NHS
Wirral University Teaching Hospital
NHS Foundation Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Notice of Meeting

This meeting will constitute both Boards of Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health & Care NHS Foundation Trust (WCHC). The matters will be considered separately by both Boards and any decisions recorded as such.

Meeting	WUTH and WCHC Board of Directors in Public
Date	Wednesday 3 December 2025
Time	09:00 – 12:30
Location	Hybrid

Agenda Item		**Lead**	**Presenter**
1.	Welcome and Apologies for Absence	Steve Igoe	
2.	Declarations of Interest	Steve Igoe	
3.	3.1 Minutes of the Previous Meeting – WUTH 3.2 Minutes of the Previous Meeting – WCHC	Steve Igoe	
4.	Action Logs	Steve Igoe	
Standing Items			
5.	Patient Story	Claire Wedge	
6.	Acting Joint Chair Update – **Verbal**	Steve Igoe	
7.	Joint Chief Executive Officer Report	Janelle Holmes	
8.	WCHC Integrated Performance Report	Executive Directors	
9.	WUTH Integrated Performance Report	Executive Directors	
10.	WUTH Joint Chief Finance Officer Report	Mark Chidgey	
11.	WUTH Joint Executive Managing Director Report	Hayley Kendall	
12.	WUTH Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
13.	WCHC Board Assurance Framework (BAF) – *to approve*	Ali Hughes	
14.	WUTH Lead Governor Report – **Verbal**	Sheila Hillhouse	

15.	WCHC Lead Governor Report – **Verbal**	Lynn Collins	
Committee Chairs Reports			
16.	WUTH Estates and Capital Committee	Steve Igoe	
17.	WUTH Charitable Funds Committee	Lesley Davies	
18.	WUTH Quality Committee	Dr Steve Ryan	
19.	WUTH Finance Business Performance Committee	Dr Steve Ryan	
20.	WCHC Quality and Safety Committee	Professor Chris Bentley	
Regulatory Reports			
21.	WUTH Quarterly Maternity and Neonatal Services Report	Julie Roy	Jo Lavery
22.	WUTH Organ Donation Annual Report 2024/25	Dr Nikki Stevenson	
23.	WUTH Learning from Deaths Report Q1 2025/26	Dr Nikki Stevenson	
24.	WCHC Learning from Deaths Report Q1 2025/26	Dr Nikki Stevenson	
25.	WCHC Controlled Drugs Annual Report 2024/25	Dr Nikki Stevenson	
26.	WCHC EPRR Core Standards Annual Self-Assessment	Hayley Kendall	
Closing Business			
27.	Questions from Governors and Public	Steve Igoe	
28.	Meeting Review	Steve Igoe	
29.	Any other Business	Steve Igoe	
Date and Time of Next Meeting			
Wednesday 28 January, 09:00 – 12:30			

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	WUTH Board of Directors in Public
Date	Wednesday 5 November 2025
Location	Hybrid

Members present:

SI	Steve Igoe	Acting Joint Chair
SL	Sue Lorimer	Non-Executive Director
SR	Dr Steve Ryan	Joint Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
NS	Dr Nikki Stevenson	Medical Director
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer

In attendance:

CW	Claire Wedge	WCHC Deputy Chief Nurse
RC	Robbie Chapman	WCHC Interim Chief Finance Officer
JC	Dr Joanne Chwalko	WCHC Chief Operating Officer & Interim Deputy CEO
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
RT	Robert Thompson	WUTH Deputy Lead Public Governor

Apologies:

SW	Sam Westwell	Chief Nurse
SH	Sheila Hillhouse	Lead Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed members to the meeting, which was held jointly with the WCHC Board of Directors. Members of that Board are listed as attendees. Apologies are noted above. SI thanked SL, who was stepping down, for her contributions as a Board member during the past 8 years.	
2	**Declarations of Interest**	

	No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 1 October were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story highlighting the success of the WUTH Leadership Conference held earlier in the year. The video story described the experience of staff who attended which had been positive. The Board **NOTED** the video story.	
6	**Acting Joint Chair Update** SI provided a verbal update, referencing the recent letter the Trust had received regarding proposed licence undertakings from NHSE. SI confirmed that Sir David Henshaw had stepped down as Joint Chair and that SI is currently Acting Joint Chair. SI added Sue Lorimer was also stepping down and a recruitment process had been agreed to recruit a Joint Non-Executive Director with a financial background. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH stated Sir David Henshaw had been appointed as Interim Chair of the Cheshire and Merseyside ICB and that Steve Igoe would take up the position of Acting Joint Chair. JH advised members about the CQC inspection of WUTH Medical Care and Urgent & Emergency Care, explaining the ratings for the hospital and urgent and emergency services remain requires improvement. JH reported the Trust declared a Critical Incident on 21 October 2025 due to an issue in the Sterile Services Department affecting surgical instruments and set out the measures taken to deal with the incident. JH gave an update regarding Better Together - Journey to Integration, highlighting the various activity undertaken in October, including the ongoing work to ensure the TUPE of corporate staff	

	from WCHC to WUTH takes place on 1 December and ongoing Joint Strategy engagement work. JH summarised the Cheshire and Merseyside Provider Collaborative meeting in October, noting the meeting was focussed on discussion and agreement of the priorities for the Collaborative. JH provided an overview of the various national developments in the last month, noting the publication of the medium term planning framework, resident doctor industrial action and the terms of reference for the independent maternity and neonatal investigation. JH reported at WUTH in September there was one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and two Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework. JH referenced various joint activity undertaken across both Trusts, including Allied Health Professionals Day, Wear Red for Red Card Racism and Speak Up Week. JH highlighted the various WUTH and WCHC employee of the month and standout winners for September. The Board **NOTED** the report.	
8	**Integrated Performance Report** DS reported sickness absence remained above the Trust's 5% target but was an improvement on the previous month. The top 3 reasons were mental health, gastro and cold/flu. DS added a new approach focussed on staff struggling to return to work would commence in November. DS stated appraisal compliance continued to not meet Trust target but was continuing to increase over the previous 3 months. DS added the Trust was exploring having an appraisal window similar to WCHC and this was being considered. LD noted sickness absence remained high for Estates, Facilities and Capital had the highest monthly rate for sickness absence and queried the progress on their changes following the deep dive at People Committee earlier in the year. DS stated this was challenging for the Division to implement due to the requirement to reduce costs. NS reported on behalf of the Chief Nurse that there had been a further reduction in Friends and Family Test (FTT) for ED to 69.1% against a target of 95%. Inpatients had also decreased by 0.8%.	

	NS stated there had been 3 hospital acquired category 3 pressure ulcers and 16 incidents of C Diff which was linked to an outbreak on ward 33. NS explained NEWS2 compliance had reduced below Trust target in month and the LocSSIPs action plan continued to progress to ensure improvements were embedded. LD queried the key themes from complaints/informal concerns and if there were any similar thematic areas across Divisions. NS stated issues were arising because of discharge summaries and work was being undertaken to improve those. NS added a triangulation of themes were discussed at each Divisional Performance Review. MD asked if each Division had a dashboard for complaints/concerns to monitor performance. NS advised each Division did have this including a suite of KPIs to monitor performance, which was discussed at speciality, divisional and Trust level. SR commented about VTE and that this can occur outside of the hospital environment and queried if there was data to evidence this. NS stated she was not aware of this but agreed to explore how VTE incidents for patients in the community is captured The Board **NOTED** performance to the end of September 2025.	Dr Nikki Stevenson
9	**Chief Finance Officer Report** RC reported at the end of September, month 6, the Trust is reporting a deficit of £12.6m which is a £9.4m adverse variance to plan driven by the withholding of Deficit Support Funding (DSF), industrial action, pay award pressures and system stretch target. RC advised to date, £7.0m of non-recurrent mitigations have been utilised to support delivery against the plan and offset the key risks. RC explained in September the Trust agreed additional actions to support delivery of the agreed plan, excluding DSF, of a £22.1m deficit. These actions are fully enacted from October. RC recapped the original 4 key risks identified within the Trust plan and these were: • Full CIP delivery; • Activity/case mix; • Aseptic pharmacy income; and • Run rate	

	RC added the cash balance at the end of month 6 was £0.36m and a cash mitigation plan has been implemented, however this issue will continue until the Trust has returned to a sustainable financial position. RC noted additional revenue support applications were in progress and work was ongoing to develop a medium term finance plan. RC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability, financial sustainability and financial efficiency were red, cash was amber, and agency spend, and capital was green. SL asked if any of the replacement trays or equipment impacting on sterile services had been accounted for in the financial position. HK advised as the capital programme was behind plan and no schemes from 2026/27 had been brought forward there was an opportunity to use those funds. The Board: • **NOTED** the report including that the Trust has reported an adverse variance to plan. • **NOTED** that the Trust's most immediate finance risk remains the cash position and approve that the CFO submits additional applications based on confirmed need. • **NOTED** the risk to delivering the 25/26 plan, that this risk is not fully addressed by the approved mitigation plan and the requirement to identify additional actions. • **APPROVED** the increase in the capital budget for cyber resilience.	
10	**Chief Operating Officer Report** HK reported September elective activity performance was 96% for outpatients and 92% for elective admissions, noting underachievement was mainly in Medicine and Surgery. HK added for Referral to Treatment (RTT) the Trust achieved trajectory for overall caseload and 18-week waits but 52-week waiters were above trajectory, mainly ENT and Dermatology. HK noted no patients were waiting 78+ weeks and 65+ week waiters had reduced to 4. HK explained for cancer performance the Faster Diagnostic Standard (FDS) was not met due to Dermatology causing the biggest pressure. HK added this was because of pathway changes and AI implementation. HK highlighted type 1 performance in the Emergency Department (ED) was 42.7% and 12-hour waits remained significantly high. HK	

	added the Trust was being supported by ECIST and were focussing on prolonged waits in ED, wait to be seen, workforce and ward processes. HK stated pressure for a mental health bed also remained challenging and the Trust was awaiting to hear about capital funding for a Mental Health Crisis Hub, which would provide an alternative location for patients requiring a bed at Arrowe Park Hospital. SR commented that the Trust's performance for ambulance handover remained positive despite the pressure and asked if system partners acknowledged the beneficial impact of this. HK agreed and stated the system partners had commented about the continued good performance for category 2 response time and NWAS welcomed this also. The Board **NOTED** the report.	
11	**Board Assurance Framework (BAF)** AH provided an overview the changes to the BAF, referencing the recommended changes following discussion at the relevant Committees. AH stated risk ID02 was proposed to increase to RR16 (4 x 4), due to the impact on elective recovery/scheduled care as a result of the critical incident declared in October. AH added risk ID04 was proposed to increase to RR16 (4 x 4), due to the upcoming period with sickness absence, the impact of financial constraints, and the impact of integration which could have a knock on effect on sickness and recruitment. AH advised risk ID was proposed to increase to RR12 (3 x 4), recognising current capacity, challenges with regional and national programmes and pressure on the hospital. Members discussed the proposed changes and agreed this accurately reflected the current position. The Board **APPROVED** the BAF.	
12	**Lead Governor Report** This item was not discussed due the absence of the Lead Governor.	
13	**Committee Chairs Reports – People Committee**	

	LD alerted members that 144 applications had been received for the Mutually Agreed Resignation Scheme (MARS), of which 8 were approved and 12 remained being considered. LD also alerted members that the Committee discussed the new Health and Safety Executive (HSE) Violence and Aggression Reduction Standards and noted the Trusts own progress to reduce this in line with the Violence and Aggression Strategy which was a priority for the Trust for 2025/26. LD alerted members that the Committee agreed to increase risk 4 of the Board Assurance Framework from a risk score of 12 to 16. This reflected the ongoing sickness absence and the potential impact of the integration programme which might also impact on recruitment and sickness absence. The Board **NOTED** the report.	
14	**Committee Chairs Reports – Finance Business Performance Committee** SL noted that the Committee reviewed the month 6 financial position, and this would be reported in the Chief Finance Officer Report. SL alerted members that the Committee was informed that the Trust had to make its own financial provision for winter pressures in order to be able to provide assurance on the winter plan, noting this would likely result in a cost pressure of £1m. SL also alerted members that Urgent and Emergency Care performance remained extremely challenged and the Committee were informed that ECIST were currently supporting the Trust in making improvements. SL summarised the various “Advise” and “Assure” matters from the meeting on 20 October. The Board **NOTED** the report.	
18	**Monthly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted that there were no areas of non-compliance for September. JL reported there were no Patient Safety Investigation Incidents (PSIIs) declared in September for Maternity or Neonatal Services. JL gave an update on the Maternity Incentive Scheme (MIS) Year 7 and the ten safety actions, noting current progress to date and	

	that this was being routinely tracked through the Women and Children's Divisional Quality Assurance meeting. JL updated members on safety action 5 of MIS, noting the statement of case and workforce plan approved by Board last month was progressing as planned in line with the timetable set out. JL referenced the maternity claims balanced score card, noting between April 2015 and Mach 2025 there had been 417 claims made and set out the total value of those claims. JL summarised the Trust's engagement with the Maternity and Neonatal Voices Partnership. The Board: • **NOTED** the report • **NOTED** the Perinatal Clinical Surveillance Assurance report. • **NOTED** the position of the Maternity and Newborn Safety Investigations (MNSI) and PSII's. • **NOTED** the position with the Maternity Incentive Scheme Year 7 requirements and progress against Safety Action 5. • **NOTED** the Maternity Claims Balanced Scorecard for Wirral University Teaching Hospital. • **NOTED** the position of the Maternity and Neonatal Voices Partnership (MNVP).	
19	**Equality Diversity and Inclusion Biannual Report** DS stated this report had been presented to the People Committee in October and reported all statutory reporting requirements were completed or on track and gave a breakdown of the workforce demographics. DS added in regard to WRES findings, improvements had been made in 5 of the 9 indicators and for WDES improvements had been made in 10 of the 13 indicators. DS referenced the priority areas for the year, including improving workforce adjustments for disabled staff, delivering NHSE 2025 EDI high impact actions and supporting BAME staff to speak up on bullying, harassment and violence. The Board: • **NOTED** the updates and progress outlined; • **NOTED** the EDI Dashboard and metrics; and • **RATIFED** the WRES and WDES narrative reports and key findings.	
20	**Freedom to Speak Up Annual Report 2024-25**	

	DS stated this report had been presented to the People Committee in October and highlighted 79 staff raised concerns during the year, down from 104 in 2023/24. The key themes related to attitudes/behaviours, bullying/harassment and patent safety. DS noted that no reports had been received of disadvantages treatment for speaking up. DS added in terms of trends the Surgery Division made up 43% of all concerns, Registered Nurses/Midwives raised the most concerns (34% followed by clerical staff (32%). DS referenced the actions being undertaken this year, including strengthening governance and reporting structures, expanding the FTSU Champion network and addressing barriers for minority and underrepresented staff groups. The Board **NOTED** the report.	
21	**NHS Sexual Safety Charter** DS stated this report had been presented to the People Committee in October and gave an overview of the report, explaining the Trust's approach to the implementation of the NHS England Sexual Safety Charter. DS stated a new Sexual Safety in the Workplace Policy had been published in June 2025 and an "Understanding Sexual Misconduct in the Workplace" course had been launched. DS set out the priority areas and next steps, including ongoing sexual safety communications campaigns, embedding training for supervisors and an ongoing review of the risk score. The Board: • **NOTED** the updates provided • **NOTED** the significant progress made to date • **NOTED** the escalation process from People Committee to Board; and • **NOTED** the work that is currently being undertaken in line with the newly revised NHS England self-assessment framework.	
22	**Guardian of Safe Working Report Q1 2025-26** NS stated this report had been presented to People Committee in October and highlighted the exception reports in this quarter continued to be from foundation year 1 doctors within Medicine, all of which had now been closed. NS referenced the current progress towards implementing the updated exception reporting process, noting this was due for	

	February 2026 and the Trust had a working group coordinating the actions. HS queried the opportunities for resident doctors to input into the rota design. NS commented this was self-rostered, but the rota design was complex due to managing the expectations of patients and resident doctors, while also ensuring the educational elements were also complaint. The Board **NOTED** the report.	
23	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards and Annual Report** HK reported for 2024/25 the Trust declared full compliance with 52 of the 62 standards for an overall rating of 84% - 'Partially Compliant'. For 2025/26 the Trust has declared full compliance with 59 of the 62 standards for a 95% rating which rates at 'Substantially Compliant'. HK added similar to last year, standard 16 (evacuation and shelter) has been recorded as partially compliant. This was due to the working group for the subject being paused with no guidance to Trusts. HK stated this is expected to be the same position for all Trusts across Cheshire and Merseyside. HK explained in September the Cheshire & Merseyside's Acting Head of EPRR undertook a site visit to discuss the core standards submission. HK noted no concerns were raised but the Trust asked for confirmation on the position with standard 16 to be discussed at regional level. HK referred to the EPRR Annual Report which had also been included and summarised the various EPRR activity undertaken during the reporting year. LD queried the Trust's preparedness for evacuation incidents. HK stated the evacuation tests had been conducted, which identified some gaps, and these had been incorporated into the action plan contained within the Core Standards. The Board **NOTED** the report.	
24	**Wirral Provider Alliance MOU and Terms of Reference** AH requested approval for the Memorandum of Understanding and Terms of Reference for the Wirral Provider Alliance, noting at the inaugural meeting on 6 October 2025 no objections were raised regarding either documents.	

	The Board: • **APPROVED** the attached Memorandum of Understanding for the Wirral Provider Alliance, noting that it will be reviewed annually and amended when required with mutual consent; and • **NOTED** the draft Terms of Reference for the Wirral Provider Alliance which are subject to further review by the WPA	
25	**Board of Directors Terms of Reference** AH requested approval to amend the Terms of Reference to include a specific provision for concurrent meetings, in line with current arrangements whereby Boards of WUTH and WCHC meet at the same time. The Board **APPROVED** the Terms of Reference.	
26	**Questions from Governors and Public** No questions were raised.	
27	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute.	
28	**Any other Business** No other business was raised.	

(The meeting closed 12:30)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 5 November 2025
Location	Hybrid

Members present:

SI	Steve Igoe	Acting Joint Chair
SR	Dr Steve Ryan	Joint Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
HS	Haris Sultan	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
DS	Debs Smith	Joint Chief People Officer
MS	Matthew Swanborough	Interim Joint Chief Strategy Officer
AH	Ali Hughes	Interim Joint Director of Corporate Affairs
RC	Robbie Chapman	Interim Chief Finance Officer
JC	Dr Joanne Chwalko	Chief Operating Officer & Interim Deputy CEO
CW	Claire Wedge	Deputy Chief Nurse (deputising for PS)

In attendance:

HK	Hayley Kendall	WUTH Chief Operating Officer
MC	Mark Chidgey	WUTH Chief Finance Officer
NS	Dr Nikki Stevenson	WUTH Medical Director
SL	Sue Lorimer	WUTH Non-Executive Director
CM	Chris Mason	WUTH Chief Information Officer
CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
RT	Robert Thompson	WUTH Deputy Lead Public Governor

Apologies:

PS	Paula Simpson	Chief Nurse
DM	Dave Murphy	Chief Digital Information Officer

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed members to the meeting, which was held together with the WUTH Board of Directors. Members of that Board are listed as attendees. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	

3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 1 October were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story highlighting the success of the WUTH Leadership Conference held earlier in the year. The video story described the experience of staff who attended which had been positive. The Board **NOTED** the video story.	
6	**Acting Joint Chair Update** SI provided a verbal update, referencing the recent letter that WUTH had received regarding proposed licence undertakings. SI confirmed that Sir David Henshaw had stepped down as Joint Chair and that SI is currently Acting Joint Chair. SI added Sue Lorimer was also stepping down and a recruitment process had been agreed to recruit a Joint Non-Executive Director with a financial background. The Board **NOTED** the update.	
7	**Joint Chief Executive Officer Report** JH stated Sir David Henshaw had been appointed as Interim Chair of the Cheshire and Merseyside ICB and that Steve Igoe would take up the position of Acting Joint Chair. JH advised members about the CQC inspection of WUTH Medical Care and Urgent & Emergency Care, explaining the ratings for the hospital and urgent and emergency services remain requires improvement. JH reported that WUTH declared a Critical Incident on 21 October 2025 due to an issue in the Sterile Services Department affecting surgical instruments and set out the measures taken to deal with the incident. JH gave an update regarding Better Together - Journey to Integration, highlighting the various activity undertaken in October, including the ongoing work to ensure the TUPE of corporate staff from WCHC to WUTH takes place on 1 December and ongoing Joint Strategy engagement work.	

	JH summarised the Cheshire and Merseyside Provider Collaborative meeting in October, noting the meeting was focussed on discussion and agreement of the priorities for the Collaborative. JH provided an overview of the various national developments in the last month, noting the publication of the medium term planning framework, resident doctor industrial action and the terms of reference for the independent maternity and neonatal investigation. JH reported at WUTH in September there were one RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and two Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework. JH referenced various joint activity undertaken across both Trusts, including Allied Health Professionals Day, Wear Red for Red Card Racism and Speak Up Week. JH highlighted the various WUTH and WCHC employee of the month and standout winners for September. The Board **NOTED** the report.	
8	**Integrated Performance Report** DS reported sickness absence had reduced by 0.3% in month due to the extensive improvement work being undertaken in addition to the business as usual sickness absence management. DS noted a sustained level of improvement would take time to achieve the target level. DS added proactive support and wellbeing management was being offered and that the EAP uptake had increased from 8.8% to 10.4%, indicating staff were increasingly accessing support. LD queried the long term sickness aspect, specifically about mental health and if a breakdown of the types of conditions was available. DS stated this was included in ESR but was not captured as standard. DS agreed to provide to People and Culture Committee a breakdown of the types of mental health conditions where sickness absence occurs. SR queried the progress regarding the TUPE of corporate services to WUTH. DS stated resilience training was available to both WUTH and WCHC staff and sessions were being held with managers. Work was also ongoing with Staff Side.	Debs Smith

	JC explained operational performance remained consistent, noting GPOOH had improved but remained below expectations and waiting lists for RTT, DM01 and non RTT continued to improve. JC added dental waits remained an issue however there has been improvements in reducing the backlog and wait times since commencing the action plan in January 2025 with slight improvement in-month. CW reported that there had been reduction in incident reporting reaching a point of concerning special cause variation and a further review through the Trust's governance framework is in progress. CW added there had also been a reduction in the Friends and Family Test (FFT) score during M6 evidencing special cause variation, with 86.1% of people recommending Trust services, based on 2,025 positive responses. RC highlighted at the end of September the Trust is reporting a surplus of £0.7m. This is an improvement on plan for M5 but there is no change to the projected year end surplus of £0.9m. RC added at M6 the Trust has transacted £5.06m of CIP in year, all full year effect, against its revised target of £6.6m. The Board **NOTED** performance to the end of September 2025.	
9	**Board Assurance Framework (BAF)** AH provided an overview the changes to the BAF, referencing the proposed increase in risk rating of ID07 to RR16 following discussion at the People & Culture Committee on 8 October 2025. AH indicated this was proposed due to the increase in sickness absence, beyond the Trust target and the impact on staff experience and their health and wellbeing. The Board: • **NOTED** the update provided on the current position in relation to the strategic risks; and • **APPROVED** the proposed increase in risk rating of ID07 to RR16 as recommended by the People & Culture Committee	
10	**Lead Governor Report** AH summarised the report in absence of the Lead Governor, noting the various Non-Executive Director changes, the recent Council of Governors meeting and the Annual Member's Meeting which took place in October. AH also highlighted the Governor election was ongoing and voting would close in early December.	

	The Board **NOTED** the report.	
11	**Committee Chairs Reports – People and Culture Committee** MD alerted members that sickness absence remained high with long term sickness at 7.7% and stress and anxiety accounting for 60% of these. MD noted an action plan was in place to drive down sickness absence. MD also alerted members that the TUPE on Corporate Services to the WUTH would take place on 1 December and then the process of restructure to create a joint corporate services function would commence MD summarised the various "Advise" and "Assure" matters from the meeting on 8 October. The Board **NOTED** the report.	
12	**Committee Chairs Reports – Audit Committee** MD alerted members as of 3 October there were 116 Trust-wide policies, of which 104 were approved and published, 12 had expired and being updated and a further 18 were due to expire in the next 6 months. Committee approved the necessary extensions. MD also alerted members that four fraud referrals had been received and set out the type of cases. MD alerted members that work was ongoing between WCHC and WCHC to appoint a single external auditor. MD summarised the various "Advise" and "Assure" matters from the meeting on 8 October. The Board **NOTED** the report.	
13	**Committee Chairs Reports – Finance and Performance Committee** SI alerted members that the Trust was progressing to a new ledger from 1 November, which would be the same as WUTH, as a number of issues had been experienced with the current ledger. SI also alerted members the high-level risk relating to the Neurodivergent pathway was again discussed in the most recent meeting. Mitigations were in place however resolution remains challenging in the absence of ICB funding. SI summarised the various "Advise" and "Assure" matters from the meeting on 15 October.	

	The Board **NOTED** the report.	
14	**NHS Sexual Safety Charter** DS stated this report had been presented to the People and Culture Committee in October and had been assured by the processes implemented and progress to date. DS gave an overview of the report, explaining the Trusts approach to the implementation of the NHS England Sexual Safety Charter. DS stated a new Preventing Sexual Misconduct Policy had been published in May 2025 and an "Understanding Sexual Misconduct in the Workplace" course had been launched. DS set out the priority areas and next steps, including ongoing sexual safety communications campaigns, embedding training for supervisors and an ongoing review of the risk score. The Board: • **NOTED** the updates provided • **NOTED** the significant progress made to date • **NOTED** the escalation process from People and Culture Committee to Board; and • **NOTED** the work that is currently being undertaken in line with the newly revised NHS England self-assessment framework.	
15	**Inclusion Annual Report** DS stated this report had been presented to the People and Culture Committee in October and had received positive feedback. DS summarised the Trust's progress on equality, diversity and inclusion during 2024/25, including key patient and workforce related equality data. DS set out the Trust's key inclusion priorities for 2025/26 and explained moving forward the reporting cycle would be aligned with WUTH reports. The Board **APPROVED** the report for publication.	
16	**Wirral Provider Alliance MOU and Terms of Reference** AH requested approval for the Memorandum of Understanding and Terms of Reference for the Wirral Provider Alliance, noting at the inaugural meeting on 6 October 2025 no objections were raised regarding either documents. The Board:	

	• **APPROVED** the attached Memorandum of Understanding for the Wirral Provider Alliance, noting that it will be reviewed annually and amended when required with mutual consent; and • **NOTED** the draft Terms of Reference for the Wirral Provider Alliance which are subject to further review by the WPA	
17	**Board of Directors Terms of Reference** AH requested approval to amend the Terms of Reference to include a specific provision for concurrent meetings, in line with current arrangements whereby Boards of WUTH and WCHC meet at the same time. The Board **APPROVED** the Terms of Reference.	
18	**Questions from Governors and Public** No questions were raised.	
19	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 12:30)

Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Action Log
Board of Directors in Public
3 December 2025

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1	5 November 2025	8	To explore how VTE incidents for patients in the community is captured	Dr Nikki Stevenson		December 2025

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1	1 October 2025	8	To gather patient experience/quality outcomes post a GP Out-of-Hours Service interaction	Jo Chwalko	Complete. Supplementary presentation appended to Integrated Performance Report.	December 2025
2	5 November 2025	8	To provide to People and Culture Committee a breakdown of the types of mental health conditions where sickness absence occurs	Debs Smith	Complete. Scheduled to be discussed at the next meeting in January.	January 2026

Board of Directors in Public **Item 7**
3 December 2025

Title	Joint Chief Executive Officer Report
Area Lead	Janelle Holmes, Joint Chief Executive
Author	Janelle Holmes, Joint Chief Executive
Report for	Information

Executive Summary and Report Recommendations
The purpose of this report is to provide members with an update on activity undertaken across Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health & Care NHS Foundation Trust (WCHC) since the last meeting and draw the Boards' attention to any local and national developments. It is recommended that the Board of Directors: • Note the report

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
This is a standing report to the Board of Directors			

1	**Narrative**
1.1	**Performance** Performance across both organisations is in line with plan. However urgent and emergency care performance at WUTH continues to be challenged and focussed improvement work continues with specific actions on 4 & 12 hour standards. The improved performance for ambulance handover has remained stable.

	At WCHC operational performance remains strong in urgent community response and Community Intermediate Care Centre (CICC). GP out of hours and 4 hour performance seen a reduction in performance and remedial action plans are in place to support improvements. Across both Trusts I would like to recognise this performance and acknowledge the efforts of staff who contribute to this strong position and support those in our care.
1.2	**Local News and Developments** **WUTH Charity's Tiny Stars Appeal to Close** WUTH Charity has confirmed that the Tiny Stars Appeal will close on 30 November 2025. Launched in 2019 as the charity's first major fundraising campaign, Tiny Stars has brought people together in an extraordinary way. Through the amazing £1.1 million raised, Tiny Stars has already made a real difference. The funds are directly supporting the refurbishment of our Neonatal Intensive Care Unit, helping us create more space, improve family facilities, and build a modern environment that reflects the outstanding care our teams provide every day. Any donations made for neonatal care after this date will be ringfenced within the Children's Fund, ensuring the money is still used specifically to benefit babies and their families. WUTH Charity is now beginning to shape its next major fundraising appeal and more information about this will be shared soon. **Opening the new Neonatal Intensive Care Unit** Following a major refurbishment programme, the Neonatal Intensive Care Unit at Arrowe Park Hospital will reopen in early December 2025. The new unit will transform the care provided to our patients, delivering more family facilities, upgraded equipment, and a more modern, spacious environment with expanded cot space to support more babies requiring specialist care, alongside the creation of dedicated areas for parents to rest and spend time with their new borns. The project was made possible by the generosity of local people who helped Wirral University Teaching Hospital (WUTH) Charity raise £1.1m through its Tiny Stars Appeal. **Sterile Services** The critical incident declared in October 2025 affecting surgical instruments was stood down in early November and services are now returning to normal. During the incident, we continued to carry out critically urgent procedures and time critical cancer-related procedures, prioritised according to clinical need and clinically prioritised cancer patients who were waiting for surgery have been provided with dates for an operation. All cancer surgery has now been reinstated, and patients will have been contacted in order of prioritisation. All patients whose routine elective surgery was postponed will also start to receive new dates for their surgery.

I apologise to patients who had their operations postponed and I would like to extend thanks to our staff, partners, and patients for their patience while we resolved the issue.

HSJ Awards Finalists – Sexual Health Wirral

Congratulations to the Sexual Health Wirral Team at Wirral Community Health & Care NHS Foundation Trust, who were finalists in the recent HSJ Awards, in the Innovation and Improvement in Reducing Health Inequalities Award.

The work of the service in the co-production of the Young Persons Clinic, 'ourPlace' was recognised by the judges and our congratulations to the whole team who work so hard to provide a safe, accessible and inclusive service to the young people of Wirral.

Clinical Support Worker (CSW) Listening Events

Following a meeting with the regional Unison team and CSW representatives, the Deputy Chief Nurse and I have held a number of listening events across both Arrowe Park and Clatterbridge to meet with CSW colleagues.

It has been useful to better understand their experiences working at WUTH and we discussed plans to review the approach to the ongoing CSW organisational change.

Better Together - Journey to Integration

Further progress is being made on the integration journey between WUTH and WCHC as we move closer to becoming one organisation.

A recent key milestone has been the appointment of the Executive Team, providing strong leadership that will guide us through the next steps in our integration journey. The following appointments have been made to the Executive Team and colleagues started their joint roles across both organisations from 17 November.

- Nikki Stevenson – Joint Chief Medical Officer and Deputy Chief Executive
- Hayley Kendall – Joint Executive Managing Director
- Mark Chidgey – Joint Chief Finance Officer
- Matthew Swanborough – Joint Chief Strategy Officer
- Debs Smith – Joint Chief People Officer
- Jo Chwalko – Joint Chief Integration and Partnerships Officer
- Ali Hughes – Joint Director of Corporate Affairs and Communications

The appointment of a substantive Chief Nurse will be confirmed in due course, with the Deputy Chief Nurses in both Trusts providing senior nurse leadership with additional support from the ICB.

Over the coming weeks, our focus will be on the smooth TUPE transfer of corporate staff from WCHC to WUTH on 1st December 2025, enabling us to work better together, more efficiently and alleviating some pressures across corporate services. The process is well underway, and we are engaging with staff in both organisations who will be affected by this transfer. The feedback and questions we are receiving from staff are insightful and extremely helpful in ensuring we provide the information needed to keep our staff informed throughout.

	The Integration Management Board continues to meet monthly and governance arrangements across both Trusts are currently under review to align where appropriate whilst supporting the process to become a single organisation. Following the support of the ICB on the next steps to integration, we are now proceeding to develop the Outline Business Case for the statutory transaction to bring the two Trusts together through a 'merger by acquisition'. As part of our integration journey to become a single organisation, engagement with our staff, patients and key stakeholders within the system on the development of a Joint Strategy is progressing well. Phase one engagement has involved several strategy focus group sessions and 1:1 conversations; to date, 43 of 89 1:1 conversations have been completed and over 200 staff across both Trusts have got involved and shared their views through focus groups. We are delighted with the positive feedback received from everyone involved so far and the insight and ideas shared are promising. Phase one engagement will be completed November 2025, and our new Joint Trust strategy remains on track for presentation to the Board in April 2026. **Cheshire and Merseyside Provider Collaborative (CMPC) Update** The Board met on 7 November and discussed a number of important system wide issues as follows. Digital Programme – An update and emerging proposition was shared by John Llewellyn. A vision for a single CMPC approach was described that needed to be underpinned by clear governance and a shared enterprise architecture that should support multi-year investment and delivery. Details explored included short term workforce issues and risks and CDIO leadership of various envisaged workstreams. The Board noted that a single approach to digital and data will yield savings. A £3m RTF bid for ambient voice technology (AVT) was noted as having been successful. Alder Hey is leading this work, and the majority of providers will pilot technology. A further update on AVT roll-out will come to a future meeting. Next the Board considered in year delivery and governance. CEO lead for this portfolio of work is Nik Khashu. The Board also discussed the system approach to 2026/27 planning. Finally, the Board discussed a number of wider system issues including UEC, Industrial Action and Children & Young People. **Cheshire and Merseyside ICB CEO Announcement** On behalf of the Executive Team I would like to thank Cathy Elliott for her work and support as Chief Executive of the ICB, as she leaves to take up a new leadership role linked to 10 Year Health Plan ambitions in the North West region, working with the ICB and NHSE North West. I would like to offer our support to Liz Bishop, former Chief Executive of The Clatterbridge Cancer Centre, who has joined the ICB Leadership Team as Interim Chief Executive to respond to the sizeable financial recovery required for the ICB and system.
1.3	**National News and Developments** **Strategic commissioning framework**

	NHS England published a strategic commissioning framework, which sets out the principles of strategic commissioning, clarifies expectations of ICBs as commissioners, and situates the approach within the emerging NHS operating model and the ambitions of the 10-year health plan. ICBs are expected to adopt this strategic commissioning approach from April 2026. NHS England » Strategic commissioning framework **Advanced Foundation Trust Programme – guide for applicants** NHS England published a draft Advanced Foundation Trust Programme – guide for applicants which is out for consultation until 11 January 2026. Advanced foundation trust (AFT) is the name for the 'new FTs' referred to in the 10-year health plan. The draft guidance sets out the rationale for the programme and the proposed eligibility criteria and assessment process. It also sets out the proposed assessment process for readiness to hold an integrated health organisation (IHO) contract. NHS England » Advanced Foundation Trust Programme – guide for applicants
1.4	**WUTH Health and Safety** There was four Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in October. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring. There were no Patient Safety Incident Investigations (PSII) opened in October under the Patient Safety Incident Response Framework (PSIRF).
1.5	**Published Reports of Interest** The following are some reports recently published and of interest to members of the Board, staff and public. • **NHS England. Medium-term planning framework: Revenue finance and contracting guidance for 2026/27 to 2028/29.** NHS England published the accompanying technical guidance and financial allocations for the three-year planning period ending in 2028/29. NHS England » Medium-term planning framework: Revenue finance and contracting guidance • **Care Quality Commission (CQC) - Better regulation, better care: consultation on improving how we assess and rate providers.** This consultation is about the CQC's proposals to evolve and improve their approach to assessing and rating health and care providers. It sets out: how the CQC proposes to develop their frameworks and guidance for assessing providers; and how they propose to change their methods for inspecting, assessing and awarding ratings to health and care services. The consultation closes at 5pm on 11 December. Better regulation, better care - Care Quality Commission • **CQC- The state of health care and adult social care in England 2024/25.** The State of Care is the CQC's annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. This report finds that demand for services is increasing across a health and social care system that is already under severe pressure – affecting how easily people can access care and the quality of care they receive. The report also highlights longstanding inequalities with some groups of people – including older people, people with

	dementia, people with a learning disability, and those with complex mental health needs – more likely to struggle to navigate services, often meaning their families and unpaid carers carry increasing burdens. https://www.cqc.org.uk/publications/major-report/state-care/2024-2025 • **NHS Providers. Annual State of the provider sector survey.** NHS Providers launched the findings of our annual State of the provider sector survey, showing that while there is a gathering sense among trust leaders that the NHS is turning a corner nobody underestimates the scale of the problems posed by long delays, financial pressures and a relentless rise in demand for care. State of the Provider Sector 2025
1.6	**Communications and Engagement** **Safeguarding Adults Week** Both WUTH and WCHC recognised National Safeguarding Adults Week from 17-21 November, offering a chance to raise awareness, start conversations and build confidence in recognising and preventing abuse or neglect. This year's national theme was Prevention. A variety of activity was undertaken across both Trusts including webinars organised by system partners and stalls across Arrowe Park Hospital and St Catherine's Health Centre. **Marking Remembrance Day** On Tuesday 11 November staff across both Trusts were encouraged to pause to honour the bravery, resilience and sacrifice of the armed forces community, past and present. Staff are also invited to a remembrance service in the Multifaith Chapel at Arrowe Park Hospital. WUTH were also part of the Birkenhead Town Hall parade. **WCHC October Standout Winner** Congratulations again to our October Standout winner, Lauren Boyle from Clinical Systems, nominated by Deb Kelly. *Lauren is always super helpful and knowledgeable in all things SystmOne. I often contact the team with obscure and complex requests and Lauren, along with the rest off the team, go out of their way to identify suitable solutions. My most recent request was for an urgent report and Lauren managed to turn it around in record time so as my response could be submitted ahead of time. Thank you Lauren and the Clinical Systems team for all you do, you are definitely the back bone of the organisations electronic health record and we would be lost without.* **WUTH Employee of the Month Winners** **Support Services Winner: Medicine Operational Management Team.** The Medicine Operational Management Team has been nominated for their exceptional commitment, resilience and teamwork in one of the Trust's busiest divisions. Described as "a fantastic, selfless team", they consistently ensure services run safely and efficiently while managing daily operational pressures

	Patient Care Winner: Critical Care Team. The Critical Care nursing and medical team has been recognised for delivering outstanding person-centred care during an exceptionally demanding period. Their dedication during this period reflects the consistent standard of care they bring every day. They embody the values of kindness, teamwork and exceptional clinical practice.

Compassion Open Trust

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Wirral Community Health and Care
NHS Foundation Trust

Board of Directors in Public **Item 8**

03 December 2025

Title	Integrated Performance Report
Area Leads	Executive Team
Author	Alison Hughes, Director of Corporate Affairs
Report for	Information

Executive Summary and Report Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of October 2025.

