North Cheshire and Mersey
NHS Foundation Trust

Trust Board – Part 1 (public)

Date and time:	3 June 2026, 10:00am – 12:30pm
Location:	Trust Conference Room, Warrington Hospital

Agenda item	Time	Agenda item	Objective/ desired outcome	Process	Lead
BM/26/06/ 023	**10:00**	Engagement Story – My ICU experience	***To note***	***Presentation***	Patient Mark Slater, Lead Nurse Medical Care Claudine Reynolds and ICU Ward Manager Alex Ingram
BM/26/06/ 024	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/26/06/ 025	**10:17**	Minutes and Action Log of the previous Trust Board meeting held on: **1 April 2026**	***For approval***	***Minutes***	Chair
BM/26/06/ 026	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/26/06/ 027	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/26/06/ 028	**10:35**	Chair's Report	***For info/update***	***Verbal***	Chair
Trust Board matters					
BM/26/06/ 029	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports	***For assurance***	***Report***	All Executive Directors

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

a)		**Quality Dashboard Including** Assurance Reports Quality Safety and Assurance Committee 14.04.2026, 12.05.2026	***For assurance***	***Report***	Chief Nurse, Cliff Richards, Committee Chair
b)		**People Dashboard Including** Assurance Reports Strategic People Committee 22.04.2026, 20.05.2026	***For assurance***	***Report***	Chief People Officer, Julie Jarman, Committee Chair
c)		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Performance Committee 27.04.2026, 22.05.2026	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
d)		**Audit Committee Including** Assurance Reports 23.04.2026, 30.04.2026	***For assurance***	***Report & Presentation***	Senior Independent Director Mike O'Connor Committee Chair
Quality					
BM/26/06/030	**11:05**	Fragile Clinical Services Update	***To note for assurance***	***Report***	Executive Medical Director
BM/26/06/031	**11:10**	**Maternity Summary Update Paper** i. Cheshire and Merseyside Perinatal Mortality Report (PMRT) Q4 ii. Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB) iii. Maternity Self Assessment Tool	***To note for assurance***	***Report***	Interim Director of Midwifery

		iv. Maternity and Neonatal Quality Review Report v. Review of Harm Events			
BM/26/06/032	**11:25**	Complaints Annual Report	***To note for assurance***	***Report***	Chief Nurse
People					
BM/26/06/033	**11:35**	Communications and Engagement Report	***For info/update***	***Report***	Director of Comms and Engagement
BM/26/06/034	**11:45**	Freedom to Speak Up Guardian Report	***To note for assurance***	***Report***	Chief Finance Officer/FT SU Exec Lead
Governance					
BM/26/06/035	**11:55**	**Terms of Reference** - Audit Committee **Cycles of Business** • Quality and Safety Assurance Committee • Strategic People Committee • Finance, Sustainability and Performance Committee • Audit Committee • Trust Board	***For approval***	***Report***	Company Secretary
BM/26/06/036	**12:05**	Council of Governors Terms of Reference and Cycle of Business	***For approval***	***Report***	Company Secretary
Closing					
BM/26/06/037	**12:10**	Review of Meeting	***For info/update***	***Verbal***	Chair
BM/26/06/038	**12:15**	Any Other Business	***For info/update***	***Verbal***	Chair

Supplementary Papers for Noting

Agenda item	Report Title	Assurance Committee	Objective/ desired outcome	Process	Lead
BM/26/06/039	Infection Prevention and Control Update Q4	Agenda Ref: QSAC/26/05/040 Date: 12.05.2026 Outcome: noted	For info/update	Report	Chief Nurse
BM/26/06/040	Patient Experience 6 Monthly Report – Patient Experience Sub-committee	Agenda Ref: QSAC/26/05/044 Date:12.05.2026 Outcome: noted	For info/update	Report	Chief Nurse
BM/26/06/041	Guardian of Safe Working Report Q4	Ref: SPC/26/05/036 Date:18.05.2026 Outcome: noted	For info/update	Report	Executive Medical Director

Date and time of next meeting:

5 August 2026, starting at 10am. Ground floor, Spencer House, Birchwood

North Cheshire and Mersey
NHS Foundation Trust

Intensive Care Experience

Mark’s story

Trust Board June 2026

Home
Community
Hospital

Background

October 2025

Attended ED after a fall from height

Multiple injuries admitted to ward for a few hours and transferred to ICU (pain management)

Discharged after 9 days

February 2026

Attended ED following a slip and suspected bleed on brain from wife due to confusion

Diagnosis Legionnaires Disease transferred to ICU and placed in an induced coma

Discharged after 4 weeks

My experience as a patient and my wife's experience as a visitor

• Home • Community • Hospital

Caring for you

Warrington ICU Experience

What went well and mattered to us

Diagnosis

Support

Warrington ICU Experience

What went well and the things that mattered

Personalised Care

Saving my life

Warrington ICU Experience

What could be improved

Communication

Consistency

Environment

Discharge

ICU Learnings

Communication

Level 1

Environment

Balcony

values

• **Home** • **Community** • **Hospital**

Caring for you

North Cheshire and Mersey
NHS Foundation Trust

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

- **Financial interests:**

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

- **Non-financial professional interests:**

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

- **Non-financial personal interests:**

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

- **Indirect interests:**

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 1 April 2026 Trust Conference Room, Warrington Hospital/Via MS Teams	
Present	
Andy Carter (AC)	Chair
Nikhil Khashu (NK)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Jayne Downey (JD)	Non-Executive Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Ali Kennah (AK)	Chief Nurse
Lynne Carter (LC)	Director of Delivery Unit
Apologies	
Paul Fitzsimmons (PF)	Executive Medical Director
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Paula Woods (PW)	Chief People Officer
John Culshaw (JC)	Company Secretary **(minutes)**
Eshita Hassan (EH)	Deputy Medical Director
Nicky Edmondson (NE)	Associate Director of Governance (**BM/26/04/001**)
Louise Dyer (LD)	PALS Officer
Tina Moors (TM)	Interim Director of Midwifery **(BM/26/04/12)**
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Alan Davies	Public Governor, Warrington and Halton
Catherine Ardern	Public Governor, Warrington and Halton
Stephen Walton	Public Governor, Warrington and Halton
Dorcas Akeju	Public Governor, Rest of England

Agenda Ref	Agenda Item
BM/26/04/001	**Engagement Story – PALS and Complaints**

	The Board received a comprehensive presentation outlining the current position of the PALS service, with a particular focus on activity, workforce capacity, service accessibility and future development. NE explained that demand has increased significantly, with activity rising by over 40 per cent in the last year. This reflects not only increased demand, but also a deliberate shift towards resolving concerns early through PALS rather than progressing to formal complaints. However, this shift had changed the nature of the workload. Cases are now more complex, frequently involve multiple services, and require coordination across clinical teams, resulting in increased administrative burden and longer closure times. The Board was advised that staffing capacity has been insufficient to respond to this demand. The loss of team members in September and November had resulted in a reduced workforce during a period of peak activity. This had direct operational consequences with reduced capacity at a time of peak activity, leading to delays in responses, reduced accessibility and the temporary closure of the walk in element of the service to protect response timeliness across other channels. AC asked for further clarity regarding the underlying drivers of increased demand. NE explained that appointment management and coordination were the primary source of patient concern, with delays and difficulties in arranging acceptable appointment times being a consistent theme. It was clarified that this aligns with known system pressures and is not isolated to PALS activity. NE confirmed that themes identified through PALS are escalated through governance processes and shared with care groups to inform service improvement and planning. The Board discussed how the service prioritises workload. LD outlined the daily triage process, where all contacts are reviewed each morning and urgent concerns, particularly those relating to inpatients, are prioritised and often result in direct ward level intervention by the PALS team. The Board noted the introduction of an updated complaints and PALS process, including a clear triage approach for simple and complex cases with defined response timeframes. The Board raised concerns regarding service accessibility and patient experience. JJ highlighted the absence of robust feedback mechanisms from service users, particularly regarding not just timeliness but the quality and effectiveness of responses. JJ emphasised the importance of understanding patient satisfaction across different modes of engagement, including telephone, electronic and face to face contact, in order to inform decisions about service model and office accessibility. NE acknowledged that this work was in development but not yet fully established. The Board also considered access across the Trust footprint. It was confirmed that face to face PALS services are currently delivered only from Warrington, with no physical presence at Halton. While telephone and remote access are available, members noted that this does not fully replace the value of in person contact, particularly for some patients. It was recognised that this reflects

	current staffing limitations and should be reviewed as part of the future integrated service model. NK advised that he reviews complaints and feedback regularly and had observed improvements in both tone and accessibility of responses. He specifically highlighted the importance of authentic apology and clear language, noting that many patient concerns relate to perceived lack of kindness or clarity rather than technical failings. This was reinforced as a key cultural message for the organisation. AC acknowledged the sustained pressure on the PALS team, including the increasing challenge of managing difficult interactions, and emphasised the need to ensure staff are supported and safe in their roles **The Trust Board noted and discussed the Engagement story and thanked NE and LM for sharing.**
BM/26/04/002	**Welcome, Apologies and Declarations of Interest** AC formally opened the meeting and reflected on the significance of the day, marking the establishment of North Cheshire and Mersey NHS Foundation Trust. He acknowledged both the scale and complexity of the integration process and the achievement of successfully delivering it on time and in line with plan AC noted apologies as detailed above. It was confirmed that there were no declarations of interest. **The Trust Board noted the apologies and declarations of interest.**
BM/26/04/003	**Minutes and Action Log of the previous meeting held on 4 February 2026, and 12 March 2026.** The minutes of the meetings held on 4 February 2026, and 12 March 2026 were reviewed. No amendments were proposed, and the Board formally agreed these as an accurate record. AC sought assurance regarding any outstanding matters arising from the former Bridgewater Board. JC advised that these had been appropriately reviewed and approved by the former Board but advised that he would review these minutes to confirm that there were no outstanding issues requiring escalation to the new Board In relation to the action log, the Board noted that the Board Assurance Framework and associated risks had been reviewed through Board development sessions and respective Committees, and were now presented for formal approval within the agenda. **Action:** JC to review Bridgewater legacy Board minutes and confirm whether any outstanding issues require escalation to the current Board. **The Trust Board approved the minutes of the meeting held on 4 February 2026, and 12 March 2026 and noted the Action Log**
BM/26/04/004	**Matters Arising**

	No other matters were raised. **The Trust Board noted that there were no matters arising.**
BM/26/04/005	**Chief Executive's Report** NK presented his report, marking the formation of the new Trust and formally recognising the contribution of both legacy organisations, their Boards, staff and governors. He noted that delivery of the integration on time and within financial parameters represented a significant achievement. NK also recognised the contribution of retiring and departing colleagues and welcomed new executive appointments to the Board. An update was provided on the Trust's regulatory position, including confirmation that enforcement undertakings had been agreed with NHS England. It was noted that this position is consistent with other organisations across the region and reflects the current challenges in urgent and emergency care, elective recovery and financial sustainability. The Board noted that the Trust remains in segment 4 of the national oversight framework but has improved its overall ranking, reflecting progress in key areas including elective and cancer performance. In response to questions regarding financial planning, NK described the recent request from NHS England to revise the Trust's financial plan within 24 hours. He confirmed that the Board had agreed to revise the plan and submit a response outlining options to achieve a 7% cost improvement target. He noted that there had been limited feedback from NHS England following submission, and that system level agreement on the overall plan remained unclear at the time of the meeting. JS asked how the Trust compared with other providers in the system. NK confirmed that the Trust was at the higher of required improvement levels alongside a small number of other organisations. The Board noted the report and the level of uncertainty associated with financial planning at system level. **The Trust Board noted and discussed the Chief Executive's**
BM/26/04/006	**Chair's Report** AC introduced his report and reflected briefly on his first three months in post, noting that this had been a transition period working closely with the outgoing Chair. AC placed on record his thanks to Steve McGuirk and Martyn Taylor for their open and supportive leadership during this period, which had significantly supported a smooth transition.

AC then drew the Board's attention to the core purpose of the NHS, referencing the Health and Care Act 2022. He emphasised that the Board should consistently focus on three areas: the effectiveness of services, the safety of services, and the quality of patient experience. AC asked Board members to actively apply these principles in all discussions and decision making, noting that this should be a practical framework for challenge rather than a statutory reference point. He highlighted that patient experience should be considered more broadly than metrics alone, referencing earlier discussion on the quality of PALS responses as an example.

The Board noted and supported this framing.

AC provided an update on a review of governance that would be undertaken, confirming that further work had been undertaken with NK and JC.. He advised that Non-Executive Directors had also discussed this at a recent development session, with agreement to structure Board focus around near-term, mid-term and long-term priorities.

AC explained that the near-term priorities relate to immediate operational and regulatory challenges and require the strongest Board focus. As part of this, he outlined a proposal to establish a dedicated governance mechanism, potentially an undertakings subcommittee reporting through Audit Committee, to ensure a clear, forward-looking focus on delivery and progress.

He noted that mid-term priorities relate to actions needed now to deliver outcomes over the next two to three years, while the long-term focus is on the development of a sustainable, integrated health organisation serving the North Cheshire and Mersey population. AC emphasised that, while all three timeframes are important, the Board's primary focus should remain on near-term delivery.

AC then provided reflections on digital and highlighted that digital should be embedded across all areas of the organisation, rather than treated as a separate function. He observed that current organisational thinking focuses on a triad of clinical, operational and financial leadership, and suggested that digital should be recognised as an equally important element.

AC outlined four key points. He noted that artificial intelligence is becoming a routine part of healthcare and that the Trust should make better use of the systems it already has. He also highlighted the need to make better use of data to support decision making and service improvement. AC encouraged the organisation to design digital services in a way that reflects how patients already use technology, rather than relying on separate systems. He also noted that automation and AI present a clear opportunity to improve productivity.

	AC emphasised that digital development will be essential to achieving the level of productivity improvement required over the next three to five years, and that the focus should now shift to practical implementation. **Action:** AC, NK and JC to develop proposals for a governance structure to oversee near-term priorities, including options for an undertakings subcommittee, for consideration by the Board. **The Trust Board noted the Chair's Report**
BM/26/04/007	**Board Assurance Framework (BAF)** JC advised that the papers were presented to approve a single consolidated Board Assurance Framework, and that he did not intend to repeat the detail given that the approach had already been reviewed through all Board Committees during the month and at the Board development session in the previous month. JC explained that the consolidated BAF brings together the legacy BAFs from Warrington and Bridgewater into one framework, with clearly defined strategic risks reflecting the Trust's expanded footprint, including community and dental services. JC confirmed that the strategic risks span the key areas the Trust needs to focus on, including quality, patient safety, urgent and emergency care and flow, elective recovery and health equity. JC further advised that the supporting papers set out the methodology used to develop the consolidated framework, including the mapping and analysis of legacy risks, and that they also explain the application of the three lines of defence model. JC reported that each Committee had supported the approach, and that further engagement had taken place with the Executive leads for each strategic risk between Committee meetings, which had resulted in minor updates. JC noted a specific point raised previously by JJ regarding strengthening the linkage between BAF 9 and BAF 4, confirming that this work was in progress and had been discussed with LG, and that the linkage would be further developed before the BAF returns to Committees and Board. JC confirmed that, taken together, the consolidated BAF and the risk appetite statements were presented for approval. NK highlighted two additional issues for note that they had not yet had an opportunity to discuss with the Executive team. The first to the potential impact of the Iran war on prices and the supply of goods, and the implications this could have for delivering services. The second related to the risk of resident doctor strikes, and the possibility of further industrial action over the next six months. It was acknowledged that the resident doctor strike risk would likely already be reflected within the BAF, but the potential inflationary and supply

	chain impacts associated with international instability were not clearly captured and warranted consideration. AC confirmed that the Board was content to approve the consolidated BAF and associated risk appetite statements, subject to the Executive team reviewing the supply chain and inflationary risk considerations and reflecting any necessary changes in the next iteration. **Action:** Executive team to review supply chain and inflationary risks arising from international instability and confirm whether any amendments are required to the BAF, with an update to the next Board meeting. **The Board approved the consolidated Board Assurance Framework, including the nine strategic risks, the quarterly reporting model and the Risk Appetite Statement for 2026/27, and noted the legacy risk mapping.**
BM/26/04/008	**Integration Update** NK confirmed that no formal paper had been brought to the meeting, explaining that this reflected the absence of any issues requiring escalation or decision on day one of the new organisation. NK advised that, during the transition period, arrangements had been in place to escalate any matters requiring Board approval ahead of go live, and confirmed that all necessary actions had been completed through the Committee structure in advance. In discussion, AC sought to confirm whether any aspect of the integration required further consideration elsewhere on the agenda. NK confirmed that there were no outstanding issues to highlight and reiterated that the programme remained on track. The Board noted the significance of reaching day one of the new organisation without the need for escalation, recognising the scale and complexity of the transaction. AC commented that the absence of issues requiring Board attention on day one was a strong position and reflected positively on the quality of planning and execution. Members acknowledged that the transaction represented a substantial organisational change and agreed that reaching this point without operational or governance concern was a significant achievement. AC formally expressed thanks to all colleagues involved in the integration, with particular recognition given to LG for leadership of the programme and to teams across the organisation for their contribution. The Board acknowledged that, whilst day one had been successfully achieved, further work remains to embed the new organisation and deliver the intended benefits of integration. It was agreed that the focus should now move to delivery and operational improvement in the next phase.

	The Board noted the successful delivery of day one of the integrated organisation, with no issues requiring escalation, and recorded its thanks to all staff involved in the programme.
BM/26/04/009	**Integrated Performance Report Refresh & Performance Assurance Framework (PAF) Refresh** JH presented the annual refresh of the Integrated Performance Report. JH explained that the IPR is refreshed at least annually, and also updated during the year where national changes or Trust requirements make this necessary. JH confirmed that the proposed changes had already been reviewed through the relevant Committees, including People Committee, Quality Committee and Finance Committee, and therefore there were no unexpected changes being brought forward. JH advised that the paper set out the recommended structure, including indicators that had been added, updated, removed or integrated, and that national oversight framework measures which had previously been shown separately were now included within the single IPR, bringing everything into one place for Board oversight. JH explained that Table 1 sets out removed indicators, noting that underlying detail will continue to be reported through Committees. Table 2 outlines updated indicators, including additional measures previously reported in Bridgewater, and Table 3 sets out new indicators. Overall, the number of metrics has increased from 94 to 104, primarily reflecting additional access and performance measures. JH sought Board approval of the revised framework and invited questions. In discussion, NK advised that the revised IPR and the effect of combining performance metrics had been discussed at the ICB Board the previous week. NK explained that the bringing together of data for the new organisation would present as a deterioration against the previous Warrington and Halton position, even though patient experience itself had not necessarily worsened, because the combined metrics would reflect a broader service footprint and different baselines. NK stated that the ICB had been supportive of the Trust being transparent about this, and he highlighted specific areas where the combined reporting position would change, including small differences in cancer performance and the RTT position, alongside the inclusion of a new community waiting metric relating to paediatric neurodevelopment. NK noted that these issues were not unexpected in the Cheshire and Merseyside context, because dermatology and paediatric neurodevelopment waits are recognised system wide challenges. NK emphasised that, whilst unsurprising, these remain significant priorities which the new organisation must address. The Board sought clarity on how dermatology is treated within RTT reporting, particularly the position on community versus hospital services. It was confirmed this remains under review. DH advised that, based on current guidance, community dermatology is unlikely to be included at present, subject

	to written confirmation. In the interim, performance will be reported separately, alongside hospital RTT excluding dermatology and a combined figure. DH also confirmed that diagnostic and cancer reporting will move to a single position, although the timing is yet to be agreed as this depends on merging two existing operational plans. NHS England will finalise the combined plan and confirm the point from which single reporting will apply, likely from month 6, with an update to be provided. JJ asked whether a summary could be provided to highlight key metrics linked to national requirements and the Board's immediate priorities. She noted that while the IPR supports discussion, a dashboard would help focus on the most important measures. AC confirmed this was being developed, with JC working on a single report bringing together key metrics. An early version has been shared internally but requires further development. JJ welcomed this and asked that it also include the Trust's ranking position. **Action:** JC to arrange for a Board dashboard summarising key national oversight framework measures and the Board's immediate priorities, including ranking position, and bring this into future reporting **The Board approved the revised Integrated Performance Report and Performance Assurance framework**
BM/26/04/010	**Integrated Performance Reports and Assurance Committee Report** The Board received the Integrated Performance Report and supporting Committee assurance, with detailed discussion focused on areas of performance risk, underlying drivers and the adequacy of improvement actions. The Board noted that the IPR pack identified a number of indicators of concern, including A & E waiting times, open incidents, capital delivery, Better Practice Payment Code performance, mortality indicators, CIP delivery and bank reduction. In relation to urgent and emergency care, the Board noted continued underperformance against 4 hour and 12 hour standards, with performance below national expectations. The Board recognised that this is largely driven by delays in patient flow, high bed occupancy and longer lengths of stay. DM explained that delayed discharges, particularly patients with no right to reside, were a key factor, reducing available capacity and contributing to pressure in the Emergency Department. The Board reviewed quality performance and noted a number of incidents remained open beyond expected timescales, reflecting pressures on team capacity. It was confirmed that processes are in place to monitor and escalate these cases, and the Board agreed that further review through the Quality Committee is required to support timely closure and learning. The Board also noted that mortality measures remain within the expected range, providing overall assurance, although some variation in trend was

	identified. It was agreed that this will be reviewed further through existing quality governance arrangements, including ongoing refinement of how performance data is interpreted. The Board reviewed financial and productivity performance and noted continued pressures across a number of areas, including capital delivery, cash performance, cost improvement delivery and workforce costs. While a revised capital forecast is expected to be achieved by year end, delivery remains behind plan at this stage. The Board noted challenges in achieving savings targets, including reliance on non-recurrent actions and the need to increase delivery of sustainable schemes. Bank spend remains above plan due to workforce pressures, although mitigations are in place. Encouraging performance was noted in diagnostics and workforce stability. The Board recognised the need for clearer oversight and stronger alignment, and agreed to strengthen reporting, maintain focus on delivery and support more effective and sustainable improvement **The Board discussed the IPR and Committee assurance, including areas of underperformance, underlying drivers and actions in place**
QUALITY	
BM/26/04/11	**Fragile Clinical Services Update** PF provided an update on the Trust's fragile clinical services, noting that the report was provided for information. It was confirmed that four services remain subject to enhanced oversight: fractured neck of femur, urology, chronic pain and rheumatology, and that cancer services had been de-escalated from fragile status during the month. It was further confirmed that no additional services had been escalated. In relation to fractured neck of femur, it was noted that there was no further update beyond what had been discussed previously, and the Board recognised that actions already described would continue to be progressed. The Board considered the position on chronic pain, where it was reported that progress had been made, including development of a new standard operating procedure for prescribing opioids and gabapentinoids, developed in partnership with community pharmacy and primary care colleagues. It was noted that this pathway is subject to final feedback prior to implementation. It was further reported that a workshop is planned for May to bring together primary and community care to develop a revised model of care with a greater focus on reablement and more holistic management, moving away from the current predominantly medical model. It was confirmed that the service would remain under fragile service status pending further progress. JJ sought assurance that patients are being involved early in developing the new chronic pain pathway, emphasising the need to draw on patient experience to ensure changes do not reduce access or shift risk

	inappropriately. In response, it was acknowledged that patient experience is key, and it was confirmed that work is underway to review patients currently waiting for treatment, including those awaiting repeat injections, with plans to engage them to understand their needs. It was noted that the immediate focus is on addressing the backlog while developing the future pathway with system partners. JJ reiterated that patient engagement should take place at the outset rather than after decisions are made. LG agreed to review and confirm that appropriate patient involvement is built into the pathway design, including alignment with any formal consultation requirements. The Board supported this and emphasised the importance of co-production The Board considered the position in urology and noted that the main issue remains a mismatch between demand and capacity. It was reported that higher priority cases, including cancer, continue to be prioritised and remain stable, while performance for routine surgery has shown some improvement. The Board noted that further work is planned with the ICB to address capacity and demand pressures at system level In relation to rheumatology, the Board noted that the service remains classified as fragile due to a backlog in prescribing disease modifying and biologic treatments. It was reported that the backlog has reduced significantly, from several hundred cases to double figures, and that patient communication has improved through the introduction of a managed email inbox. However, the prescribing pathway is still being developed, and the service will remain under close monitoring, with regular reporting through patient safety and escalation to the Quality Committee as needed. **The Board discussed the fragile services update and noted current risks and progress, agreeing that continued focus and oversight are required.**
BM/26/04/12	**Maternity Update** The Board received a detailed update on maternity quality, safety and workforce performance, noting that the reports had previously been reviewed through the Quality Assurance Committee. TM presented an overview of current performance, confirming that there had been no maternal or neonatal deaths and no severe harm events during the reporting period, with two moderate harm incidents recorded. TM advised that 141 patient safety incidents had been reported, which was considered indicative of an open reporting culture. The Board noted key areas of focus, including neonatal admissions and postpartum haemorrhage (PPH), which are monitored routinely as priority safety indicators.

TM reported that neonatal admissions remained above the Trust target, with a current rate of around 9% compared to a target of 6%. It was explained that actions are underway to address this, including implementation of a revised clinical pathway and further work on transitional care and early intervention. TM added that a significant proportion of admissions relate to respiratory issues, and changes have been made to clinical guidance, including maternal opioid use, with the aim of reducing avoidable admissions.

The Board noted that PPH rates had shown a slight increase, although robust governance arrangements are in place. TM confirmed that regional guidance has been implemented and further audit work is planned to assess the impact of these changes.

In relation to induction of labour, TM reported sustained improvement following targeted quality improvement work. Performance had improved significantly, with delays reducing in January.

NK welcomed this progress and sought to understand the reasons for the improvement.

TM explained that this had been achieved through detailed analysis of operational processes, including how patients are assessed and managed at different stages, and improvements in workforce deployment and decision making across different times of day. NK commended the team for the progress made and emphasised the value of applying similar approaches to other improvement areas.

The Board noted that workforce indicators remained stable, with no significant issues by exception, and that work is ongoing to improve appraisal completion rates. Triage performance was reported as strong, with good patient feedback and minimal delays.

TM provided an update on postnatal readmissions, noting a small number of cases in the period, some of which were identified as avoidable and linked to areas such as breastfeeding support and medication management. It was confirmed that learning has been identified and actions are being taken to improve discharge planning and communication with primary care.

AC sought assurance on external challenge and improvement support, asking whether there were sufficient opportunities for external review. TC confirmed that the service is engaged with regional networks, including LMNS, and is undertaking benchmarking and learning through site visits to other organisations. It was also noted that regular external review arrangements are in place through regional teams.

	JS emphasised the importance of maintaining Board focus on maternity quality, noting that national reviews have highlighted the risks where Boards reduce oversight. The Board agreed that continued scrutiny at Board level is essential to maintain safety and improvement. TM also provided an update on the Maternity Incentive Scheme, confirming that the Trust had submitted its self declaration within the required timescales and remained compliant. The Board noted changes to the scheme for the forthcoming year and the continued focus on safety actions. The Board reviewed the results of the CQC maternity survey, noting response rates slightly below the previous year and feedback highlighting areas for improvement including postnatal information, feeding support and discharge processes. Positive feedback was also noted in areas such as partner involvement and antenatal communication. An action plan has been developed and will be progressed through existing governance arrangements. **The Board discussed maternity quality and safety performance, noting the overall position, areas of improvement and ongoing risks.**
PEOPLE	
BM/26/04/13	**NHS National Staff Opinion Survey** The Board received an update on staff survey results, with a high level overview provided due to time constraints. It was reported that results across both organisations show a decline in several key areas. PW outlined that staff confidence in leadership has reduced, particularly in relation to visibility, responsiveness and organisational compassion. This is reflected in lower confidence among staff that concerns will be acted on, and a growing feeling that care quality is not always a priority The Board noted that wellbeing indicators have worsened, with increased reports of burnout, emotional exhaustion, bullying and violence, and a decline in overall morale and engagement. PW explained that staff are now less likely to recommend the organisation as a place to work or receive care, which aligns with national trends but remains a concern locally. PW highlighted that feedback across the People Promise themes shows a number of consistent issues. Perceptions of compassionate leadership and organisational behaviours have declined, and while staff continue to feel supported locally by immediate line managers, there is a weaker sense of being valued by the wider organisation. Confidence in staff voice has reduced, despite strong levels of perceived autonomy. PW added that access to development remains broadly positive, but the perceived value of appraisals has declined significantly. Flexible

	working remains a relative strength, although perceptions of work-life balance have worsened. Team working within teams remains strong, but coordination across the wider organisation is weaker The Board noted that staff engagement scores fell across both organisations. PW confirmed that Warrington is now below the national average for the first time in five years, while Bridgewater performed at the lower end of the benchmark group. Morale had also declined, driven by workload, pressure and burnout. PW explained that four main themes have been identified: wellbeing and workload pressures, leadership visibility, staff voice, and recognition and culture. It was noted that the organisation has moved from a more stable position to one where these issues are more prominent, and these areas will now guide the action plan going forward. It was confirmed that detailed analysis of free text responses is underway and will inform targeted actions, with results to be reviewed through the People Committee. AC sought clarity on the next steps and requested that a more detailed update be brought back to Board, including clear actions, delivery plans and expected outcomes. JS highlighted the importance of understanding more current staff sentiment, noting that survey results can lag behind real time experience, and PW confirmed that this will be supplemented with regular pulse surveys and other staff feedback mechanisms. JJ emphasised the importance of analysing free text responses to fully understand underlying issues, noting that this would provide richer insight into staff experience. PW confirmed that this work is underway and will be incorporated into the action planning process, alongside national expectations to demonstrate measurable improvement in key areas. **Action**: PW to bring a detailed action plan to a future Board meeting, including clear delivery actions, measures of impact and outcomes. **The Board noted the update and agreed the need for a focused and sustained response to address the issues identified.**
SUSTAINABILITY	
BM/26/04/14	**Bimonthly Strategy Highlight Report** The Board received an update from LG, who noted that the current report format does not fully reflect the range of ongoing work and will be revised going forward.

	LG advised that new national guidance on Best Start Family Hubs and Healthy Babies has been published, with the Trust's Living Well Hub included as a case study. LG outlined that the hub provides a wide range of services in one place, including maternity, health visiting, early years support, infant feeding and community services, and the Board noted this as a strong example of integrated delivery. LG provided an update on expected ICB requirements to submit proposals for neighbourhood health centres in June. Although formal confirmation has not yet been received, early engagement has started. LG confirmed that she has written to partners across Warrington and Halton to agree local priorities and ensure these are reflected in the ICB submission, including a request for a hub in Widnes. LG also confirmed that work has commenced on developing the Trust strategy and clinical strategy, with wider engagement planned. LG suggested that dedicated Board time would be helpful to support this work. In discussion, AC noted emerging national expectations regarding 3-5 year plans and emphasised that this aligns well with the timing of the Trust's strategy development. It was agreed that this work should be a priority for the Board. **The Board noted the update and supported the continued development of the Trust's strategy and engagement with partners to influence future service investment and design.**
BM/26/04/15	**Communications & Engagement Report** The Board received an update from KH covering communications and stakeholder engagement activity. KH advised that the report covered activity from January and February and did not require detailed walkthrough, as the information had been circulated in advance. KH highlighted that a significant focus during the period had been preparation for integration, including delivery of communications activity to support day one. This included the launch of the Trust's digital platforms, including the dermatology and dental websites, and engagement through the Patient and Public Reference Group. KH confirmed that activity had been focused on ensuring clear and consistent communication with staff, patients and stakeholders ahead of go live. KH reported that, overall, the communications and engagement activity had been delivered successfully, with day one activity proceeding smoothly and no issues identified requiring escalation.

	AC invited questions from the Board. No specific queries were raised in relation to the report. AC took the opportunity to acknowledge the scale of the communications work required to support integration and commended KH and the wider team for the quality and effectiveness of delivery. AC particularly noted the strength of internal engagement activity, including regular communication with staff and a clear and open approach throughout the process. **The Board noted the update and recognised the importance of continued communications and engagement in supporting the next phase of integration**
GOVERNANCE	
BM/26/04/14	**Terms of Reference: Quality & Safety Assurance Committee, Strategic People Committee, Finance, Sustainability & Performance Committee** JC introduced the Terms of Reference (ToR) and advised that the revised Terms of Reference establish a single, unified Committee structure for the Trust, replacing the previous Committees in Common arrangements and reflecting the new governance model following integration. It was noted that the revised arrangements create three formal Committees of the Board with clear delegated authority, providing consistent oversight across the organisation and strengthening accountability and reporting. **The Board approved the revised Committee Terms of Reference.**
Supplementary Papers – To note for Assurance	
BM/26/04/19 **BM/26/04/20** **BM/26/04/21** **BM/26/04/22**	**Learning From Experience Q3 Report** **Learning from Deaths Q3 Report** **Infection Prevention & Control Update Q3** **BCH Intersource PO Uplift Dermatology**
Closing	
BM/26/04/17	**Review of the Meeting** The Board reflected on the meeting, noting that it had been comprehensive and covered a wide range of topics. SF, in her capacity as Lead Governor, commented that the discussion on PALS had been particularly useful.
BM/26/04/18	**Any Other Business** AC invited any further business. A query was raised regarding the figures for the Intersource dermatology contract, and it was clarified that these reflected a call-off arrangement up to an agreed limit rather than a fixed allocation. The Board agreed to approve the request. **Meeting ended at 12:47pm**

Date and time of next meeting – 10am, Wednesday 3 June, Trust Conference Room, Warrington Hopstial

Signed:
Position: Chair
Date:

North Cheshire and Mersey
NHS Foundation Trust

Trust Board - Action Log

Agenda reference:	BM/26/06/003iii	Subject:	Action Log Trust Board	Date of meeting:	3 June 2026

1. Actions on agenda

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/26/04/009	**01.04.2026**	**Integrated Performance Report Refresh & Performance Assurance Framework (PAF) Refresh**	JC to arrange for a Board dashboard summarising key national oversight framework measures and the Board's immediate priorities, including ranking position, and bring this into future reporting	**John Culshaw**	**03.06.2026**	**03.06.2026**	Agenda Item BM/26/06/027	

2. Actions completed and closed off since last meeting

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/26/04/003	**01.04.2026**	**Minutes and Action Log of the previous meeting held on 4 February**	JC to review Bridgewater legacy Board minutes and confirm whether any outstanding issues	**John Culshaw**	**03.06.2026**	**03.04.2026**		

		2026, and 12 March 2026.	require escalation to the current Board.					
BM/26/04/006	**01.04.2026**	**Chair's Report**	AC, NK and JC to develop proposals for a governance structure to oversee near-term priorities, including options for an undertakings subcommittee, for consideration by the Board.	**John Culshaw**	**03.06.2026**	**06.05.2026**	ToR for Forum approved	
BM/26/04/007	**01.04.2026**	**Board Assurance Framework (BAF)**	Executive team to review supply chain and inflationary risks arising from international instability and confirm whether any amendments are required to the BAF	**All**	**03.06.2026**	**18.05.2026**	Risk added to corporate risk register	
BM/26/04/014	**01.04.2026**	**NHS National Staff Opinion Survey**	PW to bring a detailed action plan to a future Board meeting, including clear delivery actions, measures of impact and outcomes.	**Paul Woods**	**03.06.2026**	**06.05.2026**	Discussed at Board Development Session	

3. Rolling tracker of outstanding actions

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

RAG Key

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/027**			
Subject:	**Chief Executive's Report**			
Date of meeting:	3 June 2026			
Action required:	**Noting**			
Author(s):	Nikhil Khashu, Chief Executive			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This report provides an update on key developments since the last Board meeting, including the establishment of North Cheshire and Mersey NHS Foundation Trust, organisational developments and system collaboration. It also outlines ongoing engagement with NHS England in relation to enforcement undertakings and oversight arrangements, alongside progress in performance. Overall, the report reflects continued progress during a period of transition, with ongoing focus on improving patient outcomes, delivery and organisational sustainability.			
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
Recommendation:	The Board is asked to note the content of the Chief Executive's report.			
Previously considered by:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			

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

1. Background/context

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 1 April 2026, some of which are not covered elsewhere on the agenda for this meeting.

2. Key elements

2.1 Trust News

Establishment of North Cheshire and Mersey NHS Foundation Trust

April marked the formal establishment of North Cheshire and Mersey NHS Foundation Trust as a newly integrated organisation, bringing together hospital and community services under a single Trust. This represents a significant milestone in the delivery of more integrated, joined up care for the populations served across the Trust's footprint.

The transition reflects the collective efforts of colleagues across both predecessor organisations over an extended period and provides a strengthened platform from which to deliver high quality, sustainable services. The integration creates further opportunity to develop new ways of working, improve patient pathways and enhance the overall experience of care.

Introduction of the Trust Chair

Following the establishment of North Cheshire and Mersey NHS Foundation Trust, Andy Carter formally commenced in role as Chair. He brings a breadth of experience from public service and the private sector, including previous service as Member of Parliament for Warrington South and roles within central government.

The Chair has led his first Board meeting of the integrated organisation and begun engagement across services to understand priorities and opportunities for further development. Early areas of focus include improving access to care, strengthening urgent and emergency provision, enhancing patient flow and developing system partnerships.

A programme of engagement with staff, stakeholders and partners is now under way to support delivery of the Trust's strategic priorities.

Executive retirement

Ali Kennah, Chief Nurse, will retire later this year following more than 30 years of service in the NHS. Ali began her career in nursing in 1992 and has held a number of senior leadership roles, joining the Trust in 2017 as Head of Nursing before being appointed Chief Nurse in 2024.

Ali has made a significant contribution to the organisation, particularly in leading nursing, quality and patient care priorities during a period of considerable change. Her experience, leadership and commitment will be greatly missed across the Trust.

The Board places on record its sincere thanks to Ali for her longstanding service and dedication to the NHS and wishes her well for the future.

Organisational sustainability measures – Mutually Agreed Resignation Scheme

During the period, the Trust launched a further Mutually Agreed Resignation Scheme (MARS) as part of its wider approach to supporting organisational sustainability and service redesign.

MARS is a time limited, voluntary scheme which enables eligible employees, by mutual agreement, to leave employment in return for a severance payment. It is not a redundancy scheme and does not provide an automatic right to approval. All applications are subject to robust assessment, requiring a clear business case and alignment to the Trust's operational and financial priorities.

The scheme is intended to support organisational flexibility during a period of change, including creating opportunities for redeployment and reducing the risk of compulsory redundancies where possible.

Appropriate support has been made available to staff throughout the application period, including access to guidance, HR advice and trade union support, recognising the importance of ensuring colleagues are able to make informed decisions.

Awards, accreditations and achievements

The Trust has achieved a number of positive developments since the last Board meeting, reflecting continued progress in quality, inclusion and staff development.

The Trust has been re-accredited as a Veteran Aware organisation, recognising its ongoing commitment to supporting members of the armed forces community and their families. In addition, the Trust's Your Future Your Way programme has been recognised as a regional champion and shortlisted in the Valuing Our People category of the NHS Excellence Awards, providing external validation of the impact of this work in supporting leadership development and promoting equity across the workforce.

These achievements highlight the continued commitment of colleagues across the organisation to delivering high quality care and to fostering a positive and inclusive culture.

Service transformation – Gynaecology One Stop Clinic

The Trust has continued to develop its Gynaecology One Stop Clinic at Halton Hospital, which was introduced in September 2025 to streamline care for patients with symptoms suggestive of possible endometrial cancer.

The service provides a single visit pathway for assessment, diagnosis and, where appropriate, treatment, reducing the need for multiple hospital attendances and supporting earlier clinical decision making. Patients are seen promptly following referral and receive results within four weeks.

Since implementation, the clinic has supported more than 600 patients and has been associated with high levels of patient satisfaction. The model reflects effective multidisciplinary working and supports the Trust's ambition to deliver more efficient, patient centred pathways, improving both access to care and patient experience.

Celebrating the clinical workforce

During May, the Trust recognised the contribution of nursing, midwifery and operating department practitioner (ODP) colleagues through a series of national and international professional events.

These provided an opportunity to acknowledge the skill, professionalism and compassion demonstrated across hospital and community services, and the vital role these staff groups play in delivering safe, high quality care. The continued commitment, adaptability and teamwork shown by colleagues across these professions remain central to the Trust's ability to meet patient needs during a period of sustained operational challenge.

Shared learning and continuous improvement

The Trust's first Shared Learning Forum following integration was held at the end of April, bringing together colleagues, governors and Experts by Experience to share learning from quality and safety initiatives, improvement projects and patient and staff feedback.

The forum focused on continuous improvement and systems thinking, providing a platform to showcase collaborative working and highlight examples of best practice. This included a range of quality improvement initiatives aimed at enhancing patient outcomes and staff safety, alongside contributions from colleagues who have completed accredited Quality Improvement Practitioner training.

This approach supports the ongoing development of a learning culture across the organisation, enabling the spread of innovation and the continuous improvement of services.

Thank You Awards 2025 – 2026

The Trust held its annual Thank You Awards ceremony in May, marking the first awards event as North Cheshire and Mersey NHS Foundation Trust. The event recognised the contribution, achievements and teamwork of colleagues and partners across the organisation.

Awards were presented across a range of categories, reflecting excellence in clinical care, leadership, innovation and inclusion. The 2025 to 2026 winners were:

Clinical Team of the Year – Paediatric Respiratory Team;
Non Clinical Team of the Year – Medical Engineering Team;
Clinical Colleague of the Year – Dr Furhan Razzaq;
Non Clinical Colleague of the Year – Julie Cartledge;
Rising Star Award – Paula Salmon;
Inspiring Leader Award – Adam Harrison Moran;
Innovation, Improvement and Research Award – Ambient Voice Technology Project Team;
Diversity and Inclusion Award – Zetta Edwards;
Healthcare Hero – Jade Ward;
Charity Champion – Sacred Heart Catholic Primary School;
People's Choice Award – Cristobelle Federico;
Outstanding Achievement Award – Dr Lalitha Chinnappan.

The high quality of nominations reflects the significant impact of staff and volunteers in delivering care and supporting patients, families and communities. The event provided an important opportunity to recognise and celebrate excellence, reinforcing organisational values during a period of sustained operational challenge.

This event is only possible thanks to sponsorship from our generous partners, and I would like to express my heartfelt appreciation for their support.

Start of the Year Conference 2026

On 19 May 2026, the Trust held its Start of the Year Conference, bringing together leaders from across North Cheshire and Mersey NHS Foundation Trust to reflect on 2025/26 and set priorities for the year ahead.

The conference focused on organisational performance, key challenges and future direction following integration, with discussions covering priorities across urgent and emergency care, planned care, community services and clinical support functions.

A clear set of priorities for 2026/27 was outlined, including improving patient access, reducing long waits, strengthening patient flow and delivering more integrated, community based care. The event also supported early engagement on the Trust's longer term strategic ambition, including the development of an integrated, sustainable model of care aligned to the 2030 vision

2.2 National, Regional & ICB News

Appointment of Secretary of State for Health and Social Care

On 14 May 2026, The Rt Hon James Murray MP was appointed Secretary of State for Health and Social Care, succeeding The Rt Hon Wes Streeting MP. Mr Murray was previously Chief Secretary to the Treasury and now has responsibility for the work of the Department of Health and Social Care, including overall financial control and oversight of NHS delivery and performance, as well as oversight of social care policy. The appointment comes at an important time for the NHS, with continued national

focus on access, productivity, financial recovery, urgent and emergency care, community services and the development of more integrated models of care.

Resident doctors industrial action

The British Medical Association has announced a further period of industrial action by resident doctors in England, with strike action scheduled to begin at 7.00am on Monday 15 June 2026 and end at 6.59am on Friday 19 June 2026.

The announcement follows the continuation of the national dispute in relation to pay, jobs and working conditions, with the BMA indicating that further action may follow in July if progress is not made. The Trust is reviewing the implications for services and will continue to work through established operational, clinical and system arrangements to maintain safe care, prioritise urgent and emergency pathways, and minimise disruption to patients wherever possible.

The Board will be kept updated on the Trust's preparedness, operational impact and recovery arrangements as the position develops

NHS England correspondence – industrial action

The Trust received correspondence from Sir James Mackey, Chief Executive of NHS England, recognising the significant efforts of organisations in responding to the most recent period of BMA industrial action.

The letter acknowledges the increasing challenge of maintaining services during prolonged disruption, while noting that that high levels of patient care were sustained

The contribution of staff across the NHS in maintaining patient care was recognised, and the importance of continued preparedness for further industrial action was highlighted

System Collaboration - Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board meetings

As Chief Executive, I attended the recent Cheshire and Merseyside Provider Collaborative (CMPC) Leadership Board meetings held in April and May. Discussions focused on system wide priorities, including financial recovery, organisational change and the ongoing development of integrated models of care.

Updates were received from system partners on financial performance and recovery planning, alongside the introduction of proposals to simplify oversight arrangements and reduce duplication across existing governance structures. Further discussion considered the development of neighbourhood-based models of care and associated investment, with a shared focus on ensuring clear governance and effective delivery arrangements.

Updates were received on urgent and emergency care, system wide digital development and year end performance, which demonstrated continued improvement across elective, diagnostic, cancer and community services. There was a clear emphasis on maintaining this progress through coordinated system working.

In May, discussions included the system year end position, approaches to workforce and industrial action reporting, and delivery of transformation priorities. The Integrated Referral Model was identified as a key area of focus, alongside the development of community alternatives to emergency care. Across discussions, there was a consistent emphasis on prioritising a small number of high impact initiatives, supported by strong system alignment and clear delivery focus

NHS England oversight and enforcement undertakings

The Trust continues to engage with NHS England in relation to the enforcement undertakings issued in February 2026.

Progress is being made across financial planning, governance and reporting requirements, with continued focus on delivering sustained improvement in performance. The Trust remains subject to regular regional oversight, with updated arrangements bringing together performance, finance and quality within a single integrated framework.

The Trust will continue to work closely with NHS England and system partners to deliver the undertakings and support ongoing improvement.

Appendix 1 provides an update on the latest published NHS Oversight Framework metrics and highlights trend against the previous quarter publication.

