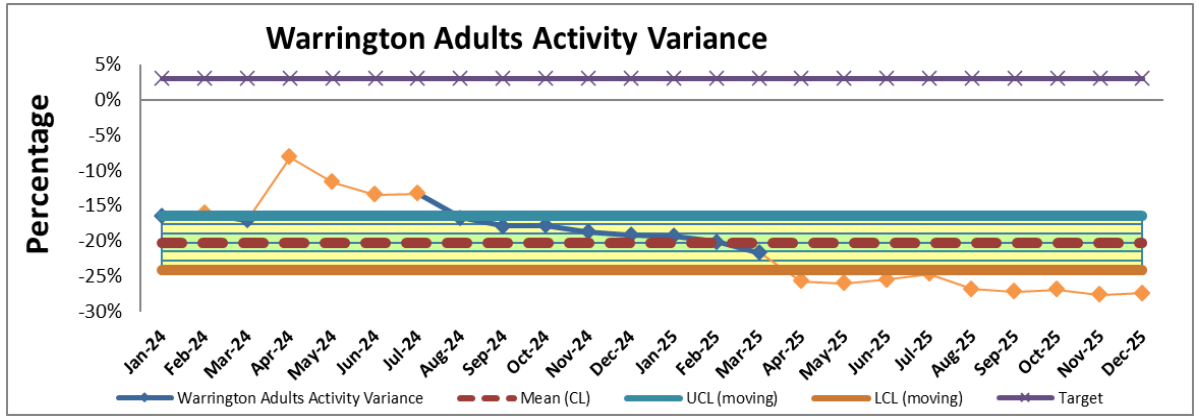
Operational narrative - Services with over 65 week waits

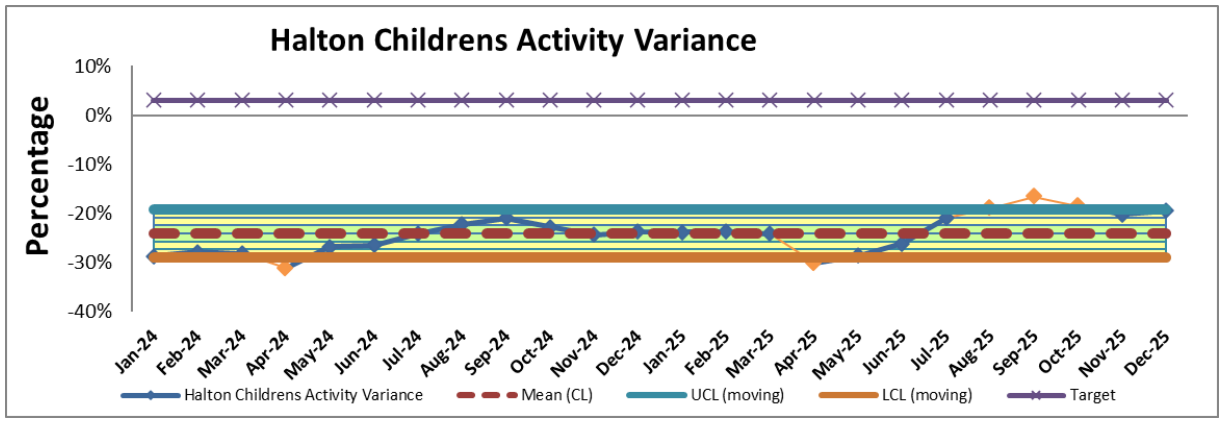
Community Paediatrics Warrington and Halton - Appointments offered to highest risk cohort of stratified caseload. Trajectories under development. Trust will present the information to commissioners as capacity is clearly unable to meet demand. This work has commenced
Dermatology - Engagement continues with NHSE regarding 65+ week waits. Waiting list initiative implemented from 28.11.2025 and positive progress has been made to date. Waiting list initiative will continue through to the end of the financial year to achieve a below 52 week position.
Podiatry Warrington – Recruited to vacancies, all posts are in place as of early January. Plans have been developed to reduce waiting times below 52 weeks by the end of the financial year.
Halton Podiatry – The volume of waits has reduced due to a change in service criteria. Waiting list initiative in place, plan to move to a below 52 week position by the end of March 2026.
Paediatric Neurodevelopment Warrington and Halton - The number of children and young people waiting for an initial appointment as part of the Autism and ADHD diagnostic assessment pathway continues to increase. The team continues to experience a level of demand which exceeds capacity. The team hold weekly performance and allocation meetings to ensure those with highest clinical need (identified via the risk stratification tool) are offered available appointments.
Dental Greater Manchester - Greater Manchester (GM) have 111 patients waiting over 65 weeks. This is same figure as last month. High waiters (109) are due to GA theatre capacity. Urgent referrals being given priority over high waiters. We continue to experience challenges with our theatre access for children with additional needs. We have very limited capacity which has led to 12 children experiencing waits in excess of 104 weeks. from 18 patients last month
Dental Cheshire & Merseyside - Operational flexibility continues to be enabled allowing targeting of areas where demand is high/staff booking at alternative sites to reduce waits. Assessment only weeks etc are planned to combat pressure points in patient journey. Capacity may be lower due to holidays /leavers in Q4

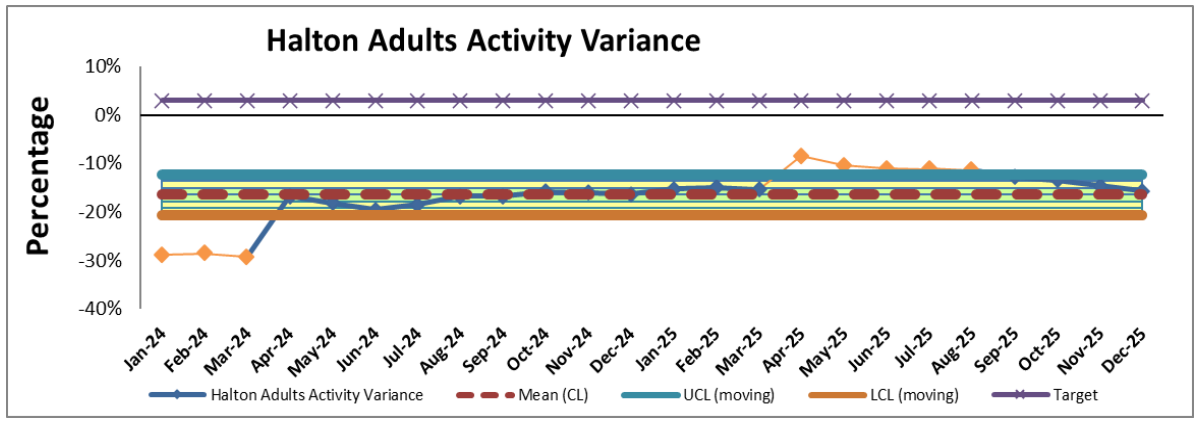
Operations: Exception Reporting

Activity Variances Local Target: 3%



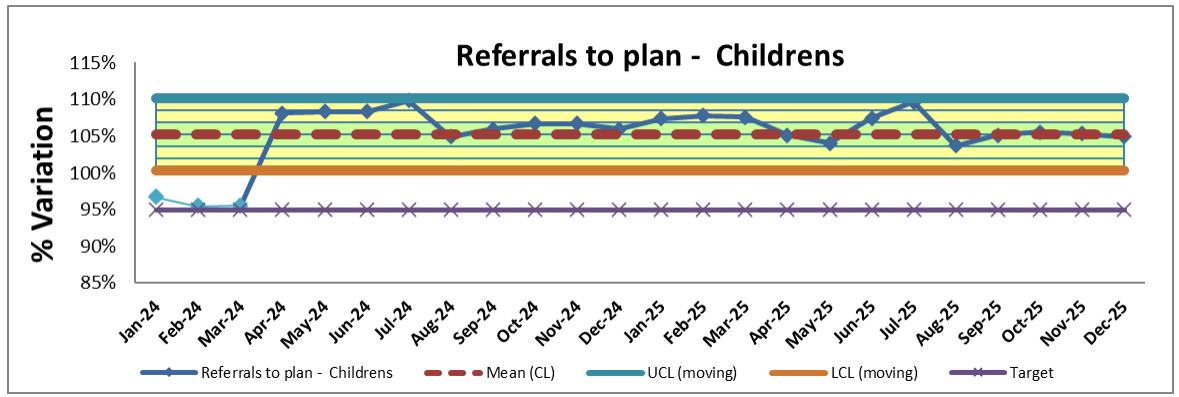


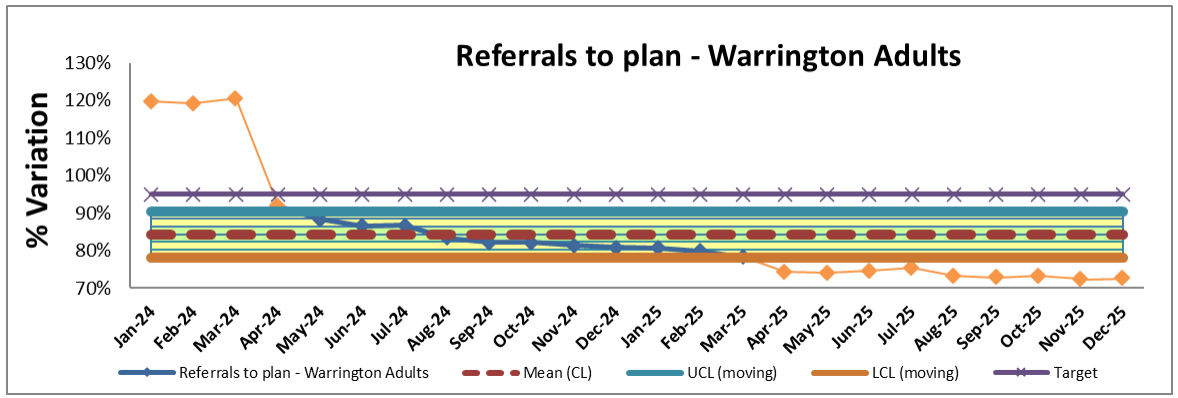


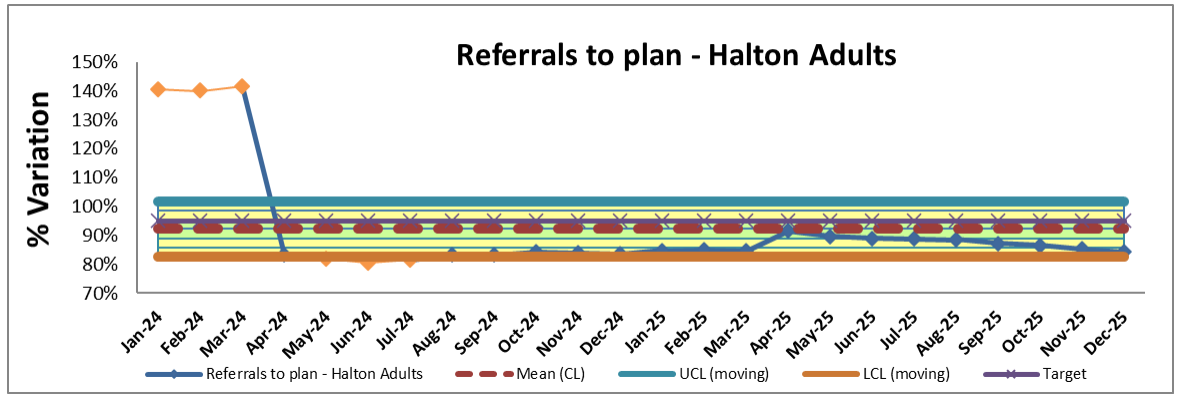


Operations: Exception Reporting

Referrals to plan Local Target 95%





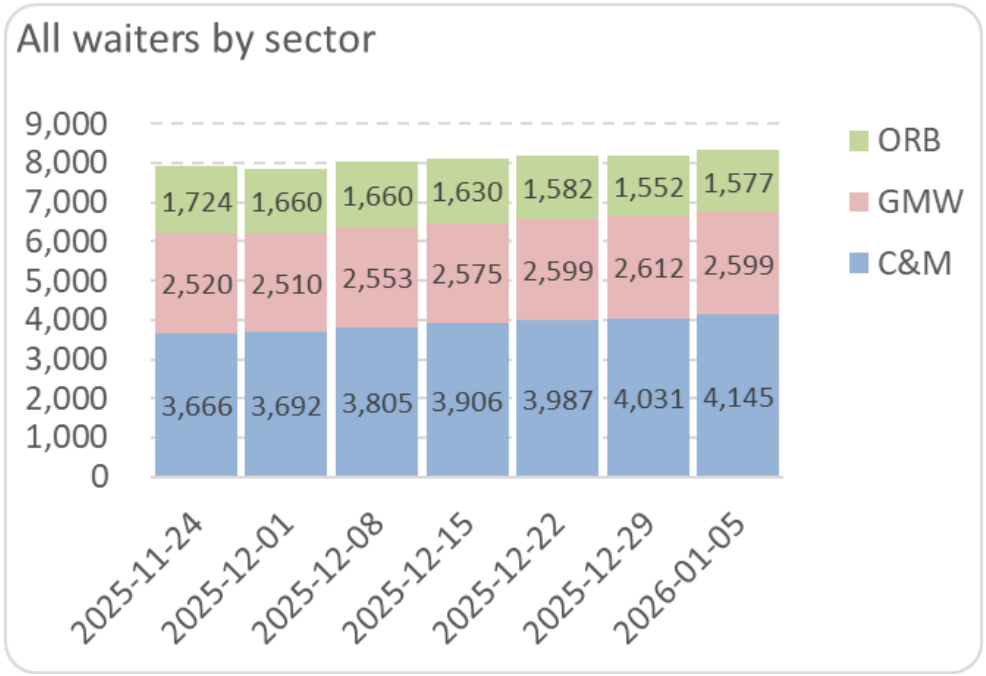


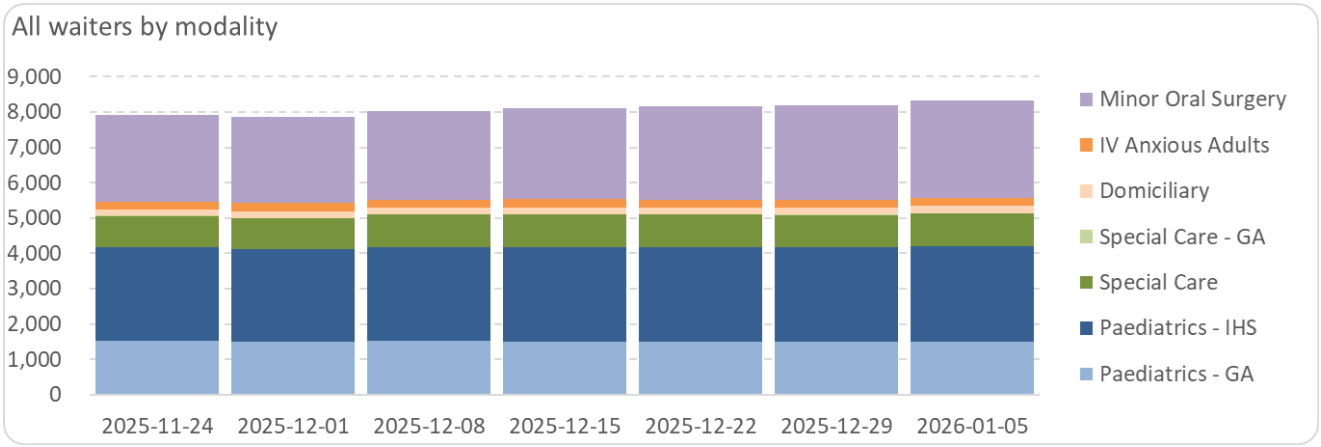
Analytical / Operational Narrative for Activity Variance and Referrals to Plan

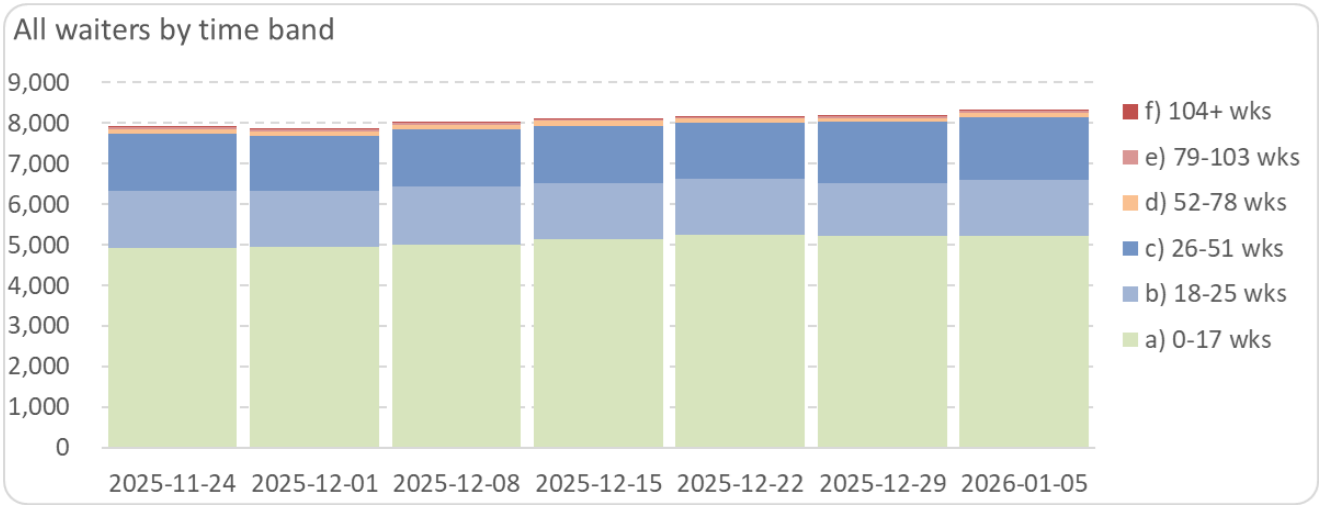
The Information team and Operational Directors are currently reviewing data and considering any individual service-line changes relating activity targets.
The timeline for completion of this work was originally end Q2, however, service-level discussions are proving challenging to arrange. Assistant Directors are helping to coordinate these sessions in as timely a manner possible.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality







Operations: Exception Reporting

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

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2025-11-24	4,911	1,425	1,395	123	40	16
2025-12-01	4,953	1,368	1,359	123	41	18
2025-12-08	5,005	1,428	1,405	124	39	17
2025-12-15	5,129	1,386	1,420	116	44	16
2025-12-22	5,257	1,375	1,367	109	46	14
2025-12-29	5,212	1,309	1,506	104	50	14
2026-01-05	5,224	1,368	1,553	111	53	12

Analytical / Data Quality Narrative

The numbers of waiters within each time band has remained mainly consistent, although a slight increase in patients waiting 0-17 weeks and a slight decrease in 18-25 weeks, increase 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 prioritised by clinical need. GM N&E patients decreased in December, W&S slight increase, C&M waiters have increased
Greater Manchester commissioners recently asked for additional data relating to activity on sessions. 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 lists in Dentally are accurate although BI informed Dental of an issue with not being able to pull through all information from the data warehouse. Need reassurance from BI team that we are accurately captured and all measures to manage the continued reduction of long waiters are in place for both sectors. This on the risk register in Dental with a possible 1000 patients not pulling through to reports. Data warehouse team are rebuilding dental data extracts to maximise load efficiency and meetings in place with BI team

Operations: Exception Reporting

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

Over 65 week waits - Cheshire & Mersey have 0 patients over 65 weeks.
Waiters are targeted via opt ins, earliest possible assessment appointments and a minimum wait for treatment. This is evident in management of waiters over 52 weeks being offered treatment , even in the most challenging pathway- Minor Oral Surgery. (MOS)- however clinician sickness has led to delays due to a drop in capacity. 1st appointments are now targeted via assessment only clinics periodically.
We currently have just 8 waiters over 52 weeks across all pathways- all with treatment appointments booked and ready to bring forward into cancellation slots.
Structured 'golden' appointments also now in place across all sites to ensure all contracts are being delivered equally and we are working to achieve KPIs. Special attention given to Special care new patients and children .The following actions are contributing to performance improvement:

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

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality

Greater Manchester Operational Narrative

Over 65 week waits - Greater Manchester (GM) had 111 patients waiting over 65 weeks. This has increased slightly since last month due to GA theatre capacity and urgent referrals being given priority over high waiters. We continue to experience challenges with our theatre access for children with additional needs. We have very limited capacity which has led to 12 children experiencing waits in excess of 104 weeks.

RBH list for children that are neuro diverse, we only have 6 patients every 6 weeks, and the highest waiters are for this hospital. We are have completed a paper exercise to move patients from RBH list to other lists in GM that have more capacity. We still have 164 patients on the RBH (neurodiverse) which will take 27 months unless we can secure more theatres in C&M (WHH) or other.

Managers book assessments in order of receiving referral or clinical priority. all GM managers are now booking in patients from other clinics that have more pressures. Now booking in assessments from 25 weeks to ensure 1st treatment by 31 weeks.

The following actions are contributing to performance improvement:

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

Quality

Executive Summary

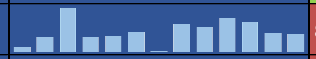
There are 9 Quality indicators reporting as red and 24 green indicators in December 2025.