The Integrated Performance Report provides a summary of performance across operational, quality, workforce and financial metrics. The report provides an in-month and YTD position.

Performance is represented in SPC chart format to understand variation and a summary table indicating performance against standards. The metrics are grouped into Executive Director portfolios with individual metrics showing under each domain identified in this report. Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Grouping the metrics by report domains shows the following breakdown for the most recently reported performance:

This report should be considered alongside the briefings from the Chairs of the committees of the Board.

It is recommended that the Board note performance to the end of October 2025.

NHS Oversight Framework (NOF)

The NOF for 2025/26 has been published and describes the approach to assessing NHS Trusts ensuring public accountability for performance against a range of agreed metrics, promoting improvement. The framework includes six domains for assessment;

- Access to services
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and productivity
- Improving health and reducing inequality

WCHC has been placed in to segment 1 and further information is available on the NHS Data Dashboard - NHS England » Segmentation and league tables.

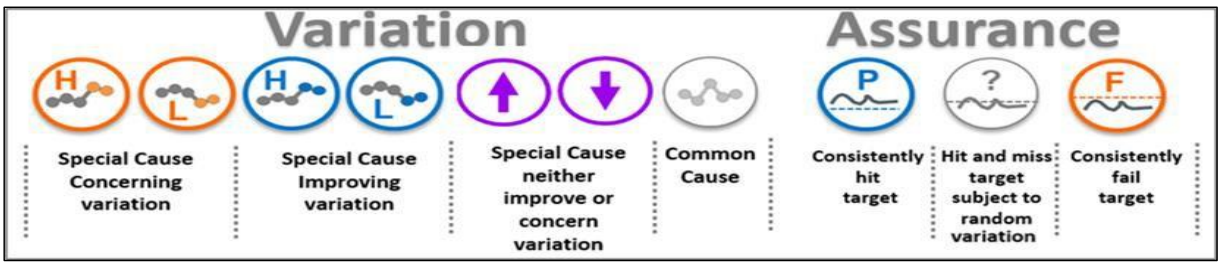
Key Risks
Strategic (Board Assurance Framework- BAF) and operational Risk and opportunities: The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the performance of the Trust, to better serve our communities and support the work of the Wirral Place, and the Cheshire and Merseyside Integrate Care Board (ICB). The IPR directly supports mitigation across all risks in the Board Assurance Framework as it provides performance against quality, people, finance and operational metrics.

The Trust Vision
Populations - We will support our populations to thrive by optimising wellbeing and independence
People - We will support our people to create a place they are proud and excited to work
Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Contribution to WCHC strategic objectives:
Outstanding Care: provide the best care and support
Compassionate workforce: be a great place to work
Continuous Improvement: maximise our potential to improve and deliver best value
Our partners: provide seamless care working with our partners
Digital future: be a digital pioneer and centre for excellence
Infrastructure: improve our infrastructure and how we use it.

1	Narrative
1.1	Performance metrics for Workforce, Operations, Quality & Governance and Finance are grouped under the responsible Executive Director in the following report.
1.2	An additional report is included as Appendix 1 in response to the following action which arose from discussion at the Board meeting in October 2025: *"To gather patient experience/quality outcomes post a GP Out-of-Hours Service interaction"*

2	Implications
2.1	Implications for patients, people, finance, and compliance, including issues and actions undertaken for those metrics that are not meeting the required standards, are included in additional commentaries and report by each Executive Director.

3	General guidance and Statistical Process Charts (SPC)
3.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance. • Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend. **Blue dots signify a statistical improvement. A data point will highlight blue if it:** • Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance. • Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend. **Grey dots signify a pattern of variation is to be expected.** Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

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Integrated Performance Report - October 2025

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

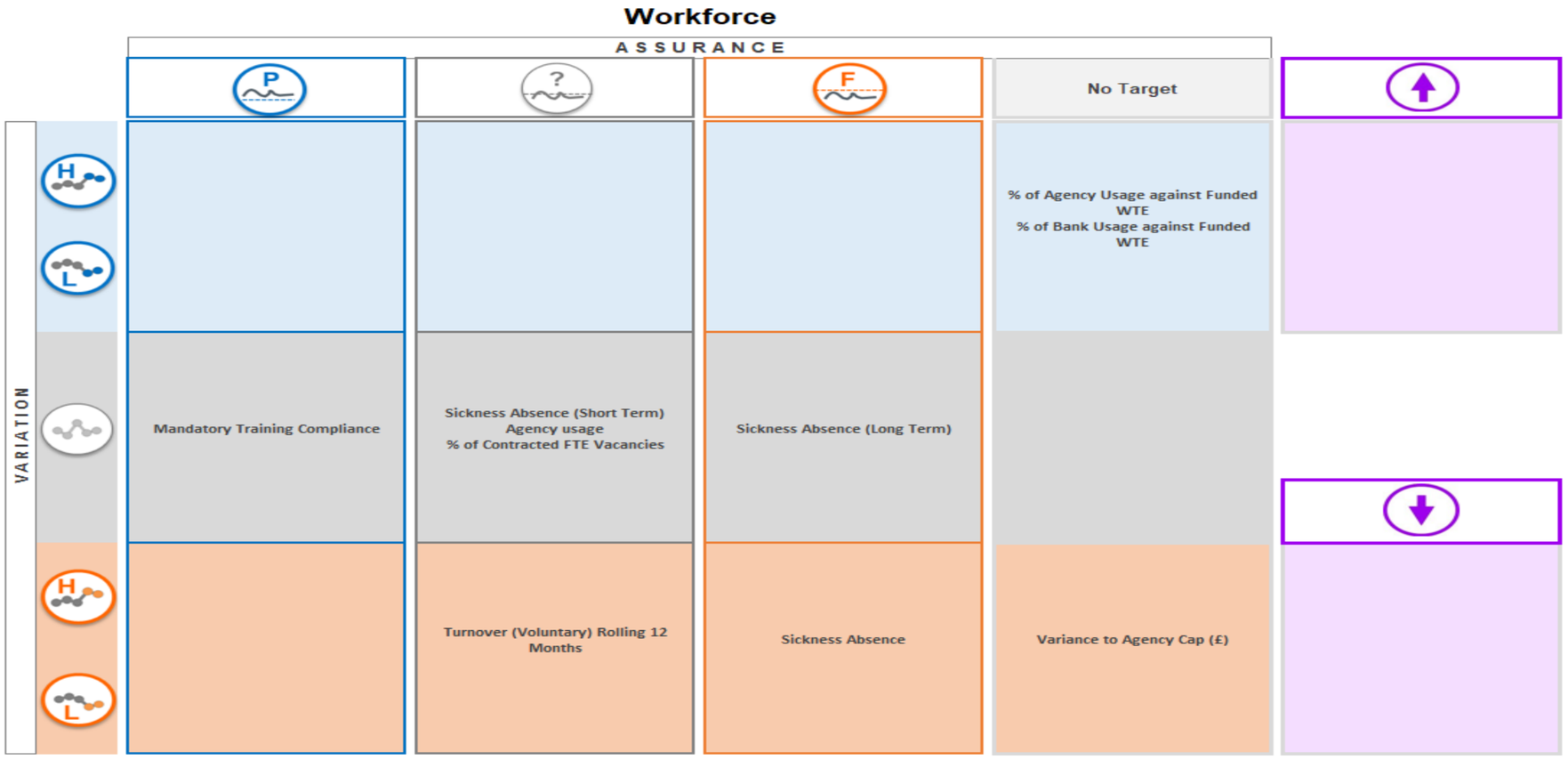
Voluntary Turnover in October was 9.7% and it is anticipated that the trend will continue to gradually increase.

Mandatory training remained steady at 94.6%. The trend is consistent and stable, and all localities are reporting over 90% target.

Agency expenditure has remained low in October at 0.1%. This is significantly below the regional 3.2% target. Greatest expenditure is in Ophthalmology and CICC.

Sickness absence levels continue to be above the Trust 5% tolerance and there is a high impact action plan in place to address the high levels of long-term absence. Sickness absence has been an area of concern for several months and latest performance is 7.5%. The Trust threshold of ≤5% was last achieved in August 2023. The absence challenges are driven mainly by long term sickness (5.4%). Long term sickness rates have improved from 6.3% in August to 5.4% in October reflecting the work undertaken in the action plan. Short term sickness has risen to 2.1%.

Workforce Domain Matrix



Workforce Summary

Highlights

Mandatory Training

Mandatory Training compliance is consistently above the target level and is a stable workforce metric.

Turnover

Turnover is below target rate, however this is likely to increase in line with plans.

Agency Use

Minimal organisational use of agency staff, well below target and systems and processes in place to oversee utilisation.

Bank Use

Use of Bank staff has reduced over the past 2 years and has fluctuated between 2-3% and has been trending down since Jan 25 and standing at 2.8% in October, the same as September.

Areas of Concern

Sickness absence remains a cause for concern as it is above the target level at 7.5%.

The top 3 reasons remain:

- mental health
- Cold Cough and Flu and
- Gastro.

Recorded RTW interviews have improved again in October to 83%.

Localities with the highest sickness absence were Specialist Medical, Therapies, Children's and Community Response.

PCOG reviewed the 12 rated risk on the register and made the decision to retain that risk level.

Through the Sickness Absence project extensive work is being undertaken across the Trust consisting of targeted interventions tailored to the requirements of the Trust, all in addition to BAU sickness absence management.

Forward Look (Actions)

Proactively supporting heath & wellbeing:

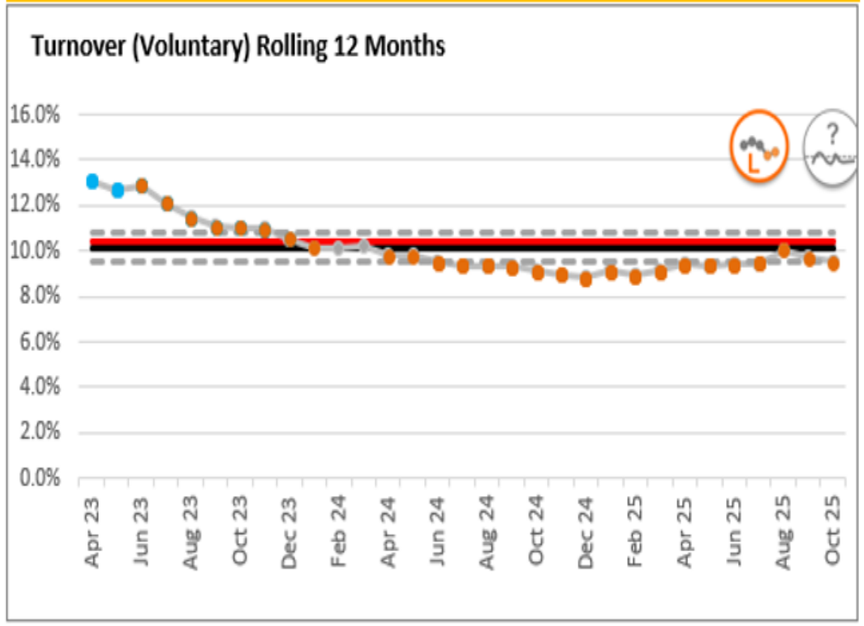
- New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - 'Every Day Counts'.
- Delivery of the annual flu campaign to prevent increase in flu related absence; given the higher levels this year, the campaign has been extended by 3 weeks to enable staff to get the flu jab.
- New Wellness Action Plan for both Trusts will launch towards the end of November.
- New Resilience through Change sessions led by WUTH's psychotherapist.
- Mental Health First Aid Training– 5 new cohorts.
- Enhanced training for managers (preventing sickness absence through wellbeing conversations).
- New Road Map for Wellbeing showcasing all the support available to staff in one place.
- EAP uptake has increased to over 10%.
- Active management of the PAM contract to deliver VfM and reduce wastage.

Managing Absence:

- PAM OH providing training to improve management referrals and improve quality of associated OH reports to effectively manage sickness. The EAP will also attend these sessions to further increase uptake.
- New PAM triage process, cases medically triaged an allocated the most appropriate practitioner and appointment length based on the case specifics / history etc.
- Case conferences reinvigorated for complex cases.
- PAM 'line by line' active LT sickness cases sessions with Service Leads and HR (with plans to progress / conclude).
- New local sickness Audits commenced in October and reported through PCOG.
- Reintroduction of the Health Indicators Report and utilisation to drive management actions related to managing sickness absence.
- Extension of the EAP Health assured 'Active Care' day one intervention for staff absence with stress and/or anxiety.

Turnover (Voluntary) – Rolling 12 Months

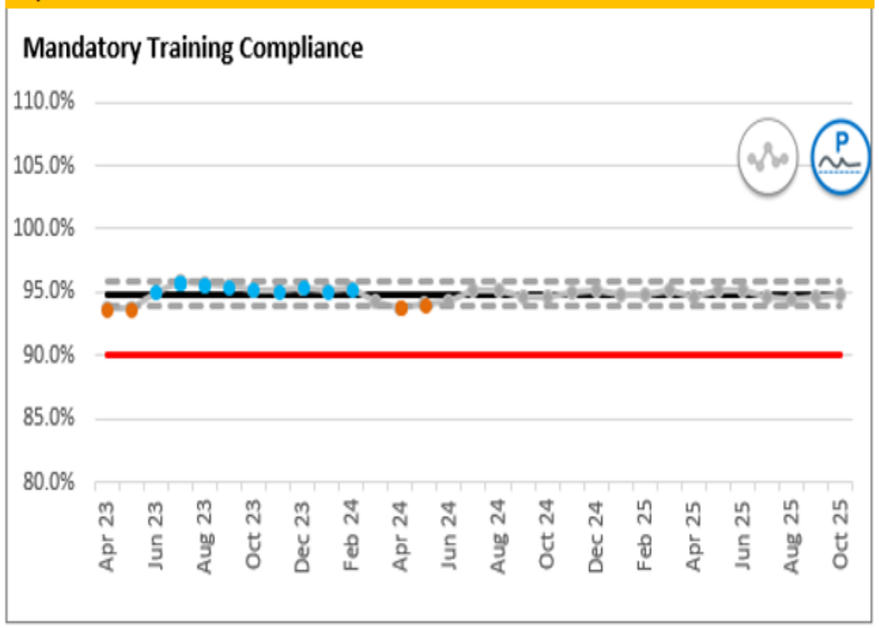
CQC Domain : Safe



Oct-25
9.5%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

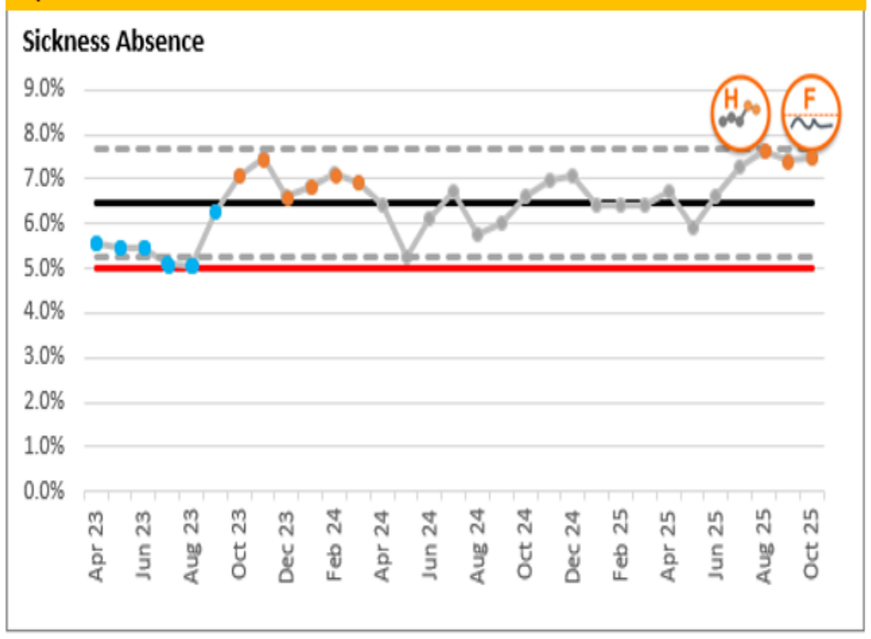
CQC Domain : Safe



Oct-25
94.8%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

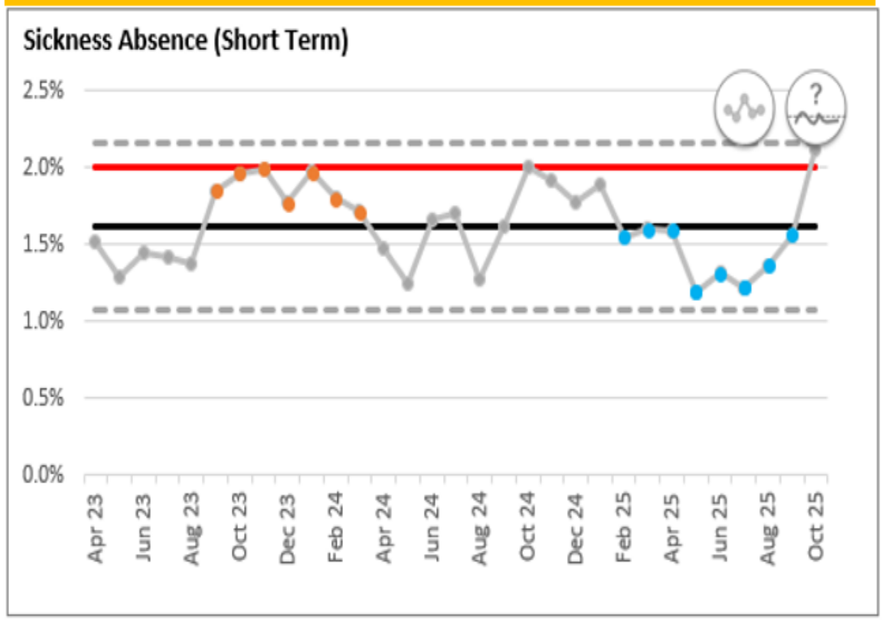
CQC Domain : Safe



Oct-25
7.5%
Variance Type
Special cause variation - Concerning
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

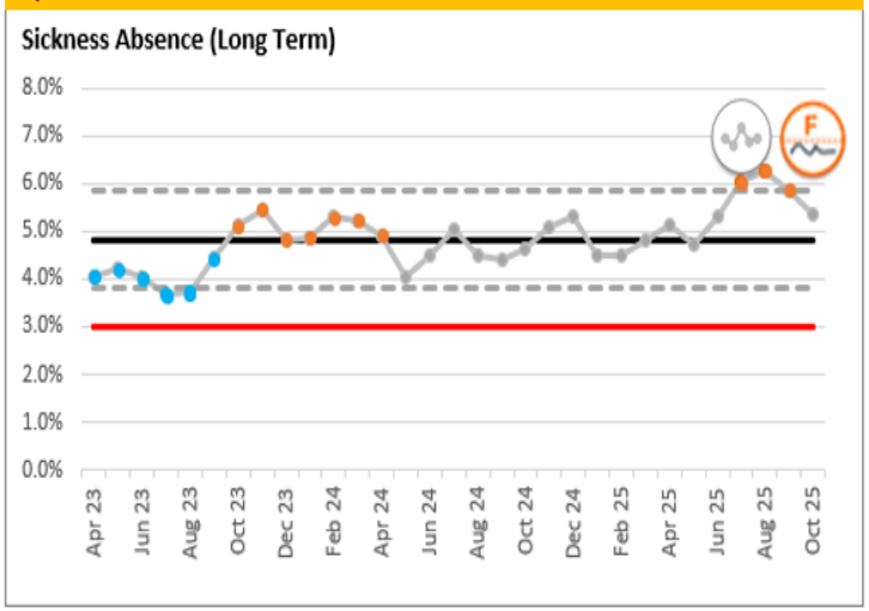
CQC Domain : Safe



Oct-25
2.1%
Variance Type
Common cause variation
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Sickness Absence (Long Term)

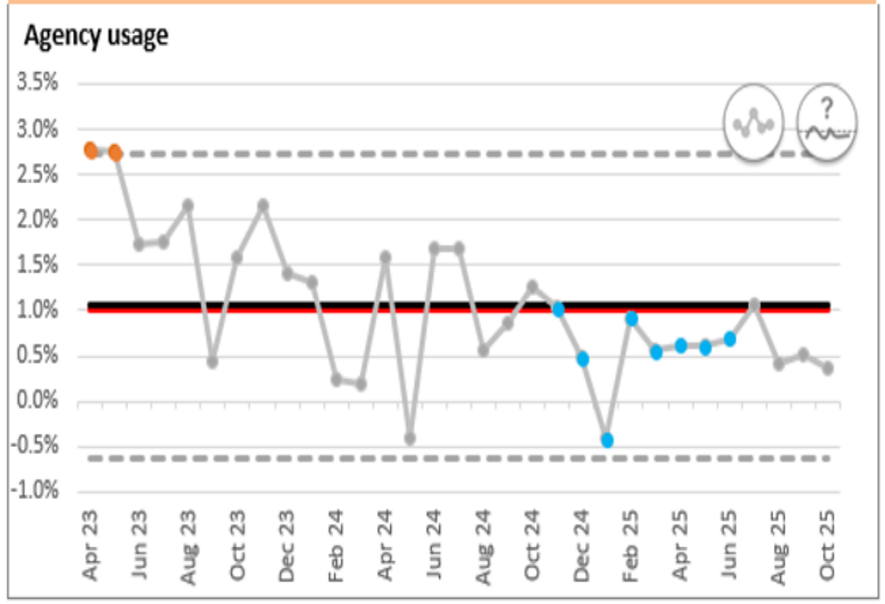
CQC Domain : Safe



Oct-25
5.4%
Variance Type
Common cause variation
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

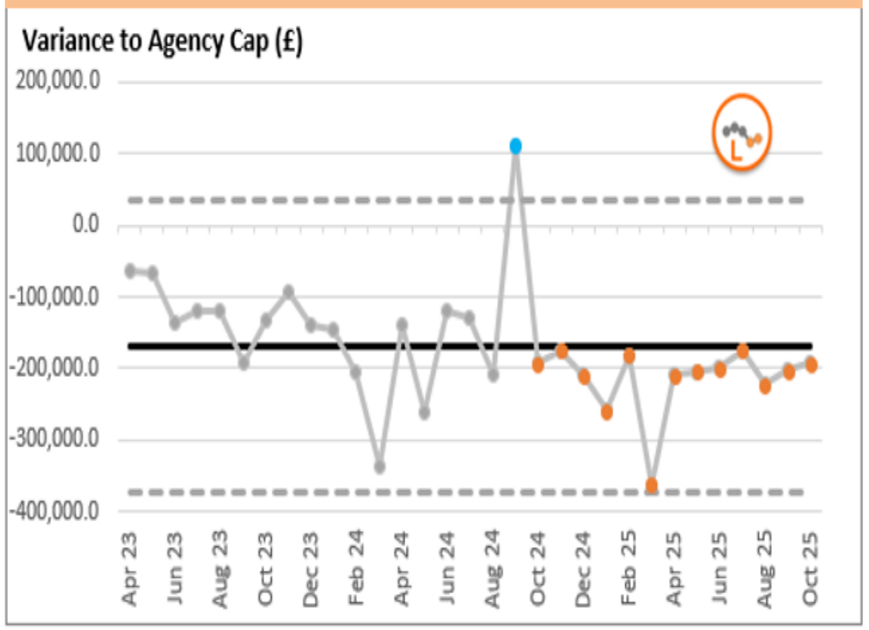
CQC Domain : Well-led



Oct-25
0.4%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

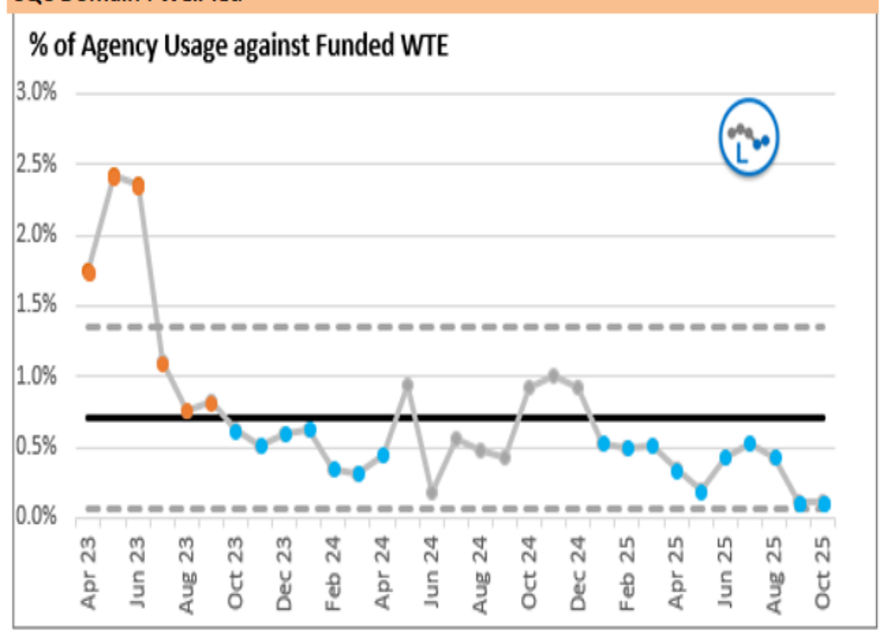
CQC Domain : Well-led



Oct-25
-£192,203.91
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

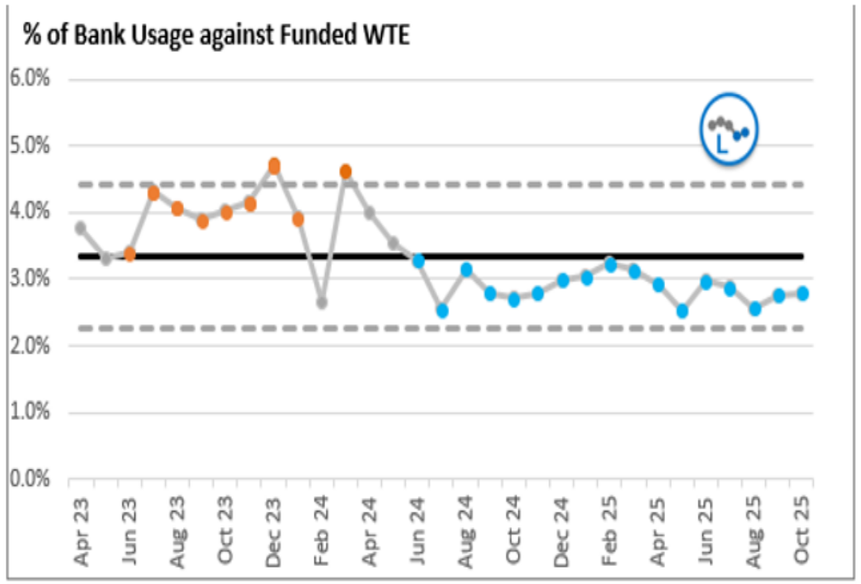
CQC Domain : Well-led



Oct-25
0.1%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Bank Usage against Funded WTE

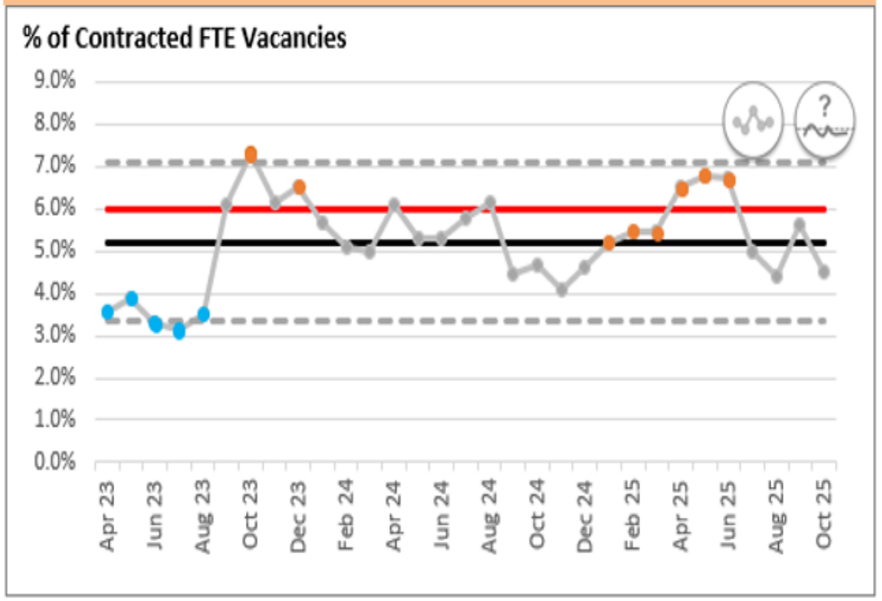
CQC Domain : Well-led



Oct-25
2.8%
Variance Type
Special cause variation - Improving
Threshold
Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led



Oct-25
4.5%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Dashboard	Operations
Lead	Chief Operating Officer

Chief Operating Officer Update

Operational performance remains strong overall. There are now 93 operational KPIs reportable to commissioners, compared to 91 in previous months. This is due to a refresh of the Rehab at Home service KPIs by commissioners, including the introduction of two additional KPIs.

The position for M6 25-26 is:

- 79 Green KPIs
- 4 Amber KPIs
- 10 Red KPIs

Highlights by exception:

- UCR performance 87.5% against a 70% target and high volume of activity.
- Intermediate care - CICC occupancy continues above 90% and length of stay at 17 days against a 21-day target
- 0-19/25 services –majority of key metrics across the four regional teams performing above target
- Waiting lists – RTT and DM01 100% and majority of non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times.

Areas for improvement:

- Urgent care, inc. GPOOH metrics. Performance remains below target given significant workforce challenges (risk 3214). Remedial action plans remain in place which include reviewing and improving the operational model through integration opportunities, recruitment into vacancies, reductions in sickness absence, daily huddles to support staff and identify learning opportunities.

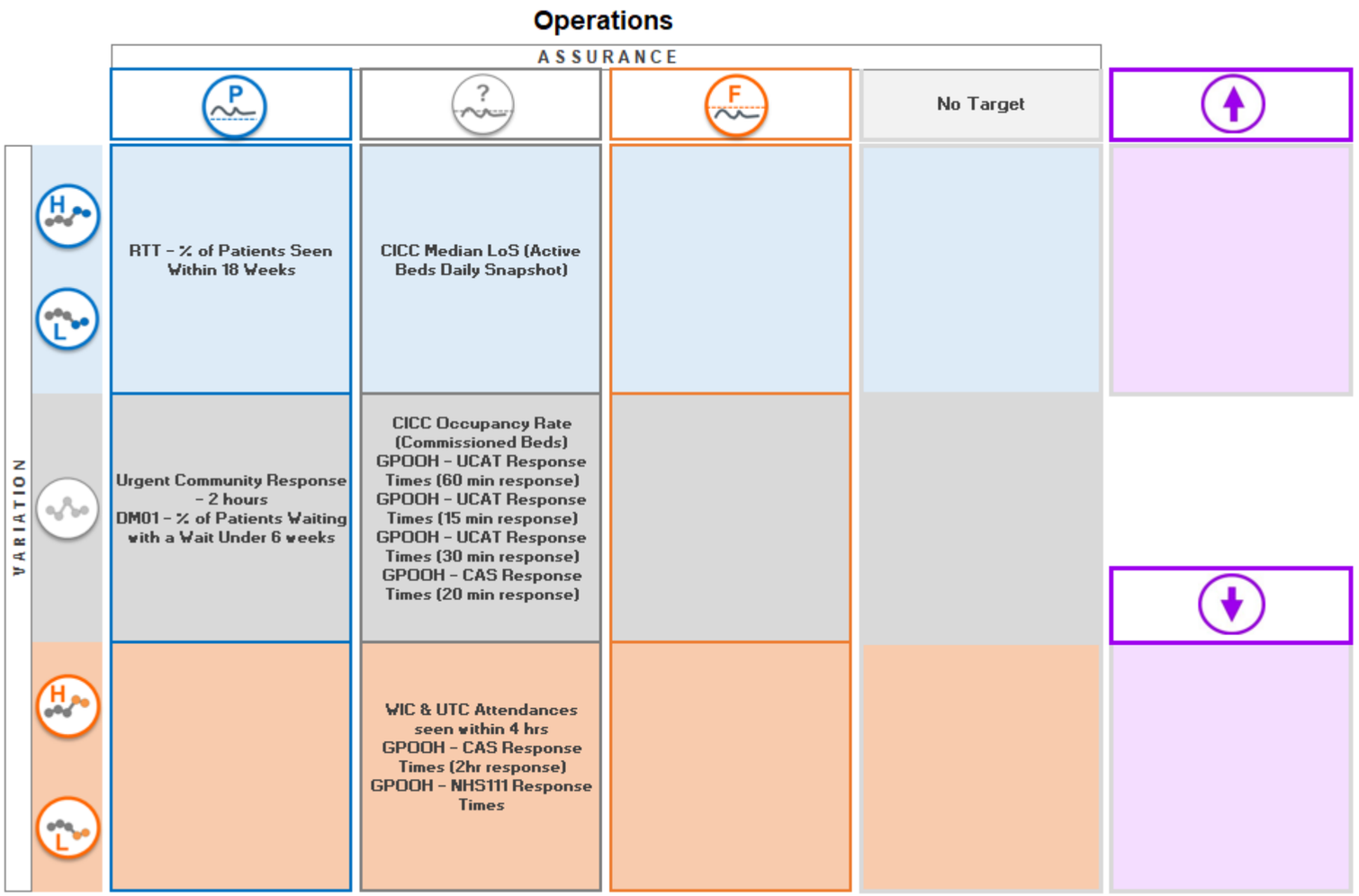
- Waiting lists: remedial action plans in place for Dental and Cardiology services.

  Dental waits are related to volume of patients awaiting paediatric exodontia (Risk 2769). There have been improvements in reducing the backlog and wait times since commencing the action plan in January 2025, however significant deterioration over the last month due to the ongoing theatre issues at WUTH and lost capacity/cancellations. Achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH. Internal and external meetings in place to monitor.

  Cardiology performance related to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. A joint action plan has been agreed collaboratively with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH (using Community Diagnostic Centre capacity). ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long-term solution. Further improvements in month with regards to backlogs and associated KPI performance.

Operational performance continues to be monitored via directorate SAFE/OPG meetings with key themes and escalations being highlighted and reviewed at the monthly Safe Operations Group (SOG) meeting. SOG reports to the monthly Integrated Performance Board where performance is triangulated with finance, HR and quality data.

Operations Domain Matrix

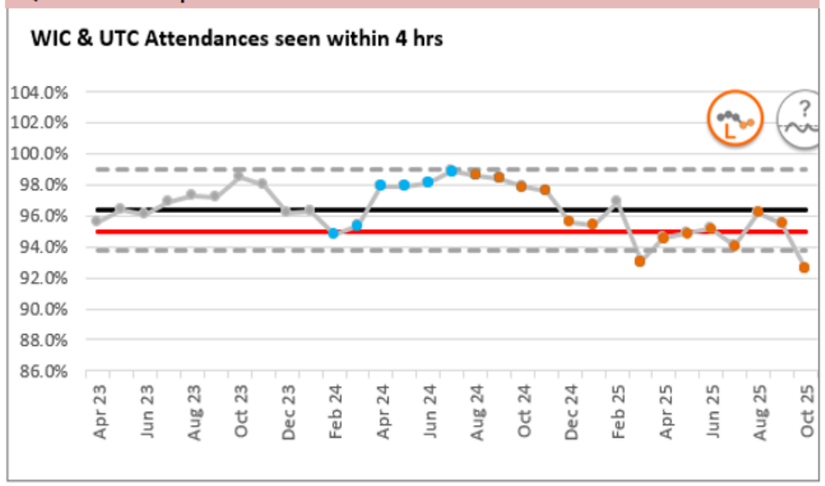


Operations Summary

Highlights	Areas of Concern	Forward Look (Actions)
• UCR performance 87.5.6% against a 70% target and high volume of activity • Intermediate care - CICC occupancy continues above 90% and length of stay remains strong at 17 days against a 21-day target • Waiting lists – RTT and DM01 100% and majority of non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times. • 0-19/25 services – majority of key metrics across the four regional teams performing above target	• UTC / WIC workforce and 4 hour performance • GPOOH performance • Waiting lists: Dental, Cardiology	• Remedial action plans are in place to support performance improvements for GPOOH and UTC • Waiting lists: remedial action plans currently in place for Dental, Cardiology (detailed below).