2.3 Overview of Trust Performance

Appendix 2 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 1 – April 2026. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.4 Special Days/Weeks for professional groups

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

April 2026

- World Autism Acceptance Week
- Brain Tumour Awareness Month
- Ovarian Cance Awareness Month

- Prostate Cancer Awareness Month
- Lymphoedema Awareness Month
- Stress Awareness Month
- Healthcare Science Week
- National Administrative Professionals Day

May 2026

- National Walking Month
- Dying Matters Awareness Week
- International Day of the Midwife
- World Hand Hygiene Day
- Deaf Awareness Week
- Mental Health Awareness Week
- ME Awareness Week
- International Nurses Day
- National Day for Staff Networks
- National Operating Department Practitioner (ODP) Day
- Learning at Work Week
- Dementia Action Week
- International Human Resources Day
- International Clinical Trials Day
- Global Accessibility Awareness Day
- World Pre-Eclampsia Day

2.5 Signed under Seal

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

- Revisionary Lease of Food Court
- Wellfield Street Carpark Lease
- Runcorn Health Education Lease (Granville Street Library)

2.6 Meetings Attended

The following is a summary of some of key external stakeholder meetings I have attended in April and May 2026 since the last Trust Board meeting:

- Sir David Henshaw, Interim Chair, Cheshire & Merseyside ICB & Dr Liz Bishop, Interim Chief Executive, Cheshire & Merseyside ICB
- Sir Jim Mackey, Chief Executive, NHS England National CEOs Meeting
- Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Meeting
- Cheshire & Merseyside Provider Collaborative (CMPC) Delivery Board
- PricewaterhouseCoopers (PwC)

- Carl Marsh, Place Director, Cheshire & Merseyside ICB
- Andrew Donaldson, Chief Executive, Halton Borough Council
- Sarah Smith, Chief Executive, Warrington Borough Council
- Representatives of Warrington and Halton Borough Councils
- Linda Buckley, Managing Director CMPC
- NHS Leadership Academy
- Esther McVey MP
- Sarah Hall MP
- NW System Leaders

3. Recommendations

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

Appendix 1: National Oversight Framework Q3
Appendix 2: CEO Dashboard – Month 11 (February 2026)

Appendix 1

NHS Oversight Framework - NCM March 2026 Update

Trust Rank
106 out of 134
Previous quarter rank: **125** out of 134
down by 12 places

NHS
North Cheshire and Mersey
NHS Foundation Trust

Access to services			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q3 2025/26	2.81	**72** out of 118	▼		Q2 2025/26	3.08	**79** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q3 2025/26	1.00	**10** out of 118	▼		Q2 2025/26	1.00	**24** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Dec-25	3.58	**111** out of 131	▼		Sep-25	3.71	**117** out of 131
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Dec-25	2.43	**63** out of 131	▼		Sep-25	2.43	**83** out of 131
Elective care	Difference between planned and actual 18 week performance	Quarterly	Dec-25	2.65	**69** out of 131	▼		Sep-25	2.98	**98** out of 131
Elective Care	Percentage of patients waiting over 52 weeks for community services*	Quarterly	Dec-25	3.56	**36** out of 41	▲	Within exception slides	Sep-25	3.55	**35** out of 41
Urgent and emergency care	A&E within 4 hours	Quarterly	Q3 2025/26	3.60	**105** out of 123	▼	Within exception slides	Q2 2025/26	3.72	**112** out of 123
Urgent and emergency care	A&E within 12 hours	Quarterly	Q3 2025/26	3.90	**104** out of 119	▼	Within exception slides	Q2 2025/26	3.95	**117** out of 123

Effectiveness and experience			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quarterly	Dec-25	3.45	**104** out of 125	▼		Sep-25	3.69	**112** out of 126
Effective out of hospital care	Urgent Community Response 2-hour performance*	Quarterly	Q3 2025/26	1.15	**3** out of 38	▼		Q2 2025/26	1.15	**4** out of 50
Patient experience	Summary Hospital-level mortality indicator	Annually	Oct-24 - Sep 25	2.00	Not Ranked	▶		July 24 - June 25	2.00	Not Ranked
Patient experience	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked	▶		2024	2.00	Not Ranked

Finance and productivity			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Finance	Planned surplus/deficit	Quarterly	Q3 2025/26	4.00	**126** out of 134	▶		Q2 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Month 9 2025	4.00	**121** out of 134	▼		Month 6 2025	4.00	**124** out of 134
Finance	Combined finance	Quarterly	Q3 2025/26	4.00	Not Ranked					
Productivity	Implied productivity level	Quarterly	Q2 25/26 vs. Q2 24/25	3.50	**112** out of 134	▼		Q1 25/26 vs. Q1 24/25	3.62	**117** out of 134

Patient Safety			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Patient Safety	Number of MRSA bacteraemia cases	Quarterly	Jan 25 - Dec 25	2.66	Not Ranked	▲	Within exception slides	Oct 24 - Sept 25	2.60	Not Ranked
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Jan 25 - Dec 25	1.00	Not Ranked	▶		Oct 24 - Sept 25	1.00	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	2024	1.81	**37** out of 134	▶		2024	1.81	**37** out of 134
Patient Safety	Proportion of C. difficile infections	Quarterly	Jan 25 - Dec 25	3.20	Not Ranked	▶		Oct 24 - Sept 25	3.20	Not Ranked

People and Workforce			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric score**	**Rank**
Retention and culture	Sickness absence rate	Quarterly	Q3 2025/26	3.38	**120** out of 134	▼		Q2 2025/26	3.53	**126** out of 134
Retention and culture	NHS Staff survey engagement theme sub-score	Annually	2024	2.29	**58** out of 134	▶		2024	2.29	**58** out of 134

* Community indicators that will become NCM NOF indicators from April 26. Q1 26/27 will be published Sept 27

Key
▶ No Change
▼ Improvement
▲ Concern

Appendix 2 - CEO Dashboard Month 1 – April 2026

North Cheshire and Mersey NHS Foundation Trust

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	61	
Sepsis Screening Emergency	above 90%	78.00%	
Sepsis Screening Inpatients	above 90%	83.00%	
Sepsis Antibiotics Emergency	above 90%	54.00%	
Sepsis Antibiotics Inpatient	above 90%	83.00%	
Inpatient Falls	below YTD 40	48 YTD	
VTE	above 95%	95.81%	
Acute Pressure Ulcers (Category 2)	below YTD 9	9 YTD	
Acute Pressure Ulcers (Category 3 and Category 4)	below YTD 1	4 YTD	
Community Pressure Ulcers (Category 2)	below YTD 16	17 YTD	
Community Pressure Ulcers (Category 3 and Category 4)	below YTD 4	3 YTD	
Medication Reconciliation (within 24 hrs)	above 80%	49.00%	
Complaints over 6 months	0	1	
Healthcare Infections - MRSA	below YTD 0	0 YTD	
Healthcare Infections - MSSA	below YTD 3	3 YTD	
Healthcare Infections – CDI (cumulative)	below YTD 5	10 YTD	
Healthcare Infections - E. coli (cumulative)	below YTD 6	8 YTD	
Healthcare Infections – Klebsiella (cumulative)	below YTD 2	0 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	below YTD 1	0 YTD	
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	3.80%	
MUST nutritional assessment completion	above 85%	70.04%	
Duty of Candor	100%	100.00%	

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	5.72%	
Workforce FTE Plan Compliance	100% or below	98.98%	
Core/Mandatory Training	above 85%	91.49%	
PDR Compliance	above 85%	81.02%	

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	92.78%	
RTT 18 Weeks	above 92%	64.64%	
RTT - patients waiting 52+ Weeks	0	248	
RTT - patients waiting 65+ Weeks	0	1	
Elective Outpatient activity	104%	104%	
A&E % patients seen within 4 hours	Below 78.00%	68.41%	
A&E % waiting longer than 12 hours	Below 2.00%	21.66%	
% Patients referred to ED from UTC	Below 3.00%	9.67%	
Cancer 28 Day Faster Diagnostic Standard	above 75%	82.70%	
Cancer 62 Day Wait	above 85%	82.72%	
Ambulance Vehicle Handovers within 45 mins	100%	80.64%	
Cancelled Operations – not rearranged within 28 days	0	7	
Capped Theatre Utilisation	above 85%	75.02%	
Average days from discharge-ready to actual discharge	1 day or below	1.45 days	
Urgent Community Response (UCR)	70.00%	97.00%	
% Of Community Waiters over 52 weeks (exc. Derm and Dental)	0.00%	18.82%	
Number of patients waiting over 52 weeks (inc. Derm & Dental)	0	1805	
Number of patients waiting over 65 weeks (inc. Derm & Dental)	0	1305	
Number of patients waiting over 104 weeks (inc. Derm & Dental)	0	200	

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£4.85	-£5.80	
Capital Spend (£m)	£0.48	£0.12	
Cash Balance (£m)	£11.87	£28.78	
Better Practice Payment Code (£m)	above 95%	57%	
Agency Reduction (£m)	£0.2 (30% reduction from 2025/65 plan)	£0.22	
Bank Reduction (£m)	£2.32 (10% reduction from 2025/26 plan)	£3.34	
CIP In Year Delivered in relation to plan	90% of plan	100%	
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	65%	

Strategy

As of April 1st, the Better Care Together programme completed the planned transaction to integrate Warrington and Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT, creating North Cheshire and Mersey NHS FT. The integration programme will continue to be monitored by NHSE to ensure that planned benefits are delivered as outlined in the business case. Phase 2 of the programme commenced in April 2026, with a focus on clinical and corporate integrations.

The newly renamed Well Runcorn Hub is due to open to our residents in June 2026. It will provide a range of health, wellbeing and education services from the core providers (North Cheshire and Mersey NHS FT, Mersey Care NHS FT, Halton Borough Council, Riverside College), supplemented by complementary teams form the voluntary and community sectors. To support delivery, we have submitted our application for the location to be registered with CQC and have recruited successfully for a manager of the new hub.

The programme to develop a new organisation strategy and clinical strategy is underway, with staff and public engagement commencing across May and June. The strategies will be ratified by Board in early 2027.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/029**
Subject:	**Integrated Performance Report**
Date of meeting:	3 June 2026
Action required:	**The KPIs that are underperforming are managed in line with the Trust's Performance Assurance Framework.**
Author(s):	Janet Parker – Deputy Chief Finance Officer Andrew Hatfield – Performance and Systems Development Lead
Executive director sponsor:	Jane Hurst, Chief Finance Officer Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Paula Woods – Chief People Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 2: Urgent and Emergency Care Flow BAF 3: Planned Care Access & Elective Recovery BAF 5: Workforce Capacity, Capability & Wellbeing BAF 6: Financial Sustainability

Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and	**Yes**	**No**	**N/A**
				✓

	Armed Forces Act 2021:			
	Further Information / Comments:			
Executive summary:	The Trust has 81 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" and "Variation" principles and performance. **Table 1** sets out the "Assurance" and "Variation" of all indicators, of these, there are **four indicators that are both failing and have special cause variation of a concerning nature**, these are: • **32. Sepsis % of patients within an emergency setting, receive antibiotics within 1 hour of diagnosis to patient** – Target 90% • **68. Percentage of patients waiting over 52 weeks for community services (excluding dental and dermatology)** – Target 0% • **69. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology) -** Target zero • **72. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology) -** Target zero There are **no indicators that have special cause variation of a concerning nature and do not have a target.** There are **two indicators that consistently fail and cannot be measured for variation,** these are: • **61. CIP (recurrent) –** % delivered against plan • **63. Bank Reduction** – delivery against 10% reduction of 2024/25 plan There is **1 Indicator that has been requested via the Action Log to be monitored going forward,** This is: • **27. A&E Waiting Times** - Under 4 hour wait (% excluding WUTC)			

	There is **1 <u>Indicator that has been highlighted via the latest published NHS Oversight Framework metrics table,</u>** This is: • **Healthcare Acquired Infections (MRSA)**- Target zero There are **<u>nine indicators with recalculation points applied</u>** to improve the accuracy of the SPC charts in identifying significant shifts in process variation. Four are recalculated due to 7 or more data points above the mean: • **15. SHMI** • **49. Diagnostic Waiting Times (within 6 weeks)** • **66. Urgent Community Response (UCR) 2-Hour Compliance** • **77. Better Payment Practice Code (Cumulative)** Five recalculated following completion of waiting list validation after the Neurodevelopment data transformation process: • **67. Percentage of patients waiting over 52 weeks for community services (excluding dental and dermatology)** • **68. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology)** • **69. Percentage of patients waiting over 52 weeks for community services (including dental and dermatology)** • **70. Percentage of patients waiting over 65+ weeks for community services (including dental and dermatology)** • **71. Percentage of patients waiting over 104+ weeks for community services (including dental and dermatology)**

<table>
<tr><td></td><td colspan="3">Financial Position
At Month 1 the Trust has recorded a deficit position of £5.8m which is £0.9m worse than plan. The difference of £0.9m is due to a £0.9m impact of industrial action.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to:
1. Approve cash support of up to £14.781m from NHSE for Quarter 2 2026/27.
2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee.
Note the contents of this report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Finance + Sustainability Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">FSPC/26/05/024 (iii)
FSPC/26/05/024 (vi)</td></tr>
<tr><td>Date of meeting</td><td colspan="2">22/05/2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Cash support application supported for approval at Trust Board.

Changes to the capital contingency supported and approved.</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

1.1 IPR Indicators

All 81 Integrated Performance Dashboard (IPR) indicators have been placed into one of several “Assurance” categories and one of several “Variation” categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

Appendix 1 provides an update on the latest published NHS Oversight Framework metrics and highlights trend against the previous quarter publication.

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

The Integrated Performance Dashboard (**Appendix 3**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance and Sustainability

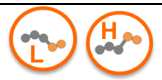
2. Key elements

2.1 Making Data Count Assurance and Variation Categories

Table 1 contains the number of IPR indicators in each Making Data Count “Assurance” and “Variation” category.

While some performance metrics do not fall within the highest-risk category highlighted in the top left of **Table 1**, those that continue to underperform should not be interpreted as improving. The current reporting approach prioritises metrics that are both underperforming and deteriorating, helping to focus attention on urgent issues. It is therefore essential that all consistently underperforming metrics – identified by an ‘F’ icon – are actively monitored and addressed, regardless of trend, to ensure sustained improvement and accountability.

Table 1: KPIs by Assurance and Variation Categories

	 Special Variation of a Concerning Nature	 Common Cause Variation	 Special Variation of an Improving Nature	 No SPC/Not Enough Datapoints/NA
 **Consistently Fails the Target (based on the last 7 months)**	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 30. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis ↓ **Access & Performance** 65. Percentage of patients over 52 weeks for community services (excluding dental and dermatology) 66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology) 69. Number of patients waiting over 104 weeks to access community services (including dental and dermatology)	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 1.Incidents ↑ 16. Medication Safety - Reconciliation within 24 hours 23. Complaints over 6 months 25. Friends and Family (ED and UCC) 27. Mixed Sex Accommodation Breaches (Non ITU) 28. Sepsis - % screening for all emergency patients 33. Maternity Postpartum Haemorrhage 35. MUST nutritional assessment completion **Access & Performance** 40. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 45 minutes 45. Percentage referred onto A&E from UTC 46. Patients seen in the Fracture Clinic within 72 hours 52. Cancer 62 Days First Treatment 59. Average number of days from discharge ready date to actual discharge date 62. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 63. Capped Theatre Utilisation 67. Number of patients waiting over 52 weeks to access community services (including dental and dermatology) 68. Number of patients waiting over 65 weeks to access community services (including dental and dermatology) **Workforce** 70. Supporting Attendance 73. PDR compliance **Finance** 76. Capital Programme **(£5.1m - *£18.9m target*)** 77. Better Payment Practice Code **(56% - *95% target*)**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 31. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ↓ **Access & Performance** 37. A&E Wait Times - % patients waiting under 4 hours (including WUTC) ↑ 38. A&E Wait Times - % patients waiting under 4 hours (excluding WUTC) ↑ 48. Referral to treatment Open Pathways 49. RTT - Number of patients waiting 52+ weeks	**CONSISTENTLY FAILING TARGET & NO SPC** **Finance** 79. Cost Improvement Programme (recurrent forecast) – % delivered against plan 81. Bank Reduction

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**Quality** 11. Acute Pressure Ulcers (Category 3 & 4) 12. Community Acquired Pressure Ulcers (Cat 2) 19. Average Fill Rate – Day registered nurses / midwives **Access & Performance** 47. Diagnostic Waiting Times 6 Weeks ↓ 56. Elective Outpatient Activity ↓	**Quality** 2.Healthcare Acquired Infections (MRSA) 3. Healthcare Acquired Infections (MSSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 8. VTE Assessment ↑ 9. Inpatient Falls & harm levels 10. Acute Pressure Ulcers (Category 2) 13. Community Acquired Pressure Ulcers (Cat 3 & 4) 21. Average Fill Rate – Night registered nurses / midwives 29. Sepsis - % screening for all inpatients 32. Acute Kidney Injury 36. Duty of Candor **Workforce** 71. Workforce FTE Plan Compliance	**Access & Performance** 50. 28 Day Faster Cancer Diagnosis Standard	**Finance** 80. Agency Reduction
	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
 **Consistently Passes the Target (based on the last 7 months)**	**Workforce** 72. Core/Mandatory Training	**Quality** 20. Average Fill Rate – Day care staff 22. Average Fill Rate – Night care staff 24. Friends and Family (Inpatients & Day cases) 26. Friends and Family (Community) **Access & Performance** 51. Cancer 31 Days First Treatment 61. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 64. Urgent Community Response (UCR) 2 hour compliance % **Finance** 78. Cost Improvement Programme – In year performance to date (£m)		

	NO ASSURANCE SPC & DECLINING PERFORMANCE	NO ASSURANCE SPC & VARYING PERFORMANCE	NO ASSURANCE SPC & IMPROVING PERFORMANCE	NO ASSURANCE SPC & NO SPC
No SPC **No SPC/Not Enough Datapoints/Not Applicable**		**Quality** 14. Mortality ratio – HSMR 15. Mortality ratio - SHMI 17. Acute Medication Incidents 18. Community Medication Incidents 34. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 39. Average time in department ED 44. Type 5 attendances 53. Reduction in Outpatient Follow Ups 57. Super Stranded Patients 58. No Criteria to Reside (NCTR) 60. % Patients discharged to their usual place of residence		**Access & Performance** 54. Elective Recovery Activity (Grouped SPCs) 55. Elective Recovery Diagnostic Activity **Finance** 74. Trust Financial Position (£m) 75. Cash Balance (£m)

Areas requiring focus – areas are failing to meet the target and declining in performance

Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either:
- **indicators not meeting (failing) their set target**
- **declining nature of the performance**

Improved category from previous IPR
Declined category from previous IPR
*** New metric**

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

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

The Trust submitted a deficit plan of £30.5m. The Trust was not allocated any deficit support funding (DSF) this year. There are several risks to the achievement of the planned deficit and future sustainability. The key risks are as follows:

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

Cash

The cash balance at the end of April is £28.8m of which £10.3m relates to capital creditors and £8.5m relates to underperformance cash being retained by the Trust until June 2026. Given the current cash position and the planned deficit for 2026/27 the Trust is in receipt of cash support. The Finance, Sustainability and Performance Committee discussed and supported the application for cash support for Quarter 2 2026/27 from NHSE. The Trust Board is asked to approve up to £14.781m cash support for Quarter 2 2026/27. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (57% against a target of 95%, 65% cumulative position in March 2026). Cash days are at 21 days which is broadly in line with last month (22 days). April's cash operating days have remained high as they were in March 2026 due to drawing down capital PDC cash before the end of year deadline some of which is still to be paid to suppliers.

CIP

At 30 April 2026, the Trust has delivered a CIP of £1.3m which is in line with plan. However, it should be noted that £0.5m has been achieved from non-recurrent vacancies and central items.

Of the £36.8m CIP plan £31.1m has been identified (84.5%) with £28.3m fully developed (76.9%). There is a significant risk to the Trust if it cannot deliver recurrent CIP in 2026/27 therefore further work is required to identify recurrent CIP and turn current non-recurrent schemes recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.

Capital Programme

The Trust total capital funding consists of £16.1m Capital Departmental Expenditure Limit (CDEL) and £5.9m external funding, a total of £22m. The Trust also has £1.6m DHSC funded IFRS16.

The Trust capital spend for month 1 is £0.1m which is £0.5m below the plan of £0.6m. This is mainly due to capital schemes originally planned for 2026/27 being brought forward to 2025/26. The plan is expected to be fully delivered by year end.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

	Acute Contingency		C&D Contingency		TOTAL	
DETAIL	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Contingency balance start of month 1		**190**		**150**		**340**
Proposed changes in month						
VAT rebate		**36**				**36**
Requests supported at CPG						
Well Sky upgrade	- 21				- **21**	
Garden Sensory - to be funded from Charitable Funds						
Sub Total		- **21**		-		- **21**
Funding no longer required and to be returned to contingency						
Decarbonisation - GBE Solar (to be funded from CIR)	256				**256**	
Additional hardware to digitise wards and OPD (Defer and ringfence in 2027/28)	913				**913**	
Sub Total		**1,169**		-		**1,169**
Contingency as at end of month 1		**1,374**		**150**		**1,524**

The Trust Board is asked to:

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

3. Actions required/responsible officer

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

4. Assurance committee

The following committees provide assurance to the Trust Board:

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

5. Recommendations

The Trust Board is asked to:

1. Approve cash support of up to £14.781m from NHSE for Quarter 2 2026/27.
2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee.
3. Note the contents of this report.

Appendix 1

NHS Oversight Framework - NCM March 2026 Update

Trust Rank
106 out of 134
Previous quarter rank: **125** out of 134
down by 12 places

NHS
North Cheshire and Mersey
NHS Foundation Trust

Access to services			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quarterly	Q3 2025/26	2.81	**72** out of 118	▼		Q2 2025/26	3.08	**79** out of 118
Cancer Care	62 day cancer treatment	Quarterly	Q3 2025/26	1.00	**10** out of 118	▼		Q2 2025/26	1.00	**24** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quarterly	Dec-25	3.58	**111** out of 131	▼		Sep-25	3.71	**117** out of 131
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quarterly	Dec-25	2.43	**63** out of 131	▼		Sep-25	2.43	**83** out of 131
Elective care	Difference between planned and actual 18 week performance	Quarterly	Dec-25	2.65	**69** out of 131	▼		Sep-25	2.98	**98** out of 131
Elective Care	Percentage of patients waiting over 52 weeks for community services*	Quarterly	Dec-25	3.56	**36** out of 41	▲	Within exception slides	Sep-25	3.55	**35** out of 41
Urgent and emergency care	A&E within 4 hours	Quarterly	Q3 2025/26	3.60	**105** out of 123	▼	Within exception slides	Q2 2025/26	3.72	**112** out of 123
Urgent and emergency care	A&E within 12 hours	Quarterly	Q3 2025/26	3.90	**104** out of 119	▼	Within exception slides	Q2 2025/26	3.95	**117** out of 123

Effectiveness and experience			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quarterly	Dec-25	3.45	**104** out of 125	▼		Sep-25	3.69	**112** out of 126
Effective out of hospital care	Urgent Community Response 2-hour performance*	Quarterly	Q3 2025/26	1.15	**3** out of 38	▼		Q2 2025/26	1.15	**4** out of 50
Patient experience	Summary Hospital-level mortality indicator	Annually	Oct-24 - Sep 25	2.00	Not Ranked	▶		July 24 - June 25	2.00	Not Ranked
Patient experience	CQC Inpatient survey satisfaction rate	Annually	2024	2.00	Not Ranked	▶		2024	2.00	Not Ranked

Finance and productivity			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Finance	Planned surplus/deficit	Quarterly	Q3 2025/26	4.00	**126** out of 134	▶		Q2 2025/26	4.00	**126** out of 134
Finance	Variance year-to-date to financial plan	Quarterly	Month 9 2025	4.00	**121** out of 134	▼		Month 6 2025	4.00	**124** out of 134
Finance	Combined finance	Quarterly	Q3 2025/26	4.00	Not Ranked					
Productivity	Implied productivity level	Quarterly	Q2 25/26 vs. Q2 24/25	3.50	**112** out of 134	▼		Q1 25/26 vs. Q1 24/25	3.62	**117** out of 134

Patient Safety			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric Score**	**Rank**
Patient Safety	Number of MRSA bacteraemia cases	Quarterly	Jan 25 - Dec 25	2.66	Not Ranked	▲	Within exception slides	Oct 24 - Sept 25	2.60	Not Ranked
Patient Safety	Proportion of E. coli bacteraemia	Quarterly	Jan 25 - Dec 25	1.00	Not Ranked	▶		Oct 24 - Sept 25	1.00	Not Ranked
Patient Safety	NHS Staff Survey - raising concerns sub-score	Annually	2024	1.81	**37** out of 134	▶		2024	1.81	**37** out of 134
Patient Safety	Proportion of C. difficile infections	Quarterly	Jan 25 - Dec 25	3.20	Not Ranked	▶		Oct 24 - Sept 25	3.20	Not Ranked

People and Workforce			Current Qtr. Published					Previous Qtr. Published		
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Metric Score**	**Rank**	**Trend**	**Narrative provided**	**Reporting Date**	**Metric score**	**Rank**
Retention and culture	Sickness absence rate	Quarterly	Q3 2025/26	3.38	**120** out of 134	▼		Q2 2025/26	3.53	**126** out of 134
Retention and culture	NHS Staff survey engagement theme sub-score	Annually	2024	2.29	**58** out of 134	▶		2024	2.29	**58** out of 134

* Community indicators that will become NCM NOF indicators from April 26. Q1 26/27 will be published Sept 27

Key
▶ No Change
▼ Improvement
▲ Concern

Statistical Process Control - Assurance & Variation

NHS
North Cheshire and Mersey
NHS Foundation Trust

Appendix 2

Key:

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

		Latest				Previous		
	QUALITY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
1	Incidents	0	61	Apr-26		160	Mar-26	F
2	Healthcare Acquired Infections (MRSA)	0 (for 2026/27)	0	Apr-26		0	Mar-26	?
3	Healthcare Acquired Infections (MSSA)	32 (for 2026/27	3	Apr-26		1	Mar-26	?
4	Healthcare Acquired Infections (CDI)	65 (for 2026/27)	10	Apr-26		7	Mar-26	?
5	Healthcare Acquired Infections (Ecoli)	75 (for 2026/27)	8	Apr-26		9	Mar-26	?
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2026/27)	0	Apr-26		1	Mar-26	?
7	Healthcare Acquired Infections (PA)	8 (for 2026/27)	0	Apr-26		0	Mar-26	?
8	VTE Assessment	95.00%	95.81%	Apr-26		95.21%	Mar-26	?
9	Inpatient Falls	10% reduction from 2025/26	48	Apr-26		57	Mar-26	?
10	Acute - Total Pressure Ulcers (Category 2)	20% reduction from 2025/26	9	Apr-26		14	Mar-26	?
11	Acute - Total Pressure Ulcers (Category 3 & 4)	20% reduction from 2025/26	4	Apr-26	H	0	Mar-26	?
12	Community Acquired Pressure Ulcers (Category 2)	20% reduction from 2025/26	17	Apr-26	L	14	Mar-26	?
13	Community Acquired Pressure Ulcers (Category 3 and above)	20% reduction from 2025/26	3	Apr-26		4	Mar-26	?
14	Mortality ratio - HSMR	No target set	91.95	Apr-26		90.27	Mar-26	No SPC

Statistical Process Control - Assurance & Variation

NHS
North Cheshire and Mersey
NHS Foundation Trust

Appendix 2

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
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15	Mortality ratio - SHMI	No target set	103.55	Apr-26		101.90	Mar-26	No SPC
16	Medication Safety Reconciliation within 24 hours	80.00%	49.00%	Apr-26		47.00%	Mar-26	F
17	Acute Medication Incidents	No target set	110	Apr-26		106	Mar-26	No SPC
18	Community Medication Incidents	No target set	13	Apr-26		28	Mar-26	No SPC
19	Average Fill Rate - Day registered nurses / midwives	90%	90.70%	Apr-26		90.63%	Mar-26	?
20	Average Fill Rate - Day care staff	90%	91.83%	Apr-26		93.06%	Mar-26	P
21	Average Fill Rate - Night registered nurses / midwives	90%	92.19%	Apr-26		88.33%	Mar-26	?
22	Average Fill Rate - Night care staff	90%	106.67%	Apr-26		106.14%	Mar-26	P
23	Complaints	Zero complaints open over 6 months old/in the backlog	1	Apr-26		2	Mar-26	F
24	Friends and Family (Inpatients & Day cases)	95%	96.10%	Apr-26		96.44%	Mar-26	P
25	Friends and Family (ED and UCC)	87%	76.47%	Apr-26		71.45%	Mar-26	F
26	Friends and Family (Community)	90%	93.65%	Apr-26		93.65%	Mar-26	P
27	Mixed Sex Accommodation Breaches (ITU)	0	13	Apr-26		14	Mar-26	F
28	Sepsis - % screening for all emergency patients.	90.00%	78.00%	Apr-26		55.00%	Mar-26	F

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

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29	Sepsis - % screening for all inpatients	90.00%	83.00%	Apr-26		88.00%	Mar-26	
30	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	54.00%	Apr-26		54.00%	Mar-26	
31	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	83.00%	Apr-26		68.00%	Mar-26	
32	Acute Kidney Injury	Less than previous month	142	Apr-26		193	Mar-26	
33	Maternity Postpartum Haemorrhage	3.70%	3.80%	Apr-26		7.60%	Mar-26	
34	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	39%	Apr-26		35%	Mar-26	No SPC
35	MUST nutritional assessment completion	above > 85%	70.04%	Apr-26		74%	Mar-26	
36	Duty of Candor	100%	100.00%	Apr-26		94%	Mar-26	

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
37	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	68.41%	Apr-26	H	66%	Mar-26	F
38	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	73.30%	Apr-26	H	71%	Mar-26	F
39	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	21.66%	Apr-26		23.6%	Mar-26	F
40	Average time in department ED	No Target	369	Apr-26		393	Mar-26	No SPC
41	Ambulance Handovers within 15 minutes	65%	36.86%	Apr-26		34.19%	Mar-26	F
42	Ambulance Handovers within 30 minutes	95%	68.90%	Apr-26		67.06%	Mar-26	F
43	Ambulance Handovers within 45 minutes	100%	80.64%	Apr-26		79.04%	Mar-26	F
44	Type 5 attendances	No Target set	2661	Apr-26		2521	Mar-26	No SPC
45	Percentage referred onto A&E from UTC	3% or below	9.67%	Apr-26		9.48%	Mar-26	F
46	Patients seen in the Fracture Clinic within 72 hours	95%	84.80%	Apr-26		69%	Mar-26	F
47	Diagnostic Waiting Times 6 Weeks	95.00%	92.78%	Apr-26	L	97.05%	Mar-26	?
48	Referral to treatment Open Pathways	92.00%	64.64%	Apr-26	H	65.27%	Mar-26	F
49	Referral to treatment - Number of patients waiting 52+ weeks	0	248	Apr-26	L	244	Mar-26	F

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50	28 Day Faster Cancer Diagnosis Standard	75%	82.70%	Mar-26	H	80.47%	Feb-26	?
51	Cancer 31 Day Wait	96%	98.23%	Mar-26		98.85%	Feb-26	P
52	Cancer 62 Day Wait	85%	82.72%	Mar-26		81.33%	Feb-26	F
53	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	77%	Apr-26		92%	Mar-26	No SPC
54	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
55	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
56	Elective Outpatient Activity	104%	84%	Apr-26	L	106%	Mar-26	?
57	Super Stranded Patients	Trajectory	125	Apr-26		153	Mar-26	No SPC
58	No Criteria to Reside (NCTR)	No Target set	168	Apr-26		188	Mar-26	No SPC
59	Average number of days from discharge ready date to actual discharge date	1 Day or less	1.45	Apr-26		1.94	Mar-26	F
60	% Patients discharged to their usual place of residence	No Current Threshold	97%	Apr-26		96%	Mar-26	No SPC
61	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	1.54%	Apr-26		1.82%	Mar-26	P
62	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	7	Apr-26		1	Mar-26	F

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

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63	Capped Theatre Utilisation	85%	75.02%	Apr-26		74.00%	Mar-26		
64	Urgent Community Response (UCR) 2 hour compliance %	70%	97.00%	Apr-26		95.00%	Mar-26		
65	Percentage of patients over 52 weeks for community services (**excluding** dental and dermatology)	0%	18.82%	Apr-26		18%	Mar-26		
66	Number of patients waiting over 104+ weeks to access community services (**excluding** dental and dermatology)	0	197	Apr-26		111	Mar-26		
67	Number of patients waiting over 52 weeks to access community services (**including** dental and dermatology)	0	1805	Apr-26		1729	Mar-26		
68	Number of patients waiting over 65 weeks to access community services (**including** dental and dermatology)	0	1305	Apr-26		1236	Mar-26		
69	Number of patients waiting over 104 weeks to access community services (**including** dental and dermatology)	0	200	Apr-26		114	Mar-26		

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

Appendix 2

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Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

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		Latest				Previous		
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
70	Supporting Attendance	5.00%	5.72%	Apr-26		5.89%	Mar-26	
71	Workforce FTE Plan Compliance	100% Plan	98.98%	Apr-26		101%	Mar-26	
72	Core/Mandatory Training	85.00%	91.49%	Apr-26		91.48%	Mar-26	
73	PDR compliance	85.00%	81.02%	Apr-26		81.76%	Mar-26	

Statistical Process Control - Assurance & Variation

North Cheshire and Mersey NHS Foundation Trust

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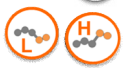
Special Cause Variation of a improving nature.

Common Cause (Normal Variation).



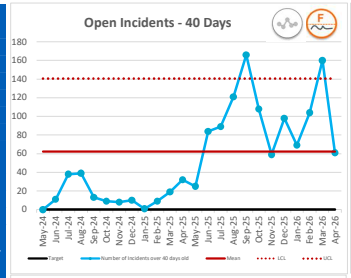
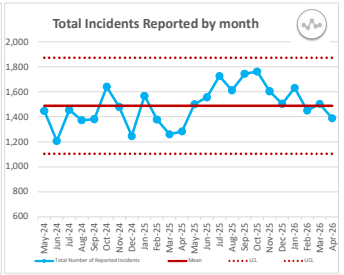
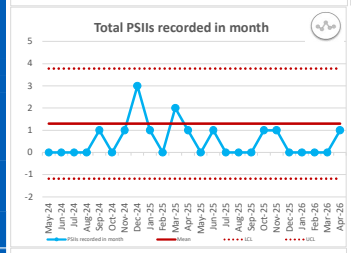
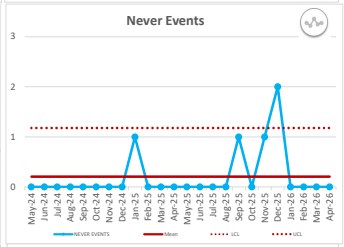
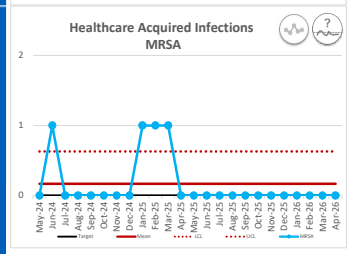
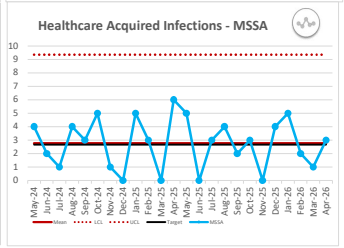
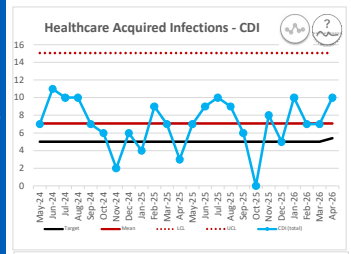
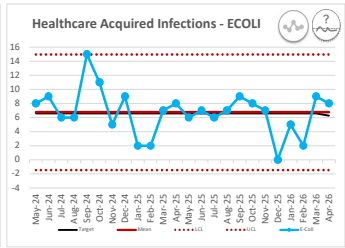
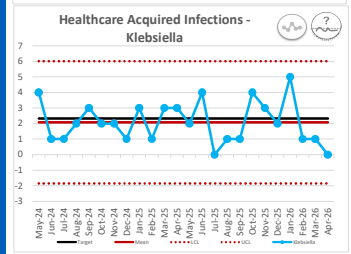
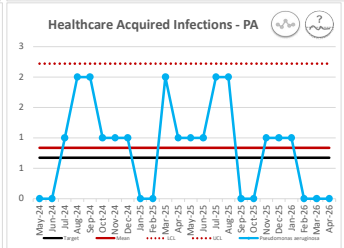
Special Cause Variation of a concerning nature.

Consistently passes the target

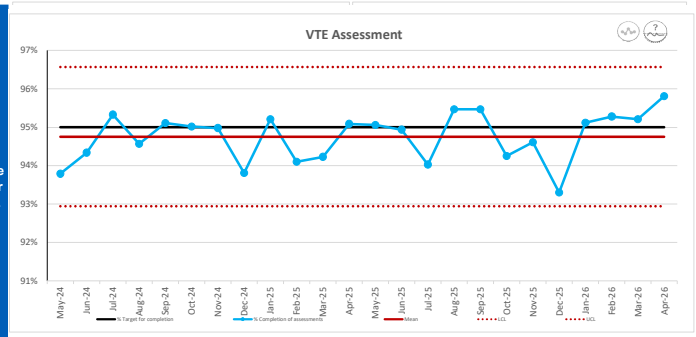
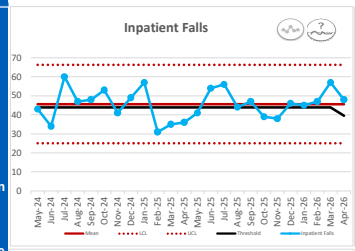
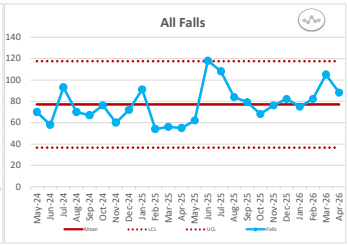
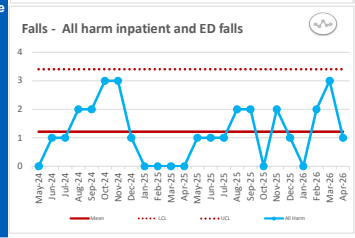
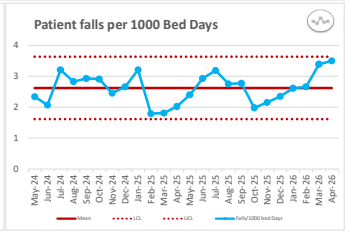
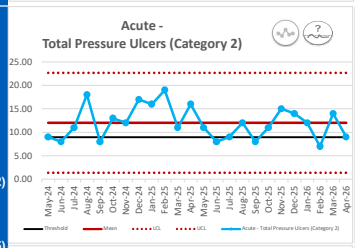
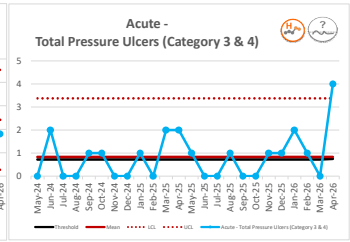
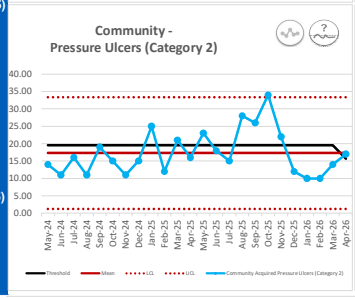
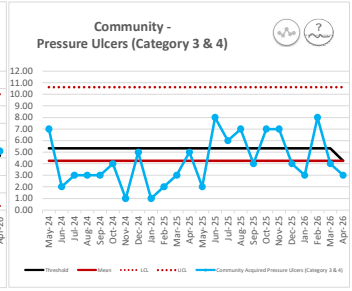
Inconsistently passes and fail the target

Consistently fails the target

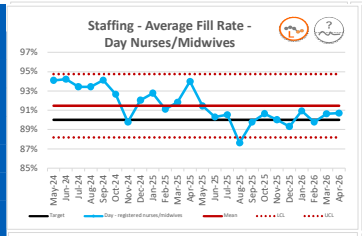
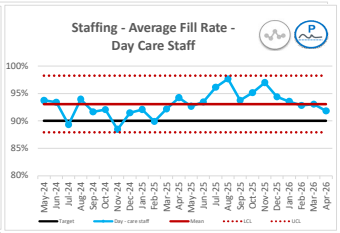
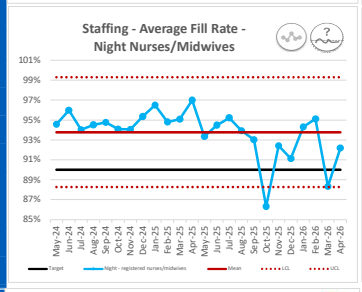
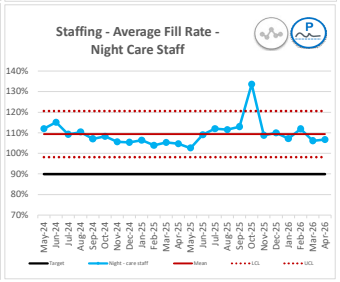
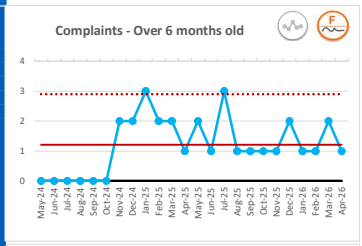
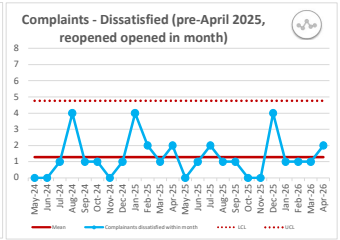
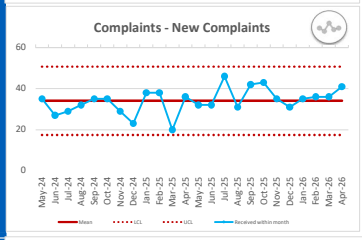
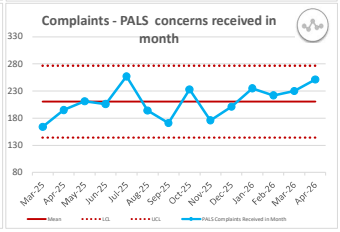
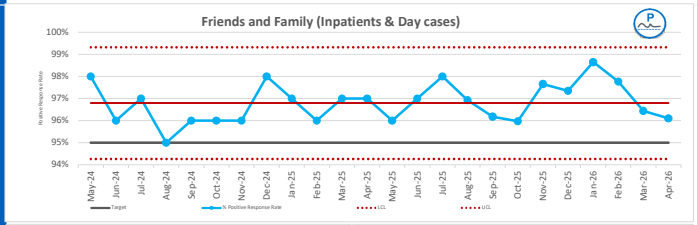
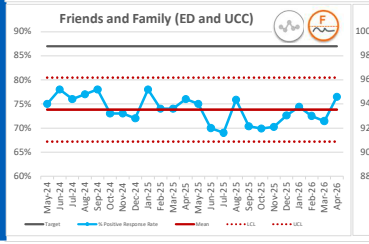
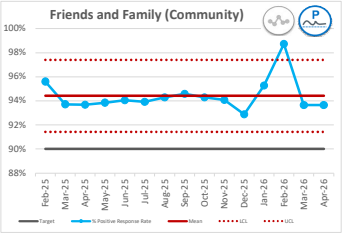
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
74	Trust Financial Position (£m)	-£4.85	-£5.80	Apr-26	No SPC	-£36.27	Mar-26	No SPC
75	Cash Balance (£m)	£11.87	£28.78	Apr-26	No SPC	£30.47	Mar-26	No SPC
76	Capital Programme (£m)	£0.48	£0.12	Apr-26		£21.69	Mar-26	F
77	Better Payment Practice Code	>95%	57%	Apr-26		69%	Mar-26	F
78	Cost Improvement Programme - In year (£m)	90% of plan	100%	Apr-26		101%	Mar-26	P
79	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	65%	Apr-26	No SPC	57%	Mar-26	F
80	Agency Reduction (£m)	£0.20	£0.22	Apr-26	No SPC	£3.22	Mar-26	?
81	Bank Reduction (£m)	£2.32	£3.34	Apr-26	No SPC	£32.48	Mar-26	F

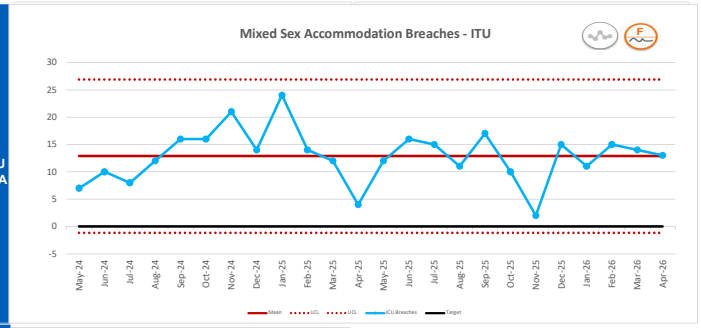
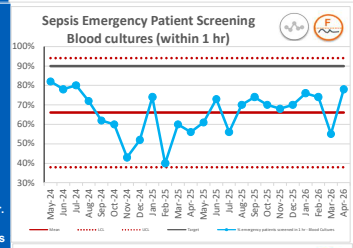
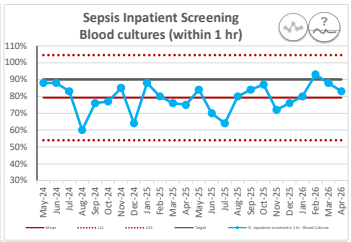
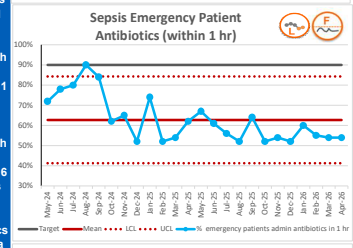
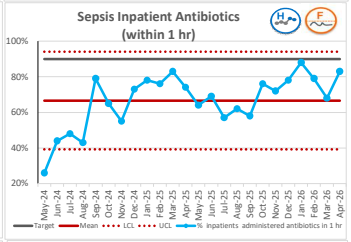
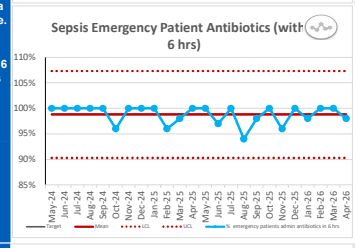
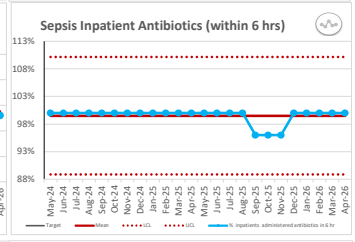
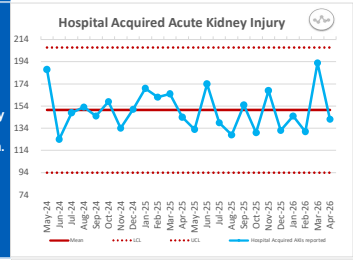
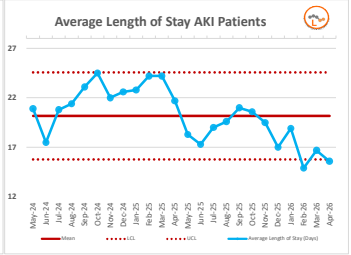
Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events	There was 61 incident/s over 40 days old.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause Variation.	In April 2026, one PSII was declared relating to a local priority theme of delay in the identification, recognition, and response to patient deterioration, resulting in delayed escalation and treatment. At the time of reporting, 37 learning response reviews—including after action reviews, MDT reviews, and swarm huddles—were underway. No incidents had been reported to MNSI in 2026 to date. As of 1 April 2026, there were 62 incidents open for more than 40 days, demonstrating a reduction compared to previous reporting periods. Note: The narrative now incorporates both acute and community data.	A weekly governance dashboard is overseen by the Executive Team to monitor reporting trends and support triangulation across incidents, complaints, claims, and inquests. Each Clinical Business Unit (CBU) is supported to promote consistency and oversight. Incidents open beyond 40 days are escalated daily to the relevant triumvirates, with focused prioritisation to improve timeliness. The Datix system also provides alerts at a 30-day threshold, enabling earlier intervention and support, with performance closely monitored. A daily report detailing the position of learning responses and associated actions is in place to support Care Group triumvirate oversight. In addition, weekly recovery reports are provided to support oversight by the Deputy Chief Nurse, the governance team, and Care Group triumvirates, driving improvement and accountability. PSII activity continues to be monitored through the weekly Executive-led Safety Oversight Meeting, with appropriate escalation to CBU leads. Further targeted progress reviews are supported through extraordinary meetings involving senior Care Group and governance team colleagues to strengthen oversight and improve performance.
2. Healthcare Acquired Infections (MRSA) 3. Healthcare Acquired Infections (MSSA) Threshold for 2025/26: 32 4. Healthcare Acquired Infections (CDI) Threshold for 5. Healthcare Acquired Infections (Ecoli) Threshold for 6. Healthcare Acquired Infections (Klebsiella) Threshold for 7. Healthcare Acquired Infections (PA) Threshold for	MRSA 0 cases YTD is equal to Threshold 0 YTD MSSA 3 cases YTD is above Threshold 2.67 YTD CDI 10 cases YTD is above Threshold 5.42 YTD ECOLI 8 cases YTD is above Threshold 6.25 YTD Klebsiella 0 cases YTD is under Threshold 2.33 YTD PA 0 cases YTD is under Threshold 0.83 YTD	     	(MRSA) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (CDI) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (ECOLI) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (K) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (PA) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Overall, reductions in healthcare-associated infections (HCAIs) were observed in 2025/26 compared to the previous financial year, and the Trust is not currently identified as a high outlier for HCAI cases or rates. There have been no MRSA bacteraemia cases reported over a rolling 13-month period. Changes in population demographics, including an increasing proportion of older patients, are contributing to the rise in Gram-negative bloodstream infections (GNBSIs). Increases have also been noted nationally in Clostridioides difficile (CDI) and MSSA bacteraemia cases. Thresholds set by NHS England for HCAIs for 2026/27 are currently awaited: for E. coli bacteraemia, Klebsiella spp. bacteraemia, P. aeruginosa bacteraemia, CDI. MRSA bacteraemia threshold has been agreed as– zero tolerance for avoidable cases; MSSA bacteraemia – no threshold A reduction in Klebsiella cases has been moted since February 2026.	An MRSA and MSSA Prevention Action Plan is in place, including review of peripheral cannula dwell times in line with EPIC3 guidance and revised cannulation policy, alongside strengthened ANTT training and competency assessment across CBUs. Support from the Quality Academy is being utilised to address gaps in peripheral cannula documentation. A CDI Prevention Action Plan is in place, with ribotyping identifying outbreaks on Wards B14 and A6; enhanced IPC measures are ongoing, alongside review of recurrent cases. Despite norovirus pressures in January 2026, there has been an overall reduction of nine CDI cases compared to the previous financial year. Progress with the Model Ward and Well Organised Ward programme is being reset, while antimicrobial stewardship activity has strengthened with restoration of substantive Consultant Microbiology capacity, including resumed ward rounds. Further work includes planned system-wide CDI education and exploration of probiotic use. For GNBSIs (E. coli, Klebsiella, Pseudomonas aeruginosa), CAUTI surveillance and catheter prevalence review have identified improvement areas. The GNBSI Prevention Group has been relaunched with strengthened clinical focus, alongside quality improvement work to support timely catheter removal and reduce use in elective surgery

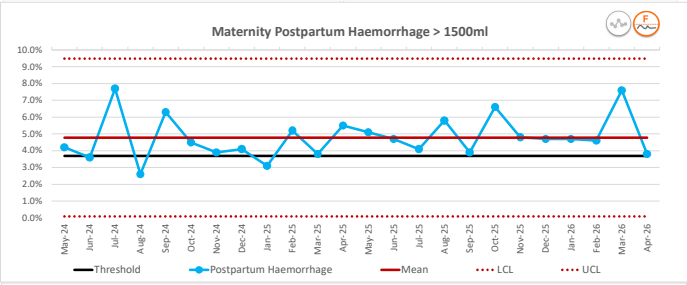
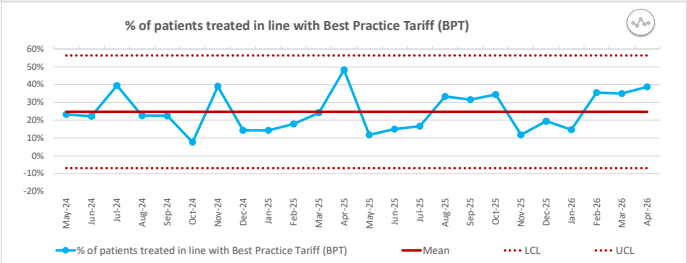
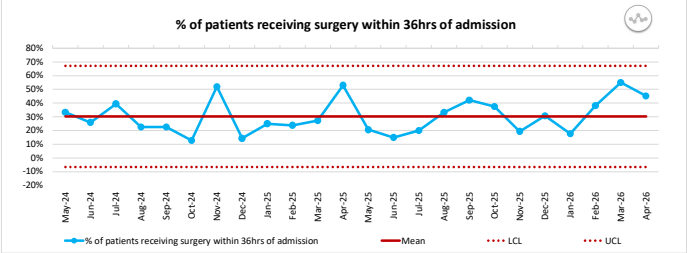
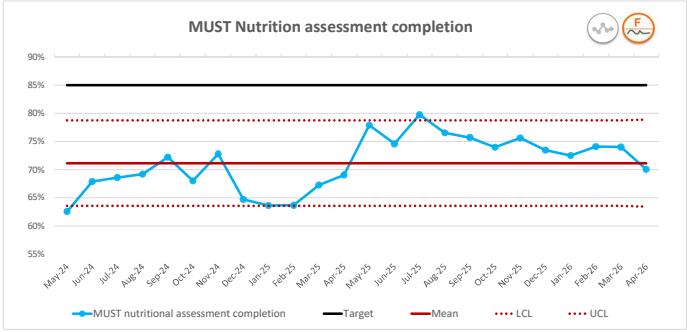
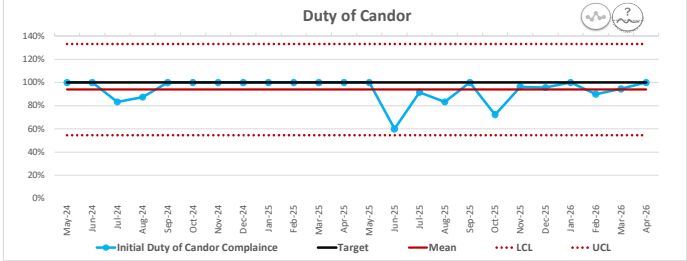
Home Community Hospital

Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
8. VTE Assessment Target: 95% (quarterly position)	The Trust did not achieve the required target at 95.81% for VTE assessments in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Further improvements in VTE risk assessment performance have been observed, with April 2026 achieving 95.81%, meeting the mandatory threshold, and no additional cases required to achieve compliance (data accessed 11 May 2026).	Actions to improve VTE risk assessment compliance have included promoting the use of real-time data via the GIRFT inpatient ward productivity dashboard to support completion of outstanding assessments, alongside regular review of compliance and non-compliance trends through the VTE dashboard within monthly CBU Clinical Governance meetings. Accountability has been reinforced through direct communication with Clinical Leads and Directors at month-end. Further improvement actions focus on embedding the use of real-time data at daily board rounds to ensure outstanding VTE assessments are reduced to zero, supported by guidance shared with ward teams and oversight from the corporate nursing executive team. Positive engagement has been reported within Women's and Children's services. Additional awareness has been promoted through nursing forums and Trust-wide safety briefs, with ongoing monitoring of performance and trends through the Thrombosis Group to inform further improvement.
9. Inpatient Falls & harm levels Target: 10% reduction from 2024/25	88 total falls were reported in month. 48 of these were inpatient falls. YTD inpatient falls: 48 (above threshold 39.5)	   	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	In April, there were 34 acute inpatient falls and a further 5 within the Emergency Department (ED). Of the acute inpatient falls, 26 resulted in no harm and 8 in low harm. Within ED, 2 falls were categorised as no harm and 3 as low harm. In addition, community data is now included, with 14 falls reported at Padgate House, including one resulting in moderate harm. Whilst this reflects an increase in falls per 1,000 bed days, the Trust continues to benchmark lower than comparable organisations	Activity to strengthen falls prevention continues across the Trust. The Turun (falls alarm representative) maintains a programme of regular visits, with upcoming sessions planned for the Emergency Department and Halton sites. The Patient Safety Improvement Nurse (PSIN) is recirculating guidance on the appropriate use of bed rails through the Trust-wide safety brief. The post-fall SWARM process has been digitalised, successfully trialled in February 2026, and was implemented Trust-wide in April 2026 following positive feedback. In addition, a comprehensive Trust-wide falls audit was completed in March; analysis is underway by the clinical audit team, with findings and a corresponding action plan to be shared once finalised.
10. Acute - Total Pressure Ulcers (Category 2) Target: 20% reduction from 2024/25 11. Acute Total Pressure Ulcers (Category 3 and above) Target: 20% reduction from 2025/26 12. Community Acquired Pressure Ulcers (Category 2) Target: 20% reduction from 2025/26 13. Community Acquired Pressure Ulcers (Category 3 or above) Target: 20% reduction from	Acute In month: 9 category 2 hospital-acquired pressure ulcers YTD: 9 (above threshold 8.92) In month: 4 category 3 & 4 pressure ulcers YTD: 4 (above threshold 0.75) Community In month: 17 category 2 community-acquired pressure ulcers YTD: 17 (above threshold 15.67) In month: 3 category 3 & 4 pressure ulcers YTD: 3 (under threshold 4.25)	   	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In April 2026, nine category 2 pressure ulcers were reported within the acute setting, representing a reduction, alongside a total of four category 3 pressure ulcers, including two affecting the same patient. There were also three device-related pressure ulcers associated with a RIG tube flange, oxygen straps and a hip brace (category 3). An increase has been observed within community services since February 2026, and a themed review is underway to identify any emerging learning themes and inform further improvement	Actions to improve the position include completion of After Action Reviews by ward managers, with learning shared with teams and through the Operational Patient Safety Group. All category 3 and above pressure ulcers undergo multidisciplinary review. Improvement plans are in place across Unplanned and Planned Care Groups, overseen by Associate Chief Nurses to support delivery and embed learning. Equipment reliability has been strengthened through additional on-site technical support to check and replace mattress pumps where required. Preventative measures have been introduced, including the application of film dressings to patients' heels in the Emergency Department to reduce friction and shear, alongside a Trust-wide safety brief on the use of TED stockings, supported by a single point lesson and enhanced audit processes. A QI pressure ulcer collaborative is also in place across key clinical areas, led by the Associate Chief Nurses, to drive sustained improvement.