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

- % Incidents reported within 48 hrs of discovering an incident has occurred – Deterioration in Month
- % of incidents causing moderate harm (Score 3) – Improvement in Month
- DOC (Duty of Candour) for moderate harms and above 10-day compliance – Deterioration in Month
- % of BCHFT risks managed in line with policy ie risks with in date reviews – Deterioration in Month
- Percentage of BCHFT risks identified as 12 or above – Deterioration in Month
- Total number of BCHFT acquired pressure ulcers – Improvement in Month
- % of Category 4 Pressure Ulcers acquired in Bridgewater – Deterioration in Month
- % of Cat 3 Pressure Ulcers acquired in Bridgewater – Improvement in Month
- Overall CQC rating (Yearly)

Quality: Exception Reporting

Trust Scorecard

Quality													
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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%		83.21% (▲)	85.07% (▲)	90.99% (▲)	85.12% (▼)	85.28% (▲)	86.14% (▲)	82.18% (▼)	87.71% (▲)	87.07% (▼)	88.95% (▲)	88.1% (▼)	85.97% (▼)	85.78% (▼)
% of incidents causing moderate harm (Score 3)	1%		2.26% (▲)	0.74% (▼)	0% (▼)	0.83% (▲)	2.45% (▲)	1.2% (▼)	5.75% (▲)	2.79% (▼)	4.76% (▲)	2.33% (▼)	3.35% (▲)	2.88% (▼)	2.94% (▲)
% of incidents causing severe/fatal harm (Score 4-5)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.37% (▲)	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% (►)	100% (►)	100% (►)	100% (►)	100% (►)	0% (▼)	75% (▲)	55.56% (▼)	100% (▲)	31.58% (▼)	90% (▲)	85.71% (▼)
% of BCHFT patient safety incidents that are medication incidents	7%		7.52% (▲)	3.68% (▲)	9.73% (▼)	5% (▲)	6.13% (▼)	8.43% (▼)	6.32% (▲)	3.35% (▲)	4.08% (▼)	5.81% (▼)	4.83% (▲)	7.55% (▼)	5.39% (▲)
% 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%		95.51% (▼)	94.51% (▼)	94.87% (▲)	95.44% (▲)	95.55% (▲)	95.43% (▼)	94.57% (▼)	93.69% (▼)	92.95% (▼)	92.97% (▲)	93.32% (▲)	94.52% (▲)	95.13% (▲)
Safeguarding Childrens Level 1	95%		98.51% (▼)	98.38% (▼)	98.05% (▼)	98.29% (▲)	98.19% (▼)	98.19% (▲)	98.19% (▲)	98.25% (▲)	98.16% (▼)	98.08% (▼)	98.3% (▲)	98.56% (▲)	98.26% (▼)
Safeguarding Childrens Level 2	95%		98.57% (▲)	98.9% (▲)	98.47% (▼)	98.89% (▲)	98.61% (▼)	98.27% (▼)	97.92% (▼)	97.74% (▼)	96.75% (▼)	97.52% (▲)	97.8% (▲)	97.68% (▼)	97.04% (▼)
Safeguarding Childrens Level 3	95%		98.3% (▼)	98.65% (▲)	98.64% (▼)	98.99% (▲)	99.66% (▲)	99.66% (▲)	98.97% (▼)	98.97% (▼)	98.59% (▼)	98.85% (▲)	100% (▲)	98.88% (▼)	99.25% (▲)
Safeguarding Adults Level 1	95%		98.21% (▼)	98.2% (▼)	97.88% (▼)	98.43% (▲)	98.21% (▼)	98.15% (▼)	98.28% (▲)	98.14% (▼)	97.84% (▼)	97.9% (▲)	98.26% (▲)	98.36% (▲)	98.34% (▼)
Safeguarding Adults Level 2	95%		98.89% (▲)	98.97% (▲)	98.88% (▼)	99.05% (▲)	99.04% (▼)	98.87% (▼)	99.04% (▲)	98.77% (▼)	97.18% (▼)	97.32% (▲)	97.43% (▲)	97.48% (▲)	97.26% (▼)
Safeguarding Adults Level 3	95%		97.64% (▼)	97.93% (▲)	97.64% (▼)	99.22% (▲)	99.48% (▲)	98.96% (▼)	98.16% (▼)	97.66% (▼)	96.04% (▼)	96.99% (▲)	97.57% (▲)	98.65% (▲)	99.18% (▲)
% of BCHFT risks managed in line with policy ie risks with in date reviews	92%		85.64% (▼)	97.06% (▲)	83.23% (▼)	100% (▲)	96.23% (▼)	96.15% (▼)	83.44% (▼)	85.06% (▲)	100% (▲)	88.05% (▼)	96.62% (▲)	93.75% (▼)	91.72% (▼)
Percentage of BCHFT risks identified as 12 or above	11%		14.92% (▼)	15.29% (▼)	15.57% (▼)	12.1% (▲)	9.43% (▲)	9.62% (▼)	9.27% (▲)	8.44% (▲)	9.38% (▼)	11.32% (▼)	8.11% (▲)	12.5% (▼)	15.17% (▼)

Quality: Exception Reporting

Trust Scorecard

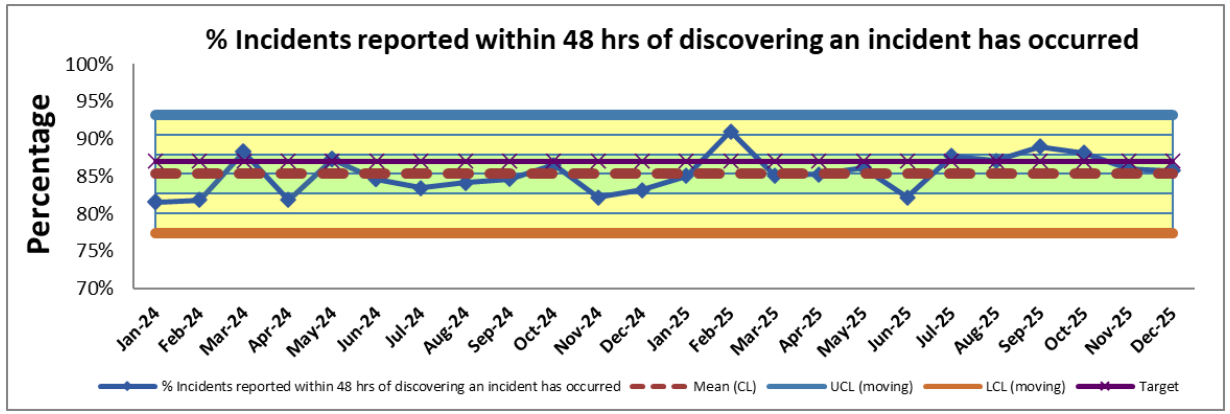
Quality														
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of BCHFT patient safety falls identified as serious	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
BCHFT patient safety Falls per 1,000 bed days - bed based	8		6.46 (▲)	14.34 (▼)	12.79 (▲)	12.83 (▼)	12.01 (▲)	5.2 (▲)	10.7 (▼)	14.57 (▼)	8.91 (▲)	3.35 (▲)	5.98 (▼)	11.83 (▼)	1.02 (▲)
Total number of BCHFT acquired pressure ulcers	15		20 (▼)	24 (▼)	14 (▲)	23 (▼)	21 (▲)	25 (▼)	26 (▼)	20 (▲)	35 (▼)	29 (▲)	40 (▼)	29 (▲)	16 (▲)
% of Category 4 Pressure Ulcers acquired in Bridgewater	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	3.85% (▼)	0% (▲)	2.86% (▼)	6.9% (▼)	0% (▲)	3.45% (▼)	6.25% (▼)
% of Cat 3 Pressure Ulcers acquired in Bridgewater	3%		25% (▼)	4.17% (▲)	14.29% (▼)	13.04% (▲)	23.81% (▼)	8% (▲)	26.92% (▼)	30% (▼)	17.14% (▲)	6.9% (▲)	17.5% (▼)	20.69% (▼)	18.75% (▲)
MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
E Coli- Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Complaints that are managed within the policy timelines	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
National Patient Safety Alerts opened and managed in line with policy timescales	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
% of all policies within review date	90%		95.13% (▲)	97.38% (▲)	95.56% (▼)	96.67% (▲)	97.41% (▲)	98.89% (▲)	97.75% (▼)	97.05% (▼)	96.01% (▼)	96.74% (▲)	98.18% (▲)	97.03% (▼)	95.56% (▼)
IPC assurance audit compliance	90%		80.4% (▼)	83.6% (▲)	82% (▼)	83% (▲)	79% (▼)	73.2% (▼)	84.2% (▲)	89% (▲)	89.6% (▲)	90.8% (▲)	86.2% (▼)	90% (▲)	91.2% (▲)
Record keeping Audit completion compliance	90%		100% (►)			100% (►)			100% (►)			100% (►)			100% (►)
Overall CQC rating (Yearly)	Good		Requires Improvement(►)												Requires Improvement(►)
Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%				61.76% (▼)			93.94% (▲)							

Quality: Exception Reporting

Trust Scorecard

Safeguarding Childrens Level 2		Points below lower control limit
Safeguarding Adults Level 2		Points below lower control limit

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% Incidents reported within 48 hrs of discovering an incident has occurred	Num	114	101	103	139	143	143	157	128	153	237	239	175
	Denom	134	111	121	163	166	174	179	147	172	269	278	204

Analytical Narrative

We are seeing a mostly consistent trend of data points sitting close to the mean and fluctuating around the target. In the past six months, the target has been met four times and remains achievable.

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

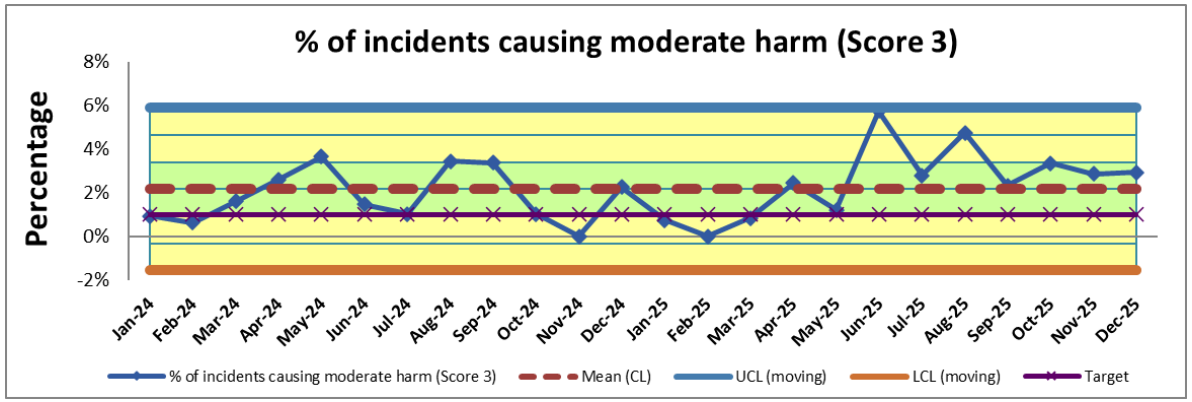
Target: 87% Compliance in December – 85.78%

Operational Narrative

The performance for this target in December 2025, increased to 85.78% compared to 84.78 in November 2025, however this is below the target level of 87%. While this remains within the upper and lower control limits, it is also consistent with the mean level of reporting for this indicator. The time taken to report incidents continues to be reviewed via the Directorate Incident Review and Learning Groups (DIRLG) and monitored at PSIRFaLP with delays being challenged to understand the delays and to promote learning.

The need to report incidents within 48 hours of discovery, is a key element of the Trust's Incident Reporting Policy and is covered in the Trust's in house training offers. To improve access to the training, in addition to existing face to face delivery, several sessions will be delivered virtually during February and March 2026.

Quality: Exception Reporting



	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of incidents causing moderate harm (Score 3)	Num	1	0	1	4	2	10	5	7	4	9	8	6
	Denom	136	113	120	163	166	174	179	147	172	269	278	204

Analytical Narrative

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

% of incidents causing moderate harm (Score 3)

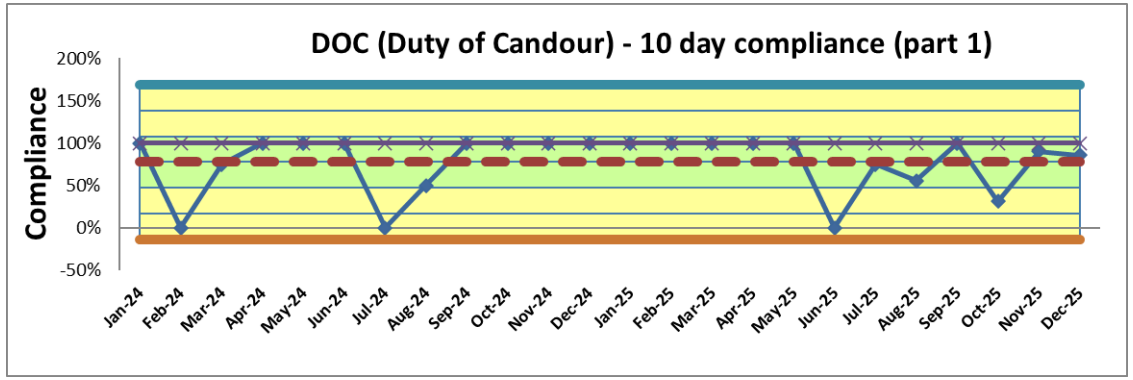
Target: 1% Compliance in December – 2.94%

Operational Narrative

The performance for this indicator has remained above target for the last seven data points, which are not due to any specific factors and suggest common cause variation. The most frequently reported moderate harms in December 2025 were pressure ulcers, with four reported incidents. There were 3 category 3 pressure ulcers and 1 category 4 pressure ulcer. For the other 2 moderate harms, one related to patient who collapsed the second related to complications following a catheter insertion, these case required hospital treatment. Both incidents will be reviewed through the Directorate DIRLGs for any identified learning.

Targeted work is continuing with specific teams in line with the Pressure Ulcer QI Learning Plan. Workstreams progress is monitored at the Pressure Ulcer Priority Group with reporting into PSIRFaLP.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DOC (Duty of Candour) - 10 day compliance (part 1)	Num	1	1	1	1	1	0	6	5	5	6	9	6
	Denom	1	1	1	1	1	4	8	9	5	19	10	7

Analytical Narrative

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

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

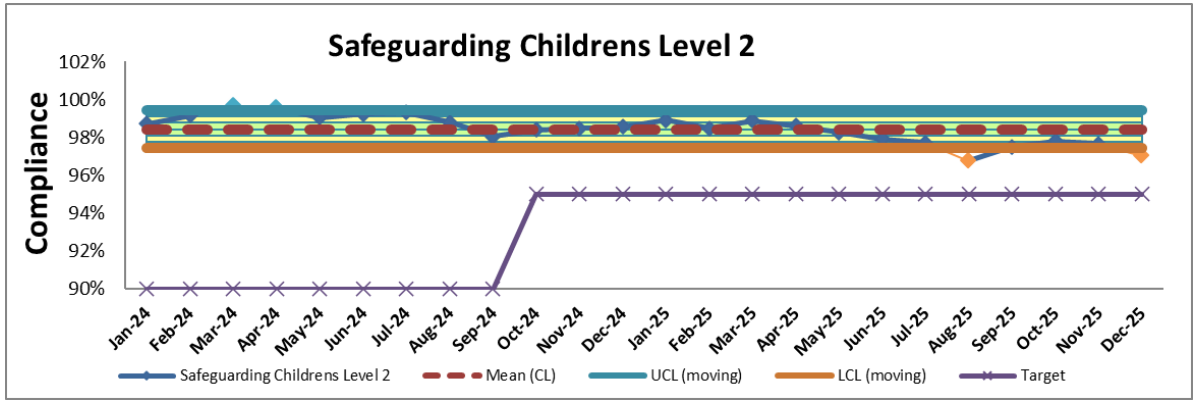
Target: 100% Compliance in December – 85.71%

Operational Narrative

During December 2025, there were 7 incidents that required part 1 Duty of Candour. In six cases this was completed within the Trust's 10-day threshold. One case was completed outside of the Trust's 10-day target, which meant that the Trust discharged its legal obligation in relation duty of candour in this case. All cases in December 2025, were therefore compliant with legal requirements for notifying patients about incidents.

The correct application and recording of duty of candour is included in the role specific training for band 7 staff. Compliance is reviewed at DIRLG meetings with monitoring at PSIRFaLP.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Safeguarding Childrens Level 2	Num	1169	1159	1154	1134	1133	1128	1122	1102	1061	1069	1052	1048
	Denom	1182	1177	1167	1150	1153	1152	1148	1139	1088	1093	1077	1080

Analytical Narrative

The data has sat below or near to the mean for the past year and is again outside the lower control limit. The target remains below the control limits and is achievable.

Safeguarding Children Level 2

Local Target: 95% December Compliance – 97.04%

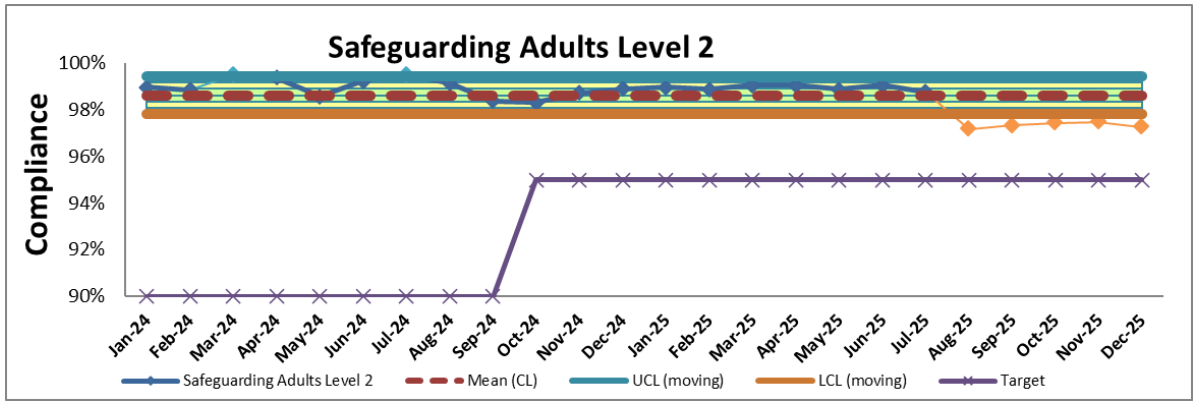
Operational Narrative

Month 9 compliance remains above both the 95% local target and the 90% target set by Cheshire and Merseyside ICB within the quality schedule.

This training is delivered via an eLearning module which staff can access at their convenience via ESR. Review of the data indicates that 19/32 outstanding competencies are staff within Halton adult directorate and a further 6 within Warrington adults.

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

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Safeguarding Adults	Num	1154	1147	1141	1136	1138	1135	1127	1103	1055	1060	1043	1029
Level 2	Denom	1166	1160	1152	1147	1151	1146	1141	1135	1084	1088	1070	1058

Analytical Narrative

The data has sat below or near to the mean for the past year yet is now outside the lower control limit yet still meeting target. There has been a slight decline in compliance the previous two months. We will continue to monitor the performance and reset baselines if required.

Safeguarding Adults Level 2

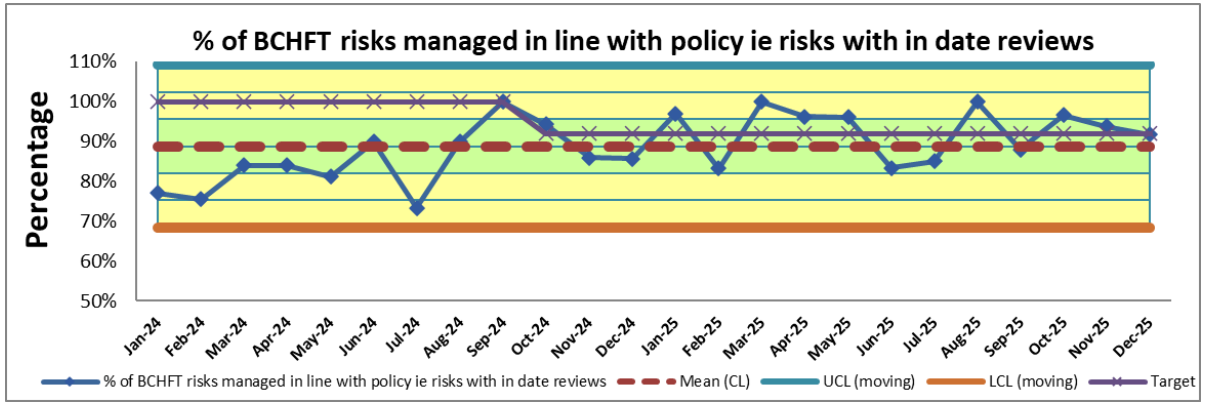
Local Target: 95% December Compliance – 97.26%

Operational Narrative

As with safeguarding children level 2 training month 9 compliance for this training remains consistently above both the 95% local target and the 90% target set by Cheshire and Merseyside ICB within the Quality schedule.

There are currently 29 staff members showing as non-complaint with completion of this eLearning module. These staff are predominately located within Halton and Warrington adult directorates.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of BCHFT risks managed in line with policy ie risks with in date reviews	Num	165	139	157	153	150	126	131	160	140	143	135	133
	Denom	170	167	157	159	156	151	154	160	159	148	144	145

Analytical Narrative

Although all data points are within normal variation, we are seeing an inconsistent trend, with fluctuations around the mean and target. The target remains close to the mean and is achievable.

% of BCHFT risks managed in line with policy i.e. risks with in date reviews

Local Target: 92%

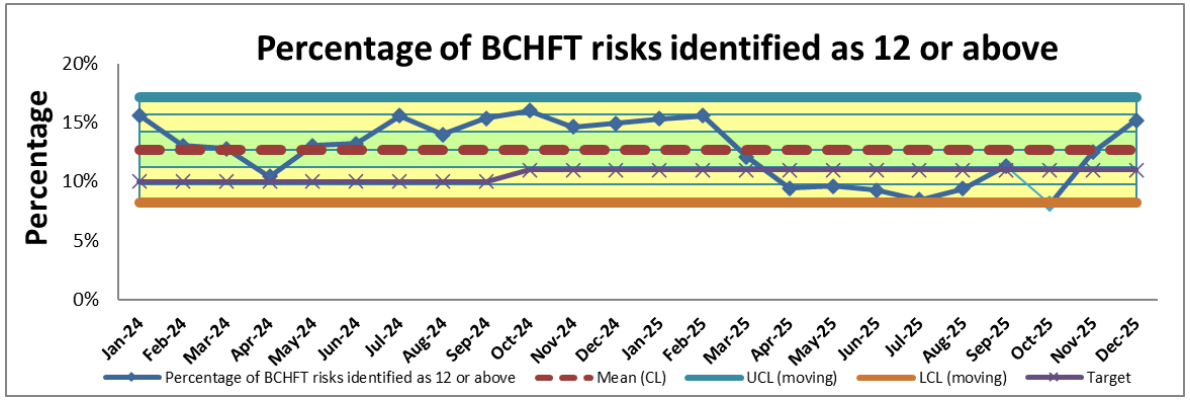
Compliance in December - 91.72%

Operational Narrative

For the last 2 data points, there have been reductions in compliance, in December 2025, the compliance was 91.72% against a target of 92%, while in November 2025, the Trust achieved 93.75% compliance which exceeded the target of 92%.

Compliance is monitored at the Risk Management Council. Risk owners are required to report to the Risk Management Council any risks that have passed their review dates. Further targeted work with Corporate and Operational services leads to provide assurance that the risks are being managed in line with Trust policy has been undertaken.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Percentage of BCHFT risks identified as 12 or above	Num	26	26	19	15	15	14	13	15	18	12	18	22
	Denom	170	167	157	159	156	151	154	160	159	148	144	145

Analytical Narrative

Following a period of improvement, the data remains above target. The target remains within control limits and is achievable.

Percentage of BCHFT risks identified as 12 or above

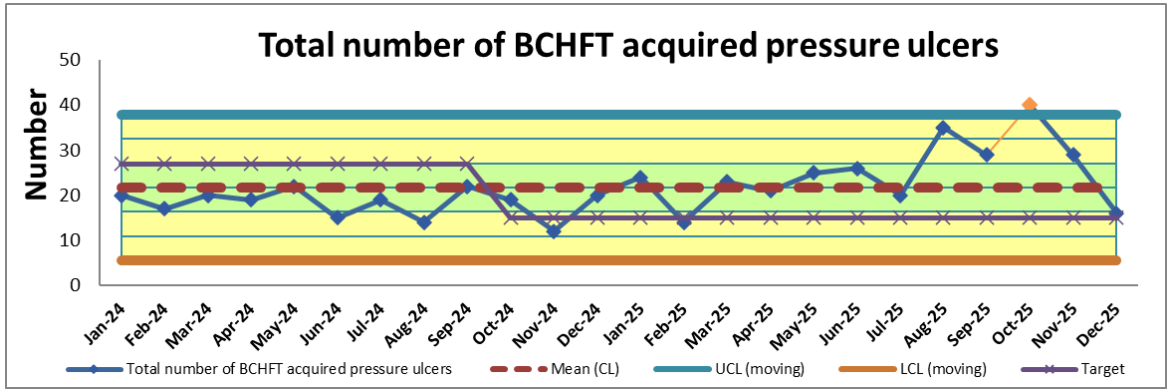
Local Target: 11% Compliance in December - 15.17%

Operational Narrative

The compliance for December 2025, was 15.17% against a target of 11%. This was above the mean level of reporting for this indicator, however it is within the upper control limit. It should be noted that several new risks relating to Dermatology were reported during December 2025 and were the main factor in this increase.

The Trust takes assurance regarding the scoring of it's risks from the risk review process that is carried out at the meetings of the Risk Management Council.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Total number of BCHFT acquired pressure ulcers	Num	24	14	23	21	25	26	20	35	29	40	29	16

Analytical Narrative

The data points usually remain within normal variation yet fluctuate around the mean. The previous two months have seen a steady reduction and is now back within control limits. Pressure Ulcer incidents can also be regraded once reviewed. The target is within limits and is achievable.