WIC & UTC Attendances seen within 4 hrs

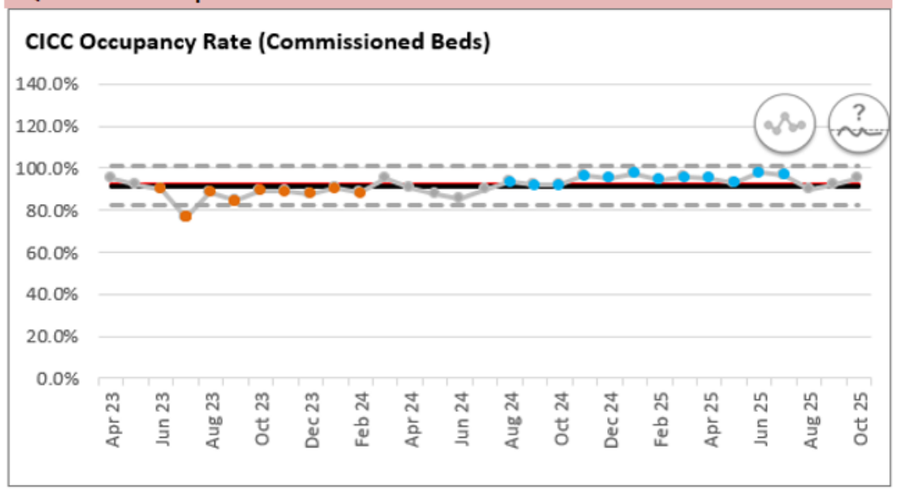
CQC Domain : Responsive



Oct-25
93.0%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CICC Occupancy Rate (Commissioned Beds)

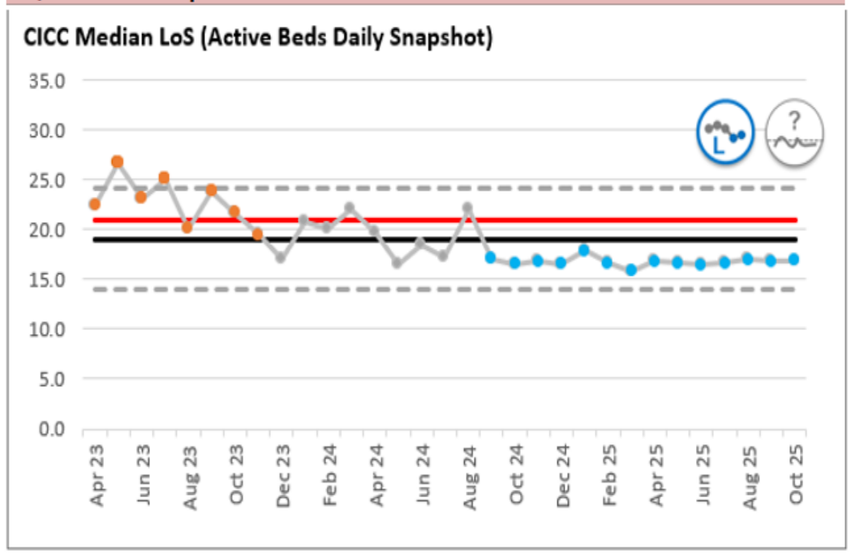
CQC Domain : Responsive



Oct-25
95.0%
Variance Type
Common cause variation
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

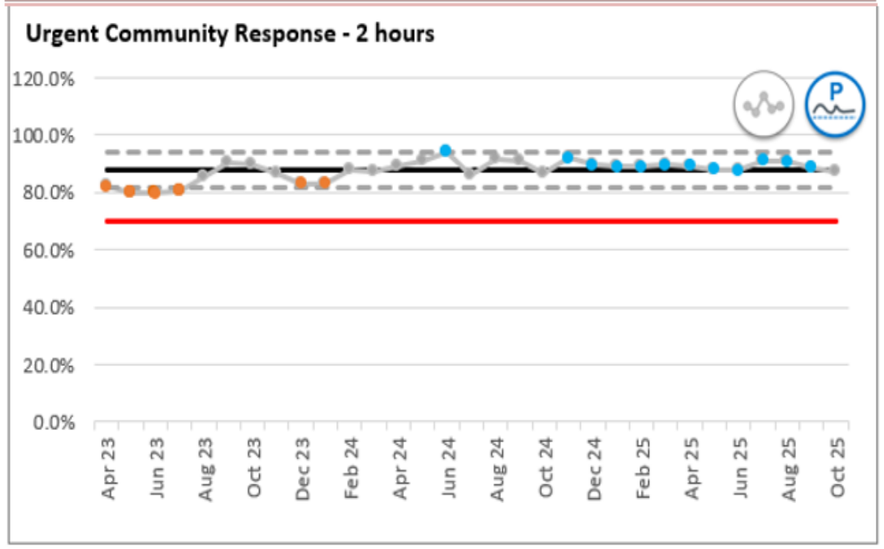
CQC Domain : Responsive



Oct-25
17
Variance Type
Special cause variation - Improving
Threshold
21
Assurance
Hit & miss target subject to random variation

Urgent Community Response - 2 hours

CQC Domain : Responsive



Oct-25
87.5%
Variance Type
Common cause variation
Threshold
≥70%
Assurance
Consistanly hit target

Commentary

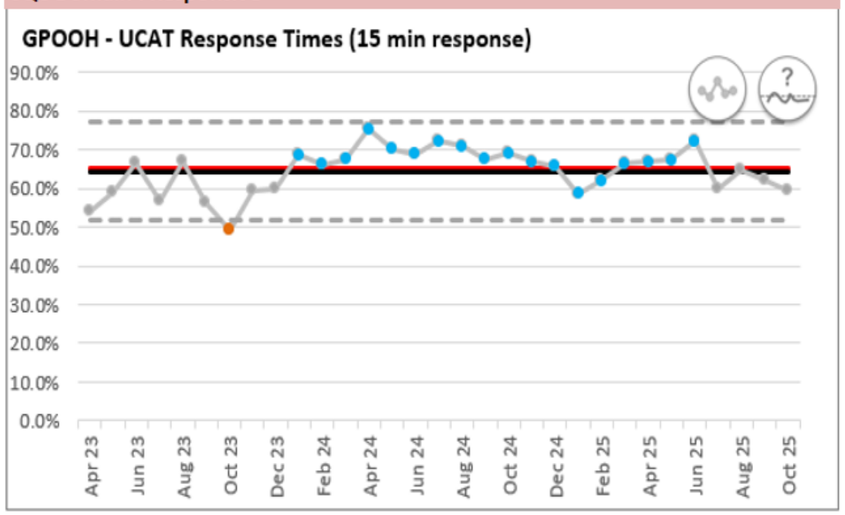
4-hour drop in month to below the 95% target, however, continue with remedial action plans to drive performance improvements. Significant workforce challenges (Risk ID: 3214, rated 16). Plans include reviewing and improving the operational service models (current model and also the future offer as part of integration plans), successful recruitment into vacancies, reductions in sickness absence, daily huddles to review breach themes to drive learning, L&OD support

CICC achieving performance against targets, no concerns

UCR achieving performance against targets, no concerns

GPOOH - UCAT Response Times (15 min response)

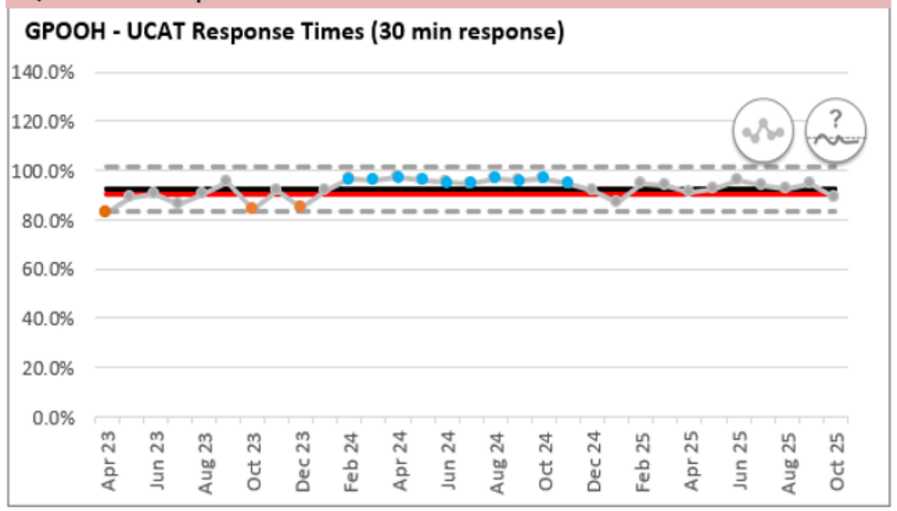
CQC Domain : Responsive



Oct-25
59.1%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

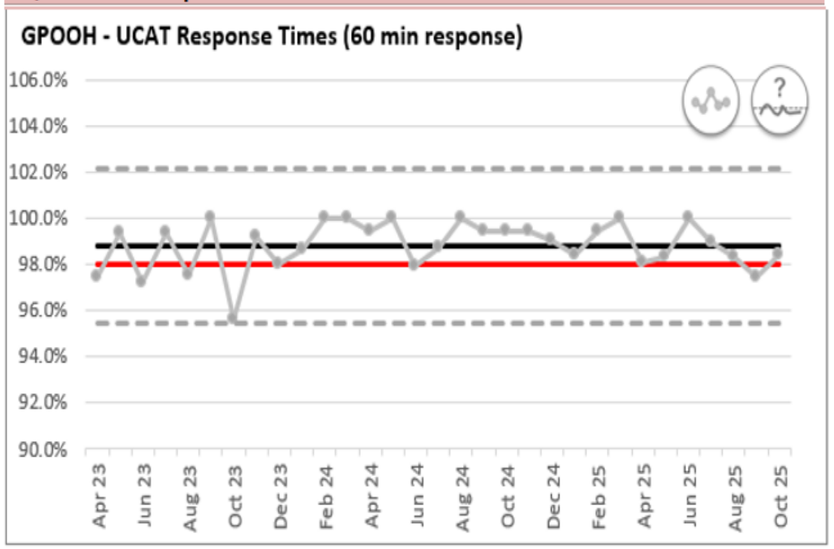
CQC Domain : Responsive



Oct-25
88.7%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

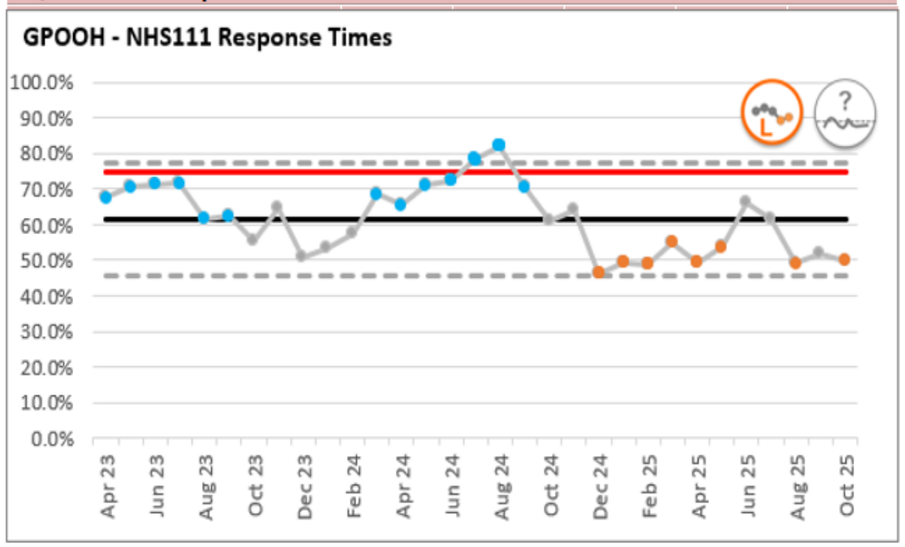
CQC Domain : Responsive



Oct-25
98.4%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive



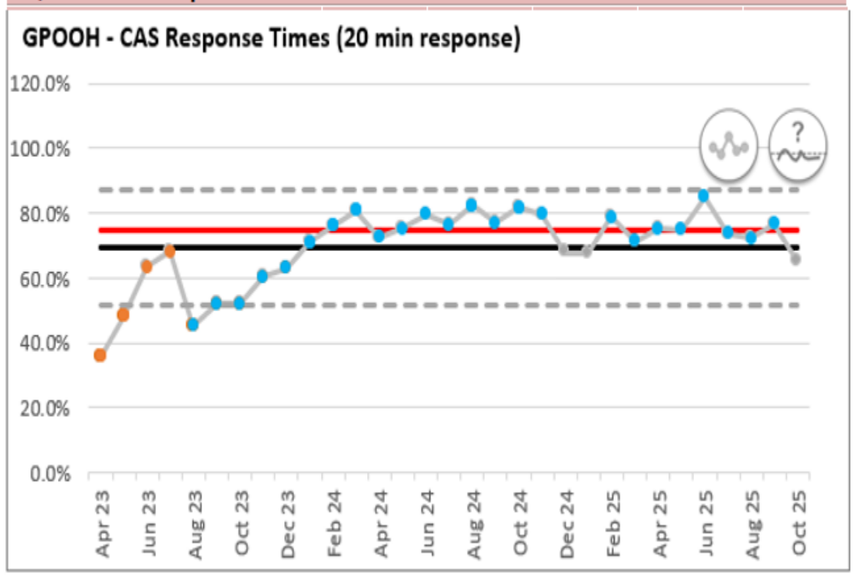
Oct-25
49.9%
Variance Type
Special cause variation - Concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

GPOOH CAS and 111 response times. UCAT 60-minute standard continues to be achieved, however reduction in performance against all other GPOOH metrics. Performance impacted by workforce challenges across urgent care and increased demand in some areas (UCAT, 20% increase on previous month). The risk is reflected on the operational risk register (ID 3227), with mitigation and action plans actively in place and progress monitored through daily oversight and monthly reporting.

GPOOH - CAS Response Times (20 min response)

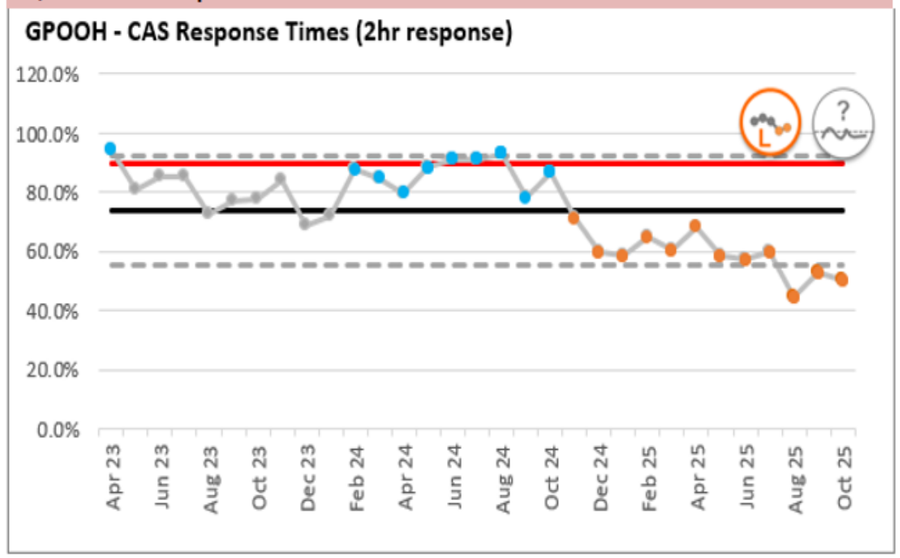
CQC Domain : Responsive



Oct-25
65.1%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

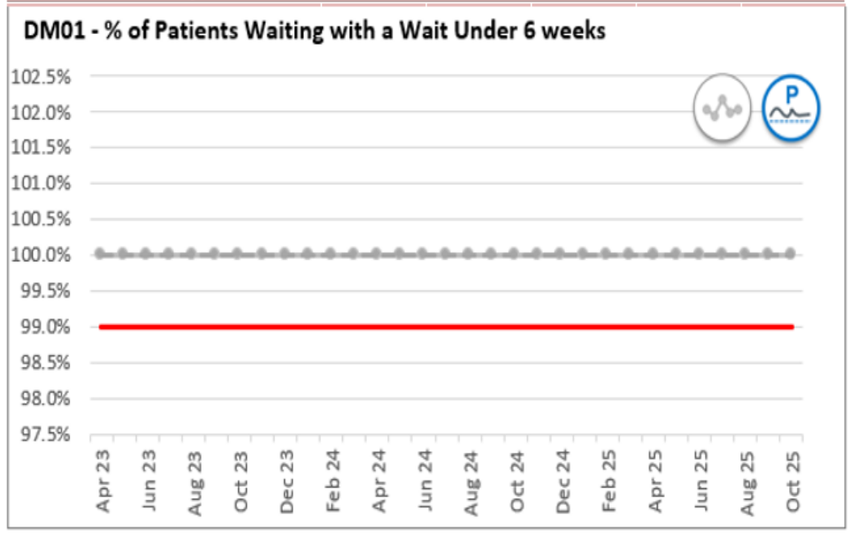
CQC Domain : Responsive



Oct-25
48.6%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

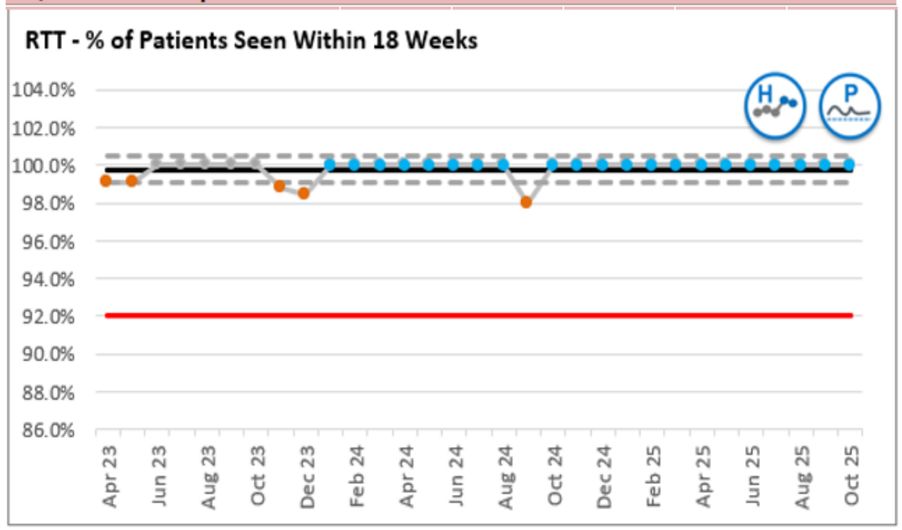
CQC Domain : Responsive



Oct-25
100%
Variance Type
Common cause variation
Threshold
≥99%
Assurance
Performance consistently achieves the target

RTT- % of Patients seen within 18 Weeks

CQC Domain : Responsive



Oct-25
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target

Commentary

DM01/RTT - 100% no concerns

Waiting Lists

Waiting list movement in Month - October 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	78% (-5%)	97% (0%)	100% (0%)	506 (68)
Specialist Medical	94% (0%)	100% (1%)	100% (0%)	1456 (118)
Specialist Medical - Dental	22% (-10%)	42% (-12%)	61% (-12%)	330 (164)
Therapies	59% (3%)	82% (3%)	92% (2%)	4255 (-127)

0-19/25 Performance

0-19/25 Services - October 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	87.5%	88.5%	81.5%	86.5%	92.0%	93.3%	94.9%	94.7%
12 month reviews	89.0%	89.8%	91.2%	89.4%	95.9%	96.6%	91.7%	91.6%
2.5 year reviews	88.0%	88.4%	89.6%	88.9%	90.9%	94.2%	85.3%	89.6%
Breastfeeding 6-8 weeks	55.3%	56.8%	37.1%	37.8%	46.9%	40.8%	43.6%	44.7%

Commentary

Waiting Lists. (*Please note this is a live position as of 25.11.25*.) The average waiting time for all services is below 18 weeks and the majority of services are demonstrating improvements in year to date performance for the volume of patients waiting.

Remedial action plans remain in place for Dental and Cardiology services. Dental waits are related to volume of patients awaiting paediatric exodontia (Risk 2769). Improvements in reducing the backlog and wait times since commencing the action plan in January 2025 however progress significantly impacted by the recent theatre issues at WUTH with lost capacity and cancellations. The recovery plan remains in place and improvement trajectories are being refreshed based on the current position. Work is ongoing with WUTH to secure the additional theatre capacity required to ensure recovery milestones are achieved, however achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH.

Cardiology performance relating to the volume of outstanding resting ECGs and the substantial increase in referrals as a result of GP collective action. A joint action plan has been agreed collaboratively with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH (using Community Diagnostic Centre capacity). ICB colleagues are also progressing with an action plan to increase capacity in Primary Care as a long-term solution. Further improvements in month with regards to backlogs and associated KPI performance.

Some slight increases in volume of patients waiting in month for Nursing (Bladder and Bowel) and Specialist Medical services, however within normal variation.

0-19/25 services. All key metrics across the four regional teams performing above target with the exception of Knowsley birth visits in month (81.5% against and 85% target). This is due to workforce challenges in the team with sickness and vacancy. Sickness being managed in line with policy and new starters in post from November so confident KPI will be green again next month.

Dashboard	Quality and Governance
Lead	Chief Nurse

Chief Nurse Update

This report provides assurance that a positive patient safety system in embedded across the Trust, with improvements robustly tracked and sustained.

During the M7 reporting period, there have been no reported never events or StEIS reportable incidents.

Incident reporting is an effective measure of safety culture across an organisation. During the previous reporting month a reduction in incident reporting had been noted, with six data points below the mean. Following targeted communications and disseminated via the Trust's governance system, M7 evidences an increase in incident reporting, with levels almost aligned to the mean. This increase is also reflected in patient safety incident reporting, however, due to the variation in reporting, these indicators remain within special cause variation and will be subject to close monitoring. This is to identify learning opportunities which recognises the importance of developing a proactive and positive culture of safety. This is aligned to the principles of the Patient Safety Incident Response Framework.

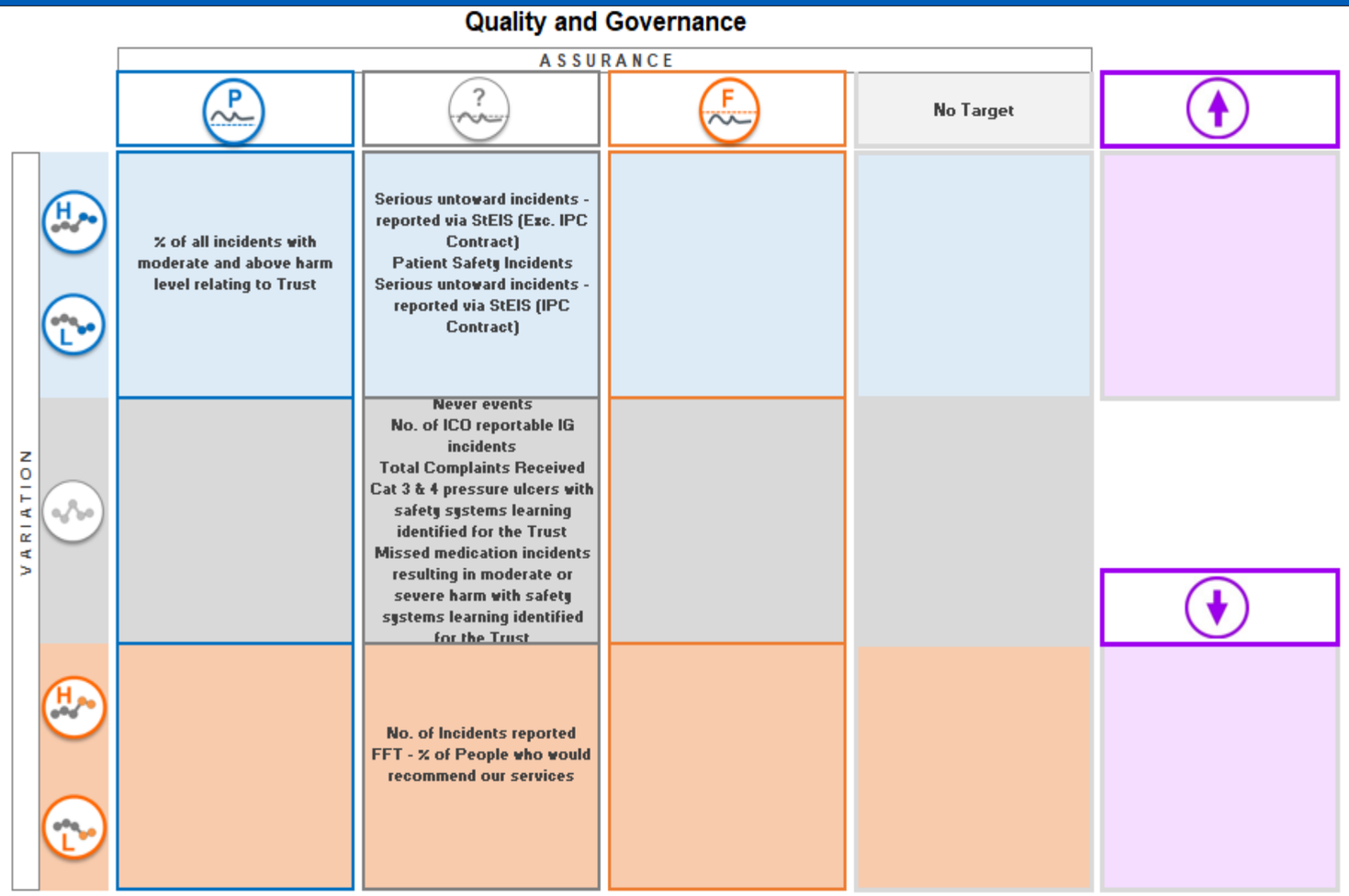
In accordance with the Patient Safety Incident Response Framework (PSIRF) the Trust monitors all patient safety incidents, including those resulting in no or low harm. During M7, 93.8% of patient safety incidents reported were no or low harm incidents.

During the M7 reporting period, there have been zero falls at CICC resulting in moderate harm, zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning for the Trust. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained. These clinical quality metrics continue to be prioritised and are being incorporated into the refresh of the Trust's 2025/26 Patient safety incident response plan.

There has been an increase in the Friends and Family Test score from 86.1% in M6 to 87.1% in M7 based on 2,140 positive responses, however, this remains below the Trust's standard of 90% and continues to evidence concerning special cause variation. Of the remaining feedback, 5.5% was neither positive or negative and 7.4% of feedback was negative. Data analysis has identified learning opportunities for urgent care services outside of the direct clinical consultation, including management of expectations regarding waiting times and access to food and drink within waiting areas. An action plan is being developed to address the identified areas for improvement based on learning from experiences of care.

Five complaints and sixteen concerns have been received by the Trust during M7, reflecting common cause variation resulting in a red RAG rating for both indicators. Of the five complaints received, four relate to urgent care services and have progressed to investigation to identify learning.

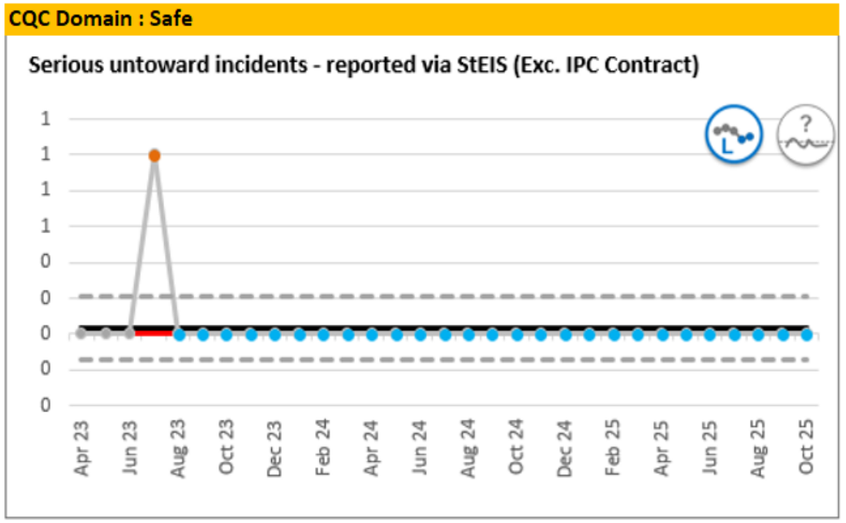
Quality and Governance Domain Matrix



Quality and Governance Summary

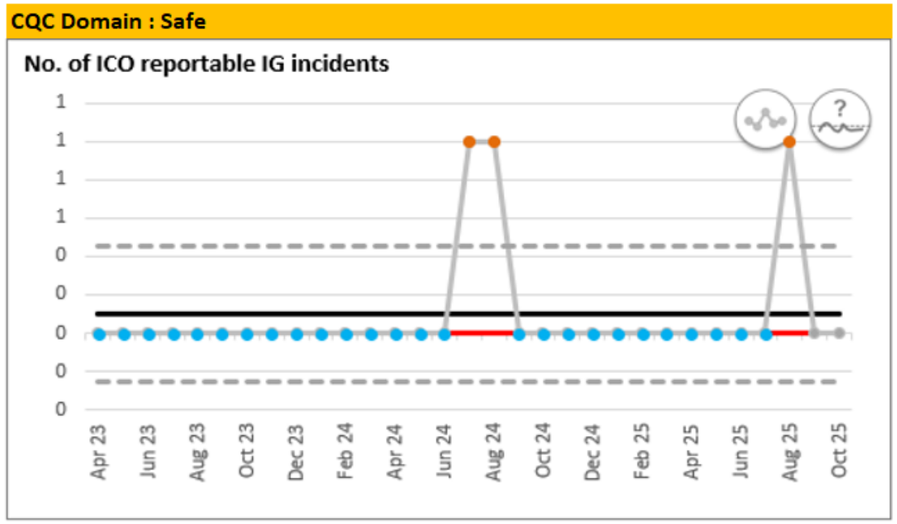
Highlights	Areas of Concern	Forward Look (Actions)
The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust governance framework; this is evidenced by the patient safety outcomes achieved.	Despite an increase in incident reporting during M7, due to the variation in reporting, this indicator remains within special cause variation and will be subject to close monitoring. The Friends and Family Test score in M7 was 87.1% based on 2,140 positive responses; this remains below the Trust's standard of 90% and continues to evidence concerning special cause variation. Of the remaining feedback, 5.5% was neither positive or negative and 7.4% of feedback was negative. Data analysis has identified learning opportunities for urgent care services.	Clinical Risk Management Group continue to track improvement plans relating to falls prevention on inpatient units, safe administration of medications, wound care management and end of life improvements. A new plan was added during 2025/26 for monitoring indwelling urinary catheter devices. All plans have demonstrated improvements in Trust wide safety systems and their consistent application.

Serious untoward incidents – reported via StEIS (Exc IPC Contract)



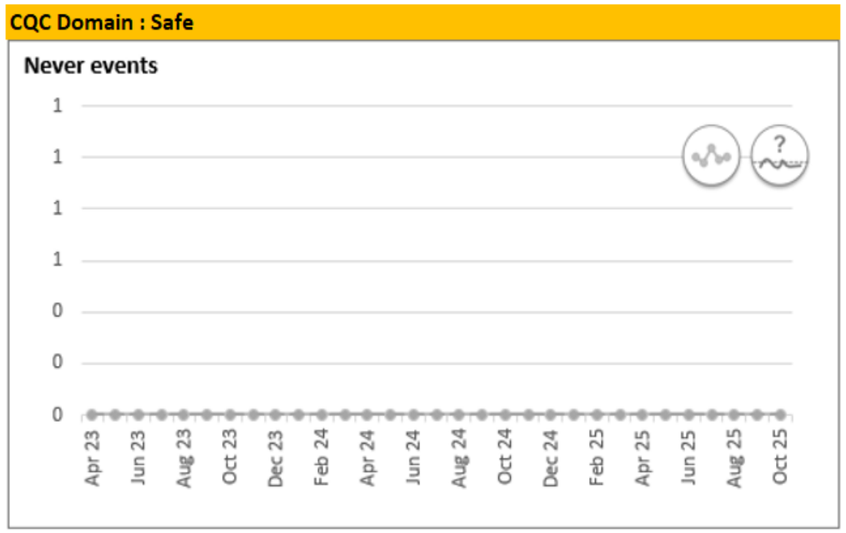
Oct-25
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

No. of ICO reportable IG incidents



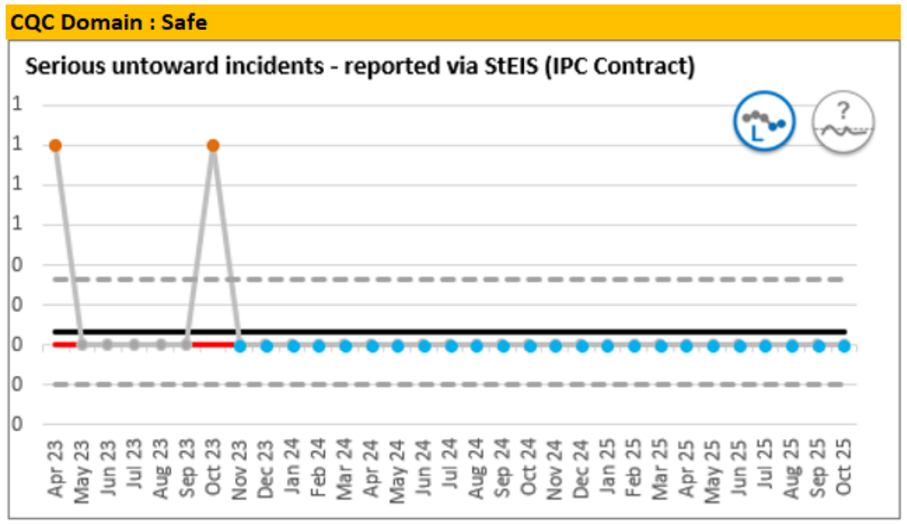
Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Serious untoward incidents – reported via StEIS (IPC Contract)



Oct-25
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Commentary

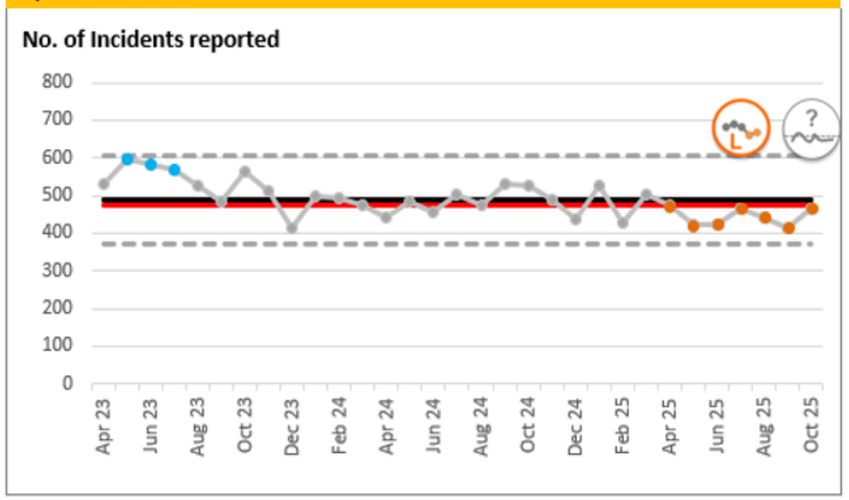
The above indicators all have tolerances of zero.

During the M7 reporting period, there have been no reported incidents relating to any of these indicators.

This demonstrates the effectiveness of the Trust's safety systems, which are robustly tracked throughout the governance of the organisation, with clear delivery of sustained outcomes.

Number of Incidents reported

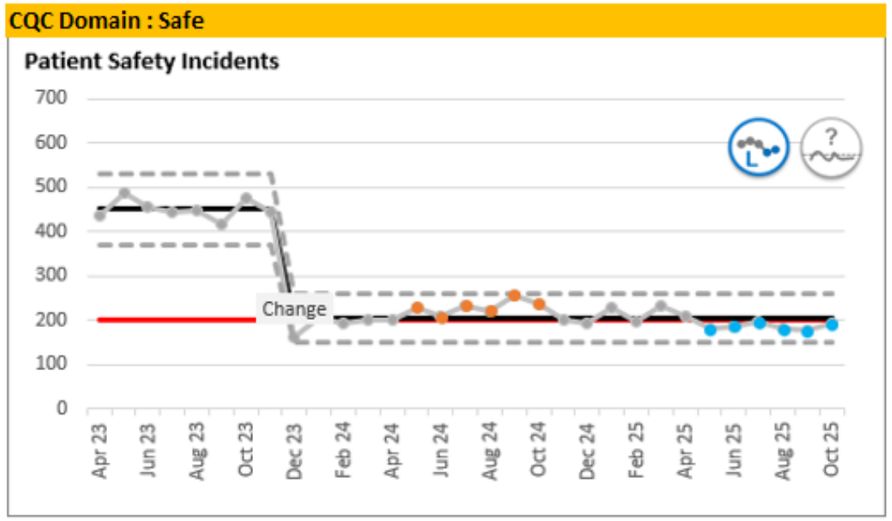
CQC Domain : Safe



Oct-25
467
Variance Type
Special cause variation - Concerning
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

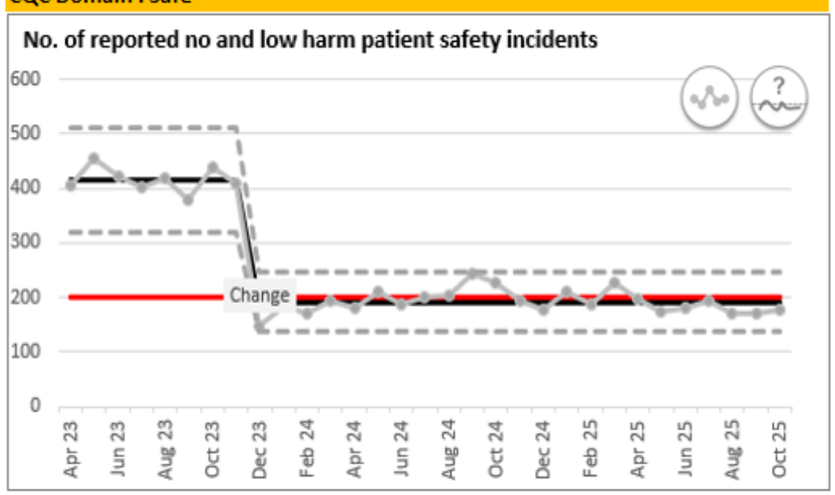
CQC Domain : Safe



Oct-25
194
Variance Type
Special cause variation - Improving
Threshold
200
Assurance
Hit & miss target subject to random variation

No. of reported no and low harm patient safety incidents

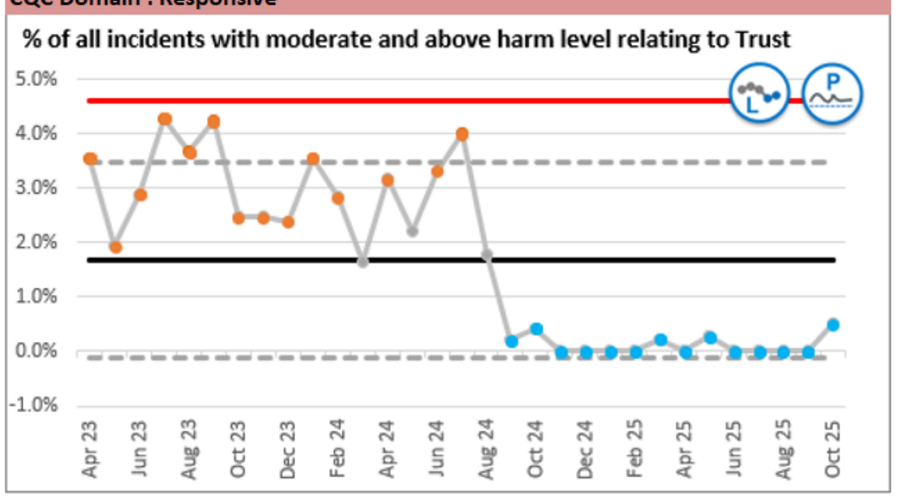
CQC Domain : Safe



Oct-25
182
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

% of all incidents with moderate and above harm level relating to Trust

CQC Domain : Responsive



Oct-25
0.5%
Variance Type
Special cause variation - Improving
Threshold
2.2%
Assurance
Consistently hit target

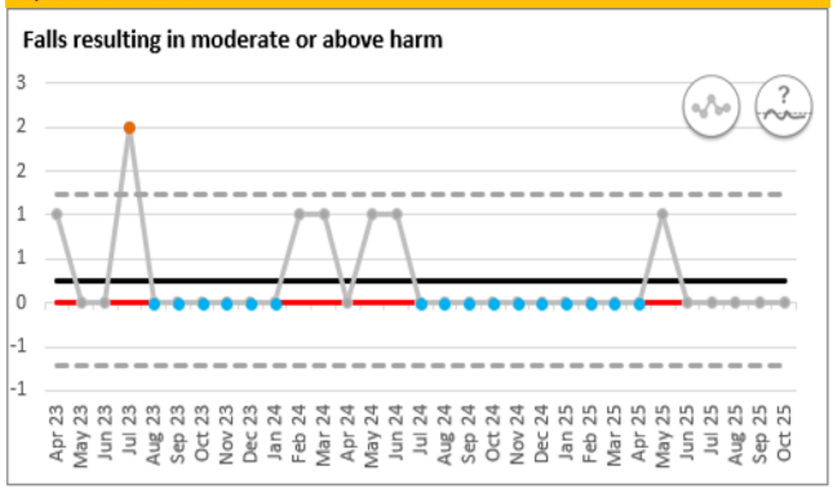
Commentary

Incident reporting is an effective measure of safety culture across an organisation. During the previous reporting month a reduction in incident reporting had been noted, with six data points below the mean. Following targeted communications and disseminated via the Trust's governance system, M7 evidences an increase in incident reporting, with levels almost aligned to the mean. This increase is also reflected in patient safety incident reporting, however, due to the variation in reporting, this indicator remains within special cause variation and will be subject to close monitoring. This is to identify learning opportunities which recognises the importance of developing a proactive and positive culture of safety. This is aligned to the principles of the Patient Safety Incident Response Framework.