Appendix 3	Trust Performance	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Mortality ratio - HSMR **Target: Plan**	The Hospital Standard Mortality Ratio (HSMR) in month was 91.95. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 103.55.	(HSMR) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature.	The overall SHMI for Warrington is close to 100 and remains within expected limits when assessed using an over-dispersed funnel plot. The in-hospital SHMI continues to represent the highest area of variation. Adjustment for palliative care results in a slight reduction in SHMI, suggesting a more complex patient case mix than is fully accounted for within the current SHMI model.	There has been a reduction in the number of spells alongside an increase in the average comorbidity score per spell, indicating a shift towards a more clinically complex patient cohort. In addition, inpatient activity has reduced following the transition of services to Type 5 pathways, including the Frailty Assessment Unit (FAU) and Gynaecology Assessment Unit (GAU). While these services operate at lower activity levels than SDEC, they account for approximately 115 spells per month and are contributing to the current SHMI profile for the Trust
15. Mortality ratio - SHMI **Target: Plan**				
16. Medication Safety **Reconciliation within 24 hours** **Target: 80%**	Medicines reconciliation was completed within 24 hours of admission for 49% of patients. 76% of patients had MR completed during inpatient stay.	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance improvements in medicines reconciliation have been sustained over the past three months, with 48% completed within 24 hours compared to 33% previously, alongside an overall increase in total completion rates. Pharmacy workforce capacity remains constrained, requiring prioritisation based on patient acuity and activity; as such, higher-risk clinical areas (e.g. ED, AMU, ICU, ACCU) are prioritised, with variation in performance across CBUs reflecting this targeted deployment. Resource allocation is supported by audit data and focused on patients prescribed high-risk medicines, with 80% receiving medicines reconciliation within 24 hours and 95% at any point during their inpatient stay. A significant proportion of patients not receiving medicines reconciliation are within Women's and Children's and Surgical Services CBUs, predominantly maternity patients in birth suite and MLU, where the majority are not on regular medication and very few are prescribed critical medicines. In surgical specialties, many patients are discharged within two days of admission, and medicines reconciliation is therefore completed as part of the TTO clinical check process, representing a more effective use of limited pharmacy resource.	Midwife recording of medicines reconciliation (MR), introduced in November 2025, is supporting a gradual increase in MR completion within maternity areas, with ongoing training and support provided by the Medication Safety Nurse to further strengthen documentation. A pharmacy prioritisation tool is being deployed to enable staff to identify and prioritise high-risk patients across the organisation, rather than by clinical area; this is currently being piloted within the IMC pharmacy team, with further development and rollout supported by the IT and Digital Analytics teams. In addition, the Lead Pharmacist for ED post has been filled, restoring establishment levels and contributing to improved urgent and emergency care MR performance observed in February and March 2026. Oversight of performance and progress is maintained through the Pharmacy Performance Meeting and the Medicines Safety and Optimisation Group.
17. Acute Medication Incidents **Target: No target set**	In month there were 110 acute medication incidents, and 13 community medication incidents	(Acute) Assurance: No Target Set Variation: Common Cause (Normal) variation. (Community) Assurance: No Target Set Variation: Common Cause (Normal) variation.	For April 2026, the number of acute medication incidents remains stable and in line with expected levels. Although there was a higher number of incidents earlier in the year, this was not sustained, and performance has since returned to usual levels. Overall, there are no new themes or concerns identified, and trends continue to be monitored through routine governance processes	Actions and ongoing oversight are reported through Medicines Governance to the Quality, Safety and Assurance Committee, ensuring appropriate scrutiny of medication incident trends and performance. Actions taken in response to medication incidents include structured review and learning, dissemination of key messages through safety briefs, and wider sharing of learning via forums such as the Chief Nurse check-in and other Trust communication channels. The current position remains stable, with no new themes identified, supported by routine monitoring, learning, and targeted actions where required.
18. Acute Medication Incidents **Target: No target set**				

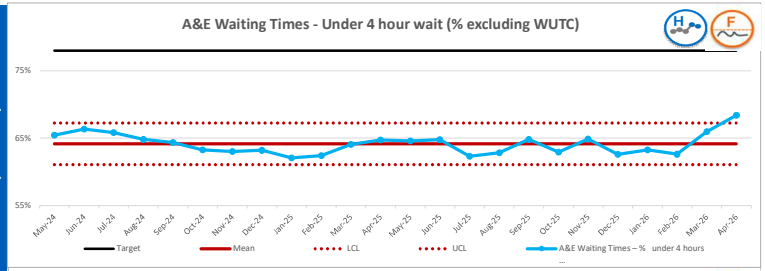
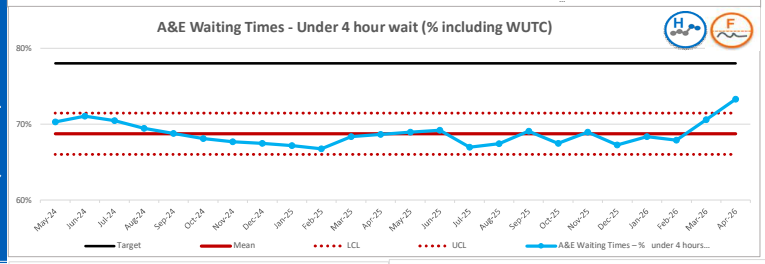
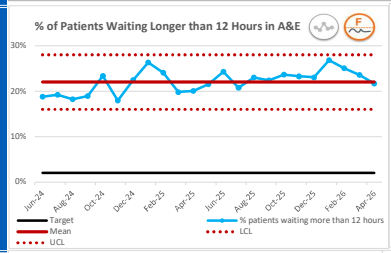
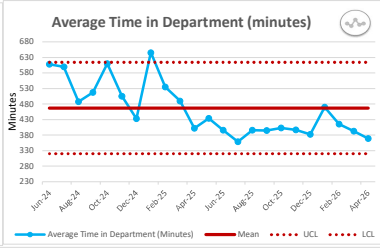
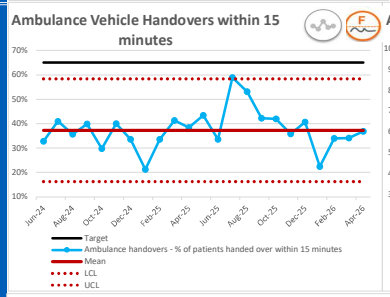
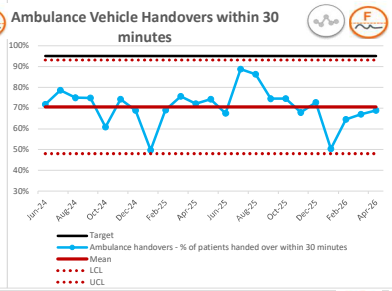
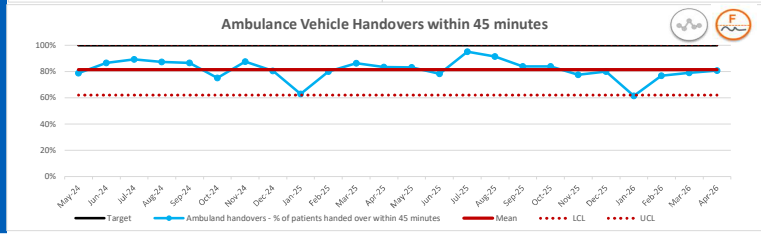
Appendix 3	Trust Performance			Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
19. Average Fill Rate - Day registered nurses/ midwives **20. Average Fill Rate - Day - care staff** **Target: 90%** **21. Average Fill Rate - Night registered nurses/ midwives** **Target: 90%** **22. Average Fill Rate - Night care staff** **Target: 90%**	**In month, the staffing fill rates were:** **Day (Nurses/Midwife) 90.7%** **Day (Care Staff) 91.83%** **Night (Nurses/Midwife) 92.19%** **Night (Care Staff) 106.67%**	   	(Day Nurses/Midwives) Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a concerning nature. (Day Care Staff) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation. (Night Nurses/Midwives) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation. (Night Care Staff) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	**Additional beds continue to be utilised across the Trust in response to increased demand within the Acute and Emergency Department (AED), alongside higher patient acuity levels. This includes the opening of escalated bed capacity, with Surgical SDEC and Ward B3 in use to support patient flow. Note: This position reflects combined acute and community data.**	**In April 2026, registered nurse day staffing fill rates were sustained at 90%, with an improvement in night staffing to 92%, reflecting continued progress in workforce deployment and safer staffing levels. Staffing is reviewed twice daily by the senior nursing team, with close monitoring of acuity and activity to maintain safe patient care.** **Actions to support further improvement include targeted recruitment activity across key areas, ongoing recruitment pipelines, and focused retention initiatives.** **Workforce deployment is continually optimised based on patient acuity, supported by the use of enhanced vacancy tracking and establishment reviews. Additional recruitment events and regular interview cycles are in place to strengthen workforce supply, alongside development opportunities for existing staff to support retention and progression**
23. Complaints **Target: Zero complaints open over 6 months old/in the backlog**	**In month there were 41 complaints received within month and 1 cases over 6 months old**	   	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **<u>Please note: Prior to April 2025, the Complaints 'dissatisfied' graph reported 'reopened complaints'.</u>**	**The Trust continues to sustain performance in the timely completion of complaints. In April 2026, the Trust received one dissatisfied complaint and one further complaint where the family raised additional questions. There is one complaint open beyond six months, which remains at the family's request due to illness. Note: This position reflects both acute and community data**	**There were 71 complaints open at the time of reporting. All complaints continue to be closely monitored to support timely responses, with appropriate cases directed to PALS where local resolution is identified as the most effective approach.** **Complainants are routinely offered an initial meeting with clinical teams, alongside follow-up discussions after receipt of the response letter to ensure queries are addressed. Each Clinical Business Unit has a designated complaints case handler to promote consistency in management and response.** **Weekly review of themes and associated actions from closed complaints is undertaken to identify areas requiring additional support and to inform ongoing improvement.**
24. Friends and Family (Inpatients & Day cases) **Target: 95%** **25. Friends and Family (ED and UCC)** **Target: 87%** **26. Friends and Family (Community)** **Target: 90%**	**The Trust achieved:** **96.1% in month for Inpatient & Day Case FFT** **76.47% for ED/UCC FFT.** **93.65% for Community FFT.**	  	**(IP/DC) Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: Common Cause (Normal) variation.** **(ED/UCC) Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: Common Cause (Normal) variation.** **(Community) Assurance: The Trust consistently fails the target.** **(Community) Variation: Common Cause (Normal) variation.**	**For April 2026, inpatient and day case services achieved a 96% positive Friends and Family Test (FFT) response rate, sustaining performance above the Trust target of 95% and continuing to benchmark favourably against both regional and national averages.** **Within ED/UCC, a 76% positive response rate was achieved, representing a 5% improvement from March 2026 and the highest level reported since April 2025. Feedback themes remain consistent, with staff attitude, waiting times, environment, and aspects of care identified in both positive and negative comments, highlighting areas for continued focus and improvement.**	**Trust-wide oversight of Friends and Family Test (FFT) performance, themes and associated action plans is maintained at Clinical Business Unit level and through the Patient Experience and Inclusion Sub-Committee. Feedback themes are triangulated with insights from observational activity, including Trust Board, Governors, senior leaders, PLACE assessments and the Patient Experience Team, with learning shared across wards and departments.** **In support of quality, access and equity, a new Accessible Information Policy was implemented from 1 April 2026, and work is underway to revise the FFT service following changes to the current supplier, aligning this with a wider Cheshire and Merseyside framework.** **Within ED/UCC, the improvement focus continues to be driven through a structured action plan monitored via the Patient Experience and Inclusion Sub-Committee, incorporating feedback from internal and external observations, including Healthwatch. A programme of weekly observational activity is in place to support improvement. Communication with patients has been strengthened through the introduction of information screens providing updates on waiting times, prioritisation and reasonable adjustments. Partnership working with Healthwatch continues to support the rollout of the "About Me" card to promote personalised, trauma-informed care, alongside alignment with the Trust's Violence and Aggression Policy to enhance safety. Further improvements include the introduction of named corridors and nurses, patient 'bed boards' and call bells to support corridor care. Volunteers are also supporting patient comfort and real-time feedback within ED, with ongoing recruitment to expand this workforce and enhance the patient experience.**

Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Mixed Sex Accommodation Breaches (ITU Only) Target: Zero	There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 13 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	There were 13 mixed sex accommodation breaches reported in March 2026, representing a reduction from the previous month. All breaches were within the Intensive Care Unit, with no breaches reported in any other ward areas. Delays in discharge continue to be escalated to the Patient Flow Team and the Tactical Manager, and are discussed at each bed meeting throughout the day to support timely resolution.	Work continues across the Care Group and patient flow teams to prioritise timely step-down of level 1 patients from ITU to the most appropriate care settings. A number of contributory factors to delays have been identified, with action plans in development to address these and improve flow. A high number of patients with extended lengths of stay remains a contributing factor. In addition, the Trust's policy relating to mixed sex accommodation breaches is currently under review to support strengthened compliance.
28. Sepsis - % screening for all emergency patients. 29. Sepsis - % screening for all inpatients Target: 90% 30. Sepsis - % of emergency patients receive antibiotics within 1 hour of diagnosis Target: 90% 31. Sepsis - % of inpatients patients receive antibiotics within 1 hour of diagnosis	The Trust achieved: 78% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. 83% screening for all inpatients with suspected sepsis within 1 hour. 54% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. 83% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made. 98% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made. 100% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made.	     	(Sepsis Emergency Screening) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation (Sepsis Inpatient Screening) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation (Sepsis Emergency Antibiotics <1hr) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature. (Sepsis Inpatient Antibiotics <1hr) Assurance: The Trust consistently fails the target. Variation: There is special cause of improving nature.	For April 2026, sepsis performance shows a variable but stable position overall, with a clear difference between inpatient and emergency care pathways. Inpatient performance remains consistently stronger, with both sepsis screening and antibiotic administration within one hour showing sustained improvement over time, and April maintaining this position close to expected levels. Within the Emergency Department, performance continues to show month-to-month variation, with April in line with the recent trend. While not yet consistently meeting target levels, performance remains within an expected range and reflects the ongoing pressures and complexity within urgent and emergency care.	Current audit data indicates improvement in blood culture completion within the Emergency Department, alongside improved timeliness of antibiotic administration within one hour, reflecting the impact of targeted interventions. This progress is supported by the reintroduction of sepsis bags to improve reliability and timeliness of blood culture collection, alongside ongoing staff education and training, including increasing the number of staff able to undertake this intervention. Sepsis management continues to be reinforced through clinical handovers and teaching sessions. The Sepsis Bleep initiative, introduced in May 2026 within the Emergency Department, is further supporting early recognition, escalation and timely treatment. While some variation remains across pathways, governance oversight through the Deteriorating Patient Group and Sepsis Improvement Group continues to support focused improvement activity. A deep dive review is scheduled for presentation to the Quality, Safety and Assurance Committee in July, to provide further analysis and inform next steps. Overall, there are no new themes identified, with continued progress in key elements of sepsis management.
32. Acute Kidney Injury Target: Less than month in previous year	There were 142 acute kidney injuries reported in month compared to 193 last month.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Length of stay (LOS) has reduced month on month, reflecting effective discharge processes, timely interventions, and increased use of early facilitated discharge pathways. However, the observed rise in hospital-acquired acute kidney injury (HA-AKI) is being reviewed to understand contributory factors and identify targeted improvement actions.	Work is underway to report HA-AKI as a percentage of total admissions to provide a more meaningful and accurate understanding of performance and trends. This will enable improved benchmarking and clearer identification of variation across clinical areas. In parallel, targeted actions are being progressed, including enhanced clinical review of HA-AKI cases to identify common contributory factors, strengthened monitoring through governance groups, and focused engagement with clinical teams to reinforce early recognition and management. Education and awareness initiatives are being utilised to support staff in identifying patients at risk, alongside review of care processes such as fluid management, medication optimisation and timely escalation. Data quality and reporting processes are also being refined to ensure accuracy and support more effective oversight and continuous improvement

Appendix 3	Trust Performance		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
33. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	Maternity Postpartum Haemorrhage was 3.80% in month compared to 7.60% last month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	Rates of postpartum haemorrhage (PPH) >1500ml continue to fluctuate, demonstrating common cause variation. Comparator data from the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) indicates an average rate of 32 per 1,000 births, while the Trust rate remains higher at 66 per 1,000 births. This variance is being reviewed to better understand contributory factors and identify focused improvement actions	PPH >1500ml continues to be reviewed on an individual case basis through established governance processes, alongside additional oversight via the Intrapartum Incident Review Group, which meets regularly to identify patterns and themes. A dedicated PPH Quality Improvement group is also progressing targeted work to strengthen local processes. A new regional PPH guideline has been implemented within the service, with Trust colleagues contributing to its development and influencing key changes now adopted within practice. The Trust position is reported monthly to the Quality, Safety and Assurance Committee, supported by SPC analysis which currently demonstrates common cause variation with relative stability. A re-audit is planned for May, six months post-implementation of the guideline, with findings to be presented to the Quality, Safety and Assurance Committee.
34. Fractured Neck of Femur **Target: Best Practice Tariff**	38.71% of patients were treated in line with Best Practice Tariff (BPT) in Apr-26.	 	Variation: Common Cause (Normal) variation.	For April 2026, 35 patients were recorded on the National Hip Fracture Database, of which 31 met criteria for Best Practice Tariff (BPT). The majority of patients were admitted in March or April, with a small number admitted earlier. Direct admission from A&E to the orthopaedic ward was achieved in 89% of cases, a slight reduction from the previous month. Timeliness of surgery remains a key area for improvement, with 45% of eligible patients receiving surgery within the recommended timeframe, although plans are in place to address this. Senior orthogeriatric review performance remains strong at 97%, with 83% completed within 72 hours, demonstrating improvement. Day one post-operative mobilisation was achieved in 83% of hip fracture patients, supported by an ongoing MDT-led quality improvement programme aimed at further aligning performance with national benchmarks. Provide your feedback on BizChat	Key improvement actions include increasing trauma theatre access and prioritising hip fracture patients to reduce delays to surgery, alongside strengthening pre-operative optimisation pathways to ensure patients are ready for theatre at the earliest opportunity. In addition, there is a focus on expanding orthogeriatric early review capacity, including weekend provision, to support timely assessment. Work is also underway to enhance multidisciplinary team coordination to improve rates of day one post-operative mobilisation and overall patient flow.
35. MUST nutritional assessment completion **Target: above 85%**	MUST Nutrition assessment completion was 70.04% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.	For April 2026, MUST nutrition assessment completion shows a generally improving and stable picture over time, with sustained gains following the introduction of the LiON dashboard. Performance improved notably through mid-2025, reaching closer to target levels, and has since remained broadly consistent, with expected month-to-month variation. While there has been a slight dip in April, overall compliance remains higher than earlier in the reporting period, particularly for 7-day assessments, which continue to demonstrate the strongest performance. Overall, this reflects continued progress with no new concerns identified, with ongoing focus to further improve timeliness of early (6-hour) assessments while maintaining the gains seen in 24-hour and 7-day compliance	The introduction of MUST as a clinical indicator within Lorenzo has supported ward teams to more easily identify patients requiring an initial assessment or reassessment, with the visual prompt (amber alert) providing advance warning ahead of the 7-day review. This has contributed to the sustained improvement seen in compliance. A coordinated, multidisciplinary approach continues to be driven through the Nutrition, Food and Hydration Group, with CBUs and key stakeholders developing high-level briefing papers that outline local action plans and quality improvement initiatives, enabling shared learning across the Trust. MUST remains a quality priority for 2025/26, with ward teams presenting compliance data and improvement plans at Quality Summits. It is also embedded within the PSIRF approach to harms, including falls and pressure ulcers. Further work is planned to strengthen training and awareness of MUST and its wider impact on patient care, particularly focusing on the HCA workforce, with development and implementation scheduled during 2026
36. Duty of Candor **Target: 100%**	Duty of Candor Compliance was 100% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.		

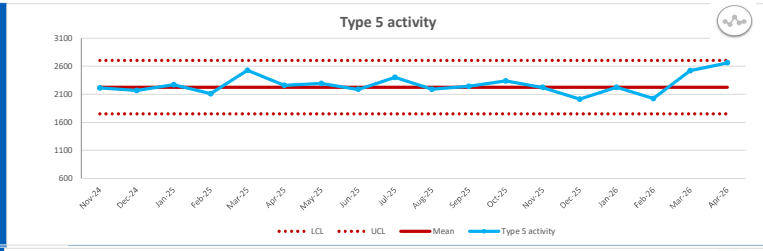
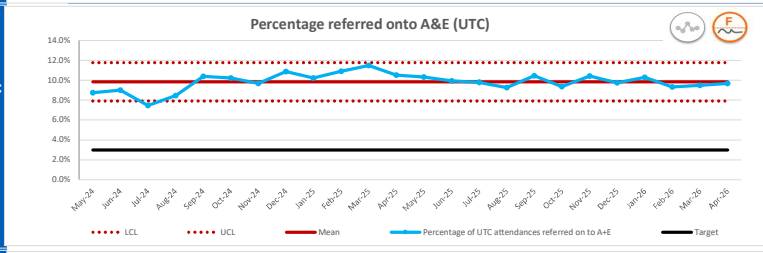
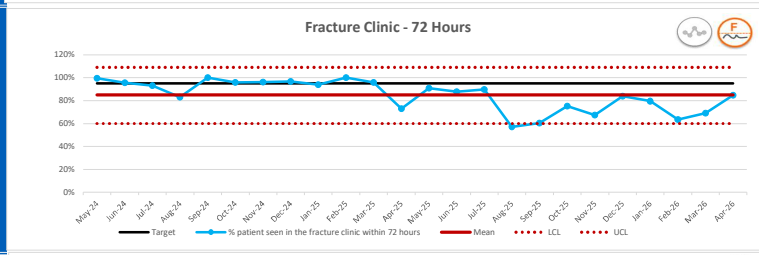
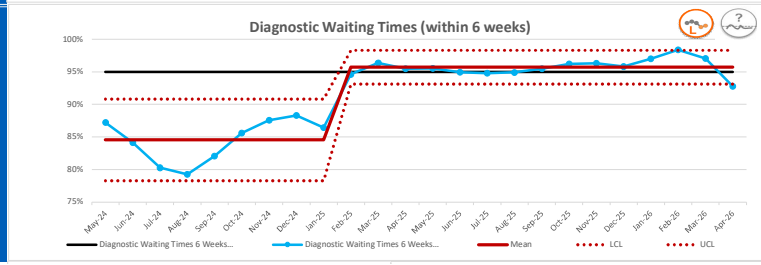
Access & Performance - Trust Position

Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
37. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC) **Target: 78%**	The Trust achieved 68.41% excluding Widnes UTC in month. The target is set at 78%, which is the national aspiration for 2026/27		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.	4 hour performance from April 26 includes 100% Widnes Type 3 activity. Excluding this the Trust still saw a 4.64% improvement from April 2025 The Target to achieve by March 27 is 84% The National constitutional target remains 95%	• An action plan of short and long term actions has been established and is monitored weekly via the executive chaired ED Improvement Group. Delivery externally is monitored via the bi-weekly NHSE Tiering meetings. • More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance • Increased capacity through SDEC through separating Medical and Surgical SDEC has supported the improvement in 4 hour performance
38. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) **Target: 78%**	The Trust achieved 73.3% including Widnes UTC in month. The target is set at 78%, which is the national aspiration for 2026/27		Assurance: The Trust consistently fails the target. Variation: Special Cause variation of improving nature.		
39. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. **Target: 2% or**	21.66% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 369 minutes.	 	Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation. Assurance: No Target set Variation: There is Common Cause (normal) Variation.	12 hour performance continues to be negatively impacted by the wait to be seen in ED and overall high bed occupancy	• An action plan of short and long term actions has been established and is monitored weekly via the executive chaired ED Improvement Group. Delivery externally is monitored via the bi-weekly NHSE Tiering meetings. • A reduction in non-admitted breaches has been supported through the ED improvement group, the next focus is on admitted breaches which has a direct correlation to flow out of ED
40. Average time in department ED No Target					
41. Ambulance Vehicle Handovers within 15 minutes **Target: 65%**	In month the Trust achieved: - 36.9% Ambulance Handovers within 15 minutes (65% target) - 68.9% Ambulance Handovers within 30 minutes (95% target) - 80.6% Ambulance Handovers within 45 minutes (100% target)	 	(15) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation. (30) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.	The Trust continues to work with NWAS to support improving this metric. Main areas of concern are out of hours and at times of surge. Please note that ambulance handover metrics are now measured to the point of vehicle handover, rather than patient handover.	
42. Ambulance Vehicle Handovers within 30 minutes **Target: 95%**					
43. Ambulance Handovers within 45 minutes **Target: 100%**			(45) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.		

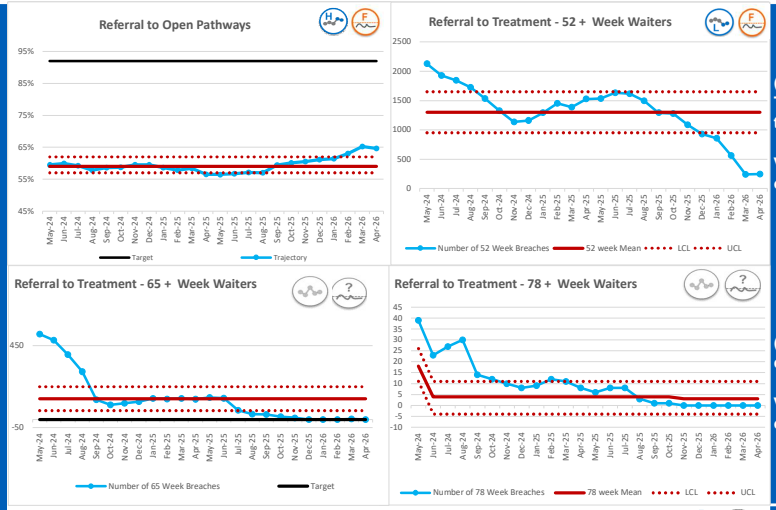
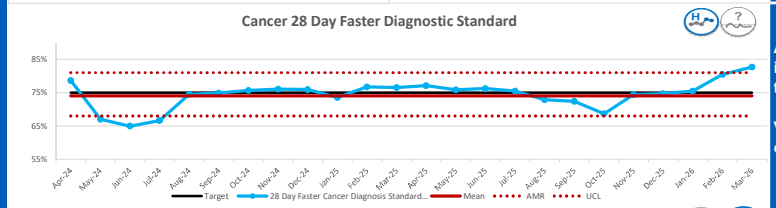
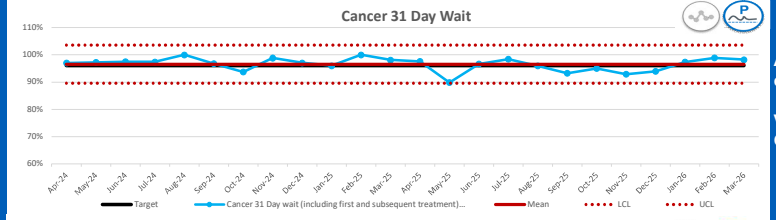
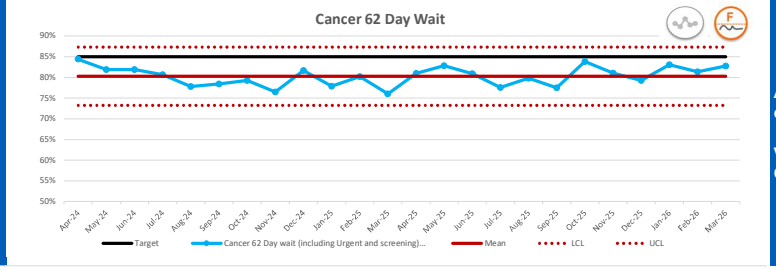
Access & Performance - Trust Position

Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
44. Type 5 activity **No Target**	In month there were 2661 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: There is Common Cause (normal) Variation.	Type 5 activity includes SDEC (Medical and Surgical), FAU, PAU, GAU and Ed ambulatory The increase in activity can be seen due the separation of Medical and surgical SDEC	
45. Percentage of UTC attendances referred on to A+E	In month: 9.7% of UTC patients were referred to ED. Runcorn UTC: 15.4% Widnes UTC: 4.7%		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	There are no specific national guidance on expected levels of referrals the Trusts supports as right patient right place right time ethos	
46. Patients seen in the Fracture Clinic within 72 hours **Target: 95%**	In month, the fracture clinic saw 84.8% of patients within 72 hours.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Workforce pressures continue to seen and accounts for fluctuations in performance	
47. Diagnostic Waiting Times 6 Weeks **Target: 95%**	The Trust achieved 92.78% in month. Acute in month was 92.70% in month. Community in month was 95.22% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a concerning nature.	The Diagnostic performance has seen a decrease due to workforce challenges in Endoscopy, recovery is forecast for August if recruitment plans are realised	A recovery trajectory has been agreed for Endoscopy modalities, achievement of this is dependant on recruitment

Access & Performance - Trust Position

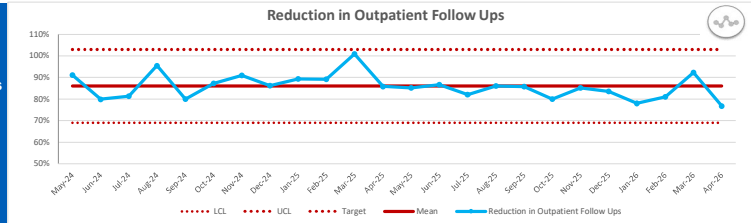
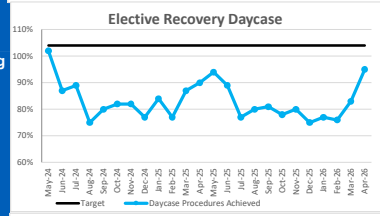
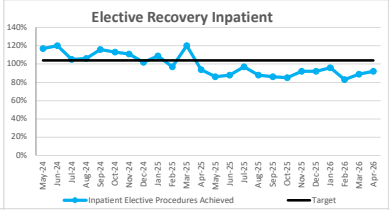
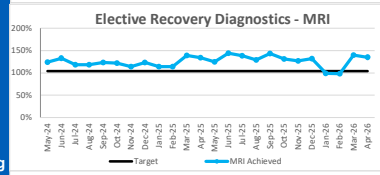
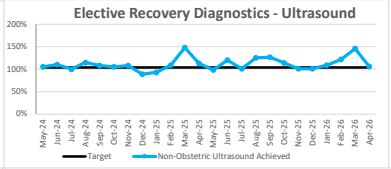
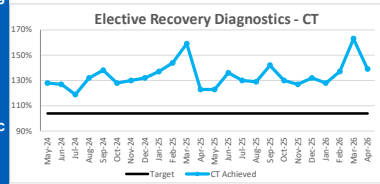
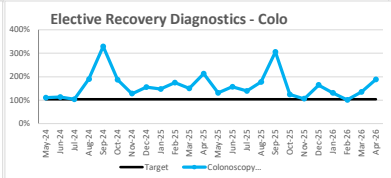
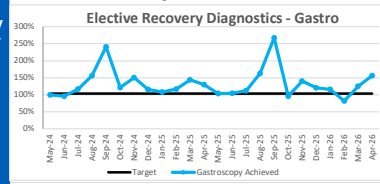
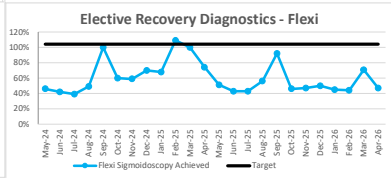
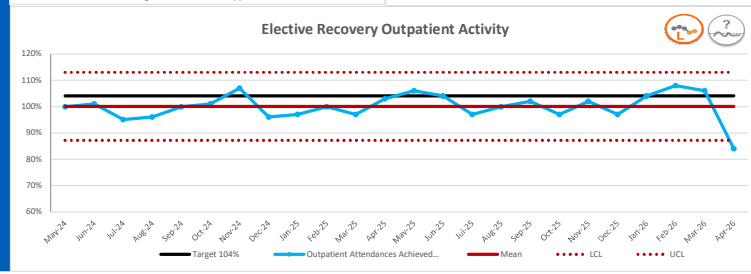
Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. Referral to treatment Open Pathways **Target: 92%** **49. RTT - Number of patients waiting 52+ weeks** **Target: 0**	**The Trust achieved 64.64% in month.** **There were 248 52-week breaches,** **0 78-week breaches and** **0 65-week breaches.**		**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: Special Cause variation of improving nature.** **(52+) Assurance: The Trust consistently fails the target.** **Variation: There is special cause of improving nature.**	**The Trust has delivered in line with the annual planning submission**	
50. 28 Day Faster Cancer Diagnosis Standard **Target: 75%**	**The Trust achieved 82.7% in month for 28 Day Faster Cancer Diagnosis Standard.** **Acute in month was 80.6% in month.** **Community in month was 92.1% in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of improving nature.**	**Under the changes to Cancer Waiting Times standards that came into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25. The Trust has achieved the committed position for March 2026. In 2026/27 there will be a commitment to achieving 80% for the year as an aggregate.**	**The Trust has delivered the 28 Day FDS. There are improvement plans in place at tumour site level specifically, Urology, Colorectal and Gynae and agreed trajectories to support these are in place which are being monitored. The Cancer Alliance is also supporting this plan**
51. Cancer 31 Day wait **Target: 96%**	**The Trust achieved 98.2% in month for Cancer 31 Day Wait.** **Acute in month was 100.0% in month.** **Community in month was 90.9% in month.**		**Assurance: Target met consistently.** **Variation: There is Common Cause (normal) Variation.**	**Target is consistently achieved. All 31-day standards, first and subsequent will be combined from 1st October 2023**	
52. Cancer 62 Day wait **Target: 85%**	**The Trust achieved 82.72% in month for Cancer 62 Day Wait.** **Acute in month was 81.64% in month.** **Community in month was 88.89% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**	**From 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 75% by March 2026, moving to 80% by March 27. A trajectory has been developed with the Cancer Alliance to achieve this and the Trust continues to perform above this trajectory.**	**The 62-day referral to treatment target remains challenging but is seeing improvement due to the combined standards. The standard was met at 85.6% for the first time in several years in October.** **The latest reported performance was 81.7% which remains above trajectory (Acute)** **88.89% (community and Dental)**

North Cheshire and Mersey NHS Foundation Trust

Access & Performance - Trust Position

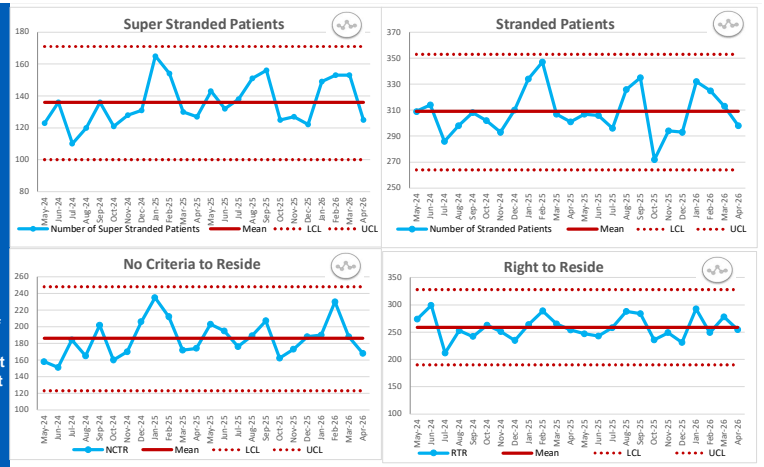
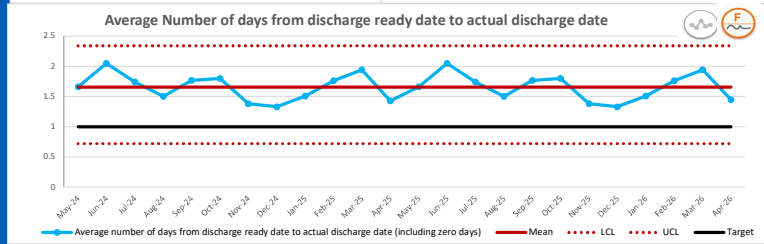
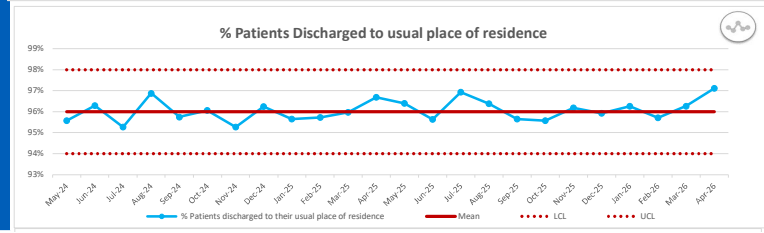
Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	Outpatient follow ups have reduced to 76.82% of 19/20 activity in month.		Assurance: N/A Trajectory Not Agreed. Variation: There is Common Cause (normal) Variation.	Outpatient follow ups is in line with the agreed trajectory as part of annual planning	
54. Elective Recovery Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following % of activity against 2019. This included 95% of Daycase Procedures and 92% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Activity is monitored inline with plan, underperformance in April seen due to some workforce challenges and referrals into the Endoscopy hub being below plan	
55. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following % of activity against 2019. This included: 104% of MRI 139% of CT 106% of Non-Obstetric Ultrasound 47% of Flexi Sigmoidoscopy 189% of Colonoscopy 156% of Gastroscopy	     	N/A - Grouped indicator.	Radiology modalities remain fully recovered, Challenges in Endoscopy and Echo seen in month	The Trust continues to restore clinical services in line with the national operating guidance. Additional insourcing support for Echo is being progressed to help reduce waiting times. Underperformance modalities are monitored at PRG with recovery trajectories in place for each service
56. Elective Recovery Outpatient Activity Aggregate Target: 104%	In month, the Trust achieved 104% of Outpatient activity.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is Common Cause (normal) Variation.	Workforce challenges across key specialties are the drivers behind the reduction in performance	Recovery plans are being monitored through Performance review Group and Delivery unit

North Cheshire and Mersey NHS Foundation Trust

Access & Performance - Trust Position

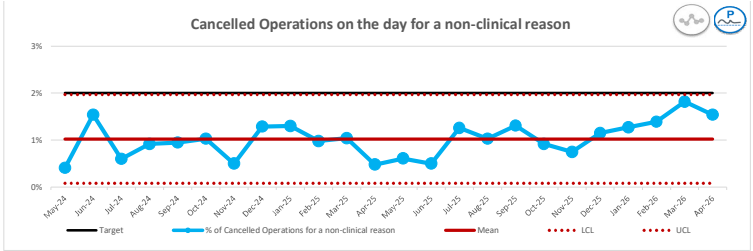
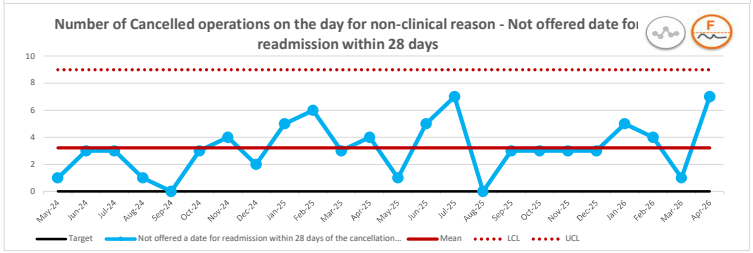
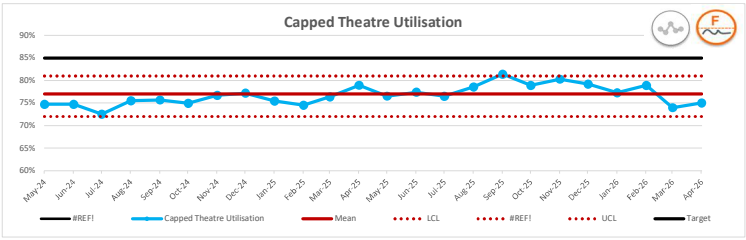
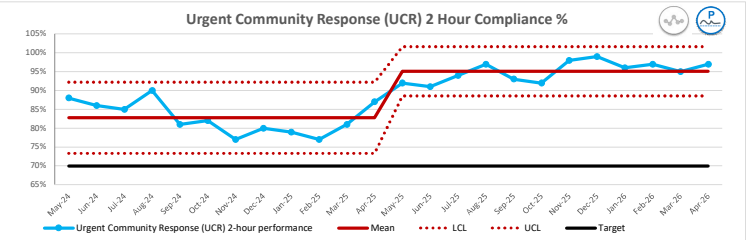
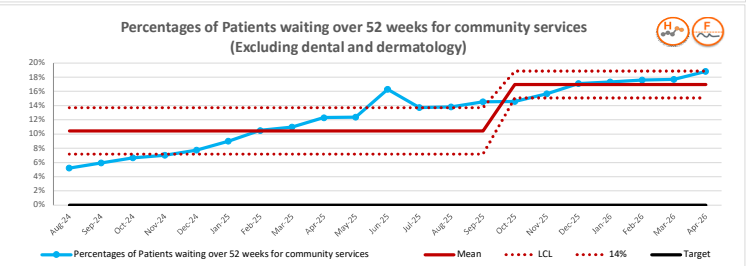
Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Super Stranded Patients **Target: No Target Set** **58. No Criteria to Reside (NCTR)** **Target: Trajectory**	There were 298 stranded and 125 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2026/27.		(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The Trust continues to monitor this inline with the operational planning guidance	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
59. Average Number of days from discharge ready date to actual discharge date **Target: 1 day or less**	In month, the Trust achieved the average of 1.45 days from discharge ready date to discharge date.		Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.		The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available. Hospital delays are monitored through the daily bed meetings
60. % Patients discharged to their usual place of residence **Target: No Current Threshold**	97.12% patients in month were discharged to their usual place of residence.		Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature.		

North Cheshire and Mersey NHS Foundation Trust

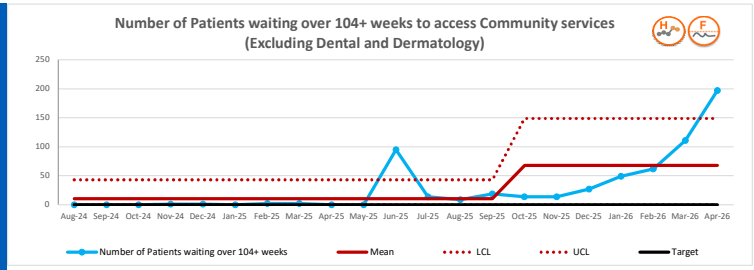
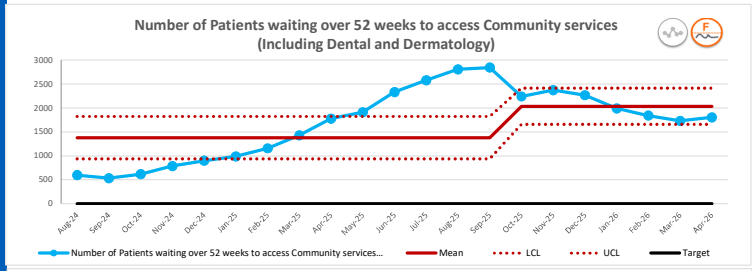
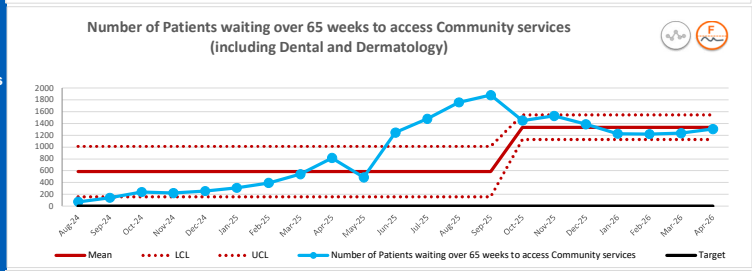
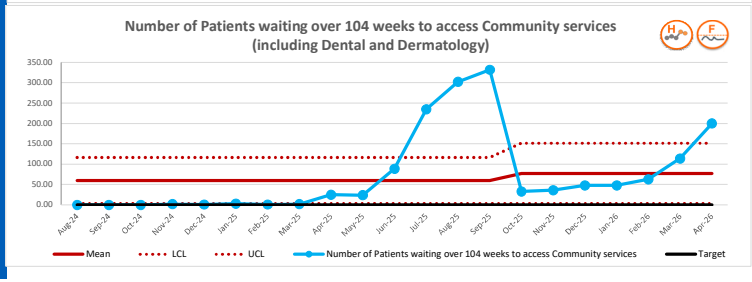
Access & Performance - Trust Position

Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
61. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 1.54% in month. 7 cancelled operation were not offered a date for readmission within 28 days.		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	The Trust continues to monitor this inline with the operational planning guidance	The planned care Transformation Group is monitoring this metric, any patient cancelled for non clinical reasons is being reviewed
62. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO			(Not offered 28 days) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.		
63. Capped Theatre Utilisation Target: 85%	Capped Theatre Utilisation was 75.02% in month		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	The Trust continues to monitor this inline with the operational planning guidance	The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are Urology & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.
64. Urgent Community Response (UCR) 2-hour performance Target: 70%	2 Hour UCR Reponse rate was 97% in month		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	The Trust continues to monitor this inline with the operational planning guidance	
65. Percentages of Patients waiting over 52 weeks for community services (Excluding dental and dermatology) Target: 0%	In month 18.82% of patients are waiting over 52 weeks for community services in month inline with the NHS Oversight Framework Indicator which does not include Dental or Dermatology community waits		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting longer than 52 weeks - 10 Podiatry patients (Halton), There will be 0 patients waiting over 52 weeks by the end of June waiting list snapshot. The remaining patients are children awaiting an appointment for the Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. The split of waits following stratification is: 2% Reds, 51% Amber, 46% Green, 1% not stratified.	