Total number of BCHFT acquired pressure ulcers

Target: 15 Compliance in December - 16

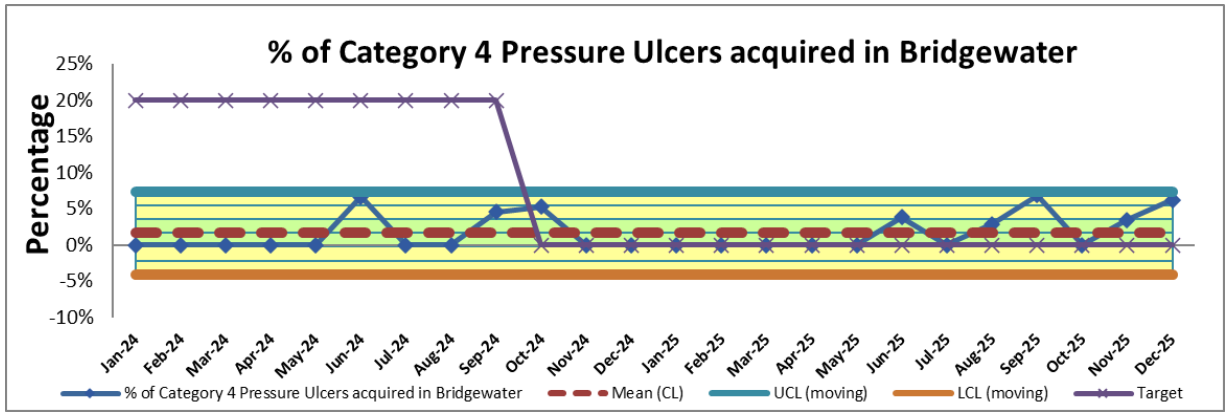
Operational Narrative:

There has been a further in month fall in pressure ulcers for December following the significant rise seen in October. The highest number of reported ulcers remains category two.

Following a rapid review of the data in November actions were initiated within the boroughs to address issues identified with greater scrutiny on the accuracy of the quality of data reported particularly of category 2 pressure ulcers. Borough specific meetings have been initiated with District Nurse Co-ordinators and TVN to identify any underlying causal factors that require actioning.

The findings of the rapid review will be escalated to the Pressure Ulcer Priority Group, and cross referenced against the Pressure Ulcer QI Learning Plan workstream actions and reporting into PSIRFalp for monitoring.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of Category 4 Pressure Ulcers acquired in Bridgewater	Num	0	0	0	0	0	1	0	1	2	0	1	1
	Denom	24	14	23	21	25	26	20	35	29	40	29	16

Analytical Narrative

We expect to see an inconsistent trend due to the low numbers of category 4 pressure ulcers reported. Pressure Ulcer incidents can also be regraded once reviewed. All data points are within standard variation, as is the target.

% of Category 4 Pressure Ulcers acquired in Bridgewater

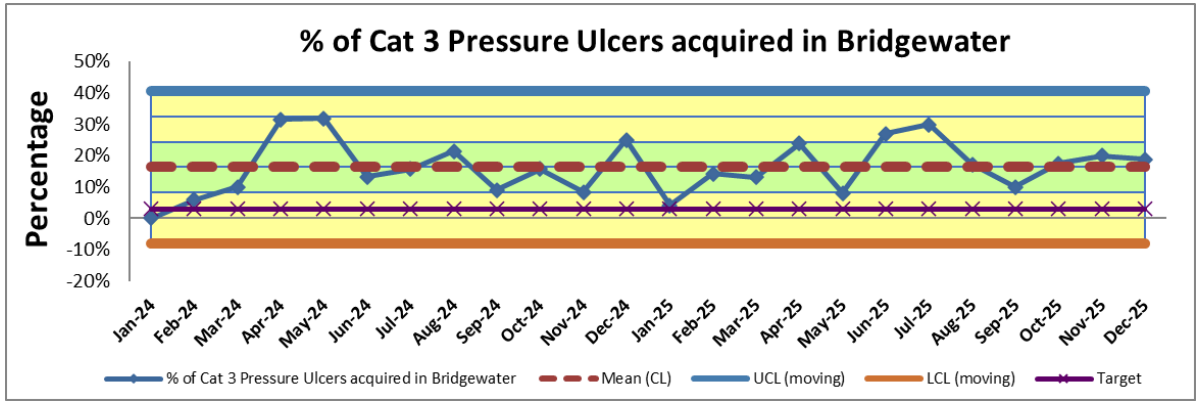
Local Target: 0% Compliance in December – 6.25%

Operational Narrative:

The patient has complex health needs and has regular Tissue Viability Nurse monitoring and support. Despite all interventions the patient's ulcer did deteriorate from a category 3 (72007) to a category 4 pressure ulcer.

A rapid review has been completed and shared with the pressure ulcer priority group to identify any new learning.

Quality: Exception Reporting



KPI Name	Unit	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of Cat 3 Pressure Ulcers acquired in Bridgewater	Num	1	2	3	5	2	7	6	6	3	7	6	3
	Denom	24	14	23	21	25	26	20	35	30	40	30	16

Analytical Narrative

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

% of Category 3 Pressure Ulcers acquired in Bridgewater

Local Target: 3% Compliance in December – 18.75%

Operational Narrative:

The inconsistent trend in category three pressure ulcer incidence remains within standard variation, although a reduction in month. There was 1 incident in the Halton Borough and 2 in the Warrington borough across different teams.

The three incidents will be benchmarked against the Pressure Ulcer QI Learning Plan to identify any themes and actions identified for improvement.

Quality: Exception Reporting

Dec-18	Requires Improvement
Dec-19	Requires Improvement
Dec-20	Requires Improvement
Dec-21	Requires Improvement
Dec-22	Requires Improvement
Dec-23	Requires Improvement
Dec-24	Requires Improvement
Dec-25	Requires Improvement

Overall CQC rating (Yearly)

Target: Good

The CQC report was published 17th December 2018 with an Overall rating of Requires Improvement.

People

Executive Summary

Three out of four People indicators are shown as red in December 2025.

The three indicators which were red in December are as follows:

- Staff turnover (rolling) – Improvement in Month
- Sickness absence rate (Actual) – Deterioration in Month
- % of staff with a current PDR – Deterioration in Month

People

Trust Scorecard

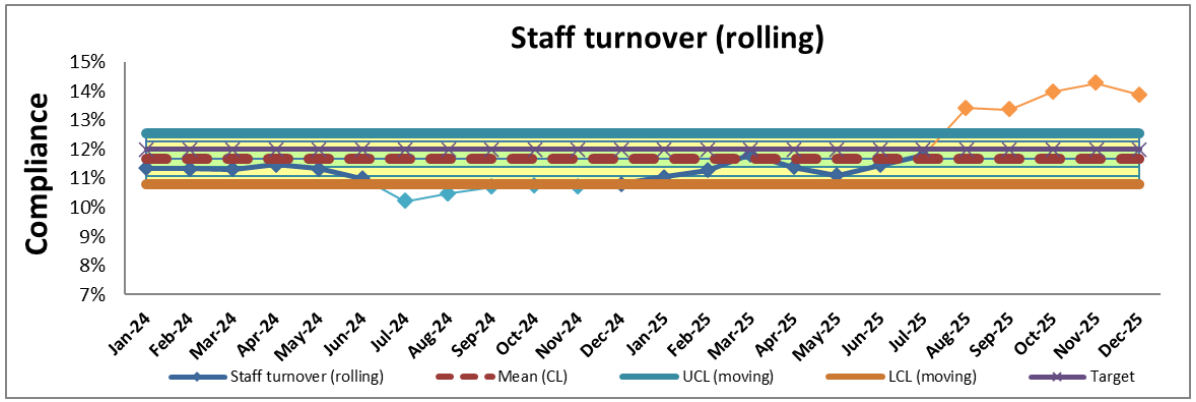
People														
KPI Name	Target	Trend Line	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Staff turnover (rolling)	12.00%		10.81% (▼)	11.06% (▼)	11.28% (▼)	11.83% (▼)	11.38% (▲)	11.1% (▲)	11.46% (▼)	11.79% (▼)	13.42% (▼)	13.35% (▲)	13.97% (▼)	14.28% (▼)	13.87% (▲)
Sickness absence rate (Actual)	5.50%		7.32% (▼)	7.97% (▼)	6.23% (▲)	6.33% (▼)	6.91% (▼)	6.57% (▲)	6.96% (▼)	7.27% (▼)	7.93% (▼)	8.15% (▼)	8.49% (▼)	8.15% (▲)	9.31% (▼)
% of staff with a current PDR	85.00%		87.37% (▼)	87.12% (▼)	87.91% (▲)	88.18% (▲)	87.43% (▼)	86.68% (▼)	85.14% (▼)	82.06% (▼)	83.23% (▲)	81.32% (▼)	83.34% (▲)	84.06% (▲)	83.17% (▼)
% Overall Mandatory Training Compliance	85.00%		95.56% (▼)	95.77% (▲)	96.11% (▲)	96.58% (▲)	96.97% (▲)	97.13% (▲)	96.69% (▼)	96.35% (▼)	96.14% (▼)	95.93% (▼)	95.81% (▼)	95.6% (▼)	94.95% (▼)

People

Trust Scorecard

Staff turnover (rolling)		Points above upper control limit
Sickness absence rate (Actual)		Points above upper control limit

People: Exception Reporting



Analytical Narrative

We are now above target and outside of the control limit due to the School Aged Immunisation Teams TUPEing out of the Organisation in August 2025. We will continue to monitor this and reset the control limits if required.

Staff turnover (rolling)

Local Target: 12%

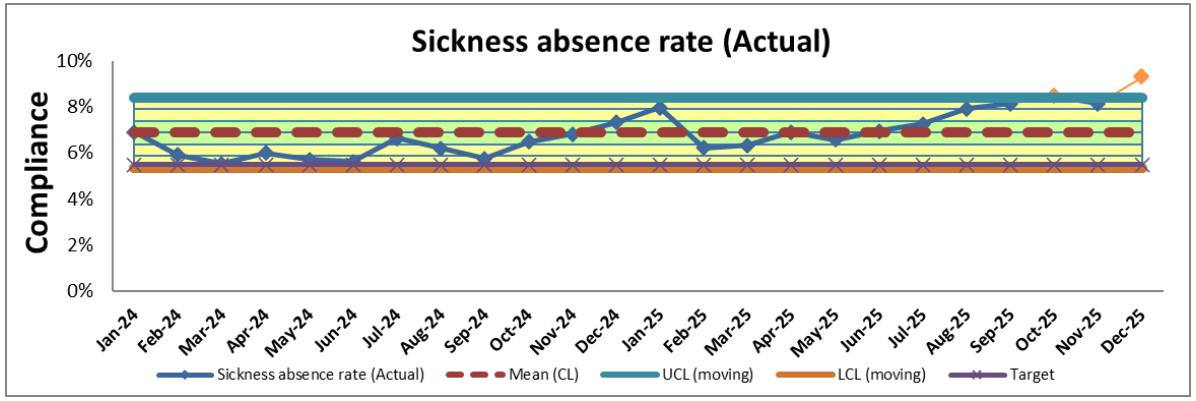
December compliance – 13.87%.

Operational Narrative

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

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

People: Exception Reporting



Analytical Narrative

We are now seeing an increasing trend, remaining above target and outside of control limits. We will continue to monitor this.

Sickness absence rate (Actual)

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

December compliance – 9.31%

Operational Narrative

Data is now outside the control limits from December 2025 and has remained above target for some time.

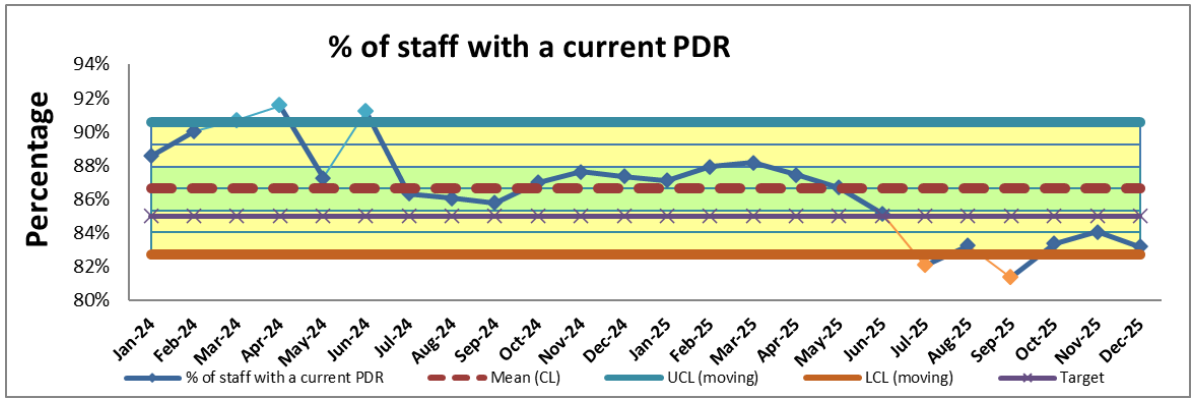
Monthly absence increased to 9.31% in December 2025 from 8.15% in November 2025

Anxiety, Stress and Depression, Cold/Flu and Gastrointestinal reasons for absence have shown an increase in December 2025.

A full review of sickness absence has been completed by the HRBPs and Managers and learning and improvements have been identified to provide further support to managers as part of earlier interventions. Actions are in progress including updating opening and closing sickness in a timely manner and HR surgeries with supporting managers on use of the attendance management decision making guides after every second absence.

The top 10 services have been identified within each borough and weekly intervention support will be in place to support the teams.

People: Exception Reporting



Analytical Narrative

The indicator has been on a downward trend since April 2025 and has fluctuated around the lower control limit in recent months, remaining below target. The target remains within control limits and is still achievable. We will continue to monitor this and reset the control limits if required.

% of staff with a current PDR

Local Target: 85%

December compliance – 83.17%

Operational Narrative

PDR rates are being monitored via the DLTs and Performance Council with weekly reporting available via the Qlik system.

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

Finance

Month Nine Finance Report

1.1 Financial performance

Summary Performance Month 09 2025-26	Month 9 Plan	Month 9 Actual	Month 9 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.34)	(8.31)	△ (0.04)	(75.23)	(75.23)	△ (0.01)	(100.27)	(100.27)
Expenditure - Pay	5.97	5.85	● 0.12	54.47	54.30	● 0.17	72.37	72.37
Expenditure - Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Expenditure - Agency	0.08	0.01	● 0.07	0.88	0.21	● 0.68	1.10	1.10
Expenditure - Non Pay	2.52	2.63	△ (0.11)	22.75	23.47	△ (0.72)	30.84	30.84
Expenditure - Non Pay - Integration Savings	0.00	0.00	● 0.00	0.00	0.00	● 0.00	(2.90)	(2.90)
EBITDA	0.23	0.19	● 0.05	2.87	2.75	● 0.12	1.14	1.14
Financing	0.03	0.08	△ (0.05)	0.29	0.42	△ (0.12)	0.39	0.39
Normalised (Surplus)/Deficit	0.26	0.26	△ (0.00)	3.16	3.16	△ (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	0.26	0.26	△ (0.00)	3.16	3.16	△ (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	0.26	0.26	△ (0.00)	3.16	3.16	△ (0.00)	1.53	1.53

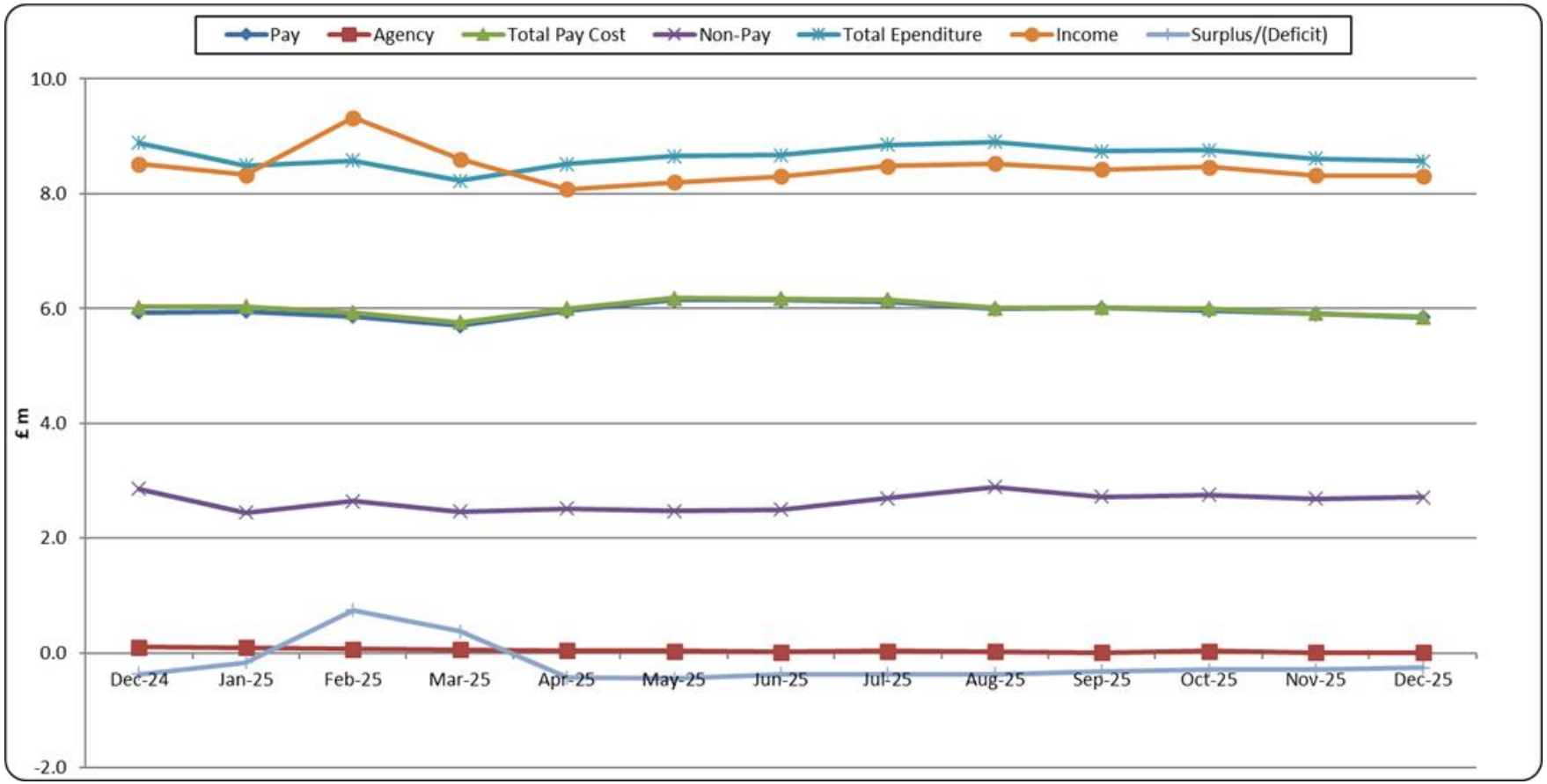
Savings - CIP Levels 1 & 2	0.50	0.51	● 0.01	3.99	4.03	● 0.04	5.48	5.48
Savings - CIP Level 3	0.00	0.00	● 0.00	0.00	0.00	● 0.00	2.90	2.90
Capital	0.25	0.03	● 0.22	1.16	0.69	● 0.48	2.10	2.10
Cash	6.66	3.30	△ (3.36)	6.66	3.30	△ (3.36)	6.85	6.85
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance △ Adverse Variance

Finance

Key Headlines

1.2 Rolling Run Rates 2024/25 to 2025/26



Finance

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

- The Trust is reporting a deficit at Month nine of £3.16m, in line with plan.
- The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3).
- The Trust is reporting a savings achievement of £4.03m against a plan of £3.99m.
- Income is £75.23m against a plan of £75.23m.
- Expenditure is £78.39m against a plan of £78.39m.
- Pay is £54.30m against a plan of £54.47m.
- Agency spend is £0.21m against a plan of £0.88m.
- Non pay expenditure is £23.47m against a plan of £22.75m.
- Capital charges are above plan by £0.12m.
- Capital expenditure is £0.69m at month nine, planned spend is £1.16m.
- Cash is £3.30m.

Finance

3. FORECAST OUTTURN AND KEY POINTS TO NOTE

3.1 At month nine, the Trust is reporting a deficit of £3.16m, in line with the planned deficit of £3.16m. At this stage, the forecast outturn reported position is equal to the plan – a deficit of £1.53m. Planned outturn cannot be amended at this time. Any changes to plan and planned outturn are likely to be actioned in month 10.

3.2 It should also be noted that as at month nine, there are £54k of savings directly recorded against integration. Additionally, the savings schemes already delivering are being reviewed to identify where integration has contributed to the scheme delivering savings, where identified. Joint workstreams with WHH continue to work on identifying integration savings opportunities.

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

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

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

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

Appendix

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

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Monthly Clinical Harms Review Report

Information Team

Reporting Period: Month 9

52 + week waits and outstanding clinical harm reviews

Services with patients waiting over 52 weeks (data as at 02/01/2026)			
Directorate	Service Line	Total over 52 weeks	Number of outstanding
Warrington Adult	Dermatology Service	735	733
Warrington Adult	Podiatry Service	46	18
Halton Adult	Podiatry (Halton)	60	27
Warrington Child	Warrington Community Paediatricians	659	285
Halton Child	Halton Children's Therapies and Community Paediatricians	787	392
Dental	Dental	2	1

Data Quality Issues

Harm reviews completed in month

Number of harm reviews completed in reported month			
Directorate	Oct-25	Nov-25	Dec-25
Warrington Child	15	11	13
Halton Child	0	0	32
Warrington Adults	36	5	0
Halton Adults	2	9	3
Dental	91	69	61

Harm levels recorded in reported month					
Directorate	**Low Harm**	**Moderate**	**Severe**	**Fatal**	**Total**
Warrington Child	1	0	0	0	**1**
Halton Child	0	0	0	0	**0**
Warrington Adults	0	0	0	0	**0**
Halton Adults	0	0	0	0	**0**
Dental	0	0	0	0	**0**

Harms recorded as PSII's in reported month					
Directorate	**Low Harm**	**Moderate**	**Severe**	**Fatal**	**Total**
Warrington Child	0	0	0	0	**0**
Halton Child	0	0	0	0	**0**
Warrington Adults	0	0	0	0	**0**
Halton Adults	0	0	0	0	**0**
Dental	0	0	0	0	**0**

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

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NHS Oversight Framework

File created on: 16/01/2026

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
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2025 01	2:Flexible support					
	MH Provider	S035a: Overall CQC rating	Month	2025 01	2 -Requires improvement					46/62
	MH Provider	S059a: CQC well -led rating	Month	2025 01	2 -Requires improvement					48/62
	MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual; calendar year	2023	6.78%	9.94%		↓		21/66
	MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual; calendar year	2023	13%	17.7%		↓		26/66
	MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, .	Annual; calendar year	2023	16.4%	25.1%		↓		3/66
	MH Provider	S067a: Leaver rate	Month	2024 12	5.91%	6.94%		↓		7/67
	MH Provider	S068a: Sickness absence rate	Month	2024 09	5.81%	5.01%		↓		47/67
	MH Provider	S069a: Staff survey engagement theme score	Annual; calendar year	2023	7.29/10	6.89/10		↑		16/66
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2023	10.7%		12%	↑	↑	26/64
	MH Provider	S071c: Proportion of staff in senior leadership roles who are disabled	Annual; calendar year	2023	7.14%		3.2%	↑		13/64
	MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientatio.	Annual; calendar year	2023	60.8%	56.4%		↓		35/67
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2023	7.56/10	7.09/10		↑		15/66
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2023	7.1/10	6.46/10		↑		11/66
	MH Provider	S133a: Staff survey - compassionate and inclusive theme score.	Annual; calendar year	2023	7.76/10	7.3/10		↑		13/66
	MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual; calendar year	2023	1.4		1	↑		26/64
	MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1		1	↑		35/64

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

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Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		**Report to:**	Board of Directors
Date of Meeting:	18 December 2025		Date of next meeting:	10 February 2026 – Committee in Common
Chair:	Elaine Inglesby, Non-Executive Director and Committee Chair		Quorate (Yes/No):	Yes
Attendance:	**Present:** Elaine Inglesby, Committee Chair and Non-Executive Director (from item 103/25ii) Gail Briers, Non-Executive Director (in the Chair to item 103/25ii) Abdul Siddique, Non-Executive Director Paul Fitzsimmons, Medical Director Ali Kennah, Chief Nurse Dan Moore, Chief Operating Officer	**In attendance:** Jeanette Hogan, Deputy Chief Nurse Mel McLaughlin, Acting Director of Operations Susan Burton, Associate Chief Nurse Suzanne Mackie, Director of Quality Governance Jan McCartney, Director of Corporate Governance Lynda Richardson, Board and Committee Administrator **Observers**: Jonathan Berry, Public Governor	**Key Members not present**:	**Apologies received from**: Mark Charman, Assistant Director Transformation Tania Strong, Interim Assistant Director of People and Organisational Development

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		**Overall Incident Reporting** Reporting increased in September and October, partly due to strengthened processes through the Director of Incident Review Groups (DIRLGs). October saw 252 incidents, exceeding the control limit (225), interpreted as a positive sign of improved quality checking. Pressure ulcers and moisture lesions remained the most frequently reported incident types. 16 incidents were graded as moderate harm; all others were near-miss, insignificant, or minor. **Timeliness and Governance** The Trust achieved 88% compliance with reporting incidents within 48 hours for both months (target: 87%). Only 30 incidents were awaiting managerial review; saved-for-later incidents reduced to nine. 93% of incidents were closed within the 30-day policy timeframe; corporate services had the highest non-compliance and will be addressed at the next Corporate DIRLG. Implementation of Purpose T at Padgate House progressing and will extend Trust-wide **Harm-Grading Audit** Audit of 220 non-pressure-ulcer incidents found 98.7% correctly graded. **Training Compliance** 223 Band 7 staff required training; 55% completed, 28% booked, 17% not booked. Non-compliance escalated to the Acting Director of Operations. **Pressure Ulcers** October saw a spike: 46 pressure ulcers, above the upper control limit. Category 2 ulcers were most common (23 in September; 37 in October). Eight cases were re-categorised following data-quality review, contributing to variation. **Medication Incidents** Slight increase (10 in September; 13 in October), but all resulted in low or no harm. Improvements underway, including enhanced prescribing-template prompts. **Falls**	The Committee noted improvements in incident-reporting compliance and accepted the report as assurance of effective processes, while recognising ongoing actions to strengthen compliance and governance.