The number of low and no harm incidents remains within common cause variation and represents 93.8% of patient safety incidents reported during M7.

Falls resulting in moderate or above harm

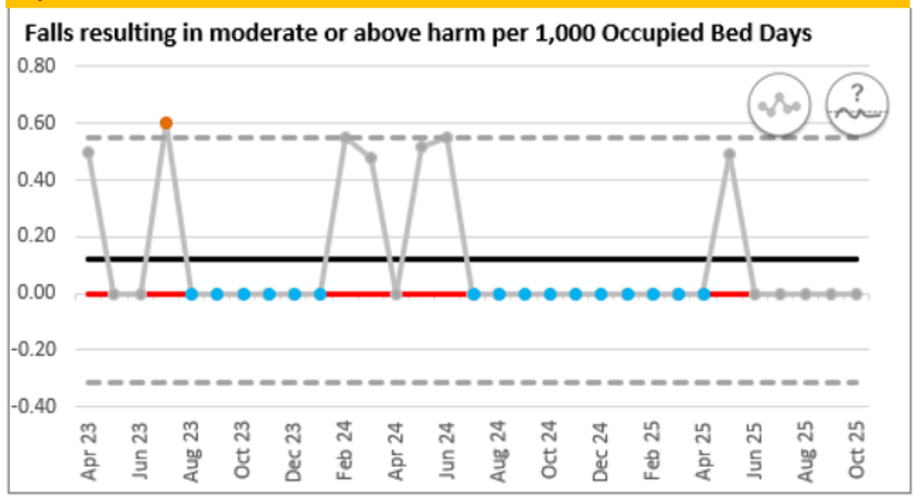
CQC Domain : Safe



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Falls resulting in moderate or above harm per 1,000 occupied bed days

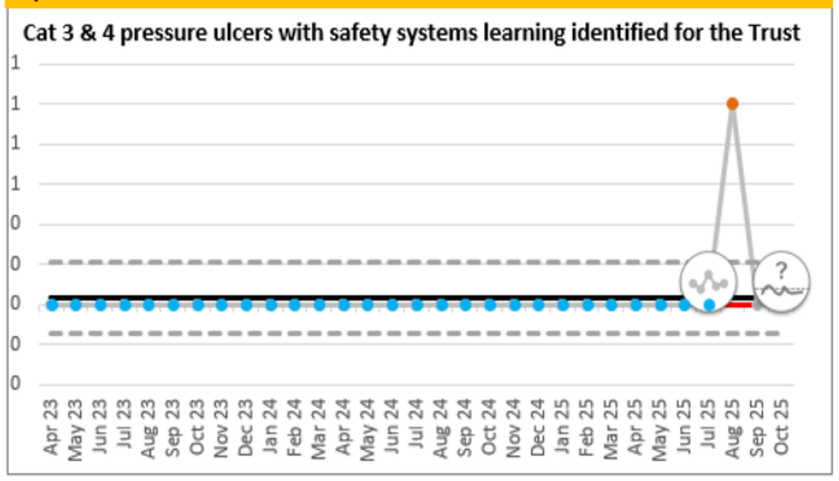
CQC Domain : Safe



Oct-25
0.00
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust

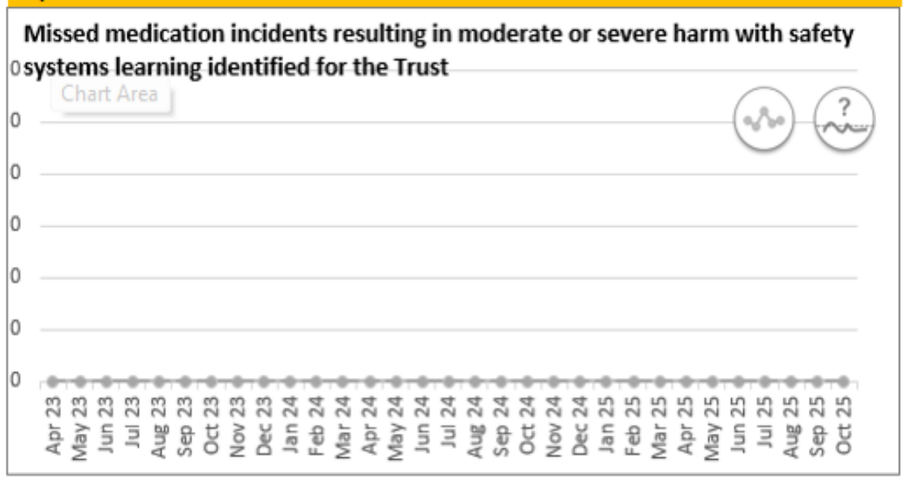
CQC Domain : Safe



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust

CQC Domain : Safe



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

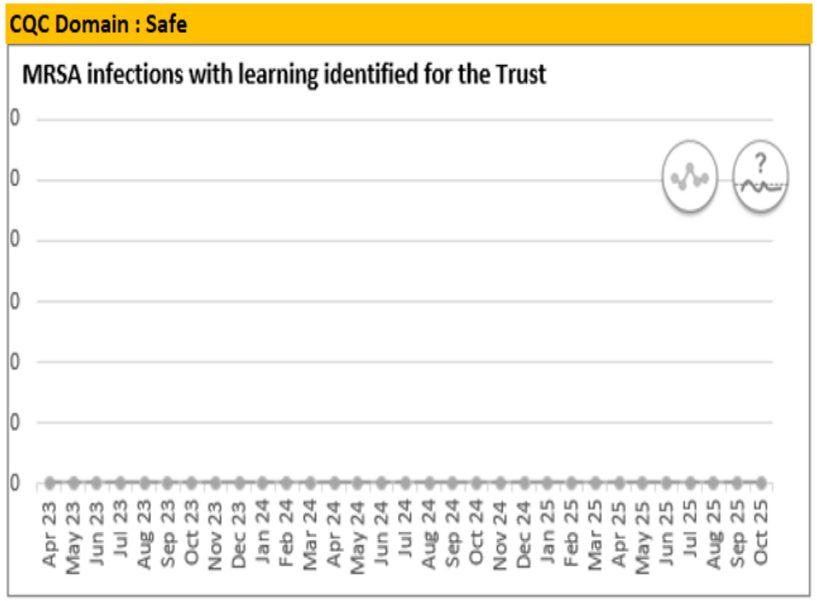
Commentary

In accordance with the Patient Safety Incident Response Framework the Trust has embedded a robust governance structure to identify safety systems learning for all moderate and above harm incidents.

During the M7 reporting period, there have been zero falls at CICC resulting in moderate harm; the year to-date position is one moderate harm fall. There have been zero category 3 and 4 pressure ulcers and zero missed medication incidents with safety systems learning identified for the Trust during the reporting period. This evidences the impact of the Trust's quality improvement work which is tracked at Clinical Risk Management Group to ensure learning is embedded and improvements sustained.

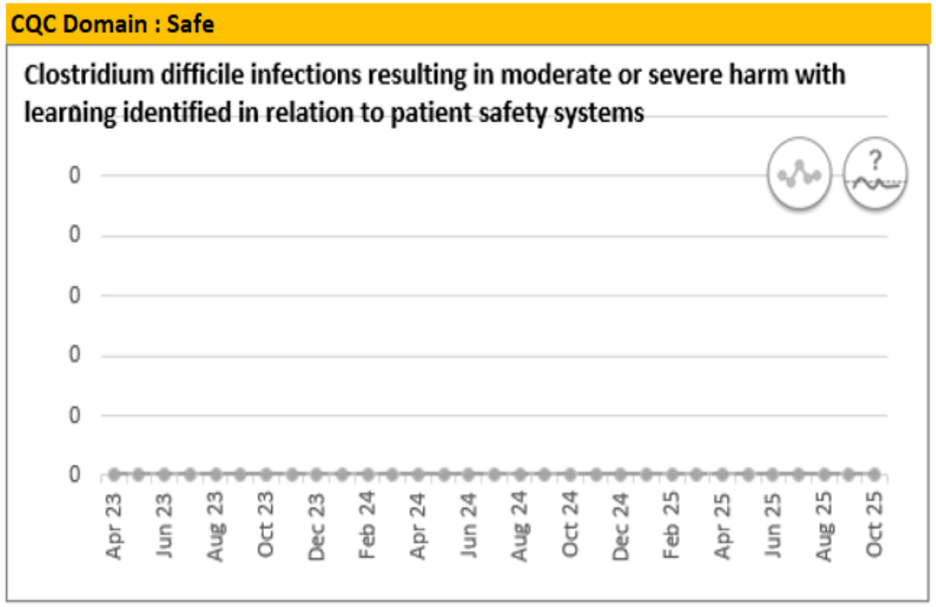
These clinical quality metrics continue to be prioritised and have been incorporated into the refresh of the Trust's 2025/26 Patient safety incident response plan.

MRSA infections with learning identified for the Trust



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Clostridium difficile infections resulting in moderate or severe harm with learning identified in relation to patient safety systems



Oct-25
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

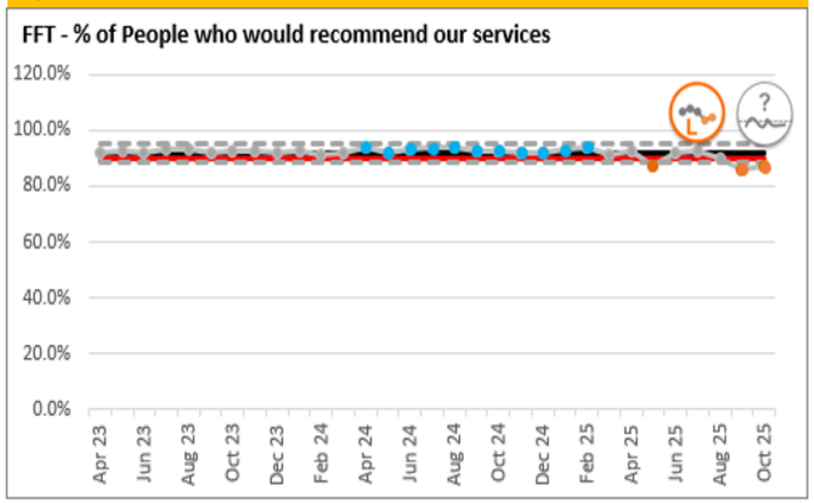
Commentary

During M7, there have been no incidents of MRSA or CDiff resulting in moderate or severe harm with learning identified in relation to patient safety systems.

Wirral is an outlier for C.diff cases nationally; a strategy has been developed with system partners to progress key workstreams across four pillars; Public Health/ICB, Primary and Domiciliary Care, Community (including complex care settings) settings and Hospital settings.

FFT - % of People who would recommend our services

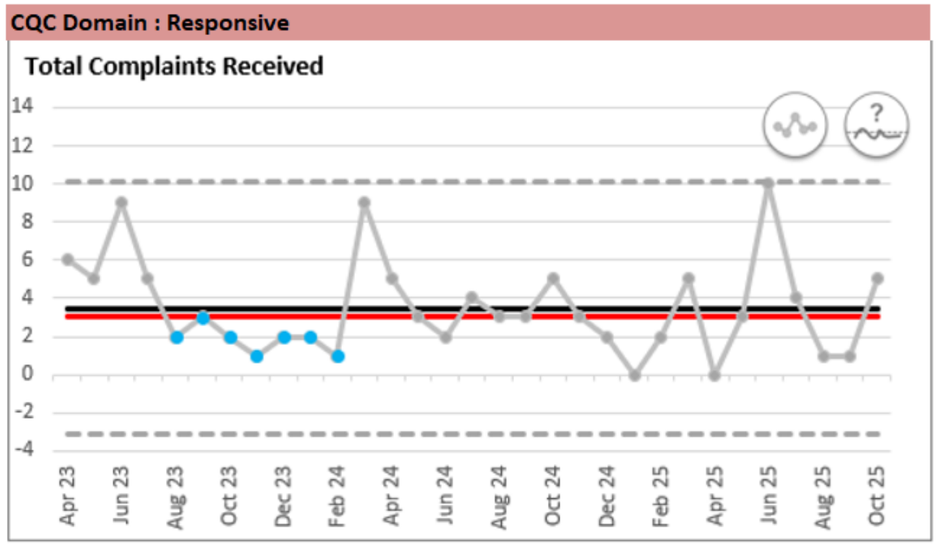
CQC Domain : Safe



Oct-25
87.1%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Total Complaints Received

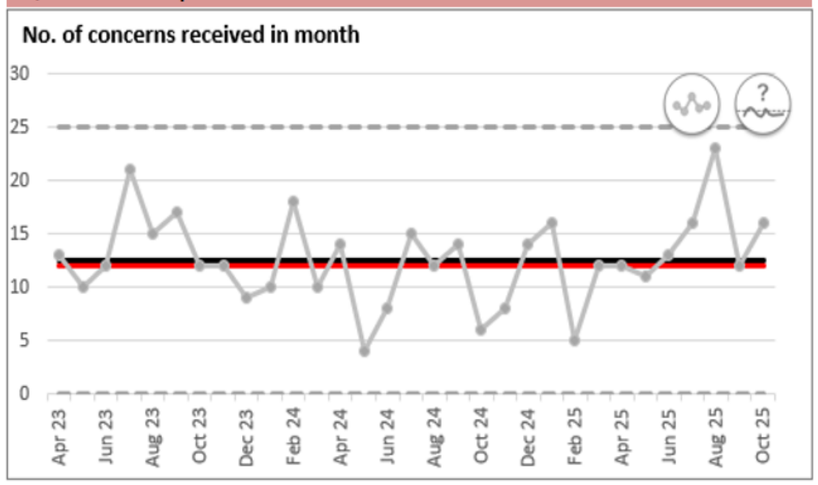
CQC Domain : Responsive



Oct-25
5
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month

CQC Domain : Responsive



Oct-25
16
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

Commentary

There has been an increase in the Friends and Family Test score from 86.1% in M6 to 87.1% in M7 based on 2,140 positive responses, however, this remains below the Trust's standard of 90% and continues to evidence concerning special cause variation. Of the remaining feedback, 5.5% was neither positive or negative and 7.4% of feedback was negative. Data analysis has identified learning opportunities for urgent care services outside of the direct clinical consultation, including management of expectations regarding waiting times and access to food and drink within waiting areas. An action plan is being developed to address the identified areas for improvement based on learning from experiences of care.

Five complaints and sixteen concerns have been received by the Trust during M7, reflecting common cause variation resulting in a red RAG rating for both indicators. Of the five complaints, four relate to urgent care services and have progressed to investigation to identify learning.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of October the Trust is reporting a surplus of £1m. This is an improvement on plan but there is no change to the projected year end surplus of £0.9m. At M7 the Trust has identified £5.06m of CIP in year, all full year effect, against its revised target of £6.6m.

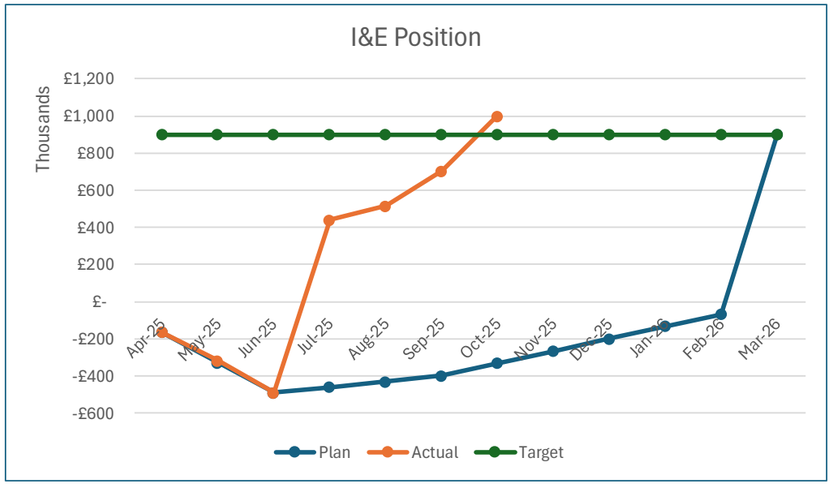
Finance Domain Matrix

Statutory Financial Targets	RAG (M7)	RAG (Forecast)
Financial stability	🟢	🟢
Agency spend	🟢	🟢
Financial sustainability	🟢	🟢
Financial Efficiency	🟡	🟢
Capital	🟡	🟢
Cash	🟢	🟢

Finance Summary

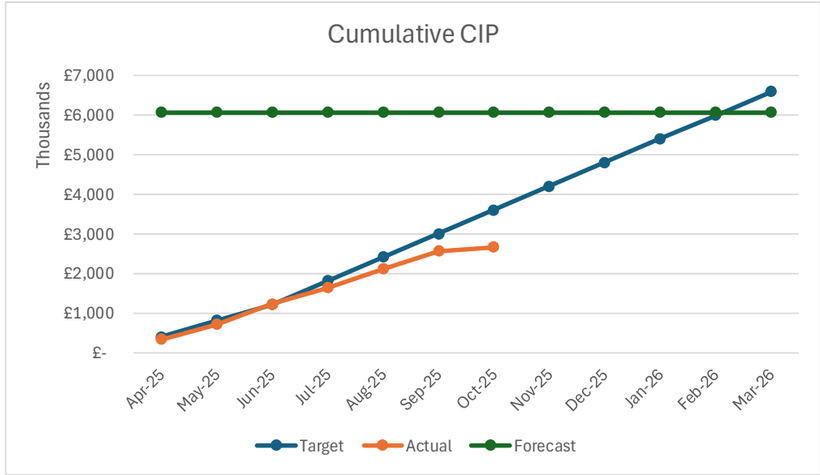
Highlights	Areas of Concern	Forward Look (Actions)
The Trust is ahead of plan at M7. Income is behind plan but this is fully offset by underspends in both pay and non-pay.	The key risk facing the Trust remains the CIP stretch target.	The Trust continues to look at identify additional CIP schemes.

I&E Position



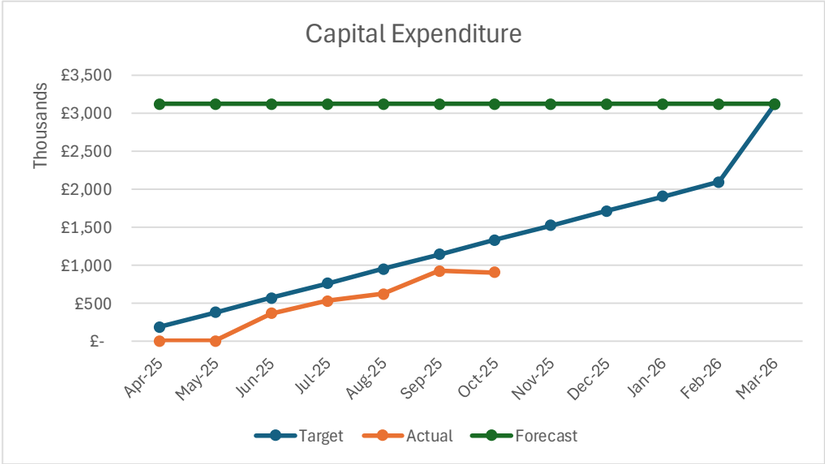
Oct-25
£1,000k
Variance
Position better plan
Target
£900k

Cumulative CIP



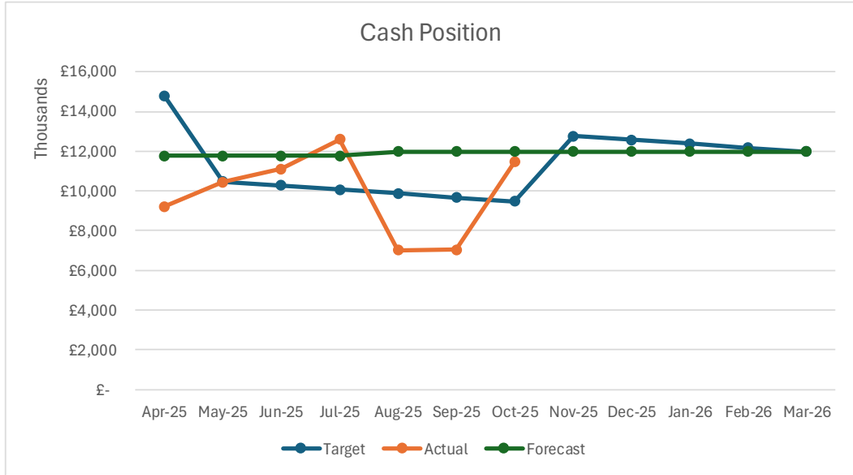
Oct-25
£2,662k
Variance
Position worse than plan
Target
£3,609k

Capital Expenditure



Oct-25
£902k
Variance
Position worse than plan
Target
£1,332k

Cash Position



Oct-25
£11,408k
Variance
Position better than plan
Target
£9,471k

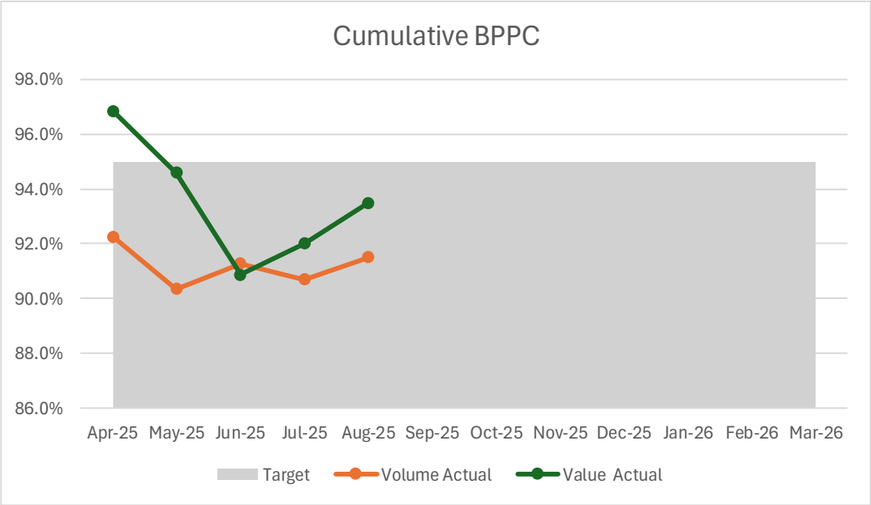
Commentary

The Trust is ahead of plan at M7. Patient care and education and training income are ahead of plan, however divisional income is behind plan. There are non-pay underspends across purchase of healthcare, supplies and services, premises and depreciation and amortisation.

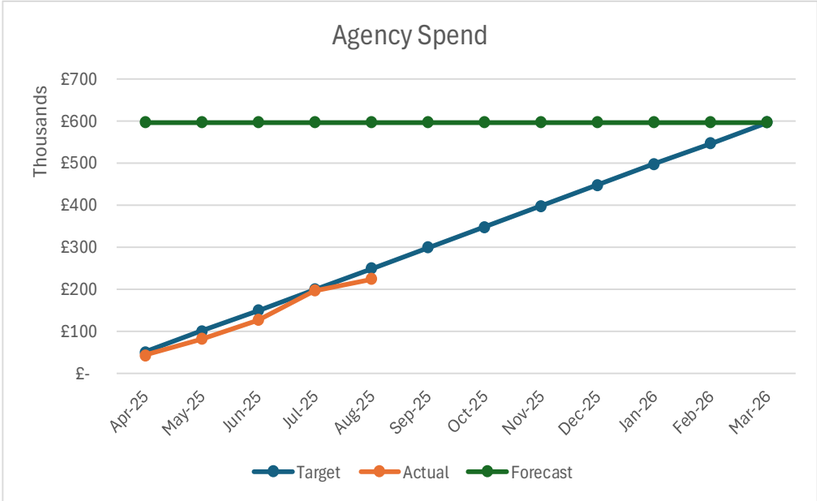
CIP transacted at M7 is £0.947m behind plan.

The cash balance at M7 is higher than plan. The underlying increase in cash is linked to staff vacancies and the increase in creditors and corresponding underperformance on BPPC to date.

Cumulative BPPC



Agency Spend



Aug-25
£225k
Variance
Position better than plan
Target
£249k

Commentary

At Month 7 the Trust is 5.9% (volume) and 1.2% (value) behind target. The number of invoices on hold continues to create a problem and this underperformance is reflected in the increase in the creditor position. It is hoped that the transfer onto NEP will enable the Trust to investigate some of the historical issues which are holding up the payment of older invoices.

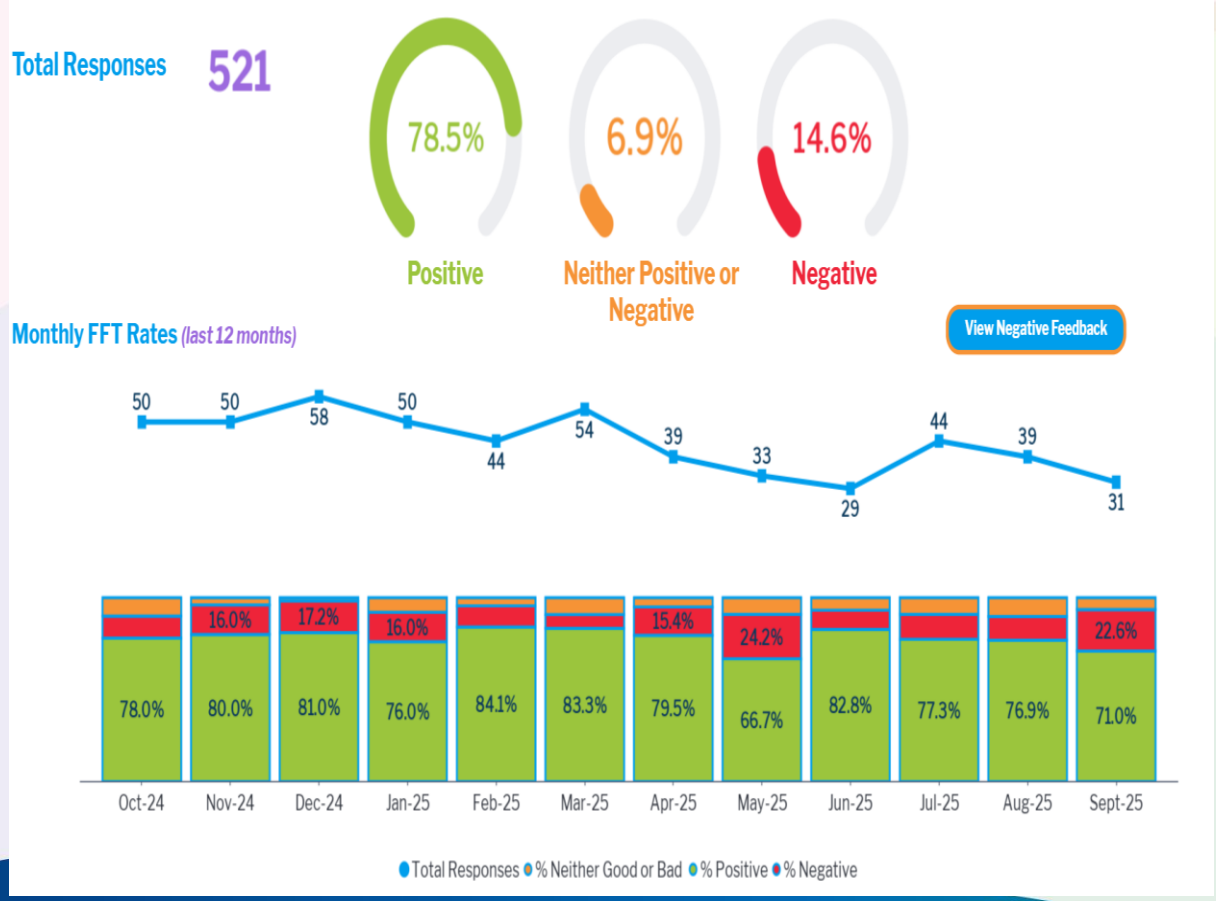
Appendix 1

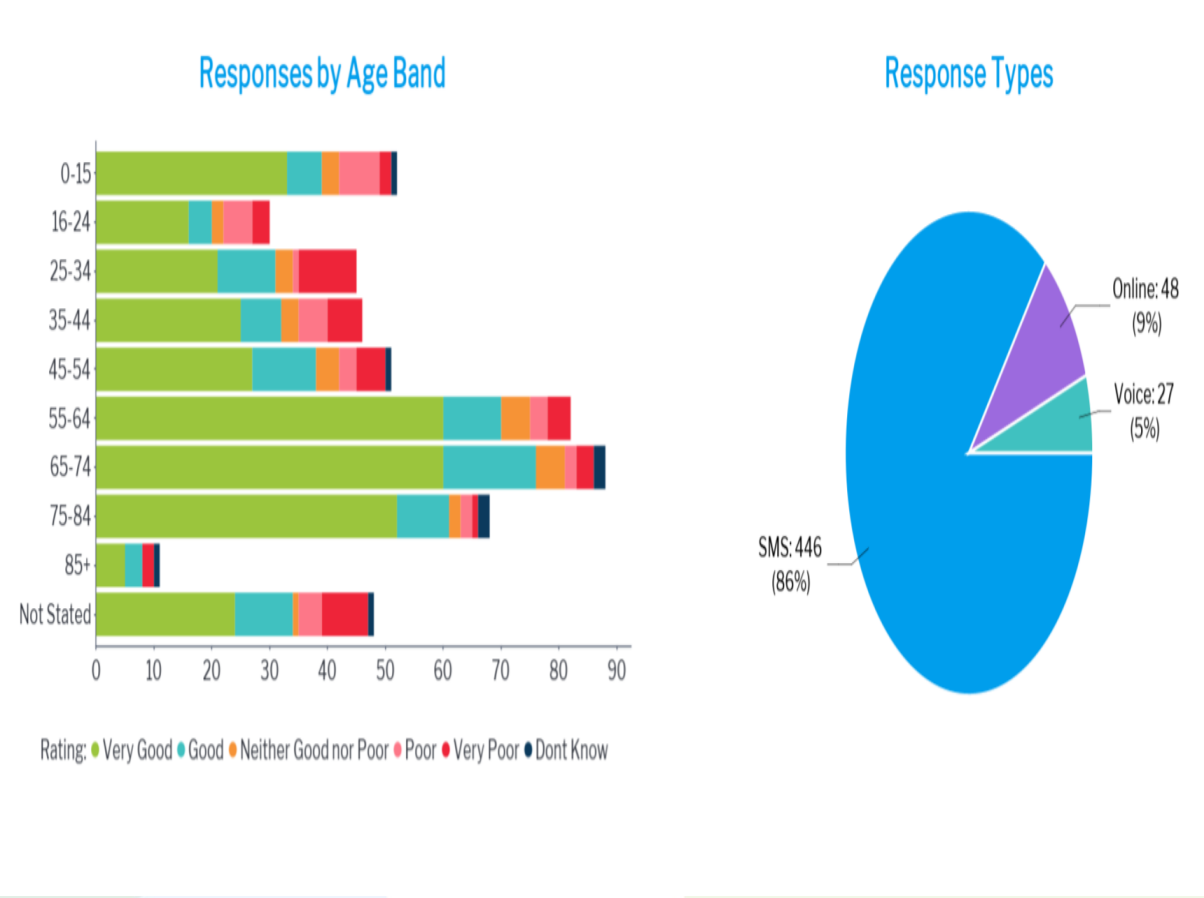
GP Out of Hours
Your Experience Feedback including FFT and Complaints (01.10.24 – 24/11/25)

Compassion | Open | Trust

Wirral Community Health and Care NHS Foundation Trust

Friends and Family Data (01.10.24 – 30.09.25)





Friends and Family Data (01.10.24 – 30.09.25)

- **Positive Ratings (Very Good + Good):**
  Most age groups lean heavily toward positive feedback, especially the **65–74** and **75–84** bands.
  The **25–34** and **35–44** groups also show strong positive responses, though slightly more mixed.

- **Neutral and Negative Ratings:**
  The **16–24** and **45–54** age bands show a more balanced mix, with noticeable segments of neutral and poor ratings.
  The **85+** group has fewer responses overall but still trends positively.

- **Don't Know Responses:**
  These are minimal across all age bands, suggesting most respondents felt confident in their ratings.

- **Not Stated:**
  This category has a wide spread of responses, indicating a mix of opinions from those who didn't disclose their age.

Friends and Family Data (01.10.24 – 30.09.25)

- There were 77 responses that were rated as “poor” or “very poor”
- Of those, 31 left no other feedback making it difficult for the service to understand why people experienced the service less positively
- 2 comments suggest the negative rating was given erroneously and patients meant to rate as positive
- 6 comments were in relation to another service, not GPOOH
- There were 38 comments describing “poor” or “very poor” experiences and the analysis is based on this data
- Of the 28 “neither good nor poor” responses and 8 “Don’t know” responses, 15 left no further feedback

Key Themes Identified:

FFT Response	Key Themes Identified
Very Good / Good	Excellent clinical care and communication; Professional and kind staff; Fast service and short wait times although some delays reported on this category; Friendly, empathetic staff; Good explanations and reassurance given; Clean facilities; Smooth coordination between services (111 and GPOOH)
Neither Good Nor Poor	Mixed experiences; Long waits and unclear communication; Some positive interactions with staff
Very Poor / Poor	Long wait times and dissatisfaction with order of people being seen; Poor communication and coordination of services between 111 and GPOOH leading to mismatch in expectations; Impact of having to wait with babies and young children and impact on experiences; impact of busy and sometimes noisy environment for people who have sensory issues or do not like noisy and busy environments;
Don't Know	***Very low numbers suggesting most people had a clear opinion about their experience***

Focussed Engagement – Nov 2025

- To further understand the experiences of people attending GPOOH, there has been some focussed engagement with people who have attended the service during November.
- 6 patients were contacted. 3 adults (aged between 23 and 67 years) and 3 children (aged between 4-12 years).
- All patients (or their parent/carer for the children) called 111 because they became unwell or needed support for their health condition at a time when they could not access their local GP i.e. out of hours.
- Each person was asked to rate their experience on a scale of 1-5 (very good – good – neither good nor poor – poor – very poor)
- 2 rated their experience as “Very Good”, 1 as “Good” and 3 as “Neither good nor poor.”
- The people that rated as “Neither Good nor Poor” did so because they experience elements that were both positive and less positive.

Focussed Engagement Contd

Clinical Outcomes:

- 3/6 of the patients had a face-to-face appointment with a GP in out of hours. They were all satisfied with the clinical outcome and have not needed to reattend any health service since their appointment with a reoccurrence of their condition.
- 2/6 of the patients had a phone consultation with a GP in out of hours. They were all satisfied with the clinical outcome and have not needed to reattend any health service since their appointment with a reoccurrence of their condition.
- 1 of the patients was advised to attend Emergency Department due to uncontrolled diabetes. They were admitted to a ward at APH where they stayed for 1 week. They report ongoing issues with their diabetes.

Focussed Engagement Contd

Access:

- 5/6 of the people contacted 111 by phone and then received a phone call back from a GP or ANP
- 1/6 of the people contacted 111 online and then received a phone call back from the GP.
- The time waiting for a phone call back ranged from 15 minutes to 10 hours.
- The 15-minute wait was for a nurse call back and advice and reassurance was provided with no further follow up needed.
- Safety netting advice (provided by 111) was given to most patients, sharing advice leaflets or signposting to the 111 online service.
- Feedback was received about the car park at APH. This related to lighting, signposting and an issue with leaving the carpark after the consultation.
- Some patients experienced difficulty accessing medication due to pharmacy capacity and availability
- Waiting time information was not always updated or communicated on site in GPOOH

Focussed Engagement Contd

Experience:

- There were mixed experiences, but most people called were pleased with the clinical outcome from their contact with 111 and GPOOH.
- 1 person reported that she received the care that she needed at the time, and this was through a phone consultation with a nurse 15 minutes after calling 111.
- The mother of one of the children, despite waiting 6 hours for a call from the GP, was grateful that her child could stay at home whilst waiting, in the comfort of their own bed. This sentiment was reflected by another parent whose son has ASD. They both valued that they could wait in their own home rather than in a hospital/clinic environment.
- The parent of the child with ASD reported that the GP adapted their communication to support the child to better understand what they were doing, relieving their anxiety.
- Whilst people experienced positive clinical outcomes, for some, their overall experience was impacted by other factors such as parking, access to refreshments whilst waiting or communication whilst waiting to be seen.

Areas for Improvement

- To ensure there is effective management of expectations about waiting times upon arrival at GPOOH - including messages given at point of check in and ongoing whilst waiting
- To ensure there is effective management of expectations about waiting times from first contact with 111 to receiving a call back from the GPOOH service
- Review accessibility for patients accessing the pharmacy portacabin at APH
- To explore the availability of food and drink during out of hours to ensure there is access – Vending machine and water cooler cups
- To explore issues raised relating to car park barrier, signage and lighting

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9**

03 December 2025

Title	Integrated Performance Report
Area Leads	Executive Team
Author	Executive Team
Report for	Information

Executive Summary and Report Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of October 2025 (or latest available months data).

Performance is represented in SPC chart format to understand variation and a summary table indicating performance against standards. The metrics are grouped into Executive Director portfolios with individual metrics showing under each domain identified in this report. Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Grouping the metrics by report domains shows the following breakdown for the most recently reported performance:

Summary of latest performance by Domain (excluding CFO and CIO):

Domain	Achieving	Not Achieving	No Target	Total
Workforce	**2**	**2**	**-**	**4**
Operations	**1**	**16**	**1**	**18**
Quality and Safety	**8**	**12**	**4**	**24**

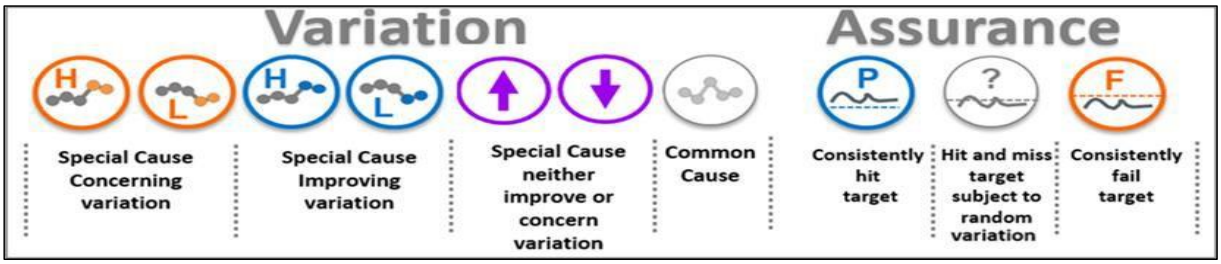
All Metrics For latest available data, where agreed targets have been defined, 15 metrics were achieving the agreed target and 35 were not achieving target.
N.B. There are 7 metrics without target at present.

It is recommended that the Board:

- Note performance to the end of October 2025 (or latest available months data).