Access & Performance - Trust Position

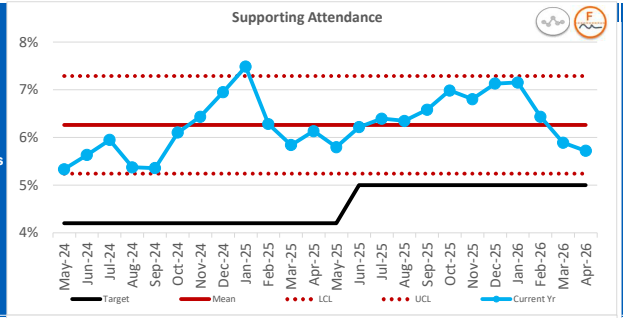
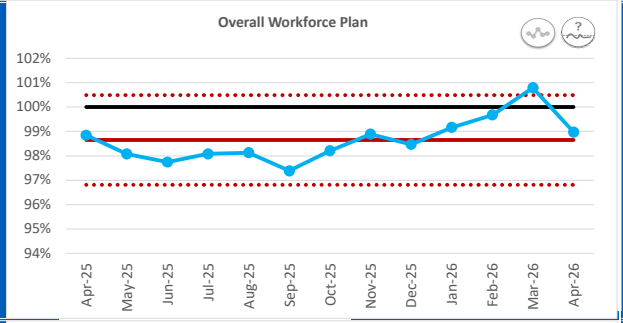
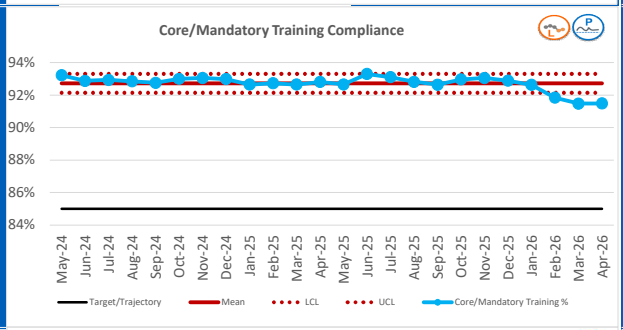
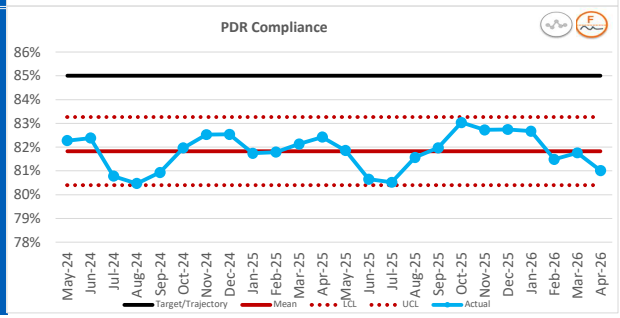
Appendix 3

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Number of Patients waiting over 104+ weeks to access Community services (Excluding Dental and Dermatology) **Target: 0**	In month 197 patients are waiting over 104 weeks for community services in month inline with the NHS Oversight Framework Indicator which does not include Dental or Dermatology community waits		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. The split of these waits following stratification is: 1% Reds, 57% Amber, 42% Green.	Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue
67. Number of Patients waiting over 52 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 197 patients are waiting over 52 weeks for community services in month including Community Dental and Dermatology		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Over 52 weeks comprises: 2 in Dermatology, 10 in Halton Podiatry, 1 in Paediatric SLT Warrington, 136 in Community Paediatrics, 1656 Paediatric Neurodevelopment Pathway. Halton Podiatry should have 0 waits over 52 weeks by the end of June waiting list snapshot Dermatology will still have 1 patient awaiting access to service over 52 weeks at the end of June - this is patient choice. (Community waits calculated referral to report date) Comm Paeds / NDP - stratification split as above	
68. Number of Patients waiting over 65 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 1305 patients are waiting over 65 weeks for community services in month including Community Dental and Dermatology		` Variation: Common Cause (Normal) Variation.	The patients waiting over 65 weeks comprises: 1 in Dermatology, 89 in Community Paediatrics, 1215 Paediatric Neurodevelopment Pathway. Dermatology will still have 1 patient awaiting access to service over 65 weeks at the end of June - this is patient choice. (Community waits calculated referral to report date) Comm Paeds - NDP - stratification split as above	
69. Number of Patients waiting over 104 weeks to access Community services (including Dental and Dermatology) **Target: 0**	In month 200 patients are waiting over 104 weeks for community services in month including Community Dental and Dermatology		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. The split of these waits following stratification is: 1% Reds, 57% Amber, 42% Green.	

North Cheshire and Mersey NHS Foundation Trust

Workforce - Trust Position

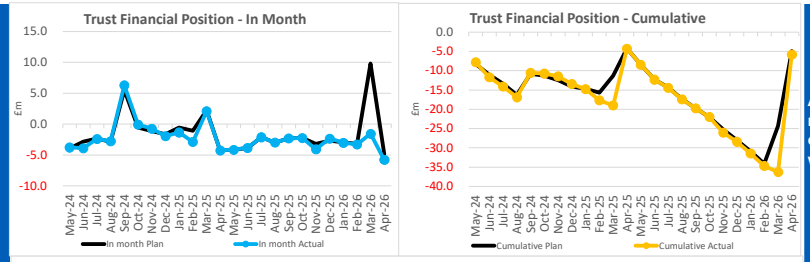
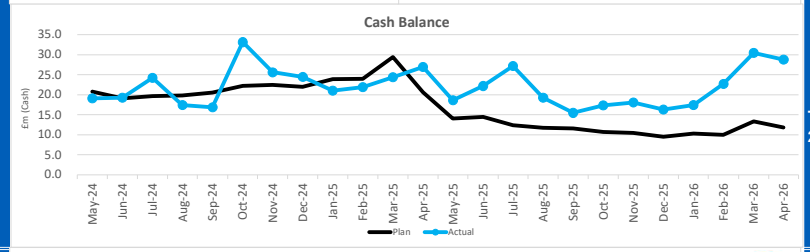
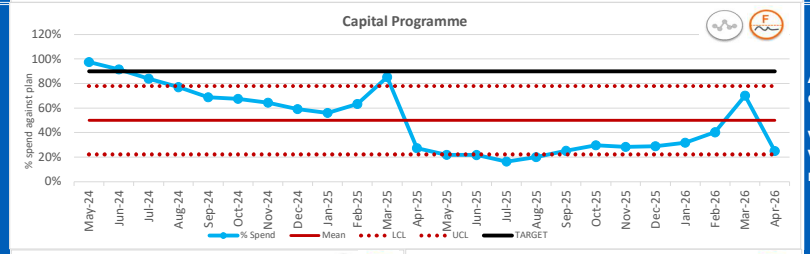
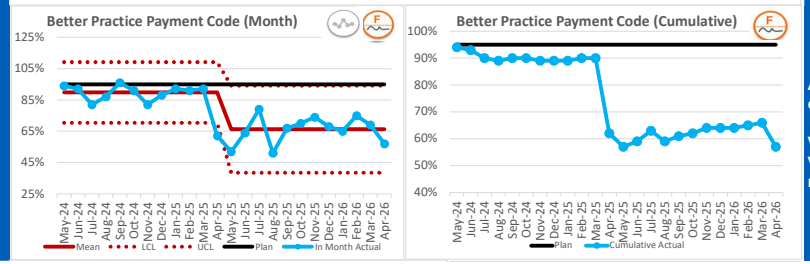
Appendix 3

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
70. Supporting Attendance **Target: Below 5%** The Trust's sickness rate was 5.72% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	The Trust has seen a significant improvement in long-term sickness absence rates reducing from 4.8% in Jan 2025 to 3% in April 2026. Short-term sickness absence is of concern at 2.5%, with data analysis undertaken to identify areas of specific concern across the Trust. Sickness absence is part of the National Oversight Framework (NOF).	The top 24 areas (12 Acute, 12 Community) with the highest absence-related temporary staffing costs have received enhanced HR and Occupational Health support, including detailed case reviews, KPI monitoring, leadership engagement and executive escalation. A new Supporting Attendance Policy is in process of ratification, implementation planned for June 2026. Digital solutions such as PowerApp notifications have been introduced to strengthen compliance and reporting. The enhanced HR and OH support focused on high-impact areas is having the desired impact, with more people remaining healthy within the workplace with the lowest absence rate since Sept 2024.
71. Workforce FTE Plan Compliance **Target: 100% plan** The Trust's Workforce FTE Plan Compliance was 98.98% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common cause (normal) variation.	The Trust is below plan in Month 1 (Apr-26), which means we are using less FTE than planned. To ensure the Trust remains on or below plan, substantive recruitment is subject to quality impact assessments (QIAs) through the vacancy control process and the use of temporary workers is scrutinised through weekly meetings with Executives and Staff Group leads.	Service leads continue to monitor progress against the Workforce Plan and are required to present their FTE reduction plans when completing the Vacancy Control Process (VCP), thus ensuring the requested recruitment is in line with their workforce plans. A series of service reviews have been agreed and assigned leads which will further inform the workforce plans, overseen by the vacancy control process and the delivery unit.
72. Core/ Mandatory Training **Target: 85%** Core/Mandatory training compliance was 91.49% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a concerning nature.	CSTF Mandatory Training compliance is consistently above the Trust target however shows a concerning nature and therefore will be closely monitored.	Training is compliance is monitored by Education Governance Group and MLOG with actions required by Care Groups to ensure minimum standards are met. Training is reviewed periodically to ensure time on training is kept to a minimum and in line with training overheads. Any requests for new training or changes to training is overseen by Mandatory Learning Oversight Group and receives EMT sign off.
73. PDR **Target: 85%** Annualised PDR compliance was 81.02% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	PDRs have continued to consistently to fail to meet the 85% target. A number of corporate areas and staff groups are now achieving target following achievement of the trajectories set, and a number of CBUs have improved significantly over the last 12 months, but still perform below target.	Significant actions have been taken to strengthen appraisal compliance and improve quality. Appraisal guides have been developed to support managers and staff. The appraisal documentation is being reviewed following integration. Digital solutions such as notifications have been introduced to support improving compliance.

North Cheshire and Mersey NHS Foundation Trust

Finance and Sustainability - Trust Position

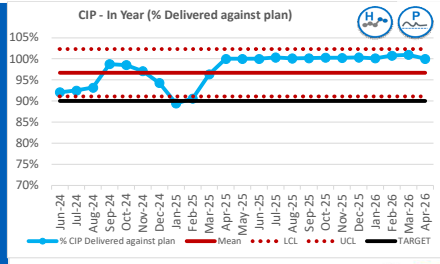
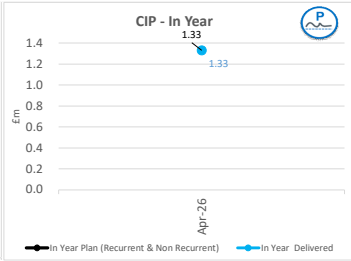
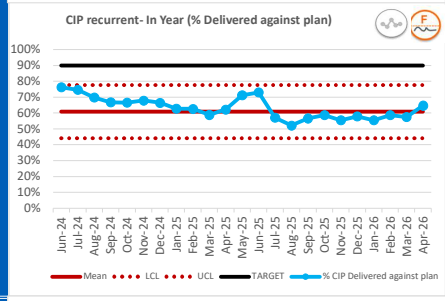
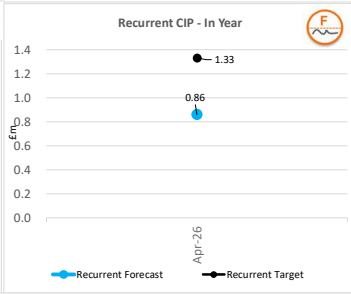
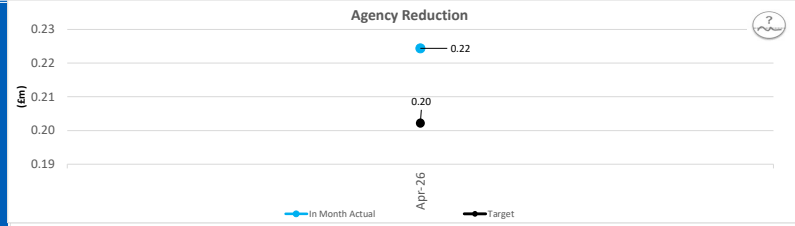
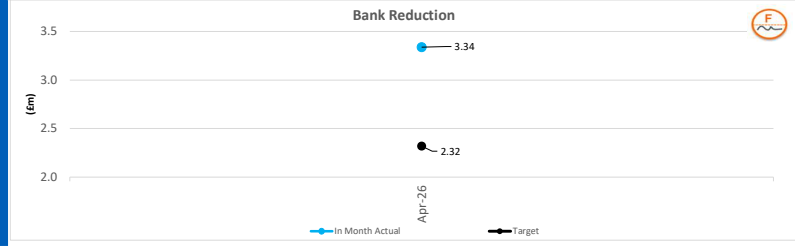
Appendix 3

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
74. Trust Financial Position **Target: Plan**		At month 1 the Trust has recorded a deficit position of £5.8m which is £0.9m worse than plan.	At month 1, the deficit position is £0.9m worse than plan due to a £0.9m impact of industrial action. There is also a £0.1m pressure relating to the cost of support from PwC via the FPRM process which has been offset by £0.1m non recurrent underspends. .	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
75. Cash Balance **Target: On or better than plan**		The cash balance at 30 April 2026 is £28.8m.	The current cash balance is £28.8m which is £16.9m higher than the cash plan. This is predominantly due to having a larger than planned cash balance at the end of 2025/26, the implementation of cash management measures, having higher capital creditors than planned for 2025/26 and underperformance cash being retained by the Trust until June 2026. Of the £28.8m cash, £10.3m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £2.781m is required for June 2026 and a further £14.781m for Q2, approval is sought from the Trust Board. The finance team produces a daily cashflow and before payment runs are made a senior review is undertaken. Weekly reviews of non-NHS and NHS payments are being undertaken to determine whether payments can be deferred without incurring late payment interest charges.
76. Capital Programme **Target: On plan 90%-100%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 1 is £0.1m against a plan of £0.5m. This is mainly due to capital schemes originally planned for 2026/27 being brought forward to 2025/26. The plan is expected to be fully delivered by year end.	The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2026/27 capital plan will be monitored at CPG and reported to FSPC.
77. Better Payment Practice Code **Target: Cumulative performance 95%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Cumulative BPPC performance is 57% which is below the national target of 95%. The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.	BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

North Cheshire and Mersey NHS Foundation Trust

Finance and Sustainability - Trust Position

Appendix 3

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
78. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date	 	**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**At month 1, CIP is in line with plan.**	**CIP progress is reviewed internally and externally on a weekly and monthly basis with oversight from the Delivery Unit. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Work continues on identification of additional schemes to mitigate against high risk schemes.**
79. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**£0.9m CIP has been delivered recurrently against the target of £1.3m.** **The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2027/28.** **Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.**	**Work continues to identify recurrent CIP schemes. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Health and GIRFT are being used.**
80. Agency Reduction **Target: 30% reduction of 2025/26 plan**		**Agency expenditure is £0.2m at month 1 compared to a plan of £0.2m.**	**At month 1, agency expenditure is in line with plan.**	**Agency expenditure will continue to be reviewed throughout the year to ensure that it stays below the target set.**
81. Bank Reduction **Target: 10% reduction of 2025/26 plan**		**Bank expenditure is £3.3m at month 1 compared to a plan of £2.3m.**	**At month 1 bank expenditure is overspent by £1m. £0.9m is due to the impact of April Industrial Action and the remainder is mainly driven by A&E medical staffing vacancies and sickness.**	**A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.**

Appendix 4 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
Quality				
Incidents		Number of incidents reported in month.		Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework. Community services data is now included, and historical data has been refreshed to update the SPC charts.
	1	Number of incidents open over 40 days.	0	
		Total PSIIs recorded in month.		
		Number of PSII Actions Breached.		
		Number of never events reported in month.		
		Number of 'prevention of future death' orders.		
Healthcare Acquired Infections (MSSA, MRSA, E. coli, Klebsiella, CDI and PA Gram Negative)	**2**	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Threshold not yet set for 2025/26	
	3	MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.		
	4	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.		
	5	Escherichia coli (E-Coli) bacteraemia which is one of the largest gram-negative bloodstream infections.		
	6	Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis.		
	7	Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.		
VTE Assessment	**8**	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month; however, this indicator is reported quarterly.	>= 95%	
Inpatient Falls & Harm Levels		Total number of falls which have occurred in month.		Community services data is now included, and historical data has been refreshed to update the SPC charts.
		Falls per 1000 bed days in month.		Community services data is now included, and historical data has been refreshed to update the SPC charts.
	9	Total number of inpatient falls which have occurred in month.	10% decrease from	Community services data is now included, and historical data has

			previous year	been refreshed to update the SPC charts.
		Levels of harm reported as a result of a fall in month for inpatient and ED falls.		
Pressure Ulcers	**10**	Acute - Total Pressure Ulcers (Category 2)	20% reduction on previous year	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
	11	Acute - Total Pressure Ulcers (Category 3 & 4)	20% reduction on previous year	
	12	Community Acquired Pressure Ulcers (Category 2)	20% reduction on previous year	
	13	Community Acquired Pressure Ulcers (Category 3 and above)	20% reduction on previous year	
HSMR Mortality Ratio	**14**	Hospital Standardised Mortality Ratio (HSMR 12-month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.		
SHMI Mortality Ratio	**15**	Summary Hospital-level Mortality Indicator (SHMI 12-month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.		
Medication Safety	**16**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
Medication Incidents	**17**	Acute Medication Incidents		
	18	Community Medication Incidents		
Staffing Average Fill Levels	**19**	Staffing - Average Fill Rate - Day nurses/midwives	>=90%	Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics. Community services data is now included, and historical data has been refreshed to update the SPC charts.
	20	Staffing - Average Fill Rate - Day care staff		
	21	Staffing - Average Fill Rate - Night nurses/midwives		
	22	Staffing - Average Fill Rate - Night care staff		
Complaints		Number of new complaints.		Community services data is now included, and historical data has

				been refreshed to update the SPC charts.
	23	Total number of cases over 6 months old in month.	0	
		Dissatisfied complaints in month (pre-April 2025 classed as 'reopened in month')		
		Number of PALS complaints received and closed in month.		
Friends and Family Test (Inpatient & Day Cases)	**24**	Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	95%	
Friends and Family (ED and UCC)	**25**	Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	87%	
Friends and Family (Community)	**26**	Percentage of Community patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	90%	
Mixed Sex Accommodation Breaches (ITU)	**27**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.
Sepsis	**28**	Sepsis Emergency Patient Screening Blood cultures (within 1 hr)	>=90%	
	29	Sepsis Inpatient Screening Blood cultures (within 1 hr)	>=90%	
	30	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	
	31	Sepsis Inpatient Patient Antibiotics (within 1hr)	>=90%	
		Sepsis Emergency Patient Antibiotics (within 6hrs)	100%	
		Sepsis Inpatient Patient Antibiotics (within 6hrs)	100%	
Acute Kidney Injury	**32**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Average Length of Stay (LoS) of patients within an AKI.		
Postpartum Haemorrhage >1500ml	**33**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against Northwest Coast Regional Dashboard.	<3.7%	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against Northwest Coast Regional Dashboard. PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the Northwest Coast Maternity Dashboard.
Fractured Neck of Femur	**34**	The % of patients treated in line with Best Practice Tariff (BPT).		The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database
		% of patients receiving surgery within 36hrs of admission		

				(nhfd.co.uk)). Shorter time to theatres significantly reduces risk of mortality and improves pain.
MUST nutritional assessment completion	**35**	MUST Nutrition assessment completion	>85%	To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE). In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity. Community services data is now included, and historical data has been refreshed to update the SPC charts.
Duty of Candor	**36**	Duty of Candor Compliance	100%	Initial Duty of Candor completed within 10 working days (by date letter sent). Community services data is now included, and historical data has been refreshed to update the SPC charts.
Access & Performance				
Under 4-hour A&E Wait time Target and ICS Trajectory (excluding WWIC)	**37**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78% (national objective)	
Under 4-hour A&E Wait time (including WWIC)	**38**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78%	Before integration with Bridgewater, 50% of Widnes UTC's 4-hour performance was included in WHH data. From 1st April, 100% of Widnes UTC performance will count toward NCM's 4-hour A&E metric.
Average Time in Department (ED)	**39**	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	**40**	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Ambulance Vehicle Handovers within 15 mins	**41**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	National guidance has redefined ambulance handover completion as the point when clinical handover is finished, the patient is on hospital equipment, and the crew is released. In line with this, NWAS has updated its KPIs to measure handover from arrival to
Ambulance Vehicle Handovers within 30 mins	**42**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	

Ambulance Vehicle Handovers within 45 mins	**43**	% of ambulance handovers that took place within 45 minutes (based on the data recorded on the HAS system).	100%	vehicle handover (A2VH), replacing the previous arrival to patient handover (A2PH) metrics. These changes aim to improve consistency, operational clarity, and performance reporting.
Type 5 Activity	**44**	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Percentage of UTC attendances referred on to A&E	**45**	Percentage of UTC attendances referred on to A&E		Combined position from both Widnes and Runcorn UTC, using data that is already flowing via Emergency Care Data Set (ECDS) to NHS England.
Fracture Clinic	**46**	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
Diagnostic Waiting Times – 6 weeks	**47**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	Community Paediatric Audiology data is now included, and historical data has been refreshed to update the SPC charts.
RTT Open Pathways and 52 & 65 week waits	**48**	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
	49	Number of patients waiting over 52 weeks.	0	
		Number of patients waiting over 65 weeks.	0	
		Number of patients waiting over 78 weeks.	0	
Cancer 28 Days	**50**	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. Community dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Cancer 31 Day wait	**51**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat. Community

				dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Cancer 62 Day wait	**52**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat. Community dermatology data is now included, and historical data has been refreshed to update the SPC charts.
Reduction in Outpatient Follow Ups	**53**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
Elective Recovery Activity	**54**	% of Elective Activity (Inpatients)	104%	
		% of Elective Activity (Day cases)	104%	
Elective Recovery Diagnostics	**55**	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	
		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	
		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	
		% of Elective Diagnostic Activity - Colonoscopy	month in previous year	
Elective Recovery Outpatients	**56**	% of Elective Recovery Outpatient Activity	104%	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	57	Super stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.		
No criteria to reside (NCTR)	**58**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Super stranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
	59	Average number of days from discharge ready date to actual discharge date		NHS Oversight Framework Indicator which benchmarks the average delay to discharge from when the patient is ready for

				discharge to the date of discharge.
% Patients discharged to their usual place of residence	**60**	% of patients who were discharged to their usual place of residence.		
Cancelled operations on the day for non-clinical reasons	**61**	% of operations cancelled on the day or after admission for non-clinical reasons.	<=2%	
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	**62**	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	0	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Capped Theatre Utilisation (measured as productive operating time only)	**63**	Capped theatre utilisation	>85%	Increase productivity and meet the 85%-day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
Urgent Community Response (UCR) 2 Hour Compliance	**64**	Urgent Community Response (UCR) 2 Hour Compliance	>=70%	NHS Oversight Framework Indicator. Percentage of urgent community response referrals seen within 2 hours
Percentage of Patients Waiting over 52 weeks for community services (excluding dental and dermatology)	**65**	Percentage of Patients Waiting over 52 weeks for community services (excluding dental and dermatology)	0%	NHS Oversight Framework Indicator. Currently the Community services sitrep submission does not allow for dental or dermatology waiters to be submitted which impact the national position used on the NHS Oversight Framework.
Number of Patients waiting over 104+ weeks to access community services (excluding	**66**	Number of Patients waiting over 104+ weeks to access community services (excluding dental and dermatology)	0	Oversight on the number of patients submitted nationally via the Community services sitrep which does not allow for dental or dermatology waiters to be included.

dental and dermatology)				
Number of Patients waiting over 52 weeks to access community services (including dental and dermatology)	**67**	Number of Patients waiting over 52 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 52 weeks to access community services including dental and dermatology.
Number of Patients waiting over 65 weeks to access community services (including dental and dermatology)	**68**	Number of Patients waiting over 65 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 65 weeks to access community services including dental and dermatology.
Number of Patients waiting over 104 weeks to access community services (including dental and dermatology)	**69**	Number of Patients waiting over 104 weeks to access community services (including dental and dermatology)	0	Overall number of patients waiting over 104 weeks to access community services including dental and dermatology.
Workforce				
Supporting Attendance	**70**	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<5%	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Workforce FTE Plan Compliance	**71**	Workforce FTE Plan Compliance	100% plan	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Core / Mandatory Training	**72**	Percentage of the Core/Mandatory Training Compliance, this includes:	>85%	Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and most recently, safeguarding. Community services data is now included, and historical data has been refreshed to update the SPC charts.
Performance & Development Review (PDR)	**73**	Percentage of the PDR compliance.	>85%	Community services data is now included, and historical data has been refreshed to update the SPC charts.
Finance				

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

Appendix 5 - Statistical Process Control

1.0 What is SPC?

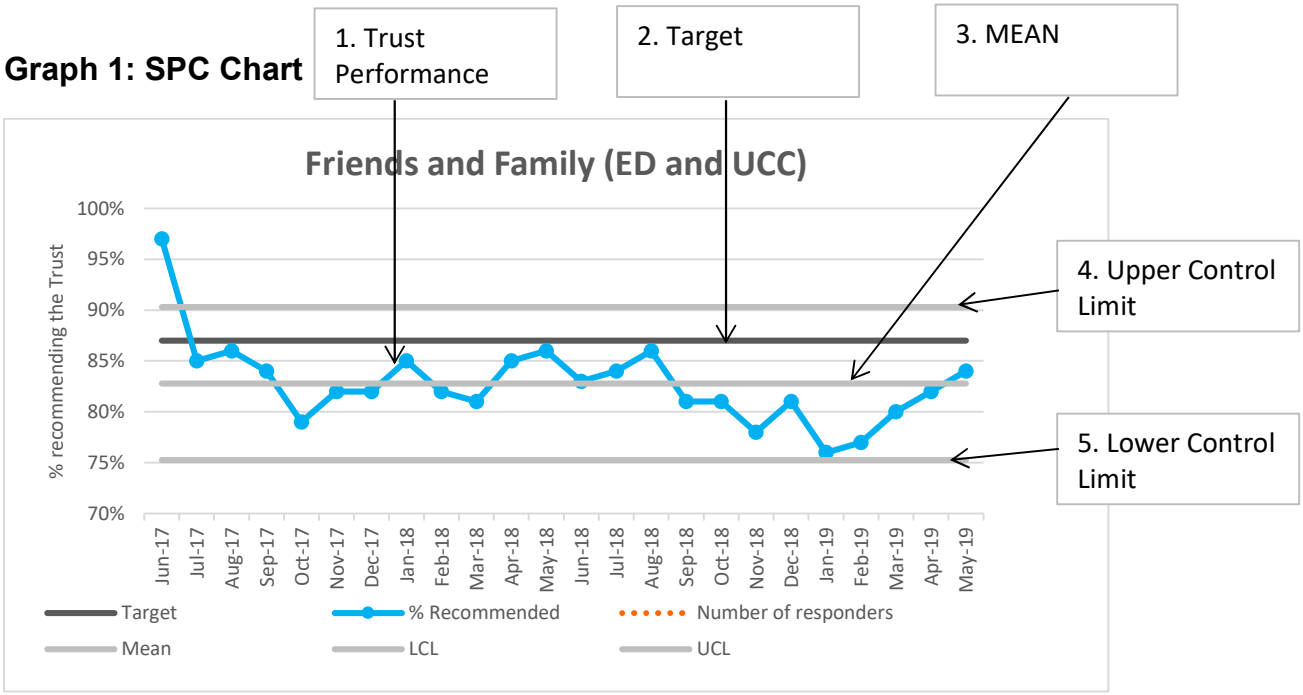
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trends or patterns.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

Graph 1: SPC Chart

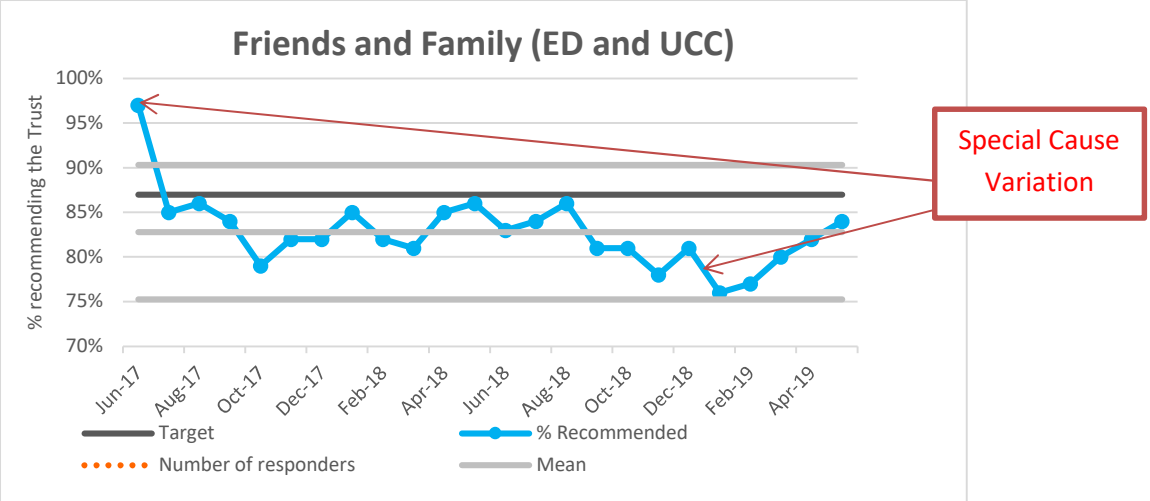


2.1 Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, this means that there is special cause variation present and that the process is not in control and requires investigation. Please note that breaching a rule does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 7 consecutive data points are above or below the mean line.
3. There are more than 6 consecutive points either increasing or decreasing.

Graph 2: Outlining Special Cause Variation



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it is possible for a process to be within control but not meeting the target.

3.0 Making Data Count Assurance & Variation Icons

The Trust has introduced the "Making Data Count" variation and assurance icons in 2022/23. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five variation icons which

is based solely on the data and the SPC rules. Ideally the assurance icon should be blue “P” icon which notes the indicator is consistently passing its target over the last 7 months. Again, ideally the variation icon should be either the grey “common cause variation” icon or a blue “H” or “L” icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

Assurance			Variation		
					
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

3.1 Business Rules

- Where there are not enough data points for an SPC chart, the target is based on a cumulative position (e.g. an annual target) or SPC is not appropriate, a “No SPC” icon is utilised as outlined below.

- Assurance icons are based on the last 7 months. E.g. if the Trust has consistently passed a target in the last 7 months the blue “P” icon will be used.

- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured “H” or “L” icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

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

Income Statement at 30th April 2026

Income Statement	Annual	Month		
	Budget £000	Budget £000	Actual £000	Variance £000
Operating Income				
NHS Clinical Income	**433,246**	**35,645**	**35,178**	**-467**
Non NHS Clinical Income				
Private Patients	8	1	0	-1
Non NHS Overseas Patients	72	6	1	-5
Other non protected	816	68	28	-40
Community & Dental - Non NHS	18,000	1,500	1,264	-236
Notional Pension Income	0	0	0	0
Sub total	**18,896**	**1,575**	**1,292**	**-283**
Other Operating Income				
Training & Education	13,847	1,154	1,152	-2
Donations and Grants	0	0	46	46
Miscellaneous Income	17,538	1,461	1,326	-135
Sub total	**31,385**	**2,615**	**2,523**	**-92**
Total Operating Income	**483,527**	**39,835**	**38,994**	**-842**
Operating Expenses				
Employee Benefit Expenses	-356,378	-30,765	-31,670	-905
Drugs	-24,342	-2,153	-1,837	316
Clinical Supplies and Services	-30,201	-2,928	-2,158	770
Non Clinical Supplies	-72,106	-6,264	-6,642	-378
Depreciation and Amortisation	-25,182	-2,090	-2,088	1
Net Impairments (DEL)	0	0	0	0
Net Impairments (AME)	0	0	0	0
Restructuring Costs	0	0	0	0
Total Operating Expenses	**-508,208**	**-44,200**	**-44,395**	**-195**
Operating Surplus / (Deficit)	**-24,681**	**-4,365**	**-5,402**	**-1,037**
Non Operating Income and Expenses				
Profit / (Loss) on disposal of assets	0	0	0	0
Interest Income	842	70	205	135
Interest Expenses	-524	-44	-43	2
PDC Dividends	-6,777	-565	-565	-1
Total Non Operating Income and Expenses	**-6,459**	**-539**	**-404**	**135**
Surplus / (Deficit) - as per Accounts	**-31,140**	**-4,903**	**-5,805**	**-902**
Adjustments to Financial Performance				
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0
Less Donations & Grants Income	0	0	-46	-46
Add Depreciation on Donated & Granted Assets	669	56	56	0
Total Adjustments to Financial Performance	**669**	**56**	**10**	**-46**
Adjusted Surplus / (Deficit) as per NHSE Return	**-30,471**	**-4,847**	**-5,795**	**-948**

North Cheshire and Mersey
NHS Foundation Trust

IPR – April 2026 Detail

Home
Community
Hospital

Introduction

There is **1 Indicator that has been requested via the Action Log to be monitored going forward,** This is:

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

There is **1 Indicator that has been highlighted via the latest published NHS Oversight Framework metrics table,** This is:

- **2. Healthcare Acquired Infections (MRSA)** - Target zero

There are **4 indicators that are both failing and have special cause variation of a concerning nature**, these are:

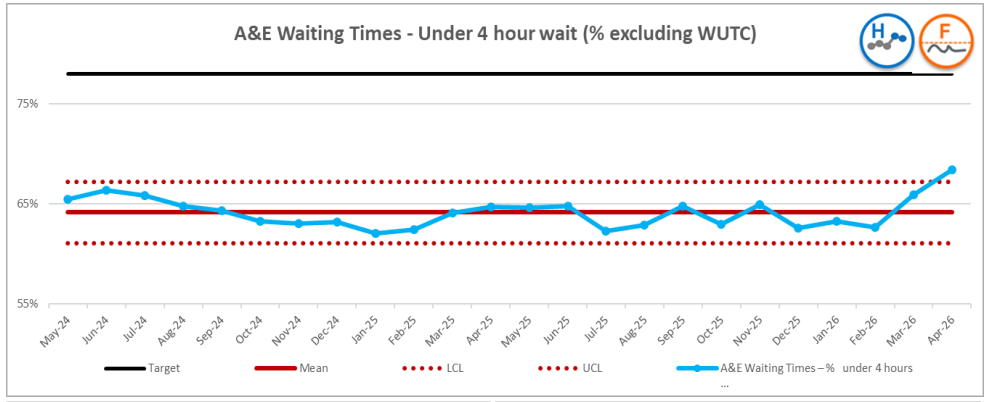
- **30. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag** – Target 90%
- **65. Percentage of patients over 52 weeks for community services (excluding dental and dermatology)** – Target 0%
- **66. Number of patients waiting over 104+ weeks to access community services (excluding dental and dermatology)** – Target zero
- **69. Number of patients waiting over 104+ weeks to access community services (including dental and dermatology)** – Target zero

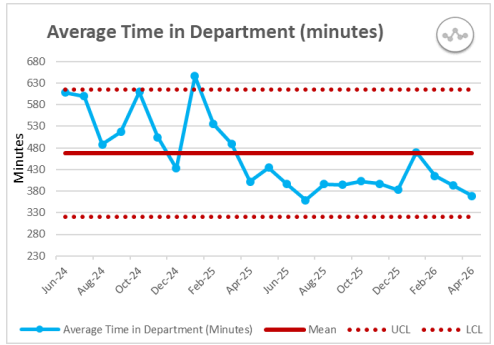
There are **two indicators that consistently fail and cannot be measured for variation**, these are:

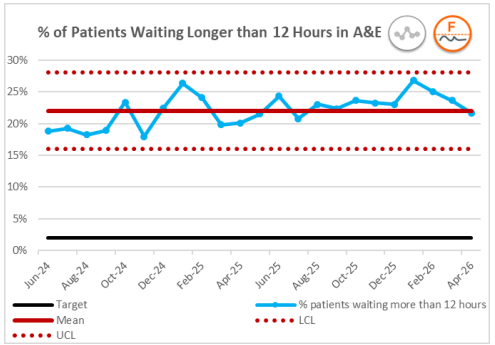
- **79. CIP (recurrent) –** % delivered against plan
- **81. Bank Reduction –** delivery against 10% reduction of 2025/26 plan

April 2026 IPR by Exception

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







Reasons for variation and what is the impact

- 4-hour performance from April 26 includes 100% Widnes Type 3 activity.
- Excluding this the Trust still saw a 4.64% improvement from April 2025
- The Target to achieve by March 27 is 84%
- The National constitutional target remains 95%
- 12 hour performance continues to be negatively impacted by the wait to be seen in ED and overall high bed occupancy

How are we going to improve the position

- An action plan of short and long term actions has been established and is monitored weekly via the executive chaired ED Improvement Group. Delivery externally is monitored via the bi-weekly NHSE Tiering meetings.
- More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4-hour compliance.
- Increased capacity through SDEC through separating Medical and Surgical SDEC has supported the improvement in 4-hour performance.
- A reduction in non-admitted breaches has been supported through the ED improvement group, the next focus is on admitted breaches which has a direct correlation to flow out of ED

Acute Provider Table Update

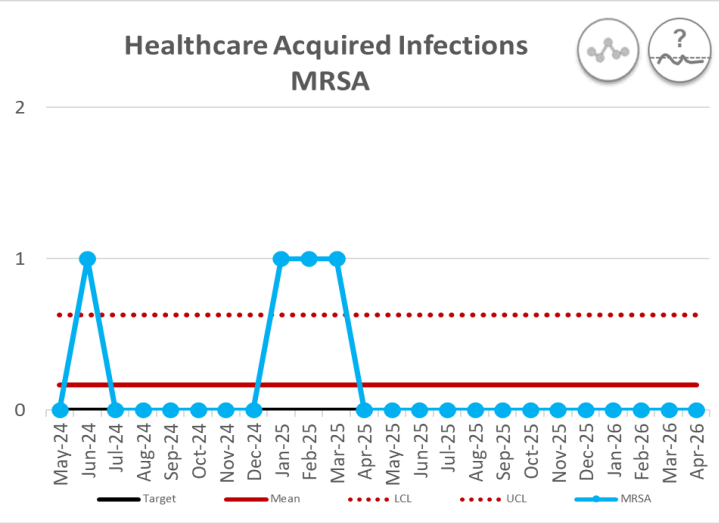
A&E 4-hour performance	A&E 12-hour performance
61 out of 118	117 out of 118
Sourced: Acute Provider Table April 26 data published May 26	Sourced: Acute Provider Table April 26 data published May 26

April 2026 IPR by Exception

2. Healthcare Acquired Infections - MRSA

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

Description	Refreshed	Reporting Date	Metric Score	Rank	Trend	Reporting Date	Metric Score	Rank
Number of MRSA bacteraemia cases	Quaterly	Jan 25 - Dec 25	2.66	Not Ranked	▲	Oct 24 - Sept 25	2.60	Not Ranked



Reasons for variation and what is the impact

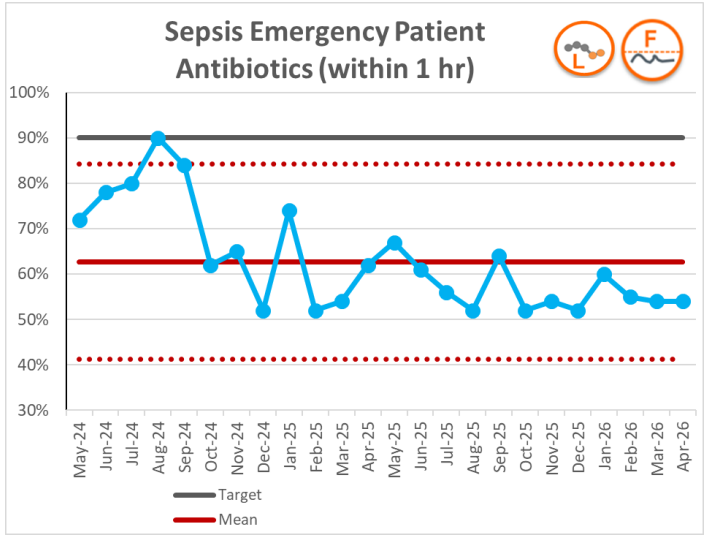
- March 2026 NHS Oversight Framework data covered January 25 to December 25.
- There have been no MRSA bacteraemia cases reported over a rolling 13-month period.
- Data to be published in June 26 will cover April 25 to March 26, which will demonstrate an improving performance against the previous period reported

How are we going to improve the position

- An MRSA and MSSA Prevention Action Plan is in place, including review of peripheral cannula dwell times in line with EPIC3 guidance and revised cannulation policy, alongside strengthened ANTT training and competency assessment across CBUs. Support from the Quality Academy is being utilised to address gaps in peripheral cannula documentation.

April 2026 IPR by Exception

30. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag



Reasons for variation and what is the impact

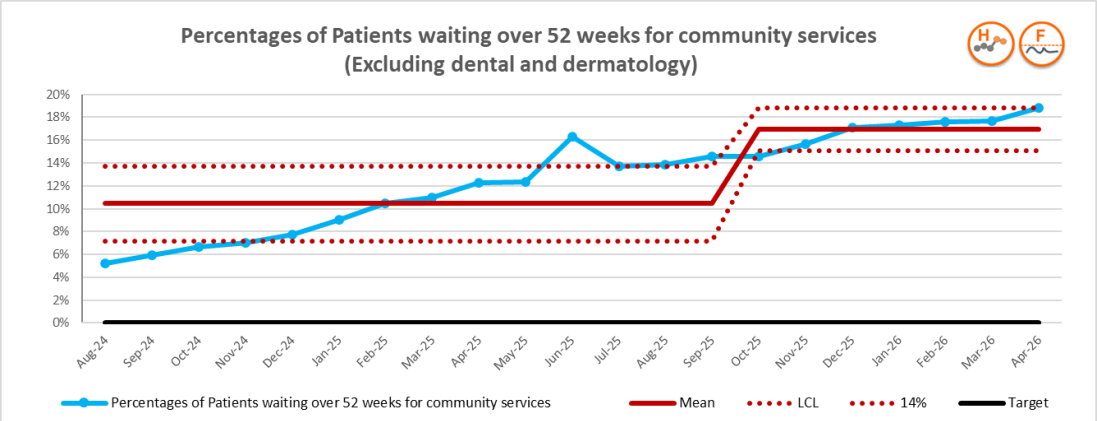
- Within the Emergency Department, performance continues to show month-to-month variation, with April in line with the recent trend. While not yet consistently meeting target levels, performance remains within an expected range and reflects the ongoing pressures and complexity within urgent and emergency care.

How are we going to improve the position

- Recent audit data shows improved blood culture completion in ED and better 1-hour antibiotic administration, demonstrating impact of targeted interventions.
- Reintroduction of sepsis bags has strengthened reliability and timeliness of blood culture collection.
- Ongoing staff education and training, with increased numbers able to perform blood culture collection.
- Sepsis management reinforced through clinical handovers and teaching sessions.
- Sepsis Bleep initiative (launched May 2026 in ED) supports early recognition, escalation, and timely treatment.
- Some variation remains across pathways, but governance oversight via the Deteriorating Patient Group and Sepsis Improvement Group continues to drive focused improvement.
- A deep dive review will be presented to the Quality, Safety and Assurance Committee in July to inform next steps.

April 2026 IPR by Exception

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



Reasons for variation and what is the impact

- Patients waiting longer than 52 weeks - 10 Podiatry patients (Halton), There will be 0 patients waiting over 52 weeks by the end of June waiting list snapshot.
- The remaining patients are children awaiting an appointment for the Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. The split of waits following stratification is: 2% Reds, 51% Amber, 46% Green, 1% not stratified.

How are we going to improve the position

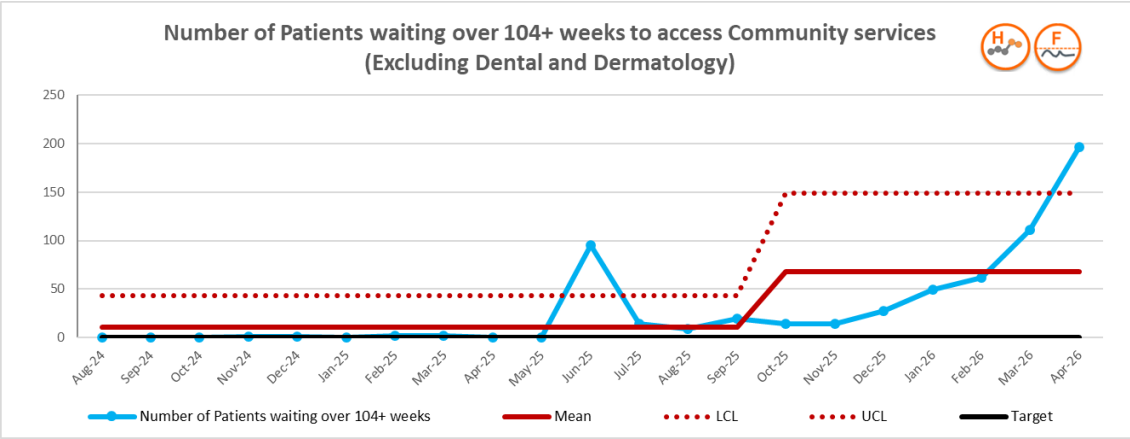
- Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue

Important to note:

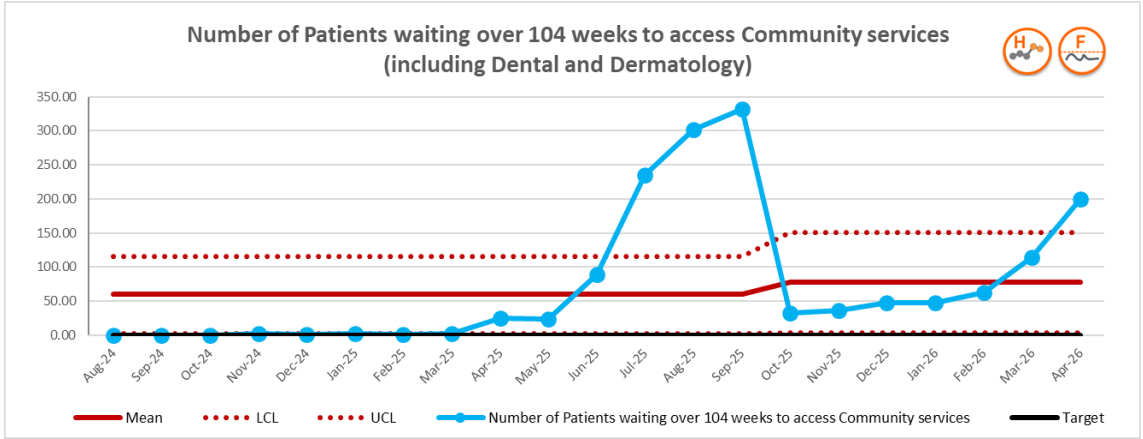
This is a Community NOF Indicator that will become an NCM NOF Indicator. The data is submitted via the Community Services Sitrep, the Sitrep does not allow the submission of Dental or Dermatology community waiting lists.

April 2026 IPR by Exception

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



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



Reasons for variation and what is the impact

- Patients waiting over 104 weeks are children waiting Neurodevelopmental Pathway (NDP) or Community Paediatrics in both Warrington & Halton. The split of these waits following stratification is: 1% Reds, 57% Amber, 42% Green.

How are we going to improve the position

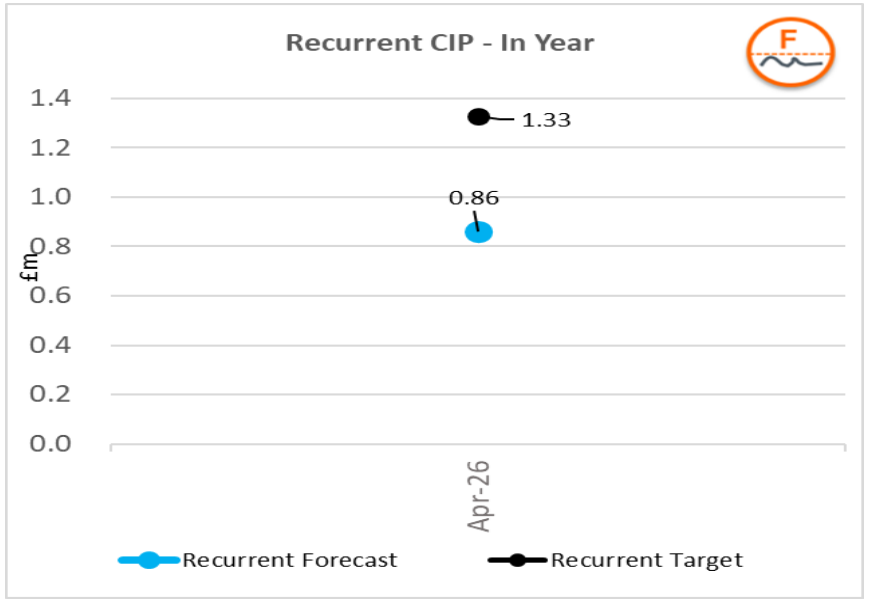
- Service review being undertaken for Paediatric Neurodevelopment Pathway to support redesign of service delivery, this is a recognised national issue

Important to note:

From June to October, NDP waiting lists were manually corrected for the national submission; however, patient level reports were not corrected due to the technical challenges until October 25. This explains why the graphs only align from 25 October onwards.

April 2026 IPR by Exception

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



Reasons for variation and what is the impact

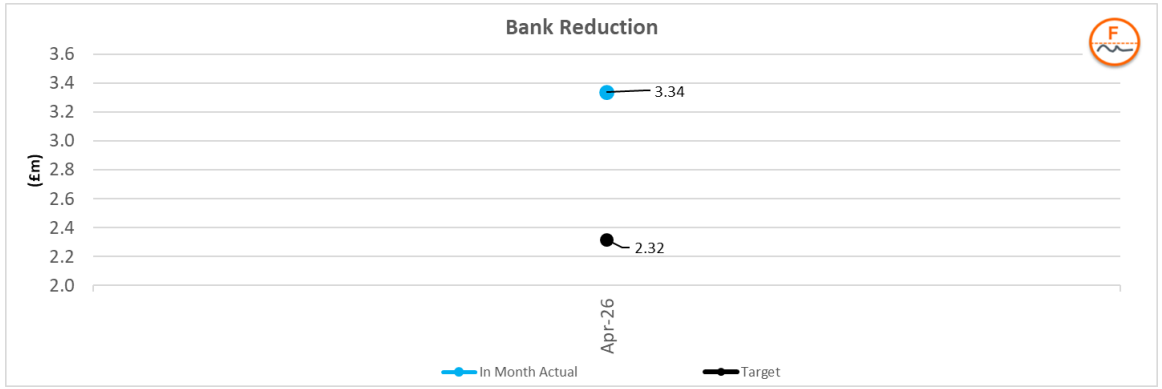
- £0.9m CIP has been delivered recurrently against the target of £1.3m.The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2027/28.Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.