Committee Chair's Report

			Falls reduced significantly: 12 incidents in both September and October (down from 37 in June). Padgate House also saw reductions. All falls resulted in insignificant or minor harm. Patient education and personalised falls-prevention plans are being strengthened. **Learning Responses** 29 learning responses commissioned; 21 approved by DIRLGs. **Duty of Candour** September: 6 cases, all compliant with 10-day timescales. October: 20 cases (many historical); only 6 met timescales. Delays often due to difficulty contacting relevant persons. **Clinical Harm Reviews** 263 reviews completed; only 7 cases showed low harm, the rest no harm. **Committee Discussion and Concerns** Assurance noted on improved harm categorisation, though historical mis-categorisation leading to a death remained a concern. ADHD prescribing protocol feasibility questioned; update to be provided in next report. Clarification sought on harm grading for a fatal osteomyelitis case; governance processes to be reviewed for consistency. WHH governance route described, with emphasis on ensuring serious incidents are not lost in reporting lines. Joint governance processes expected from February 2026.	
Risks related to Quality and Safety	2		**Overall Position of Corporate Risks** The report covered all corporate risks scoring 12+ relating to quality and safety, incorporating outputs from the October and November Risk Management Councils. Proportion of corporate risks linked to quality and safety increased from 56% (October) to 67% (November) due to a reduction in total risks (from 18 to 12), not worsening risk. Demand and capacity remained the dominant theme across risks. **New and Adjusted Risks** Two new corporate risks were escalated in October: Staffing in Halton district nursing out-of-hours. Reduction in Warrington virtual ward beds. No risks fully closed, but:	The Committee received and discussed the report and would receive updates on key areas to the next meeting.

Committee Chair's Report

			Halton palliative care staffing risk reduced to a score of 9 and removed from corporate register. Halton district nursing out-of-hours risk (score 12) re-mapped due to dual relevance to staffing and patient safety. A broader exercise to moderate risk mapping against the BAF will begin from December 2025. **Assurance Level Review** Risk Management Council reviewed assurance levels (significant / moderate / limited). Two risks originally judged as limited assurance—dental services and neurodevelopmental pathway—were upgraded to moderate assurance following evidence review. Risk 3376 (NDP pathway) had its consequence score increased to "major", bringing the total score to 12. **Community Equipment Service** Two risks (3377 and 3398) remained at limited assurance. The service holds eight risks scored 9, indicating systemic issues. A new risk scored 15 was raised relating to demand and capacity pressures. Significant delays in servicing equipment such as mattresses, hoists, bed rails, beds, bath lifts, slings. High-risk items (e.g., suction machines, nebulisers) are serviced on time. The service cannot quantify the total volume of overdue equipment or provide an improvement trajectory. Assurance remains limited until this gap is resolved. **Committee Concerns** The lack of visibility, triangulation, and escalation of Community Equipment Service risks. Risks had been previously viewed in isolation. Interdependencies and cumulative impact only became clear after recent review. Governance and escalation had been insufficient. A new Associate Director is now overseeing and consolidating these risks. **Assurance Gaps and Required Actions** The Committee agreed that there was further information would be required for assurance around: Whether unserviced equipment was causing patient delays. Whether out-of-date equipment remained in use. How high-risk equipment categories were defined and by whom.	

Committee Chair's Report

			A comprehensive update on the Community Equipment Service was requested for the next meeting, including: Full quantification of overdue equipment. Risk categorisation methodology. Clear improvement timeline. Issues with Risk Descriptors and Scoring Risk wording focused on reputation rather than patient/staff safety. Inconsistent risk scoring (e.g., NDP pathway previously rated 20 but shown as 15). Lack of October/November narrative in the report despite being referenced. Dental services risk reduction (12 → 9) lacking supporting information. The Committee questioned whether risks were being rated too low and whether the Risk Management Council was applying consistent methodology. It was agreed improvements were needed in risk oversight, scoring, and governance, noting that governance teams would be combined. **Next Steps** A revised, clearer, and accurate risk management report is required for the next meeting which would include correct scoring, accurate mapping, inclusion of all high-rated risks.	
Community Paediatrics/Neurodevelopment Action Plan	2		The Committee received a comprehensive report which is appended to this report (as appendix 1) for Board's oversight as requested as the December Board meeting. The Committee discussed the potential benefits of shared care around ADHD prescribing which could release substantial clinical time. Discussions were taking place around this internally with work to quantify this information. It was also noted that Ambient Voice Technology had the potential to dramatically increase clinical productivity.	The Committee received the report and was assured that risks were being managed and mitigated appropriately.
Report from Quality Council	2		**Overall Quality Council Position** Directorate submissions showed ongoing quality-improvement progress, but also highlighted persistent risks and operational challenges. The November Quality Council meeting focused heavily on audiology, Adult Services, and clinical holds governance. **Children's Services – Audiology** A substantial update was provided on audiology across Warrington, Halton, and St Helens. The Trust has an agreed improvement plan with the ICB addressing six areas of concern, with monthly oversight meetings now in place.	

Committee Chair's Report

			Warrington's review has been received; Halton and St Helens' reviews are still awaited despite repeated requests. The ICB expressed assurance during their site visit, and formal letters now confirm: Both BCH and WHH audiology services sit in the low-risk, high-quality quadrant. No further national follow-up is required, though the ICB will continue monitoring. Committee members welcomed this as a significant and positive transformation. **Adult Services – Areas of Progress and Concern** Reduction in out-of-date patient information leaflets. Clearing of outstanding Quality Impact Assessments (QIAs). Five of eight delayed policies have now been completed and merged. Concerns Quality Council identified the need for stronger focus on: Overdue complaints, Outstanding action plans, Clinical audit completion, NICE guidance trajectories. Adult Services required to submit clear completion trajectories for NICE guidance and audit actions by January. Community Equipment Stores and Dermatology issues contributed to limited assurance for the Adults Directorate. Limited assurance themes aligned with wider concerns raised earlier in the meeting about system-wide risk management. **Community Equipment Stores** Some progress noted, but capacity shortfalls and escalating challenges remain significant. The issues contributed directly to the limited assurance rating for Adult Services. **Clinical Holds – Governance and Assurance** Following a Committee request, the report now includes a detailed explanation of: Historical use of clinical holds (mainly in Community Dental and LD Matron services). Benchmarking with neighbouring trusts. 2024 policy changes and strengthened governance. A specific incident category for clinical holds has been added to Ulysses, improving visibility and enabling safeguarding thematic review. Safeguarding now reviews every clinical hold to ensure: Mental capacity assessments are completed, Best-interest decisions are documented, Least-restrictive practice is applied, Incidents are also reviewed at Directorate Incident Review and Learning Groups, embedding the process. The Committee felt assured by the strengthened approach and improved visibility. The Committee requested: Data on the number of clinical hold incidents	

Committee Chair's Report

			Safeguarding's assessment of compliance. Information would be included in the next Quality Council report.	
IQPR	2		**Overall Quality Performance** Eight quality indicators were rated red for the reporting month. **Moderate Harm Incidents** 11 moderate-harm incidents occurred (target: 1%; actual: 4.3%), marking the fifth consecutive month above expected levels. Pressure ulcers accounted for most cases, with seven incidents in district nursing. Wider learning and mitigation actions are being addressed through the Pressure Ulcer Improvement Plan. **Duty of Candour Compliance** Compliance dropped to 31.58%, but this was due to an exceptional one-off spike. 13 historical pressure-ulcer incidents were regraded during harm reviews, triggering retrospective Duty of Candour and distorting performance. Present-day processes were not at fault; performance is expected to normalise. Duty of Candour requirements have been strengthened in the new Band 7 incident-management training. **Training Compliance** Information Governance training remains below the 95% target, but performance has improved for two consecutive months and is on an upward trajectory. Safeguarding Adults Level 2 remains above target, with an ambition to exceed 95% consistently. **Falls Performance** Falls data shows month-to-month variation, but remains within control limits. Three incidents were controlled descents with insignificant or minor harm. Improvement work continues, especially at Padgate House, where falls care bundles and post-falls assessments are fully in place. **Pressure Ulcers – Significant Concerns** October saw a major spike: 46 pressure ulcers reported (target: 15). A rapid data review found: Most increases were in Warrington District Nursing. Category 2 ulcers reduced from 29 to 18 after data cleansing. One reported Category 4 ulcer was reclassified and removed. Seven Category 3 ulcers were validated, with no new learning beyond existing	

Committee Chair's Report

			improvement actions. IQPR figures have been updated to reflect corrected classifications. **IPC Assurance Audit** Compliance dipped to 86.2% (target: 90%), driven by lower performance in Halton Adults and Warrington Children's. Targeted operational work is underway, with improvement expected in November. **Indicator Design and Target Setting** The percentage-based target for Category 3 pressure ulcers was challenged, with a suggestion made that a numerical annual target was used instead. It was clarified that the indicator originated from legacy performance tools and could be revised locally. IQPR architecture was being reviewed as part of quality alignment with WHH. It was highlighted that some indicators—especially pressure ulcers—may need separate reporting for community vs acute services going forwards, given differing risk profiles.	
Dermatology SBAR – update	2		**Activity, patients, and harm** Data correction: An error in the slide deck figures (page four) was acknowledged and corrected in the verbal update. 181 patients issue: Of 181 patients not recorded on Somerset in October, all but one had been seen or declined; the remaining patient is in hospital and an appointment is being arranged post-discharge. Current pathway position: 52 patients seen, treated, and downgraded. 92 discharged. 32 remain on the skin cancer pathway (down from 37). Harm so far: Of ten histologies reviewed, no harm identified; harm reviews on other incidents show low or minimal risk only, with patients awaiting surgery results. **Causes of the problem and service pressures** Reduced clinical capacity: Clinical sessions dropped from 47 to 33, significantly contributing to the backlog and pathway issues. Staffing pressures: Clinical and administrative staff sickness, plus admin staff covering multiple roles, led to incomplete pathway tasks and contributed to incidents. Digital change impact: Implementation of Skin Analytics is under review as a contributing factor and part of the improvement work.	The Committee requested that updates continue to be provided. The Committee agreed a 'look-back' would be provided on QIAs from the last 12 months. This would include areas considered to be particularly high risk.

Committee Chair's Report

			Ongoing demand pressure: Two-week wait referrals continue to exceed capacity, requiring active management and system-level support. **Performance standards and recovery actions** Faster Diagnosis Standard (FDS) impact: FDS performance reduced to 67% (previously reported as 80%) due to the 181 patients. Aim to reach 80% by end of December, with additional clinical sessions diverted to the two-week wait pathway. Targets and funding: Cancer Alliance funding of £75,000 to support recovery. Targets: 84% FDS and 85% 62-day wait, rising to 90% FDS in 2026/27. Recovery plan: Plan in place to reduce >52-week waits by year-end, supported by ICB transformation funding for an extra 16 sessions per week (capacity for 128 patients). Early signs show a reduction in long waits since 1 December. External oversight: Cancer Alliance and external cancer manager (WHH) involved in reviewing the two-week wait pathway and monitoring FDS and 62-day standards. **Additional incidents and risk profile** Incident 1: 48 patients upgraded but not entered onto Somerset RPTL; five breaches of the 31-day standard (all seen within 31–62 days). Incident 2: Seven patients on Somerset without appointments; some seen within target, some discharged, others still on pathway. Harm assessment: Harm reviews show one low-risk and four minimal-risk cases; no evidence of significant harm to date, but close monitoring continues. Communication with patients: Letters sent to affected patients in an open and transparent way, though not under duty of candour as no harm is currently evidenced. **Governance, QIA concerns, and assurance gaps** QIA process issues: A QIA was submitted in December 2024 for reduced clinical sessions, with reviews in November 2025 identifying increased operational and financial risks. Concerns raised that earlier risk scoring and review were inadequate and that a scheduled July 2025 review did not occur.	

Committee Chair's Report

			A new QIA is being prepared to reflect the updated service model and risk profile. Strengthened current process: All QIAs from both organisations now go through a single, weekly panel with clinical, operational, and financial oversight, with the Chief Nurse and Medical Director providing oversight. **Retrospective assurance gap**: The Committee shared its concerns about the robustness of QIA reviews over the past 18–24 months, not just the present. Proposal agreed to conduct a retrospective review of QIAs over the past 12 months to ensure patient safety and restore confidence in risk management. **Dermatology concerns and future risk** Longstanding service fragility: BCH Dermatology has a history of cyclical investment/disinvestment, leading to predictable fluctuations in performance and waiting lists. Previous improvement efforts have not delivered sufficient, sustained capacity or waiting list reduction. Risk foreseeability: Committee members stressed that the dermatology issues were foreseeable even without a formal QIA, especially given reliance on a small specialist workforce vulnerable to sickness. Active work was taking place to match capacity to demand, including reviewing inclusion/exclusion criteria and collaborating across BCH and the wider system. External perspectives and Cancer Alliance support are being used to strengthen cancer pathway management. There is recognition that without prompt and sustained action, backlogs could quickly re-emerge, so the situation is improved but not yet fully resolved.	

Committee Chair's Report

Review of accuracy of criteria associated with incident reporting	2		**Purpose and Scope of the Review** A review was undertaken in response to concerns about inconsistent harm grading across services. It examined all patient safety incidents (excluding pressure ulcers and moisture lesions) from April–September 2025. Total incidents: 1,405; after exclusions: 871. A 25% random sample (220 incidents) was reviewed, ensuring representation across all directorates. **Accuracy of Harm Grading** 98.7% accuracy found in harm grading. Only two incidents showed discrepancies: both originally graded as low harm but narratives suggested moderate harm. Both occurred in the Adults Directorate and were third-party incidents. Misclassification occurred because: Initial harm grading was done before the clinical outcome was clear. Later updates to the narrative were not accompanied by updated harm grading. **Actions Already in Place** Daily governance checks now include routine validation of harm grading, with corrections made promptly. Directorate Incident Review Groups (DIRGs) are being strengthened to reinforce oversight. Incident management training has been revised to: Improve understanding of harm levels. Emphasise when harm grading must be updated. Ensure staff understand the harm framework. A condensed training package for Band 5 and below will launch in January 2026, focusing on accurate initial reporting. **Importance of Band 5 Staff Training** Band 5 staff often submit the first incident report. Improving their understanding of harm grading is expected to reduce the small number of discrepancies identified. Audit results show high accuracy already, but enhanced knowledge will strengthen reliability.	The Committee was assured from the report and the explanation and findings.

Committee Chair's Report

			Pressure Ulcer Reporting Concerns Concerns were raised about delays between initial reporting and final harm grading for pressure ulcers. It was confirmed that work was underway to address this. The Committee requested that future reports demonstrate measurable improvement.	
Pressure Ulcer Learning Plan	2		**Overall Progress** Measurement and monitoring processes are now fully embedded, enabling clearer evaluation of the new learning plan and improvement actions. Three recent learning responses were reviewed: One showed no lapse in care. Two identified learning, all aligning with an established theme: the need for strong clinical leadership, accurate assessment, reassessment, and staff support. No new learning emerged beyond this recurring theme. **October Spike in Pressure Ulcers** A significant rise in pressure ulcers was seen in Warrington, especially Category 2. A rapid review found 29 Category 2 ulcers reduced to 18 after data cleansing. The discrepancy was due to data-entry and quality-checking issues, highlighting the need for improved data accuracy and earlier intervention. **New Learning Theme** A new pattern was identified: patient deterioration within seven days prior to ulcer development. This will be added to the improvement plan, with a focus on rapid response to changes in patient condition. **Early-Intervention Opportunities** In 2–3 cases, ulcers developed between scheduled visits for patients on long-term caseloads (e.g., B12 injections every 12 weeks). Where assessments were accurate at the last visit and no lapse in care occurred, no new learning was identified.	The Committee was assured that the work being carried out was comprehensive and directly targeted at the most significant issues.

Committee Chair's Report

			District Nursing Capacity Concerns Warrington district nursing continues to face capacity pressures, reflected in a risk score of 12. Contributing factors include sickness and leave; mitigations include: Cross-team support NHSP temporary staffing Staff well-being measures Weekly oversight meetings are in place with operational leads. **Strengthening Clinical Support** A round-table meeting on 10 December agreed that tissue viability nurses willspend more time working clinically with district nurses. Joint visits will support: Prevention and management of pressure ulcers Embedding training and capability assessments These actions will be added to the improvement plan and monitored. **Caseload Management Issues** Some patients remain on caseloads solely due to having pressure-relief equipment, despite not requiring active nursing input. Routine 12-week visits can lead to unnecessary assessments, diverting staff from patients with genuine clinical need. A review of caseload practices is underway to ensure appropriate, safe, and efficient allocation of nursing resources. Committee members welcomed this focus, noting similar issues observed during visits. The full improvement plan will be reported twice per year, unless urgent issues arise. Future reports to include numbers rather than percentages to show the real trajectory of improvement.	

Committee Chair's Report

Patient Experience Report	2		**Overall Patient Experience Position** No significant concerns required escalation this quarter. Compliments decreased, likely due to reduced activity over the Summer period (notably in School Nursing). Friends and Family Test feedback remained consistently positive. **Complaints and Enquiries** 11 complaints received (slightly fewer than Q1): 5 Adult Services 3 Children's Services 1 Corporate 2 joint complaints 9 MP letters were received, an increase from previous quarters. No new Parliamentary Ombudsman cases; one historical case from 2023 was closed with no further action. **MP Letters and Neurodevelopmental Pathway (NDP) Concerns** Increase in MP enquiries largely linked to Community Paediatrics and the NDP pathway. Discussions with the ICB were taking place about improving communication to families. A system-wide communication is planned across Cheshire and Merseyside to explain pressures, waiting lists, and available support. This will not resolve past complaints but should help reduce anxiety and improve understanding going forward.	
CQC Update report including any CQC enquiries	2		The CQC update is now provided as a formal written paper to strengthen governance, ensure clearer documentation of regulatory activity, and improve oversight. **Recent CQC Engagement** A CQC engagement meeting took place on 15 December with Ali Kennah, Chief Nurse and Paul Fitzsimmons, Medical Director The meeting was very positive, brief, and raised no further questions, indicating strong regulatory confidence in the Trust's current position. **CQC Enquiries** Three enquiries were received during the period, all triggered by external concerns forwarded by CQC. The Trust responded to all three in full.	

Committee Chair's Report

			CQC has formally closed all enquiries, with no further action required. **Unregistered Dental Premises** On 17 December, the Trust discovered that one dental site was not CQC-registered, despite delivering regulated activity. The issue dated back to 2015, when multiple dental locations were deregistered nationally due to a misinterpretation that separate registrations were no longer required. Current regulations make clear that this site should be registered, creating an urgent compliance issue. Immediate actions were being taken, including a full review of all dental locations (including those in acute hospitals) to confirm correct registration status. The Associate Director of Operations for Dental Services had been alerted to assess whether services can safely continue at the location while registration is corrected. The Chief Nurse was contacting the Trust's CQC Engagement Manager to determine: • Whether immediate restrictions are required. • Whether services can continue safely during the registration process. • The issue is being treated with highest urgency due to regulatory implications. The Committee requested: A detailed explanation of how the registration lapse occurred. Assessment of whether this reflects a wider systemic problem. Confirmation of compliance and safety at the location. A full Trust-wide status update on all dental premises. A comprehensive update, including root cause analysis and full location review, will return to the next meeting. **Dermatology Issue** It was confirmed that dermatology service concerns had been discussed verbally at the engagement meeting and that CQC was fully sighted and satisfied with how the Trust is managing the situation.	
Learning from Deaths	2		**Deaths Reviewed**: 13 deaths occurred in the reporting period, all meeting the threshold for a structured Learning from Deaths review. No evidence of harm or failure in BCH care or systems was identified in any case. The most substantial learning came from a child death review. Central issue: a gap in information-sharing between CAMHS and the	The Committee received the report for assurance. It requested that a future summary of the actions and any remaining gaps be provided for information

Committee Chair's Report

			Neurodevelopmental Pathway (NDP). Although this omission did not contribute to the death, it exposed a system weakness in how risk information is shared and escalated. **Actions Taken**: CAMHS and NDP teams have begun implementing: A standardised approach for telephone follow-ups. Consistent risk prompts across services. Clear guidance for escalating risk-related information between teams. These improvements aim to strengthen visibility of risk and ensure safer cross-service communication. **Coroner's Position**: BCH provided a formal written statement to the Coroner. The Coroner raised no concerns about BCH's care. Accepted the Trust's statement as fully addressing all queries.	once improvements are fully embedded.
Quality Impact Assessment (QIA) Report	2		The Committee received the report and noted the content. It would await the look back requested earlier in the meeting before any further detail was requested.	
Risk Strategy 2022-25	1, 2		The Committee received and reviewed the Risk Management Strategy which contained no significant changes from the previous version. The Committee was assured that the current strategy remained safe, functional and compliant with regulatory expectations, providing a clear governance structure until the new organisation developed a replacement document.	The Committee agreed that it would recommend the Strategy to the Board, noting that the Strategy remained adequate for the transition period and that a new version would be developed once the merged organisation was formed. The Strategy is appended to this report as appendix 2.
Items to be shared/escalated with the Board or other Committees	1, 2		The Board is asked to note the key areas of concern outlined above in relation to: ▪ Risk scoring and the Risk Management Council ▪ QIA process ▪ CQC registration issues around dental premises	

Committee Chair's Report

Review of meeting	1		There had been a good level of challenge and important questions raised, as well as robust discussions.	
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

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QUALITY AND SAFETY COMMITTEE

Title of Meeting	**QUALITY AND SAFETY COMMITTEE**	**Date**	**18 DECEMBER 2025**
Agenda Item	**109/25**		
Report Title	**COMMUNITY PAEDIATRICS / NEURODEVELOPMENTAL ASSESSMENT PATHWAY IMPROVEMENT PLAN**		
Executive Lead	Paul Fitzsimmons, Medical Director		
Report Author	Heather Toft Director of Nursing Children's Services Karen Worthington Associate Director Children's Services		
Presented by	Karen Worthington Associate Director Children's Services		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

Delivery of the Community Paediatric Medical Service/ Neurodevelopmental Pathway Service in Halton and Warrington Boroughs continues to be challenging. The number of referrals received each week continues to exceed capacity. The waiting list position therefore continues to increase.