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

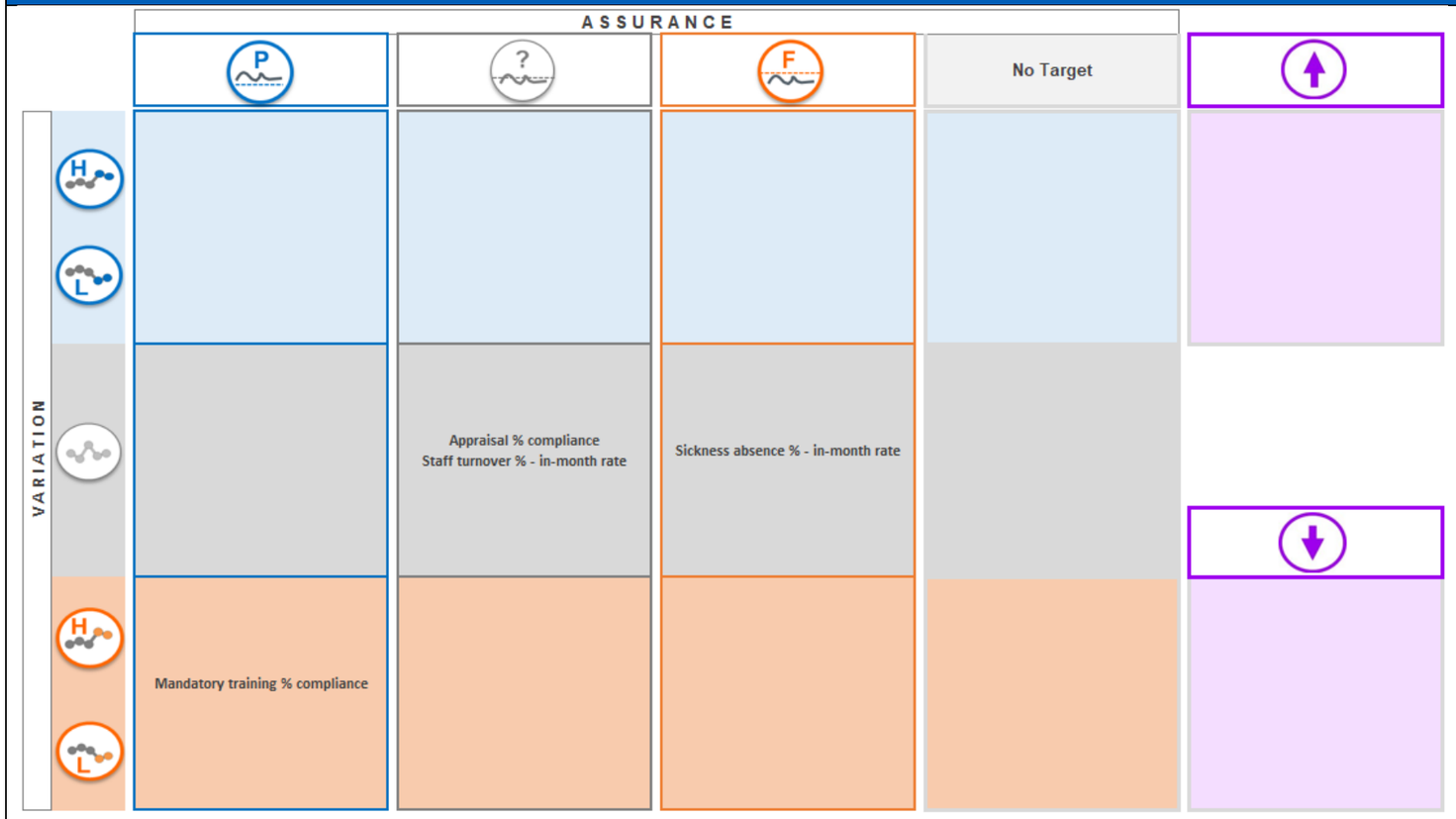
2	General guidance and Statistical Process Charts (SPC)
2.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance. • Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend. **Blue dots signify a statistical improvement. A data point will highlight blue if it:** • Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance. • Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend. Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Dashboard	All Indicators
Lead	All Execs

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Oct 25	6.29%	≤5%			5.97%
Staff turnover % - in-month rate	Oct 25	0.71%	≤1%			87.79%
Mandatory training % compliance	Oct 25	92.53%	≥90%			92.63%
Appraisal % compliance	Oct 25	86.95%	≥88%			0.86%
4-hour Accident and Emergency Target (including APH UTC)	Oct 25	57.48%	≥95%			61.2%
Number of inpatients not meeting the Criteria to Reside	Oct 25	129	-			159
Patients waiting longer than 12 hours in ED from a decision to admit	Oct 25	822	≤0			617
Proportion of patients more than 12 hours in ED from time of arrival	Oct 25	21.39%	≤0%			18.0%
Ambulance Handovers: % < 30 mins	Oct 25	72.54%	≥95%			53.7%
Ambulance Handovers: % < 45 mins	Oct 25	90.28%	≥100%			72.2%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Oct 25	60.96%	≥92%			58.7%
Referral to Treatment - total open pathway waiting list	Oct 25	49453	≤48266			45114
Referral to Treatment - cases exceeding 52 weeks	Oct 25	1313	≤800			1536
Referral to Treatment - cases waiting 78+ wks	Oct 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Sep 25	130	≤77			136
Cancer - Faster Diagnosis Standard	Sep 25	62.88%	≥77%			73.3%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Sep 25	91.29%	≥96%			91.5%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Sep 25	90.84%	≥96%			92.7%
Cancer Waits - 62 days to treatment (monthly)	Sep 25	75.22%	≥85%			74.8%
Cancer Waits - 62 days to treatment (quarterly)	Sep 25	75.36%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Oct 25	94.67%	≥95%			92.9%
Long length of stay - number of patients in hospital for 21 or more days	Oct 25	159	≤79			165
Clostridioides difficile (healthcare associated)	Oct 25	13	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Oct 25	6	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Oct 25	0	≤0			0
Patient Safety Incidents	Oct 25	1514	-			1194
FFT Overall experience of very good & good: ED	Oct 25	68.1%	≥95%			76.0%
FFT Overall experience of very good & good: Inpatients	Oct 25	93.8%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Oct 25	94.7%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Oct 25	100.0%	≥95%			96.0%
Patient Experience: concerns received in month - Level 1 (informal)	Oct 25	319	≤173			225
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Oct 25	7	≤3			3
Falls – Moderate to Severe Harm	Oct 25	0.09	≤0			0.13
WUTH Average RN Day Staffing Fill Rates	Oct 25	90.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Oct 25	94.0%	≥90%			90.1%
WUTH Average CSW Day Staffing Fill Rates	Oct 25	85.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Oct 25	99.0%	≥90%			99.7%
MRSA Cases	Oct 25	0	≤0			0
MSSA Cases	Oct 25	3	≤0			2
% of adult patients VTE risk-assessed on admission	Oct 25	96.2%	≥95%			97.4%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Oct 25	89.2%	≥90%			89.3%
Mortality (SHMI)	Jun 25	1.013	0.95-1.05			1.020
Number of studies open	Oct 25	44				
% of current studies meeting recruitment target	Oct 25	27.3%				
% of open studies with a commercial sponsor	Oct 25	4.5%				

Dashboard	Workforce
Lead	Chief People Officer

Workforce Domain Matrix



Workforce Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Oct 25	6.29%	≤5%			5.97%
Staff turnover % - in-month rate	Oct 25	0.71%	≤1%			87.79%
Mandatory training % compliance	Oct 25	92.53%	≥90%			92.63%
Appraisal % compliance	Oct 25	86.95%	≥88%			0.86%

Areas of Concern

Sickness

Although above Trust threshold, sickness absence levels continue to show improvement from the same period in the previous year.

Latest performance is 6.29%.

The top 3 reasons in month are:
Cold/flu
mental health
Gastro

The three main staff groups for sickness are: Estates and Ancillary, Additional Clinical Services and Nursing & Midwifery.

WUTH Board increased BAF risk number 4 from 12 to 16 due to the increased likelihood of sickness absences during winter pressures and significant period of change for corporate services and the impact Trust financial pressures are having on delivery (vacancy freeze etc).

The Sickness Absence project includes targeted interventions tailored to the requirements of the Trust, in addition to standard BAU sickness absence management.

The Trust is currently piloting a new approach to reducing sickness absence, targeted at staff that are struggling to return to the work place; '**Well WUTH Back to Work'** programme which launched in November'25. If successful, it will be rollout across WUTH and Wirral Community Trust as a mechanism to support faster returns to work and also as a supportive measure for staff to prevent absence / enable a return to work. Initial feedback is very positive.

Forward Look (Actions)

Sickness

Proactively supporting physical health and wellbeing:

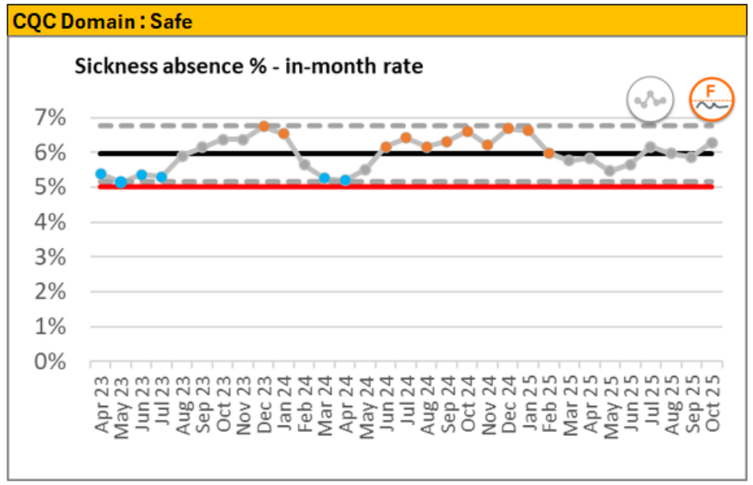
- New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - 'Every Day Counts'.
- Delivery of the annual flu campaign to prevent increase in flu related absence; given the higher levels this year, the campaign has been extended by 3 weeks to enable staff to get the flu jab.
- New Wellness Action Plan will launch at end of November.
- Resilience through Change sessions led by Trust's psychotherapist.
- Dedicated Psychotherapist support to Surgery Division following bereavement.
- Smoking cessation plan reinvigorated and new staff clinics.
- Mental Health First Aid Training – 5 new Cohorts and MHFA Refresher training was delivered in October.
- Enhanced training for managers (preventing sickness absence through wellbeing conversations)
- New Road Map for Wellbeing showcasing all the support available to staff in one place.
- New 'Living Well' Bus providing free convenient drop-in cervical screening (mobile clinic) for those who are due or overdue.

Managing Absence:

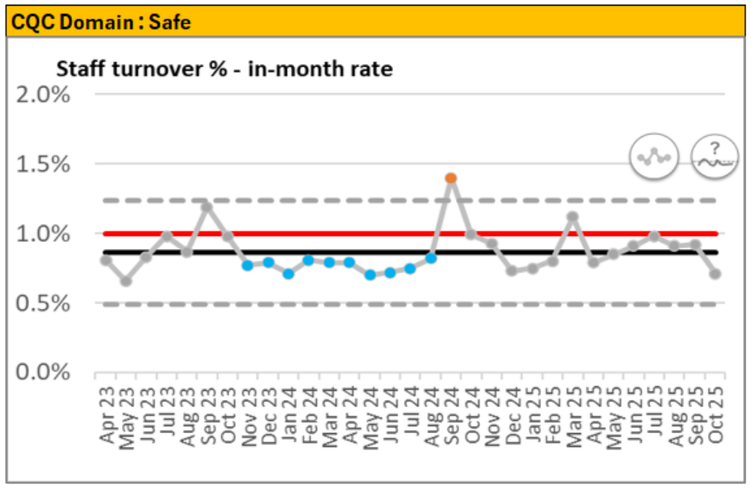
- Operationalising **Well WUTH.** The pilot launched in November 2025, aiming to return staff to work in December 2025 to support with winter pressures.
- New Crib sheet to assist managers with the effective management of Estates and Ancillary being trialled and new OH drop in for managers to signpost to improve referral process and access support.
- Focus on Resident Doctors' sickness due to absence rates and lack of visibility (in some cases) which are creating operational challenges.
- New mini manager essentials training has launched focusing on OH referrals, reasonable adjustments, LTS, Return to Work Interviews and Absence Triggers.
- High impact action plans for each Division focused on hot spots continue to be implemented.
- Proactive targeted letters issued to individuals with trend for sickness during December / Christmas leave period.
- HR drop-in sessions provide managers with access to dedicated HR resource to support with case management.

		• The Attendance Management Policy continues to be embedded, and numbers of final stage hearings continue to increase. • Local Sickness Audits remain on going and are reported into WSB as BAU within the new performance report.

Sickness absence % in month rate	Staff turnover % in month rate

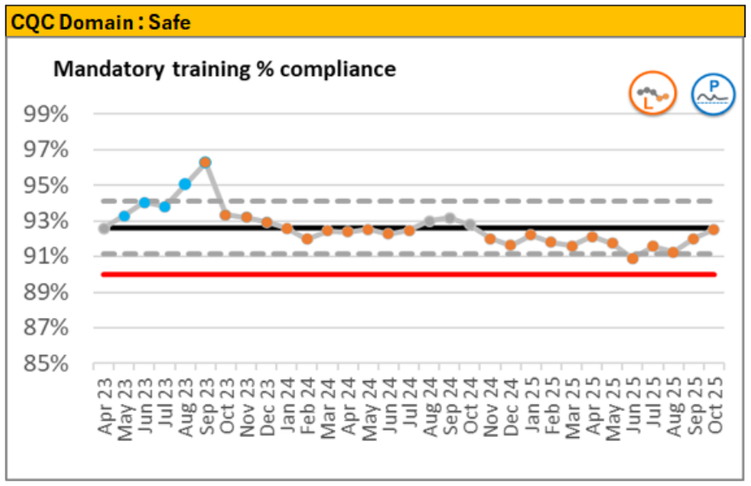


Oct-25
6.3%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Consistently fail target



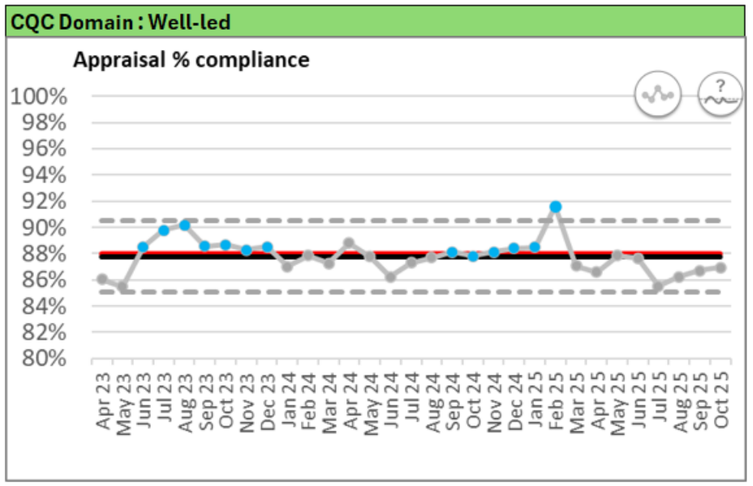
Oct-25
0.7%
Variance Type
Common cause variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance



Oct-25
92.5%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Consistently hit target

Appraisal % compliance



Oct-25
87.0%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

Appraisal % compliance

Overall organisational Appraisal compliance has so far, not met the 88% KPI during the financial year 2025/26 (last met Feb 2025 91.61%). There has been divisional compliance against target in some areas during this period.

Data from October demonstrates a minimal increase in Trust compliance in comparison to September data (86.95% vs 86.70%), with improved compliance in Clinical Support, Corporate Support, Emergency (ED), Medicine and Women & Children's (W&C) divisions. Data shows a reduction in compliance (October 2025) in Estates, Facilities and Capital (EF&C) and Surgery Divisions. Divisional compliance data for October, compared to September is below:

Division	Sep 2025	Oct 2025	Monthly comparison	Difference	KPI	Compliance
Clinical Support	90.50%	90.20%	↑	0.30%	88%	
Corporate Services	80.97%	81.68%	↑	0.71%		
ED	66.23%	73.82%	↑	7.59%		
EF&C	84.09%	82.25%	↓	1.84%		
Medicine	91.89%	92.77%	↑	0.88%		

Surgery	84.18%	81.86%	↓	2.32%		
W&C	88.85%	92.41%	↑	3.56%		
Total	86.70%	86.95%	↑	0.25%	88%	

This shows that the following divisions met the 88% KPI in October:

- Clinical Support – 90.20%
- Medicine – 92.77%
- Women & Children's – 92.41%

A deep dive into appraisal was recently conducted and presented at October Workforce Steering Board. Recommendations are incorporated into further actions being taken to drive compliance include:

- A review of the training materials to include an increased focus on the effective recording of appraisals has been undertaken.
- Feedback has been sought to identify how well the new Appraisal and Check In documentation has been received since its launch in August. Generally, feedback is positive, indicating that it's more intuitive, and it flows better and that there's prompt questions to support both the reviewer and reviewee in having more meaningful conversation.
- Deep dive data to be made available per division monthly, in line with the production of the divisional monthly compliance reports.
- Finalize and launch an eLearning package to support staff in engaging with and gaining more value from their appraisal meetings.
- Plans to implement appraisal audit lunching in Q4 to support the drive of quality and compliance.
- Ongoing proactive targeting of appraisal compliance for outstanding and 'due' appraisals.
- HRBP's working with their respective divisional leadership teams to drive compliance improvement, with OD support, where required.
- Plans to undertake a further evaluation of the appraisal paperwork in Q1 2026, to identify additional opportunities for improvement.
- Ensure that all staff with people management responsibility have access to the monthly compliance reports, so that they can proactively monitor and manage compliance positions, as discussed at October's workforce steering board.

Dashboard	Operations
Lead	Chief Operating Officer

Operations Domain Matrix

VARIATION \ ASSURANCE	P	?	F	No Target	↑
H / L		Referral to Treatment - cases waiting 78+ wks	Ambulance Handovers: % < 30 mins Ambulance Handovers: % < 45 mins 18 week Referral to Treatment - Incomplete pathways < 18 Weeks Referral to Treatment - cases exceeding 52 weeks Cancer Waits - 62 days to treatment (monthly)	Number of inpatients not meeting the Criteria to Reside	
		Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly) Cancer Waits - reduce number waiting 62 days + Cancer - Faster Diagnosis Standard Diagnostic Waiters, 6 weeks and over - DM01	Patients waiting longer than 12 hours in ED from a decision to admit Long length of stay - number of patients in hospital for 21 or more days		↓
H / L	Referral to Treatment - total open pathway waiting list		4-hour Accident and Emergency Target (including APH UTC) Proportion of patients more than 12 hours in ED from time of arrival Cancer Waits - 2 week referrals (monthly)		

Operations Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Oct 25	57.48%	≥95%			61.2%
Number of inpatients not meeting the Criteria to Reside	Oct 25	129	-			159
Patients waiting longer than 12 hours in ED from a decision to admit	Oct 25	822	≤0			617
Proportion of patients more than 12 hours in ED from time of arrival	Oct 25	21.39%	≤0%			18.0%
Ambulance Handovers: % < 30 mins	Oct 25	72.54%	≥95%			53.7%
Ambulance Handovers: % < 45 mins	Oct 25	90.28%	≥100%			72.2%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Oct 25	60.96%	≥92%			58.7%
Referral to Treatment - total open pathway waiting list	Oct 25	49453	≤48266			45114
Referral to Treatment - cases exceeding 52 weeks	Oct 25	1313	≤800			1536
Referral to Treatment - cases waiting 78+ wks	Oct 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Sep 25	130	≤77			136
Cancer - Faster Diagnosis Standard	Sep 25	62.88%	≥77%			73.3%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Sep 25	91.29%	≥96%			91.5%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (quarterly)	Sep 25	90.84%	≥96%			92.7%
Cancer Waits - 62 days to treatment (monthly)	Sep 25	75.22%	≥85%			74.8%
Cancer Waits - 62 days to treatment (quarterly)	Sep 25	75.36%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Oct 25	94.67%	≥95%			92.9%
Long length of stay - number of patients in hospital for 21 or more days	Oct 25	159	≤79			165

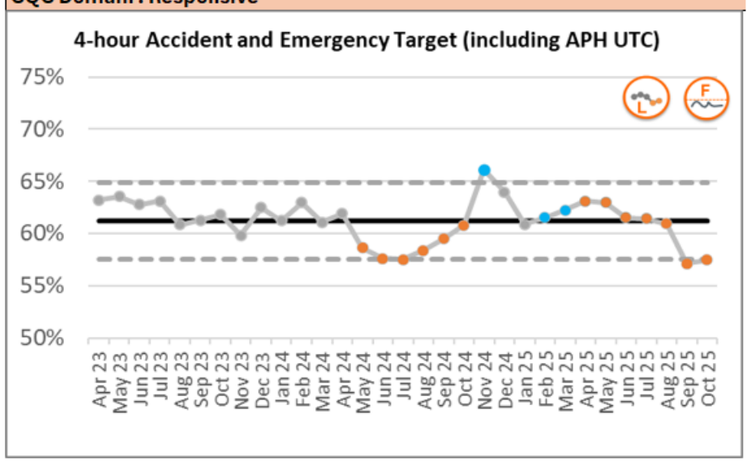
Areas of Concern

- 4 hour performance – covered in COO report
- 12 hours in department – covered in COO report
- 28 day faster diagnostic standard – covered in COO

Forward Look (Actions)

4-hour Accident and Emergency Target (including APH UTC)

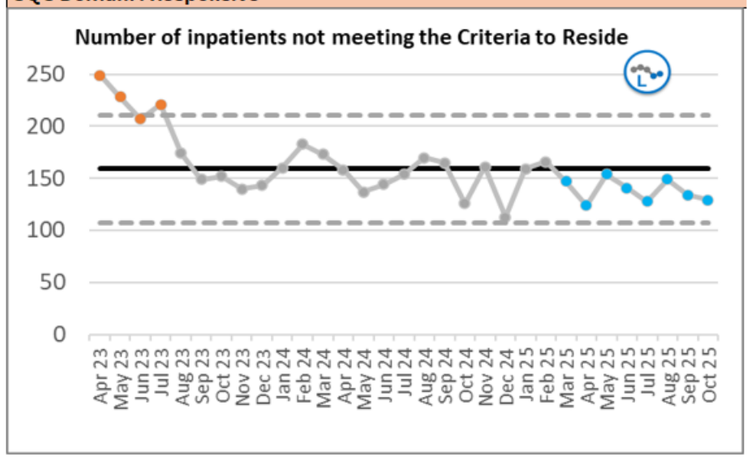
CQC Domain : Responsive



Oct-25
57.5%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

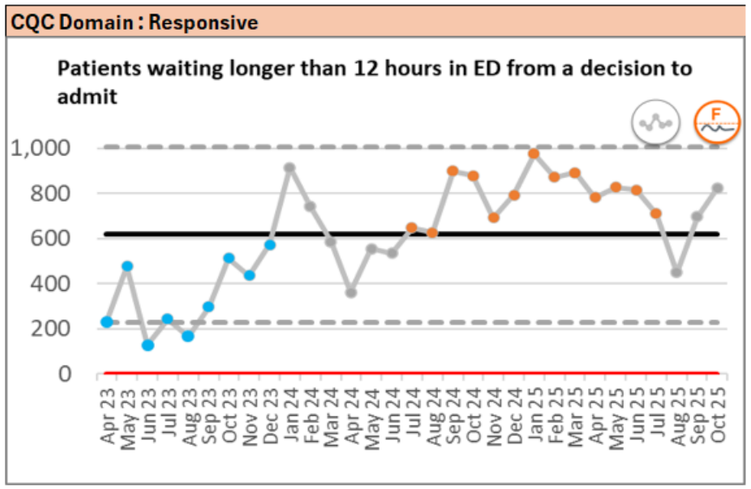
CQC Domain : Responsive



Oct-25
129
Variance Type
Special cause improving variation
Threshold
-
Assurance
Not applicable

Patients waiting longer than 12 hours in ED from a decision to admit

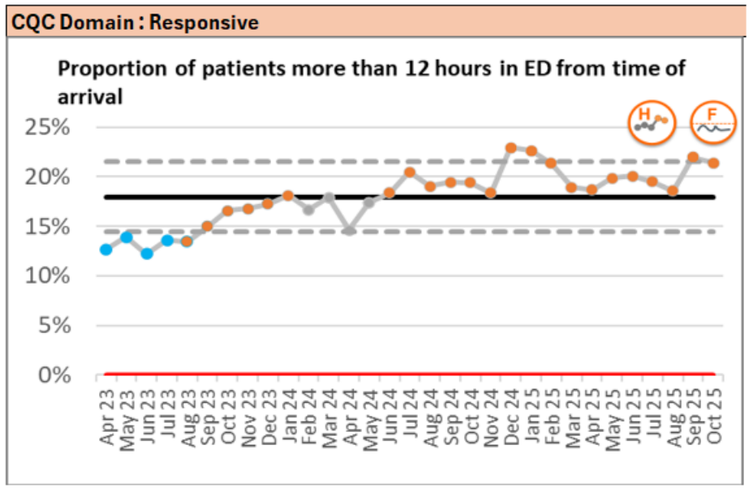
CQC Domain : Responsive



Oct-25
822
Variance Type
Common cause variation
Threshold
≤0
Assurance
Consistently fail target

Proportion of patients more than 12 hours in ED from time of arrival

CQC Domain : Responsive



Oct-25
21.4%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

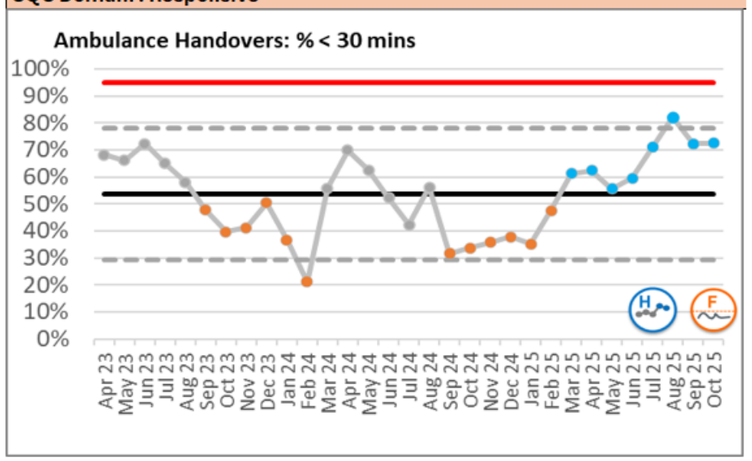
Commentary

4 Hours- In October, performance against the 4-hour Accident and Emergency standard (including APH UTC) was 57.5%, an improvement of 0.4% from the previous month. This remains significantly below the national target of 95%. Performance has been stable but remains short of the required standard. This reflects the ongoing pressure on the department. A number of actions commenced in month to improve Type 1 4-hour performance which are anticipated to deliver performance improvement in November. These are contained within the UEC Improvement Plan and include a progress tracker pilot and zoning of medical staff.

12-hour LoS and DTA- In October, 21.4% of patients remained in ED for more than 12 hours from their time of arrival. This is an improvement of 0.6% from the previous month, but this remains significantly above the national standard. Flow into inpatient beds remains the key challenge. Focused improvement work remains ongoing to address the challenges with 12-hour LoS, and the Trust continues to receive support from GIRFT (ECIST). The Trust plans to utilise one of the temporary escalation spaces as a reverse cohort area in December, in order to improve patient experience and 12-hour LoS performance.

Ambulance handover % < 30 minutes

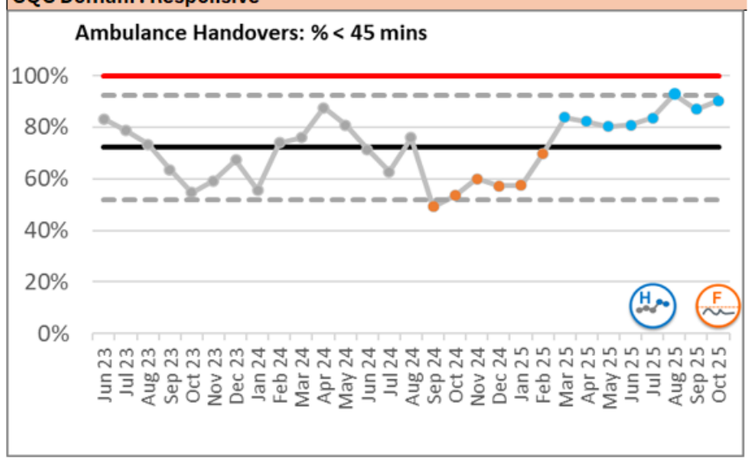
CQC Domain : Responsive



Oct-25
72.5%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

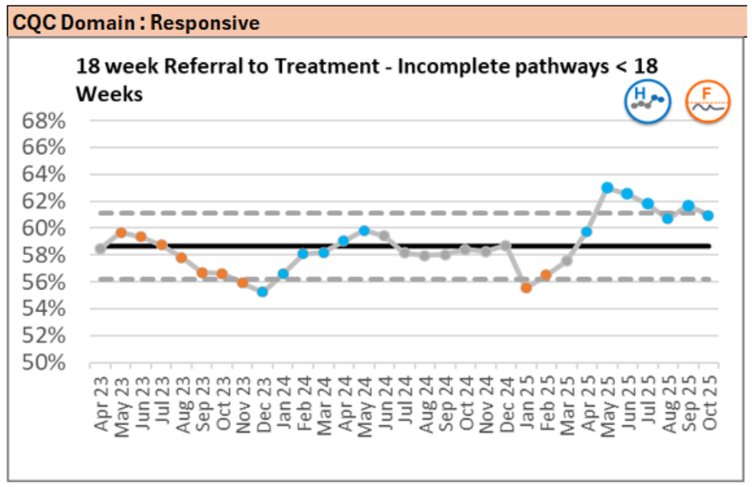
CQC Domain : Responsive



Oct-25
90.3%
Variance Type
Special cause improving variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

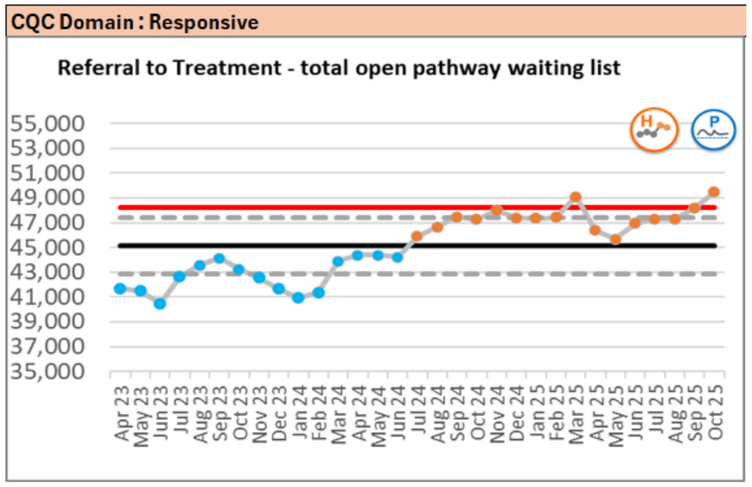
CQC Domain : Responsive



Oct-25
61.0%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



Oct-25
49453
Variance Type
Special cause concerning variation
Threshold
≤48266
Assurance
Consistently hit target

Commentary

Ambulance Handover

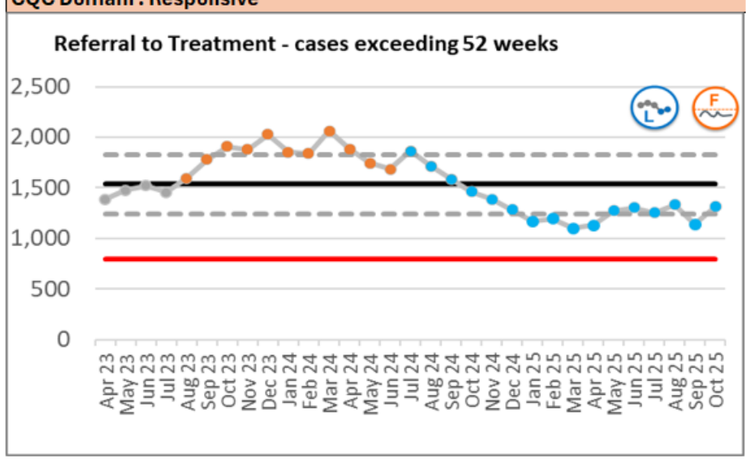
Performance for handover in less than 30 minutes has remained stable (0.2% improvement from September), but there has been a 3% improvement in handovers in less than 45 minutes to 90.3%. Robust processes and systems are in place to maintain good performance.

RTT - The Trust achieved trajectory for RTT percentage of patient waiting 18 weeks or under, but not for caseload as a result of the sterile service incident.

RTT position for October was impacted by the sterile services incident which as noted saw the cancellation of 1,378 elective cases in October and November. This has seen RTT caseload exceed planned trajectory for the first time in 2025/26. Divisions are developing activity recovery plans, in addition, a 3rd national sprint commenced in November to support reduction of caseload. Pressures on caseload are noted in ENT, Dermatology and Physiotherapy. Outsourcing within ENT commenced in October, with insourcing planned within Dermatology in December and Physiotherapy on track with recovery plans.

Referral to Treatment – cases exceeding 52 weeks

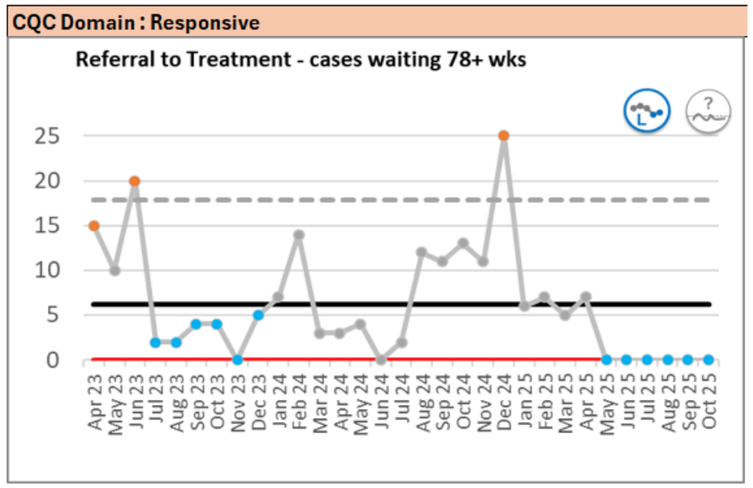
CQC Domain : Responsive



Oct-25
1313
Variance Type
Special cause improving variation
Threshold
≤800
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

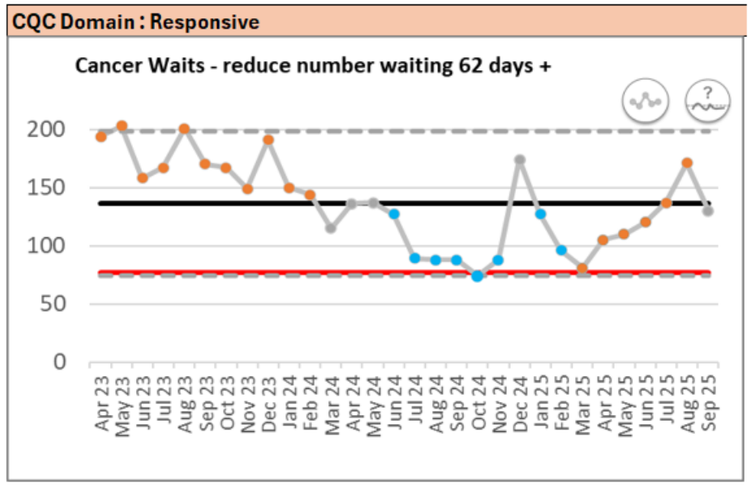
CQC Domain : Responsive



Oct-25
0
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Cancer Waits – reduce number waiting 62 days +

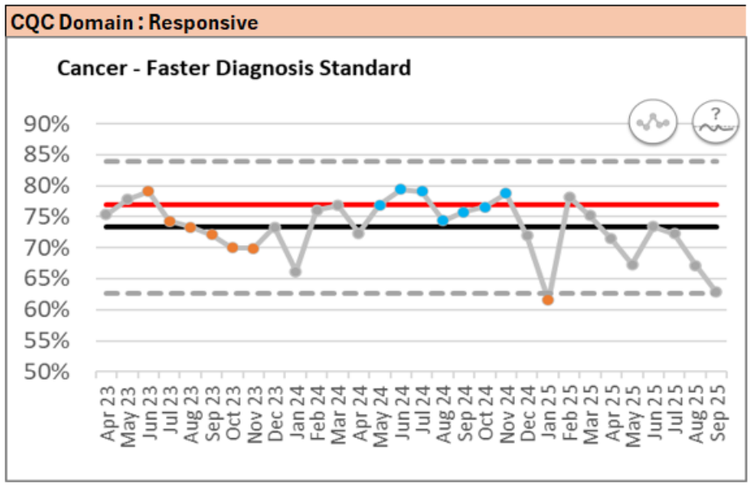
CQC Domain : Responsive



Sep-25
130
Variance Type
Common cause variation
Threshold
≤77
Assurance
Hit and miss target subject to random variation

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



Sep-25
62.9%
Variance Type
Common cause variation
Threshold
≥77%
Assurance
Hit and miss target subject to random variation

Commentary

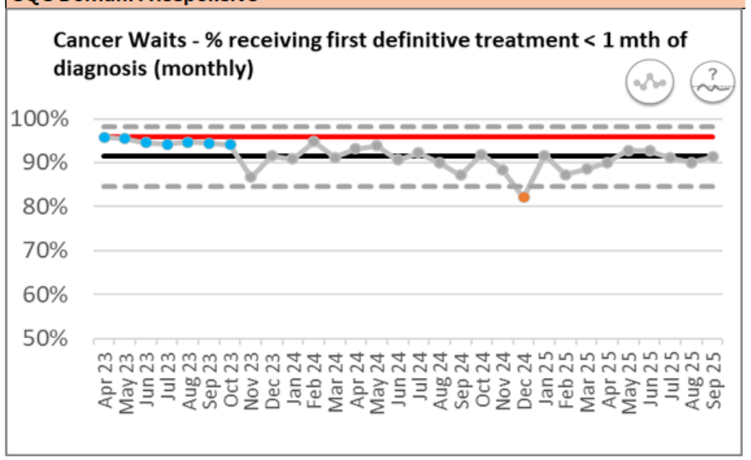
RTT - The Trust achieved 0 x 78-week waiters in October. The number of 65-week waiters has increased to 26 in October as a result of the sterile services incident. 21 breaches are attributed to the incident – with non-incident related 65 week breaches in ENT (4 x patients) and T&O (1 x patient awaiting input from another Trust). Divisional teams are developing recovery plans for 52-week waiters, having focused on reduction of 65 weeks. As noted above, outsourcing has commenced in ENT to create additional capacity and is reducing waiting times for first appointment.

Cancer – The Trust has failed to meet the local trajectory for the Faster Diagnosis Standard (FDS), with September performance at 62.88% versus trajectory of 78.66%. Performance has improved in Gynaecology, Urology, Lower GI and more recently in Breast following change in pathway, improvements in tracking and improved cross-Divisional working. Skin cancer performance has deteriorated following regional ceasing of funding for tele-dermatology, alongside regional implementation of an AI pathway. Insourcing (funded by the Cancer Alliance) in Dermatology is scheduled to commence in December to support recovery of FDS by January 2026.

Skin performance is having a significant negative impact on overall Trust performance against FDS. A deterioration in Skin FDS Performance and is seen in a number of Trusts across the region. Costs of recovering the position will exceed the funding received from the Cancer Alliance with a knock-on requirement for additional minor ops once patients have been seen initially. Options to reduce demand are being explored, as part of phase 2 of the recovery plan, linking in with a regional skin summit in December.

Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (monthly)

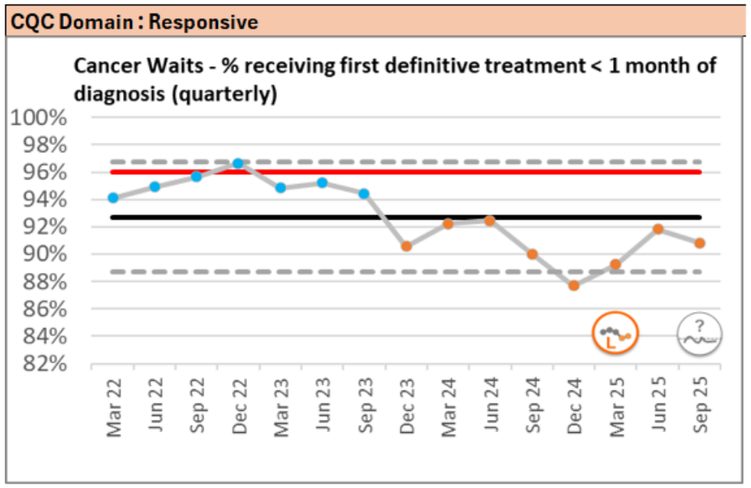
CQC Domain : Responsive



Sep-25
91.3%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)

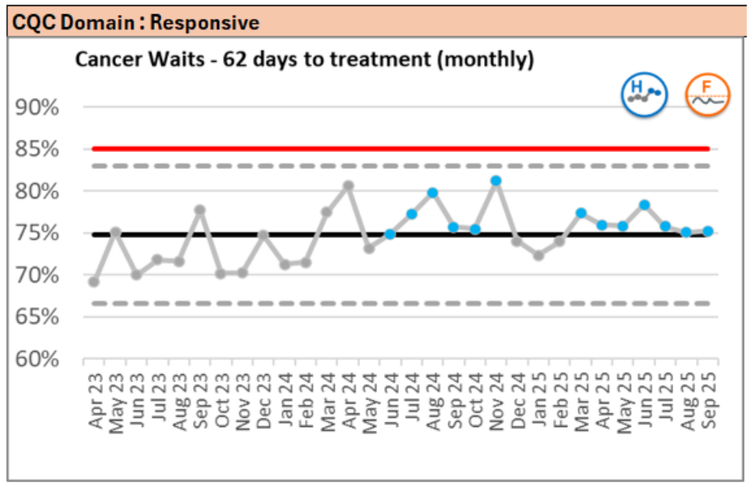
CQC Domain : Responsive



Sep-25
90.8%
Variance Type
Special cause concerning variation
Threshold
≥96%
Assurance
Hit and miss target subject to random variation

Cancer waits - 62 days to treatment (monthly)

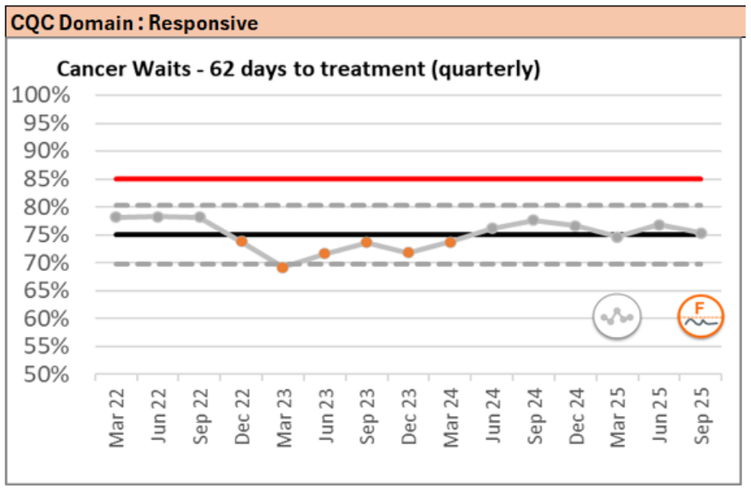
CQC Domain : Responsive



Sep-25
75.2%
Variance Type
Special cause improving variation
Threshold
≥85%
Assurance
Consistently fail target

Cancer waits - 62 days to treatment (quarterly)

CQC Domain : Responsive



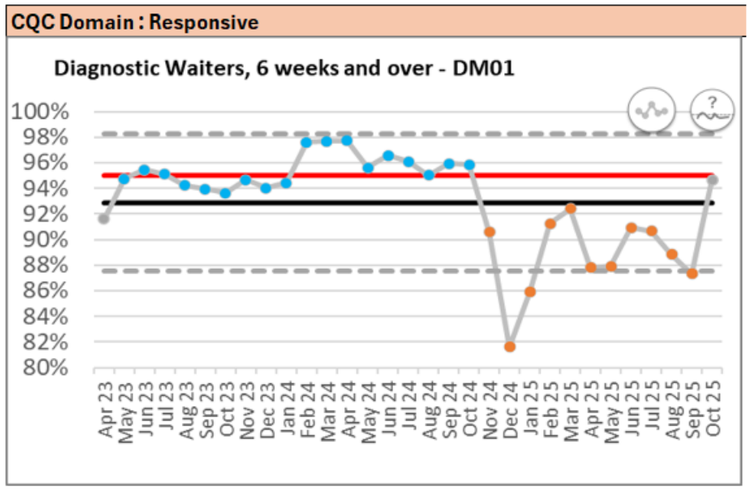
Sep-25
75.4%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Consistently fail target

Commentary

31 Day Treatment Standard - The Trust failed to achieve local trajectory in September 2025 at 91.29% versus trajectory of 92.37%. Skin performance was seen to deteriorate, impacting the Trust overall position.

62 Day Treatment Standard - The Trust failed to achieve local trajectory in September 2025 at 75.22% versus trajectory of 76.81%. 62-day performance is noted as impacted by reduction in 28-day performance in earlier months. Improvements in 28-day performance in Gynaecology (tracked weekly through October) will have a positive impact on 62-day performance from November, whilst Skin remains a challenge.

Diagnostic Waiters – 6 weeks and over – DM01



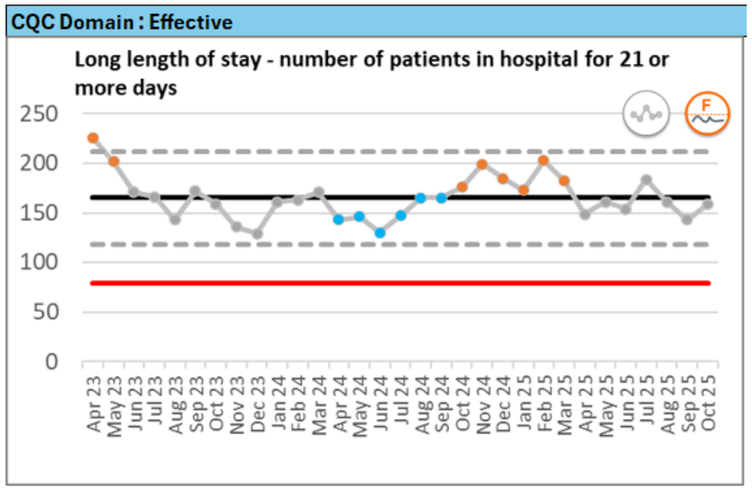
Oct-25
94.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

The Trust achieved 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 94.7% for October.

This is an increase on the September position of 87.4%, as a result of an improvements in non-obstetric ultrasound.

Long length of stay – numbers of patients in hospital for 21 or more days



Oct-25
159
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

Commentary

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix

VARIATION	ASSURANCE: P	?	F	No Target	↑
H / L		Duty of Candour compliance - breaches of DoC standard for Serious Incidents			
	WUTH Average CSW Night Staffing Fill Rates	Clostridioides difficile (healthcare associated) FFT Overall experience of very good & good: Outpatients FFT Overall experience of very good & good: Maternity Falls – Moderate to Severe Harm (per 1000 bed days) WUTH Average RN Day Staffing Fill Rates WUTH Average RN Night Staffing Fill Rates WUTH Average CSW Day Staffing Fill Rates MRSA Cases MSSA Cases			↓
H / L		Pressure Ulcers - Hospital Acquired Category 3 and above FFT Overall experience of very good & good: Inpatients Patient Experience: concerns received in month - Level 1 (informal) Patient Experience: complaints in month per 1000 staff - Levels 2 (formal)	FFT Overall experience of very good & good: ED	Patient Safety Incidents	

Quality and Safety Care Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Oct 25	13	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Oct 25	6	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Oct 25	0	≤0			0
Patient Safety Incidents	Oct 25	1514	-			1194
FFT Overall experience of very good & good: ED	Oct 25	68.1%	≥95%			76.0%
FFT Overall experience of very good & good: Inpatients	Oct 25	93.8%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Oct 25	94.7%	≥95%			95.3%
FFT Overall experience of very good & good: Maternity	Oct 25	100.0%	≥95%			96.0%
Patient Experience: concerns received in month - Level 1 (informal)	Oct 25	319	≤173			225
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Oct 25	7	≤3			3
Falls – Moderate to Severe Harm	Oct 25	0.09	≤0			0.13
WUTH Average RN Day Staffing Fill Rates	Oct 25	90.0%	≥90%			88.7%
WUTH Average RN Night Staffing Fill Rates	Oct 25	94.0%	≥90%			90.1%
WUTH Average CSW Day Staffing Fill Rates	Oct 25	85.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Oct 25	99.0%	≥90%			99.7%
MRSA Cases	Oct 25	0	≤0			0
MSSA Cases	Oct 25	3	≤0			2

Areas of Concern

C Diff- continued focus

HAPU category 3 and above

FFT- ED & inpatients % of patients that would rate their experience as very good or good.

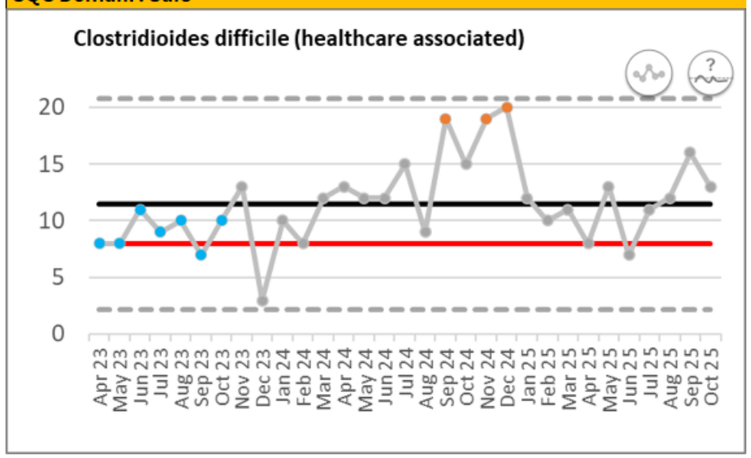
Complaints/concerns received in month

CSW fill rates - days

Forward Look (Actions in commentary below)

Clostridioides difficile (healthcare associated)

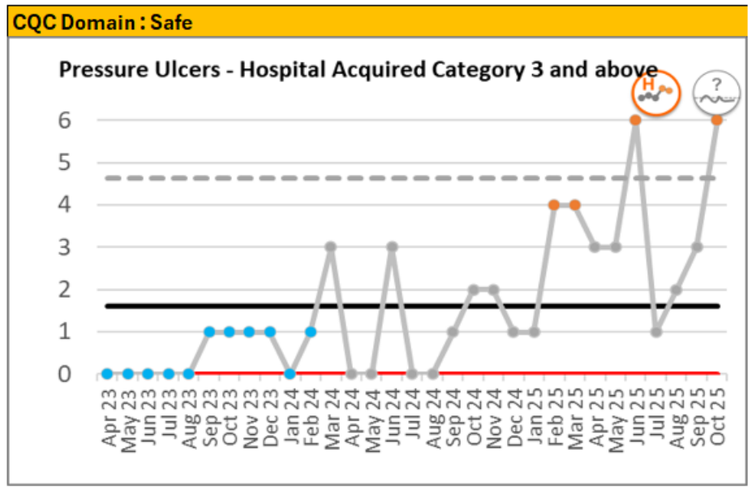
CQC Domain : Safe



Oct-25
13
Variance Type
Common cause variation
Threshold
≤8
Assurance
Hit and miss target subject to random variation

Pressure Ulcers – Hospital Acquired Category 3 and above

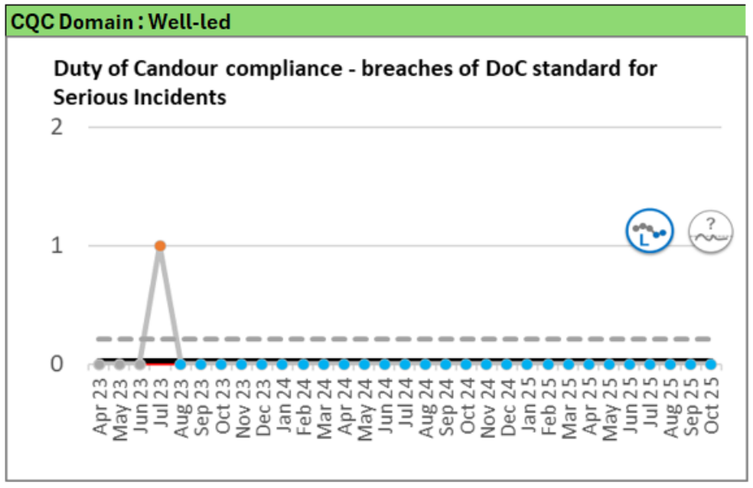
CQC Domain : Safe



Oct-25
6
Variance Type
Special cause concerning variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Duty of Candour Compliance

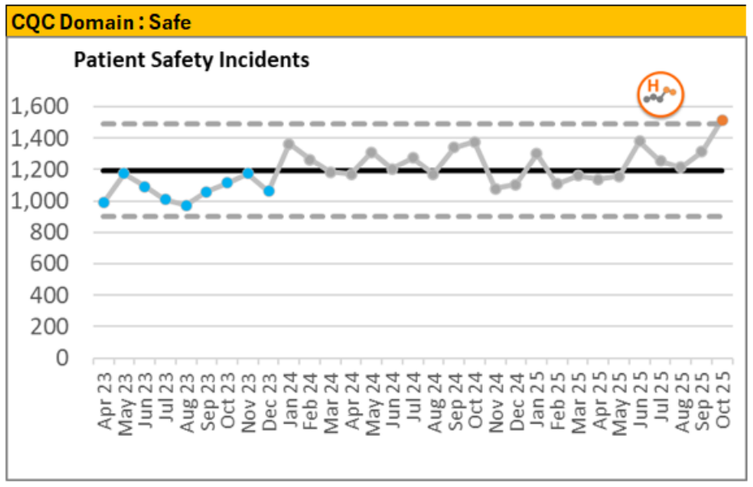
CQC Domain : Well-led



Oct-25
0
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Patient Safety Incidents

CQC Domain : Safe



Oct-25
1514
Variance Type
Special cause concerning variation
Threshold
-
Assurance
Not applicable

Commentary

C Diff

In October there have been 9 HOHA and 4 COHA CDTs, this is a slight reduction from the previous month. 3 of the patients have previously had CDI this year and 7 patients have been nursed on a ward at the same as other patients with CDI, when transmission may have occurred.

Actions:

- IPC review patients in ED who require isolation to support assessment
- Missing stool sample report sent daily identifying patients with Type 5, 6 or 7 on the Bristol Stool Chart but no sample has been collected
- In-house HPV/Misting of bays following CDT /CDE
- Reviewing dedicated decant area to accommodate HPV/Misting of bays
- Plan to refresh and relaunch key quality improvements to reduce CDI under new IPC team leadership

HAPU:

During October there were 3 Hospital Acquired Pressure Ulcer (HAPU) Category 3 reported to Sacral Area and 3 Pressure Ulcers (Category 3 and above) reported to Sacral Area that worsened in our care

Actions:

- Tissue Viability team validate all HAPU category 3 and above.
- Collaboration with Community Tissue Viability Team to promote Stop the Pressure Day

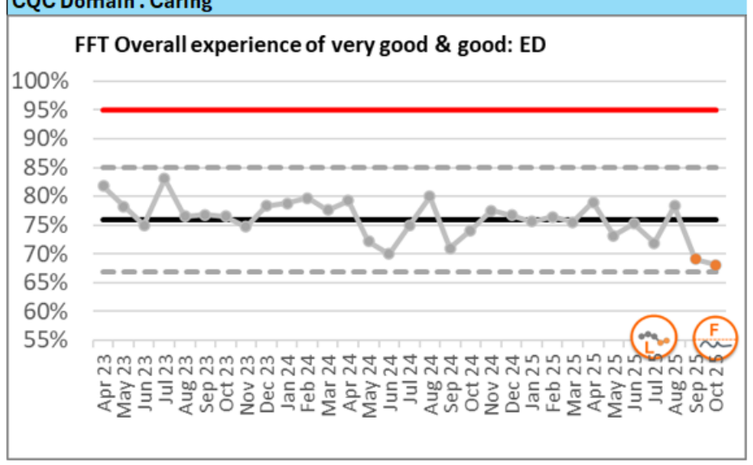
- Stop the Pressure campaign within WUTH on 20th November
- Further mattress training to be completed on all wards
- Tissue Viability Team attended Wounds UK conference
- A Trust wide Wound care formulary has been developed
- CSW band 3 upskilling is being rolled out
- Tissue Viability Team meeting with Medicine Division to provide support

Risks to position and/or actions:

Part time Tissue Viability Lead – potential opportunities with integration with WCHC

FFT Overall experience of very good & good – ED

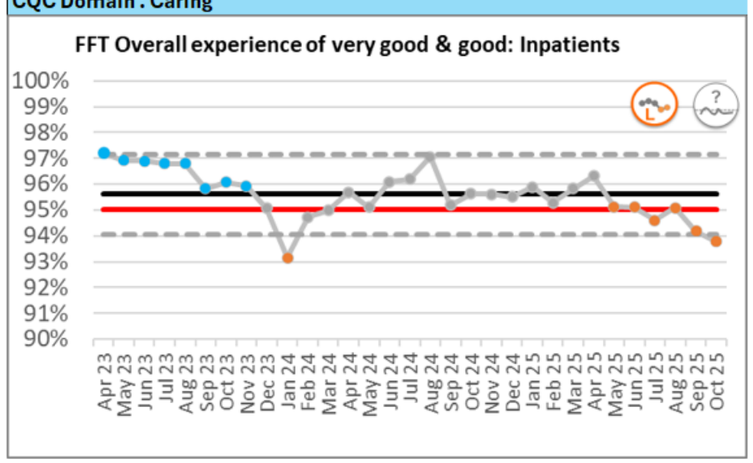
CQC Domain : Caring



Oct-25
68.1%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

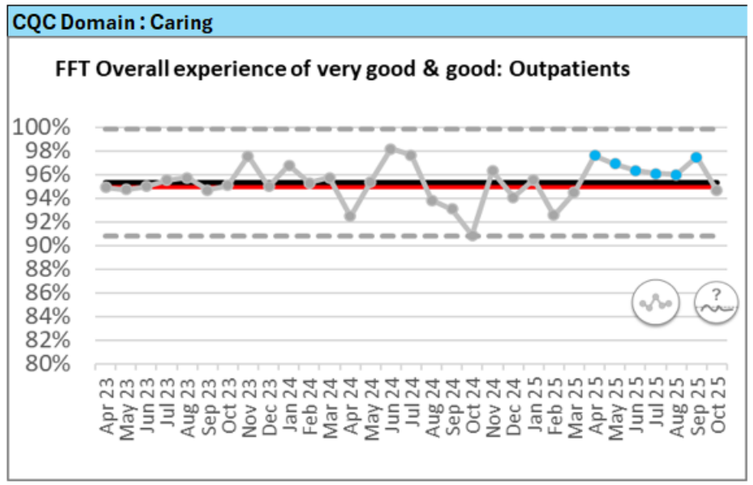
CQC Domain : Caring



Oct-25
93.8%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

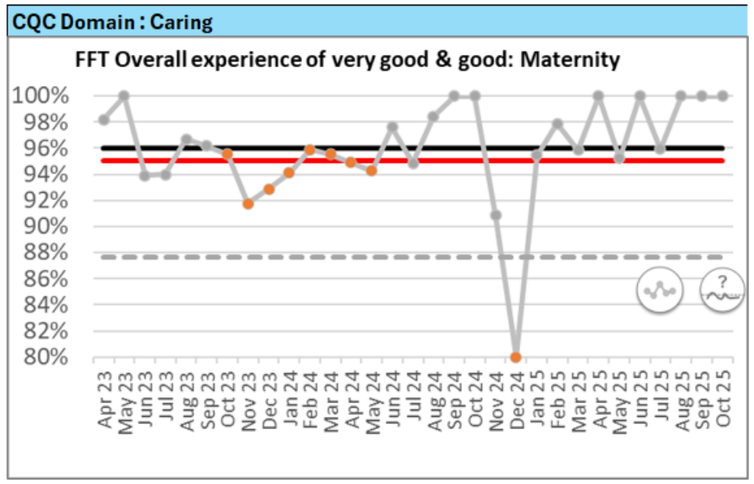
CQC Domain : Caring



Oct-25
94.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Maternity

CQC Domain : Caring



Oct-25
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

Commentary

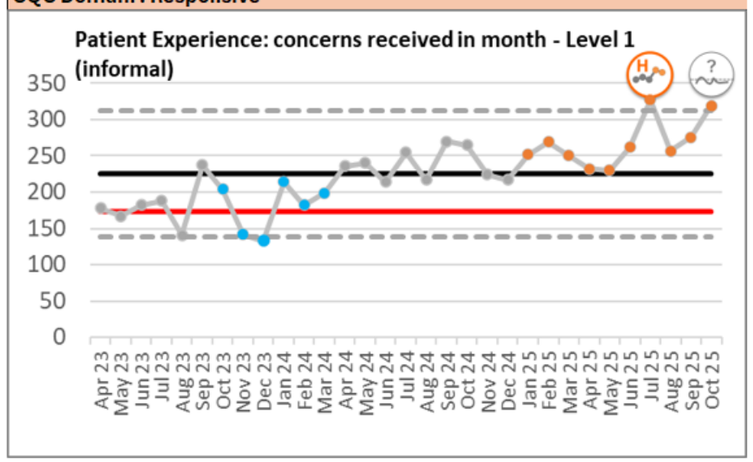
FFT ED:
Further decline and 10% below the National Average (NHSE sept data)
The declining score has been influenced by a significant increase in " undecided" ratings ie "Don't know / Neither" .
Thematic review suggests that in addition to Waiting times, waiting room overcrowding, pain management and expectations / communication in relation to investigations are the main reasons for experiencing a poor experience.
Actions include the introduction of 5 ED Volunteers, a full breakdown of response and potential solutions provided to the ED senior team. These include, increased compliance with intentional rounding, accessing charitable funds and increasing the number of FFT responses

FFT Inpt:
Second month below localised target, comparable score with other neighbouring Acute NHS Trusts (NHSE sept data)
8 wards identified as not achieving localised target of ≥95% for 3 or more consecutive months.
Service user feedback indicates that there is some influence on scores based on their ED experience.
Action: Resonding to feedback action plans underway for targeted 8 focus areas as well as routine scheduling for other areas, full analysis breakdown provided . Patients to be asked to respond to FFT based on current areas and provided with a further opportunity to provide feedback on ED.

FFT OPD:
0.34% below target, continue to monitor and ensure areas receive feedback. Challenges in relation to Car parking continues to be an influencing theme.

Patient Experience: concerns received in month – level 1 (informal)

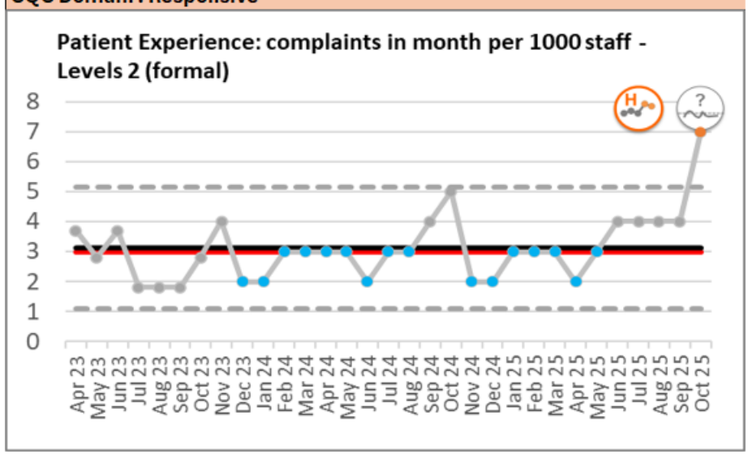
CQC Domain : Responsive



Oct-25
319
Variance Type
Special cause concerning variation
Threshold
≤173
Assurance
Hit and miss target subject to random variation

Patient Experience: complaints in month per 1000 staff – levels 2 to 4 (formal)

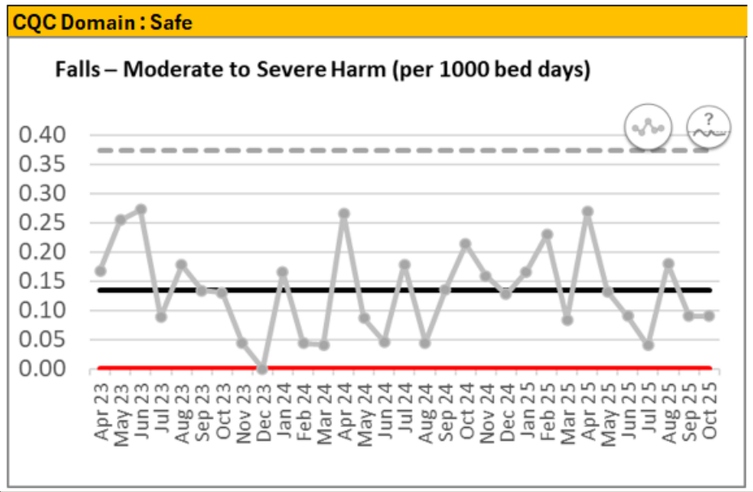
CQC Domain : Responsive



Oct-25
7
Variance Type
Special cause concerning variation
Threshold
≤3
Assurance
Hit and miss target subject to random variation

Falls – Moderate to Severe Harm

CQC Domain : Safe



Oct-25
0.09
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

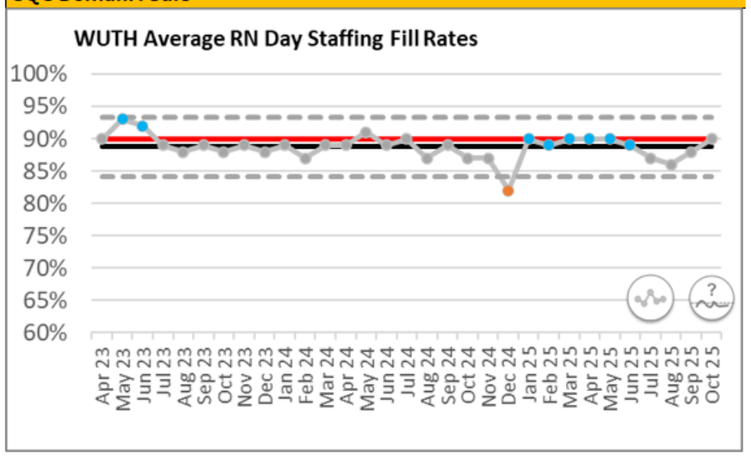
Commentary

Complaints/concerns:
In October, the Trust recorded 319 informal concerns and 40 formal complaints, increases of 15.6% and 66.7% respectively compared with September. Both exceeded the 2024/25 monthly averages and the 2025/26 year-to-date averages, reflecting rising patient concern/complaint activity.
Key themes continued to focus on clinical care, communication, and access, with informal concerns dominated by access, admission, and treatment issues, and formal complaints emphasising communication and treatment. Operational pressures, including theatre disruption and delays in surgery or appointments, contributed to increased activity.
Actions: Ongoing oversight, daily performance reporting, weekly divisional meetings, and staff training continue to support structured management and quality improvement. However, operational pressures, variability in investigation quality, and higher required response rates remain key risks to timely backlog reduction and overall performance. Meeting 17/11/25 to develop an improvement plan to manage the backlog of complaints and develop robust processes to mitigate future delays in responses.

Falls:
There were 3 falls with short-term harm reported in October – 2 fractured neck of femurs and one patient sustained a fractured big toe following a fall.
64% of falls reported as found on floor
42% of falls occurred at night
22% of falls occurred at the weekend
Of the moderate falls reported in the Trust in October – 28% of patients had assistive technology in place, 70% of patients who fell were assessed to be independent (Level 1 supervision).

Average Registered Nurse Day Staffing Fill Rates

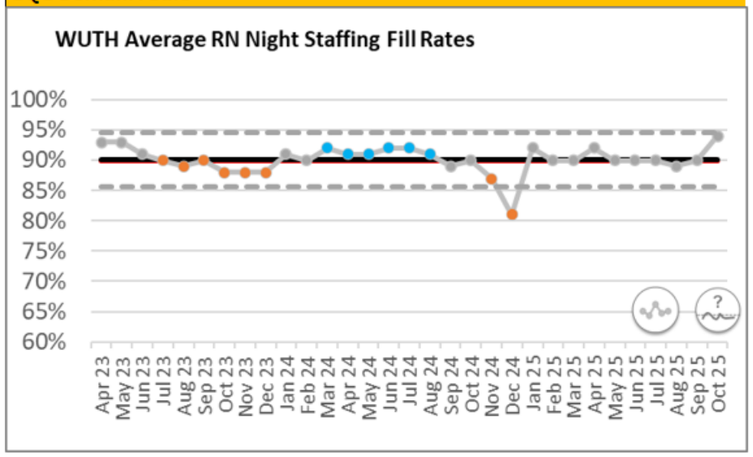
CQC Domain : Safe



Oct-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse

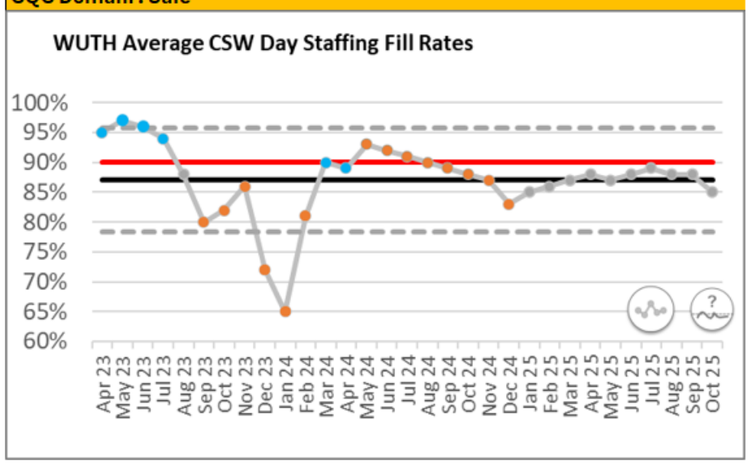
CQC Domain : Safe



Oct-25
94.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Day Staffing Fill Rates

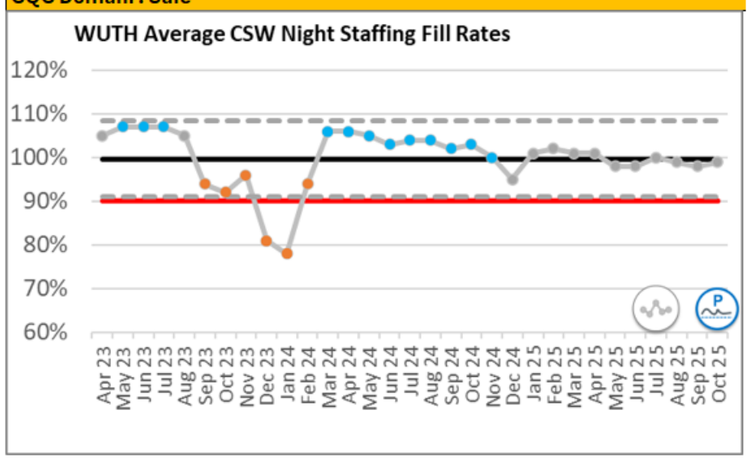
CQC Domain : Safe



Oct-25
85.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Night Staffing Fill Rates

CQC Domain : Safe



Oct-25
99.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target

Commentary

RN Fill Rates

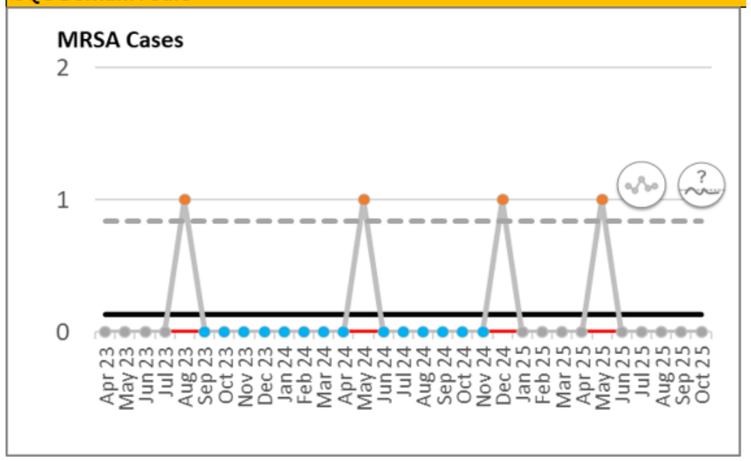
Both day & night increased – newly qualified nurses commencing in post and limited impact following reduction of NHSP rates across inpatient areas

CSW Fill Rates:

Night rates maintained however continuing challenges experienced during day. Trust wide CSW recruitment event 28/11/25 and review and refresh of CSW organisational change

MRSA Cases

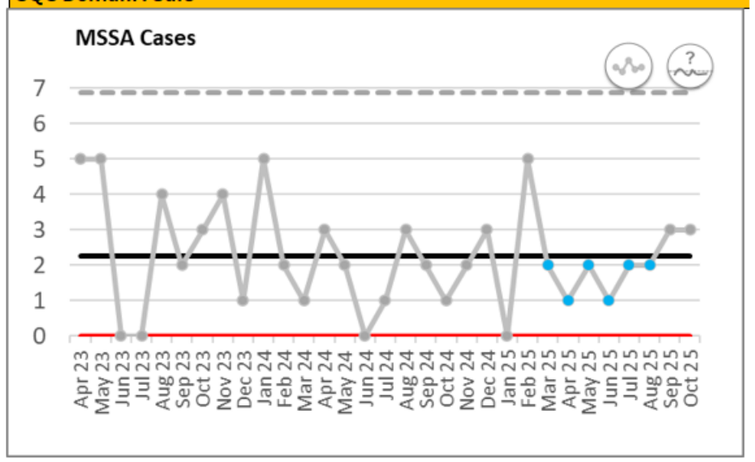
CQC Domain : Safe



Oct-25
0
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

MSSA Cases

CQC Domain : Safe



Oct-25
3
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Commentary

MRSA
There have been no MRSA BSIs reported in October.

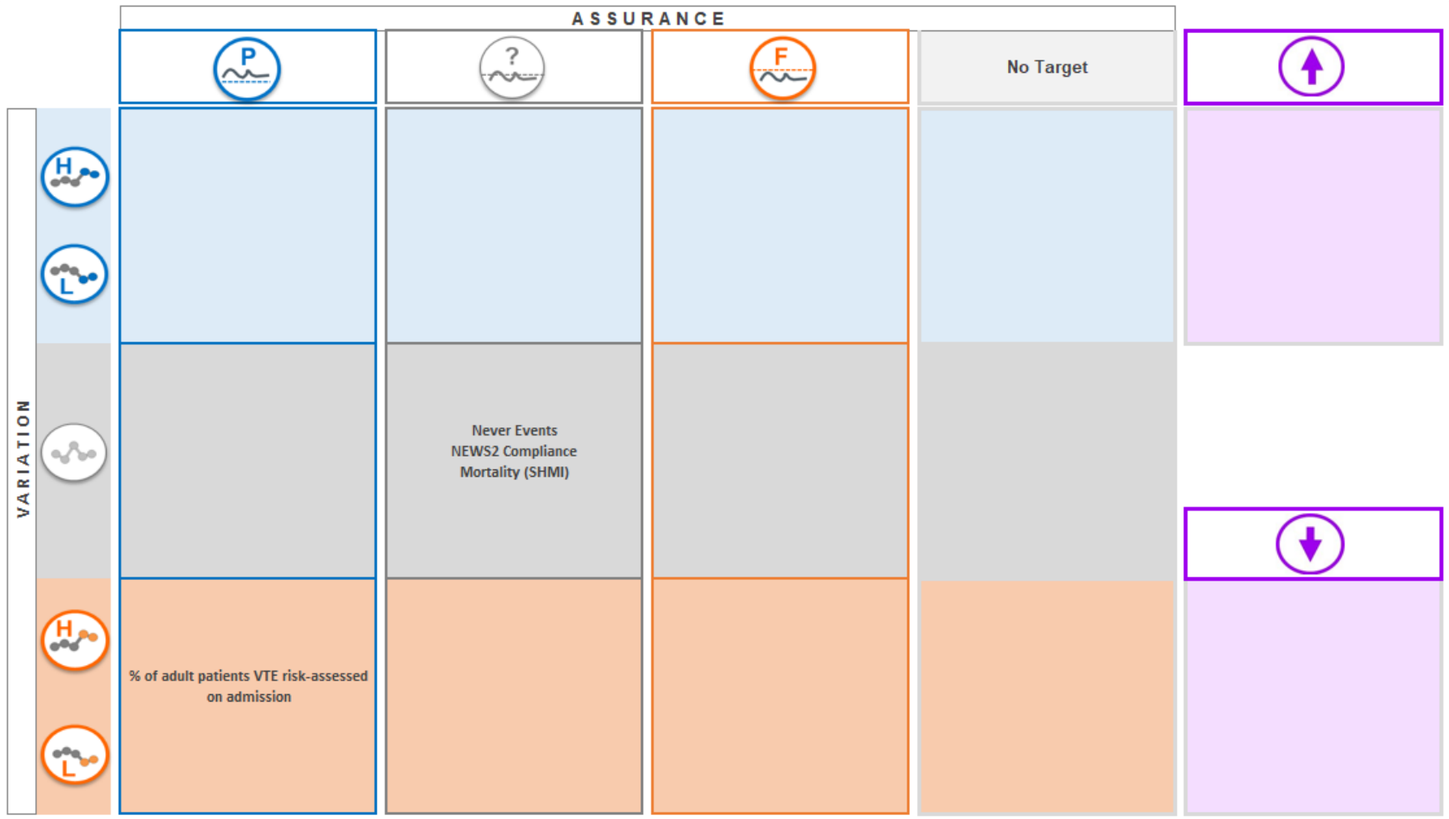
MSSA
2 HOHA BSIs reported in October. One was CVC related and one was due to underlying morbidities, but may have been cannula related.
All patients should received Octenisan washes for the first 5 days of admission, as per the Trust MRSA Policy, but will also help to prevent MSSA infections.