How are we going to improve the position

- Work continues to identify recurrent CIP schemes. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Health and GIRFT are being used.

April 2026 IPR by Exception

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



Reasons for variation and what is the impact

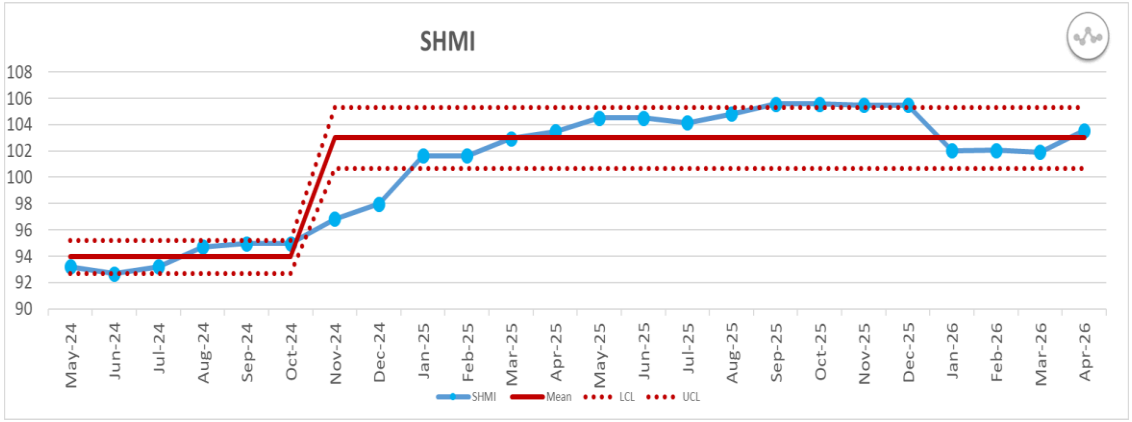
- At month 1 bank expenditure is overspent by £1m. £0.9m is due to the impact of April Industrial Action and the remainder is mainly driven by A&E medical staffing vacancies and sickness.

How are we going to improve the position

- A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

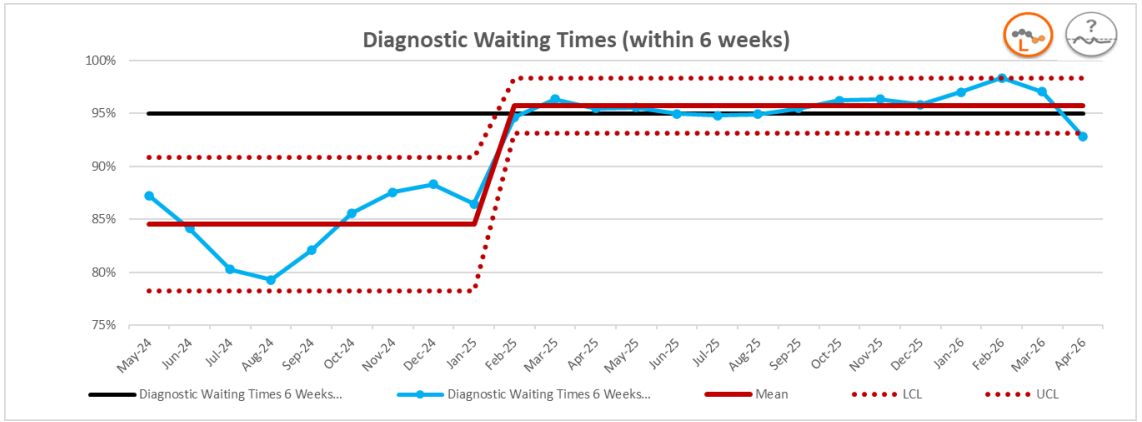
Recalculations

Details of the indicators for which recalculation points are defined to enhance SPC accuracy in identifying significant shifts in process variation.



15. SHMI

- 7 or more consecutive data points above the mean signalling a shift in variation.
- Due change in Type 5 coding
- SHMI remains within expected limits and is not an outlier

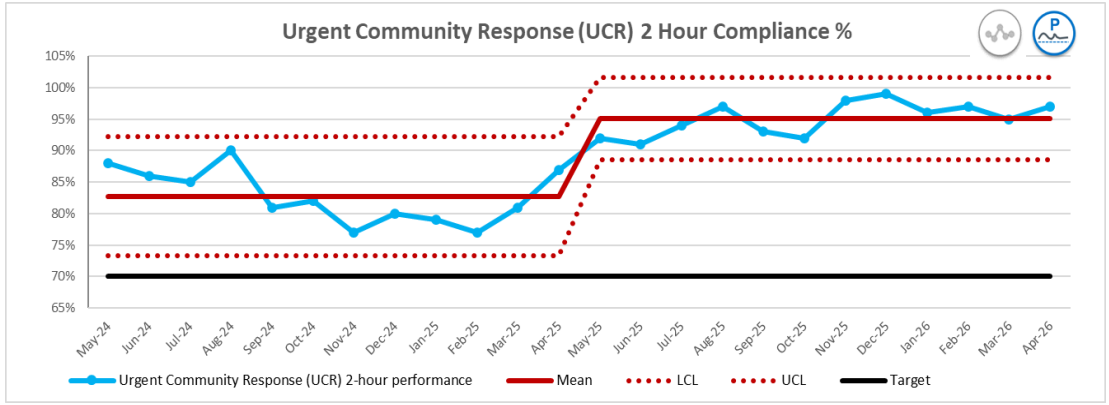


49. Diagnostic Waiting Times (within 6 weeks)

- 7 or more consecutive data points above the mean signalling a shift in variation.

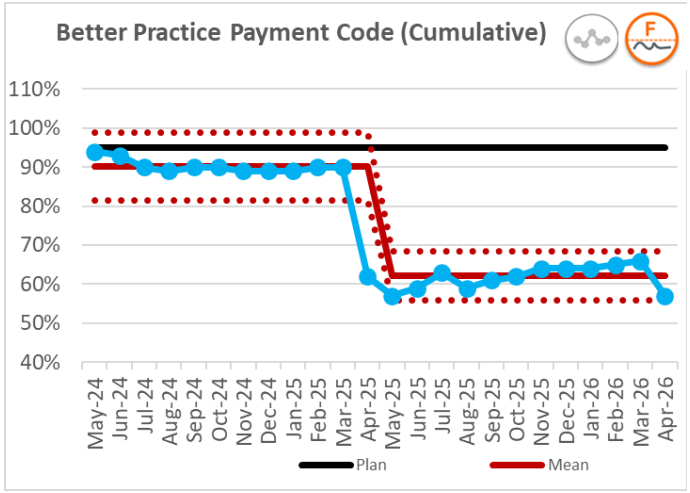
Recalculations

Details of the indicators for which recalculation points are defined to enhance SPC accuracy in identifying significant shifts in process variation.



66. Urgent Community Response (UCR) 2 Hour Compliance

- 7 or more consecutive data points above the mean signalling a shift in variation.

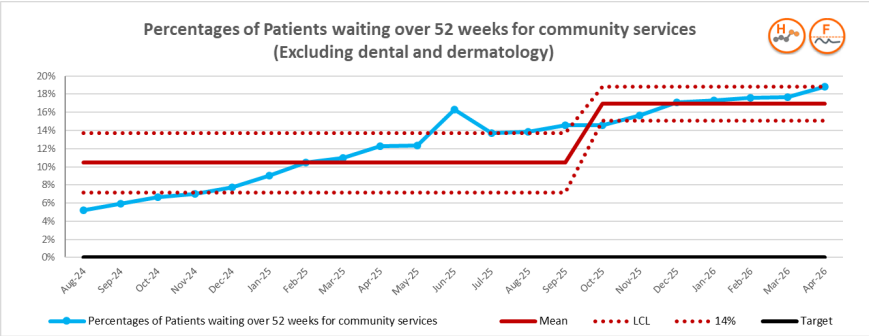


77. Better Payment Practice Code (Cumulative)

- 7 or more consecutive data points above the mean signalling a shift in variation.

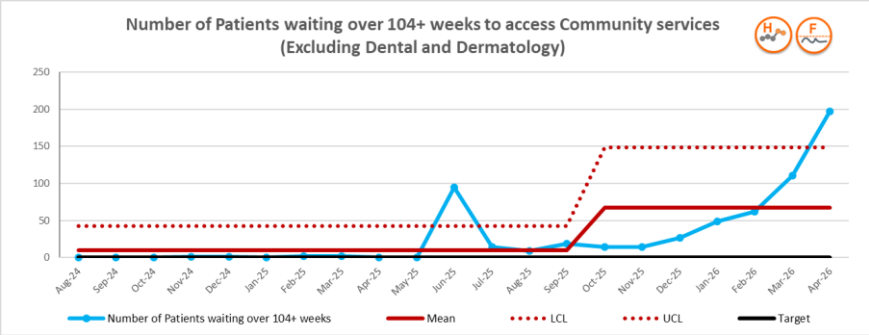
Recalculations

Details of the indicators for which recalculation points are defined to enhance SPC accuracy in identifying significant shifts in process variation.



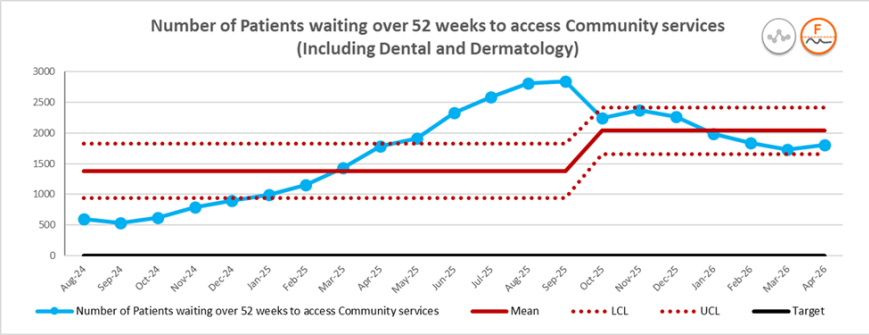
65. Percentage of Patients waiting over 52 weeks for community services (excluding dental and dermatology)

- NOF Indicator
- Following Neurodevelopment data transformation process waiting lists have been validated. From October a new baseline is set.



66. Percentage of Patients waiting over 104+ weeks for community services (excluding dental and dermatology)

- Following Neurodevelopment data transformation process waiting lists have been validated. From October a new baseline is set.

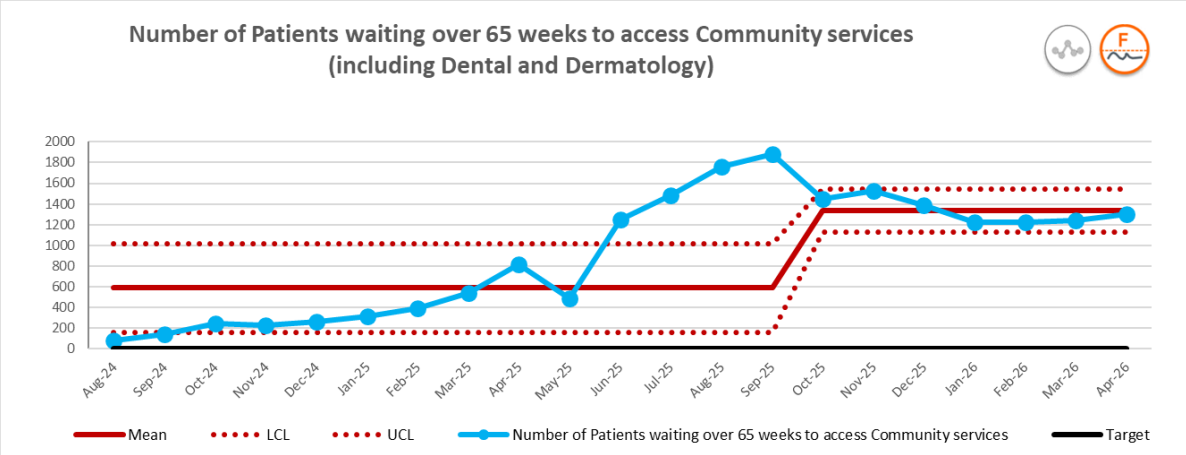


67. Percentage of Patients waiting over 52 weeks for community services (including dental and dermatology)

- Following Neurodevelopment data transformation process waiting lists have been validated. From October a new baseline is set.

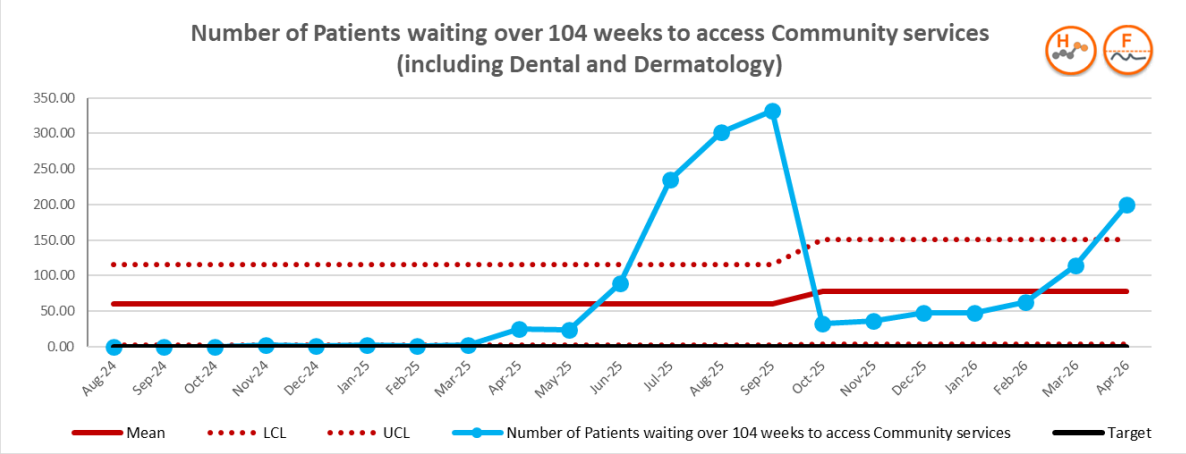
Recalculations

Details of the indicators for which recalculation points are defined to enhance SPC accuracy in identifying significant shifts in process variation.



68. Percentage of Patients waiting over 65+ weeks for community services (including dental and dermatology)

- Following Neurodevelopment data transformation process waiting lists have been validated. From October a new baseline is set.



69. Percentage of Patients waiting over 104+ weeks for community services (including dental and dermatology)

- Following Neurodevelopment data transformation process waiting lists have been validated. From October a new baseline is set.

Recommendation

The Trust Board is asked to note the actions being taken in relation to these IPR indicators of concern and note the recalculations applied to the SPC charts

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/06/027a (i)	**Date of Board meeting:**	3 June 2026

Date of meeting:	14 April 2026
Name of meeting and chair:	Quality and Safety Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QSAC/26/04/004	**Deep Dive Community Equipment Stores**	Associate Chief Nurse (Community and Dental Services) presented a deep dive on Community Equipment Stores The committee discussed the challenges experienced in the Community Equipment Stores. These issues included estate issues, sickness levels and delivery delays. The committee noted that a full action plan was now in place which has already significantly reduced the servicing backlog.	**Limited** Some progress noted ,not yet assured required regarding sustained improvements	**High** Governance strengthened with monthly Care Group oversight, bimonthly to Quality Safety Assurance Committee	2 months to Quality Safety and Assurance Committee(QSAC)

		The committee will continue to monitor progress			
QSAC/26/04/006	**ED Harms Update**	Performance has shown improvement, with a 3% increase in 4-hour performance and a 1.3% rise in 12-hour performance, alongside higher patient attendance levels. Corridor care continues to be a national priority, reinforced by a planned summit in May 2026, and there has been a sustained reduction in the average time patients spend in corridors. Additionally, the opening of a Surgical SDEC service in February 2026 has contributed positively to Type 5 performance.	**Limited** Performance improving however remains below expected range	**High** Strong governance in place. Care Group Governance in place. Monthly reporting to QSAC	Monthly reporting to QSAC
QSAC/26/04/005	**Surgical Site Infection**	The IPC Clinical Lead and Associate Chief Nurse reported a positive reduction in SSI rates to 0.7%, with only one confirmed case in Q3 following robust review. Improvements are being strengthened through a fortnightly Oversight Group to address timeliness and ownership, and the Trust is no longer identified as an outlier.	**Limited** Whilst Trust not currently flagging as an outlier ownership from Trauma and Orthopaedics (T and O)team not evident.	**Moderate** Whilst T and O ownership not evident governance processes are being overseen by the IPC Team to ensure SSIs are monitored.	Trauma and Orthopaedics Team to present in 2 months to Quality Safety and Assurance |Committee.
QSAC/26/04/012	**Neurodevelopment (NDP) Update**	Demand has increased significantly without a corresponding uplift in	**Limited**	**High**	Options paper being drafted for

		commissioning support, resulting in a growing number of patients waiting over 65 weeks, in line with the national position. The situation continues to be monitored through the NDP steering group, with no additional funding identified to date, and work underway to explore new pathway models to improve delivery.	Significant waiting lists observed, demand outstretches demand	Strong governance in place. Care Group Governance in place. Monthly reporting to Regional Team and oversight at QSAC	Executive Management Team Q1.
QSAC/26/04/008	**#Neck of Femur data issues**	It was noted that differences between NHFD admission data and Best Practice Tariff discharge data account for reporting discrepancies, and the team has been asked to clarify the datasets used to ensure consistency. Notwithstanding this, both data sources indicate that significant improvements have been achieved. There is an intention to open a theatre on Saturdays from June.	**Limited** Improvements noted , need to address data accuracy issues	**Moderate** High level of oversight at Patient Safety Clinical Effectiveness meeting and Quality, Safety and Assurance Committee , data set needs clarifying clearly	Data set to be clarified and standardised for future reports ensuring consistency. Continue reporting in line with Cycle of Business.

Assurance key:

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

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/06/029a (ii)	**Date of Board meeting:**	3 June 2026

Date of meeting:	12 May 2026
Name of meeting and chair:	Quality and Safety Assurance Committee, chaired by Cliff Richards
Was the meeting quorate:	Yes

The Committee draws the following matters to the attention of the Board:

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QSAC/26/05/030	**Patient Story**	The patient's granddaughter shared the experience of Patient V, aged 92, highlighting the importance of open and honest end-of-life conversations. The family felt that clearer communication regarding the diagnosis would have influenced their decision to remain with the patient and that they lost valuable time as a result. Learning from this experience has informed an action plan, with key insights shared to improve future care.	**Moderate** Communication with this family was not sufficiently clear; however, learning has been identified and will be monitored through complaints, patient	**High** Emergency Department governance has been strengthened through monthly Care Group oversight and bimonthly reporting to the Quality, Safety and	Monthly Emergency Department updates to the Quality, Safety and Assurance Committee

			feedback, and ward accreditation processes.	Assurance Committee.	
QSAC/26/05/032	**ED Harms Update**	The Deputy Chief Nurse and Director of Governance highlighted significant improvements in 4-hour performance, alongside a reduction in non-elective admissions following the introduction of the Surgical SDEC, now approved to operate permanently Monday to Friday. Oversight of corridor care continues, with reductions achieved despite increased attendances, and a notable decrease in the harm profile in Q4. An overview of ongoing improvement projects was also provided, demonstrating continued progress in quality and patient flow.	**Moderate** The harm profile has reduced significantly and corridor care has also reduced. Performance is improving, although it remains below the expected range.	**High** Robust governance arrangements are in place, including Care Group oversight and monthly reporting to the Quality, Safety and Assurance Committee.	Monthly reporting to the Quality, Safety and Assurance Committee
QSAC/26/05/034	**Neck of Femur Performance and Action Plan**	The Associate Medical Director for Planned Care reported on neck of femur performance, noting that four KPIs are now above the national average. While 45.7% of cases were operated on within 36 hours, below the national average of 57%, Best Practice Tariff performance for March 2026 was 37.8%. Data sets have now been clarified to ensure consistent future reporting. It was also noted that Theatre 2	**Limited** Performance remains below the national average across a number of metrics; however, improvement is being seen.	**High** Oversight is provided through the Patient Safety and Clinical Effectiveness Subcommittee and the Quality, Safety and	A further presentation will be provided to the Quality, Safety and Assurance Committee in two months.

		capacity exceeded demand on weekends, although it was not required during weekdays in March and April.		Assurance Committee, supported by weekly Executive review.	
QSAC/26/05/035	**Planned Care Recovery Programme**	The Deputy Medical Director provided an update on assurance and escalation programmes, noting progress within the pain service and ongoing plans to address weekend theatre capacity challenges for neck of femur patients. Ophthalmology outpatient follow-up backlogs remain a pressure due to demand exceeding capacity, with recruitment underway to fill vacancies and efforts to secure additional agency support, although none has been identified to date.	**Limited** A significant waiting list backlog remains. Demand continues to exceed capacity, and weekend theatre capacity challenges are not yet resolved.	**High** Governance arrangements are in place through Care Group oversight, monthly reporting to the Patient Safety and Clinical Effectiveness Subcommittee, and oversight by the Quality, Safety and Assurance Committee.	Bimonthly reporting to QSAC. Monthly reporting to PSCESC
QSAC/26/05/036	**Typing Backlog**	The Care Group Operational Team reported positive progress in reducing the typing backlog, with a notable decrease in both standard and urgent letters. The rollout of the Lyrebird AI script is	**Moderate** Rapid improvement has been noted from the	**High** Oversight is provided through the Patient Safety and Clinical	Reporting to QSAC bimonthly

		progressing well, with multiple specialities live and further staff trained across services. A substantial volume of letters has been completed, with the remaining backlog expected to be cleared within the next two months, ahead of a full Trust-wide rollout planned for the end of May 2026.	previous position; focus is now required on full Trust-wide rollout and clearance of the remaining backlog.	Effectiveness Subcommittee and the Quality, Safety and Assurance Committee. The dataset has now been clarified to support consistent future reporting.	
QSAC/26/05/042	**Mental Health Update**	The Deputy Chief Nurse and Director of Governance provided an update on Section 136 arrangements, highlighting proactive engagement with the ICB and strengthened internal governance through an established working group, decision matrix, and SOP. Whilst acute Trusts have been asked to accept patients from Q1 2026, NCM continues to support patients with physical and mental health needs, with increased capacity at Hollins Park contributing to a more structured and resilient approach.	**Limited** Processes have been drafted; however, the environment remains unsuitable and no capital funding has been identified to make it safe and appropriate. There remains significant concern regarding the	**High** Oversight is provided monthly through the Mental Health Steering Group and quarterly through the Quality, Safety and Assurance Committee. The issue has also been escalated internally to	A further update will be provided to the Executive Management Team in June 2026 to support a decision on acceptance or decline, escalation routes, and next steps.

			safety of patients and staff, and the impact on Emergency Department performance.	EMT in Q3 2025 and externally via the Integrated Care Board and the strategic oversight group.	

Assurance key:

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

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/06/029bi	Date of Board meeting:	3rd June 2026

Date of meeting:	22nd April 2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPC/26/04/005	**Hot Topic – Staff Survey**	The Committee reviewed detailed analysis of staff survey free-text responses, with key concerns centred on: • Workforce capacity and workload pressures • Leadership visibility, credibility and trust • Organisational culture, behaviours and psychological safety Despite these challenges, positive feedback highlighted strong teamworking, supportive line management, and flexible working arrangements, which remain important for retention. 6 organisational priorities based on the results of the Staff Survey were proposed, with the Committee agreeing	**No**	**Substantial**	May 2026

		further review by the Board was required to agree the organisational priorities.			
SPC/26/04/006	**CPO Report**	The report provided an update on Preference Rostering following a request from SPC in March 2026 for an update. It was confirmed that a charitable bid for funding to support wider roll out of the pilot had not been successful, and there was limited resource internally to widen the pilot at pace. When the Preference Rostering pilot was first launched in 2025, KPIs showed a positive improvement. It was agreed that a detailed analysis of the impact of Preference Rostering on QPS KPIs and Staff Survey for pilot areas would be brought to the next SPC, with options for further roll out.	**No – Preference Rostering**	**Substantial**	May 2026
SPC/26/04/008	**Workforce Plan**	The Workforce Plan reported that month 12 of 25/26 was 58 FTE above plan. This was due to temporary staffing. The Committee was advised that the workforce reduction plan for 26/27 was 5.2%, circa 306.9 FTE. There are a number of actions in place to support grip and control to achieve the workforce plan, including enhancing the VCP process to include Care Groups, executive led CIP meetings with Care Groups, weekly nursing review groups on temporary staffing usage, medical staffing meetings and the workforce non-pay delivery unit group. The People Performance Committee was also holding budget holders to account for the delivery of workforce reductions and CIP.	**Limited**	**Substantial**	May 2026

The Committee also received the following reports:

SPC/26/04/004 – Staff Story: Professional Learning from Overseas Military Experience

Reports for Assurance:
SPC/26/04/007 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
SPC/26/04/009 – Safer Staffing Report
SPC/26/04/010 – Better Care Together Integration and Due Diligence Update
SPC/26/04/012 – Improving People Practices Report
SPC/26/04/014 – SPC Cycle of Business

Assurance key:

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

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/06/027(b)	Date of Board meeting:	3rd June 2026

Date of meeting:	18 May 2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPC/26/05/023	**Deep Dive – Post integration review of the impact of consultation**	The Committee received a deep dive into the closure of the TUPE process, specifically lessons learned, evidence of meaningful consultation and additional arrangements post transaction which need to be monitored. The Committee noted the evidence of meaningful consultation and positive feedback received from Trade Union representatives.	**Substantial**	**High**	N/A
SPC/26/05/024	**Hot Topic – E-preference rostering**	The Committee received a presentation focused on analysing the impact of e-preference rostering with a view of expanding the implementation across the trust. The Committee noted that whilst there are positive benefits in staff experience, evidenced through the 2025	**Moderate**	**Substantial**	November 2026

		Staff Survey for the pilot areas, this has not fully translated into overall workforce benefits for other KPIs. The Committee noted the requirement to have a prioritisation review completed for rostering to align community and acute systems. The Committee agreed an approach to continue the rollout of e-preference rostering whilst this review takes place with a full update on rostering to come back at a later date.			
SPC/26/05/025	**CPO Report**	The Committee noted the Chief People Officer report and specifically highlighted the changes to Annex 31 of the agenda for change terms and conditions. The Committee requested a full update to be brought back at a later date to identify the risks to the organisation in relation to the review of job descriptions and profiles as well as the Nursing and Midwifery job evaluation review which is currently ongoing.	**Moderate**	**Moderate**	July 2026
SPC/26/05/027	**Workforce Plan Update**	The Committee received a paper in relation to the workforce plan and discussed the impact of the TUPE transfer of Pathology services on the plan. The Committee noted that there is further work to do at committee level to identify the progress against the plan at Care Group level and this will be reflected in future papers.	**Moderate**	**Moderate**	June 2026

The Committee also received the following reports:

Reports for Assurance:

SPC/26/05/026 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
SPC/26/05/028 – Workforce IPR (Acute and Community and Dental)
SPC/26/05/029 – Workforce Policies and Procedure Overview Report – Q3 and Q4 2025/26
SPC/26/05/031 – Freedom to Speak Up Report
SPC/26/05/033 – Safer Staffing Report – including quarter four red flag data
SPC/26/05/036 – Guardian of Safe Working Report Q4

Matters to note for assurance:

SPC/26/05/038 – Workforce Review Group Committee Chair's Log

Assurance key:

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

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/06/29ci	Meeting	Trust Board	Date Of Meeting	3 June 2026

Date of Meeting	27 April 2026
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSPC/26/04/004	**Deep Dive – Delivery of CIP / Delivery Unit Governance and Reporting**	The Committee received the report noting:- • The new Delivery Unit governance, structure and accountability • Dashboard reporting to cover CIP delivery, pay and non-pay spend compared to budget and productivity monitoring. This will be summarised under three categories: assure, advise and alert • Discussion around Care Group or department being escalated to FSPC if they have not delivered, terms of reference to be reviewed to reflect this • £36m CIP to be delivered for 2026/27, Executive Leadership for Care Group and CBU accountability and delivery • Focus needs to be on transformational schemes rather than just transactional schemes with the requirement to review ongoing actions • Governance risk status (paperwork completion) has improved from the same time last year and delivery risk status has also been RAG rated • CIP phased with an increase at Q2 and again in Q4 (additional 1%)	N/a as currently no delivery recorded	The Committee **noted** and discussed the report and gave **moderate** assurance	**FSPC May 2026**
FSPC/26/04/005	**Hot Topic – Delivery of 2026/27 Plan and Activity**	The Committee received the report noting:- • The overarching questions of: have we got enough resources to deliver the performance required and can we make modifications to the current way of working to reduce premium spend • RTT improvement of 7% required as part of operational planning which equates to approximately 13,000 patients	N/a as currently no delivery recorded	The Committee **noted** and discussed the report and gave **moderate** assurance	**FSPC May 2026**

		• Plan for theatres for the year is 38,322 patients of which only 11,806 are through main theatres, the remaining through areas such as Endoscopy, Catheter lab, Outpatient Department, etc • If job plans are adhered to this gives enough capacity in all apart from Urology and Gynaecology where additional workforce is required to deliver this • Plan for outpatients for the year is 105,741 new appointments and 85,715 procedures • Capacity and demand deep dive undertaken for Gynae and this will be replicated for all specialities			
FSPC/26/04/006	**WHH Finance Update**	The Committee received the report noting:- • Month 12 deficit position is £12m worse than plan at £40.7m (before deficit support funding (DSF)) due to stretch CIP not delivered (£11.2m) and unfunded integration costs (£0.8m). • The Trust underlying deficit is £45.5m with the variance to plan driven by the stretch target and non-recurrent CIP offset by non-recurrent benefits in 2025/26. • £21.5m CIP delivered at month 12, however £14.4m delivered recurrently (£7.1m non-recurrent). • Income remained off plan mainly in Endoscopy, T&O and Gynae, consistent performance throughout the year. • Bank not meeting 10% reduction, mainly due to IA and A&E medical staffing. • Agency on plan, mainly driven by nursing.	The Committee received **moderate** assurance due to the risk of overall plan delivery and level of non-recurrent CIP	The Committee **noted** the paper receiving **substantial** assurance	**FSPC May 2026**
FSPC/26/04/007	**BCH Finance Report**	The Committee received the report noting:- • Month 12 deficit position is £2.9m worse than plan at £4.4m due to stretch CIP not delivered. • £5.7m CIP delivered at month 12 with 94% being delivered recurrently. • Non-pay expenditure is £1.7m above plan mainly due to unexpected rent reviews. This has mainly been offset by an underspend on agency expenditure.	The Committee received **moderate** assurance due to the risk of overall plan delivery	The Committee **noted** the paper receiving **substantial** assurance	**FSPC May 2026**
FSPC/26/04/008	**Workforce Plan Update – including monthly targets and achievements**	The Committee received the report noting:- • The Trust finished the year 58 WTE above plan (1%), which was mainly driven by temporary staffing rather than substantive staff • Based on current predictions a further 29 WTE reduction is required to achieve the plan in month 1	N/a as currently no delivery recorded	The Committee **noted** the paper receiving **moderate** assurance	

FSPC/26/04/009	**WHH Corporate Performance Report**	The Committee received the report noting:- • ED 4 hour performance 70.9% (including Widnes UTC), (improvement from last month) mainly due to a continuing deterioration in NCTR. • Percentage waiting over 12 hours remains a challenge, improvement on last three months however not an improvement from March 2025. • Improved RTT performance at 65%, 52 week wait finished at 0.72% compared to target of 1%, 65 week wait reported four patient breaches. Meeting to take place this week to determine tiering, awaiting the outcome. • Cancer performance – all cancer standards achieved. • BCH IQPR – nothing to report by exception.	The Committee received **moderate** assurance given the balance between NOF improvements whilst some metrics are not achieving	The Committee **noted** the paper receiving **substantial** assurance	**FSPC May 2026**

Items for noting

FSPC/26/04/006 (ii)	*WHH Cost Pressures*
FSPC/26/04/006 (iii)	*WHH Cash Support Update – supported cash application for June for £5,334k*
FSPC/26/04/006 (iv)	*WHH Monthly CIP Update*
FSPC/26/04/006 (v)	*WHH Monthly Productivity Update*
FSPC/26/04/006 (vi)	*WHH Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency and the ringfencing of £1.9m into 2026/27*
FSPC/26/04/010	*Elective Recovery Update*
FSPC/26/04/011	*EPR Outline Business Case – supported the likely case for Trust Board approval*
FSPC/26/04/012	*Pay Assurance Report*
FSPC/26/04/013	*Integration Update*
FSPC/26/04/014	*Committee Cycle of Business*

Assurance Key:

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

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/06/29cii	Meeting	Trust Board	Date Of Meeting	3 June 2026

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

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSPC/26/05/022	**Deep Dive – Workforce Plan**	The Committee received the report noting:- • WTE reductions in line with planning guidance and the finance submission (15% bank reduction for Acute and 10% for Community and 30% agency reduction). • Reduction of 324.7 WTE required to deliver pay CIP following change from 10% to 15% bank reduction. • 60.7 WTE under plan in April 2026 with a 144.5 WTE reduction since March 2026 mainly due to Pathology TUPE, MARS leavers and reduced working hours. • VCP process has been strengthened with Care Group attendance to ensure live discussion and challenge as well as further discussion at EMT prior to approval. • QIA sign off required before posts can be removed recurrently to ensure patient safety. • Concern raised around absence due to sickness and maternity leave (585 WTE), work ongoing in the trust as well as system working.	The Committee received **moderate** assurance	The Committee **noted** and discussed the report and gave **substantial** assurance	
FSPC/26/05/023	**Hot Topic – Corridor Care**	The Committee received the report noting:- • NCM currently ranked 117/118 for 12 hour time in department nationally and NCTR remains high (24.6% at 11 May). • The trust is reporting 28.5% for instances of corridor care in ED as a proportion of Type 1 attendance, data has been refreshed and an improved performance of 16.2%. • Trust is committed to eradicating corridor care by Winter 2026 and a reduction in over 12 hour stays in ED.	N/a as currently no delivery recorded	The Committee **noted** and discussed the report and gave **moderate** assurance	

		• Actions being taken include opening an Emergency Frailty Unit, an SDEC and being compliant with guidance. • Opportunities to improve further have been included in an improvement plan to cover both admitted and non-admitted patients and cover ambulances, ED, alternatives admission, culture and leadership and inpatient care.			
FSPC/26/05/024	**Finance Update**	The Committee received the report noting:- • Month 1 deficit position is £0.9m worse than plan at £5.8m due to the impact of Industrial Action. • PwC monitoring to continue through Q1 and potentially into Q2 with a cost of £40k per month which is a cost in excess of plan. • Letter received from NHSE given our plan is non-compliant (1 of 16 trusts in the country) requesting evidence of discussion around opportunity to improve the plan, investments, loss making services, outpatient reform, temporary staffing and CIP delivery including productivity. • £1.3m CIP delivered at month 12, however £0.5m delivered non-recurrently. • Income off plan mainly in T&O, Endoscopy, Ophthalmology, ENT and Gynae. • Bank not meeting 15% reduction, mainly due to IA and A&E medical staffing. • Agency broadly in line with plan, mainly driven by nursing. • Risks to not delivering the plan relate to CIP delivery, further IA, unfunded pay awards and delivery of activity to deliver planned income (including Endoscopy Hub referrals).	The Committee received **moderate** assurance due to the risk of overall plan delivery and level of non-recurrent CIP	The Committee **noted** the paper receiving **substantial** assurance	**FSPC June 2026**
FSPC/26/05/027	**WHH Corporate Performance Report**	The Committee received the report noting:- • Improvement seen on Access and Performance NOF scores improving from 4 to a 3. • ED 4 hour performance 76.4% (including Widnes UTC), (improvement from last month) mainly due to Widnes UTC now being 100% recognised (previously 50%) and improved ED programme. • Operational plan resubmitted to reflect the 100% recognition of Widnes UTC (reduction in MWL plan) • Percentage waiting over 12 hours remains a challenge due to pressures in NEL pathway. • Improved RTT performance at 64.6%, 65 week wait achieved with zero breaches. • Cancer performance – all cancer standards achieved.	The Committee received **moderate** assurance given the balance between NOF improvements whilst some metrics are not achieving	The Committee **noted** the paper receiving **substantial** assurance	**FSPC June 2026**

Items for noting

FSPC/26/05/024 (ii) *WHH Cost Pressures*

FSPC/26/05/024 (iii)	*WHH Cash Support Update – supported cash application for Q2 for £14,781k for Trust Board approval*
FSPC/26/05/024 (iv)	*WHH Monthly CIP Update*
FSPC/26/05/024 (v)	*WHH Monthly Productivity Update*
FSPC/26/05/024 (vi)	*WHH Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency and the ringfencing of £0.9m into 2027/28*
FSPC/26/05/025	*Benefits Realisation Quarterly Report – Quarter Four*
FSPC/26/05/026	*Delivery Unit Report*
FSPC/26/05/028	*Elective Recovery Update*
FSPC/26/05/029	*Estates Strategy 2024-29 Bi-Annual Progress Report*
FSPC/26/05/030	*Co-Located Urgent Treatment Centre (UTC)*
FSPC/26/05/031	*Sustainability Strategic Priorities Update*
FSPC/26/05/032	*Medical Workforce Review Group Quarterly Report – deferred to June*
FSPC/26/05/033	*Indicative Financial Cost of Harm Annual Report*
FSPC/26/05/034	*Digital Strategy Group (DSG) update*
FSPC/26/05/035	*Minutes/Action Log – EPR Procurement Oversight Group*

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

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North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/06/029 (dii)**	**Date of Board meeting:**	3 June 2026

Date of meeting:	23 April 2026
Name of meeting and chair:	Audit Committee, John Somers (Non-Executive Director)
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
AC/26/04/002	Draft unaudited accounts and financial statements	The Committee reviewed draft accounts for both Warrington & Halton Teaching Hospitals NHS FT and Bridgewater Community Healthcare NHS FT. The financial positions were consistent with in-year reporting, with drivers of variance explained including pay pressures, cash management, and technical adjustments. External audit confirmed no significant concerns and adherence to reporting timelines.	Substantial	High	Audit Committee – 22 June 2026
AC/26/04/003	Going Concern Report	The Committee considered going concern assessments for both organisations and supported the continuation of the going concern basis. This was underpinned by commissioner support,	Substantial	High	Audit Committee – 22 June 2026

		accepted financial plans, and continuation of services post-acquisition. External audit confirmed no material concerns or changes to audit approach.			
AC/26/04/004	Draft Annual Reports	The Committee reviewed progress on both annual reports, noting alignment with NHS Annual Reporting Manual requirements and that delivery remained on track. Narrative sections were largely complete, with governance statements to follow. Strong project management and engagement across the organisation were highlighted.	Substantial	High	Audit Committee – 22 June 2026

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/06/029d(ii)**	**Date of Board meeting:**	3 June 2026

Date of meeting:	30 April 2026
Name of meeting and chair:	Audit Committee, Mike O'Connor (Non-Executive Director and SID)
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
AC/26/04/012	Updates from Chairs of Committees	The Committee received updates highlighting key operational and financial risks. Of particular note from QSAC were the ongoing clinical correspondence backlog and associated operational risks, with no identified patient harm and actions in place to address the position, alongside continuing performance challenges in orthopaedics, subject to active management and oversight. From FSPC, financial pressures were highlighted including a £40.7m variance to plan, reflecting previously reported stretch targets and delivery challenges associated with the 2026/27 cost improvement programme. The Committee recognised these as material risks requiring continued oversight through Committees and Executive management.	Limited	Moderate	August Committee (clinical letters update) Finance matters were ongoing

AC/26/04/014	Head of Internal Audit Opinion	The Committee reviewed the draft Head of Internal Audit Opinions for WHH and BCH, noting overall substantial assurance for both in respect of governance, risk management and internal control. The Committee noted digital risk and Data Security and Protection Toolkit compliance as key areas of national challenge and emerging organisational focus. Assurance was provided that outstanding audit work would not impact the final opinion.	Substantial	High	Final report June 2026
AC/26/04/016	External Audit Plan and Fees	The Committee reviewed External Audit Plans for both organisations, noting that key audit risks remained consistent with prior years and aligned with standard NHS audit requirements. No significant new risks were identified, and value-for-money assessments indicated no anticipated material weaknesses. The Committee received assurance regarding audit approach, timeline and scrutiny of previously identified weaknesses.	Substantial	High	Final audit report June 2026
AC/26/04/022	Declarations of Interest Annual Report and Policy	The Committee reviewed compliance with declarations of interest, noting a high level of compliance (97%) and continued improvement over recent years. Whilst a small cohort of non-compliance remains, assurance was provided through robust processes and internal audit review. The Committee approved the updated Conflicts of Interest Policy and noted alignment across the integrated organisation.	Substantial	High	As per CoB – April 2027

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

Other agenda items:
AC/26/04/011 Changes or updates to the Board Assurance Framework
AC/26/04/013 Internal Audit Progress Report and Follow-Up Actions
AC/26/04/015 Internal Audit Charter and Draft Internal Audit Plan
AC/26/04/016 External Audit Plan and Fees
AC/26/04/018 Annual Counter Fraud Report
AC/26/04/019 Review of Losses and Special Payments
AC/26/04/020 Review of Quotation and Tender Waivers
AC/26/04/021 Draft Annual Governance Statement

Level of Assurance	Description
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North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/030**			
Subject:	Fragile Clinical Services			
Date of meeting:	**3/6/2026**			
Action required:	**To note**			
Author(s):	Paul Fitzsimmons, Executive Medical Director			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This paper serves to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: Orthopaedics – Fractured Neck of Femur Urology Chronic Pain Service Rheumatology Services de-escalated from Fragile Services oversight None Services entering Fragile Services oversight since last report: None			

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

1. Background/context

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

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

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

2. Key elements

2.1 Fragile Services De-escalated from oversight since last board

None

2.2 Services entering Fragile Services oversight since last Board

None

2.3 Services remaining under Fragile Services oversight since last Board

Progress against improvement plans and trajectories for 2 Planned Care services under Fragile Service Oversight (Orthopaedics – Fractured Neck of Femur and Chronic Pain) has not been satisfactory

These services were escalated in January 2026 into a formal Planned Care Quality Recovery Plan. This reports twice weekly to the Deputy Medical Director with a bi-weekly escalation report to the Executive Management Team and monthly to QAC.

Orthopaedics – Fractured Neck of Femur

Summary

National Hip Fracture Database data has demonstrated a deterioration in mortality in Q2 and Q3 2025/26 resulting in an outlier status alert being received by the Trust, Case adjusted Q4 data is awaited.

Improvement in prompt surgery has not been adequate leading to escalation into a formal Planned Care Quality Recovery Plan in January 2026.

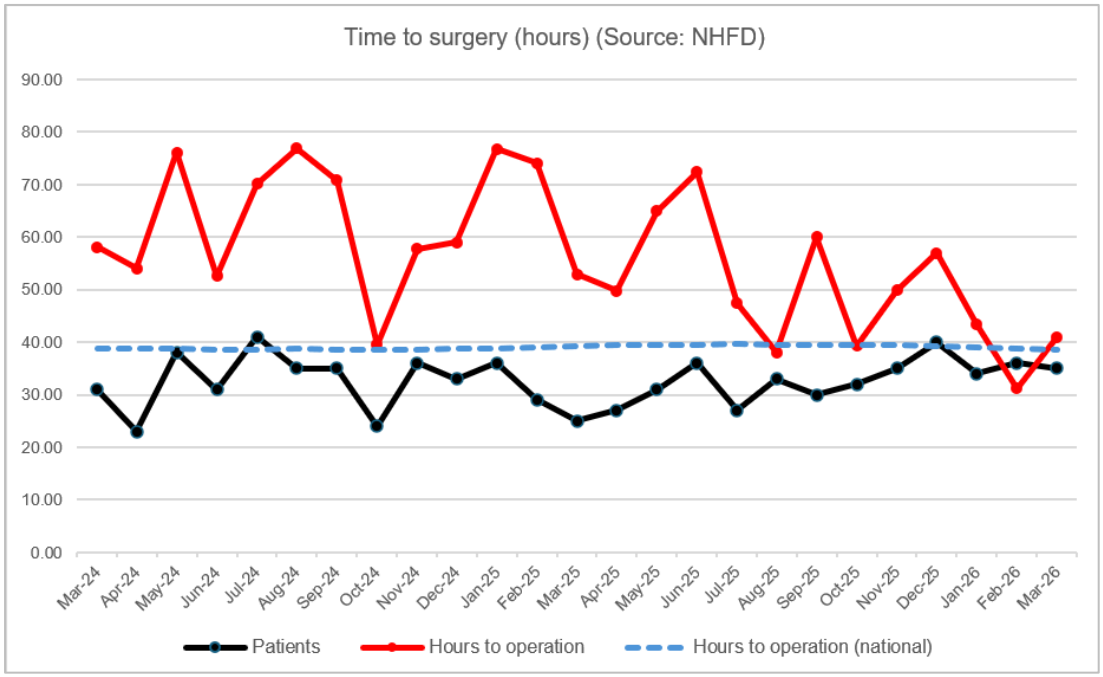
Following this performance has improved with improvements in time to surgery and surgery in February and March (April data not published at time of production of this report)

30-day NHFD mortality was 0% in Jan and February

The key improvement action for June is to realign resource to increase weekend operating list capacity. This will be followed by actions to improve weekday performance.

Previous inconsistencies in data reporting have been addressed by standardising reporting conventions using NHFD published data

Figure 1 – Average time to Surgery



Average time to theatre for March was 40.97 hours (national average 38.98 hours). In February, average time to theatre was 31.23 hours (national average of 38.79 hours).

The service now needs to sustain and further improve this performance in a sustainable and efficient theatres model with the key action for June to realign resource to increase weekend operating list capacity. This will be followed by actions to improve weekday performance.

Previous inconsistencies in data reported to QAC and Board resulted from variance between local Trust and NHFD patient cohorts, timing points and datasets. To ensure there is no further inconsistency in reporting all data, other than latest month Prompt Surgery data will be exported directly from the NHFD published dataset. It should be noted that as 'prompt surgery' best practice data in NHFD is calculated at discharge this metric may change

A mortality review has been undertaken for all fracture neck of femur deaths in the last 12 Months, this will report to QAC. This review has identified that 9 of 35 (25.7%) of deaths did not have an ASA grade submitted to the NHFD. This is very likely to have resulted in significant underestimation of risk of death in these patients by the NHFD casemix adjusted mortality algorithm, and this has been confirmed by case note review of clinical risk.

This may explain the discrepancy seen between NHFD Casemix adjusted mortality and both crude mortality and SHMI, which are not outliers. Controls are now in place to ensure co-morbidity data integrity.

These data issues will not distract or detract from the focus on accountability for delivering actions to improve the performance of this service for our patients.

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

Rheumatology

Summary

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

Improvement in prescribing backlog and patient enquiry backlog. Significant outpatient backlogs and ongoing risk around DMARD monitoring remain.

Key areas of risk identified for improvement include:

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

Completed Actions:

- Twice weekly recovery meeting chaired by Associate Director
- Single email point of access introduced for all email patient queries – reduction in unanswered queries
- Reduction in DMARD prescription/initiation backlog to 80 patients – requires further list validation
- Reduction in Biologic prescription backlog from 324 to 1
- Demand and Capacity exercise for patient queries has demonstrated current administrative and nursing capacity should be sufficient to meet this level of demand – new query log implemented
- Peer service visit to Countess of Chester department
- Locum consultant in post
- Dedicated specialist pharmacist in post
- Consultant and Specialist Nurse (prescriber) returning to work after absence
- Medical and Nursing job plan changes made to support demand and capacity mismatch

Gaps in Assurance

- DMARD prescription/initiation list requires further clinical validation
- DMARD monitoring system remains suboptimal with associated clinical risk
- Full understanding of demand and capacity across each element of service
- Significant pressures in RRT and follow up waits

Key Actions for Next Reporting Period:

- Urgently complete validation of DMARD prescription/initiation list
- Reduce prescription backlogs to zero
- Finalise DMARD monitoring process in line with best practice and progress emergency capital case for proprietary system
- Develop virtual DMARD education programme for patients – record education videos and implement
- Undertake demand capacity exercise for remaining areas of service GIRFT pathway review

Chronic Pain Service

Summary

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

Following escalation into a formal Planned Care Quality Recovery Plan in January, progress noted has been noted.

Clinical Model Workshop held with key stakeholders on 22nd May 2026

Completed Actions

- Ongoing pharmacy review of all opioid recommendations
- Service Gap analysis against NICE guidelines
- No new patients have been commenced on facet joint or trigger point injections out with NICE guidance
- Review of injection activity and caseloads undertaken
- Opioid/gabapentoid prescribing SOP and standardised GP and patient letter format produced with Primary Care input
- Initial meeting with Primary Care regarding future service model
- Meeting with East Chesire regarding their community model
- Successful Clinical Model Workshop held 22nd May 2026 to identify future service clinical model with key stakeholders

Key Actions for Next Reporting Period

- Operationalise SOPs and standardised letters
- Agree process and programme timeline with commissioners to decommission current hospital-based service and recommission future community based reablement service.

Urology

Summary

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

Emergent staffing risk from possible consultant staff retirements in next 12 months – mitigation now identified

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

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand
- Significant volume of high-risk patients on waiting lists confirmed by AI list validation

- P2 – waiting list has stabilised, but is not reducing
- P3 waiting lists continue to reduce
- P4 waiting lists continue to improve following increases over summer 2025
- Transperineal prostate biopsy position shows sustained improvement, (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance and diagnostic cystoscopy position very significantly improved with undated waiting list now fewer than 25 patients for both (from a peak >200 and >300 respectively)

Completed Actions

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

Key Actions for Next Reporting Period

- WLI and outsourced sessions where required to support activity plan and safety
- Complete revenue request for additional Urologist
- Complete validation of patients transferred onto new prostate surveillance access plan

Medium Term Actions:

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

3. Recommendations

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note outstanding risk in Fractured Neck of Femur and Rheumatology services with actions to mitigate
- Note progress on new clinical model in Pain Service
- Receive further Fragile Service Oversight reports

Appendix 1

Chronology of Fragile Service Status

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/031 i**			
Subject:	**Maternity & Neonatal Update March/April 2026**			
Date of meeting:	3 June 2026			
Action required:	**To note**			
Author(s):	Tina Moors Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	This paper provides an overview of activity, performance and quality within the maternity and neonatal services for the period February and March 2026. This paper provides the Board of Directors with oversight of the Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7 and local improvement actions. The paper provides a summary in relation to the following reports for oversight and discussion: *Appendix 1a: MBRRACE 2024 Trust Report* *Appendix 1b: Perinatal Mortality Report Slides* *Appendix 2: Maternity Incentive Scheme MIS* *Appendix 3: Maternity Self Assessment – Deferred to present July 2026*			

	Appendix 4a and b: Maternity and Neonatal Quality Review Report *Appendix 5 Maternity Harms Position*		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Trust Board is asked to note the contents of this report.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QSAC/26/04/016i QSAC/26/04/016ii QSAC/26/04/016iii QSACiC/26/03/39iii	
	Date of meeting	10th February and 10th March 2026	
	Summary of Outcome	Noted and Approved	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

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

The paper provides the Trust Board with oversight of the WHH position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7 and local improvement actions.