Quality and Safety Committee have requested an improvement plan update to be presented to the next committee meeting that describes timeframes, trajectories, and the link between actions and risks.

It must be noted that the Improvement Plan aims to ensure that the total resources available to the Trust are utilised as efficiently and effectively as possible however will not address the key issue in that the commissioned capacity does not meet demand. Information shared at the weekly performance and allocation meetings demonstrate that the number of appointments currently available each week are only able to accommodate the children who have been risk stratified as being in the "Red" cohort of children. More accurate waiting list trajectories are being developed with support from the trusts business Intelligence team and should be available by 30.12.25

Previously considered by:

☐ **Quality Council** ☐ **Risk Management Council**

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** Failure to work in close collaboration with partners and staff in place and across the system

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

Title of Meeting	QUALITY AND SAFETY COMMITTEE	Date	18 DECEMBER 2025
Agenda Item	109/25		
Report Title	COMMUNITY PAEDIATRICS / NEURODEVELOPMENTAL ASSESSMENT PATHWAY IMPROVEMENT PLAN		
Report Author	Heather Toft Director of Nursing Children's Services Karen Worthington Associate Director Children's Services		
Purpose	To provide the Quality and Safety Committee with an update regarding the refreshed NDP Improvement Plan describing timeframes, trajectories, and the link between actions and risks.		

1. INTRODUCTION

1.1 Delivery of the Community Paediatric Medical Services/ Neurodevelopmental Pathway Service in Halton and Warrington Boroughs continues to be challenging. The number of referrals received each week continues to exceed capacity. The waiting list position therefore continues to increase

1.2 In Autumn 2025, reports to the Quality and Safety Committee detailed a Rapid Intervention over May and June 2025 that stratified children awaiting Neurodevelopmental Assessment, prioritising and expediting care for those at highest risk.

1.3 This paper provided an updated assessment of the risks associated with the Neurodevelopmental Diagnostic Assessment Pathway/Community Paediatric service. The risk scores were revised in November 2025 in accordance with recommendations from Quality & Safety Committee.

1.4 Building on the risk updates, this paper will present the Quality and Safety Committee with an update on the refreshed Improvement Plan, outlining the timeframes, projected progress, and a clear connection between planned actions and risk scores.

1.5 Referrals

The table below shows the number of referrals received over each 12-month period

Number of referrals	Halton	Warrington
2020	621	984
2021	603	1021
2022	1184	1377
2025/26 (8-month period)	798	957

	Estimate 1,197 full year 25/26 Average 100 per month	Estimate 1,435 full year 25/26 Average 119 per month

1.6 Capacity

The table below shows the number of initial appointments undertaken each month

During Rapid Intervention the different pathways were established. Community Paediatrics non NDP (genetic conditions/neuro-disability etc) and NDP specifically.

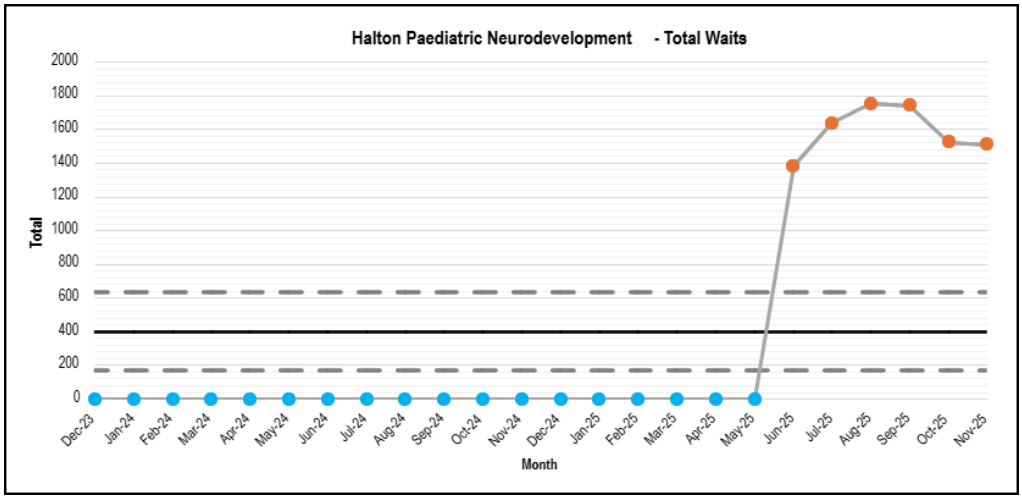
First appointments offered	**Halton**		**Warrington**	
	Community Paediatrics pathway	NDP**	Community Paediatrics pathway	NDP**
April	31		46	
May (Rapid Intervention)	33		15	
June (Rapid Intervention)	20	13	17	23
July	19	41	12	28
August	23	53	21	32
September	15	115	21	32
October	17	79	30	42
November	9	111	6	31*

*The number of initial appointments offered by the Warrington team in November reduced as the team focused on progressing those children part way through the diagnostic assessment pathway

**For NDP the initial appointment contact reported may have been undertaken by a community paediatrician, highly specialist speech a language therapist or specialist nurse

1.7 Total number of children and young people waiting for initial appointment

As stated above referrals and activity was only able to be reported by Community Paediatrics and NDP following rapid intervention. Prior to this all referrals and activity were captured under community paediatrics.


Halton Paediatric Neurodevelopment - Total Waits
Total
Month
2000
1800
1600
1400
1200
1000
800
600
400
200
0
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
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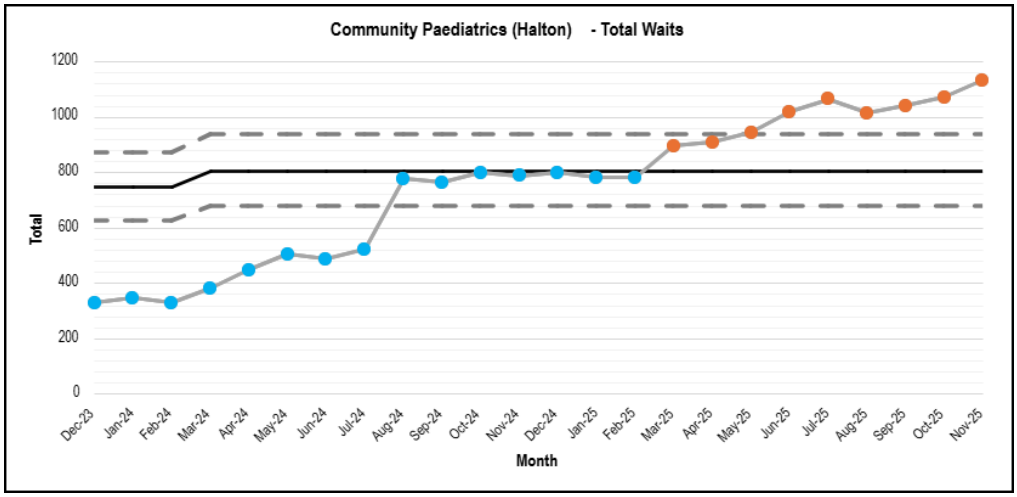
Community Paediatrics (Halton) - Total Waits
Total
Month
1200
1000
800
600
400
200
0
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
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May-25
Jun-25
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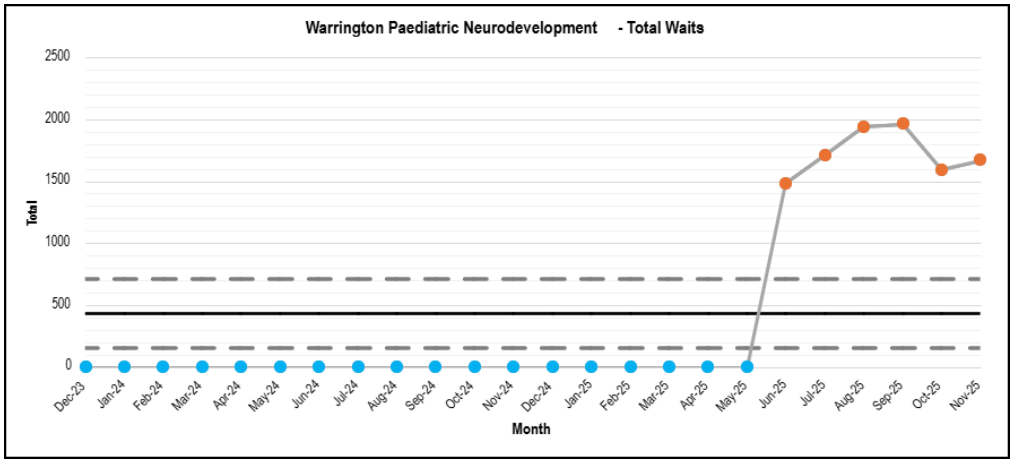
Sep-25
Oct-25
Nov-25


Warrington Paediatric Neurodevelopment - Total Waits
Total
Month
2500
2000
1500
1000
500
0
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
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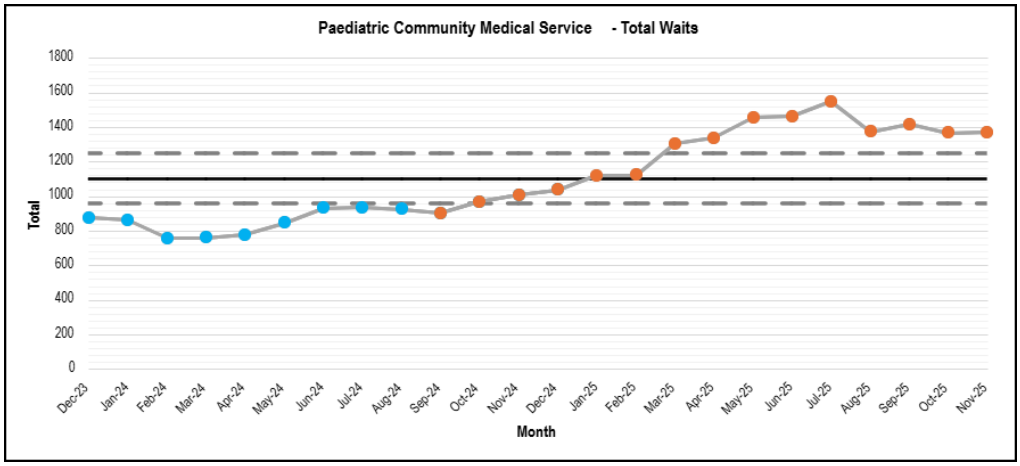
Nov-25



Waits by pathway and by Red, Amber Green cohorts of children is now available however data cleansing activity continues to ensure accurate reporting

Please see below number of children waiting broken down by the red, amber and green stratification.

November 2025 Total

Stratification	Number on waiting list	Number >52 weeks	% >52 weeks	Number > 18 weeks	% > 18 weeks	Median wait	Longest wait
Red	86	25	29.1%	58	67.4%	36.3	116
Amber	1383	603	43.6%	1261	91.2%	48.4	113
Yellow	1464	546	37.3%	1207	82.4%	43.3	134
Routine (not stratified yet)	251	1	0.4%	61	24.3%	10.6	76
Totals	3184	1175	36.9%	2587	81.3%	42.8	134

November 2025 Halton

Stratification	Number on waiting list	Number >52 weeks	% >52 weeks	Number > 18 weeks	% > 18 weeks	Median wait	Longest wait
Red	38	14	36.8%	25	65.8%	38.4	116
Amber	670	349	52.1%	631	94.2%	53.3	113
Yellow	551	269	48.8%	534	96.9%	53.5	134
Routine (not stratified yet)	251	1	0.4%	61	24.3%	10.6	76

Totals	**1510**	**633**	**41.9%**	**1251**	**82.8%**	**45.9**	**134**

November 2025 Warrington

Stratification	Number on waiting list	Number >52 weeks	% >52 weeks	Number > 18 weeks	% > 18 weeks	Median wait	Longest wait
Red	**48**	**11**	**22.9%**	**33**	**68.8%**	**34.6**	**98**
Amber	**713**	**254**	**35.6%**	**630**	**87.6%**	**43.9**	**104**
Yellow	**913**	**277**	**30.3%**	**673**	**73.7%**	**37.2**	**104**
Totals	**1674**	**542**	**32.3%**	**1336**	**79.5%**	**39.9**	**104**

The Data Transformation project introduced a new logic for waiting list reporting in October 2025, causing a plateau in reported figures.

In Warrington the biggest impact was accounting for the QB tests at the start of the initial assessment and bringing this in line with how Halton reported their new patient waiting times. Warrington ADHD QB Test are currently recorded in a different unit and not linked to the NDP referral. However, in Halton, they have always stopped the wait at QB test, as the face to face contact is recorded against the Halton NDP referral.

Alternatively, Halton has a different issue around the SLT provision, which is provided externally, the patients initial assessment had been completed outside our system, following the data transformation work the system can now account for these assessments to confirm exactly who is waiting for an initial assessment.

Historically for these patients we would be reporting the wait times until the Doctors Assessment or MDT which is usually the final stage of the diagnostic pathway. This has been raised with NHS England several times who have not confirmed or denied if this is acceptable, but they have confirmed that their current logic looks at first face to face contact with the patient or patient proxy, which aligns with the outcome of the new system data recording.

2. IMPROVEMENT PLAN POSITION

2.1 The Operational and Quality teams conducted a review of the NDP Improvement Action Plan after concluding the rapid intervention. Current operational and quality priorities and risks were presented and incorporated to guide the development of the refreshed Improvement Plan.

2.2 The Improvement Plan consists of ten workstreams as outlined below:

Workstream	What Needs to Improve
Communication and Engagement	Children, young people and their parents/carers to have a clearer understanding of the NDP pathway journey and to feel fully informed of their progress along the pathway
Partnerships	The way in which partners in place work together to improve access to information, advice and support for families with children experiencing early indications of neurodiversity
Digital	Services need to increase the way in which they utilise digital enablers to improve patient experience and service efficiency
Estates	Our teams need to be supported to work as efficiently and effectively as possible by means of co-location and having access to clinical rooms as required
Finance	Community Paediatrics / NDP activity to be appropriately funded
Performance/ BI	To have an improved understanding of activity and waits across the NDP pathway
Medicines Management	To agree roles and responsibilities in relation to prescribing practices
Patient Experience	Children, young people and their families need to be able report good /very good levels of satisfaction with their NDP pathway experience
Quality	To ensure a safe, effective, patient centred service that provides positive experiences for children and families
Operations	To ensure total resources available are utilised as efficiently as possible

2.3 Each workstream includes multiple actions aimed at achieving necessary improvements. These actions are connected to current risks, insights from the rapid intervention, business intelligence/data, staff feedback, as well as themes and trends identified from incidents and patient experience feedback.

2.4 Currently, 11 risks are listed on the Trust Risk Register for NDP/Community Paediatricians. Six of these relate to service capacity and demand pressures. The Improvement Plan addresses these risks within each workstream as detailed below:

Workstream	How the actions reflect capacity and demand
Communication and Engagement	This workstream aims to keep children and families informed about waiting times, the escalation of concerns, and available support, ensuring families feel safe and supported while they wait. Examples of this would be the co-production of a communication pathway with both boroughs' parent/carer forums, and the work underway with commissioners regarding the development of an agreed communication for parents regarding the outcome of the stratification and what that would mean for individual families
Partnerships	This section is dedicated to assisting partner agencies that are working with children and families who are awaiting diagnostic assessment, alongside supporting the development of the multi-agency approach to the management of emerging needs. Examples of this would be the Trusts contribution the development of the ICB led "This is me" model

	(Neurodiversity Profiling Tool) in both Halton and Warrington Boroughs, which is currently at the staff training stage in preparation for an initial pilot phase with named schools, and the conversations underway with both Halton Borough Children's Services and Addvanced Solutions Community Network (non-profit organisation) with regard to the support they can make available to families with children waiting for an assessment
Digital	The actions in this workstream are designed to leverage the most suitable digital technology, ensuring practitioners have access to resources that enhance productivity and efficiency. Examples of the work being undertaken include the development on an electronic referral form and the use of digital dictation software
Estates	This workstream contributes to capacity and demand management by evaluating existing estates to assess their suitability for service provision, considering factors such as operating hours and accessibility. An example of the work undertaken in this workstream is the move of the Halton paediatric and secretarial workforce from the lister road site to Woodview CDC and in Warrington CDC opening and closing times are being reviewed with an aim to be able to offer early evening clinic sessions
Finance	This section aims to conduct demand and capacity modelling and determine the financial resources necessary to reduce the wait time for initial assessments to 52 weeks.
Performance/ BI	This workstream encompasses initiatives designed to leverage data in supporting capacity and demand projections, thereby facilitating informed analysis of activity and enabling effective service planning. The development of the NDP dashboard has been a significant piece of work that continues to be further populated and refined
Medicines Management	This workstream concentrates on managing the ongoing pressures related to ADHD medication prescribing within the team. It explores alternative approaches and new working methods to ensure safe, efficient prescribing while also aiming to ease pressure and demand in this area through the progression of shared care arrangements with local general practices. Three places across Cheshire and Merseyside ICB footprint do not have shared care arrangements in place; they are Halton, Warrington and St Helens Boroughs. The absence of general practices willingness to take this forward locally has been escalated to ICB commissioners.
Patient Experience	Long waiting times remain a key issue in patient experience. This section examines ways the team can learn from children's and families' perspectives, home life pressures, and suggestions for improvement.

Quality	This section acknowledges how ongoing capacity and demand affect safety, and it highlights actions related to issues seen in incidents, including record keeping, proper use of systems, clinical harm, harm while waiting, and maintaining quality by learning from the Trusts Quality Review Visits. There is also a specific action in relation to the future management of Clinical Harm Reviews, which following advice and guidance from the Trusts Medical Director has now been confirmed. As all referrals received are risk stratified the clinical harm review takes place at the first clinical appointment. Referrers are advised to contact the service directly should there be a deterioration in the child/ young persons presenting condition.
Operations	This workstream primarily addresses capacity and demand pressures, exploring operational strategies to provide effective support. Key areas of focus include enhancing processes related to child non-attendance, refining referral procedures, and reviewing and developing supporting Standard Operating Procedures (SOPs). The team are well engaged in the Cheshire and Merseyside NDP programme workstreams /communities of practice and are implementing best practice guidance as it is developed and shared. An example of this is the implementation of the Stratification tool.

2.5 The remaining five risk areas for the ND Pathway/Community Paediatric service include Equipment, Medicines Management, Administrative Pressures, Treatment Delays, and Clinical Assessment. As can be seen above, these issues are addressed throughout the action plan to drive improvements in each domain. Addressing these themes also contributes to managing ongoing risks. The following table demonstrates how the action plan supports these risks more specifically:

Risk Theme	**How these areas are supported by the actions within the Improvement Plan**
Equipment	Equipment is primarily reflected within the digital and estates workstreams of the Improvement Plan. The objective is to ensure that practitioners are provided with the most appropriate equipment to deliver efficient, effective, and accessible services to children and families.
Medicines Management	As shown in the table above, all actions to improve safe, effective, and efficient prescribing fall under the medicines management workstream. Support from the medicines management team is essential to address these risks/ actions.
Admin Pressures	Efforts to address administrative pressures are integrated across multiple workstreams. These initiatives target improvements in procedures, communication, systems, equipment, and team development or support. Their primary goal is to enhance administrative processes, so they are

	efficient, safe, and effective, ultimately helping the service operate smoothly.
Treatment Delay	Similar to the section addressing administrative pressures, actions regarding treatment delays are integrated throughout the action plan. These initiatives emphasize enhancing communication, utilizing business intelligence tools, reviewing processes and standard operating procedures, and implementing improvements in medicines management, among other strategies.
Clinical Assessment	This risk is addressed through multiple workstreams, each implementing actions related to equipment, estates, processes and SOPs, accessibility, communication, and other relevant areas.

2.6 The Improvement Plan will be reviewed monthly with representatives from the operational, quality and relevant corporate teams with action owners providing updates, escalations and remedial plans where required.

2.7 As requested by the Medical Director a new ND Pathway/ Community Paediatrics Steering Group will be launched with the Deputy Medical Director and Deputy Chief Operating Officer co-chairing. The first meeting is being scheduled for January 2026

2.8 Taking account of the work needed to advance this Improvement Plan alongside ongoing operational, quality and corporate team demands, the completion dates reflect these challenges. The majority of actions have already begun with several well underway. At the time of reporting no actions are overdue and the overall Improvement Plan is progressing as anticipated. The final planned completion dates for all of each section's actions are listed below:

Workstream	Last Planned end date
Communication and Engagement	August 2026
Partnerships	April 2026
Digital	October 2026
Estates	April 2026
Finance	April 2026
Performance/ BI	April 2026
Medicines Management (including shared care arrangements)	April 2027
Patient Experience	December 2025
Quality	April 2026
Operations	August 2026

3. SUMMARY

3.1 Following the rapid intervention work, all children waiting for NDP or Community Paediatric Services have been risk stratified and placed on the appropriate clinical pathway on SystmOne, New knowledge and learning from this activity then facilitated a review and

refresh of the NDP Improvement Plan and associated risks. An update regarding the new risk status for this service was presented at the Quality and Safety Committee meeting in October 2025. Based on recommendations from the meeting, adjustments were then made to the risk assessment/ score.

3.2 The Improvement Plan was refreshed to align with the updated position resulting from the stratification process. In developing the plan, consideration was given to identified risks, quality and operational priorities, staff input, and patient experiences.

3.3 To ensure actions continue to advance, regular meetings will be taking place with operational, quality and corporate team colleagues via the newly re-established NDP Steering Group (previously NDP Improvement Board). This will be an opportunity for action leads to share progress, escalate any barriers to success and present remedial plans where required. Progress will also be reported at the Trusts monthly Performance Council and Quality Council meetings

Bridgewater Community Healthcare NHS Foundation Trust

Risk Management Framework

Policy Number	**Gov/Pol/019**
Target Audience	**All Bridgewater Staff**
Lead Executive Director	**Chief Nurse / Deputy Chief Executive**
Recommending Committee/Group	**Risk Management Council**
Approving Committee(s)	**Corporate Clinical Policy Group**
Ratifying Committee	**Trust Board**
Date First Ratified	**September 2018**
Last Full Review Date	**April 2025**
Next Full Review Date	**April 2028**
Extension approved until	**n/a**
Lead Author(s)	**Head of Risk Management and Patient Safety**
Version Number	**3.0**

Applicable Statutory, Legal or National Best Practice Requirements	Audit Commission (2009) - Taking it on Trust Department of Health (2024) - NHS Audit Committee Handbook Financial Reporting Council (2024) UK Corporate Governance Code Good Governance Institute (2012) Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts HM Treasury (2009) - Risk Management Assessment Framework HM Treasury (2023) - The Orange Book National Audit Office (2011) Good Practice Guide: Managing Risks in Government National Patient Safety Agency (2008) - A Risk Matrix for Risk Managers

The Trust is committed to an environment that promotes equality, embraces diversity, and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

This document can only be considered valid when viewed via the Trust's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Document retention – lifetime of the Trust or 20-year review
Document owner – Head of risk management and patient safety

Version Control Sheet

Version	Date	Reviewed By	Comment
1.0	Sept 2018 Sept 2018 Dec 2018 Dec 2018	L. Carter & D. Valentine Trust Board Alan Lee Lynn Carter	New document developed Approved with minor amendments Amendments completed Amendments approved
2.0	September 2019 Sept 2019 Nov 2021 Nov 2021 Feb 2022 March 22 27th April 22	Alan Lee S. Arkwright Alan Lee Jeanette Hogan Corporate Clinical Policy Group Alan Lee Trust Board e-governance	Minor amendments made to sections 15, 16 and 25 Approved by chair action Updated following comments Sign-off confirmed Approved subject to amendments, final chair approval and ratification by the Trust Board Amendments completed Ratified
2.1	Feb 25	Alan Lee	Full review - minor amendments to reflect
2.2	February 25	M. Corkery	Reviewed, comments made
2.3	March 2025	Risk Management Council	Sign-off confirmed
2.4	April 2025	Corporate Clinical Policy Group	Approved subject to minor amendments and final chair approval
2.5	April 2025	Adie Richards	S.5.14 updated
2.6	April 2025	Alan Lee	Amendments completed
2.7	April 2025	P. Mumberson	Amendments approved by action
3.0	5th June 25	Trust Board	Ratification confirmed

Equality impact assessment

Consider if this document impacts/potentially impacts:

- Staff
- Patients
- Family members
- Carers
- Communities

Yes [ ] **complete box A**	**No** [x] **complete box B**
Box A Contact the Trust's equality & inclusion manager at: **Email: ruth.besford@nhs.net** **Date contacted:**	**Box B** Complete details below: **Name: Alan Lee** **Email: Alan.lee5@nhs.net** **Date: Dec 2024**

Education & professional development (EPD) question

To ensure that any training requirements are discussed, and resources planned and allocated to meet the needs of the service, you must consider whether this document has additional training requirements. Please answer the following question by entering a cross in the Yes or No box below:

	Yes	**No**
Does this document have any additional training requirements or implications?		x

If you have answered **YES,** you must forward a copy of this document to EPD **before** submitting to the policy officer.