Actions:

- Learning to be discussed at vascular Access Steering Group (VASG)
- VASG are reviewing guidance related to monitoring sites following device insertion
- Ostenisan washes must now be recorded in iView on CERNER to provide assurance

Dashboard	Quality and Safety
Lead	Medical Director

Quality and Safety Domain Matrix



Quality and Safety Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Oct 25	96.2%	≥95%			97.4%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Oct 25	89.2%	≥90%			89.3%
Mortality (SHMI)	Jun 25	1.013	0.95-1.05			1.020
Number of studies open	Oct 25	44				
% of current studies meeting recruitment target	Oct 25	27.3%				
% of open studies with a commercial sponsor	Oct 25	4.5%				

Areas of Concern

4 Never Events for this financial year

News 2 compliance below target of 90%

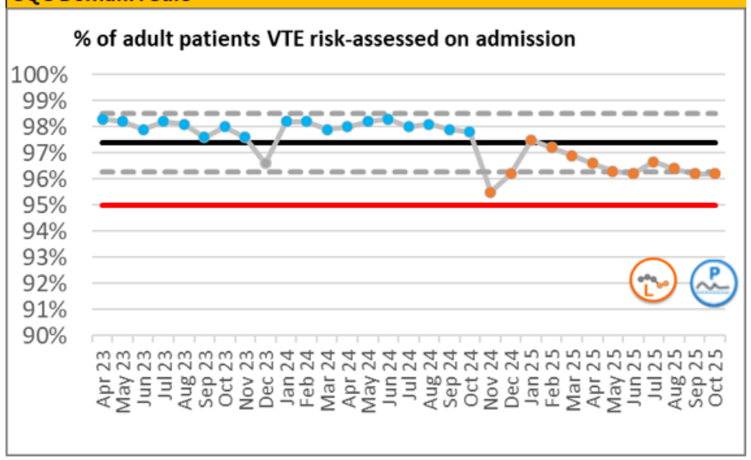
Forward Look (Actions)

LocSSIPs action plan tracked through audit committee and quality committee.
New policy has been approved to support effective use of LocSSIPs, as well as a standardised LocSSIP template.
Departmental audit programme in place to monitor LocSSIP compliance and monitored through DQB and PSQB.
Review of PSIRF process underway to support timely Review and learning (to be completed by end of November 2025)

NEWS 2 compliance is monitored in real time through live ward level dashboards. There is senior nursing oversight to monitor compliance, improve areas of low compliance and ensure all clinical staff are up to date with mandatory training. Divisional NEWS 2 compliance is monitored through DQB's and DPR.

% of adult patients VTE risk assessed on admission

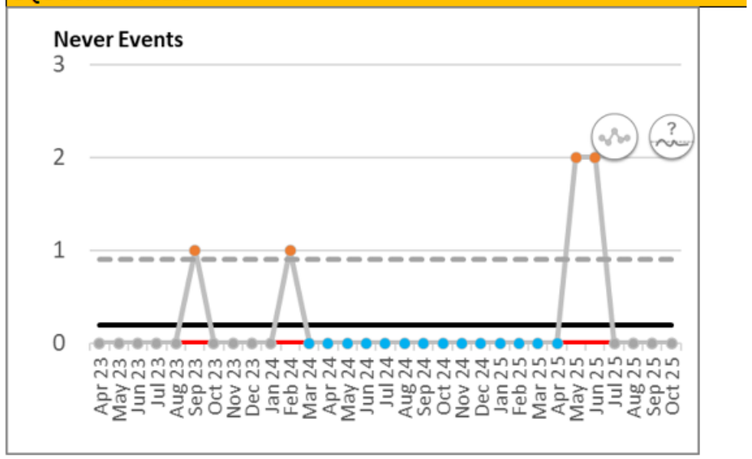
CQC Domain : Safe



Oct-25
96.2%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

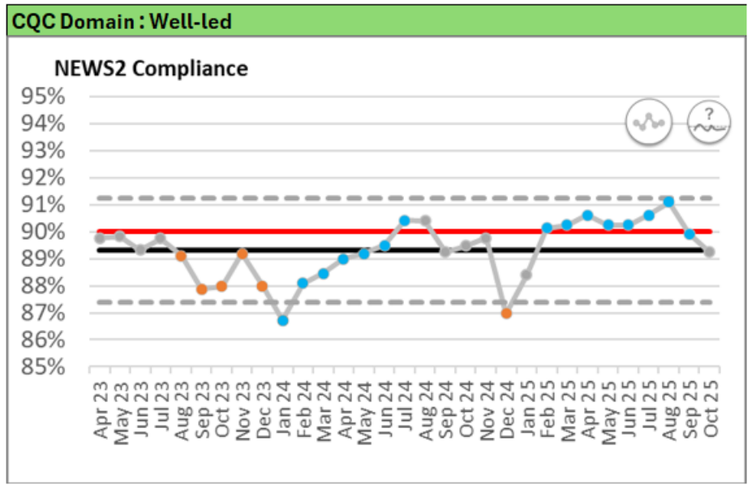
CQC Domain : Safe



2025/26
4
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

NEWS 2 Compliance

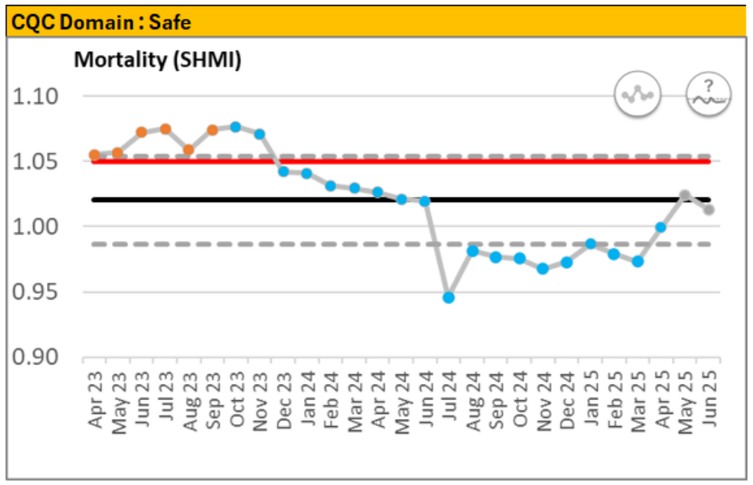
CQC Domain : Well-led



Oct-25
89.2%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Jun-25
1.0131
Variance Type
Common cause variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

Commentary

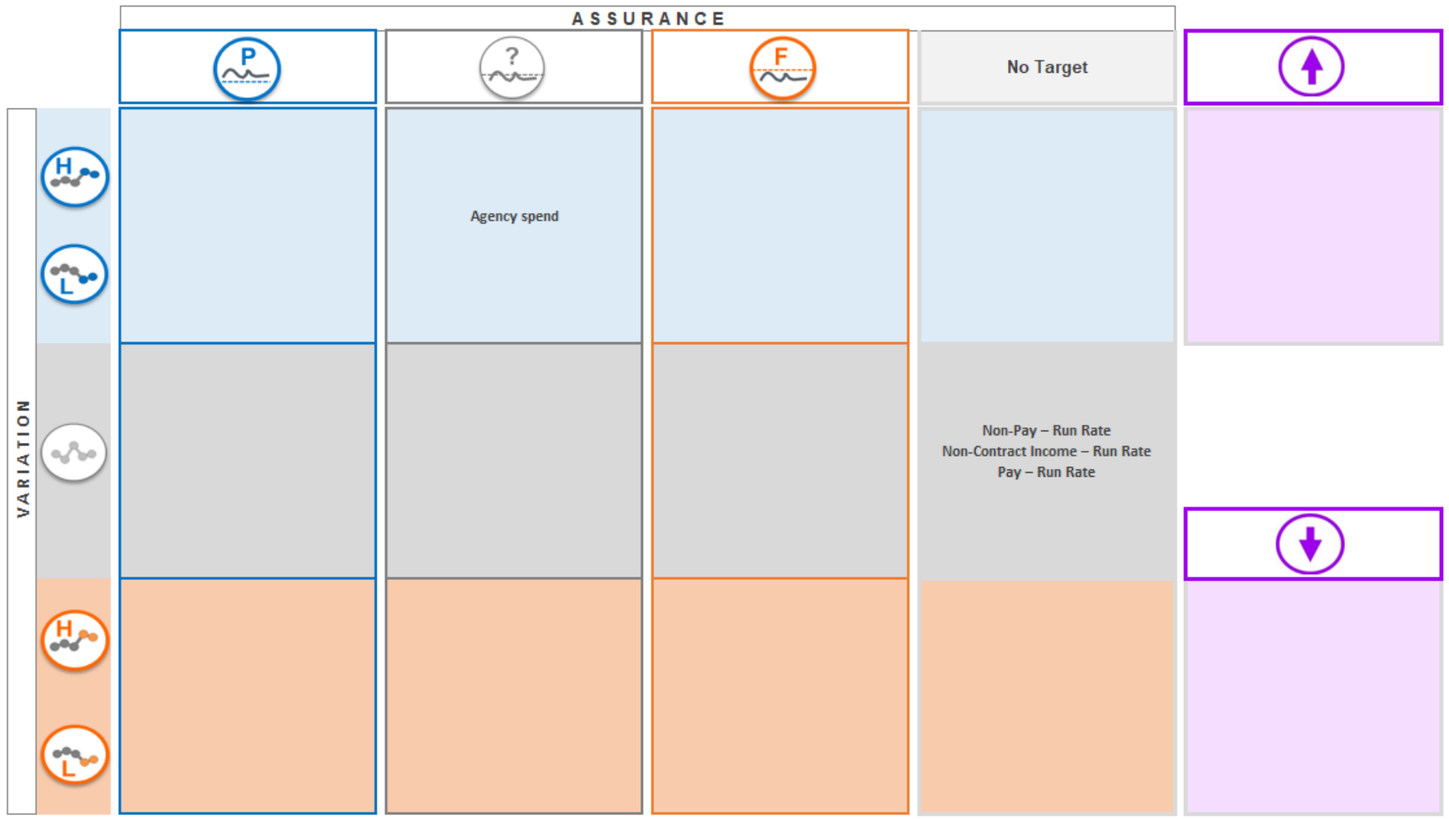
Number of studies open – Snapshot position	% of current studies meeting recruitment target – Snapshot position
44	27.3%

% of open studies with a commercial sponsor – Snapshot position
4.5%

Commentary

Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix



Finance Summary

Highlights

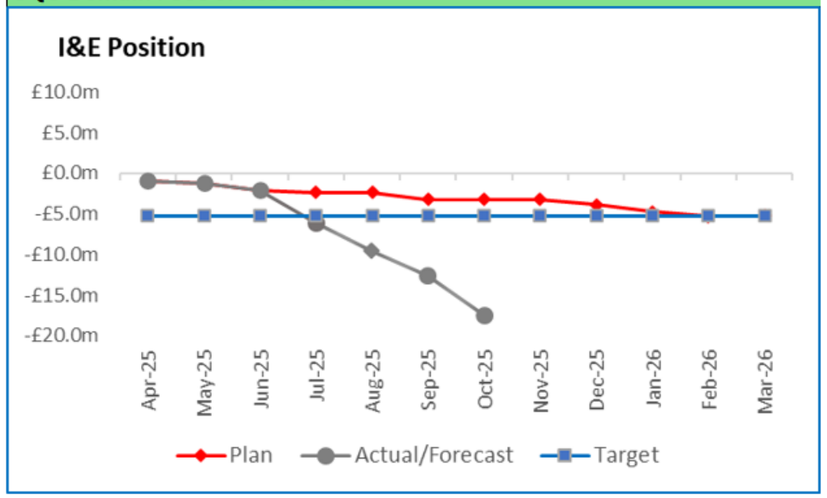
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Oct 25	1.5%	≤3%			2.7%
I&E Position	Oct 25	-£17.6m	-£5.2m			
Cumulative CIP	Oct 25	£18.7m	£18.7m			
Capital Expenditure	Oct 25	£11.6m	£15.3m			
Cash Position	Oct 25	£0.3m	£2.7m			

Areas of Concern

Forward Look (Actions)

I&E Position

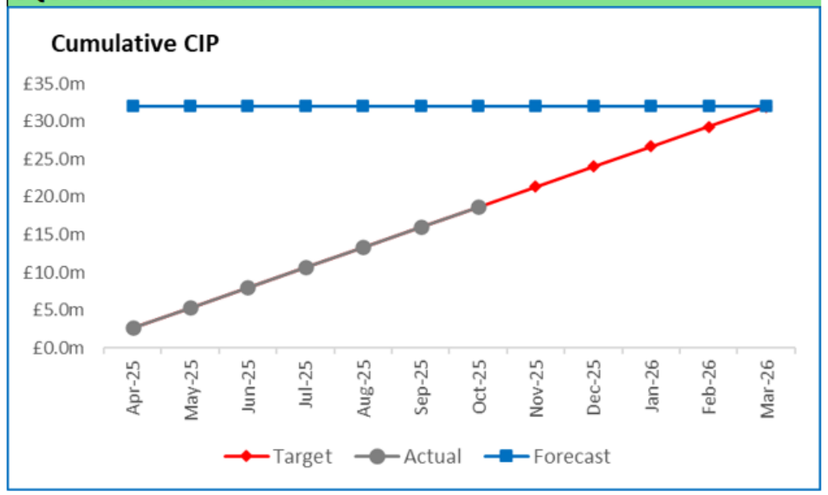
CQC Domain : Use of Resources



Oct-25
-£17.6m
Variance Type
Position doesn't meet the plan
Target
-£5.2m

Cumulative CIP

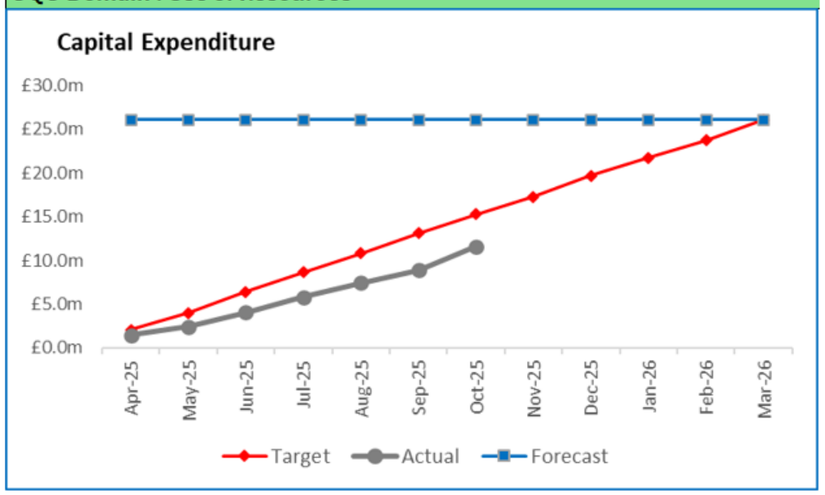
CQC Domain : Use of Resources



Oct-25
£18.7m
Variance Type
Position meets the plan
Target
£18.7m

Capital Position

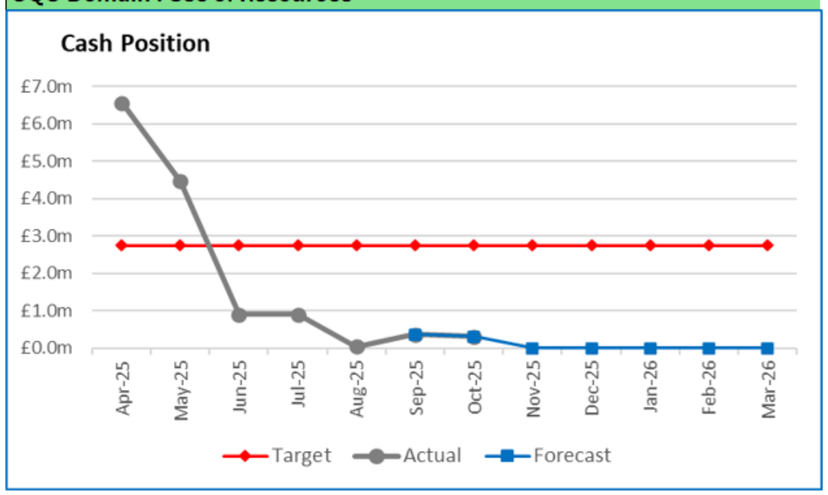
CQC Domain : Use of Resources



Oct-25
£11.6m
Variance Type
Position meets the plan
Target
£15.3m

Cash position

CQC Domain : Use of Resources

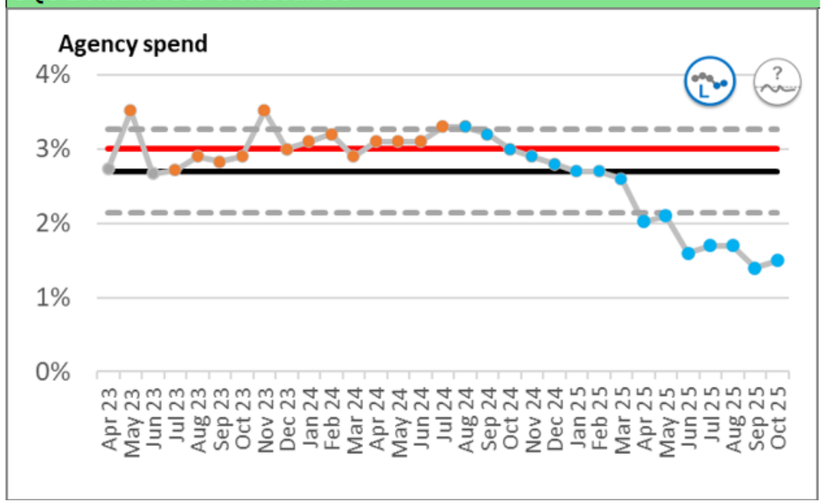


Oct-25
£0.3m
Variance
Position doesn't meet the plan
Target
£2.7m

Commentary

Agency spend %

CQC Domain : Use of Resources



Oct-25
1.5%
Variance Type
Special cause improving variation
Threshold
≤3%
Assurance
Consistently hit target

Commentary

Chief Finance Officer

Executive Summary

At the end of October 2025 (M7) the Trust is reporting a deficit of £17.6m which excluding DSF is a £8.8m adverse to plan. This is driven by; industrial action, pay award pressures, system stretch target and the Sterile Services (SSD) critical incident which has impacted the Trusts elective programme. To date, £8.5m of non-recurrent mitigations have been utilised to support delivery against plan and offset the key risks outlined below.

During September the Trust agreed additional actions to support delivery of the agreed plan, excluding DSF, of a £22.1m deficit. This includes enhanced controls across variable pay, non-core spend, discretionary non pay, elective income and a non-clinical vacancy freeze. All controls are fully enacted in October.

These factors are mitigations to the original 4 key risks identified within the Trust plan which are:

- Full CIP delivery – This is the primary risk to achieving the 2025–26 financial position. The risk adjusted annual forecast is below the required target. This risk includes the delivery of the ICS schemes (£14.1m).
- Activity / Casemix – Adjusting for the impact of IA, elective income remains below plan at M7.
- Aseptic Pharmacy – This risk is materialising with a significant reduction in income resulting from production compliance changes.
- Run-rate – 80% of targeted run-rate reductions have been identified and actioned.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). The cash balance at the end of M6 was £0.31m. The Trust implemented a cash mitigation plan in September but until a sustainable financial position is achieved this significant issue will continue. Further revenue support applications have been made for November (approved) and December (in progress).

Management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance plan (MTFP). The MTFP for 2026/27 to 2028/29 has been developed and is now being reviewed.

The risk ratings for delivery of statutory targets in 2025/26 are:

Statutory Financial Targets	RAG (M7)	RAG (Forecast)	Section within this report / associated chart
Financial Stability	●	●	I&E Position
Agency Spend	●	●	I&E Position
Financial Sustainability	●	●	N/A (quarterly update)
Financial Efficiency	●	●	Cumulative CIP
Capital	●	●	Capital Expenditure
Cash	●	●	Cash Position

Note – Financial stability is an in-year measure of achievement of the (deficit) plan whereas financial sustainability reflects the longer-term financial position of the Trust and recovery of a break-even position.

The Board is asked to:

- Note the report including that the Trust has reported an adverse variance to plan.
- Note that the Trust's most immediate finance risk remains the cash position and approve that the CFO submits additional applications based on confirmed need.
- Note that the Trust Board has agreed a plan to deliver the 25/26 plan and significant risks to delivery of this plan remain to be fully mitigated.
- Approve the increase in the capital budget of £0.069m for retinal imaging.

I&E Position

Narrative:

The table below summarises the M7 position:

	In Month			Year to Date			Forecast		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£40.4m	£37.9m	-£2.5m	£282.9m	£274.0m	-£8.9m	£485.0m	£478.0m	-£7.0m
Other Operating Income	£3.0m	£3.0m	-£0.0m	£20.6m	£19.6m	-£1.0m	£35.1m	£32.7m	-£2.3m
Total Income	**£43.4m**	**£40.9m**	**-£2.5m**	**£303.6m**	**£293.6m**	**-£9.9m**	**£520.0m**	**£510.7m**	**-£9.3m**
Employee Expenses	-£31.3m	-£31.8m	-£0.5m	-£222.5m	-£224.8m	-£2.3m	-£380.2m	-£385.8m	-£5.6m
Operating Expenses	-£12.7m	-£13.6m	-£0.9m	-£89.8m	-£90.5m	-£0.7m	-£153.6m	-£156.9m	-£3.3m
Non Operating Expenses	-£0.4m	-£0.5m	-£0.1m	-£2.9m	-£3.0m	-£0.2m	-£4.9m	-£5.1m	-£0.2m
Recurrent CIP	£1.1m	£0.0m	-£1.1m	£8.4m	£0.0m	-£8.4m	£13.5m	£1.8m	-£11.7m
Non Recurrent Mitigations	£0.0m	£0.0m	£0.0m	£0.0m	£7.0m	£7.0m	£0.0m	£7.0m	£7.0m
Total Expenditure	**-£43.4m**	**-£46.0m**	**-£2.6m**	**-£306.8m**	**-£311.3m**	**-£4.5m**	**-£525.3m**	**-£539.0m**	**-£13.8m**
PFR Reported Position Month 7	**£0.0m**	**-£5.0m**	**-£5.1m**	**-£3.2m**	**-£17.6m**	**-£14.4m**	**-£5.2m**	**-£28.3m**	**-£23.1m**
Adjust for DSF	**-£1.4m**	**£0.0m**	**£1.4m**	**-£9.9m**	**-£4.2m**	**£5.7m**	**-£16.9m**	**-£12.7m**	**£4.2m**
Position excluding DSF	**-£1.4m**	**-£5.0m**	**-£3.7m**	**-£13.1m**	**-£21.8m**	**-£8.8m**	**-£22.1m**	**-£41.0m**	**-£18.9m**
Mitigations								**£5.9m**	**£5.9m**
Trust Mid-case Scenario							**-£22.1m**	**-£35.1m**	**-£13.0m**

Key variances within the YTD position are:

Clinical Income – £8.9m adverse variance relates to elective underperformance, the CSSD incident, industrial action and loss of DSF.
Employee Expenses - £2.3m adverse variance relates to use of bank, agency, industrial action and undelivered vacancy factors.
Operating expenses – £0.7m adverse variance relates clinical supplies and depreciation.
Cost Improvement Programme – £8.4m underdelivered at month 7 which is offset by non-recurrent mitigations.

The Trust's agency costs were 1.5% of total pay bill for the month, which is significantly below the NHSE threshold of 3.2% of total staff costs.

Cumulative CIP

Narrative:
The Trust has transacted CIP with a part year effect of £28.7m at M7 of which, £7.0m has been delivered non-recurrently. The Trust has identified recurrent CIP with a full year effect of £31.4m, however, this figure reduces to £25.7m once risk adjusted reflecting a risk adjusted shortfall of £6.3m.

Review of the CIP position is ongoing through weekly CIP Assurance, chaired by the COO and monthly Productivity Improvement Board, chaired by the CEO. The Trust also meets frequently with colleagues from the ICB and across the ICS to identify and deliver the collectively agreed additional savings target (WUTH share £14.1m).

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £61.6m at Month 7 (M7), reflecting an adverse variance of £4.9m. Elective underperformance to M6 was primarily driven by the Surgical Division, specifically Trauma & Orthopaedics (T&O). Daycase underperformance is driven by the Medicine division, specifically Dermatology and Cardiology. However, in M7 the primary factor is the CSSD incident which has significantly impacted elective capacity.

Bi-weekly elective recovery plan meetings now in place to review activity performance against forecast – chaired by the COO.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2025/26 at M7:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M5	Revision to budget M6	Revision to budget M7	Revised Budget
CDEL						
Internally Generated	£9.765m	£0.000m	£0.000m	£0.000m	£0.000m	£9.765m
ICB/PDC/WCHC	£14.550m	£0.516m	£0.034m	£0.058m	£0.069m	£15.227m
Charity	£1.100m	£0.000m	£0.000m	£0.000m	£0.000m	£1.100m
Confirmed CDEL	£25.415m	£0.516m	£0.034m	£0.058m	£0.069m	£26.092m
Total Funding for Capital	£25.415m	£0.516m	£0.034m	£0.058m	£0.069m	£26.092m
Capital Programme						
Estates, facilities and EBME	£3.100m	£0.516m	£0.034m	£0.000m	£0.000m	£3.650m
Operational delivery	£8.440m	£0.000m	£0.000m	£0.000m	£0.069m	£8.509m
Medical Education	£0.080m	£0.000m	£0.000m	£0.000m	£0.000m	£0.080m
Transformation	£0.250m	£0.000m	£0.000m	£0.000m	£0.000m	£0.250m
Digital	£0.750m	£0.000m	£0.000m	£0.058m	£0.000m	£0.808m
UECUP	£7.800m	£0.000m	£0.000m	£0.000m	£0.000m	£7.800m
PDC commitments	£0.304m	£0.000m	£0.000m	£0.000m	£0.000m	£0.304m
ICB hosted	£3.591m	£0.000m	£0.000m	£0.000m	£0.000m	£3.591m
Charity	£1.100m	£0.000m	£0.000m	£0.000m	£0.000m	£1.100m
Approved Capital Expenditure Budget	£25.415m	£0.516m	£0.034m	£0.058m	£0.069m	£26.092m
Total Anticipated Expenditure on Capital	£25.415m	£0.516m	£0.034m	£0.058m	£0.069m	£26.092m
Under/(Over) Commitment	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m

In M7 the Trust has received an additional £0.069m for Retinal Imaging which is now included within the Capital Plan.
Spend at M7 totals £11.61m which is £3.656m behind plan

Cash Position

Narrative:

The cash balance at the end of M7 was £0.31m. This includes the impact of £5.6m withheld Deficit Support Funding; the impact of which will continue at least until Month 9 (December). Since August 2025 the Trust has been successful in accessing national cash support. The requirements are driven by; non-cash backed deficit, unplanned deficit, withheld deficit support.

A new cash regime has been included within the NHSE recently published document "2025/26 Financial management expectations, tools, interventions and oversight". This is in the process of being reviewed to align the existing mitigation plan which includes:

- Management of payments - continued daily management of payments to and from other organisations both NHS and non NHS.
- Analysis/CFO oversight - Continued daily monitoring and forecasting of the Trust cash position and our Public Sector Payment Performance metrics.
- Debt recovery - Monitoring and escalation of any aged debt delays.

- Support - Negotiations with ICB and NHSE around mitigations for cash position and the process for applying for cash support.

The reduction in the cash balance is presenting difficulties daily with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11**
3 December 2025

Title	Joint Executive Managing Director Report
Area Lead	Hayley Kendall, Joint Executive Managing Director
Authors	Hayley Kendall, Joint Executive Managing Director Steve Baily, Director of Operations Alistair Leinster, Divisional Director – Performance and Planning
Report for	Information

Report Purpose and Recommendations

This paper provides an overview of the Trust's current performance against the elective recovery programme for planned care and standard reporting for unscheduled care.

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times but the continued challenge in achieving reduced waiting times in gynaecology services.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Emergency Department (ED) and in particular 12 hour waiting times.

The Board should note improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED along with system partners.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

- BAF 1 - Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience.
- BAF 2 - Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes

Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
This is a standing report to Board			

1 Introduction / Background

1.1 WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway as an output of the widescale cancellation of activity during Covid. Since April 2025 many cancer services have seen unexpected levels of referrals that are much higher than the capacity available, leading to challenges in the delivery of the 28 day faster diagnostic standard. The critical incident with the sterile services department has impacted on elective and cancer waiting time target delivery.

Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. There is regional and national focus on the Trust's 4 and 12 hour performance and the Trust is receiving support from the Emergency Care Intensive Support Team (ECIST). A daily executive performance huddle has been introduced with the Emergency Department to drive improvements in performance.

2 Planned Care

2.1 Elective Activity

In October 2025, the Trust attained an overall performance of 97.5% against plan for outpatients (95% for new outpatient attendances), and an overall performance 80% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for October	Actual for October	Performance
Out pt New	12,436	11,838	95.2%
Out pt Follow up	26,827	26,503	98.8%
Out pt procedures	4,002	3,861	96.5%
Total Out pts	43,265	42,202	97.5%
Day case	4,766	3,988	83.7%
Inpatients	586	308	52.5%
Total - Elective and Daycase	5,352	4,296	80.3%

The Trust underachieved plan for outpatients and elective/daycase, with activity impacted by the sterile service incident. The impact of this has been captured separately and will be updated to Board.

Underachievement for elective / daycase activity was seen in Medicine, Surgery and Women's and Children's. The sterile services incident impacted activity (outpatient procedures, daycase and elective inpatients).

2.2 Referral to Treatment (RTT)

The Trust's performance at end of October 2025 against RTT metrics was as follows *(RAG rated versus monthly trajectories from Trust planning submission)*:

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Total RTT Caseload	46,400	45,691	46,939	47,312	47,271	48,195	49,453
% RTT	59.74%	63.01%	62.54%	61.80%	60.68%	61.70%	60.96%
52 weeks	1,128	1,272	1,302	1,255	1,335	1,138	1,313
52 weeks % of caseload	2.43%	2.78%	2.77%	2.65%	2.82%	2.36%	2.66%
104+ Week Wait Performance	0	0	0	0	0	0	0
78+ Week Wait Performance	7	0	0	0	0	0	0
65+ Week Wait Performance	24	22	13	16	7	4	26

The Trust achieved trajectory for percentage of patient waiting 18 weeks or under, but was over trajectory for RTT caseload, number and percentage of 52-week waiters in September 2025.

RTT position for October was impacted by the sterile services incident with increasing numbers on the waiting list. Whilst quantifying the impact of the incident on RTT performance is complicated by there being lists lost that were not booked, at simple level, overall caseload increased by +1022 and 52-week waiters by +118 across the period of the incident.

This has seen RTT caseload exceed planned trajectory for the first time in 2025/26. Divisions are developing activity recovery plans, in addition, a 3rd national sprint is commencing in November. Previous validation sprints have been effective in reducing overall caseload. Additional validation resource has been agreed to support maintaining an improved caseload following the validation sprint. Further to this, ENT outsourcing is continuing, and Dermatology insourcing (see section 2.3 Cancer Performance) will commence in December, which will have a positive impact on caseload.

There were 0 x patients waiting 78+ weeks at the end of October 2025, this position has been maintained since May 2025.

The number of patients waiting 65+ weeks has increased to 26 from 4 in the previous month. 21 were as a result of the Sterile Service Incident, with a remaining 4 x ENT and 1 x T&O awaiting input from another Trust.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2:

Quarter	2
Period	01/07/2025 - 30/09/2025

National Standards:

Standard	Indicator	Threshold	July-25	August-25	September-25	Quarter 2
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	77.00%	72.24%	67.14%	62.88%	67.54%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.07%	90.09%	91.29%	90.84%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.78%	75.07%	75.22%	75.36%

Sub Standards:

Standard	Indicator	Threshold	July-25	August-25	September-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	72.24%	67.14%	62.88%
28 Day Wait	Breast >=90%	90.00%	84.95%	87.47%	85.17%
28 Day Wait	Skin >=90%	90.00%	77.02%	62.20%	38.35%
31 Day Wait	Individual Trust Provider Trajectory	Per Month	91.07%	90.09%	91.29%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.78%	75.07%	75.22%

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the trajectory for the FDS standard for September 2025. Areas of pressure include Dermatology as a result of impact of regional ceasing of A&G / introduction of AI, Breast, Gynaecology and Urology. Improvement is seen all of these areas, with the exception of Dermatology which is a concern to the delivery of the Trust target. It is expected that this will be recovered by the end of January.
- *62-day treatment* - The Trust did not achieve trajectory in September 2025 with performance of 75.22% versus trajectory of 76.81%. The impact of pressures on 28-day performance is seen to impact 62-day treatment delivery.
- *62-day waiters* – The number of waiters remains high as a result of pressure on 28-day performance and impact of the sterile services incident.

	07/04	05/05	02/06	07/07	04/08	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10
Actual 25/26	81	105	110	120	137	171	156	138	139	128	130	140	144	132
Trajectory 25/26	105	98	91	84	77	69	69	69	69	69	61	61	61	61
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104-day long waiters* – the number of waiters has increased in October as a result of the sterile services incident.

	07/04	05/05	02/06	07/07	04/08	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10
Actual 25/26	26	21	26	28	32	45	40	32	29	23	31	30	26	32
Trajectory 25/26	22	21	19	17	15	13	13	13	13	13	11	11	11	11
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12

Performance in Urology, Gynaecology, Breast and Dermatology tumour sites were seen to have an impact on overall 28-day FDS performance at Trust level. Performance is improving within Urology, Gynaecology and Breast in response to Divisional improvement plans. Dermatology cancer performance remains the most significant pressure on the overall Trust position.

The sterile service incident has had an impact on cancer performance, having greatest effect on 62 and 104-day waiters to-date, with impact still to be seen on the 31-day treated and 62-day referral to treatment standard.

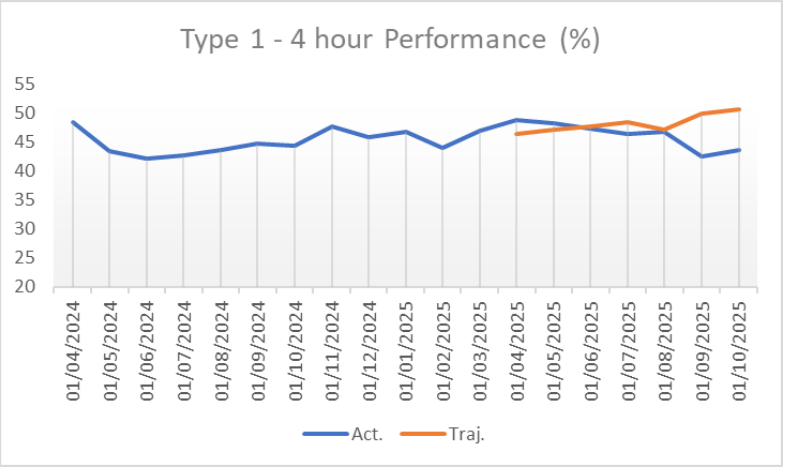
Dermatology performance deteriorated following implementation of pathways changes; introduction of AI pathway and regional ceasing tele-dermatology, with the sharpest decrease coinciding with tele-dermatology switch off. This deterioration is also reflected across the region. Demand now significantly exceeds capacity impacting FDS performance which has dropped from 91% in April 2025 to 38% in September with a corresponding impact being seen against the 31-day and 62-day referral to treatment standard.

	Dermatology recovery is being approached in two phases. An initial prioritisation of recovery of the faster diagnostic standard by January 2026, utilising Cancer Alliance funding to support insourcing. Phase two will focus on reducing demand using tele-dermatology and meeting the increased demand for minor operations that will created through the additional activity in phase one. Both the introduction of tele-dermatology and additional minor operation capacity will require further additional funding. Following implementation of Gynaecology pathway changes in September, performance continues to improve as planned, with performance forecast to meet tumour site trajectory in October. The Breast Service is also on track to continue to improve FDS performance in October and meet tumour site trajectory in November. Focus remains in Urology on optimising the cancer pathway with additional triage capacity and improved escalation for diagnostics and tracking. Divisions are developing cancer recovery plans following the sterile services incident. Recovery plans focus on returning to pre-incident waiting times from decision to admit to treatment / diagnostic. Risk to recovery has been flagged within Head and Neck due ongoing issues with the availability of instruments.
2.4	**DM01 Performance – 95% Standard** The Trust achieved the standard of 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 94.7% for October. This is an increase on the September position of 87.4%, as a result of an improvements in non-obstetric ultrasound.
2.5	**Risks to recovery and mitigations** The main areas of concern are recovery of cancer performance and delivering 0 x 65 weeks by December in line with regional expectations. Cancer improvement plans have been developed by divisions, including tumour site level trajectories, as well as plans to address more immediate performance issues. The Trust has been supported with regional recovery funding in Gynaecology, Breast and Dermatology. Improvements have been seen across tumour sites for 28 day cancer performance, with the exception of Dermatology which remains the most significant risk to Trust performance. The sterile services incident saw the cancellation of over 1,300 elective theatre cases. This has impacted on activity, income, RTT performance and cancer performance. Divisional teams are currently developing activity recovery plans.

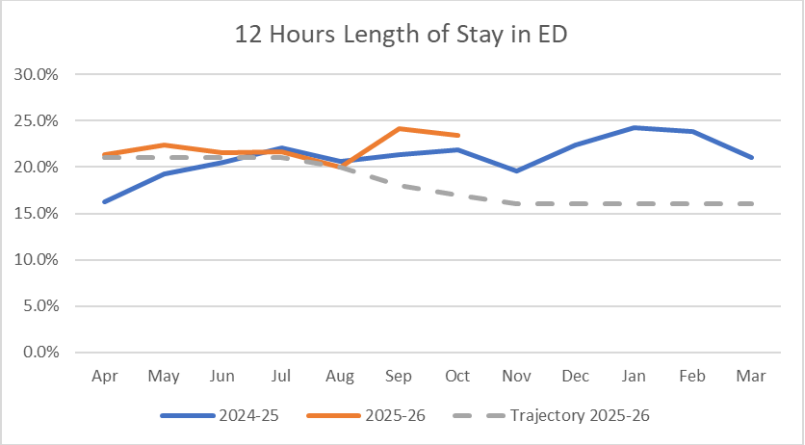
3.0	**Unscheduled Care**
3.1	**Performance** In October, Type 1 performance was reported at 43.83%, with a combined performance across all Wirral sites reaching 70.05%. This was a small improvement from September. Type 1 ED attendances: • 8,030 in September (avg. 268/day) Type 3 ED attendances: • 2,926 in September (avg. 97/day)

• 8,314 in October (avg. 268/day) • 3.5% increase in attendances from previous month however daily attendances avg. remained the same as previous month	• 2,972 in October (avg. 96/day) • 1.5% increase in attendances from previous month

In October, Urgent and Emergency Care daily demand remained at similar levels seen in September. While performance against the Type 1 4-hour standard was below trajectory, performance did show an increase.



Focus remains on reducing 12 hour waits in the Emergency Department. Performance improved in month compared to September however at 23% remains above the revised target set by Cheshire and Merseyside. The Trust and the wider Cheshire and Merseyside system continue to report are national outliers, with an average of 20% of patients experiencing a stay beyond 12 hours. The Trust continues to report the position and progress on improvement projects through the NHSE Tier 1 meetings.