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

Appendix 1a: MBRRACE 2024 Trust Report
Appendix 1b: Perinatal Mortality Report Slides
Appendix 2: Maternity Incentive Scheme MIS
Appendix 3: Maternity Self Assessment – Deferred to present July 2026
Appendix 4a and b: Maternity and Neonatal Quality Review Report
Appendix 5: Maternity Harms Position

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

2. Maternity and Neonatal Quality

See Appendix 4a and 4b Maternity Neonatal Quality

This paper provides an overview of activity, performance and quality within the Maternity and Neonatal Services for the period February and March 2026. It provides assurance to the Board of Directors on the Trust's position in relation to key national safety and quality standards and ongoing improvement activity.

The service continues to demonstrate a stable safety profile, with:

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

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

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

Overall, the service demonstrates strong operational performance, particularly in workforce and triage, with continued focus on key improvement areas including neonatal admissions, PPH and induction of labour pathways.

2.1 Key Quality & Safety Indicators

- February:
  - 0 severe harm events
  - 6 moderate harm events (OASI)

- March:
  - 0 severe harm events
  - 1 moderate harm event (OASI)

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

Position:

- Improvement in OASI rates observed from February to March
- No escalation in severe harm trends

2.2 Areas of Focus & Improvement

Neonatal Admissions (ATAIN)

- Remains above national target (6%)
- Improvement noted with Q4 rate reducing to 8.11% from Q3 9.18%

Actions and Improvements

- Development of a 'grunting baby pathway', enabling babies to remain with their mothers while receiving enhanced monitoring
- Continued use of PEEP for 30 to avoid early escalation to neonatal admission
- Ongoing review of opioid prescribing to reduce potential neonatal respiratory depression
- Provision of transitional care staffing from NNU to support care outside the unit
- Strengthened multidisciplinary (MDT) review processes to identify learning and improve decision-making
- Link in with LMNS and visit Whiston to review their processes
- Peer review to attend ATAIN meeting

Position
Continues to present as a key quality risk, with early signs of improvement.

<u>Postpartum Haemorrhage (PPH)</u>
- February rate (≥1500ml): **4.35%**
- March rate: **7.57%**
- PPH ≥1500ml, which remains higher than regional rates. NCM 46 per 1000 births in comparison to Cheshire and Mersey (C&M) 28 per 1000 births

Position
- Increase in March recognised, but remains within expected variation
- Improved data quality and visibility of contributing factors

The Northwest Regional PPH Guideline is now fully embedded, with improvements observed through:
- Strengthened risk assessment
- More consistent escalation
- Improved third-stage management practices
- Reinforcement through safety huddles, case reviews and intrapartum governance

Key Actions and Improvements
The PPH Quality Improvement Programme continues in its Test of Change phase, focusing on:
- Standardised risk assessment at every contact
- Accurate quantification of blood loss
- Clear escalation triggers aligned to regional guidance
- Multidisciplinary simulation and emergency leadership training
- Real-time learning and feedback loops

All PPH cases are subject to structured review within the Intrapartum Review Group, ensuring:
- Rapid identification and sharing of learning
- Strong linkage between incident review, practice change and re-evaluation
- A 6-month re-audit (Nov 2025 – May 2026) is underway and will assess compliance with the regional guideline and impact of improvement actions
- Findings will inform the next phase of the improvement plan

<u>OASI (3rd/4th Degree Tears)</u>
- February: 3.26%
- March: 0.54%

Position
- Reduction following February increase
- Variation consistent with expected patterns

<u>Induction of Labour (IOL)</u>
- February: **10.7% total delays**

- March: **16.6% total delays**

Position
- Overall improvement sustained compared to earlier months
- March increase linked to cervical ripening delays

Actions
- Implementation of balloon cervical ripening pathway
- Continued work to improve flow and pathway efficiency
- Joint oversight with LMNS

2.3 Workforce Position
- Mandatory training compliance: 88–90% (above target)
- Safeguarding compliance: 92%
- Vacancy rate: 0.2%
- Turnover: below Trust target (8.9–9.5%)

Improvement:
- PDR compliance improved from 73% (February 2026) to 83% (March 2026)

2.4 Performance & Activity
Maternity Triage
- February:
  - 95% seen within 15 minutes
  - 100% within 30 minutes
- March:
  - 98% seen within 15 minutes
  - 100% within 30 minutes
- Sustained high performance and compliance with national standards

Service User Experience
- February: 1 complaint
- March: 0 complaints

Position
- Low volume of complaints.

Governance and Assurance
- MNSI cases ongoing with reduction in March and appropriate oversight
- No Coroner Regulation 28 notices
- Robust governance through:
  - Monthly quality and safety review
  - Audit and QI programmes
  - MDT learning processes

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

The Trust Board is asked to:

- Note the contents of this report
- Acknowledge the continued stable safety position across February and March 2026
- Support continued focus on neonatal admissions, PPH and induction of labour pathways

3. MBRRACE-UK 2024

The Warrington and Halton Teaching Hospitals NHS Foundation Trust MBRRACE-UK 2024 perinatal mortality report demonstrates that the Trust's outcomes remain consistent with those of comparable organisations.
Appendix 1a MBRRACE 2024 Trust Report
Appendix 1b Perinatal Mortality Report Slides

Highlights
WHH stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **2.69 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

WHH stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.83 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.

WHH stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.52 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Recommended Actions
The stabilised & adjusted mortality rates for the Trust were similar to, or lower than, those seen across similar Trusts.

However, if the aspiration of the Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

We will continue to use the PMRT for Stillbirth and Neonatal Death, as recommended. There is improvement work that we can focus on in terms of key data items recorded (for births in 2024, we received **98%** of information on key data items for the deaths which occurred within your Trust). There are 18 key items and we recorded 100% in 16 of the 18 with 85.7% recorded under Booking and Antenatal Care for Smoking and Intended type of care at booking – Achieving this may well require collaboration with receiving and referring units as it may not be our recorded data.

4. Maternity Incentive Scheme MIS

The Trust position, outlining that all safety actions have been met (two require external verification however WHH's robust processes have ensured the requirements have

been met) for MIS Year 7 was presented on 4 February 2026 to the Board. The LMNS attended the Board meeting, in line with the requirements of MIS.

Following the presentation to Board, the self-declaration form was signed by the Chief Executive Officer. The declaration form was countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation, ahead of the deadline on 3 March 2026.

MIS Year 8 requirements will be published on 31 March 2026. Launch events will be taking place throughout April 2026. The maternity SLT are registered to attend. Updates on MIS Year 8 will be provided to the Quality, Safety and Assurance Committee in Common.

5. Maternity Harms Position Sept 2025 – Feb 2026

Appendix 5 Maternity Harms Position

The review of maternity harm events from September 2025 to February 2026 shows that overall outcomes at WHH remain safe and largely better than national benchmarks**,** particularly in neonatal mortality and stillbirths. All qualifying cases continue to undergo full review through PMRT, MBRRACE and, where appropriate, MNSI, ensuring strong external scrutiny and learning.

Most harm categories remain stable or improving. There were two cooling transfers**,** four low-harm birth trauma cases, and no maternal VTE**,** reflecting strengthened preventative work. Pressure ulcers reduced to two cases, and only one maternal ITU transfer occurred in the period. Rates of 3rd and 4th degree tears remain significantly better than regional comparators.

Two areas continue to require focused improvement:

- Term admissions to the neonatal unit**,** with 97 cases and performance below national targets.
- PPH >1500ml, which remains higher than regional rates despite all cases being low harm. NCM 46 per 1000 births in comparison to Cheshire and Mersey (C&M) 28 per 1000 births

Both areas have active action plans, including a refreshed PPH guideline and a recommenced QI programme.

Overall, the service demonstrates strong, consistent reporting of all moderate, severe and fatal harms, and a clear commitment to learning. The Board is asked to note the positive performance in key safety indicators and to support continued improvement work on reducing term NNU admissions and PPH rates, alongside embedding the new LFPSE psychological harm reporting requirements

6. Assurance committee (if relevant)

The contents of this report have previously been noted and discussed at Quality Assurance Committee on 10th February 2026 and 10th March 2026

7. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/031 ii**			
Subject:	**Cheshire and Merseyside Perinatal Mortality Report (PMRT) Q4**			
Date of meeting:	03.06.2026			
Action required:	**For information and to note**			
Author(s):	Tina Moors, Interim Director of Midwifery, Lisa Davies Governance Quality Lead – Women's & Children's CBU			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	Choose an item.			
Link to risks on the board assurance framework:	Choose an item.			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and focusses attention on improving outcomes for this protected group.			
Executive summary:	The Perinatal Review Tool was developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 7) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports. This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 3 (Q3) PMRT report for the period covering 01/09/2025 – 31/12/2025.			

	During Q3, WHH reported two babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): **Two stillbirth:** • One baby was born at 24+6 weeks gestation. • One baby was born at 34+6 weeks gestation. The key findings, learning, good practice, and action plan for these cases will be reported in Quarter 4 (Q4) 2025/26 QAC following a PMRT review panel. WHH stillbirth rate for Q3 2025/26 was 3.27 per 1000 births. WHH annual stillbirth rate (2024/25) was 1.6 per 1000 births. The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births. WHH Neonatal mortality rate during Q3 2025/2026 was 0.00 per 1000 live births. The MBRRACE-UK national neonatal rate is 3.0/1000 live births. During Q3, WHH undertook two PMRT review panels. Parental perspective of the care they received was sought in both cases. The panels reviewed: One stillbirth: • One baby was born at 27+2 weeks One neonatal death: • One baby was born at 39+1 weeks In both cases, there were no issues with care identified for the mother and baby up to the point that the baby was born. In one case, there were issues with care identified for the mother and baby from birth up to the death of the baby that may have made a difference to the outcome for the baby. In both cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action

	plan is shared at Safety Oversight Meeting and monitored through Women's and Children's Governance Committee. Full compliance is reported in relation to the Maternity Incentive Scheme; Safety Action 1 standards being met.		
Purpose: (please select as appropriate)	**Approval** ✓	**To note** ✓	**Decision**
Recommendation:	For the QAC members to receive and discuss this report and for the report to be shared with the Trust Board.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QASCiC260213i**	
	Date of meeting	QSAC April 14.04.2026 QSAC May 12.05.2026	
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	Choose an item.		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	Choose an item.		

1. Background/context

The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 7 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 3 PMRT audit data for 2025/2026 and highlights good practice and lessons learned identified through the mortality reviews completed during the period.

Definitions:

- **Perinatal mortality** refers to the number of stillbirths and early neonatal deaths in the first week of life.
- **Late Fetal Loss** is when a baby is born between 22+0 weeks and 23+6-weeks' gestation showing no signs of life.
- **Stillbirth** is when a baby is born showing no signs of life after 24+0 weeks of pregnancy.
- **Early Neonatal death** occurs when a baby is born after 20+0 weeks gestation or weighs 400grams or more and lives but dies within 7 days of being born.
- **Neonatal Mortality Rate** refers to the number of babies which have died within the first 28 days of life.
- **Perinatal Mortality Review Tool (PMRT)** is a national standardised approach to systematically review circumstances and care leading up to and surrounding each stillbirth and neonatal death. The review should incorporate a multidisciplinary approach which includes communication with parents on their experience of care provided and any questions they may have. Following the review, a grading of care is provided by the multidisciplinary review team.

2. Quarter 3 2025/26 Stillbirths & Neonatal Mortality

The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland, and Wales. This paper has extracted the key findings of the report for information and noting.

There were four cases reported to MBRRACE-UK during Q3 reporting period.

Two Stillbirths:
One baby born at 24+6 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 26 January 2026 and will be included in the Q4 2025/26 Perinatal Mortality Review Audit report to QAC.

One baby born at 34+6 weeks. The death was notified to MBRRACE, and surveillance was complete. The PMRT review panel for this case will take place on 26 January 2026 and will be included in the Q4 2025/26 Perinatal Mortality Review Audit report to QAC.

The other two stillbirth cases recorded were as below and do not meet the criteria for PMRT:
*24+0 termination of pregnancy for fetal abnormality (Complex cardiac abnormality)
*25+3 termination of pregnancy for fetal abnormality (T18 Edwards Syndrome)

2.1 Quarter 3. WHH Stillbirth Rate:

- WHH Q3 stillbirth rate for 2025/2026 is 3.70 per 1000 births.
- WHH rolling 12-month stillbirth rate is 2.90 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2024 is 3.9/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH annual stillbirth rate for Q1-Q4 2024/25 is 1.6 per 1000 births. The MBRRACE-UK national rate is 3.9 per 1000 births.

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

Metric	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**12-month total**
Number of live births	580	571	652	610	2413
Total number of stillbirths >24 weeks	2	2	*1	*2	*7
Total Stillbirth Rate >24 weeks (per 1000 births)	**3.44**	**3.50**	**1.53**	**3.27**	**2.90**
Number of intrapartum stillbirths	0	0	0	0	0
Number of term stillbirths (>37 weeks)	1	1	0	0	2
Neonatal deaths before 28 days (per 1000 births)	**0.00**	**1.75**	**1.53**	**0.00**	**0.83**
Neonatal deaths before 28 days	0	**1	1	***0	2
WHH neonatal deaths (born >24 weeks) before 28 completed days	0	1	1	0	2

*BadgerNet data includes TOPFA stillbirths that do not meet the criteria for PMRT.

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

***BadgerNet data includes neonatal deaths of babies born at WHH who died elsewhere and not included in WHH PMRT data.

2.2 Q1. WHH Neonatal Mortality Rate:

- WHH neonatal mortality rate during Q3 2025/2026 is 0.00 per 1000 live births.
- WHH rolling 12-month neonatal mortality rate is 0.83 per 1000 live births.
- The MBRRACE-UK national rate is 3.0/1000 live births.

3. Quarter 3 2025/26 PMRT Review Findings

3.1 Quarter 3 PMRT Review Panel Key Findings
Synopsis of Findings

One baby born at 27+2 weeks gestation was a stillbirth. This mother presented to the emergency department extremely unwell with evidence of widespread varicella rash and fetal death in utero was confirmed. There were no issues with care identified in this case. The cause of death was confirmed as varicella pneumonia.

One baby born at 39+1 weeks gestation was a neonatal death. This mother gave birth by elective caesarean section for breech presentation and was discharged with baby on day 4. Baby was found unresponsive at home the next morning and was pronounced dead following ambulance transfer to the emergency department. Care issues related to infant feeding support and translation services were identified which may have made a difference to the outcome for the baby. The cause of death has not yet been determined.

Surveillance Findings:

- Both babies were of a singleton pregnancy.
- The women were aged between 32-42 years.
- One woman was identified as Iraqi ethnicity

One woman was identified as White British.

- Neither woman had any communication problems because of learning difficulties/hearing problems.
- One woman had a BMI within normal range.

One woman had a raised BMI

- One woman was a smoker and accepted the offer of support but did not engage with stop smoking services.
- In both cases there were no issues identified with the care provided in relation to safeguarding.

3.2 PMRT Grading of Care

Each PMRT review panel consists of senior obstetric, midwifery, bereavement, and governance representation from WHH and external peer review members from another maternity provider within Cheshire and Mersey Local Maternity and Neonatal System (LMNS). Parental perspective is also included as part of the PMRT review and contributes to the grading of care.

The PMRT review concludes with each panel member reporting if, in their professional opinion, the care given up to the point where the baby was confirmed as having died and or care provided following the birth of the baby could have made a difference.

3.2.1 PMRT Grading of Care – Stillbirth

During Q3 one PMRT review panel took place. Parental perspective of the care received was sought.

There were no issues with care identified for the mother and baby.

Table 2: Q3 WHH Grading of care following a Stillbirth.

PMRT Grading	Care provided to the mother up to the point that her baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
Grade A The review group concluded that there were no issues with care identified	**1**	**1**
Grade B The review group identified care issues which they considered would have made no difference to the outcome	**-**	**-**
Grade C The review group identified care issues which they considered may have made a difference to the outcome	**-**	**-**
Grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	**-**	**-**
Not graded	**-**	**-**
Total cases	**One case**	**One case**

3.2.2 PMRT Grading of Care – Neonatal Death

During Q3 one PMRT review panel took place. Parental perspective of the care received was sought.

In this case, there were no issues with care identified for the mother and baby up to the point of the birth of the baby.

In this case, there were issues with care identified for the mother and baby from birth up to the death of the baby that may have made a difference to the outcome for the baby.

In this case, there were no issues identified with the care of the mother following confirmation of the death of her baby.

Table 3: Q3 WHH Grading of care following a Neonatal Death.

PMRT Grading		Care provided to the mother up to the point that her baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
Grade A The review group concluded that there were no issues with care identified	**1**	**-**	**1**
Grade B The review group identified care issues which they considered would have made no difference to the outcome	**-**	**-**	**-**
Grade C The review group identified care issues which they considered may have made a difference to the outcome	**-**	**1**	**-**
Grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	**-**	**-**	**-**
Not graded	**-**	**-**	**-**
Total cases	**One case**	**One case**	**One case**

3.2.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q3 2025/26:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum monitoring were a contributory factor to perinatal mortality. Table 5 details the outcome of the PMRT reviews completed in Q3 assessed against these interventions:

Table 4 – Saving Babies Lives interventions.

Intervention		**%**
Intervention 2.8	Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue	0.0%
Intervention 3.2	Percentage of stillbirths which had issues associated with RFM management identified	0.0%
Intervention 4.3	Percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0.0%
Intervention 5.2	Percentage of late second trimester singleton births and preterm births (using PMRT) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared, and percentage of late second trimester singleton births and preterm births	0.0%

3.2.4 WHH PMRT Panel Attendance

There have been two PMRT panel reviews in Q3 which were attended by multidisciplinary internal and external panel members.

Table 5: Q3 WHH PMRT Panel Attendance

Number of participants involved in PMRT reviews. Total number of reviews from 01/09/2025 – 31/12/2025 = 2			
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	1	1	2
Admin/Clerical	0	0	0
Bereavement Midwife	1	1	2
External Rep	1	1	2
Management Team	1	1	2
Midwife	1	1	2
Neonatal Nurse	0	0	0
Neonatologist/Paediatrician	0	1	1

Obstetrician	1	1	2
Other	0	0	0
Governance Manager	1	1	2
Safety Champion	0	0	0

3.3 Maternity Incentive Scheme Year 7 Compliance

WHH is compliant with all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 7 as per table 5.

Table 6: PMRT MIS Safety Action 1 Compliance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Standard Required		**Compliant Y/N**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days	Assessed as compliant
b)	For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	Assessed as compliant
c)	For deaths of babies who were born and died in your Trust from 1 December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multidisciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	Assessed as compliant
d)	Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.	Assessed as compliant

3.4 Learning and Good Practice

- Parental involvement was sought in all cases as part of PMRT panel review.
- Both cases were notified to MBRRACE-UK and surveillance completed within the required timescale.
- In one case it was noted that interpreting services were not used to support the family with postnatal care and discharge home.
- It was noted that bereavement care was good in both cases.

3.5 Action Plan Summary

All actions identified following PMRT reviews are recorded in full on the Trust incident reporting system and monitored through Women's and Children's CBU Governance Meetings.

Table 7: PMRT Action Plan

Action	Lead	Due Date	RAG rating
Safety Alert for interpreting care on the maternity ward. This cohort of women must be supported with communication in their first language	Maternity Ward Manager	21/11/2025	
Ensure discharge leaflets are available on the digital system in other languages.	Digital Midwife	09/09/2025	
Infant feeding support from colleagues in Bridgewater whilst there is a vacancy at WHH for specialist support	Maternity Matron	31/10/2025	
Enhanced Maternity Support worker support for inpatient women who require interpreting services.	Maternity Matron	31/10/2025	
Audit the care of women whose first language is not English and provide assurance to the 'English is not the first language' improvement group.	Maternity Ward Manager	31/01/2026	
Link with the ED&I team to support the maternity ward team with education.	Maternity Ward Manager	31/07/2026	

4. Summary

WHH Q3 PMRT audit recorded two babies reported to MBRRACE born between 01/09/2025 and 31/12/2025.

- WHH stillbirth rate for Q3 2025/26 was 3.27 per 1000 births. WHH annual Mean stillbirth rate is 1.6 per 1000 births which is below the 2024 MBRRACE-UK national rate 3.9 per 1000 births.
- WHH Neonatal mortality rate during Q3 2025/2026 was 0.00 per 1000 live births. The MBRRACE-UK national rate is 2.7 per 1000 births.
- There were two babies requiring PMRT review panel in Q3.
- Full compliance reported in relation to Maternity Incentive Scheme; Safety Action 1 standards are being met.

5. Monitoring/reporting routes

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

6. Recommendations

The Quality Assurance Committee is asked to note the findings of this paper and share the findings with the Trust Board as per MIS Year 7 recommendations.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/031 iii**			
Subject:	**Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)**			
Date of meeting:	03.06.2026			
Action required:	**For information, discussion and to note**			
Author(s):	Helen Wall – Assurance & Improvement Manager (Women's and Children's)			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
Executive summary:	This paper outlines the Trust's position and progress in relation to the NHS Resolution's Maternity Incentive Scheme (MIS), which aims to support the delivery of safer maternity care across NHS Trusts in England. The scheme provides financial incentives for meeting ten safety actions designed to improve clinical governance, workforce planning, and patient outcomes in maternity services. These safety actions align with the national maternity ambition to halve the rates of stillbirths, neonatal and			

	maternal deaths, and brain injuries by the end of 2025, compared to the 2010 baseline. This paper provides an overview of current progress and incorporates feedback received from the Local Maternity and Neonatal System (LMNS) The Trust has undertaken a detailed self-assessment against all ten safety actions for the current reporting period. Progress is summarised below: • **Safety Action 1 – PMRT**: Requirements met (awaiting external verification). • **Safety Action 2 – MSDS**: Requirements met. • **Safety Action 3 – Transitional Care**: Requirements met. • **Safety Action 4 – Medical Workforce**: Requirements met. • **Safety Action 5 – Midwifery Workforce**: Requirements met. • **Safety Action 6 – Saving Babies' Lives:** LMNS confirmed requirements met for this safety action at meeting on 20 November 2025. • **Safety Action 7 – MNVP:** Requirements met. • **Safety Action 8 – Training**: Requirements met. • **Safety Action 9 – Board Oversight**: Requirements met. • **Safety Action 10 – MNSI/EN**: Requirements met; external review by Maternity and Neonatal Safety Improvement Programme and NHS Resolution is pending. WHH's final position for MIS Year 7 was presented to Board on 4 February 2026 with the LMNS in attendance. Following the presentation, the MIS declaration form was signed by the Chief Executive Officer. This has been countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation within the specified timeline. The Board is asked to: Note the current status of the MIS submission.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	For the QSACic members to receive and discuss this report and for the report to be shared with the Trust Board as part of the quarterly maternity and neonatal overview.		

Previously considered by:	**Committee**	Choose an item.
	Agenda Ref.	**QSACiC/26/03/39ii**
	Date of meeting	10.03.2026
	Summary of Outcome	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	Choose an item.	
Freedom of information status (foia):	Release Document in Full	
Freedom of information exemptions applied: ***(if relevant)***	None	

1. Background/context

NHS Resolution has now commenced year seven of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2025. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2026.

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

2. Current position

2.1 Current position against MIS Year 7

The Trust position, outlining that all safety actions have been met (two require external verification however WHH's robust processes have ensured the requirements have been met) for MIS Year 7 was presented on 4 February 2026 to the Board. The LMNS were in attendance at the Board meeting, in line with the requirements of MIS.

Following the presentation to Board, the self-declaration form was signed by the Chief Executive Officer. The declaration form was countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation, ahead of the deadline on 3 March 2026.

The Trust Board minutes from February 2026 will be shared with the Local Maternity and Neonatal System (LMNS) for completion.

2.2 MIS Year 8

MIS Year 8 requirements will be published on 31 March 2026. Launch events will be taking place throughout April 2026. The maternity SLT are registered to attend. Updates on MIS Year 8 will be provided to the Quality, Safety and Assurance Committee in Common in May 2026.

3. Monitoring/reporting routes

Progress relating to the Saving Babies' Lives Care Bundle version 3 (SBLCBv3) and Maternity Incentive Scheme (MIS) Year 7 is regularly reviewed and discussed at Clinical Business Unit (CBU) Governance meetings. The content of this report will be formally presented at the Women's Health Governance meeting in March 2026 to ensure continued oversight and alignment with service improvement priorities.

4. Recommendations

The Quality, Safety and Assurance Committee in Common members are requested to:

Note the current status of the MIS submission

North Cheshire and Mersey
NHS Foundation Trust

Maternity Quality

Quality and Safety Assurance Committee

Maternity Service – Review of harm events Sept 2025 – Feb 2026

Tina Moors – Interim Director of Midwifery

Lisa Davies – CBU Governance Quality Lead

Home
Community
Hospital

Grading of harm - Context

- Changes in the way providers record patient safety through guidance published in August 2023 as part of the implementation of the learning from patient safety events framework (LFPSE)
- This includes assessing the degree of harm which relates to the actual impact on a patient from the particular incident being reported.
- This builds on the previous assessment guidance in the National Reporting and Learning System (NRLS) and maintains the principle.
- Patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording.
- The new addition in the policy guidance in relation to patient safety incident data in the LFPSE service relates to specific capture of information on psychological harm.
- Previously in the NHS, harm grading included psychological harm as well as physical harm within one measure, in the new guidance and reporting these are now split out into two separate measures.

New physical harm grades	New psychological harm grades
No physical harm	No psychological harm
Low physical harm	Low psychological harm
Moderate physical harm	Moderate psychological harm
Severe physical harm	Severe psychological harm
Fatal	n/a

Grading of physical harm

No physical harm

No physical harm

Low physical harm is when **all of the following** apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment.
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit.
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- did not or is unlikely to affect that patient's independence.
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe harm is when **at least one** of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

- You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Grading of psychological harm

No psychological harm

- No specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

WHH harm events Sep 25 – Feb 26

Harm	LFPSE grading	WHH position	Assurance pathway
Neonatal mortality (refers to the number of babies which have died within the first 28 days of life)	Fatal	➢ WHH annual mean neonatal mortality rate is **0.76** per 1000 live births. ➢ Office for National Statistics rate for England in 2024 was **3.0** per 1000 births.	➢ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper ➢ All cases reported to MBRRACE ➢ Select criteria referred to MNSI for investigation (>37weeks following labour and died within the first 7 days) ➢ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board
Intrauterine death (>24 weeks gestation)	Moderate	➢ WHH annual stillbirth rate is **1.6** per 1000 births. ➢ The Office for National Statistics rate for England in 2024 was **3.9** per 1000 births	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ All cases reported to MBRRACE ➢ Intrapartum Term stillbirths referred to MNSI for investigation ➢ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board

MBRRACE-UK PERINATAL MORTALITY REPORT: 2024 BIRTHS

Metric	Recommendation	Progress
The stabilised & adjusted mortality rates for WHH were similar to, or lower than, those seen across similar Trusts and Health Boards.	Ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in the report to assess care, identify and implement service improvements to prevent future similar deaths.	All qualifying cases are reviewed using the tool with an MDT approach and external representation and scrutiny.

WHH harm events Sep 25 – Feb 26

Harm	LFPSE grading	WHH position	Assurance pathway
Babies transferred for cooling	Moderate	➢ Two cases Sep 25-Feb 26 ➢ 0.16% all births in the period	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ Intrapartum cases referred to MNSI for investigation ➢ Overview of MNSI referrals/investigations shared monthly to QAC and Board ➢ Annual review of MNSI to QAC
Term admission to Neonatal Unit	Unavoidable - No harm Avoidable – Low harm	➢ 97 cases Sep 25-Feb 26	➢ Not meeting national/regional targets ➢ Quarterly reporting of position to QAC ➢ Action plan in place
Neonatal birth trauma	Case dependent	➢ Four cases Sep 25-Feb 26 ➢ All low harm (2 c/s births 2 instrumental births)	➢ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper

WHH harm events Sep 25 – Feb 26

Harm	LFPSE grading	WHH position	Assurance pathway
3rd & 4th degree tears	Moderate	➢ 20 cases Sep 25-Feb 25 (19 cases Mar 25-Aug 25) ➢ 16 per 1000 births ➢ C&M rate 31 per 1000 births	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper
PPH >1500mls	Low – occasionally moderate	➢ 56 cases Mar 25-Aug 25 (58 cases Mar 25-Aug 25) ➢ All low harm ➢ 46 per 1000 births ➢ C&M 28 per 1000 births	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper ➢ PPH workstream standing item within monthly QAC Quality & Safety paper ➢ QI Project recommenced / New Guideline implemented
Maternal VTE	Low – occasionally moderate	➢ No cases Sep 25-Feb 26 ➢ Improvement noted – one case Mar 25-Aug 25	➢ All moderate harms reported as part of monthly QAC Quality & Safety paper
Pressure Ulcer	Case dependent	➢ Two cases Sep 25-Feb 26 ➢ Improvement noted - 5 cases Sept 23- August 25	➢ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper
Maternity - Transfer to ITU	Moderate	➢ 1 case Sep 25-Feb 26 – moderate harm ➢ 0.08% of births in the period	➢ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/032**			
Subject:	**Complaints Annual Report 2025/26**			
Date of meeting:	3 June 2026			
Action required:	**The members of The Trust Board are asked to note the contents of this paper.**			
Author(s):	Nicola Edmondson, Associate Director of Governance Amy Smith, Complaints Liaison Lead Abby Bird, Datix Administrator			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This report provides assurance to The Trust Board that complaints are managed effectively. Where areas for improvement are identified, organisational learning is captured and appropriate actions are implemented. The report presents a summary of formal complaints received during the 2025/26 financial year, with comparative analysis against 2024/25 where relevant. The report will focus on information pertaining to Warrington and Halton Hospitals NHS Foundation Trust prior to its integration into North Cheshire and Mersey NHS Foundation Trust. • There were 374 complaints received in 2025/26, an increase of 64 complaints compared to 2024/25. • Urgent and Emergency Care received the highest number of complaints (99), followed by Women's and Children's (76) and Surgical Specialties (74). • There were 366 complaints closed in 2025/26, an increase of 67 complaints compared to 2024/25. • The majority of complaints were partially upheld (201), with 136 not upheld and 29 upheld. • There were 28 complaints reopened in 2025/26, 14 of these were dissatisfied complaints. • There were no PHSO investigations started and 4 closed in 2025/26.			

<table>
<tr><td></td><td colspan="3">There were 2265 Patient Advice and Liaison Service (PALS) received in 2025/26, an increase of 644 concerns compared to 2024/25.
Surgical Specialties received the highest number of concerns (649), followed by Medical Care (507) and Digestive Diseases (249).
The average response time between a concern being received and closed by the Trust for 2025/26 is 6 days.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The members of The Trust Board of Directors are asked to note the contents of this paper.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QSAC/26/05/043</td></tr>
<tr><td>Date of meeting</td><td colspan="2">12 May 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied: (if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background

North Cheshire and Mersey NHS Foundation Trust (NCM) is committed to providing high standards of patient centred care by listening to the views and opinions of patients, their families and other members of the public, and responding with positive action.

The purpose of the Annual Complaints Report is to satisfy the requirements of the NHS Constitution (2023) and the Parliamentary and Health Service Ombudsman NHS Complaints Standards (2022). The report provides analysis of formal complaints, identifying themes and trends to support learning and associated improvements. To ensure accurate analysis, the report will compare 2025/26 and 2024/25 performance using information from Warrington and Halton Hospitals NHS Foundation Trust (WHH) only, reflecting the organisation's acute trust configuration prior to integration in April 2026.

The Trust recognises that there are times when its actions do not meet the expectations of those that use our services. When that happens, the Trust has a policy which sets out a procedure to ensure that we listen and respond to complaints and concerns.

The Trust understands that by listening to people about their experience of our services, staff can learn new ways to improve and prevent the same issues from happening in the future. By seeking, monitoring, and acting upon feedback, we can make improvements in areas that matter most to those using Trust services.

Effective complaints handling is a cornerstone of patient experience, and the Trust always aims to provide local resolutions to complaints, taking all complaints seriously. By listening and responding to complaints, we aim to remedy the situation as quickly as possible and ensure that the individual is satisfied with the response they receive. The learning from complaints is used to improve experiences for the people who use services as well as for the staff delivering the service.

In accordance with the NHS Complaints Standards, the annual complaints report is made available to the public. It is publishable as part of the Freedom of Information Act publication.

1.1 Principles of Application

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties.
- High standards of conduct are always expected from all staff to ensure that service users/representatives will be treated respectfully, courteously, and sympathetically.
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise).
- All patients and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on wards, clinical service units and the internet.
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint.
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered.
- The Trust will aim to resolve complaints within the Trust as part of local resolution (first stage of the national complaints procedure) wherever possible.
- Complainants receive a meaningful apology when appropriate.
- The Trust will identify appropriate learning and implement change as the result of a complaint where appropriate.

- The Trust will cooperate with other organisations when a complaint involves other outside organisations.
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race/ethnicity, disability, age, or sexual orientation or because they have made a complaint.

1.2 NHS Complaints Standards 2022

In December 2022, the NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. The standards apply to NHS organisations in England and independent healthcare providers that deliver NHS-funded care. The Complaint Standards support organisations to provide a quicker, simpler, and more streamlined complaint handling service. They have a strong focus on:

- Early resolution by empowered and trained staff.
- All staff, particularly senior staff, regularly reviewing what learning can be taken from complaints.
- How all staff, particularly senior staff, should use this learning to improve services.

1.3 Complaints Monitoring

The Complaints Handling Team report complaints management assurance into the Patient Safety and Clinical Effectiveness Sub Committee. Learning is reported into the Patient Experience Sub-Committee and is shared in the Quarterly Learning from Experience Report, presented at The Trust Board.

2. Key Elements

During the last financial year work has focused on:

- Maintaining the timeliness of responses to complainants.
- Working collaboratively with Care Groups and associated Clinical Business Units (CBUs) to improve standards of care and the production of high-quality complaint responses.
- Ensuring visibility to support the clinical teams in the provision of timely responses to Patient Advice Liaison Service (PALS) concerns.
- Offering all complainants a meeting with appropriate teams as a line of response.
- Complaints handlers continue to meet with the CBU Senior Management Teams weekly with dissemination of actions to the CBU Teams.
- Triangulation of the themes of complaints alongside thematic learning from Patient Safety Incident Investigations was undertaken. The findings directly informed Quality Priority planning.
- Reviewing of the Complaints Policy. The Complaints Policy was reviewed and updated to strengthen governance arrangements and better integrate complaints, incident management, and patient safety processes.

The successes in 2025/26 have included:

- The PALS service has continued to provide timely and responsive support, with an average response time of 6 days in 2025/26. While this exceeds the previous internal target of 3 working days, the review and update of the Complaints Policy now recognises the complexity of some concerns. Revised timescales have been introduced, with simple concerns responded to within 3 working days and more complex concerns within 20 working days, better reflecting the nature of enquiries received.
- Co-Production: The Trust has undertaken work with Governors and Experts by Experience to strengthen patient involvement. And improve the experience of those contacting the PALs service.
- Reopened complaints remain a small proportion of overall activity, with 28 complaints reopened in 2025/26. Fourteen of these related to dissatisfaction with the Trust's original response, while others reflected additional questions or requests for further discussion, demonstrating ongoing engagement with complainants.
- Amendments to the complaints response letter template continue to encourage complainants to re-engage directly with the Trust should they have further questions or wish to meet. This approach supports local resolution and is reflected in the absence of new PHSO investigations being opened during 2025/26.
- Complaints staff development has remained a priority, with team members completing specialist training in systems-based approaches to learning from patient safety incidents, strengthening the quality and consistency of complaint handling.

Planned Quality Improvements for 2026/27 include:

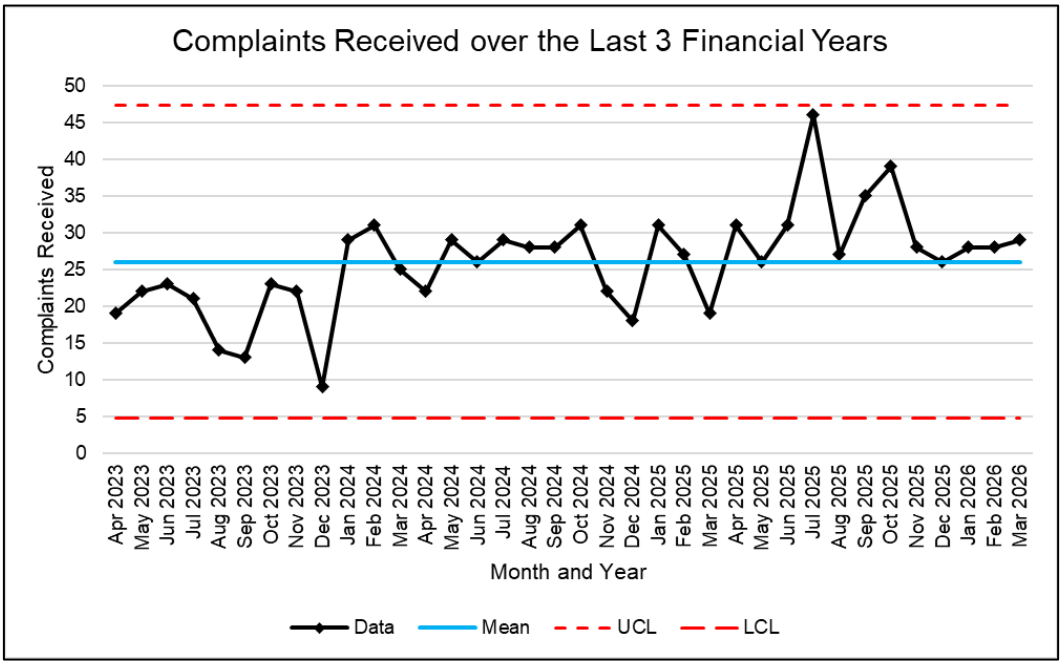
- Development of a more formal approach in seeking feedback from both complainants and staff: Supporting continuous improvement and assurance of the effectiveness of the complaints process.
- Development of a Trust-wide Training Needs Analysis: To support effective complaints management.
- Front-Desk Presence: volunteers improving accessibility and provision of immediate support for patients and families.
- Environment Improvements: Exploring charity funding to refurbish the PALS Office, to enhance confidentiality and comfort.
- Co-Production: Ongoing work with Governors and Experts by Experience to strengthen patient involvement. This will report to Patient Experience and Inclusion Sub Committee attended by the Governors.
- Strengthened processes and IT improvements: Voicemail-email linkage
- Improved communication and signposting: Ensuring patients and families know how and when to access PALS.

2.1 Complaints Received

There were 374 complaints received in 2025/26. This is an increase of 64 complaints (20.65%) compared to 2024/25 where 310 complaints were received. This is an average of 31 complaints received per month, compared to 26 complaints in 2024/25.

A review of complaints received across the Trust over the last 3 years, see **Graph 1**, shows overall normal variation with data remaining within the expected control limits. A peak is observed in July 2025, with the number of complaints received approaching the upper control limit, but there are no sustained upward or downward trends surrounding this and no single identified cause. It is notable however that the overall number of complaints received has increased in 2024 and 2025, compared to 2023.

Graph 1



2.2 Complaints Received by Theme

Due to the multifactorial nature of complaints, which can involve multiple linked themes, the Complaints Team categorise complaint themes according to the primary subject identified. The table below identifies the primary themes of complaints received in 2025/26 compared to 2024/25.

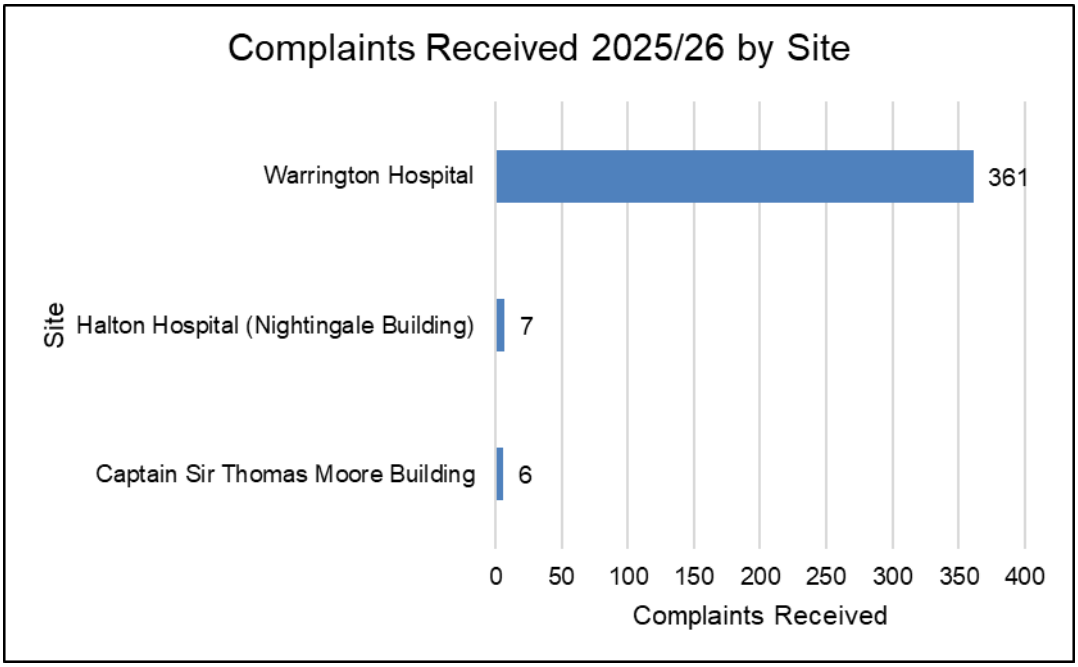
Primary Theme	2024/25	2025/26	Change
Clinical Treatment	230	301	+71
Communication (oral)	18	18	0
Admissions/Transfers/Discharge Procedure	13	15	+2
Attitude and Behaviour	20	14	-6
Personal Records	6	6	0
Patient Privacy/Dignity	4	4	0
Failure to Follow Agreed Procedures	3	3	0
Date for Appointment	5	3	-2
Bed Shortages	2	3	+1
Test Results	0	2	+2
Cleanliness/Laundry	0	1	+1
Catering	0	1	+1
Policy and Commercial Decisions of NHS Board	0	1	+1
Consent to Treatment	0	1	+1
Communication (written)	4	1	-3
Premises	2	0	-2
Telephone	1	0	-1
NHS Board Purchasing	1	0	-1
Complaint Handling	1	0	-1

Clinical Treatment remained the most frequently reported primary theme in both 2024/25 (230) and 2025/26 (301), representing an increase of 71 complaints (30.87%). Communication (oral) was the second most reported theme in both years, with 18 complaints received in both years. Admissions/Transfers/Discharge Procedures ranked third, with a slight increase from 13 complaints in 2024/25 to 15 complaints in 2025/26.

2.3 Complaints Received by Area

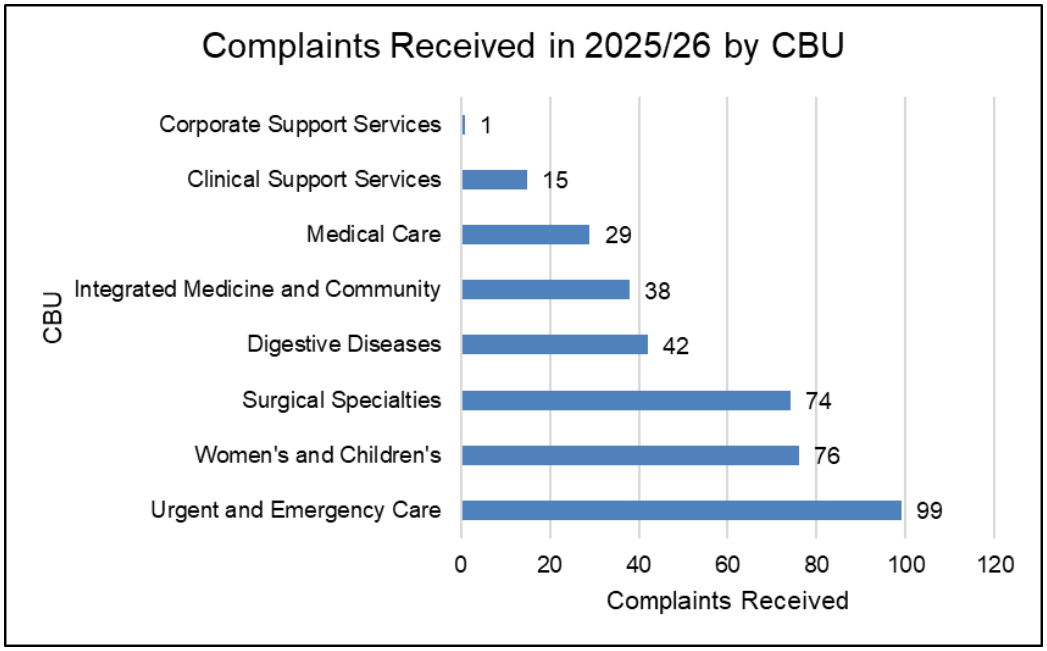
Consistent with the previous financial year, the majority of incidents in 2025/26 were reported under the Warrington Hospital site (361). This is expected as this is the largest site across the Trust, with more services and acute care delivery operating from Warrington Hospital, including the Emergency Department.

Graph 2



Urgent and Emergency Care received the highest number of complaints (99) in 2025/26, followed by Women's and Children's (76) and Surgical Specialties (74). These remained the top 3 CBUs, consistent with 2024/25, indicating sustained areas of pressure for the Trust. Within Urgent and Emergency Care, the majority of complaints related to Emergency Medicine (85), with smaller numbers associated with Acute Medicine (13) and Patient Flow (1). The continued prominence of these CBUs reinforces the need for ongoing focus, learning and targeted improvement actions within these CBUs.

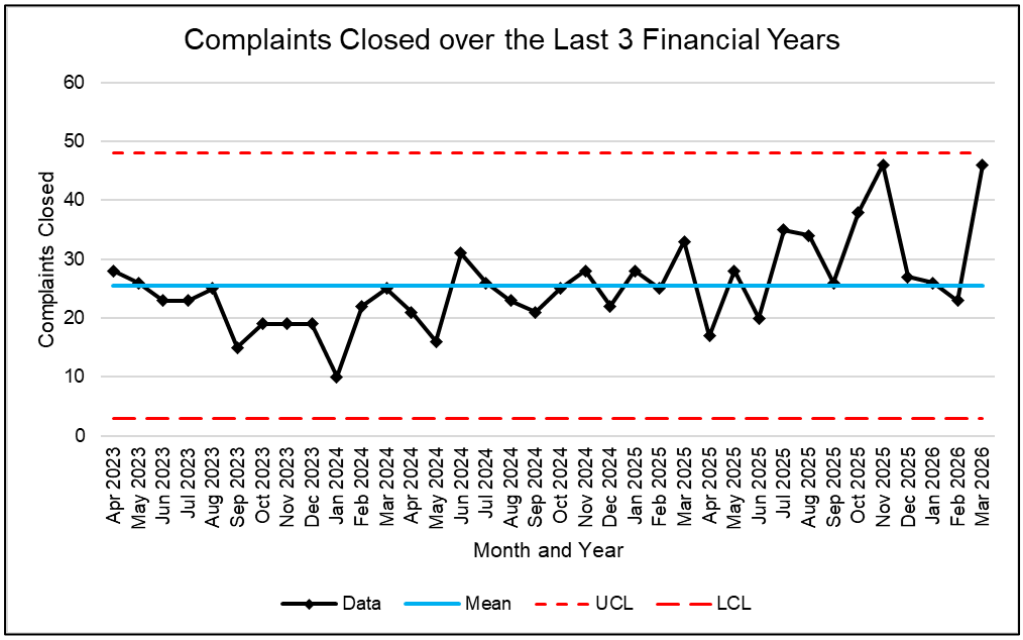
Graph 3



2.4 Closed Complaints

There were 366 complaints closed in 2025/26, an increase of 67 complaints (22.41%) compared to 2024/25 where 299 complaints were closed. This is consistent with the rise in complaints received between the 2 financial years and shows that the Trust is closing complaints at a consistent rate compared to the number of complaints being received.

Graph 4



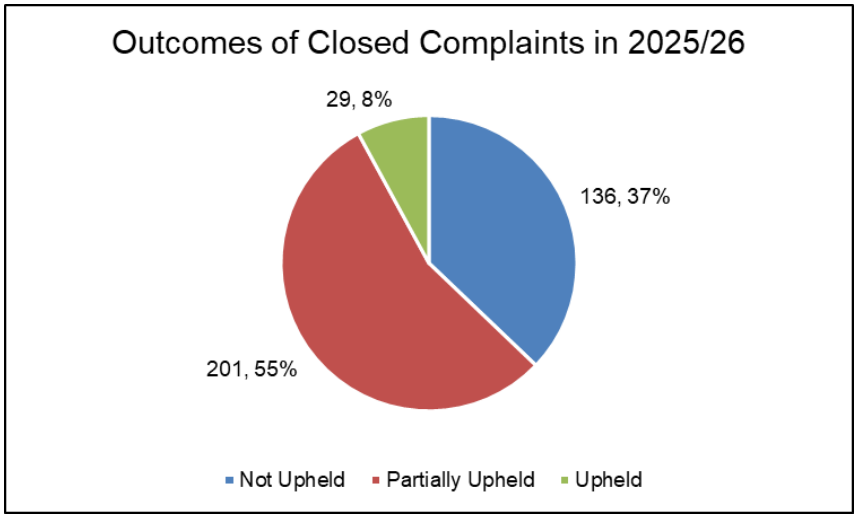
2.5 Complaint Outcomes

Once a complaint has concluded, either following a local resolution meeting or once a formal written response has been sent to the complainant, the outcome is recorded in line with the findings of the investigation:

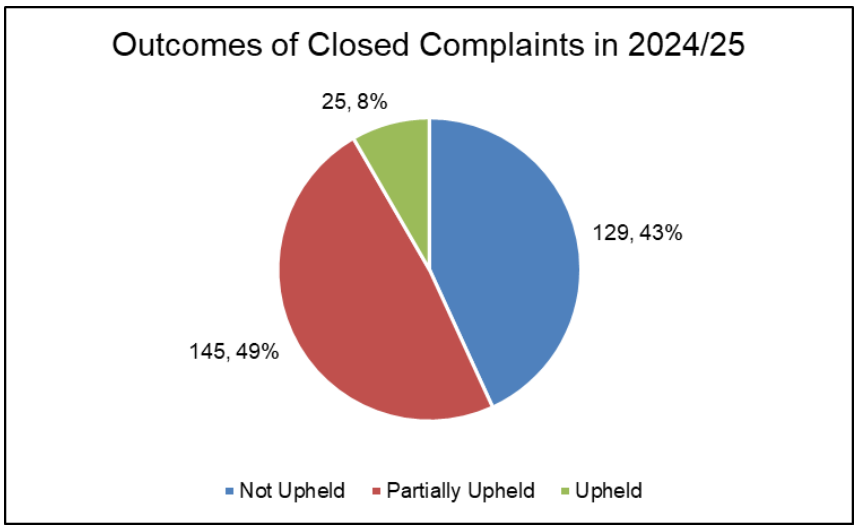
- Upheld – those where the concerns raised have been found to be valid.
- Not Upheld – those where the investigation has not found any deficiency in the care, treatment or service provided.
- Partially Upheld – those where some aspects of the case are upheld, but the main issues are not.