Date submitted to EPD: N/A……

No further action is required if you have answered NO.

This table below must be completed in full for audit and governance purposes. Please note documents will be returned if section 1 in the table below is not completed fully. This will result in a delay in listing the document for approval.

Name of document	Risk Management Framework
Document number	Gov/Pol/019
Document author	Alan Lee

Section 1 - actions required by author	**Authors response**
Date proposal form submitted to policy officer (new documents)	n/a
Date proposal form presented to CCPG (new documents)	n/a
Date proposal approved by CCPG (new documents)	n/a
Date literature search/reference review requested	Not required
Date EqIA considered	Dec 2024
Date additional training requirements considered	No new requirements, existing provision to be maintained
Date fraud-proofed by the Anti-Fraud Specialist (AFS) if applicable	n/a
Date template accessed on the Hub Add 'OFFICIALSENSITIVE: COMMERCIAL' to front cover if the document can be shared on the internet Add 'OFFICIALSENSITIVE: PERSONAL' to appendices if they include or will include personally identifiable information (PID)	Feb 2025
Date literature review completed (check references are formatted correctly, and hyperlinks working)	N/A
Date first draft submitted to policy officer for initial review	06/02/25
Date returned by policy officer following initial review	10/02/25
Date submitted to key individuals/groups/subject matter experts for comments (add names and designations of responders to consultation table)	19/02/2025
For clinical documents, date document submitted to consultation group for sign-off i.e., IPC, Medicines Management (this applies if the document contains medication or medical gases - update version control sheet to confirm sign-off)	N/A
Name of Recommending Committee/group	Risk Management Council
Date sent to Recommending Committee/group for sign-off	19/03/2025
Date signed-off by the Recommending Committee/group (update version control sheet once signed-off)	19/03/2025
Date submitted to policy officer for listing at CCPG	27/03/25
Section 2 – for completion by the policy officer	
Date approved by CCPG	17th April 2024

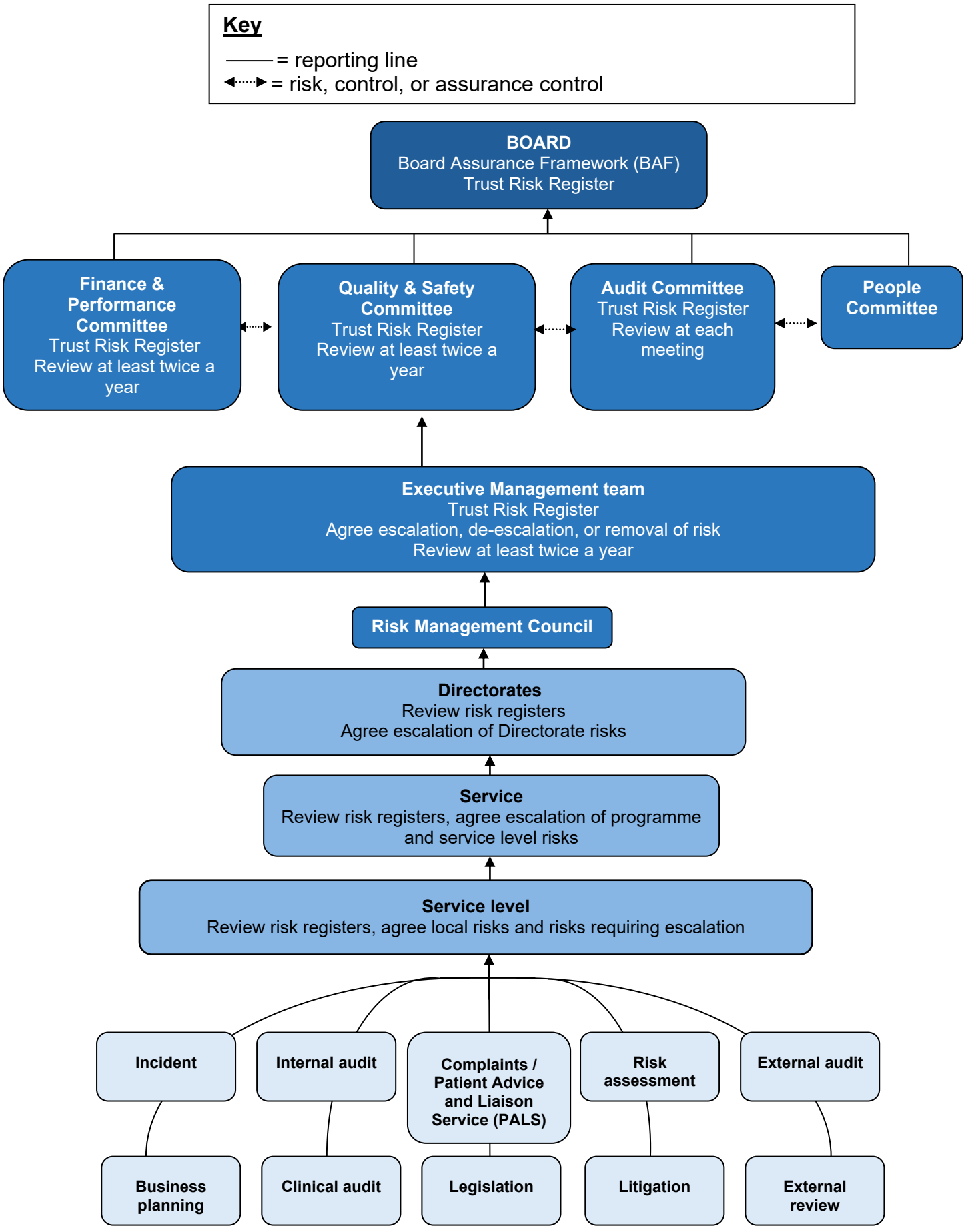
The following policies require Board approval and must be submitted to Board following CCPG approval:

- Risk Management Framework Policy
- Health & Safety Policy
- Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")

Date submitted for Board approval: 2nd May 2025
Date approved by Board: 5th June 2025

Contents

Reporting structure and sources of risk



1 Introduction

Risk is an inherent part of the delivery of healthcare. This risk management framework outlines Bridgewater Community Healthcare NHS Foundation Trust's (hereafter the Trust) approach to risk management throughout the Trust.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

This Trust Board approved strategy for managing risk identifies the accountability arrangements the resources available and provides guidance on what may be regarded as acceptable risk within the Trust.

Successful risk management involves:

- Identifying and assessing risks
- Taking action to anticipate or manage risks
- Monitoring risks and reviewing progress in order to establish whether further action is necessary or not
- Ensuring effective contingency plans are in place.

1.1 Objective

The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure that:

- The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected

- The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk based upon the support and leadership offered by the Trust Board. The Trust has processes in place to assess the risks to the population it serves, including where appropriate assessment of community and national risk registers.

1.2 Scope

The objective of the Risk Management Strategy is to promote an integrated and consistent approach across all parts of the Trust to managing risk.

The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.

Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

1.3 Risk statement

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust.

The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the Trust. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as a Trust the Board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational, and reputational risks.

Senior management will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed, and managed.

Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

All staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally

There will be active and frequent communication between staff, stakeholders, and partners. This may include engagement with local Resilience forums in respect of wider population risk assessment incorporating Community and National Risk Registers.

1.4 Risk appetite statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation’s risk appetite should address several dimensions:

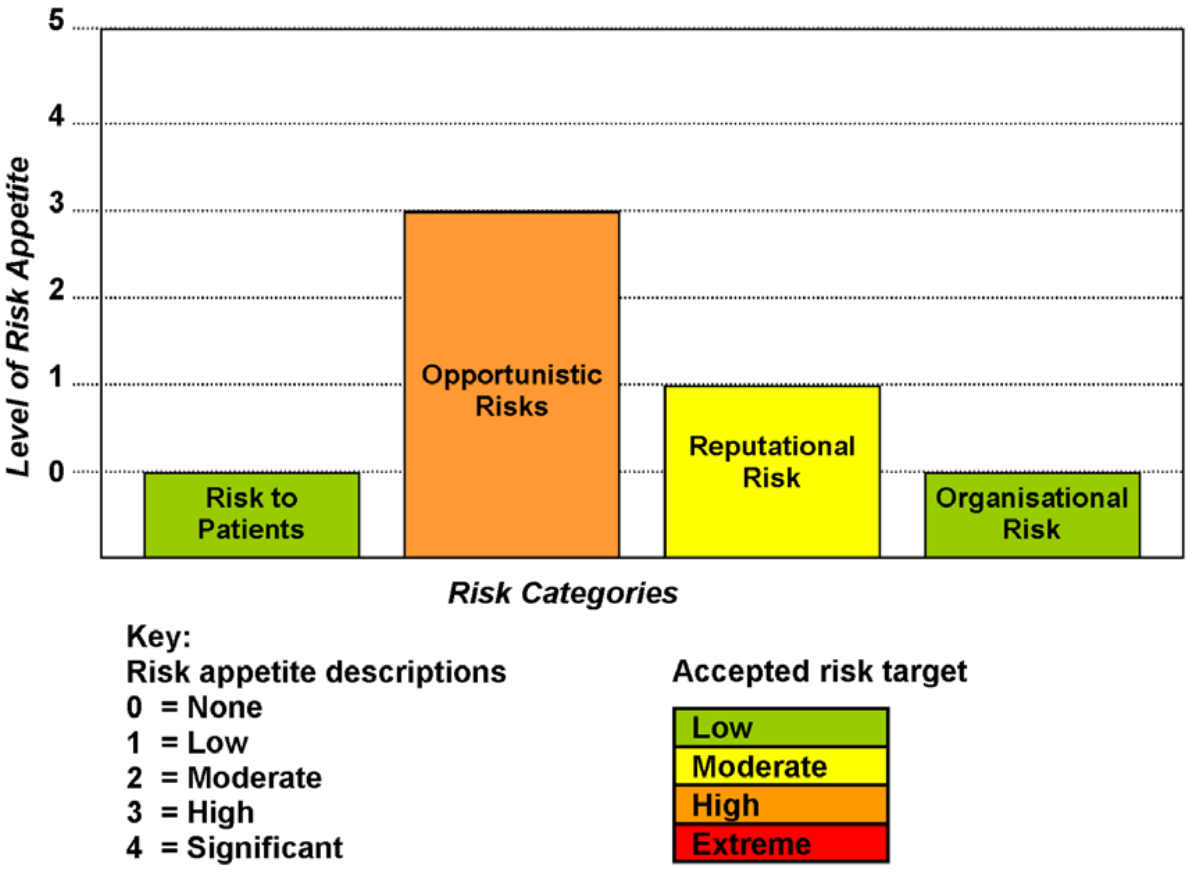
- The nature of the risks to be assumed
- The amount of risk to be taken on
- The desired balance of risk versus reward.

On an annual basis the Trust will publish its risk appetite statement as a separate document covering the overarching areas of:

- Risk to patients
- Organisational risk
- Reputational risk
- Opportunistic risk

These categories of risk are more fully explained in appendix 1.

Example risk appetite by area



The risk appetite statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the Trust should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the Trust, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk.

The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Board to determine the organisational capacity to control risk.

The review will consider:

- Risk leadership
- People
- Risk Management Framework
- Partnerships
- Risk management process
- Risk handling
- Outcomes.

Tolerances for each management level of the risk management framework are defined for staff in the Risk Management Framework.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and will be available on the Trust's external and internal websites.

1.5 Principles of Successful Risk Management

It is the role of the Trust Board to lead and support risk management across the Trust. The principles of successful risk management are:

- To embrace an open, honest, objective, and supportive culture
- To acknowledge that there are risks in all areas of work
- For all staff to be actively involved in recognising and reducing risk
- To communicate risks across the Trust through escalation and de-escalation processes
- To learn from mistakes and areas of innovative good practice.

2 Definitions

The definitions applicable to this policy are as follows:

Risk	The chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high-quality care.
Risk management	The proactive identification, classification and control of events and activities to which the Trust is exposed.
Risk identification number	The unique identifier to distinguish the risk from the other risks in the register.
Assurance	External evidence that risks are being effectively managed.
Control(s)	Actions in place to manage the risk in order to reduce the likelihood and / or consequence of that risk.

Internal control	A method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the Trust, the result of robust planning and good direction by management. If a control is not working effectively then it is not a control.
Inherent risk	The level of risk before any control activities are applied.
Consequence	The potential consequence if the adverse effect occurs as a result of the hazard.
Likelihood	The chance or possibility of something happening.
Residual risk	The current risk 'left over' after controls, actions or contingency plans have been put in place.
Risk appetite	The level of risk considered the Trust is prepared to accept, tolerate, or be exposed to at any point in time.
Risk capacity	Maximum level of risk to which the Trust should be exposed, having regard to the financial and other resources available.
Risk maturity	The overall quality of the risk management framework.
Risk owner	The individual who is responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk profile	The overall exposure of the Trust to risks (or a given level of the Trust).
Risk rating	The total risk score worked out by identifying the consequence and likelihood scores and cross referencing the scores on the risk matrix.
Risk register	The tool for recording identified risks and monitoring actions and plans against them.
Risk tolerance	The boundaries of risk taking outside of which the Trust is not prepared to venture in the pursuit of its objectives.

3 Abbreviations

The abbreviations applicable to this document are as follows:

AEO	Accountable emergency officer
AGS	Annual Governance Statement
BAF	Board Assurance Framework
CAS	Central Alerting System
CRR	Community Risk Registers
DIGIT	Digital Information Governance and Information Technology

EMT	Executive Management Team
EPD	Education and Professional Development
EPRR	Emergency Preparedness, Resilience & Response
ID	Identification
MRO	Medical Responsible Officer
NICE	National Institute for Health and Care Excellence
PALS	Patient Advice and Liaison Service

4 Other relevant procedural documents

This document should be read in conjunction with the following documents: -

Anti-Fraud, Bribery and Corruption Policy

Central Alerting System (CAS) Policy and Procedure

Claims Management Policy

Communities Matter Strategy

EPRR Policy

Fire Safety Policy

Freedom to Speak Up in the NHS

Health and Safety Policy

Identification, Assessment and Referral of Domestic Abuse, Honour Based Violence, Forced Marriage and Female Genital Mutilation Policy

Incident Investigation Procedure

Incident Reporting Policy

Infection Prevention and Control Bridgewater Manual

Information Governance Framework Policy

Information Security Policy

Lockdown Policy and Managers Guidance

Management of Slips, Trips and Falls Policy (including falls from height)

Managing Allegations of Abuse Policy

Mandatory Training and Induction Policy

Medical Devices Policy

Medical Gases Policy

Medication Incident Policy

Mental Capacity and Deprivation of Liberty Policy

Mobile Computing Policy

Non-Medical Prescribing Policy

Occupational Stress Management Policy and Guidance

Patient Leaflet Policy

Patient Safety Incident Response Plan

Patient Safety Incident Response Policy

Policy and Procedure for the Development and Review of Policy and Procedural Documents

Quality Impact Assessment Policy

Risk Assessment and Risk Register Process Guideline

Waste Management Policy

Trust policies and procedural documents can be accessed on MyBridgewater.

5 Roles and responsibilities

Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks.

To support the governance and escalation process, this section sets out the specific risk management responsibilities of the following staff/staff groups:

- Chief executive
- Director of finance
- Medical director
- Chief nurse / deputy chief executive
- Executive directors
- Director of corporate governance
- Director of quality governance
- Head of risk management and patient safety
- Associate directors
- Clinical directors
- Senior managers and senior staff
- All staff

- Staff side representatives

The roles and responsibilities of the Trust Board and the sub-ordinate committees are detailed in section 16 of this document.

5.1 Chief executive

The chief executive is the responsible officer for the Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk.

As accountable officer, the chief executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the chief executive has responsibility for implementation of risk management.

5.2 Director of finance

The director of finance has responsibility for financial governance and associated financial risk. The postholder is also the senior information risk officer.

5.3 Chief nurse / deputy chief executive

The chief nurse / deputy chief executive has delegated authority for the risk management framework and is the executive lead for maintaining the Board Assurance Framework (BAF) and its supporting processes.

The chief nurse / deputy chief executive has responsibility for:

- Clinical governance and clinical risk, including incident management, and has joint responsibility with the medical director for quality

- Patient safety and patient experience.

5.4 Chief operating officer / accountable emergency officer

The chief operating officer who is the Trust's accountable emergency officer (AEO), informs the Risk Management Council about annual risk assessments provided in National, Community Risk Registers (CRR) and any local EPRR risk registers, to ensure that these risks are reflected in Trust planning.

5.5 Executive directors

The executive directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

Executive directors also have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

5.6 Director of corporate governance

The director of corporate governance is accountable to the chief executive and the Trust Board for the overall performance of corporate governance functions, including monitoring the system of internal control, including the system, and supporting processes for risk registers and maintenance of the BAF. The director of corporate governance is also the Trust's data protection officer.

5.7 Director of quality governance

The director of quality governance is responsible for the assurance of the system of internal control to ensure effective management of risk.

5.8 Head of risk management and patient safety

The head of risk management and patient safety is responsible for ensuring that the Trust has suitable and sufficient systems and processes for the effective management of risk.

5.9 Associate directors

These directors are accountable for ensuring that appropriate and effective risk management processes are in place within the directorates, and that all staff are aware of the risks within their work environment, together with their personal responsibilities. The directors must ensure:

- Risks are identified, assessed, and acted upon
- Where appropriate, risks are captured on local risk registers, ensuring that risks are reviewed by an appropriate directorate group at least quarterly as part of performance monitoring, to consider and plan actions being taken.
- Appropriate escalation of risks from services or directorates to divisional level within the defined tolerances.
- Compliance with standards and the overall risk management system as outlined in this strategy and related documentation.
- Staff receive the relevant elements of risk management training, and that non-attendance is followed up.

5.10 Directors of nursing

The Directors of nursing (or equivalent in the Dental Directorate) are responsible for ensuring appropriate and effective risk management processes are in place in their designated area and scope of responsibility, these include:

- Implementing and monitoring any control measures identified
- Ensuring risks are captured on the relevant risk register

- Ensuring local groups review risk registers on a regular basis to consider and plan actions being taken.

5.11 Senior managers

Senior managers take the lead on risk management and set the example through visible leadership of their staff. They are therefore responsible for:

- Taking personal responsibility for managing risk
- Sending a message to staff that they can be confident that escalated risks will be acted upon
- Ensuring risks are updated regularly and acted upon
- Identifying and managing risks that cut across delivery areas
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach
- Communicating downwards in plain English what the top risks are
- Escalating risks from the front line
- Linking risk to discussions on finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities
- Ensuring staff are suitably trained in risk management
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve
- Ensuring people are not blamed for identifying and escalating risks, and fostering a culture which encourages them to take responsibility in helping to manage them
- Ensuring risk management is included in appraisals and development plans where appropriate.

5.12 Senior staff

Senior staff are expected to be aware of and adhere to the risk management best practice to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation – drawing on the knowledge of front-line colleagues
- Identify risk owners with the seniority to influence and be accountable should the risk materialise

- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do
- Identify the actions needed to reduce the risk and assign action owners
- Is there an opportunity to benefit from the risk or the work done to mitigate against the risk materialising?
- Record risks on a risk register
- Check frequently on action progress, especially for high severity risks
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so
- Implement a process to escalate the most severe risks and use it.

5.13 All staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they should be aware and encouraged to follow the Freedom to Speak Up process in the NHS, incorporating guidance on raising concerns.

5.14 Education & professional development

Education & professional development (EPD) are responsible for:

- Facilitating the annual training needs analysis process
- Facilitating the delivery of risk management related training
- Maintaining accurate records of all compliance and training data relevant to this document on the oracle learning management system on electronic staff record as provided to the EPD team by the relevant subject matter expert
- Provide training and compliance reports as requested in relation to this document.

5.15 Staff side representatives

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate and providing advice in the event of a dispute to the validity of a risk assessment.

6 Equipment

Trust risk management reporting system – Ulysses.

7 Risk management process

The Trust adopts a structured approach to risk management, whereby risks are identified, assessed, and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

Risks are events that 'might happen', which could stop the Trust achieving its objectives or impact upon its success. Risk management also includes issues that 'have' happened and were not planned but require management action.

Risks are clarified and managed in the following key stages:

- Clarifying objectives
- Identifying risks that relate to objectives
- Defining and recording risks
- Completion of the risk register
- Identifying mitigating actions
- Recording the likelihood and consequence of risks
- Reviewing identified risks in a timely manner
- Escalation, de-escalation and archiving of risks as appropriate

7.1 Stage 1: Clarifying objectives

Clarifying objectives enables staff to recognise and manage potential risks, threats or opportunities that may prevent the achievement of strategic and local objectives.

In order to clarify:

- Strategic (Corporate) objectives determine which Trust strategic objective(s) is relevant to the directorate

- Local objectives determine objectives that are only relevant to the directorate.

7.2 Identifying risks to objectives

Once the objectives are clarified, risks are more easily identified. Where appropriate, working collaboratively with colleagues, with consideration of the following suggested questions. This enables stakeholders to identify risk more accurately:

- What are the risks which may prevent the delivery of your objectives?
- What risks have an impact on the delivery of high quality, safe care?
- What could happen or what could go wrong?
- How and why could this happen?
- What must we do to enable continued success in achieving objectives?
- Who else might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

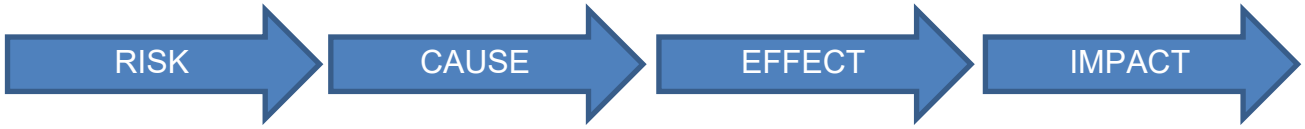
7.3 Stage 3: Describing risk and assigning controls

Risks are described in a clear, concise, and consistent manner to ensure common understanding by all. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk that….. This is caused by ….. and would result in…. leading to an impact upon……"

The Trust's standard for recording risks is to define risks in relation to:



- A risk is described as something uncertain that may happen and could prevent us from meeting its objectives.
- The cause is the problem or issue that 'could' cause the risk to happen.
- The effect is the result of something that will happen if we do nothing about the risk.
- The impact is the wider impact of the risk on the objectives if we do nothing.

An example of describing risk in the Trust standard is detailed below:

Objective

To ensure safe staffing levels:

Risk:

- Risk of failure to maintain safe staffing levels.

Cause:

- High staff sickness rate
- Difficulties in recruiting clinical staff
- Inability to release clinical staff for mandatory training.

Effect:

- Staff not receiving compulsory training in resuscitation or blood safety.

Impact:

- Increased safety risk to patients.

7.4 Key controls

Key controls are the actions put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does.

Staff must ensure that each control (or action where a gap in control has been identified) has an owner (i.e., a named individual, responsible for the action) and target completion date.