In 2025/26, there were 29 upheld complaints (an increase of 4 complaints), 136 not upheld complaints (an increase of 7 complaints) and 201 partially upheld complaints (an increase of 56 complaints).

Graph 5



Graph 6



2.6 Timeliness of Responding to Complaints

Of the 366 complaints closed in 2025/26, 96.45% (353/366) were responded to within the agreed timescales. The remaining responses were delayed by one working day.

2.7 Examples of Learning from Complaints

You Said…	We Did...
During pregnancy, the absence of adequate mental health support left a mother feeling vulnerable, resulting in postnatal depression. This experience highlighted the need for comprehensive mental health provision throughout the perinatal period. The patient was also not given enough information regarding the use of a health passport.	The Maternity Team met with the Learning Disabilities Team to develop a maternity specific health passport. In addition, learning was shared with the wider Maternity Team, with focus on improving contingency plans and inter-trust coordination of care. This work supports more timely, joined up responses and helps ensure that women with complex mental health needs receive prompt and effective support.
The patient attended the Ultrasound Department at Halton Hospital and reported feeling unwell during their visit. Subsequently, the patient experienced an episode of loss of consciousness. At the time, a blood pressure monitor was not available to assess the patient's condition. This incident highlighted the importance of ensuring that essential medical equipment is readily accessible in clinical areas to facilitate prompt assessment and management of patients presenting with acute symptoms.	A blood pressure monitor has been procured for the Ultrasound Department at Halton Hospital and will be stored in an accessible area for use by trained staff, when clinical concerns arise.
The patient was transferred to Halton Hospital, and due to the timing of the transfer, missed their evening meal. This situation demonstrated the importance of considering patient needs during transfer processes.	Discharge procedures have been reviewed to minimise unnecessary transfer of patients to other wards or hospitals at mealtimes, wherever possible, and to ensure that family involvement is considered where it is believed to enhance patient experience.
The patient presented with marked lymphoedema. On several occasions, relatives intervened to prevent staff from placing a blood pressure cuff on the affected arm. These incidents highlighted the importance of recognising lymphoedema, ensuring staff awareness of associated risks, and adapting clinical practice to safeguard patient safety.	To address this, the Ward Manager has confirmed that lymphoedema awareness has now been included in recent staff education sessions, with additional guidance shared to help staff identify and escalate concerns more confidently. This will support earlier recognition and ensure patients receive appropriate care without unnecessary delay.
The patient's dentures were not properly secured, creating a risk of choking. This highlights the importance of ensuring that	The Matron for Ward A9 has since worked collaboratively with the Speech and Language Therapy Team and colleagues from the Stroke Ward to introduce structured

dentures are correctly fixed to maintain patient safety during care.	oral assessments on Ward A9. These discussions focused on improving oral care practices for patients.
Over the course of multiple telephone calls, the patient and family received inconsistent information regarding ongoing investigations and available tests. This lack of clear, coordinated communication led to confusion and uncertainty, making it difficult for them to fully understand the processes and options relating to the patient's care.	Within the Gynaecology Team, families and patients will be given a single, named point of contact. This person will support patients and families throughout their care, providing continuity and helping to avoid conflicting information or repeated calls from multiple members of staff. This enables a gentler, more coordinated and supportive approach at a vulnerable time.

3. Referrals to Parliamentary Health Service Ombudsman

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint however, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. In addition, in instances where the Trust has thoroughly investigated and responded to a complaint and the complainant remains dissatisfied the Trust as a last resort, would signpost the complainant to the PHSO.

The PHSO will consider the complaint file and medical records together with any other relevant information. The PHSO may decide not to investigate further, and no action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and/or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

There were no PHSO investigations started in 2025/26, compared to 2 started in 2024/25.

There were 4 PHSO investigations closed in 2025/26, compared to 7 closed in 2024/25.

PHSO Outcome	Number of Cases
Partially Upheld	2
No Further Action	2

There are currently 3 open PHSO cases at the time of reporting.

4. Patient Advice and Liaison Service (PALS)

4.1 PALS Received

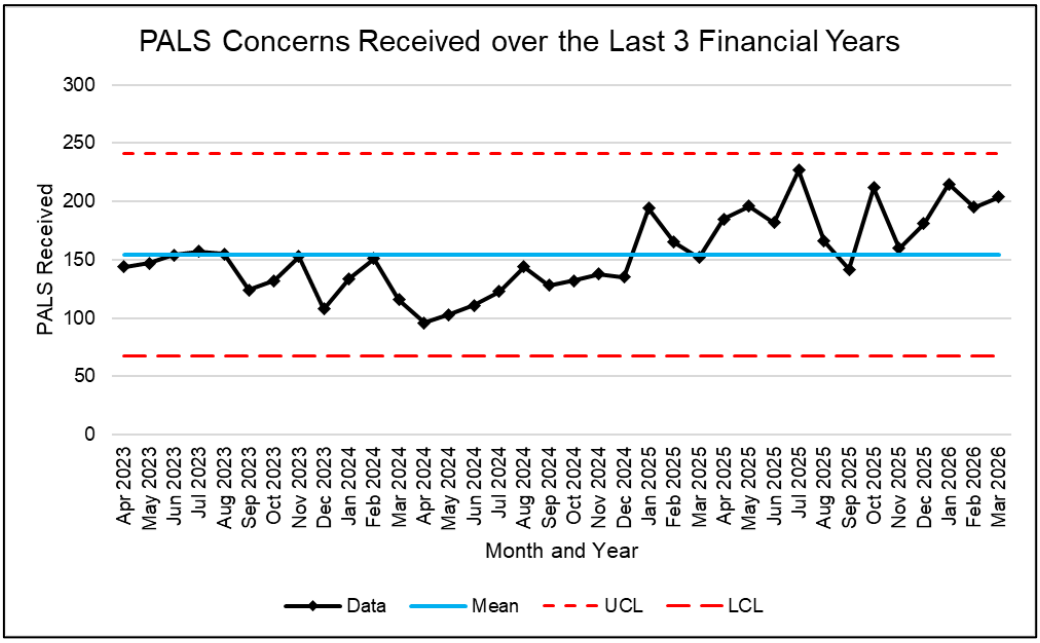
There were 2265 PALS concerns received in 2025/26. This is an increase of 644 concerns (39.73%) compared to 2024/25 where 1621 concerns were received. This is an average of 189 concerns received per month, compared to 135 concerns in 2024/25.

A review of PALS concerns received across the Trust over the last 3 years, see **Graph 7**, shows variations consistent with normal variation with data remaining within the established control limits and no evidence of sustained trends. This is not considered special cause variation currently due to data points in March and September 2025 being below the average expected.

However, there is evidence of a sustained increase in the volume of PALS concerns received from 2025 onwards, suggesting a higher underlying level of activity compared to earlier years.

A review of PALS data was undertaken in Quarter 4 2025/26, comparing activity in the calendar years 2025 and 2024. Surgical Specialties remained the highest reporting CBU and recorded the largest year-on-year increase in PALS concerns. Medical Care also demonstrated a notable rise in concerns when compared to the previous year. Consistent with complaints data, Clinical Treatment remained the most frequently reported theme. Other recurring themes included Appointment Delays and Communication (combining oral, written and telephone communication themes), reflecting ongoing areas of focus for patient experience improvement.

Graph 7



4.2 PALS Received by Theme

The table below identifies the primary themes of concerns received in 2025/26 compared to 2024/25.

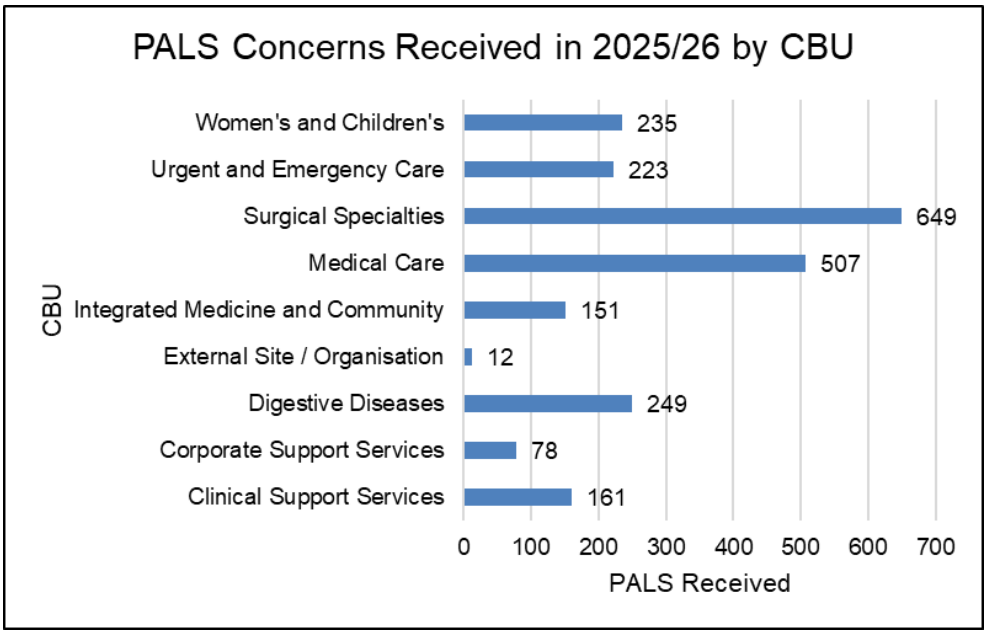
Primary Theme	2024/25	2025/26	Change
Clinical Treatment	477	721	+244
Date for Appointment	306	507	+201
Communication (oral)	120	197	+77
Attitude and Behaviour	191	177	-14
Communication (written)	104	175	+71
Test Results	128	141	+13
Patient Property/Expenses	54	72	+18
Admissions/Transfers/Discharge Procedure	73	70	-3
Premises	18	41	+23
Date of Admission/Attendance	43	41	-2
Personal Records	28	37	+9
Telephone	34	24	-10
Aids/Appliances/Equipment	9	13	+4

Failure to Follow Agreed Procedures	4	11	+7
Patient Privacy/Dignity	9	10	+1
Transport	0	7	+7
Competence	1	3	+2
Cleanliness/Laundry	1	3	+2
Outpatient and Other Clinics	2	3	+1
Patient Status	4	3	-1
Catering	5	2	-3
Complaint Handling	1	2	+1
Mortuary/Postmortem Arrangements	0	2	+2
Bed Shortages	3	2	-1
Shortage/Availability	3	1	-2
NHS Board Purchasing	1	0	-1
Policy and Commercial Decisions of NHS Board	2	0	-2

Clinical Treatment remained the most frequently reported primary theme in both 2024/25 (477) and 2025/26 (721), representing an increase of 244 concerns (51.15%). Date for Appointment was the second most reported theme in both years, with 507 concerns received in 2025/26 and 306 concerns in 2024/25. In 2025/26, this was followed by Communication (oral) (197).

4.3 PALS Received by Area

Graph 8

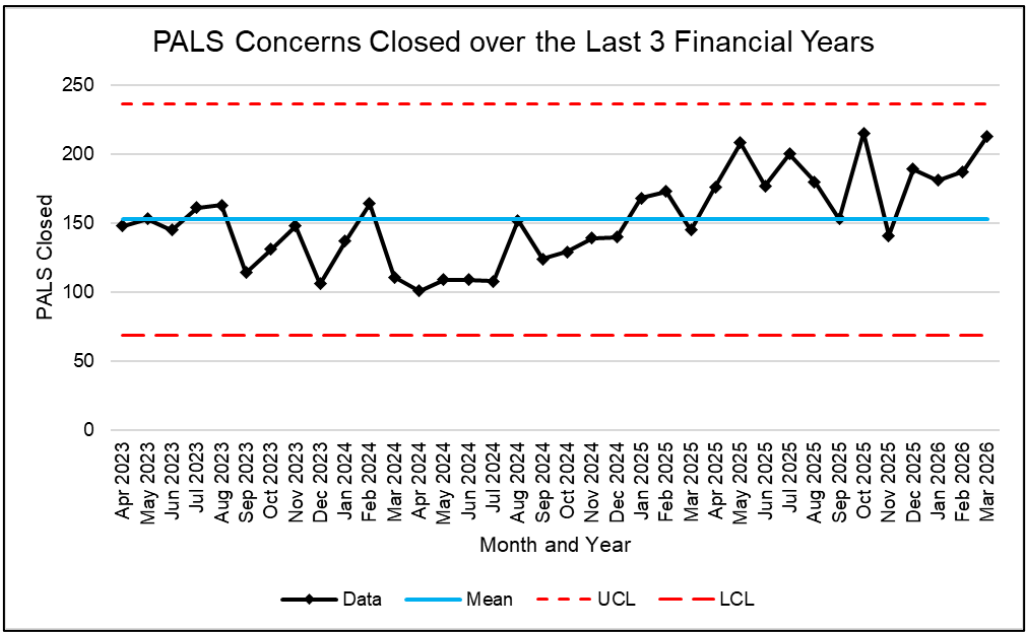


Surgical Specialties received the highest number of concerns (649) in 2025/26, followed by Medical Care (507) and Digestive Diseases (249). Surgical Specialties also received the highest number of concerns in 2024/25. Within Surgical Specialties, the top 3 specialties for 2025/26 concerns were Trauma and Orthopaedics (236), Ear, Nose and Throat (214) and Urology (118).

4.4 Closed PALS

There were 2220 PALS concerns closed in 2025/26, an increase of 623 concerns (29.01%) compared to 2024/25 where 1597 concerns were closed. This is consistent with the concerns received between the 2 financial years.

Graph 9



PALS provide a real time response following receipt of a concern, and the engagement and relationship between the PALS Team and the CBU's is positive which enables timely responses.

5. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/033**			
Subject:	Communications and engagement acitivty report, April 2026			
Date of meeting:	3 June 2026			
Action required:	**N/A**			
Author(s):	Alison Aspinall / Mike Baker, heads of communications and engagement			
Executive director sponsor:	Kate Henry, director of communications and engagement			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	Choose an item.			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	This report provides an overview of communications and engagement activity across North Cheshire and Mersey NHS Foundation Trust during April 2026, a period of significant organisational change following formal integration. Activity focused on ensuring clear, consistent messaging to staff and stakeholders, including delivery of day one communications, launch of new channels and rollout of			

<table>
<tr><td></td><td colspan="4">the trust's refreshed brand identity. Demand for communications and engagement support remained high alongside business-as-usual delivery, with increased job requests reflecting expanded service scope.

The report introduces a refreshed format, with clearer dashboards and insights to strengthen performance reporting. As a new communications job request system was implemented partway through April, some data is incomplete and reporting will continue to evolve, with fuller analysis available in subsequent reports.

Future priorities include strengthening channels, growing digital engagement and supporting the next phase of integration.

During March 2026, BCH and WHH communications and engagement colleagues were working together to prepare branding, materials and other assets for integration and the launch of the North Cheshire and Mersey NHS Foundation Trust brand. This includes significant updates to the staff intranet and public facing websites. Much of this detail is referenced within the April report.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the contents of this update on communications and engagement activity during the reporting period.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Choose an item.</td></tr>
<tr><td>Freedom of information status (FOIA):</td><td colspan="3">Choose an item.</td></tr>
<tr><td>Freedom of information exemptions applied (if relevant):</td><td colspan="3">Choose an item.</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

April activity report

Communications and Engagement Team

Trust Board: Wednesday 3 June 2026

Home
Community
Hospital

Contents

	Page
Executive summary	3
Communications and engagement job requests	4
Key activity	6
Internal communications	7
External communications / media	9
Social media	11
Integration update	15
Strategic projects	18
Patient information	20
Engagement and involvement report	22
Upcoming events	25
WHH Charity	26
Appendices	30

Executive summary

This report aims to update the Board of North Cheshire and Mersey NHS Foundation Trust on our corporate communications and engagement activities, providing highlights and statistics to show how we have connected with our staff, patients and communities during April 2026.

The monthly figures included in the dashboards are a useful barometer in helping us to understand our activity performance and impact, and how we can continue to develop our methods of communication throughout the ongoing integration process to meet increased demand for our services.

The refreshed format features clearer dashboards and insights, providing a more structured overview. It is important to note that a new communications job request and allocation process was introduced to the trust partway through April, therefore data is not available for the full month. Full reporting will be available from May onwards.

Reporting highlights:

- April activity was primarily focused on supporting the trust and staff through the formal integration process, ensuring clear and consistent communications during a period of significant change.
- This included the successful delivery of day one communications and core integration activity, including leadership briefings and the launch of new communications channels and North Cheshire and Mersey brand identity.
- High demand for communications support continued across the organisation as services transitioned, alongside continued delivery of business as usual activity. Final preparations were also taking place ahead of the annual Thank You Awards in May.
- Going forward there will be a renewed focus on the development of our channels and social media platforms, strengthening engagement and supporting the next phases of integration.

Communications and engagement job requests

• Home • Community • Hospital

Caring for you

Team job requests

A new process for recording support requests to the NCM Communications and Engagement Team was introduced during April to embed a consistent approach across our newly integrated team.

Request volume increased between April and May as more NCM colleagues began to access the new job system. We will be able to provide further analysis and evaluation of data over the coming months.

- This month the majority (70%) of job requests were submitted by corporate services.
- The top job type requested in April was design and branding, following the launch of our new North Cheshire and Mersey identity.
- Job request numbers have significantly increased following the integration of acute, community and dental services and completion of large-scale priority projects.
- Key job request examples for this month which the team supported included:
    - Cheshire and Merseyside Endoscopy Hub communications campaign to support referral numbers
    - Materials re-branding post integration
    - Smoke free signage

Job requests received

Total: 102
Approved: 88
More information needed: 6
Rejected (out of scope): 2

Month on month comparison
March 2026: 10 (up 92)

Key activity

• Home • Community • Hospital

Caring for you

April at a glance: Internal communications

Intranet – top 5 viewed pages	Views
1. NCM Brand Hub pages	12,401
2. Staff Hub	3,115
3. Communications Hub	1,329
4. Clinical Hub	1,253
5. Clinical quick references	981

Intranet – top 3 news stories	Views
1. Mutually Agreed Resignation Scheme (MARS) – applications open	826
2. Welcome to North Cheshire and Mersey NHS Foundation Trust	310
3. Join us for a night to remember at the Thank You Awards!	272

Intranet – key stats (no. of)	Total
Thank You messages	20
Approved message board posts	12
News articles	10
Announcements	7

Team Brief

Wednesday 22 April, 11am

Live attendees: 330
Questions: 40
Total views incl. recording: 370

Month on month comparison
March 2026: 286 (up 44)

NCM news (staff bulletin)

Email views (number of times NCM news email accessed):

- 27 April: 6,276
- 20 April: 3,372
- 13 April: 5,234
- 7 April: 9,515

Month average: 6,099 views

Top stories:

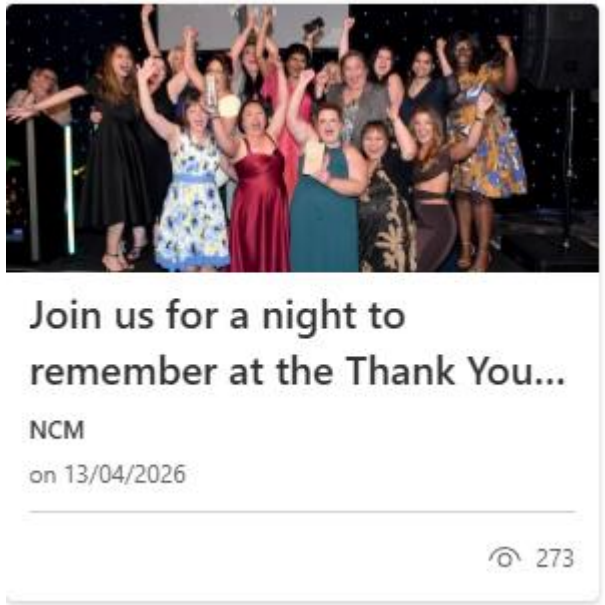
- Welcome to NCM
- Thank You Awards ticket sales extended
- MARS applications
- Staff awards recognition

Examples:

Lesley O'Hara: I wanted to tell you how big of a support system you are for me. I hope to make you proud every day. Thank you for being so awesome!

Carole Gannon: Thank you so much for your help Carole. I really appreciate you taking the time to support me with this, and I'm genuinely grateful.

James Staff: Going above and beyond creating locks for our wheelchairs, using his own resources and time. Thank you from us all.



April at a glance: External communications

Trust website – top 5 viewed pages	Views
1. Work with us / job vacancies	17,780
2. Urgent and emergency care wait times	9,445
3. Our services – Urgent Treatment Centre (UTC) Widnes	2,417
4. Our services – Urgent Treatment Centre (UTC) Runcorn	2,357
5. Contact us	2,207

Trust website – top 3 news stories	Views
1. Our name change to North Cheshire and Mersey NHS Foundation Trust	997
2. Hospital and community trusts officially join together to continue improving healthcare	432
3. Hospital parking update	60

Media

Coverage / enquiries handled during the reporting period:

Proactive

- Media releases written: 4
- News stories published: 3
- CEO column: 1
- Charity articles published: 1

Reactive requests: 7

- Support (e.g. fact checking): 1
- Statements issued: 2
- No response provided: 3
- Interviews / visits: 1

Examples:

NHS
North Cheshire and Mersey
NHS Foundation Trust

Hospital and community trusts officially join together to continue improving healthcare

Wednesday 01 April 2026

NHS Excellence Awards 2026

North Cheshire and Mersey named as regional champion at first NHS Excellence Awards

Wednesday 29 April 2026

Warrington Guardian

What the North Cheshire and Mersey NHS trust means for patients in Warrington

New North Cheshire and Mersey NHS Foundation Trust launched, uniting hospital and community care across Warrington and Halton.

1 month ago

Warrington Guardian

Warrington scheme hailed at NHS Excellence Awards

A LEADERSHIP programme focused on diversity has been named regional champion at a major NHS awards scheme. The 'Your Future Your Way' scheme...

3 weeks ago

Warrington Worldwide
1,871 followers
1mo •

+ Follow ···

WARRINGTON South Sarah Hall MP has today (Sunday) confirmed that architects are now drawing up plans for a new Urgent Treatment Centre at #Warrington #Hospital https://lnkd.in/eNr7vUuq

Plans being drawn up for new Urgent Treatment Centre at Warrington Hospital

warrington-worldwide.co.uk

Social media

• Home • Community • Hospital

Caring for you

April at a glance: Social media

Facebook		
	Page followers	Total: 14,639 New: 224
	Page engagement	15,052
	Page reach	183,165 people

Instagram		
	Page followers	Total: 4,464 New: 70
	Page engagement	151
	Page reach	9,684 people

LinkedIn		
	Page followers	Total: 299 New: 39
	Page engagement	57
	Page reach	1,156 connections

X		
	Page followers	Total: 12,964 New: 3
	Page engagement	108
	Post impressions	3,623

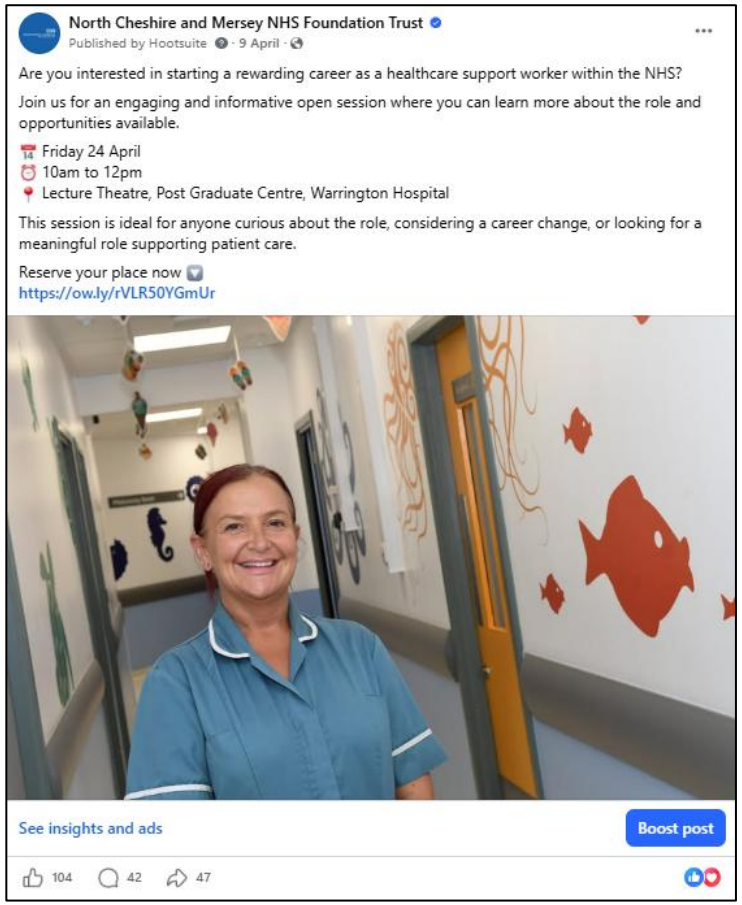
Page engagement – the total number of interactions with content, including likes, comments, shares and clicks

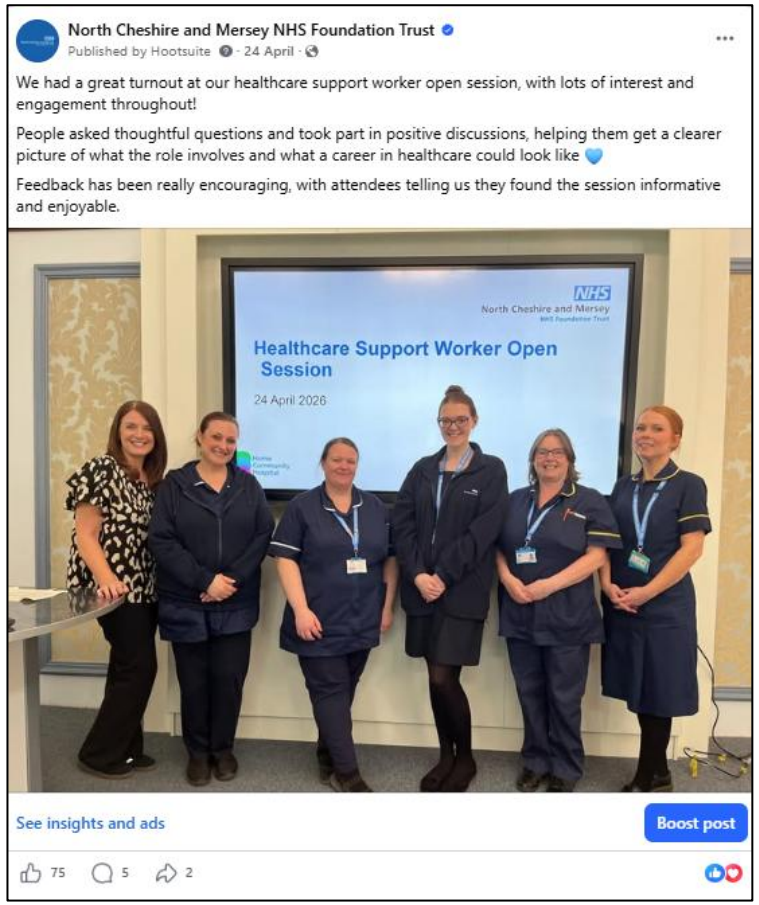
Page reach – the number of unique users who have seen the content

Post impressions – the total number of times content has been displayed to users, including repeat views

April at a glance: Social media

Below are a few examples of the best performing posts (based on engagement rate) during April:





What worked well / next steps

What went well

- From April, we updated social media branding and page names to align with the new trust name, supporting a clear and consistent identity across channels.
- We increased people-focused content, highlighting staff, patients and services. These posts achieved strong engagement and have been continued, with further impact expected in next month's reporting.
- We carried out detailed analysis across all social media channels, giving a clear picture of what works well and where audiences engage most. This insight has helped shape our strategy for social media and inform our approach.

What we want to improve

- Rebuild LinkedIn presence following the need to create a new account due to external platform issues, with a focus on growing followers and reach.
- Use insight from channel analysis to refine content planning, prioritising posts that resonate most with our audiences.
- Continue strengthening consistent branding, tone and messaging across all platforms.
- Increase planned, people-centred content to support engagement and trust.
- A new social media development plan is underway.

Updated social media profile image

Updated social media banner

NCM integration

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April integration update

Communications highlights / progress this period*	Status	Next steps
Day one communications programme successfully implemented on 1 April including chief executive's staff briefing and morning message. The team worked alongside staff engagement on the rollout of new lanyards, 'Welcome to NCM' boxes and cakes.	Complete	New lanyard design for governors, volunteers and dental staff. Ongoing comms and engagement support for clinical and ops workstreams.
New Brand Hub created on intranet featuring a variety of templates e.g. email signature, teams background, reports etc. Wider digital changes implemented including public facing website, staff intranet and social media platforms, and consolidation of comms inboxes.	Ongoing	Further brand development rollout and continued staff communication / feedback to ensure correct implementation. Launch of new NCM style guide.
Final preparations for staff Thank You Awards 2025-26	Ongoing	Awards event taking place on Friday 15 May 2026.
Updating of external signage to either NCM or generic NHS	Complete	Phase 2 signage updates for any remaining signage and internal wayfinding approach.

*Significant communications and engagement work was undertaken to support teams throughout the April reporting period. The above shows key highlights that had the biggest impact during this time.

Case study: Digital comms integration

Website and intranet rebrand

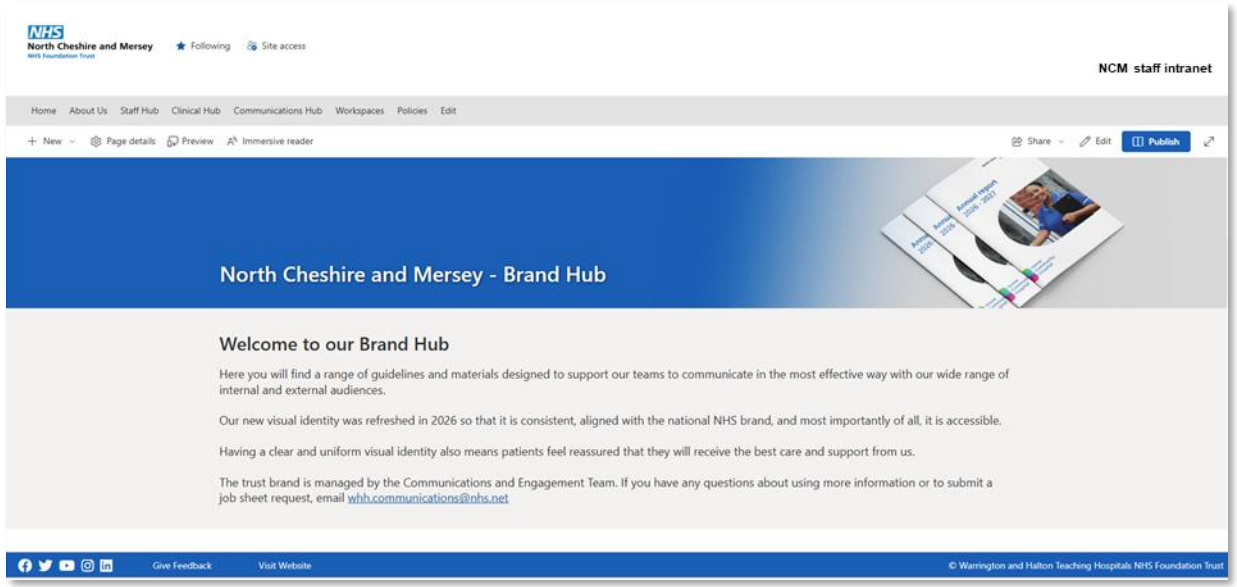
The rebrand of the trust website and intranet went live on 1 April, reflecting our new name: North Cheshire and Mersey NHS Foundation Trust.

As part of this work, all content from the former Bridgewater website and intranet was successfully transferred to the newly rebranded trust website and intranet.

This ensures staff and the public can continue to access information in one place, under the new trust identity, with minimal disruption.

A new Brand Hub was launched on our intranet, making it easy for all staff to access our updated brand guidelines, style guide and templates.

Further work will now be undertaken to ensure style guide consistency across website and intranet departmental sections.



Strategic projects

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Strategic projects and campaigns

Project	Progress / actions	Impact / outcomes
1. WELL Runcorn Hub	Further progress around planning and next steps as the build nears completion. Early preparations underway around a planned official launch event in September (date to be confirmed).	▪ Coordinating internal and external stakeholders to ensure operational readiness ahead of opening. ▪ Developing launch comms and engagement plan to maximise awareness and attendance. ▪ Identifying opportunities to position the WELL Hub as a key community health and wellbeing asset from day one.
2. Thank You Awards	Work continued with less than a month until the ceremony at the Titanic Hotel on Friday 15 May. This included confirming guest numbers / cancellations following a ticket extension, final sponsor arrangements, and a pre-event call with the hotel.	▪ 280 attendees confirmed. ▪ 18 sponsors secured (including all but one category – a significant increase from last year).

Next steps:

- Most of the campaign work during April was connected to integration and launching NCM.
- Further projects, both internal within the team and supporting other departments and the wider trust, will develop as the Communications and Engagement Team integration progresses and settles.

Patient information (PINFO)

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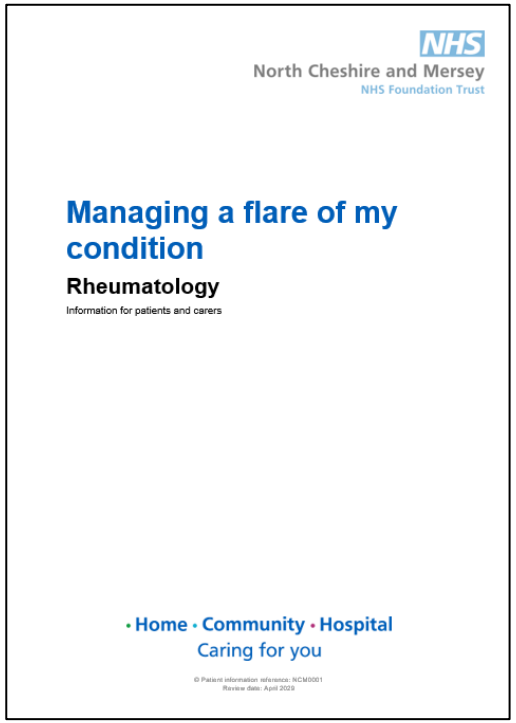
Patient information (PINFO)

During the April reporting period the Communications and Engagement Team:

- adopted a new policy for the management and processing of patient information across community and hospital services – including new templates for NCM and services with their own logo
- identified there are **604** trust-generated patient information leaflets across all care groups (including Community and Dental)
- supported clinical teams in putting **2** new leaflets through the PINFO process
- completed review / edit of **1** existing leaflet to meet review date and reflect NCM style guidelines
- identified **204** expired leaflets (including 141 which have been temporarily archived pending updates requested from authors)



Next steps:

A new SharePoint database is in development to improve management of patient information through automating some process workflows and improving reporting metrics.

Additional resource from community and dental is being made available to support follow-up on expired patient information to improve compliance.

Engagement and involvement report

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Key activity

Staying Connected Disability Forum

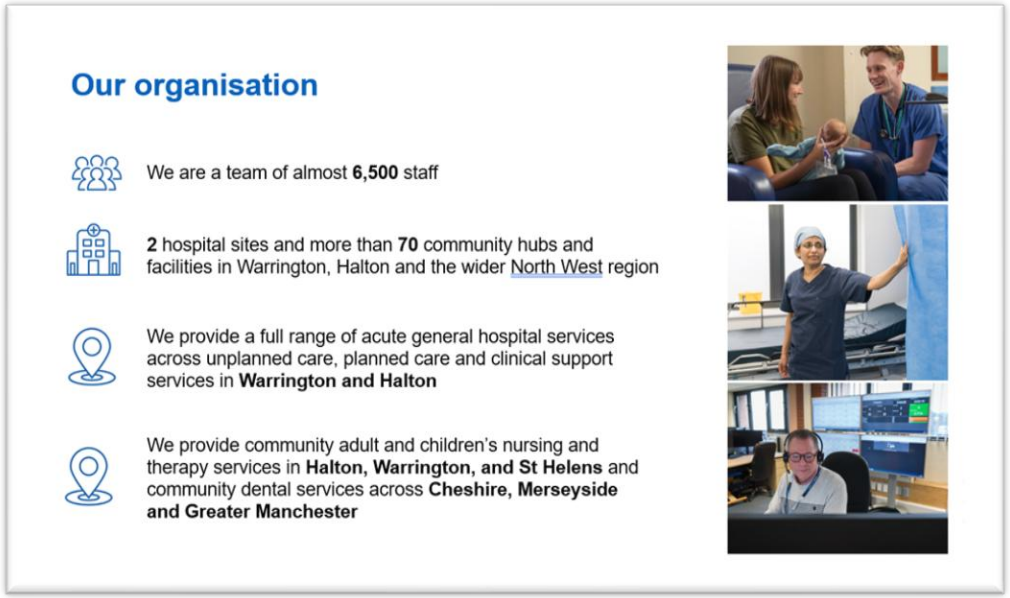
Introducing North Cheshire and Mersey NHS FT

Led by Warrington Disability Partnership, the Staying Connected Disability Forum is a monthly online network that provides a focus for consultation and information exchange for all matters about disability and long-term conditions in Warrington. On Monday 13 April, Lucy Gardner, chief strategy and partnerships officer, presented to a range of local organisations and representatives, including Warrington Carers Hub, Vision Support, United Utilities and CAB to introduce NCM and outline improvements, financial benefits and next phases of the integration programme.

Feedback and discussion highlighted key areas of public interest:

- how savings from the integration will be used (e.g. service improvement vs. addressing the deficit)
- availability of printed information for those affected by digital exclusion
- tangible improvements the integration will deliver in priority areas (e.g. corridor care)

Overall, the session generated constructive discussions, with a strong interest in the integration delivering visible, equitable and accessible benefits for local communities.



Experts by Experience

Current period

Project	EbyEs recruited	EbyE involvement	Outcomes / impact
MSK student simulation exercise	3	EbyEs requested to join a simulation day for physiotherapy students' MSK assessments at Hope University.	2 EbyEs became 'patients' during the simulation day, helping MSc physiotherapy students to develop diagnostic skills and prepare for similar assessments in final exams. 1 EbyE withdrew.
Pulse – Eli Lilly campaign	2 (plus 2 Governors)	EbyEs requested to evaluate materials for Eli Lilly's 'Obesity is a disease' campaign.	2 EbyEs cited potential commercial campaign conflicts, as Eli Lilly treatments (e.g. Mounjaro) are not available to all via the NHS.
Ward A8 – single room privacy measures	1	EbyEs requested to inform privacy measures in single rooms within Ward A8 refurbishment.	EbyE preferred Vistamatic-style vision panels (instead of curtains), to support patient privacy without impeding ward care / patient safety.

Year on year comparison

EbyEs recruited April 2025	Total EbyEs April 2025	No. projects supported
1	185	8

EbyEs recruited April 2026	Total EbyEs April 2026	No. projects supported
2	222	5

Upcoming events

Date	Event	Time	Venue	Event purpose
13 June 2026	Warrington Pride	10am to 4pm	Warrington town centre / Golden Square	Annual partnership event celebrating the town's LGBTQIA+ community.
27 June 2026	Warrington Armed Forces Day	10am to 6pm	Crosfields Rugby Club, 131 Hood Lane North, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces rugby league games, military vehicle displays, stands and activities for residents of Warrington and the wider area.
12 July 2026	Disability Awareness Day	10pm to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual family fun day and pan-disability event led by Warrington Disability Partnership, supporting independent living.
6 September 2026	Warrington Mela	11am to 4pm	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within Warrington.

WHH Charity

Comms and engagement support

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Warrington and Halton Hospitals' Charity

Communications support

Key activity:

Website activity

- April 1,838 (1,676 active)

The most viewed pages were home page, WHH Charity Crafters and news.

Newsletters

- April 2026 newsletter

News

Items published in this period included:

- New Intensive Care Unit balcony opens at Warrington Hospital

Next steps:

Continue to promote summer fundraising initiatives and encourage event registrations for the Dragon Boat Race and Warrington Running Festival. Launch a targeted paid social media campaign aimed at local businesses to increase membership of the Supporters' Club and strengthen community engagement during the charity's 30th birthday year.

Appendices

Team / social media channels

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Communications and engagement channels

Platform	Frequency	Distribution / audience	How to access
CEO ‘Good morning message’	3 per wk (Mon, Wed, Fri)	Internal: All staff	Global email
NCM news (staff bulletin)	Weekly	Internal: All staff	Global email via comms
Stakeholder bulletin	Monthly	Ext: Stakeholders / VIPs	Email distribution list
Media summary	Daily	Internal: Board	Via email
Team Brief	Monthly	Internal: All staff	Teams calendar invitation
Staff engagement session (integration)	Monthly	Internal: All staff	Teams calendar invitation
Desktop / screensaver messages	Scheduled calendar dates	Internal: All staff	Via work PC/laptop devices
Leadership Forum	Bi-monthly	Internal: Senior managers	By invitation
Dept newsletters (e.g. Culture and Engagement / Governor update)	Monthly / bi-monthly / quarterly	Internal / external (audience dependant)	Via email
Other (e.g. Chief Nurse Check-In / Culture Corner / Housekeeper Forum etc)	Dependant on initiative	Internal	By invitation
WHH Charity (and internal / external newsletters)	Site regularly updated	External: All	Accessible here
Thank You Awards	September to May	Internal: All staff	Global email via TYA inbox / CEO

Digital / social media platforms

Platform	Frequency	Distribution / audience	How to access
North Cheshire and Mersey public website	3 per wk (Mon, Wed, Fri)	Internal: All staff	Global email
NCM news (staff bulletin)	Weekly	Internal: All staff	Global email via comms
BCT staff microsite (and assoc email inbox)	As required	Internal: All staff	Accessible here
Facebook	4 per wk	External: All	Facebook
Instagram	4 per wk	External: All	Instagram
X	When relevant	External: All	X
LinkedIn	When relevant	External: All	LinkedIn
YouTube	As required	External: All	YouTube
TikTok	As required	External: All	TikTok

WHH Charity platform	Frequency	Distribution / audience	How to access
Public website	As required	External: All	Online
Facebook	4 per wk	External: All	Facebook
Instagram	4 per wk	External: All	Instagram
LinkedIn	4 per wk	External: All	LinkedIn

Contact us

Email: ncm.communications@nhs.net

Website: northcheshireandmersey.nhs.uk

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North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/034**			
Subject:	**Freedom to Speak up**			
Date of meeting:	3 June 2026			
Action required:	**For information**			
Author(s):	Alison Jordan FTSU Guardian			
Executive director sponsor:	Jane Hurst, Chief Finance Officer			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	In 2025/26 Freedom to Speak up (FTSU) for acute services has managed 108 cases of disclosure, in 2024/25 87, in 2023/24 31 and 42 cases in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU guardian continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted. In 2025/26 FTSU for community and dental services has managed 107 cases of disclosure. In 2024/25 36 and in 2023/24 43 and 14 cases in 2022/23. Most issues raised relate to bullying / harassment and issues within teams. Systems and process are also a theme, poor communication, morale and feeling undervalued have also been highlighted by staff who have raised concerns.			

<table>
<tr><td></td><td colspan="3">The FTSU team continues to engage with colleagues across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU.

Following a review of 2025/26 staff survey results, triangulated with other workforce data, the FTSU Guardian will be working with HR,OD people promise ,workforce culture and engagement colleagues to support managers and leaders to improve psychological safety by.

✓ Strengthening speak up culture across hospital and community settings
✓ Re launch See it Report it Stop it campaign across the Trust
✓ Quarterly ‘you said, we did’ publication
✓ Leadership development focused on transparency and follow through</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the progress of Freedom To Speak Up</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Strategic People Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2">18 May 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>Freedom of information status (FOIA):</td><td colspan="3">Release document in full</td></tr>
<tr><td>Freedom of information exemptions applied (if relevant):</td><td colspan="3">None</td></tr>
</table>

1. Background/context

In 2025/26 Freedom to Speak up (FTSU) for acute services has managed 108 cases of disclosure, in 2024/25 87, in 2023/24 31 and 42 cases in 2022/23. Most issues raised related to culture, allegations of bullying and relationship issues within teams. The FTSU guardian continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted.

In 2025/26 FTSU for community and dental services has managed 107 cases of disclosure. In 2024/25 36 and in 2023/24 43 and 14 cases in 2022/23.

Most issues raised relate to bullying / harassment and issues within teams. Systems and process are also a theme, poor communication, morale and feeling undervalued have also been highlighted by staff who have raised concerns.

The FTSU team continues to engage with colleagues across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU.

Following a review of 2025/26 staff survey results, triangulated with other workforce data, the FTSU Guardian will be working with HR,OD people promise ,workforce culture and engagement colleagues to support managers and leaders to improve psychological safety by.

- ✓ Strengthening speak up culture across hospital and community settings
- ✓ Re launch See it Report it Stop it campaign across the Trust
- ✓ Quarterly 'you said, we did' publication
- ✓ Leadership development focused on transparency and follow through

2. Key elements

Table 1 sets out the number of disclosures for the last 4 years for acute services.

The table represents the number of disclosures by individual so even if several themes form the disclosure this is counted as one.

Table 1. Number of disclosures by individual (WHH)

	2022/23	2023/24	2024/25	2025/26
Quarter 1	17	6	15	19
Quarter 2	5	6	15	44
Quarter 3	13	9	36	29
Quarter 4	7	10	21	16
Total	**42**	**31**	**87**	**108**

Table 2 includes the themes contained within an individual disclosure. In 2025/26 there have been individual disclosures containing 133 recorded themes. This equates to 25 of those individual disclosures including more than one of the six listed recordable themes.

Table 2. Themes from disclosures (WHH)

Reportable themes	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total 2025/26
Worker wellbeing	16	28	26	14	84
Bullying harassment	2	7	2	2	13
Other inappropriate behaviour	1	0	3	0	4
Pt Quality	3	13	3	3	22
Pt Safety	1	4	2	2	9
Detriment	1	0	0	0	1
Total	**24**	**52**	**36**	**21**	**133**

Table 3 shows the number of disclosures for community and dental services over the past four years. It counts each individual and collective disclosure as a single concern.

Table 3. Number of disclosures by individual (BCH)

	2022/23	2023/24	2024/25	2025/26
Quarter 1	7	3	16	44
Quarter 2	0	20	2	23
Quarter 3	6	17	7	21
Quarter 4	1	3	11	19
Total	**14**	**43**	**36**	**107**

Table 4 includes the themes contained within an individual disclosure. In 2025/26 there have been individual disclosures containing 107 recorded themes.

Table 4. Themes from disclosures (BCH)

Reportable themes	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Worker wellbeing / safe safety		5		
Systems / process	3	7	3	1
Bullying harassment	11	11	16	6
Leadership	12			1
Infrastructure / environment			2	11
Pt Safety & Quality	18			
Total	**44**	**23**	**21**	**19**

National Staff Survey Freedom to Speak Up
The 2025 Staff Survey includes four questions which provides intelligence for staff reporting on unsafe clinical practice and their experience of the organisation addressing concerns. The Acute and Community sectors of the now combined organisation received their data independently from the 2025 staff survey. The questions are:

Acute:

- **I would feel secure raising concerns about unsafe clinical practice** – 70% of staff reported feeling secure raising concerns about unsafe clinical practice This was a deterioration of 3% compared with 2024 and 2023.**I am confident that my organisation would address my concern** – 54% of staff felt the organisation would respond if concerns were raised regarding unsafe clinical practice. This was a deterioration of 6% compared with 2024 and a further deterioration from 2023.
- **I feel safe to speak up about anything that concerns me in this organisation** – 58% of staff reported feeling safe to speak up at the Trust. This was a deterioration 4% compared with 2024 with a further deterioration from 2023.
- **If I spoke up about something that concerned me, I am confident my organisation would address my concern** – 44% of staff felt confident that the organisation would address concerns raised, 8% deterioration in comparison to 2024 and 2023.

Community:

- **I would feel secure raising concerns about unsafe clinical practice** – 75% of staff reported feeling secure raising concerns about unsafe clinical practice This was a deterioration of 6% compared with 2024.
- **I am confident that my organisation would address my concern** – 59% of staff felt the organisation would respond if concerns were raised regarding unsafe clinical practice. This was a deterioration of 11% compared with 2024.
- **I feel safe to speak up about anything that concerns me in this organisation** – 59% of staff reported feeling safe to speak up at the Trust. This was a deterioration of 13% compared with 2024.
- **If I spoke up about something that concerned me, I am confident my organisation would address my concern** – 47% of staff felt confident that the organisation would address concerns raised, a 16% deterioration in comparison to 2024.

The data highlights that results have deteriorated in both the acute and community sectors. Both sectors are also below the national average for their respective comparator groups (acute; acute and community; and community trusts) across all four questions. This demonstrates that there is significant work to be done to strengthen our speak-up culture and ensuring that all staff feel safe to speak up at the Trust and improving feedback loops so staff can see concerns are listened to, acted on and actions are communicated.