Key controls must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The '5 T's provide an easy list of options available to anyone considering how to manage risk:

- Tolerate – the likelihood and consequence of a particular risk happening is accepted

- Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action)

- Transfer – shifting the responsibility or burden for loss to another party, e.g., the risk is insured against or subcontracted to another party

- Terminate – an informed decision not to become involved in a risk situation, e.g., terminate the activity

- Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

In most cases, the chosen option will be to treat the risk. When considering the action to take, remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.

- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Contingency plans – if a risk has already occurred and cannot be prevented *or* if a risk is rated red or orange (extreme or high) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded underneath the key controls on the register.

Good risk management is about being risk aware and able to handle the risk, not risk averse. All risks and controls are to be described in accordance with Trust standard and recorded in the risk register following assessment.

7.5 Stage 4: Completing the risk register

Trust Risk Registers are web based and stored electronically as part of the Trust Risk Management System. All staff with permissions to access risk registers are able to see risks for the whole Trust. It is a transparent system to enable users to share learning.

7.6 Process for completing the risk register

The process for completing risk registers:

- Assign an owner to the risk
- List the key controls (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact
- If it is a severe risk (red or amber) then consider what the contingency action plan is, i.e., what will you do should the risk happen (see escalation)
- Rate the likelihood of the risk materialising
- Rate the consequence of the risk happening.

Headings in the register that need to be completed are:

- Risk ID - the ID will not change throughout the life of the risk. Risks without a risk ID will be omitted from any report. It is therefore crucial to include an ID for each risk and control
- Risk owner - high severity corporate risks, for example, will be owned by one executive director, but there may be many action owners.

The risk owner must know, or be informed, that they are the owner, and accept this.

Source of risk

Source of how or where the risk was identified. This could include:

- Business planning
- Clinical audit
- Complaints/Patient Advice and Liaison Service (PALS)
- External audit
- External review
- Incident
- Internal audit
- Legislation
- Litigation
- National Institute for Health and Care Excellence (NICE) guidance
- Regulatory standard
- Risk assessment
- Risk register (existing)
- Community & National Risk Registers

7.7 Previous risk rating and current risk rating

These columns are mirror images of each other. Each time the register is reviewed or updated the risk register should move the current rating into the previous column and recalculate the current rating. This is so the history and progress of a risk can be reviewed.

7.8 Review date

The review date should be used to indicate when this risk was reviewed, i.e., the date of the latest information including rating and key controls. Red or amber risks must be reviewed monthly.

7.9 Risk target

The risk target is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to. When deciding the risk target, consider the following:

- What risk rating should an individual risk be managed down to in an ideal world?
- What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
- Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?

Having considered the above, assign the risk target a colour that best represents what it is possible and practical to manage it down to using the existing risk matrix. If the risk target is:

RED - represents a very high tolerance of the risk, i.e., willing to tolerate a risk rated with either a very high likelihood or consequence (or both).

AMBER - represents a reasonably high tolerance to the threat occurring, i.e., more open to the threat occurring, often if there are operational or resourcing constraints.

YELLOW - prepared to tolerate and accept a little more threat but are prepared to be more ‘scared’ as more risk is accepted, but still cautious.

GREEN - averse to the risk as if the risk materialises this cannot be tolerated.

7.10 Stage 5: Escalation and de-escalation of risks

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example, from a directorate risk register to the corporate risk register, or from the corporate risk register to the BAF which will be reviewed by the Trust management executive, finance and performance, audit, quality and safety, and people committees, and finally the Board.

Risks will be escalated or de-escalated within the defined tolerances and authority to act for each level. The risk owner should discuss and seek approval from their manager who in turn should consult the risk register owner before risk escalation to the next level.

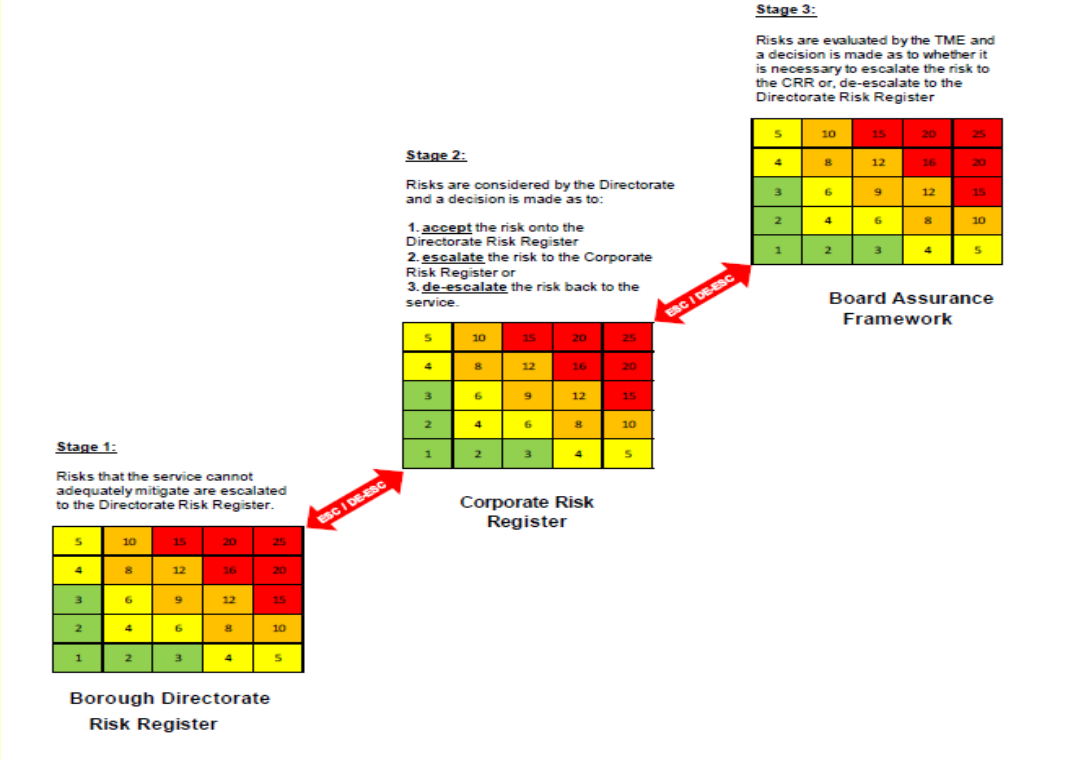
A risk will then be reviewed and either accepted at the next level and agreed at the relevant risk forum or rejected and returned to the management team to review and rescore, or for further action. Where risks are escalated to the next management level, they will be reassessed against the objectives at that level, i.e., a risk rated 25 (red, or extreme) at directorate level will be re-evaluated and may not be rated at 25 at Trust level.

Once an escalated risk has reached the accepted target for the risk, following mitigating actions or a change in the nature of the risk, it will be de-escalated. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Risk registers at directorate level are also reviewed to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is considered. This will aid in identifying lower risk issues which may be common across many areas.

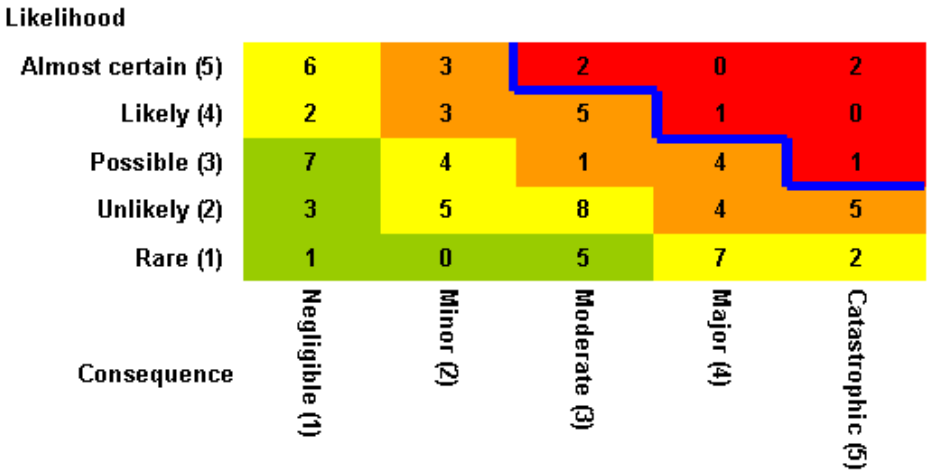
Registers will also be reviewed to identify high impact but low frequency risks which may pose a threat. These will be included in the corporate risk register reports for review.



7.11 Risk profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register.

A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk. The risk profile allows the risk tolerance at the level of reporting to be considered.



The Trust must use risk profile diagrams to facilitate and monitor risk registers via the Risk Management Council for risks that score 12 or above.

7.12 Project and programme risk

Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of project documentation.

Project and programme opportunities and threats are generally identified:

- If delivery of a programme is threatened, through the escalation of risks from projects within the programme
- During project or programme start up
- By other projects or programmes with dependencies or interdependencies with this project or programme
- By operational areas affected by the project or programme

Although a project or programme should adhere to the Trust Risk Management Strategy, it should also have its own risk management guidelines, which should:

- Identify the owners of a programme and individual projects within the programme

- Identify any additional benefits of adopting risk management within this project or programme

- Identify the nature and level of risk acceptable within the programme and associated projects

- Clarify rules of escalation from projects to the programme and delegation from programme to projects, or for a project with no overarching programme, the escalation link from the project to the divisional or corporate level

- Identify mechanisms for monitoring the successful applications of this strategy within the programme and its projects

- Identify how inter-project dependencies will be monitored and managed

- Clarify relationships with associated strategies, policies, and guidelines.

Project and programme risk management must be designed to work across appropriate organisational boundaries in order to accommodate and engage stakeholders.

In many of the risks identified at project and programme level it will be possible to work out the financial cost of the risk materialising. This should be recorded in the risk description column of the risk register as part of the impact description.

The cost of mitigating the risk should also be recorded in the 'Key controls and contingency plans' column if this can be determined. Both these figures will be relevant to the calculation of risk targets. If, for example, a risk will have a big financial impact and it is likely to actually happen, how much are you prepared to spend to counter it?

At the end of a project or programme, any risks that have not been eliminated, must be discussed with the service, agree the new risk owner, and then transfer the risk(s) to the operational risk register.

8 Governance structure

The Trust's governance structure identifies the relevant committees and their relationship to the Board.

Specific responsibilities in relation to this strategy, for the management of risk and assurance on its effectiveness are monitored by the following Committees:

- Board of directors
- Executive Management team (EMT)
- Audit Committee
- Finance and Performance Committee
- Quality and Safety Committee
- People Committee
- Digital Information Governance and Information Technology (DIGIT)

Additionally, the Audit Committee and other Board subcommittees (finance and performance, quality and safety, people) exist to provide assurance of the robustness of risk processes and to support the Trust Board.

Each directorate, will have a management forum where risk is discussed, including the risk register, actions, and any required escalation. This will be monitored via the Risk Management Council.

EPRR risks are monitored at the Trust EPRR Group which reports to EMT.

Risks are correspondingly monitored at operational level (team, department, clinic and service) through the following team meetings and forums:

- Borough/service
- Risk Management Council.

Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk principally through three related mechanisms – see sections 8.1, 8.2 and 8.3.

8.1 Board Assurance Framework

The BAF sets out the strategic objectives, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the Board agenda.

The BAF will be reviewed at each meeting of the Trust Board.

8.2 Corporate risk register

The corporate risk register is a high-level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust. All risks at 12 or above will be on the corporate risk register

The corporate risk register will be reviewed at each meeting of the Risk Management Council and the content will be monitored by the sub committees of the Trust Board. Corporate risks will be linked to the BAF.

8.3 Annual governance statement

The annual governance statement is signed by the chief executive as the accountable officer and sets out the Trust approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the Board with the accounts.

9 Horizon scanning

Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business.

Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach, it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- Department of Health publications
- Local demographics
- Seeking stakeholder's views.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

10 Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

Specific training will be provided in respect of high-level awareness of risk management for the Board. Risk awareness sessions are included as part of the Board's Development Programme.

Training will be available on risk assessment, particularly the scoring or grading of risks, and how to use the risk register.

11 Consultation

Key individuals/groups involved in the development of the policy to ensure it is fit for purpose once approved:

Name	Designation
Suzanne Mackie	Director of Quality Governance
Kristine Brayford-West	Director of Safeguarding
John Morris	Deputy Director - Estates
Sharan Herbert	Head of Clinical Governance & Quality
Mary Corkery	Policy Officer
Alan Lee	Head of Risk Management & Patient Safety
Samantha Scoles	Head of Corporate Governance
Risk Management Council	
Corporate Clinical Policy Group	
Trust Board	

12 Dissemination and implementation

12.1 Dissemination

The head of risk management and patient safety will disseminate this framework to associate directors for cascading to staff.

The framework will be made available on MyBridgewater and published in the bulletin.

12.2 Implementation

All managers and key staff will ensure this framework is implemented in their respective areas of responsibility.

New staff will be made aware of this framework at local induction.

13 Process for monitoring compliance and effectiveness

Process for reviewing compliance and effectiveness i.e., audit, review, survey, incident reporting	Responsible	Frequency of monitoring	Assurance group
Review of Risk Management Framework	EMT	Annual	EMT / Audit Committee
Audit of Annual Governance Statement	EMT	Annual	Audit Committee
Audit of risk management process	Directorates	Annual	Audit Committee

14 Standards/key performance indicators

Not applicable.

15 References

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Appendix 1

Categories of risks

Risks to patients

The Trust recognises there is inherent risk as a result of being ill or injured, and the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible.

The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good healthcare and that positive risk management, conducted in the spirit of collaboration with patients and carers, is essential to support recovery. In order to deliver safe, effective, high-quality services, the Trust will encourage staff to work in collaborative partnership with each other and patients and carers to minimise risk to the greatest extent possible and promote patient well-being.

Organisational risks

The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

The Trust's appetite is to minimise the risk to the delivery of quality services within the Trust's accountability and compliance frameworks whilst maximising our performance within value for money frameworks.

A range of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

Reputational risk

The Board models risk sensitivity in relation to its own performance and recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment. The Trust endeavours to work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

Opportunistic risks

The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures, consistent with the strategic direction set out in the Quality and Place Strategy and plans, whilst respecting and abiding by its statutory obligations.

Taking action based on the Trust's stated risk appetite will mean balancing the financial budget and value for money in a wide range of risk areas to ensure safety and quality is maintained.

Council Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee / Group:	Strategic People Committee in Common		**Report to:**	Board of Directors
Date of Meeting:	18 December 2025		**Date of next meeting:**	21 January 2026
Chair:	Julie Jarman, Non-Executive Director		**Parent Committee:**	Board of Directors
			Quorate (Yes/No):	Yes
Members Present / Attendees:	**Membership of the BCHT Committee** Abdul Siddique, Non-Executive Director (in the Chair) Elaine Inglesby, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Paula Woods, Director of People and OD Jo Waldron, Deputy Director of People and Organisational Development **Membership of the WHH Committee** Julie Jarman, Non-Executive Director Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director 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 Jane Hurst, Chief Financial Officer	**Attendees** Jennie Dwerryhouse, Deputy Chief People Officer Carl Roberts, ACPO Michelle Cloney, CPO John Culshaw, Company Secretary Paul Fitzsimmons, Joint Medical Director Paula Woods, Director of People and OD Adam Harrison Moran, Head of Strategic Workforce Development Ali Kennah, Joint Chief Nurse Mike O'Connor, Non-Executive Director Kate Henry, Director of Communications and Engagement Jane Hurst, Chief Finance Officer Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive	**Key Members not present:**	Committee Member: Elaine Inglesby, Non-Executive Director Jennie Dwerry House, Deputy CPO Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Tania Strong, Assistant Director of People and OD Lucy Gardner, Director of Strategy

	For WHH and BCH (Joint Directors) Dan Moore, Chief Operating Officer and WHH Deput Chief Executive Paul Fitzsimmons, Executive Medical Director Ali Kennah, Chief Nurse	Dan Moore, Joint Chief Operating Officer and WHH Deputy CEO Lucy Garnett, HR Business Partner Audrey Fitzpatrick, Governor Margaret Bamforth, Governor Abdul Siddique, Non-Executive Director Laura Hilton, ACPO Executive Director Lynda Richardson, Administrator		

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**
Deep Dive - WEG Update	BAF 4 and 6		Warrington Together Workforce Strategy Programme Review: a comprehensive review of the Warrington Together workforce strategy programme, outlining its development, challenges, and the decision to pause the programme pending a Partnership Board decision in February, with committee members raising questions about governance, outcomes, and future direction.	The Committee noted the update.
Hot Topic – TUPE Update	BAF 4 and 6		TUPE Consultation and Workforce Integration Update: provision of a detailed update on the TUPE (Transfer of Undertakings) process for staff transferring between Bridgewater and WHH, covering legal steps, consultation with trade	The Committee – noted green for assurance and green for delivery

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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

			unions, communication with staff, and the assurance process, with further updates planned as the integration progresses.	
Director of People Report	BAF 4 and 6		Chief People Officer's Report and Workforce Updates: MARS uptake (39 applications to date), staff survey results (53% vs 63% last year – at the bottom of the response rates league table) and plans to address staff survey results jointly. Flexible working programme further update provided. Research into increasing physical activity of healthcare workers, attainment of Level 3 in terms of e-Roster usage against national standards within plans to achieve Level 4 (the highest level) Attendance initiatives in line with the ICM C&M absence initiatives. HWB fortnight update with committee members discussing challenges and actions in each area.	The Committee noted the update.
Workforce Brief on National, Regional, ICB, or Local Workforce Issues	BAF 4 and 6		**Sexual Misconduct update** pending in January, new national training available. **Changes to the National Living Wage** and impact on AfC payscales – previously an interim solution has occurred, when this is confirmed then the committee will receive further updates. **Reforms to the Apprenticeships Levy** - removal of level 7 schemes, but introduction to a bidding scheme for these, along with new options for roll forwards of the levy – further work is required to better understand the impact once terms are confirmed.	The Committee noted the update.
ICB Workforce Programmes	BAF 4 and 6		ICB Workforce Programmes and Governance Changes: a summary of recent changes in the governance of ICB workforce programmes, noting the transition of workstreams to the Cheshire and Merseyside Provider Collaborative and the need to align reporting and priorities with the new structure. Mandy Nagra	The Committee noted the update.

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			has departed the ICB, the various workstreams have now been stood down, workstreams (system CIPs) have however been replaced by the Provider Collaborative as the governance mechanism for these.	
Better Care Together Integration Update (Workforce and Corporate Services)	BAF 4 and 6		**Workforce** - An overview of the workstream was provided to look into our plans for post-integration and the work being undertaken in terms of Due Diligence, Business Case Submission and development of ongoing strategy. TUPE workstreams are ongoing and a date for ESR merger in 2027 has been secured. Future plans include toolkits for workforce design and working within the Model Health system parametres. **Corporate** – workstream is nearing completion in terms of the deliverables and can be transferred into another mainstream group as part of 'business as usual'.	The Committee noted the update.
Improving People Practices Report (including Employee Relations data)	BAF 4 and 6		Employee Relations and Casework Trends: presentation of reports on employee relations activity at Bridgewater, highlighting a significant increase in formal and informal cases but with praise given for the percentage of cases that have been able to be resolved informally, the complexity of issues, and the impact of organisational pressures, with committee members discussing assurance processes and actions for fragile services. The HR Team was thanked for their hard work in maintaining the service in light of the case work increases. Cases are now also discussed at the Nursing & AHP triangulation meeting to review progress.	The Committee noted the update.
Health and Wellbeing Update (including the Health and Wellbeing Guardian Report)	BAF 4 and 6		Health and Well-being Initiatives: Update provided on health and well-being programmes at WHH and Bridgewater, including the use of diagnostic toolkits, development of well-being plans, mental health support, and innovative initiatives such as therapy dogs and winter well-being days.	The Committee noted the update.

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Board Assurance Framework	BAF 6		**Paula Woods, Director of People and OD.** No changes were proposed for BAF 6.	The Committee noted the update.
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK	BAF 4 and 6		None.	
Risks Escalated	BAF 4 and 6		None.	

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Council Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee / Group:	Strategic People Committee in Common		**Report to:**	Board of Directors
Date of Meeting:	21 January 2025		**Date of next meeting:**	18 February 2026
Chair:	Abdul Siddique, Non-Executive Director		**Parent Committee:**	Board of Directors
			Quorate (Yes/No):	Yes
Members Present / Attendees:	**Membership of the BCHT Committee** Abdul Siddique, Non-Executive Director (in the Chair) Elaine Inglesby, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Jo Waldron, Deputy Director of People and Organisational Development **Membership of the WHH Committee** Julie Jarman, Non-Executive Director Michelle Cloney, Chief People Officer Mike O'Connor, Non-Executive Director 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 Jane Hurst, Chief Financial Officer	**Attendees** Julie Jarman, Non-Executive Director Jennie Dwerryhouse, Deputy Chief People Officer John Culshaw, Company Secretary Kate Henry, Director of Communications and Engagement Paul Fitzsimmons, Joint Medical Director Ali Kennah, Joint Chief Nurse Mike O'Connor, Non-Executive Director Jane Hurst, Chief Finance Officer Rachel Hurst, Deputy Director of Finance (for Nick Gallagher) Ruth Besford, EDI Manager Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive	**Key Members not present:**	Committee Member: Nick Gallagher, BCH Director of Finance Adam Harrison Moran, Head of Strategic Workforce Development Elaine Inglesby, Non-Executive Director

	For WHH and BCH (Joint Directors) Dan Moore, Chief Operating Officer and WHH Deput Chief Executive Paul Fitzsimmons, Executive Medical Director Ali Kennah, Chief Nurse	Dan Moore, Joint Chief Operating Officer and WHH Deputy CEO Zinnirah Zainodin, Emergency Department Lead Andy Carter, WHH Chair (observing) Abdul Siddique, Non-Executive Director Lynne Carter, Director of Delivery Unit and BCH Deputy Chief Executive Director Tania Strong, Assistant Director of People and OD for Jo Waldron. Kathryn Sharkey, Assistant Director of Workforce Carol Kelly, Governor Kevin Goucher, Governor Lynda Richardson, Administrator		

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Council Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

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 – Children's Services (flexible working)	BAF 4 and 6		**Flexible Working Initiatives and Impact:** Jo Gibbins and Avril Smith from the 0-19 children's services, presented a detailed account of flexible working arrangements, including the nine-day fortnight and flexible retirement, discussing their implementation, benefits for staff and patients, and the challenges and outcomes observed, with questions and feedback. Flexible working isn't a magic bullet, but it's one part of an overall positive culture. National interest and case studies shared via NHS Employers for the 'Making Flexible Work' campaign Happier staff, healthier patients: the benefits of flexible working | NHS Employers	The Committee noted the update, with a request for data to see the quality impact of flexible working since the initiative's introduction.
Deep Dive PTIP Workforce and People Directorates	BAF 4 and 6		**Post-Transaction Workforce Integration and Communication:** Outline of the post-transaction implementation plan for workforce integration following the organisational acquisition, focusing on stabilisation, communication challenges, governance, and the management of staff concerns, with extensive discussion on assurance, benchmarking, and the role of middle management in effective communication.	The Committee noted the update. The committee noted a substantial rating for governance on this issue and a substantial rating for delivery.

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Workforce Brief on National, Regional, ICB, or Local Workforce Issues			Highlights were provided on the continuation of graduate employment for prescribed groups. Danny Mortimer has been appointed to the CPO for the department of health and social care. Employment Rights Act update was provided, impact identified being predominantly linked to changes to Industrial Action legislation.	The Committee noted the update.
Board Assurance Framework	BAF 6		**Paula Woods, Director of People and OD.** No changes were proposed for BAF 6.	The Committee noted the update.
Director of People & OD Report			**Paula Woods, Director of People and OD.** **The NHS Annual Staff Survey 2025 – Initial Staff Survey Result Tables** Initial embargoed survey results received in December. Confirmation received that due to our acquisition and integration agendas, we're able to share our results with WHH as the acquiring organisation. Work is well underway to have a joined-up approach to communication, engagement and action planning in relation to our respective results. **Delivering the Future NHS Workforce Solution (successor of the ESR System) -** We've been advised that Bridgewater hasn't been selected to be in the early adopter group, which means that we'll deploy in a later wave and will benefit from a more refined and proven approach, informed by early adopter learning. Based on NHSBA's current timelines, from Q3 (July–September) 2026, they'll be letting every organisation know which implementation group they're in. **Flexible Working: NHS Employers Webinar – 5th of March 2026** - NHS Employers and NHS England will jointly be hosting a webinar on the 5th of March to launch their refreshed flexible working hub on the NHS Employers website. The new toolkits and 'play your case study' videos (ours alongside two others) will feature and as part of the webinar. We're delighted to partake as a panellist speaker which will present an opportunity to share our experiences and take any questions that may arise.	The Committee noted the update.