3. Freedom to speak up information

Changes to national support for guardians' closure of NGO move to NHSE

From 1 July 2026, following a recommendation in July 2025 by the Dash review of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

NHS England will:

- support existing guardian networks and individual guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- provide and maintain the platform for free online guardian foundation training
- collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with guardian networks
- review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

NHS healthcare providers and commissioners will:

- have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up guardian is kept accurate, made publicly available and is accessible
- routinely submit their Freedom to Speak Up data through NHS England's national data collection system (for 2026/27, this will be trusts and ICBs only)
- ensure that any guardian they appoint completes the mandatory guardian foundation training before starting their role and support their continuing professional development
- ensure appropriate psychological support is available for their guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026

Temporary workers survey results

Published March 2026 the Temporary Workers, Permanent Voices: A Speak Up Review explores the experiences and perceptions of temporary colleagues in the NHS – specifically, the barriers and enablers that influence whether they feel able to speak up. Drawing on insights from temporary workers, guardians and system partners, the review sets out six recommendations aimed at improving consistency, visibility and protections across the system.

About two-thirds (64.6 per cent) of participants surveyed said they knew speaking up arrangements in their organisation

- 5 per cent of workers from NHS Professionals were not aware of Freedom to Speak Up guardians whereas 18.8 per cent of workers from Trust Bank were not aware of Freedom to Speak Up guardians
- Seniority had an impact on whether workers knew the arrangements for speaking up. 71 per cent of staff pay bands five-to-eight knew what the speaking up arrangements were, whereas only 59 per cent of bands one-to-four did.
- The review report contains six recommendations to help tackle the issues identified, aimed at both the healthcare system and provider organisations and temporary workforce suppliers.

The recommendations include calls for the strengthening of support allowing temporary workers to speak up and the promotion of a culture of inclusion and belonging for temporary workers. Full report can be found using the link below.
Temporary Workers, Permanent Voices: A Speak Up Review

Actions taken to address FTSU disclosures 2025/26

- Cultural reviews following concerns being raised around communication styles, and implementation of new processes without full understanding of those affected
- Awareness raising of routes to speak up following medicines management incidents

- Listening and awareness raising events in care groups as a response to concerns raised about confidentiality
- Investigations into concerns raised around patient safety
- Promotion of ‘See it Report it Stop it’
- Promotion of active bystander training
- Improved response rate to disclosers in community and dental
- Joint review by community and dental FTSUG and governors around alleged case of detriment through speaking up

Planning for the future FTSU model for NCM

Work to align FTSU processes began during the NCM integration programme. The following has been established

- **Agreed shared principles** – one consistent, fair approach to speaking up across the trust, with clear executive accountability.
- **Mapped and stabilised existing arrangements** before integration so staff don’t lose trusted routes during transition.
- **Use a hub-and-spoke model** – central Guardian oversight and case management, with locally visible champions in acute and community services to sign post.
- **Created one trust-wide policy and pathway**, with consistent standards and timescales, while allowing local flexibility in how support is delivered.
- **Integrated FTSU with patient safety, HR, and safeguarding** to avoid duplication and ensure issues raised lead to organisational learning.
- **Strengthened board oversight early**, focusing on themes, and differences between acute and community settings.

Actions to be completed over the next few months

- **Develop Guardian capability and consistency** across acute and community settings through shared decision-making standards, and cross-service learning.
- **Communicate clearly and repeatedly**, including community-specific examples, to build confidence and visibility.
- **Measure confidence as well as activity**, recognising that lower volumes may mask higher risk in community services.
- **Acknowledge cultural differences openly** – build one speak-up culture without erasing local context.
- **Consolidate standards, systems, and oversight**, while preserving local access and trust across acute and community services.

4. Recommendations

The Trust Board is asked to note the progress of Freedom To Speak Up.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/035**			
Subject:	**Terms of Reference - Audit Committee** **Cycles of Business – Committees and Trust Board**			
Date of meeting:	3 June 2026			
Action required:	**Approval**			
Author(s):	John Culshaw, Company Secretary			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	Following the acquisition of Bridgewater Community Healthcare NHS Foundation Trust, the Trust Board is required to approve a revised governance framework reflecting the establishment of North Cheshire and Mersey NHS Foundation Trust as a single statutory organisation. The Terms of Reference for all but one of the formal committees of the Board were approved by the Trust Board at its meeting on 1 April 2026. The Terms of Reference for the Audit Committee are now presented to the Trust Board for formal approval. The Terms of Reference have been reviewed by each respective committee and have been supported. They are now presented for approval for the following committees: Quality and Safety Assurance Committee; Strategic People Committee; and Finance, Sustainability and Performance Committee.			

<table>
<tr><td></td><td colspan="3">The proposed Terms of Reference reflect the transition from previously aligned but sovereign decision-making arrangements to a model of clear, unified accountability, with direct delegated authority from the Trust Board. They support consistent oversight across acute, community and dental services and align with the Trust's revised operating and leadership model implemented from April 2026.

In addition, the Cycles of Business for both the committees and Boards of BCH and WHH have been reviewed, harmonised and formally aligned to support the operation of a single, integrated governance framework. This alignment ensures that committee business is structured consistently across the organisation, with clear lines of accountability, reduced duplication, and comprehensive assurance coverage in line with the Trust Board's priorities.

Together, the revised Terms of Reference and aligned Cycles of Business provide a coherent and robust framework to support effective oversight, assurance and decision-making during the ongoing integration of services within North Cheshire and Mersey NHS Foundation Trust.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to review and approve the Committee Terms of Reference for Audit Committee and the Cycles of Business for:
Quality and Safety Assurance Committee
Strategic People Committee
Finance, Sustainability and Performance Committee
Audit Committee, and
Trust Board</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps:</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

Audit Committee Terms of Reference

1. Purpose

The Audit Committee is constituted as a standing committee of the Board of Directors. The Committee has primary responsibility for overseeing and providing the Board with independent and objective assurance in respect of the adequacy and effectiveness of the Trust's arrangements for integrated governance, risk management and internal control across all activities, both clinical and non-clinical.

The Committee supports the Board in discharging its duties in relation to financial reporting, internal and external audit, counter fraud, the Annual Governance Statement and regulatory compliance. In fulfilling this role, the Committee provides assurance as to the independence of both internal and external audit, ensures that appropriate standards are set and compliance with them is monitored across all areas within its remit, and oversees compliance with corporate governance requirements, including the Trust's Licence, Constitution, codes of conduct, standing financial instructions and the maintenance of registers of interests.

Following the acquisition of Bridgewater Community Healthcare NHS Foundation Trust, the Committee will also be responsible for receiving, considering and, where appropriate, approving audit and assurance matters relating to Bridgewater that remain outstanding from the period prior to acquisition, including statutory audit matters required to be concluded post-transaction.

2. Frequency of meetings

The Committee shall normally meet at least five times per year. Additional meetings may be convened where necessary.

The internal and external auditors shall be afforded the opportunity at least once per year to meet privately with the Committee, without Executive Directors present.

3. Membership

3.1. Membership of the committee will comprise of:

The Committee shall be composed of all independent Non-Executive Directors of the Trust (not including the Chair of the Trust), at least one of whom shall have recent and relevant financial experience. At least one member of the Quality Assurance

Committee shall be a member of the Audit Committee. The Chair of the Trust shall not be a member of the Committee.

The Board of Directors shall appoint one of the Non-Executive Director members to act as Chair of the Committee. In the absence of the appointed Chair, the members present may appoint one of their number to chair the meeting.

Members may participate in meetings by two-way audio or audio-visual means, including telephone or video, and participation in this way shall be deemed to constitute presence for the purposes of the meeting and quorum. Where necessary, the Committee may approve matters in writing, provided that written agreement is received from all members, including via Trust email accounts.

Only members of the Committee have the right to attend meetings. The Trust Chair may be invited to attend where required. The Lead Governor, or nominated deputy, may be invited to attend where items of specific interest or concern raised by Governors are being considered.

The following individuals shall normally be in attendance:

- Chief Finance Officer
- Deputy Chief Nurse & Director of Governance
- Representative(s) of the external audit service provider
- Representative(s) of the internal audit service provider
- Representative(s) of the counter fraud service provider
- Company Secretary
- Head of Financial Services
- Associate Director of Finance – Operational

The Chief Executive may be invited to attend meetings as required and shall attend at least annually to discuss the process of assurance supporting the Annual Governance Statement.

The Committee may require individual Executive Directors or senior managers to attend for specific agenda items and may extend an open invitation to all Trust Directors to attend meetings.

3.2. Observers:

- A Governor representative
- Others by agreement of the Chair

4. Quorum

The quorum for the Committee shall be two Non-Executive Director members.

5. Authority

The Committee is authorised by the Board of Directors to investigate any matter within its terms of reference. It may seek any information it requires from any officer or employee of the Trust, and all staff are required to cooperate with such requests.

The Committee is authorised to obtain independent professional advice and, where necessary, to invite external parties with relevant experience or expertise to attend meetings.

The Committee has no executive powers other than those explicitly delegated to it through these terms of reference.

6. Duties and responsibilities

Duties – decision making:

The Committee is responsible for recommending to the Board, or approving where delegated, the following matters:

- the internal audit plan and any significant amendments
- the external audit strategy and fee, where applicable
- the Annual Governance Statement
- the annual report and annual accounts
- statutory audit matters relating to the Trust and, where required, outstanding statutory and audit matters relating to Bridgewater Community Healthcare NHS Foundation Trust for the period prior to acquisition

Duties – advisory:

The Committee shall advise the Board on:

- the adequacy and effectiveness of the Trust's framework for governance, risk management and internal control
- the robustness of the assurance framework supporting the Board Assurance Framework
- the appropriateness of accounting policies, significant judgements and estimates within the financial statements

- the fitness for purpose of financial reporting and assurance processes

Duties – monitoring:

The Committee shall oversee and monitor:

- the integrity of the Trust's financial statements and formal financial reporting
- the effectiveness of internal audit, external audit and counter fraud arrangements
- management responses to audit recommendations and assurance findings
- compliance with statutory, regulatory and governance requirements, including standing financial instructions, scheme of delegation and standards of business conduct
- the effectiveness of arrangements for preventing, detecting and investigating fraud and corruption
- providing oversight and independent assurance on the Board Assurance Framework and the Strategic Risk Register, including the completeness and quality of assurance mapped to principal risks.

This oversight will include assurance over legacy matters associated with Bridgewater Community Healthcare NHS Foundation Trust where these remain open or require closure following acquisition.

Duties of members:

Members of the Committee are expected to:

- attend meetings regularly and prepare adequately for each meeting
- contribute actively and constructively to discussions
- exercise independent judgement and appropriate professional scepticism
- maintain confidentiality and comply with the Trust's standards of conduct

7. Attendance

Core members are expected to attend at least 75% of meetings over a rolling 12-month period.

Deputies should be appropriately briefed and of sufficient seniority to contribute fully.

In-person attendance is preferred, but secure audio/video attendance is acceptable and counts as full participation.

Attendance will be monitored by the Corporate Governance Team and reported annually to the Board

8. Administrative arrangements

The Committee will be supported by the Corporate Governance Team.

- Papers will be circulated at least five working days before the meeting. Papers received after the deadline will be accepted only with the Chair's approval and must be identified as late papers.
- Papers must clearly identify purpose (information/ assurance/ approval), key issues, implications (including regulatory and risk), and recommendations.
- No papers will be tabled at the meeting without prior approval of the Chair.
- An action log will be maintained and overdue actions escalated to the Chair and, where necessary, the Board.
- A Cycle of Business will be maintained.

9. Review and effectiveness

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

The Cycle of Business will be reviewed by the Committee every 12 months.

Terms of reference revision tracker

Name of committee:	
Version:	
Implementation date:	
Review date:	
Approved by:	
Approval date:	

Revisions			
Date	**Section**	**Reason on change**	**Approved**

Terms of reference obsolete		
Date	**Reason**	**Approved by:**

NHS
North Cheshire and Mersey
NHS Foundation Trust

QUALITY AND SAFETY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2026-2027

CALENDAR YEAR (APRIL 2026 - MARCH 2027)				2026										2027		
Item	**Reporting Frequency**	**Process**	**Lead**	**April**	**May**	**June**	**July**	**July Extra**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
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		✓		✓			✓		✓		✓		✓
Deep Dive	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Compliance Update	Quarterly	**Assurance**	Chief Nurse/Dep Dir Gov			**✓Q4**			**✓Q1**			**✓Q2**			**✓ Q3**	
Hot Topics	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
COMPLIANCE & OVERSIGHT																
Quality IPR Metrics	Bi-Monthly	**Discuss & Assurance**	Chief Nurse	✓		✓			✓		✓		✓		✓	
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**			**✓ 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						✓						✓	
Birth Trauma position (limited time)	Annually - timescale TBC	**Assurance**	Director of Midwifery													
SAFETY																
Mental Health Update	Bi monthly	**Assurance**	Chief Nurse		✓		✓			✓			✓			✓
Safeguarding Update Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse				✓							✓		
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**	Chief Finance Officer and Head of Finance-Improvement, Performance and Commercial Development		✓							✓				
Learning from Experience Report	Quarterly	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality			**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	
Six month Chief Nurse Staffing Report - Safe Staffing	Bi-Annually	**Assurance**	Chief Nurse			✓							✓			
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				✓							✓		
PSIRF Bi-Annual Report	Bi-Annually	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓							✓				
Mortuary Licensed Activity Report (Including Fuller update)	Bi-Annually	**Assurance**	Chief Nurse				✓							✓		
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**	
Neck of Femur (NoF) Update	Monthly	**Assurance**	Assoc Director of Planned Care	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
MIAA Theatre Safety Audit		**Assurance**	Exec Med Director				✓									
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		✓						✓					
Complaints Report	Annually	**Approval**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓											
COMPLIANCE & OVERSIGHT																
Board Assurance Framework/Corporate Risk Register	Quarterly	**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						✓					✓		
Enabling Strategy Alignment Progress report	Bi-Annually	**Assurance**	Chief Strategy & Partnerships Officer			✓								✓		
Patient Safety & Clinical Effectiveness Sub Committee Exception Report	Monthly	**Assurance**	Exec Medical Director	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
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		**✓Q4**					**✓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		✓							✓				
BCT Integration and Due Diligence update	Monthly	**Assurance**	Chief Strategy and Partnerships Officer				✓				✓			✓		
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 including Annual Review of BAF risks	Annually	**Assurance/ Approval**	Chair/Co Secretary				✓									
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 Research Oversight Sub Committee	Bi-Monthly	**Assurance**	Executive Medical Director	✓		✓			✓		✓		✓		✓	
CLOSING MEETING																
Items for Escalation to the Trust Board	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Meeting	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

STRATEGIC PEOPLE COMMITTEE
CYCLE OF BUSINESS

CALENDAR YEAR (APRIL 2026 - MARCH 2027)				2026									2027		
	Reporting Frequency	Process	Lead	April	May	June	July	August	September	October	November	December	January	February	March
OPENING BUSINESS															
Apologies for Absence	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Standing Item	**Approval**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising / Action log	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
STANDING ITEMS															
Staff Story	Quarterly	**Noting**	CPO	√			√			√			√		
Deep Dive	Monthly	**Assurance**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
Hot Topic	As required	**Assurance**	CPO	√	√	√		√	√	√	√	√	√	√	√
BAF & Corporate Risk Register - Workforce	Bi-Monthly	**Assurance/ Approval**	CS				√			√			√		
Chief People Officer Report (including Agenda for Change Update (including rebanding/banding creep/B5 work/Integration/new roles, re-banding or related changes)	Monthly	**Assurance**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
Workforce Brief on National, Regional, ICB, or Local Workforce Issues	Monthly	**Assurance**	CPO/DCPO	√	√	√	√	√	√	√	√	√	√	√	√
Better Care Together - Post Integration Plan Update (PTIP) and Due Diligence Update	Monthly	**Assurance**	CPO/CS&PO				√			√			√		
Workforce Integrated Performance Report	Bi-Monthly	**Assurance**	DCPO		√		√		√		√		√		√
Workforce Integrated Performance Recommendations	Annually	**Assurance**	DCPO											√	
People Strategy Update	Bi-Annually	**Assurance**	DCPO							√ **Bi-annual Report**					√ **Bi-annual Report**
Staff Survey - Organisational Priorities Update	Quarterly	**Assurance**	CPO				√			√			√		
Equality, Diversity and Inclusion Strategy Update	Bi-Annually	**Assurance**	DCPO					√						√	
Culture Plan Update	Bi-Annually	**Assurance**	CPO						√ **Bi-annual Report**						√ **Bi-annual Report**
Workforce Policies and Procedures Overview Report	Bi-Annually	**Assurance**	DCPO		√ **(Q3&Q4)**						√ **(Q1&Q2)**				
Workforce Plan Update	Monthly	**Assurance**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
Improving People Practices Report (including Employee Relations data)	Bi-Annually	**Assurance**	CPO			√ **Bi-annual Report**						√ **Bi-annual Report**			
National Staff Opinion Survey	Annually	**Assurance**	CPO												√
Freedom to Speak Up Report	Bi-Annually	**Assurance**	CFO/FTSUG		√ **Bi-annual Report**						√ **Bi-annual Report**				
Health and Wellbeing Update (including the Health & Wellbeing Guardian Report)	Bi-Annually	**Assurance**	CPO/ H&WBG			√ **Bi-annual Report**						√ **Bi-annual Report**			
Safer Staffing Report – Key Issues Report to include Red Flag data quarterly	Monthly	**Assurance**	CN	√ **(Q4 Red Flag Data)**	√	√	√ **(Q1 Red Flag Data)**	√	√	√ **(Q2 Red Flag Data)**	√	√	√ **(Q3 Red Flag Data)**	√	√
Volunteer Report	Annually	**Assurance**	CN		**Deferred**	√									
Internal Audit Action Plans	As required	**Assurance**	DCPO	√	√	√	√	√	√	√	√	√	√	√	√
NATIONAL/ STATUTORY REPORTS															
Midwifery Staffing Report	Quarterly	**Assurance**	CN/DoM			√ **Q4**		√ **Q1**			√ **Q2**			√ **Q3**	
General Medical Council (GMC) National Trainee Survey	Annually	**Assurance**	EMD						√						
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA) and Respsonsible Officer Annual Report	Annually	**Assurance**	EMD						√						

NHSE Self Assessment Report for Education and Training	Annually	**Assurance**	CPO								√				
National Education and Training Survey (NETS) Report	Annually	**Assurance**	CPO		**Deferred**										
Guardian of Safe Working Hours Report	Quarterly	**Assurance**	EMD		√ **Q4**			√ **Q1**			√ **Q2**			√ **Q3**	
Guardian of Safe Working Annual Report	Annually	**Assurance**	EMD				√								
Resident Doctors Improving Workers Lives	Annually	**Assurance**	EMD								√				
EQUALITY DIVERSITY & INCLUSION – REGULATED REPORTS															
EDI Annual Report (Public Sector Equality Reporting – Patients and Workforce) – including: - Equality Duty Assurance Report - Workforce Equality Assurance Report - Pay Gap Reporting (Race and Disability) - National EDI Improvement Plan - Anti-Racism Framework Update	Annually	**Approval**	ACPO												√
Equality Delivery System (EDS)	Annually	**Approval**	ACPO										√		
Gender Pay Gap Report	Annually	**Approval**	ACPO		**Deferred**		√								
Workforce Race Equality Standard (WRES) including Bank and Medical Workforce Race Equality Standard	Annually	**Approval**	ACPO					√							
Workforce Disability Equality Standard (WDES)	Annually	**Approval**	ACPO					√							
GOVERNANCE															
Terms of Reference	Annually	**Approval**	CS					√ **Review**							√
Annual Cycle of Business	Annually	**Approval**	CS	√											
Committee Chairs Annual Report to Trust Board to include Annual Review of BAF Risks	Annually	**Approval**	Chair/CS			√									
Committee Effectiveness – Annual survey	Annually	**Assurance/Approval**	CS						√						
SUB-COMMITTEE CHAIR'S LOGS															
Workforce EDI Improvement Plan Sub-Committee	Bi monthly	**Noting**	CPO		√		√		√		√		√		√
People Delivery Sub-Committee	Bi-monthly	**Noting**	CPO			√		√		√		√		√	√
CLOSING MATTERS															
Review of Meeting	Monthly	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√

North Cheshire and Mersey
NHS Foundation Trust

FINANCE, SUSTAINABILITY AND PERFORMANCE COMMITTEE
CYCLE OF BUSINESS 2026/27

CALENDAR YEAR (APRIL 26 - MARCH 27)				2026									2027		
AGENDA ITEM	**Reporting Frequency**	**Process**	**LEAD**	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
INTRODUCTION & ADMINISTRATION															
Apologies for Absence	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Business Cycle	Monthly Standing Item or as	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the Last Meeting & Action Log	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Rolling attendance log + cycle of business	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
GOVERNANCE & COMPLIANCE															
Hot Topic	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Deep Dive	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Committee Terms of Reference	Annually	For Approval	**Company Sec**												√
Committee Cycle of Business	Annually	For Approval	**Company Sec**												√
Pay Assurance Report	Monthly	For assurance	**CPO**	√		√		√		√		√		√	
Board Asssurance Framework & Risk Register	Monthly	For Approval	**Company Sec**				√			√			√		
Annual Review of BAF & Risk Register	Annually	For Assurance	**Company Sec**				√								
PAF Review and Refresh of Trust KPIs	Annually	For Assurance	**CFO**												√
Committee Effectiveness Review and follow up report	Annually	For Assurance	**Chair/Company Sec**						√	√					
Annual Chair's Report to the Board	Annually	For Assurance	**Chair/Company Sec**				√								
Sustainability Strategic Priorities Update	Bi-Annually	For Assurance	**Chief Strategy & Partnerships Officer**		√						√				
Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance	Annually	For Assurance	**COO**							√					
Minutes/Action Log of the EPR Procurement Oversight Group	Monthly	For Assurance	**COO**	√	√	√	√	√	√	√	√	√	√	√	√
PERFORMANCE															
Corporate Performance Report	Monthly	For Assurance	**COO**	√	√	√	√	√	√	√	√	√	√	√	√
Winter Plan	Annually	For Assurance	**COO**						√						
Estates Strategy 2024-29 Progress Report	Bi-Annually	For Assurance	**COO**		√						√				
Recovery Updates	Monthly	For Assurance	**COO & CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Digital Strategy Group	Monthly	For Assurance	**CIO&SIRO**	√	√	√	√	√	√	√	√	√	√	√	√
SIRO (Senior Information Risk Owner) Report	Annually	For Assurance	**CIO&SIRO**						√						
FINANCIAL ASSURANCE															
Monthly Finance report, Finance + Resources Group Minutes & Capital Planning Group Minutes	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Cost Pressures	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Capital Planning Group Annual Report	Annually	For Assurance	**COO/Dep CEO**				√								
Monthly CIP	Monthly	For Assurance	**CFO/EMD/DofS&P**	√	√	√	√	√	√	√	√	√	√	√	√
Monthly Productivity Improvement Update	Monthly	For Assurance	**DCFO**	√	√	√	√	√	√	√	√	√	√	√	√
Indicative Financial cost of harm annual report	Annually	For Assurance	**EMD/CS&PO**		√										
Capital Expenditure Approvals (schemes above £500k) wef May	Monthly	For Assurance	**Exec Lead**	√	√	√	√	√	√	√	√	√	√	√	√
Cash Support Update	Quarterly	For Assurance	**CFO**		Q1			Q2				Q3			Q4
Elective Restoration Update	Quarterly	For Assurance	**COO**				Q1			Q2			Q3		

Benefits Realisation Quarterly Report	Quarterly	For Assurance	**CFO**		Q4			Q1				Q2		Q3	
Costing Update	As per business cycle	For assurance	**CFO**			Q4							Q1 & Q2 Bi Annual		Q3
Cash Position Update	Monthly	For assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Delivery Unit report - escalation committee, pay, non-pay and performance	Monthly	For information	**CFO**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Workforce Review Group Quarterly Report	Quarterly	For Assurance	**EMD**		deferred	✓		Q1			Q2			Q3	
Use of Resources Annual Report	**on hold**		**CFO**												
INVESTMENT															
Annual Capital Programme	Annually	For Assurance	**CFO**											√	
PLANNING															
Operational Plan & Budgets	Annually	For Approval	**CFO**	x										**X** Draft 2026/27	**X** Final 2026/27
MISC															
Integration and Due Diligence Update	Monthly	For Noting	**Chief Strategy & Partnerships Officer**				√			√			√		
CLOSING															
Items for Escalation to the Trust Board &	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Review of Meeting	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Any Other Business	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Next Meeting Date & Time	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√

North Cheshire and Mersey
NHS Foundation Trust

AUDIT COMMITTEE – CYCLE OF BUSINESS
2026/27

CALENDAR YEAR APRIL 2026 - MARCH 2027										
AGENDA ITEMS	**Reporting Frequency**	**Process**	**Lead**	**2026**					**2027**	
OPENING BUSINESS				**23-Apr**	**30-Apr**	**22-Jun**	**27-Aug**	**26-Nov**	**25-Feb**	
Welcome, apologies, declarations of interest, cycle of business, rolling attendance log	Standing Item	Noting	**Chair**	✓	✓	✓	✓	✓	✓	
Review Minutes and Action Log	Standing Item	Approval	**Chair**		✓	✓	✓	✓	✓	
QPS ASSURANCE										
Update from Chairs of F&SC QAC CFC SPC	Standing Item	For assurance	**JS/CR/AC/JJ**		✓		✓	✓	✓	
Changes or Updates to BAF	Standing Item	For assurance/approval	**Company Secretary**		✓		✓	✓	✓	
INTERNAL AUDIT										
Internal Audit Plan & Fees	Annually	For assurance	**MIAA**						✓	
Progress Report on Internal Audit follow-Up actions	Monthly	For assurance	**Chief Finance Officer**		✓		✓	✓	✓	
Internal Audit Progress Report on Follow-Up actions	Monthly	For assurance	**MIAA**				✓	✓	✓	
Internal Audit Progress Report	Monthly	For assurance	**MIAA**				✓	✓	✓	
Head of Internal Audit Opinion	Annually	For Approval	**MIAA**		✓					
Internal Audit Charter Annual Report	Annually	For Approval	**MIAA**		✓					
EXTERNAL AUDIT										
External Audit Plan & Fees	Bi-Annually	For Approval	**GT**		✓				✓	
Report and Updates from External Audit		For assurance	**GT**		✓		✓	✓	✓	
Audit Findings Report	Annually		**GT**			✓				
Auditor's Annual Report	Annually		**GT**			✓				
Annual Audit Letter (AC following year-end Audit Cttee)	Annually	For Approval	**GT**				✓			
Renewal/Refresh of External Audit Contract (at term)	Annually	For Approval	**GT/AMcG/JC**				✓			
COUNTER FRAUD										
FINAL Annual Counter Fraud Plan	Annually	For Approval	**MIAA**						✓	
Counter Fraud Progress Updates	Monthly	For assurance	**MIAA**				✓		✓	
Annual Counter Fraud Annual Report	Annually	For Approval	**MIAA**		✓					
FINANCE										
Review Losses & Special Payments	Monthly	For assurance	**Chief Finance Officer**		✓		✓	✓	✓	
Review Quotation and Tender Waivers of Standing Financial Instructions	Monthly	For assurance	**Assoc Director of Finance**		✓		✓	✓	✓	
Going Concern Report	Annually	For assurance	**Chief Finance Officer**	✓						
QPS GOVERNANCE AND COMPLIANCE										
Annual report and accounts timetable and plans	Annually	For assurance	**Chief Finance Officer**						✓	
Draft Annual Governance Statement	Annually	For assurance	**Company Secretary**		✓					
Draft Annual Report	Annually	For assurance	**Chief Executive**	✓						
Draft unaudited Accounts & Financial Statements	Annually	For assurance	**Chief Finance Officer**	✓						
Annual Report	Annually	For Approval	**Chief Executive**			✓				
Quality Account	Annually	For Approval	**Dir Integrated Gov**			✓				
Draft Annual accounts accounting policies	Annually	For assurance	**Chief Finance Officer**						✓	
FINAL and Audited Accounts & Financial Statements	Annually	For Approval	**Chief Finance Officer**			✓				
To accompany Annual Accounts 1) TAC confirmation schedule 2) Trust Accounts Consolidated Certificate 3) Letter of Representation	Annually	For assurance	**Chief Finance Officer**			✓				
Review of Schemes Reservation & Delegation (SoRD) & Standing Financial Instructions (SFIs)	Annually/as required	For Approval	**CFO/Company Secretary**					✓		
Review other reports and policies as appropriate – e.g. changes to standing orders – as arise			**ALL**							
Code of Governance Compliance + Compliance with Licence Annual Return – Condition G6 & CoS 7	Annually	For Approval	**Company Secretary**			✓				
Risk Management Annual Report update	Annually	For Approval	**Chief Nurse**				✓			
Code of Governance Compliance Declaration – e.g. changes as required	As required	For Approval	**Company Secretary**							
Review of Trust Registers (e.g. Conflicts of Interest)	Annually	For Approval	**Company Secretary**		✓					
Fit & Proper Persons Test Annual Report	Annually	For assurance	**Company Secretary**			✓				
Cycle of Business and Terms of Reference Annual Review	Annually	For assurance	**Company Secretary**		✓				✓	
On-Call and Overtime Annual Update Report	Annually	For assurance	**Chief People Officer**				✓			
NW Skills Network Bi-Annual Report	Bi-Annually	For Assurance	**Chief Finance Officer**				✓		✓	
EFFECTIVENESS										
Committee Chairs Annual Report (for Trust Board & Council of Governors)		For assurance	**Chair**				✓			
Committee Effectiveness - annual review	Annually	For assurance	**Company Secretary/Chair**				**✓advise of survey**	✓		
DEEP DIVE REVIEWS										
Commission and receive ANY additional scrutiny projects										
CLOSING										
Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually			**Chair**						✓	
Any Other Business			**Chair**	✓	✓	✓	✓	✓	✓	

North Cheshire and Mersey
NHS Foundation Trust

Trust Board Cycle of Business 2026-27									
	Frequency		Lead	01-Apr	04-Jun	05-Aug	07-Oct	02-Dec	03-Feb
				2025					2026
Engagement Story	**frequency**	**Sup Pack**	**Chief Nurse Head of Patient Experience and Inclusion**	**X**	**X**	**X**	**X**	**X**	**X**
Opening Business									
Chairman's Welcome, Apologies & Declarations	Standing Item		**Chair**	**X**	**X**	**X**	**X**	**X**	**X**
Minutes of Previous Meeting(s) & Action Log	Standing Item		**Chair**	**X**	**X**	**X**	**X**	**X**	**X**
Chief Executive's Report	Standing Item		**Chief Exec**	**X**	**X**	**X**	**X**	**X**	**X**
Chairman's Report	Standing Item		**Chair**	**X**	**X**	**X**	**X**	**X**	**X**
QPS Assurance									
Integrated Performance Dashboard **inc Cash Support**	Standing Item		**Execs**	**X**	**X**	**X**	**X**	**X**	**X**
Refresh of Trust Integrated KPIs (formal signing in May)	Annually		**Chief Finance Officer**	**X**					
Performance Assessment Framework (PAF)/ Review (formal signing in May)	Annually		**Chief Finance Officer**	**X**					
Quality									
Complaints Report	Annually		**Chief Nurse**		**X**				
Learning From Experience Summary Report	Quarterly	✓	**Chief Nurse**	**Q3**		**Q4**	**Q1**	**Q2**	
Health & Safety Report	Annually	✓	**Chief Nurse**			**X**			**X**
Director of Infection Prevention & Control Annual Report (DIPC)	Annually	✓	**Chief Nurse**			**X**			
Infection Prevention & Control Update	Quarterly	✓	**Chief Nurse**	**Q3**	**Q4**		**Q1**	**Q2**	
Mortuary Update	Bi-Annually		**Chief Nurse**			**X**			**X**
Infection Prevention and Control Board Assurance Framework Compliance	Bi-Annually	✓	**Chief Nurse**			**X**			**X**
Safeguarding Report	Annually	✓	**Chief Nurse**			**X**			
Compliance Update (CQC)	Quarterly		**Chief Nurse**	**XQ3**		**XQ4**	**XQ1**	**XQ2**	
Learning from Deaths	Quarterly	✓	**Executive Medical Director**	**XQ3**		**XQ4**	**XQ1**		**XQ2**
Medicines Management	Annually	✓	**Executive Medical Director**			**X**			
Controlled Drugs Annual Report	Annually	✓	**Executive Medical Director**			**X**			
Safe Nurse Staffing	Bi-Annually	✓	**Chief Nurse**			**X**			**X**
Violence Reduction Strategy	Bi-Annually	✓	**Chief Operating Officer**			**X**			**X**
Patient Experience 6 Monthly Report – Patient Experience Sub-committee (PESC) no includes in Patient Survey Dec Report)	Bi-Annually	✓	**Chief Nurse**		**X**			**X**	
Fragile Clinical Services Update	Bi-Monthly		**Chief Nurse & Executive Medical Director**	**X**	**X**	**X**	**X**	**X**	**X**
Quality Strategy Update	Annually		**Chief Nurse**	**X**			**X**		
Quality - Maternity Papers									
Maternity Summary Report	Bi-Monthly		**Director of Midwifery**	**X**	**X**	**X**	**X**	**X**	**X**
Cheshire & Merseyside Perinatal Mortality Report (PMRT)	Quarterly			**Q3**	**Q4**		**Q1**	**Q2**	
Avoiding Term Admission into Neonatal Unit (ATAIN)	Quarterly			**Q3**		**Q4**	**Q2**		**✓Q2**
Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	Monthly			✓	✓	✓	✓	✓	✓
Maternity Self Assessment Tool	Bi-Annually				✓			✓	
Maternity & Neonatal Quality Review Report (includes TC Audit as appendix)	Monthly			✓	✓	✓	✓	✓	✓
Review of Harm Events	Bi-Annually				✓		✓		
Post Partum Haemorrhage (Audit)	Bi-Annually			✓			✓		
CQC Maternity Survey	Annually			✓					
MNVP biannual report	Bi-Annually			✓			✓		
People									
NHS National Staff Opinion Survey	Annually		**Chief People Officer**	**X**					
GMC Re-validation Annual Report inc Statement of Compliance	Annually		**Executive Medical Director**				**X**		
Communications & Engagement Report	Quarterly		**Director of Comms & Engagement**	**X**	**X**	**X**	**X**	**X**	**X**
Guardian of Safe Working Report	Quarterly	✓	**Executive Medical Director**	**XQ3**	**X Q4**		**X Q1**	**XQ2**	
Guardian of Safe Working Annual Report	Annually	✓	**Executive Medical Director**			**X**			
Workforce Race Equality Standard (WRES) Annual Report 2024/25 Workforce Disability Equality Standard (WDES) Annual Report 2024/25	Annually		**Chief People Officer**				**X**		
Freedom To Speak Up Guardian Report	Bi-Annually		**Freedom to Speak Up Guardian**		**X**			**X**	
Hospital Volunteer Report	Annually	✓	**Chief Nurse**				**X**		
Gender Pay Gap Annual Report	Annually		**Chief People Officer**		**X**				
Health & Wellbeing Report	biannual	✓	**Chief People Officer**			**X**			**X**
Finance, Sustainability and Performance									
Operational Plan & Budgets Approval	Annually		**Chief Finance Officer**		**X**				
Capital Programme	Annually		**Chief Finance Officer**	**X**					
Emergency Preparedness Report	Annually		**Chief Operating Officer**			**X**			
EPRR Assurance Letter/Statement of Compliance	Annually	✓	**Chief Operating Officer**					**X**	
Strategy Programme Highlight Report (on hold whilst Strategy is under review)	Bi-Monthly		**Director of Strategy & Partnerships**	**X**	on hold	**X**	**X**	**X**	**X**
Strategy Bi-annual Delivery Report	Bi-Annually		**Director of Strategy & Partnerships**			**X**			**X**
Senior Information Risk Owner Report	Annually	✓	**Chief Information Officer**				**X**		
Use of Resources Annual Report (on hold see FSPC CoB)			**Chief Finance Officer**						
Committee Assurance Reports									
Audit Committee	Bi-Monthly		**Company Secretary**	**X**	**X**	**X**	**X**	**X**	
Quality Assurance Committee	Bi-Monthly		**Chief Nurse**	**X**	**X**	**X**	**X**	**X**	**X**
Finance & Sustainability Committee	Bi-Monthly		**Chief Finance Officer**	**X**	**X**	**X**	**X**	**X**	**X**
Strategic People Committee	Bi-Monthly		**Chief People Officer**	**X**	**X**	**X**	**X**	**X**	**X**
Charitable Funds Committee	Quarterly		**Director of Comms and Engagement**	**X**		**X**			**X**
Year End									
Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7	Annually		**Company Secretary**		**X Cos7**				
Code of Governance Compliance & Compliance with Licence Annual report (for Year End / Audit Committee)	Annually					**Yr End Audit**			

Governance									
Strategic Risk & BAF (Q4 will go June 2027)	Bi-Monthly		**Company Secretary**	**Q4**		**Q1**		**Q2**	**Q3**
Annual Review of BAF & Risk Appetite Statement	Annually			**X**					
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	Annually		**Chief Finance Officer**					**X**	
Risk Management Strategy Report	Annually		**Chief Nurse**			**X**			
Board Cycle of Business (typically to go April)	Annually		**Company Secretary**		**X**				
Board Sub-Committee Cycle of Business and Terms of Reference	Annually		**Company Secretary**	TORs only COBs Deffered	COBs and Audit ToR				
Charitable Funds Committee Governing Document & Cycle of Business	Annually	✓	**Chair/Company Secretary**	**X**					
Charities Commission Checklist	Annually		**Director of Comms & Engagement**						**X**
WHH Charity Annual Report	Annually		**Director of Comms & Engagement**						**X**
Board Effectiveness Review	Annually		**Chair/Company Secretary**						**X**
Approval of Constitution Changes	Ad Hoc		**Company Secretary**	**X**					
Governor Elections Results	Annually		**Company Secretary**					**X**	
Council of Governors ToR and CoB	Annually		**Company Secretary**		**X**				
Fit and Proper Persons Test - Annual Report on Board Members (audit)	Annually		**Chair/Company Secretary**			**X**			
Committee Chairs Annual Reports									
Quality Assurance Committee	Annually		**Chair**			**X**			
Finance & Sustainability Committee	Annually		**Chair**			**X**			
Audit Committee	Annually		**Chair**			**X**			
Strategic People Committee	Annually		**Chair**			**X**			
Closing Business									
Review of Meeting	Standing Item		**Chair**	**X**	**X**	**X**	**X**	**X**	**X**
Any other Business & Date of next meeting	Standing Item		**Chair**	**X**	**X**	**X**	**X**	**X**	**X**

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/06/036**			
Subject:	**NCM Council of Governors** - **Terms of Reference** - **Cycle of Business**			
Date of meeting:	3 June 2026			
Action required:	**Approval**			
Author(s):	Emily Kelso, Head of Corporate Governance			
Executive director sponsor:	Nikhil Khashu, Chief Executive John Culshaw, Company Secretary			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	Following the establishment of North Cheshire and Mersey NHS Foundation Trust, the Council of Governors (CoG) operates as a statutory body in accordance with the Trust's Constitution and the requirements set out in Schedule 7 of the National Health Service Act 2006 (as amended). In line with good governance practice, the Council of Governors is required to review and refresh its Terms of Reference (ToR) and Cycle of Business (CoB) on an annual basis to ensure these remain fit for purpose, constitutionally compliant, and supportive of the Council's statutory role and responsibilities. The proposed 2026/27 Terms of Reference and Cycle of Business have been updated to: • ensure full alignment with the Constitution of North Cheshire and Mersey NHS Foundation Trust;			

<table>
<tr><td></td><td colspan="3">• avoid duplication by referring directly to relevant constitutional provisions where appropriate; and
• provide greater clarity and conciseness while maintaining fidelity to the statutory duties, powers and limitations of the Council of Governors.

No new powers or responsibilities have been introduced through these changes. The revisions are intended to clarify and rationalise existing arrangements and to ensure consistency with the Constitution.

The updated Terms of Reference and Cycle of Business were considered and supported by the Council of Governors at its meeting on 12 May 2026. They are now presented to the Trust Board for formal approval in line with the Trust's governance arrangements.

The refreshed Terms of Reference and Cycle of Business are attached at Appendices 1 and 2.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to:
• approve the refreshed Terms of Reference for the North Cheshire and Mersey Council of Governors; and
• approve the associated Cycle of Business for 2026/27.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Council of Governors</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">COG/26/05/013i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">12 May 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">supported</td></tr>
<tr><td>Next steps:</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

Terms of reference – Council of Governors

1. Purpose

The Council of Governors is a statutory body established under Schedule 7 of the National Health Service Act 2006 as amended by the Health & Social Care Act 2012 and operates in accordance with the **Constitution of North Cheshire and Mersey NHS Foundation Trust**.

The Council of Governors has two principal aims:

- To **hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors**; and
- To **represent the interests of members of the Trust as a whole and the interests of the public**.

This Terms of Reference must be read alongside the Trust's Constitution and does not override any constitutional provision.

2. Authority and Status

The Council of Governors exercises only those powers explicitly conferred by:

- National Health Service Act 2026 (as amended); and
- The Trust's Constitution.

The Council of Governors may not exercise executive powers or become involved in the day-to-day management of the Trust.

The Council of Governors discharges its duties collectively through formal meetings. Only the **Council of Governors meeting as a whole**, and the **Nominations and Remuneration Committee (as a formal committee of the Council)**, have decision-making authority. All other forums, groups or engagement mechanisms are advisory.

Approved Trust Board: TBC:

Approved: CoG 12.05.2026

3. Membership

The composition of the Council of Governors, including the number and categories of elected and appointed governors, is set out in **Annex 4 of the Constitution**.

The **Chair of the Trust (Chair of the Board of Directors)** presides at meetings of the Council of Governors in accordance with the Constitution and Standing Orders. In the absence of the Chair, the **Deputy Chair** acts in accordance with the Constitution.

4. Meetings

The Council of Governors will meet at least **four times per year**.

Meetings shall be conducted in accordance with:

- The Constitution; and
- The **Standing Orders for the Practice and Procedure of the Council of Governors (Annex 7)**.

Meetings of the Council of Governors shall be held in public, except where the Council resolves to exclude the public for special reasons, as permitted by the Constitution.

5. Quorum

The quorum for meetings of the Council of Governors is as set out in the Constitution:

- At least **one-third of all governors** must be present; and
- At least **five elected governors** must be present.

Where a governor is excluded from discussion or voting due to a declared conflict of interest, they shall not count towards the quorum for that item.

6. Core Duties and Responsibilities

The Council of Governors shall discharge the following duties, strictly in accordance with the Constitution.

6.1 Holding Non-Executive Directors to Account

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

- Agree and maintain appropriate processes and dialogue with the Board to enable effective challenge and assurance.
- Require one or more directors to attend meetings to provide information where necessary, as a last resort.

6.2 Appointments, Remuneration and Audit

- Appoint and, where appropriate, remove the Chair and other Non-Executive Directors.
- Decide the remuneration, allowances and other terms and conditions of office of the Chair and Non-Executive Directors.
- Appoint or remove the Trust's external auditor and approve the auditor's terms of engagement.
- Approve the appointment of the Chief Executive (other than the initial appointment).

All such functions shall be exercised in accordance with the Constitution and the recommendations of the Council of Governors' Nominations and Remuneration Committee.

6.3 Constitution and Regulatory Oversight

- Jointly approve amendments to the Trust's Constitution with the Board of Directors, in accordance with constitutional requirements.
- Present amendments affecting the role or powers of the Council of Governors to Members at the Annual Members' Meeting where required.
- Notify NHS England, via the Lead Governor, where the Council has unresolved concerns that the Trust may be failing to comply with its licence or statutory obligations.

6.4 Strategy, Planning and Significant Transactions

- Provide advice and feedback to the Board on the Trust's strategic direction and forward plans.
- Determine whether proposed non-NHS income-generating activity would interfere with the Trust's principal purpose and notify the Board accordingly.
- Approve increases of 5% or more in non-NHS income.
- Approve or reject proposals for mergers, acquisitions, separations, dissolutions or significant transactions, as defined in the Constitution.

6.5 Representing Members and the Public

- Represent the interests of Trust members and the public.
- Approve and oversee the Membership Strategy.
- Engage with members, patients, the public and partner organisations.
- Act as ambassadors for the Trust and promote membership.
- Report annually on the performance and effectiveness of the Council of Governors.

7. Governor Conduct, Skills and Development

Governors shall:

- Comply with the Trust's **Code of Conduct for Governors** and the Nolan Principles;
- Declare and manage conflicts of interest in accordance with the Constitution;
- Participate in induction, development and training as set out in the Membership Strategy;
- Act collectively, constructively and in the best interests of the Trust.

The Trust shall take steps to ensure governors are equipped with the skills and knowledge required to fulfil their role.

8. Committees and Working Groups

The Council of Governors shall establish:

- A **Nominations and Remuneration Committee**; and
- Such other committees or task-and-finish working groups as required.

Committees operate under approved Terms of Reference and may not exercise powers beyond those delegated by the Council in accordance with the Constitution.

9. Attendance and Removal

Governors are expected to meet attendance requirements (75% of meetings) as set out in the Constitution.

Removal, suspension or disqualification of governors shall be dealt with strictly in accordance with the Constitution and its annexes.

10. Administrative Support

The Council of Governors shall be supported by the Company Secretary and Corporate Governance team, who will:

- Agree agendas with the Chair;
- Produce and circulate papers;
- Maintain records, action logs and registers.

11. Review

These Terms of Reference shall be reviewed **annually** to ensure ongoing compliance with legislation, the Constitution and best practice.

Terms of reference revision tracker

Name of committee:	Council of Governors
Version:	V1 NCM
Implementation date:	15 May 2026
Review date:	15 May 2027
Approved by:	Council of Governors, Trust Board
Approval date:	12 May 2026 – CoG, TB TBC

Revisions			
Date	**Section**	**Reason on change**	**Approved**

Terms of reference obsolete		
Date	**Reason**	**Approved by:**
15 May 2025	This revised Council of Governors Terms of Reference (ToR) has been updated to ensure full alignment with the duties, powers and responsibilities of Governors as set out in the Constitution of North Cheshire and Mersey NHS Foundation Trust (effective 1 April 2026), in particular: • Paragraphs 18–19 of the Constitution (Council of Governors – duties and meetings) • Annex 6 – Additional Provisions (Roles, Responsibilities and Conduct of Governors) • Paragraphs 28, 30, 31, 37, 42, 45, 49 of the Constitution (appointments, remuneration, auditor, forward plan, non-NHS income and significant transactions) No duties have been added or removed beyond those conferred in the Constitution; wording has been clarified, strengthened or rationalised to avoid duplication, inconsistency, or ambiguity.	TBC CoG 12 May 2026 Trust Board TBC

North Cheshire and Mersey
NHS Foundation Trust

NCM Council of Governors Cycle of Business 2026/27						
	Lead	**May-26**	**Aug-26**	**AMM 09/10/2026**	**Nov-26**	**Feb-27**
OPENING						
Chair's Opening Remarks & Welcome	**Chair**	**X**	**X**		**X**	**X**
Apologies & Declarations of Interest	**Chair**	**X**	**X**		**X**	**X**
Minutes of Previous Meeting	**Chair**	**X**	**X**		**X**	**X**
Action Log	**Chair**	**X**	**X**		**X**	**X**
GOVERNOR BUSINESS						
Lead Governor Update	**Lead Governor**	**X**	**X**		**X**	**X**
Items Requested by Governors - Governor Questions	**Lead Governor**	**X**	**X**		**X**	**X**
Annual Appraisal of Non-Executive Directors	**Lead Governor**		**X**			
Annual Appraisal of Trust Chairman	**Lead Governor**		**X**			
GNARC Ratification of NED Appointments (as required)	**Lead Governor**					
Governor Engagement Group - Chair's Report	**Chair GEG**	**X**	**X**		**X**	**X**
Board Committee Observations, Trust Board/SPC/CFC/Audit/FSPC/QSAC/	**Nominated Govs**	**X**	**X**		**X**	**X**
Board Committee Assurance Reports	**NEDs**	**X**	**X**		**X**	**X**
Membership Strategy Progress Quarterly Report	**Head of Corporate Governance**	**Q4**	**Q1**		**Q2**	**Q3**
Governor Engagement Group Terms of Reference & Cycle of Business	**Chair GEG**	**X CoB & ToR**				
TRUST BUSINESS						
Chief Executives Report	**CEO**	**X**	**X**		**X**	**X**
Chair's Update	**Chair (V)**	**X**	**X**		**X**	**X**
Trust Operational Plan	**CFO**	**X**				
Annual Reports & Accounts including Auditors Letter and Report on Quality Account	**GT Auditors**		**X**			

Quality Account	**Deputy Chief Nurse Director of Clinical Governance**		**X**			
Communications & Engagement Update	**Dir Comms & Engagement**	**X**	**X**	**X**	**X**	**X**
Bi-monthly Strategy Programme Highlight Report	**Chief Strategy & Partnerships Officer**	**X**	**X**	**X**	**X**	**X**
GOVERNANCE						
Council of Governors Cycle of Business + ToR	**Company Secretary**	**X**				
Appointment of External Auditors (as required)	**Company Secretary**					
Compliance Trust Provider Licence (bi-annually)	**Company Secretary**				**X**	
Elections Activity Bi-Annual Report : Vacancies & Governors Terms of Office as rq'd	**Company Secretary**		**X**		**X**	
Governor Training & Development Programme	**Company Secretary**	**X**				
Audit Committee Chairs Annual Report & review of Audit Committee Terms of Reference	**Chair Audit Cte**				**X**	
Annual Council of Governors Effectiveness Survey	**Company Secretary**				**X**	
Fit and Proper Person Requirements for Board members - Compliance Report (Audit Committee in June)	**Company Secretary**		**X**			
Lead Governor role (every two years, last done Feb 2024)	**Company Secretary**					
SUPPLEMENTARY PAPERS						
Workforce Race Equality Standard (WRES) Update (legislative requirement) & WDES Workforce Disability Equality Standard - 6 month update report	**Chief People Officer**	**X**				
WHH People Strategy Bi-annual Update (s)	**Chief People Officer**		**X**		**X**	
Learning From Experience Update	**Chief Nurse**	**X Q3**	**X Q4**		**X Q1**	**X Q2**
OTHER BUSINESS / CLOSING						
Annual Members Meeting	**Company Secretary**			**X**		