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			Cheshire & Merseyside Organisational Development Network – Bridgewater chairing/launching an inaugural meeting to re-establish the OD Network - Members of Bridgewater's OD Team have reached out to OD Practitioners across Cheshire and Merseyside to invite them to attend a 'virtual' meeting on the 12th of January to explore setting up an OD Network. This is supported by the CPO Network and if established it will then report to that Network. **Warrington Together – Workforce & Organisational Development Group (the "WEG") -** The Committee received a 'Deep Dive' on the WEG in December and were advised that we now await the feedback from the Warrington Together Partnership Board meeting that's due to take place in February. Pending that, the WEG meetings have been 'paused' **Mutually Agreed Resignation Scheme - MARS Applications -** The Trust received a total of 67 MARS applications, QIAs took place on the 16th and 17th January, with Executive Panels scheduled to take place on the 28th and 30th January. **Staff Health & Wellbeing: Stress Survey** – Positive uptake seen since the launch on the 7th January, being used to understand the drivers of stress within our workforce. Further updates to be submitting following survey closure (31st January) **Captain Emma Grimshaw (Employee in our Children's Services) – Awarded MBE for services to the Military -** Emma, an army reservist was released from her role to become the Safeguarding Lead for "Operation Lazurite". The operation brought eligible Afghan civilians, who were at risk under the Taliban due to their work supporting UK forces, safely to locations all over the UK,	
ICB Workforce Programmes	BAF 4 and 6		**Lynne Carter, Director of Delivery/Deputy Chief Executive for BCH.** An update was provided in relation to the ICB initiatives including workforce reduction, reducing bank and agency usage. Mandy Nagra's replacement, Jude Lawson has paused all network groups pending further information on future direction.	The Committee noted the report.

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			Principle of internal sign-off identified prior to collective agreement on targets, with the provider collaborative blueprint being used as the vehicle for any actions. External training has been restricted with a focus on mandatory training. There is a recruitment freeze in place for non-clinical roles, and all vacant posts of longer than 6 months are being asked to be removed.	
Better Care Together Integration Update (Workforce and Corporate Services)	BAF 4 and 6		The estates workstream was discussed with the status noted. The Behavioural Framework has been approved along with development of an OD/Workforce design toolkit. Items escalated included the ESR demerge process and the requirement for Secretary of State approval for the new Trust, however a slot has now been 'held' for the new or pending this. Work is being undertaken on policies to prioritise what policies needs to be reviewed or changed prior to the 1st April (1500 to assess in total).	The Committee noted the report.
Workforce Integrated Performance Report	BAF 4 and 6		**Workforce Metrics, Sickness, and Recruitment Challenges** - An update was provided updates on workforce metrics, including sickness absence, turnover, vacancy rates, and recruitment challenges, with a focus on specific areas such as Padgate House, district nursing, and discussed ongoing interventions and monitoring processes. Seasonal absence and S10 data were the predominant reasons for absence, weekly meetings, top 10 areas for absence and triangulation to taking place and being reported via EMT. The ongoing stress survey data will also be used to inform actions. PDRs are being reported as below target and actions are underway to improve this. The impact of absence is being monitored via daily 'core staffing data' and the red flag system provides assurance in terms of professional judgements on	The Committee noted the update.

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			service delivery, business continuity plans, incident reporting and deferred visits in order to measure impact. A reduction in the apprenticeship levy data is representative of the need to run down the account prior to acquisition, however the levy is already being accessed via WHH in terms of funds.	
BCH People Strategy Bi-Annual Update	BAF 4 and 6		Progress against the Trust's People Strategy was highlighted, committee members discussed the pending survey results, noting lower response rates overall, discussed ongoing well-being initiatives, and highlighted the importance of continuous measurement and targeted interventions to address staff morale and engagement. Ongoing work is being predominantly focused around integration and how both organisations can contribute towards ongoing work and new people strategy, so there is a shift in focus towards this.	The Committee noted the update.
Annual Equality Delivery System (EDS) 2025/26	BAF 4 and 6		**Equality Delivery System Reports and Approvals:** BCH and WHH presented the mandated Equality Delivery System (EDS) reports, seeking committee approval for submission to the respective boards, with both reports demonstrating engagement with stakeholders and incremental improvements in organisational scores.	The Committee approved the report for escalation to Board.
REVIEW OF MEETING ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK	BAF 4 and 6		None.	
Risks Escalated	BAF 4 and 6		None.	

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Communities Matter
Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**5 FEBRUARY 2026**
Agenda Item	**12/26**		
Report Title	**QUALITY, SAFETY AND ASSURANCE COMMITTEE IN COMMON TERMS OF REFERENCE AND CYCLE OF BUSINESS**		
Executive Lead	Nikhil Khashu, Chief Executive		
Report Author	John Culshaw, WHH Company Secretary		
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 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 Quality, Safety and Assurance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1), effective February 2026). 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.

Previously considered by:

☐ **Audit Committee**	☐ **Quality and Safety Committee**
☐ **Finance, Sustainability and Performance Committee in Common**	☐ **Remuneration and 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**	**5 FEBRUARY 2026**
Agenda Item	**12/26**		
Report Title	**QUALITY, SAFETY AND ASSURANCE COMMITTEE IN COMMON TERMS OF REFERENCE AND CYCLE OF BUSINESS**		
Report Author	John Culshaw, WHH Company Secretary		
Purpose	This report seeks approval from the Board for the establishment of the Quality, Safety and Assurance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1), effective February 2026).		

1. BACKGROUND/CONTEXT

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 Quality, Safety and Assurance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective February 2026). 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 & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

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 Quality, Safety and Assurance Committee in Common is established to enable collaboration, shared oversight, and aligned decision-making on all aspects of quality, patient safety, clinical effectiveness, patient experience, and quality governance across Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

The Committee will provide assurance to both sovereign Trust Boards that high-quality, safe and effective care is being delivered and that quality strategies and governance arrangements support the Trusts' progression toward integration.

The CiC replaces the existing WHH Quality Assurance Committee and BCHT Quality and Safety Committee 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 two Non-Executive Directors (one serving as Chair per meeting location), Joint Chief Nurse and Joint Executive Medical Director and other joint roles such as the Joint Chief Operating Officer, Director of the Deliver Unit as well WHH and BCH roles such as but not limited to, Chief People Officer, Director of People and Organisational Development, Chief Strategy and Partnerships Officer Chief Finance Officer/Director of Finance, ensuring cross-Trust representation.

Quorum: Requires four members: two from each Trust, including one Non-Executive Director per Trust and the Joint Chief Nurse (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. maintaining flexibility for unilateral decisions if needed.

Authority: Authorised 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.

Duties: Provides strategic oversight and assurance on Quality Governance, Risk, Deep Dives and Performance Insight, Patient Safety and Investigations, Clinical Effectiveness, Patient Experience Staff Safety, Culture and Workforce-Related Quality Learning, Policy and Action Planning, Regulatory Compliance and External Requirements**,** Governance Structures and Connectivity Quality Accounts and Statutory Reporting

Benefits and Alignment

The CiC will:

- Enhance coordination, transparency, and shared scrutiny of quality governance, patient safety, clinical effectiveness and patient experience across both organisations ahead of integration.
- Provide a unified mechanism for identifying and managing quality-related risk 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. RECOMMENDATION

The Trust Board is asked to:

1. Approve the Terms of Reference for the Quality, Safety and Assurance Committee in Common (Version 1), effective February 2026.

2. Note the Committee's review schedule

TERMS OF REFERENCE
QUALITY, SAFETY & ASSURANCE COMMITTEE IN COMMON

1. PURPOSE

The Quality, Safety & Assurance Committee in Common (the *Committee*) is established to enable collaboration, shared oversight, and aligned decision-making on all aspects of quality, patient safety, clinical effectiveness, patient experience, and quality governance across Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the implementation and effectiveness of the integrated quality governance framework, ensures compliance with statutory and regulatory standards, and scrutinises risks, performance, learning and improvement activity across both organisations.

The Committee provides assurance to both sovereign Trust Boards that high-quality, safe and effective care is being delivered and that quality strategies and governance arrangements support the Trusts' progression 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)
- Joint Chief Nurse
- Joint Executive Medical Director
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Chief Finance Officer (WHH)
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Chief People Officer
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Deputy Chief Nurse & Director of Clinical Governance
- Deputy Medical Director
- Chief Pharmacist
- Director of Midwifery & Associate Chief Nurse /Midwifery Safety Champion Lead
- Associate Director of Quality

3.2 Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Joint Chief Nurse

- Joint Executive Medical Director
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Director of Finance (BCHT)
- Director of People and Organisational Development (BCHT)
- Deputy Chief Nurse

Attendees

- Joint Chief Executive
- Obstetrics/Obstetrics Safety Champion Lead & Governance Lead (WHH)
- Associate Chief Nurse (Planned Care) (WHH)
- Associate Chief of Nursing (Unplanned Care) (WHH)
- Head of Therapy / Lead AHP (WHH)
- Associate Medical Director - Patient Safety (WHH)
- Associate Medical Director - Clinical Effectiveness (WHH)
- Associate Chief Nurse/Associate DIPC (WHH)
- Senior Information Risk Owner (WHH)
- Associate Chief Nurse (BCH)
- Director of Quality 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 Joint Chief Nurse (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.

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

Quality Governance, Strategic Oversight & Assurance

- Monitor delivery of quality objectives as set out in each Trust's Quality Strategy and associated KPIs, ensuring alignment with organisational mission, vision and strategic priorities.
- Oversee the development, implementation and impact of enabling strategies relating to quality, including Quality Strategy, Risk Management Strategy, Clinical Effectiveness, Patient Experience, and Quality Improvement.
- Provide assurance that governance arrangements across both Trusts support safe, effective, compassionate and continuously improving care.

Risk, Deep Dives & Performance Insight

- Receive and scrutinise quality dashboards, IPR/ IQPR data, and thematic performance reports to provide assurance on all aspects of care quality, patient safety, patient experience and regulatory compliance.
- Commission and receive Deep Dive Reviews into key quality risks or areas of concern, including Serious Incidents and monitor delivery of related actions.
- Initiate additional reviews where Committee-led analysis indicates emerging risks or trends.
- Ensure effective escalation of quality concerns into sRisk Register and Board Assurance Framework of each Trust.

Patient Safety & Investigations

- Ensure each Trust maintains an appropriate incident reporting and investigation framework, including Mortality Review processes consistent with the Royal College of Physician's Structured Judgement Review methodology.
- Seek assurance that incident investigations, complaints, claims and learning reviews are undertaken to a high standard and that lessons learned are embedded across both organisations.
- Monitor delivery of national patient safety actions, statutory duties and summit recommendations.

Clinical Effectiveness

- Approve and oversee the Clinical Audit and Research Programmes for both Trusts, ensuring findings are acted upon and drive improvement.
- Monitor compliance with NICE guidance, external accreditation requirements and internal audit recommendations, ensuring appropriate remedial action where gaps exist.

Patient Experience

- Receive and scrutinise patient experience intelligence including complaints, compliments, survey results, patient involvement activity and equality considerations.
- Ensure patient voice, engagement and co-production influence service improvement and strategic quality priorities.

Staff Safety, Culture & Workforce-Related Quality

- Receive assurance regarding staff safety, safeguarding, training, wellbeing and other workforce-related quality risks that may impact patient care.
- Ensure links between workforce strategies and quality outcomes are clearly established and monitored.

Learning, Policy & Action Planning

- Ensure robust frameworks exist for policy development and review, staff training and organisational development relating to quality, safety and governance.
- Provide oversight of action plans arising from internal and external reviews, regulatory inspections, investigations and risk assessments—ensuring progress, escalation and sustained improvement.
- Oversee system-wide learning processes across both organisations so that aggregated insights lead to improvements in practice and reductions in avoidable harm.

Regulatory Compliance & External Requirements

- Obtain assurance on ongoing compliance with Care Quality Commission (CQC) registration requirements and other statutory and contractual obligations.
- Oversee implementation of recommendations arising from national inquiries, regulatory reviews, external inspections and significant audit findings.

Governance Structures & Connectivity

- Receive assurance that all reporting sub-committees across both Trusts have effective reporting lines, business cycles and escalation mechanisms.

Quality Accounts & Statutory Reporting

- Monitor processes for producing each Trust's annual Quality Account and provide assurance before submission to Audit Committees and Trust Boards.
- Review Committee assurance reports and support both Boards in fulfilling their responsibilities for quality.

Board Escalation

- Alert each Trust Board to emerging or significant concerns regarding standards of care, patient safety or quality governance, and advise on required actions.

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:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience and Inclusion Sub-Committee
- Health & Safety Sub-Committee
- Information Governance and Corporate Records Group
- Adult & Child Safeguarding Sub Committee

- Risk Review Group
- Quality Academy Sub-Committee
- Infection Prevention and Control Sub Committee
- Palliative Care and End of Life Sub Committee
- Medicines Governance Group
- Quality Compliance Oversight Group
- Research & Oversight Suc-Committee

BCHT:

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

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 5 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.

TERMS OF REFERENCE
REVISION TRACKER

Name of Committee:	Quality, Safety & Assurance Committee in Common
Version:	V1
Implementation Date:	January 2026
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:**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2025-2026

CALENDAR YEAR (APRIL 2025 - MARCH 2026)				2025											2026			
Item	**Reporting Frequency**	**Process**	**Lead**	**08-Apr**	**13-May**	**10-Jun**	**08-Jul**	**Extra 31-Jul**	**12-Aug**	**09-Sep**	**14-Oct**	**11-Nov**	**09-Dec**	**13-Jan**		**10/02/2025 CiC**	**10/03/2026 CiC**
STANDING AGENDA ITEMS																		
Welcome, apologies, declarations, cycle business, rolling attendance log	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Review Minutes and Action Log	Monthly	**Approval**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
OPENING AGENDA ITEMS																		
Patient Story	Bi-Monthly	**Noting**	Dep Chief Nurse		✓		✓			✓			✓ defer Nov	✓ defer Dec			✓
Deep Dive	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Compliance Update (WHH)	Quarterly	**Assurance**	Chief Nurse/Dep Dir Gov		✓Q4 deferred	✓Q4			✓Q1			✓Q2				✓Q3	
Hot Topics	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
COMPLIANCE & OVERSIGHT																		
Quality IPR Metrics (WHH)	Bi-Monthly	**Discuss & Assurance**	Chief Nurse	✓		✓			✓		✓		✓		Combined Committee	✓	
IQPR (BCH)	Bi-Monthly	**Discuss & Assurance**	Joint Chief Nurse/ Joint Chief Operating Officer													✓	
UEC Update	Monthly	**Assurance**	Chief Strategy & Partnerships Officer									✓	✓	✓		✓	✓
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	Chief Nurse														✓
MATERNITY UPDATE																		
Cheshire & Merseyside Perinatal Mortality Report (PMRT)	Quarterly	**Assurance**	Director of Midwifery		✓Q4				✓Q1			✓Q2			Common Committee in	✓Q3	
Avoiding Term Admission into Neonatal Unit (ATAIN)	Quarterly	**Assurance**	Director of Midwifery			✓Q4				✓Q1			✓Q2				✓Q3
Perinatal Mortality Report	Annually	**Assurance**	Director of Midwifery	✓													
Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Maternity Self Assessment Tool	Bi-Annually	**Assurance**	Director of Midwifery		✓							✓					
Maternity & Neonatal Quality Review Report	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Review of Harm Events	Bi-Annually	**Assurance**	Director of Midwifery	✓							✓						
Transitional Care Audit (limited time)	Quarterly	**Assurance**	Director of Midwifery			✓Q4				✓Q1			✓Q2				✓Q3
Post Partum Haemorrhage (Audit)	Bi-Annually	**Assurance**	Obstetric Governance Lead							✓						✓	
CQC Maternity Survey	Annually	**Assurance**	Director of Midwifery														✓
MNVP biannual report	Bi-Annually	**Assurance**	Director of Midwifery				deferred Aug		✓					deferred Feb		✓	
Birth Trauma position (limited time)	Annually	**Assurance**	Director of Midwifery				deferred 31 Jul	✓									
SAFETY																		
Mental Health Update	Quarterly	**Assurance**	Chief Nurse		deferred	✓ deferred	✓			✓			✓		Committee in		✓
Safeguarding Update Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse			✓ deferred	✓						✓ deferred	✓			
Medicines Management Report	Annually	**Assurance**	Exec Med Director		✓ deferred	✓											
Controlled Drugs Report	Annually	**Assurance**	Exec Med Director		✓ deferred	✓											
CIP/GIRFT Quality Impact Assessment Compliance QIA High Level Briefing	Bi-Annually	**Assurance**	Exec Med Director / Chief Finance Officer & Deputy CEO		✓							✓					
QIA Report (BCH)	Bi-Monthyl	**Assurance**	Chief Nurse														✓
Learning from Experience Report	Quarterly	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		Q4 deferred	✓Q4			✓Q1			✓Q2				✓Q3	
Serious Incident Oversight (BCH)			TBC													✓	
Staffing report - Safe Nurse Staffing	Bi-Annually	**Assurance**	Chief Nurse			✓ deferred	✓ deferred	✓					✓				
Director of Infection Prevention & Control (DIPC) Report	Quarterly	**Assurance**	Associate Director Infection Prevention and Control		✓Q4				✓Q1			✓Q2				✓Q3	
DIPC Report	Annually	**Assurance**	Associate Director Infection Prevention and Control				✓ deferred	✓									
Infection Prevention and Control BAF	Bi-Annually	**Assurance**	Associate Director Infection Prevention and Control				✓						Def Jan	✓			
PSIRF Bi-Annual Report	Bi-Annually	**Assurance**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓ deferred	✓						✓					

Mortuary Licensed Activity Report (Including Fuller update)	Bi-Annually	**Assurance**	Chief Nurse				✓							✓	Common		
Violence Reduction Strategy Update	Bi-Annually	**Assurance**	Chief Nurse			✓ deferred		✓						✓			
Health and Safety Report	Annually	**Approval**	Deputy Chief Nurse & Director of Clinical Governance & Quality				✓ deferred	✓						✓			
Sepsis High Level Update	Quarterly	**Assurance**	Dep Chief Nurse		✓Q4				✓Q1			✓Q2			✓Q3		
~NOF	Monthly	**Assurance**	Assoc Director of Planned Care						✓	✓	✓	✓	✓	✓	✓	✓	
MIAA Theatre Safety Audit	Monthly (until assurance received)Bi-monthly from June 2025	**Assurance**	Exec Med Director	✓	✓	✓			✓		✓		✓ defer as deep dive I November	✓ - can be included as part of Dec deep dive	✓		
Cardiopulmonary Resuscitation (CPR) Decisions and Discussions (Adults) Position Report	Bi-Annually	**Assurance**	Exec MD / Dep Chief Nurse	✓							✓						
CLINICAL EFFECTIVENESS																	
Learning From Deaths Review	Quarterly	**Assurance**	Exec Med Director			✓Q4				✓Q1			✓Q2				✓Q3
Clinical Audit Forward Plan	Annually	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality	✓													✓
Clinical Audit Report	Bi-Annually	**Assurance**	Associate Director of Quality						✓					✓			
PATIENT EXPERIENCE																	
Dementia Strategy Report and Annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse			✓ deferred		✓				✓					
Patient Experience & Inclusion Sub Committee Bi-annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓							✓						
PALS & Complaints Report (BCH)	Annually	**Approval**	Chief Nurse														✓
Complaints Report	Annually	**Approval**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓												
COMPLIANCE & OVERSIGHT																	
Board Assurance Framework ▪ WHH (inc Corporate Performance Report) ▪ BCH (Inc Risk Management Council Report)	Bi-Monthly	**Approval**	Company Secretary		✓		✓			✓		✓		✓	Committee in Common		✓
Annual Review of BAF risks (now included within the Committee Chair's Annual Report)	Annual	**Approval**	Company Secretary				✓										
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	CFO & Deputy CEO														✓
Quality Priorities Report	Quarterly	**Assurance**	Deputy Chief Nurse			✓Q4				✓Q1			✓Q2				✓Q3
Quality Priorities 2023-24	Annually	**Approval**	Chief Nurse														✓
Quality Account	Annually	**Approval**			✓ DRAFT	✓ FINAL											
Quality Strategy Update	Annually	**Assurance**								✓							✓
Quality Strategy Refresh 2024-27	3-yearly	**Assurance**															✓
Risk Management Strategy Report	Annually	**Assurance**				✓ deferred		✓									
Nursing & Midwifery Strategy Update	Annually	**Approval**	Dep Chief Nurse			✓ deferred		✓									
ED Improvement Programme Update	Monthly	**For assurance**	COO/EDM/CN& Dep CEO	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Quality Improvement Progress Report	Bi-Annually	**Assurance**	Associate Director of Quality						✓					✓			✓
Trust improvement Plan (BCH)	Bi-Monthly	**Assurance**	TBC														
Enabling Strategy Alignment Progress report	Bi-Annually	**Assurance**	Chief Strategy & Partnerships Officer			✓							✓ deferred	✓			
Patient Safety & Clinical Effectiveness Sub Committee Exception Report	Monthly	**Assurance**	Exec Medical Director	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Quality Council Report (Inc Effectiveness & Safety Group & NICE Guidelines Compliance **(BCH)**	Monthly	**Assurance**	Joint Chief Nurse													✓	
Palliative and End of Life Care Report (strategy updates)	Bi-Annually	**Assurance**	Cons Palliat Med	✓												✓	
Quality Impact Assessment high-level briefing paper (from July 25)	Bi-Monthly	**For assurance**	Chief Nurse, Executive Medical Director				✓			✓		✓		✓			✓
Information Governance + Corporate Records Group	Quarterly	**Assurance**	Chief Information Officer		✓					Q1				✓Q2			✓Q3
Quality Management System (paused awaiting **Impact**)	Annually	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance and Quality														
In-Patient Survey in the Patient Safety & Clinical Effectiveness Sub Committee Exception Report (October Report)	Annually	**Assurance**	Chief Nurse								✓						
Ward Accreditation Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓							✓						
Due Diligence update (from Jan 2026)	Monthly	**Assurance**	Chief Strategy and Partnerships Officer											✓		✓	✓
Review of MIAA Audits (as required) **BCH**																	✓
Claims Report	Bi-Annually	**Assurance**	Chief Nurse	✓							✓						
GOVERNANCE																	
Terms of Reference	Annually	**Approval**	Chair/Co Secretary														✓
Cycle of Business	Annually	**Approval**	Chair/Co Secretary														✓

Committee Effectiveness Annual Review	Annually	**Assurance**	Chair/Co Secretary	✓													
Committee Chair's Annual Report	Annually	**Assurance**	Chair/Co Secretary				✓										
Committee Annual Report (BCH)	Annually	**Assurance**	Director of Corporate Governance														✓
Committee Effectiveness Action Update	Annually	**Assurance**	Chair/Co Secretary								✓						
High Level Enquires & External Assessment / Inspections (when notified)	Monthly	**Assurance**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
MATTERS TO NOTE FOR ASSURANCE																	
Minutes from the Quality Academy Sub-Committee	Bi-Monthly	**Assurance**	Med Director/Chief Nurse			✓			✓				✓				
minutes from the Research Oversight Sub committee			Chief Nurse	✓		✓			✓		✓		✓			✓	
CLOSING MEETING																	
Items for Escalation to the Trust Board	Monthly	**Assurance**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Review of Meeting	Monthly	**Assurance**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