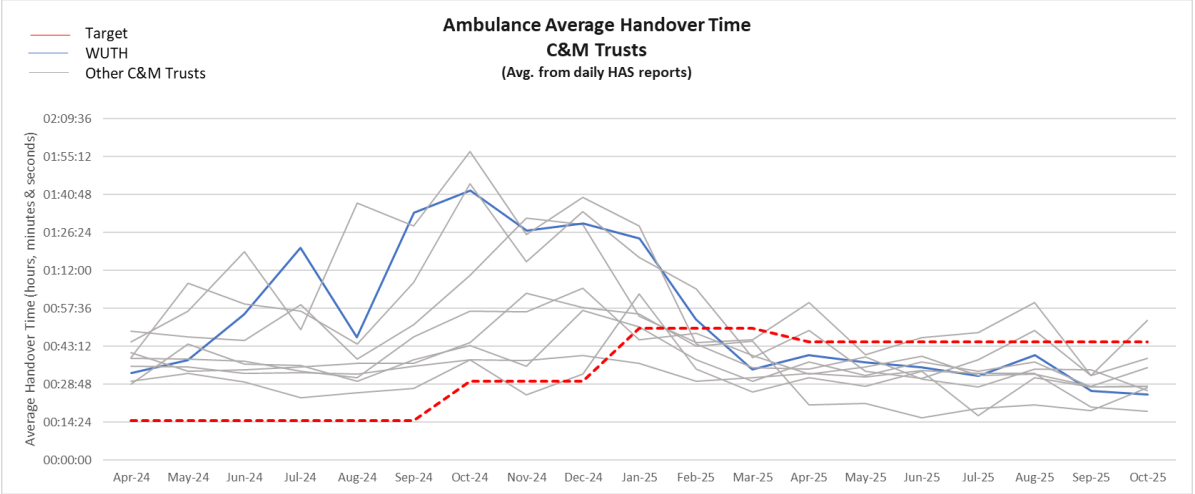


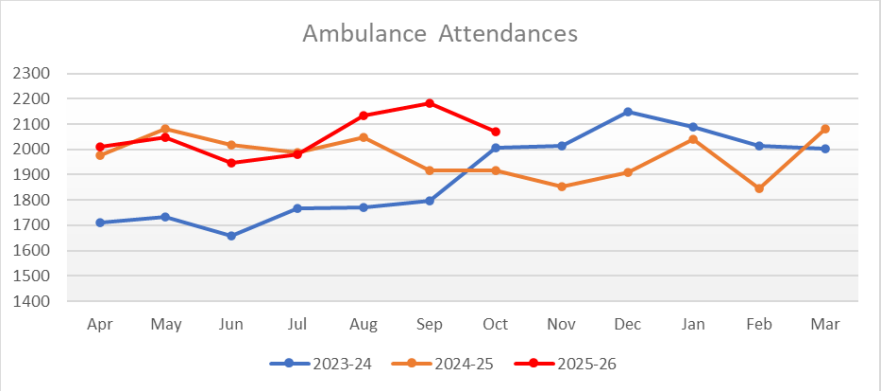
The programme of work with GIRFT (ECIST) continues with the agreed work programme of improvement. Areas of focus are reducing wait to be seen by review of medical workforce rotas ensuring medics on shift reflect prediction in demand, ward discharge process including earlier flow from the wards, improving streaming pathways from ED and improving triage waits.

Outputs of the medical review is expected in November however changes in streaming approach were made at the end of October with early performance showing and average reduction of 7 minutes per patient.

The improvement compliments the wider improvement projects that are focusing on pre-hospital attendance/admission avoidance, in hospital flow and post-hospital pathways focusing on reducing delays for patients with no criteria to reside.

Ambulance handover performance improved in October. The demand on ambulance conveyances continues to remain above previous years activity. The Trust plans to reconfigure an area in ED to improve flow from the ED to medical assessment which should reduce corridor waits by creating additional capacity and improve 12 hour in department performance.





3.2 **Transfer of Care Hub development and no criteria to reside (NCTR).**

In October, the position has remained stable, with 12.2% of patients occupying acute beds despite having no criteria to reside (NCTR). The Trust is beginning to see an increased frequency of days where the proportion of patients with NCTR reduces to 10%, demonstrating positive movement towards achieving the Trust's local trajectory of 10% by March 2026. This level of consistency reflects sustained operational grip from the team in the Transfer of Care Hub and ongoing focus across clinical and operational teams.

Winter planning with system partners is progressing at pace. Multi Agency Discharge Events are scheduled for both the pre-Christmas and post-Christmas periods to support safe and timely discharge during peak demand. There is collective agreement at Wirral Place to prioritise patients on Pathway 3 and to increase the number of

patients able to be discharged either to Home First or to available Community bed capacity.

This focused approach aims to optimise flow, reduce pressure on acute beds, and ensure patients are transferred to the most appropriate care setting as efficiently as possible.

Provider	Current
Countess	22.0%
East Cheshire	42.3%
LUHFT	17.3%
Mid Cheshire	20.7%
MWL	20.6%
W&H	21.7%
WUTH	12.2%
Total	**19.8%**

3.3 Mental Health

Work continues with our mental health provider. Early indications from the mental health action cards and the strengthened escalation process suggest a positive shift, with fewer prolonged waits for mental health patients in ED. An audit is currently underway to validate this improvement and identify any further opportunities to enhance flow and patient experience.

Alongside this, several additional offers are planned for November and December to reduce demand on ED and shorten the time mental health patients spend in the department. The additionality includes the introduction of a side-by-side triage model to support earlier assessment and decision-making. There is also the opening of a Mental Health Crisis Assessment Centre (MHCAS) in December, located at the Countess of Chester Health Park. This development will provide a dedicated, therapeutic environment for Mental Health crisis assessment and is expected to further support improved patient flow and timely access to specialist care.

3.4 Risks and mitigations to improving urgent care performance

The Trust continues to make steady progress in delivering the actions set out within the urgent care improvement plans, with a focus on achieving key quality standards. Performance is being closely monitored through the Urgent and Emergency Care (UEC) Improvement Group, with oversight of sentinel metrics provided by Wirral Place leads and the System Control Centre (SCC).

Despite this progress, several risks remain. Increased patient acuity and sustained demand for beds continue to place significant pressure on patient flow and the delivery of planned improvements.

The Trust is also now seeing an increase in patients presenting with respiratory illnesses including influenza which has resulted in limiting flow on wards.

4 Implications

4.1 Patients

- The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position

	regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

5	**Conclusion**
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point, although impacted by the recent critical incident. Resident doctor industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 12**

03 December 2025

Title	Board Assurance Framework (BAF)
Area Lead	Ali Hughes, Joint Director of Corporate Affairs & Communications
Author	Ali Hughes, Joint Director of Corporate Affairs & Communications
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with information and assurance as it relates to the Board Assurance Framework (BAF) and the current high level and strategic risks within the Trust.

Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the Committee. This update provides the position following review during November 2025.

It is recommended that the Board:

- Note the position reported in relation to the strategic risks; and
- Approves the strategic risk positions

Key Risks

This report relates to these key risks:

- The BAF records the principal risks that could impact on the Trust's ability in achieving its strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trust not being able to achieve its strategic objectives or its statutory obligations.
- There are opportunities through the effective development and use of the BAF, to enhance the delivery of the Trust's strategic objectives and effectively mitigate the impact of the principal risks contained within the BAF.
- The BAF also records significant operational risks for the current month to determine any cumulative impact on the strategic risks.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes

Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
November 2025	Quality Committee	Board Assurance Framework	The Committee reviewed the position in relation to strategic risks and supported onwards reporting to the Board of Directors.
November 2025	Executive Assurance & Risk Committee	Board Assurance Framework	The members of EARC noted the position in relation to strategic risks, particularly noting alignment to any high-level risks presented by Clinical Divisions.

1	Narrative
1.1	**Current position** The dashboard at appendix 1 confirms the current position of strategic risks as reviewed during November 2025. Of the 12 strategic risks, 6 are scored 15 or above - *ID1,2,3,4,6 and 11.* There are no proposed changes to risk ratings. The Quality Committee met on 24 November 2025 and reviewed the detail in relation to strategic risk 3 - *Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints* and noted the updates included relating to the recent CQC report, the impact of the SSD critical incident and the on-going FRPM programme across Cheshire & Merseyside. The Audit & Risk Committee will meet on 10th December 2025 to have oversight of all strategic risks and progress to mitigation and achievement of target risk ratings. The Finance & Business Performance Committee will meet on 15th December to review the finance, performance and digital risks. The People Committee will meet in January 2026. The IMB maintains oversight of the risk related to integration with WCHC with good progress being made.

2	Implications
2.1	**Patients** • The quality impact assessments and equality impact assessments to assess implications for patients are undertaken through the work streams that underpin the BAF.
2.2	**People** • The quality impact assessments and equality impact assessments to assess implications for people are undertaken through the work streams that underpin the BAF.
2.3	**Finance** • Any financial or resource implications are detailed in the BAF for each strategic risk
2.4	**Compliance** • The BAF is key to effective governance and is subject to an annual Assurance Framework Review as per internal audit standards in order to inform the Head of Internal Audit Opinion (HOIA) each year. The strategic risks tracked through the BAF are reported annually through the Annual Governance Statement.

12 Month - Dashboard and Current and Quarterly Trend

Impact x Likelihood

Risk No	Strategic Priority	Risk Appetite	Owner	Risk Description	Initial Score (I x L)	Target	Mar 25	June 25	July 25	Sept 25	Oct 25	Nov 25		Dec 25
1	Outstanding Care **R, O, C, F**	Minimal	ExecMD	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)		20 (4 x 5)
2	Outstanding Care **R, O, C, F**	Minimal	ExecMD	Failure to meet targets and standards in relation to Planned/Scheduled care, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	↑	16 (4 x 4)
3	Outstanding Care **R, O, C, F**	Minimal	CN/ CMO	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	↔	16 (4 x 4)
4	Compassionate Workforce **O, C, F**	Open	CPO	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	16 (4 x 4)	↑	16 (4 x 4)
5	Compassionate Workforce **R, O, C, F**	Open	CPO	Failure of the Trust to have the right culture, staff experience, safety and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
6	Continuous Improvement **R, O, F**	Minimal	CFO	Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision.	16 (4 x 4)	8 (4 x 2)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	↔	20 (4 x 5)
7	Digital Future and Infrastructure **R, O, F**	Seek	CFO	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
8	Continuous Improvement **R, F**	Open	ExecMD	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	12 (3 x 4)	12 (3 x 4)	↑	12 (3 x 4)
9	Our Partners **R, S, F**	Seek	CEO/ CSO	Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce and financial) not being realised.	9 (3 x 3)	6 (3 x 2)				9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
10	Digital Future and Infrastructure **R, S, F**	Seek	CSO	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Digital Future and Infrastructure **R, O, C, F**	Seek	ExecMD /CFO	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	15 (5 x 3)	15 (5 x 3)	15 (5 x 3)	15 (5 x 3)	15 (5 x 3)	15 (5 x 3)	↔	15 (5 x 3)
12	Outstanding Care **R, O, C**	Minimal	CSO/ CIPO	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)

Risk Categorisation

All BAF Risk are further identified by the following risk categories - Reputational risk. **R** Operational risk. **O** Strategic risk. **S** Financial risk. **F**

BAF RISK 1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.

Strategic Priority	Outstanding Care				
Risk Appetite	Minimal				
Review Date	Q3 2025/26	Initial Score	Previous month	Current	Target
Lead	Executive Managing Director	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action, although the actions do not mitigate the demand and capacity gap. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. With Executive Triumvirate. • Business Continuity and Emergency Preparation planning and processes in place. This includes escalations to Critical Incident as required. • Winter plan initiated that includes additional resource and capacity to aid strong UEC flows and performance • Full review of post take model to ensure sufficient resource is allocated to manage volumes • Implementation of continuous flow model to improve egress from ED.	• EARC Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO • Trust wide response to safe staffing of ED when providing corridor care

Gaps in Control or Assurance
• NOF segmentation (Q1 25-26) - 4 (0.03 below segment 3) • NOF domain score - Access to Services - 2.57 • NOF metric score - UEC 4 hours - 2.7 • NOF metric score - UEC 12 hours - 3.95 • The Trust continues to be challenged delivering the national 4-hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.

Action	Responsible	Deadline
There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post.	Chief Operating Officer	March 2026
System 4-hour performance response to deliver 78% in March 2026.	Director of Operations	March 2026
External support into ED from ECIST reviewing 4 hour and 12-hour performance – commenced work with ECIST and through October and November current improvement plans will be tested and providing on-site	COO	December 2025
Full engagement with the national Tier 1 process for UEC performance (engaging in fortnightly calls)	COO	March 2026

BAF RISK 2	Failure to meet targets and standards in relation to Planned/Scheduled care, resulting in an adverse impact on patient experience and quality of care.

Strategic Priority	Outstanding Care				
Risk Appetite	Minimal				
Review Date	Q3 2025/26	Initial Score (I x L)	Previous month	Current	Target
Lead	Executive Managing Director	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Clinical harm reviews in place for long waiting patients, full divisional and trust oversight of the overdue follow-up appointments by specialty, the specialities utilise the national clinical prioritisation process which is monitored weekly in divisions. • Utilising of insourcing and LLP to provide capacity to achieve the new national targets. • Access/choice policy in place. Detailed operational plans agreed annually. • Weekly review via the performance meeting, chaired by the COO, on key targets and indicators with agreed actions and mitigations. • Full engagement in the Cheshire and Merseyside Elective Recovery Programme	• Performance Oversight Group (Weekly) • Divisional Access & performance Meetings (weekly) • Monthly Divisional Board meetings • Divisional Performance Reviews • EARC Oversight • There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full-service review with the COO and action plans as required.

Gaps in Control or Assurance

- NOF segmentation (Q1 25-26) - 4 (0.03 below segment 3)
- NOF domain score - Access to Services - 2.57
- NOF metric score - 18 weeks - 2.27
- NOF metric score - planned v actual 18 weeks - 1
- NOF metric score - 52 weeks - 3.03
- NOF metric score - 52 weeks (community) - 3.85
- National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity.
- Impact of the Cyber-attack was significant and deteriorated the Trust's progress with recovering elective waiting times.
- 2 specialities are challenged in delivery of 65 and 75 weeks.
- One specialty is challenged in delivering 65 weeks by the end of the financial year given the impact of the cyber-attack.

Action	Responsible	Deadline
Review data submission for NOF metrics - *Access to Services*	**Chief Operating Officer / Chief Finance Officer**	**COMPLETE**
Continue with delivery of mitigation plans for scheduled care,	COO	March 2026
Utilisation of premium time capacity to bridge gaps in capacity and demand	COO	March 2026

BAF RISK 3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.
Strategic Priority	Outstanding Care
Risk Appetite	Minimal
Review Date	Q3 2025/26
Lead	Chief Medical Officer and Chief Nurse

Initial Score	Previous month	Current	Target
16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

Controls

- Patient Safety, Quality and Research and Innovation Strategies
- Quality Governance Structure (including patient safety) established trust-wide
- Quality Governance Accountability Framework includes monitoring and review of quality and patient safety indicators at monthly Divisional Performance Reviews
- PSIRF plan and policy
- Patient Safety Partners in post
- WISE accreditation programme
- Infection Prevention and Control (IPC) Board Assurance Framework (with oversight at the Quality Committee) - *compliant in 46 areas; partial compliance in 8 areas with action plans in place*
- All actions from CQC 2018 action plan formally closed
- CQC action plan (following 2025 inspection) developed for tracking through quality governance structures
- CQC engagement meetings
- Safety huddles
- Nursing and Maternity Champions including MNVP
- PSQB divisional reporting
- Senior leads for statutory roles in place - DIPC, Safeguarding, CDAO, Medicines Safety Officer
- Incident reporting culture and processes trust-wide - open reporting culture *(as evidenced in CD Annual Report - high number, low harm)* with digital dashboard
- CMO participation and engagement in NHSE mid-year review meetings and FPRM meetings with PWC
- Strengthening of LoCSSIPs across the Trust to manage identified variation
- IPC new leadership structure
- Wirral system strategy for C.Diff

Assurance

- CQC report of UEC (1 out of 5 rated 'good') & Medicine (3 out 5 rated 'good')
- Executive Patient Safety and Quality Board (PQSB) oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Committee
- Healthwatch invited to attend Quality Committee
- PSQB AAA Chair's Report to Quality Committee
- Patient Safety Incident Response Panel (reporting to PSQB) - *identified opportunity for learning across WUTH and WCHC*
- Safeguarding Assurance Group & Safeguarding Annual Report *(11 areas of improvement)*
- Never-events Thematic Review *(reporting to Quality Committee)*
- Achievements against Antimicrobial Stewardship (AMS) priorities for 24-25 *(reporting to Board)*
- Mortality Review Group oversight
- Regular board review of Quality Performance via Integrated Performance Report
- Cheshire and Merseyside ICB oversight of Trust clinical governance, including Serious Incidents and Never Events action plans.
- Annual Internal Audit Plan (MiAA) and Annual Clinical Audit Programme (e.g. IPC, CD) reporting through governance structure including to Audit & Risk Committee
- Maternity report and compliance with standards reported to Board of Directors (monthly)
- Maternity self-assessment
- JAG, AXA, ACCA accreditation and national SNAPP audits
- C and M Surgical Centre
- LLP Assurance
- GIRFT including NCIP data
- CEO Complaints sign-off
- Mortality Assurance Paper ('Fuller Report') update to Quality Committee - November 2025
- Involvement of Patient Safety Partners (beyond PSIIs)

Gaps in Control or Assurance

- CQC report of UEC & Medicine published - RI overall
- Potential impact of financial grip and control (i.e., FPRM) on the delivery of safe and efficient services
- Business continuity plans for SSD services
- Recent critical incident related to SSD has impacted elective surgery timescales with potential consequential impact on patient experience
- Fully complete and embedded patient safety and quality strategies.
- Current operational impacts and organisational pressure.
- Capital availability for medical equipment.
- Medical workforce gaps.
- Impact of unscheduled care demand.
- Significant financial controls in place.
- Update required to WISE accreditation programme - *see action below.*
- Lack of BI capacity impacting on patient outcome data
- Delays in incident investigation
- Inconsistent learning from complaints and incidents
- MiAA IPC Review - completion of action plan to mitigate identified risks

Action	Responsible	Deadline
Revised PSIRF plan and policy to be launched	Chief Nurse	Q3, 25-26
Complete implementation, monitoring and delivery of the patient safety and quality strategies	Chief Nurse	Q3/Q4, 25-26
Strengthening of LoCSSIPs across the Trust to manage identified variation (e.g. audit programme, training)	Chief Medical Officer	COMPLETE
Agreement of CQC action plan (following 2025 inspection)	Chief Nurse	December 2025

Complete delivery of the Maternity Safety action plan	Chief Nurse	COMPLETE
On-going review of IPC arrangements	Chief Nurse	COMPLETE
Review and revise ward accreditation linked to CQC	Chief Nurse	Q4, 25-26
Development of Mental Health Strategy	Chief Nurse	Q4, 25-26
Wirral system strategy for CDiff.	Chief Nurse	COMPLETE

BAF RISK 4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.

Strategic Priority	Compassionate Workforce				
Risk Appetite	Open				
Review Date	Q3 2025/26	Initial Score (I x L)	Previous month	Current	Target
Lead	Chief People Officer	16 (4 x 4)	12 (3 x 4)	16 (4 x 4)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group • Staff drop-in sessions • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring as Workforce Steering Committee

• Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this. • New communication campaign aimed at raising awareness that the Trust are proactively tackling sickness - 'Every Day Counts'. • Delivery of the annual flu campaign to prevent increase in flu related absence. • New Resilience through Change sessions led by Trust's psychotherapist with 2 further sessions planned before the TUPE transfer in December'25. • Increased number of mental health first aiders across the Trust with deliver of additional cohorts of Mental Health First Aiders MHFA) Training and refresher training for existing MHFA. • Enhanced training for managers (preventing sickness absence through wellbeing conversations) made available. • Wirral CiC providing health checks across the Trust; resulting in a report of findings to inform future wellbeing action / initiatives. • New Road Map for Wellbeing showcasing all the support available to staff in one place launched. • HR drop-in sessions provide managers with access to dedicated HR resource to support with case management. • Local sickness audits conducted monthly to review manager capability and offer support to improve management of absence.	

Gaps in Control or Assurance

- National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes.
- Availability of required capabilities and national shortage of staff in key Trust roles.
- Increases in illness related to stress and anxiety.

Action	Responsible	Deadline
Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy.	Deb Smith	
Wellbeing Surgeries across sites	Deb Smith	
OH Capacity and Demand Review	Deb Smith	
Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing	Deb Smith	
Talent mapping exercise for senior leaders	Deb Smith	
Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months.	Deb Smith	
The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.	Deb Smith	

BAF RISK 5	Failure of the Trust to have the right culture, staff experience, safety and organisational conditions to deliver our priorities for our patients and service users.

Strategic Priority	Compassionate Workforce				
Risk Appetite	Open				
Review Date	Q3 2025/26	Initial Score	Previous month	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Just and Learning Culture work delivered and embedded as 'business as usual'. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum. • Just and Learning Plan implemented. • Provision for mediation and facilitated conversations as part of new Fairness in Work Policy • New approach to coaching and mentoring • New supervision and appraisal process • Talent Management approach launched • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool • Business as usual support continues to be in place such as FTSU. OH&WB, HR and line manager support • CPO working with local networks	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance
• Full understanding of the experience of multi-cultural staff across the Trust • Impact of financial pressures • Impact of large-scale organisational change (integration)

Action	Responsible	Deadline
Debriefing tools (hot and cold) and guidance on the intranet for supporting staff affected by unplanned events.	Chief People Officer	
Develop and implement the WUTH Perfect Start	Chief People Officer	
Work ongoing to resolve dispute in theatres	Chief People Officer	
Working in progress to progress the settlement for CSWs – led by DCN	Chief People Officer	
Q1 project planned for Q3 to address team working – led by CN	Chief People Officer	

BAF RISK 6	Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision

Strategic Priority	**Continuous Improvement**				
Risk Appetite	**Minimal**				
Review Date	**Q3 2025/26**	**Initial Score**	**Previous month**	**Current**	**Target**
Lead	**Chief Finance Officer**	**16 (4 x 4)**	**20 (4 x 5)**	**20 (4 x 5)**	**8 (4 x 2)**

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • 25/26 plan approved • PWC review action plan - all actions complete - RAG rated green for governance and grip and control action plan. • WUTH fully engaged with C&M Finance review • Mitigation plan (i.e., variable pay, discretionary non-pay, income) approved by Board and implemented • FPG meetings fortnightly with Divisions • CIP assurance meetings fortnightly with Divisions	• Monthly reports to Divisional Boards, EARC, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Board approval of 25-26 plan. • FBPAC meeting moved to monthly. • 25-26 mid-case risk mitigated from £25m to £13m. • Board briefed on 25/26 plan and drivers of the gap to control total. • Board considered additional actions in relation to finance and associated risk. • Board has reviewed best, mid and worst scenarios and actions required for best case to be achieved. • FPRM process continues led by PWC; M06 meeting completed. • MTFP 25-26 – 28-29 developed including drivers

Gaps in Control or Assurance
• NOF segmentation (Q1 25-26) - 4 (0.03 below segment 3) • NOF domain score - Finance and Productivity - 2.36 • NOF combined finance metric score - 3.00 • Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • Significant variance for 25/26 to approved control total. • Board not fully assured on actions to deliver the 25/26 plan • Draft financial undertakings issued to the Trust (with response sent to NHSE)

Action	Responsible	Deadline
Continue delivery of CIP programme and maintain oversight of divisional progress.	Chief Operating Officer	On-going
Confirm impact of mitigation plan	Chief Finance Officer	COMPLETE.
Finalise MTFP including board approval – scheduled for Board of Directors in December 2025	Chief Finance Officer	December 2025
Finalise action plans for SW, PWC and Finance Well-Led Reports	Chief Finance Officer	COMPLETE.
Complete SLR and fragile service review	Chief Finance Officer	~~November 2025~~ December 2025

BAF RISK 7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	**Digital Future**				
Risk Appetite	**Seek**				
Review Date	**Q3 2025/26**	**Initial Score**	**Previous month**	**Current**	**Target**
Lead	**Chief Finance Officer**	**12 (4 x 3)**	**12 (4 x 3)**	**12 (4 x 3)**	**8 (4 x 2)**

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • FBPAC Oversight. • Audit Committee oversight. • Integration of PMO and Digital Project Teams. • DIPSOC Oversight.	• Scale of projects versus resources. • FBPAC Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance. • MIAA Audit. • Digital Maturity Assessment.

Gaps in Control or Assurance
• Resources to remain up to date with emerging technology. • Current team vacancy levels.

Action	Responsible	Deadline
Delivery of Digital Healthcare Team annual plan.	Chief Finance Officer / Chief Information Officer	March 2026
Review digital risk and priorities against available capacity	Chief Finance Officer	October 2025

BAF RISK 8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.

Strategic Priority	**Continuous Improvement**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**	**Initial Score**	**Previous month**	**Current**	**Target**
Lead	**Chief Operating Officer**	**16 (4 x 4)**	**9 (3 x 3)**	**12 (3 x 4)**	**6 (3 x 2)**

Controls	Assurance

• Monthly Programme Improvement Board oversight and alignment with WCHC efficiency programme.
• Partnership Agreement in place with WCHC allowing exercising of joint functions related to the integration programme.
• 2-year integration programme includes opportunity for efficiency and service transformation.
• Improvement Team resource and oversight.
• Implementation of a programme management process and software to track delivery.
• Quality/Equality Impact Assessment undertaken prior to projects being undertaken.
• Developed and embedded improvement methodology.
• CIP principles 26-27 (including definition and measurement) outlined
• Exec led element of the Trust CIP/Sustainability Programme with the key drivers including:
  ○ Productivity
  ○ Integration
  ○ UEC
  ○ Sickness
  ○ Decommissioning
	• Quarterly Board assurance reports.
	• Monthly Programme Improvement Board chaired by CEO to track progress and delivery of improvements.
	• Monthly tracking of individual projects with scrutiny at programme board meetings.
	• Rotational presentations by divisions to FBPAC meetings
	• Improvement presentations at Board Seminar on a twice yearly basis
	• CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required.
	• Annual review and approval of improvement team supported projects, aligning to Trust priorities and risks
	• Project completion reviews
	• Development and delivery of Improvement for All methodology and approach, shifting focus to improvement/transformation training and facilitation for staff
	• Delivery of Improvement for All conference in July 2025
	• Review of good practice with visit to University Hospitals of Coventry and Warwickshire, a pilot site for Virginia Mason Institute, scheduled for September 2025
	• MTFP 25-26 - 28-29 developed including drivers and approach to planning including CIP delivery

Gaps in Control or Assurance
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Ability to deliver system wide change across Wirral NHS organisations and wider partners.

Action	Responsible	Deadline
Delivery of 25-26 improvement projects to plan	Executive Managing Director	March 2026
Strong Governance through PMO working of all schemes, risk and outputs	Executive Managing Director	March 2026
Implementation of Improvement for All approach and training to staff	Chief Strategy Officer	March 2026
Development of Improvement Programme for 26-27	Chief Strategy Officer	March 2026

BAF RISK 9	Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce, financial and patient experience/outcomes) not being realised.

Strategic Priority	Continuous Improvement				
Risk Appetite	Open				
Review Date	Q3 2025/26	Initial Score (I x L)	Previous month	Current	Target
Lead	Chief Executive Officer	9 (3 x 3)		9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Partnership Agreement (PA) agreed and approved by both statutory boards • Joint functions and delegated functions described in the PA • Integration Management Board (IMB) established as a special purpose Joint Committee with Terms of Reference • IMB reporting to both statutory boards via Chair's AAA report • Integration Management Group (IMG) established reporting to the IMB • 2-year project plan developed for integration with oversight at IMG (and bi-monthly reporting to IMB) • Transaction type approved by IMB following consideration of multiple options and risk/benefit analysis • Active engagement with the ICB and NHSE on the transaction timeline and process • Internal communications and staff engagement plans developed • TUPE transfer of Corporate Services from WCHC to WUTH agreed and project group established and reporting to IMG • Councils of Governors of both Trusts engaged with regular briefings • Development of Joint Strategy commenced with workshops and focus groups with staff across both Trusts • TUPE transfer of corporate services • Corporate Services Collaboration Agreement / SLA for Corporate Services approved by IMB and Boards of Directors	• IMB reporting to both statutory boards via Chair's AAA report • 2-year project plan developed for integration with oversight at IMG (and bi-monthly reporting to IMB) • C&M ICB approval of transaction type • C&M ICB support for transaction external expertise / resource

Gaps in Control or Assurance
• ~~ICB approval of the case for change~~
• ~~Available resource associated with the delivery of the statutory transaction~~
• Delivery of financial plans in both Trusts including CIP targets for the integration of services

Action	Responsible	Deadline
• Presentation of the case for change to ICB	Chief Strategy Officer	COMPLETE
• Agreement of costs to support the necessary resources associated with the statutory transaction	Chief Strategy Officer	COMPLETE
• Procurement and appointment of consultancy resource to support transaction	Chief Strategy Officer	January 2026
• Procurement and appointment of legal resource to support transaction	Chief Strategy Officer / Director of Corporate Affairs	May 2026

BAF RISK 10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	**Infrastructure**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**	**Initial Score**	**Previous month**	**Current**	**Target**
Lead	**Chief Operating Officer**	**16 (4 x 4)**	**12 (4 x 3)**	**12 (4 x 3)**	**12 (4 x 3)**

Controls	Assurance
• Implementation of 3-year capital programme • Delivery of 2021-2026 Estates Strategy. • Business Continuity Plans. • Procurement and contract management. • Assigned 3-year capital budgets, with Executive Director accountability • Assessment of current backlog maintenance risk and future potential risk	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks and completion of business continuity plans for critical infrastructure • Independent review of risks carried out. • Appointment of authorised engineers. • NHS England Premises Assurance Model

Gaps in Control or Assurance
• Delays in backlog maintenance and funding of backlog maintenance and minor works • Timely reporting of maintenance requests.

Action	Responsible	Deadline
Develop Arrowe Park development control plan and Prioritisation of estates improvements		
Heating and ventilation programme completion		
Replacement of generators and ventilation systems		
Delivery of 2024/25 Capital Programme to plan and budget allocation.		
Development of bids in preparation for potential NHSE Capital Grants for 2024/25 and 2025/26		
Examination of options to relocate corporate and clinical functions to community		

BAF RISK 11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure				
Risk Appetite	Open				
Review Date	Q3 2025/26	Initial Score	Previous month	Current	Target
Lead	Executive Managing Director	20 (5x4)	15 (5 x 3)	15 (5 x 3)	10 (5x2)

Controls	Assurance
• Implementation of the national Business Continuity Toolkit with a process underway to re-write all Business Continuity Plans (BCP) in the Trust. • Full risk assessment undertaken on critical infrastructure and mitigations for major failure in these areas. • Full engagement and adaptation of regional and national EPRR guidance and alerts. • Submission of Data Security and Protection Toolkit (DSPT) Annual assessment and associated audit. • Privileged Access Management (PAM) for external providers accessing systems. • Additional controls in place with Multi Factor Authentication.	• Trust command and control framework in place and tested thoroughly the Covid pandemic and industrial action over the last 12 months. • Regional core standards self-assessment process and central peer review. • Planned exercise programme in place to test BCPs. • Quarterly updates provided to the Risk Management Committee. • Annual report to the Board of Directors and updates in between as required. • Estates and Capital Committee sighted on the risk relating to the critical infrastructure • Trust received substantial assurance received from the MIAA DSPT audit. • Trust policy is to follow Privileged Access Management – preventing unauthorised access to 3rd parties.

Gaps in Control or Assurance

- System BCPs raised as a gap in the core standards self-assessment and a Wirral wide discussion on this is lacking.
- Internal resource limited to cover the large spectrum of EPRR assurance - 1 WTE working to the Accountable Emergency Officer (AEO)
- Issues identified as part of Dionach, Penetration testing conducted on Trust Network.
- Some 3rd parties and national providers have not adopted PAM

Action	Responsible	Deadline
Continue with the actions highlighted in the core standards peer review assessment.	Chief Finance Officer	
Engage with the regional Local Health Resilience Forum (LHRP) ensuring the Trust is up to date with the latest guidance and central notifications.	Chief Finance Officer	
Operational Cyber programme addressing the risks raised within the Dionach, Penetration test.	Chief Information Officer	
Working with suppliers to irradicate legacy connections, expressing importance of the standards.	Chief Information Officer	
Cyber incident action plan	Chief Information Officer	

BAF RISK 12	There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.

Strategic Priority	**Our Partners**				
Risk Appetite	**Seek**				
Review Date	**Q3 2025/26**	**Initial Score**	**Previous month**	**Current**	**Target**
Lead	**All Executive Directors**	**16 (4 x 4)**	**9 (3 x 3)**	**9 (3 x 3)**	**9 (3 x 3)**

Controls	Assurance
• Wirral Provider Alliance established with WUTH as members • MOU drafted and ToRs for WPA Programme Board • Chair and Deputy Chair of WPA appointed • WUTH/WCHC providing administrative support • Chief Integration & Parterships Officer appointed (working across system partners) • Development of WUTH/WCHC Joint Strategy including stakeholder engagement	• Wirral Place Based Partnership Board. • Health and Wellbeing Board. • Wirral Provider Alliance MoU • Wirral Provider Alliance established with multi-sector membership including primary care, Local Authority and VCSFE. • Development of Joint Strategy for WCHC and WUTH, for completion in 2026

Gaps in Control or Assurance
• Lack of strategic alignment between partner bodies.

Action	Responsible	Deadline
Full stakeholder engagement in Joint Strategy Development and Clinical Service Strategy Development	Chief Strategy Officer	Q4, 25-26
Establishment of the Wirral Provider Alliance - workshop session to define principles and priorities in November 2025	Director of Corporate Affairs	COMPLETE
Refreshment of Wirral Place Governance.	Director of Corporate Affairs	~~October 2025~~ January 2026

Appendix - Risk Scoring Matrix

Table 1 - Impact scores

Consequence scores can be used to assess actual and potential consequences: -

- The actual consequence of an adverse event e.g. incidents, claims and complaints.
- The potential consequence of what might occur because of the risk in question e.g. risk assessments, and near misses.

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

Consequence	Patient	Reputational	Financial	Workforce	Legal / Regulatory*
5 Catastrophic	**Prolonged failure or severe disruption** of **multiple** services Multiple deaths caused by an event; **major impact** on patient experience	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability. Hospital closure	**>£5m** directly attributable loss / unplanned cost / reduction in change related benefits	Workforce experience / engagement is **fundamentally undermined** and the Trust's reputation as an employer damaged	Breach of regulation Trust put into Special Administration / Suspension of CQC registration. Civil/Criminal **Liability > £10m**
4 Severe	**Prolonged failure or severe disruption** of a **single** patient service Severe permanent harm or death caused by an event. **Significant impact** on patient experience	**Prolonged** adverse social / local / national media coverage with **serious impact** on patient trust and public confidence	**£1m - £5m** directly attributable loss / unplanned cost / reduction in change related benefits	**Widespread material impact** on workforce experience / engagement	Breach of regulation likely to result in enforcement action. Civil/Criminal **Liability < £10m**
3 Moderate	**Operation of a number** of patient facing services is disrupted Moderate harm where medical treatment is required up to 1 year. Temporary disruption to one or more CSUs Resulting in a poor patient experience	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**£100k - £1m** directly attributable loss / unplanned cost / reduction in change related benefits	**Site material impact** on workforce experience / engagement	Breach of regulation or other circumstances likely to affect our standing with our regulators. Civil/Criminal **Liability < £5m**
2 Minor	**Operation of a single** patient facing service is disrupted. Minor harm where first aid required up to 1 month. **Temporary service restriction** **Minor impact** on patient experience	**Short lived** adverse social / local / national media coverage which **may impact** on patient trust and public confidence in the short term	**£50k - £100k** directly attributable loss / unplanned cost / reduction in change related benefits	**Department / CSU material impact** on workforce experience / engagement	Breach of regulation or other circumstances that may affect our standing with our regulators, with minor impact on patient outcomes. Civil/Criminal **Liability < £2.5m**.
1 Limited	**Service continues with limited/no patient impact**	**Short lived** adverse social / local / traditional national media coverage with **no impact** on patient trust and public confidence	**£Nil - £50k** directly attributable loss / unplanned cost / reduction in change related benefits	**Material impact** on workforce experience / engagement for a **small number of colleagues**	Breach of regulation or other circumstances with limited impact on patient outcomes. Civil/Criminal **Liability < £1m**.

Table 2 – Likelihood

The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.

In considering the likelihood, the following supports the conversations and assessment from British Standards Institution (BSI) (2011) Risk management – Code of practice and guidance for the implementation of BS ISO 31000:

In risk management terminology, the word "likelihood" is used to refer to the chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively and described using general terms or mathematically [such as a probability or a frequency over a given time period].

Appendix – Risk Appetite

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some risks where there is a required to mitigate risks to patient safety or quality of care. We will ensure that all such responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an **OPEN** risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept and have an **OPEN** appetite in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and productivity. The Trust Board has a **MINIMAL** appetite for any risk that effect sound financial control and management.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an **OPEN** risk appetite and is eager to pursue infrastructure options which will benefit the efficiency and effectiveness of services.

Appendix – Significant Operational Risks (November 2025)

536	Med	Clinical, Quality, Safety and Access risks associated with poor patient flow.	(4 x 5) 20	⇔
2151	D&CS	Limitations of OP Speech and Language Therapy workforce to deliver the out-patient service.	(5 x 4) 20	↑
2007	Surg	Replacement of portable anaesthetic ventilators that are no longer supported by the manufacturer.	(4 x 5) 20	↑
2086	EF&C	Potential failure of APH medical/surgical air assets (compressors, receivers and controls) serving operating theatres, Critical Care and Neonatal Unit.	(5 x 4) 20	↑
1547	Corp	Cash management	(5 x 5) 25	↑
1578	Surg	Financial risk to the Division if the CIP target is not met in full	(4 x 5) 20	↑
516	ECARE	There is a risk of harm to care quality and patient experience caused by slow egress from the Emergency Department	(4 x 5) 20	↑
1756	Corp	Clostridioides difficile	(4 x 5) 20	⇔
886	Med	There is a risk that insufficient medical staffing capacity within the division will potentially result in poorer patient outcomes and harm.	(5 x 4) 20	↑

Appendix – Monitoring Schedule

Forum	September	October	November	December	January	February	March
Board							
People Committee							
Quality Committee							
Estates and Capital Committee							
Finance Business and Performance Committee							
Audit and Risk Committee							
EARC							
Divisional Boards							

Key	
Ongoing Review	
Committee Annual Review	
Annual Review including RMS and Appetite	

Annual Closedown	

Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Public Board of Directors **Item 13**

03 December 2025

Title	WCHC Board Assurance Framework 2025-26
Lead Director	Alison Hughes, Joint Director of Corporate Affairs & Communications
Author	Alison Hughes, Joint Director of Corporate Affairs & Communications
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with an update and assurance on the management of strategic risks through the Board Assurance Framework for 2025-26.

This update provides the position following review during November 2025.

It is noted that due to the change of date for the Board of Directors meeting, the meeting of the Finance & Performance Committee and the People & Culture Committee has not taken place. Both committees will meet in December 2025 where each of the relevant strategic risks will be discussed, and an update provided to the Board in January/February 2025. It is noted that the update provided to the Board in November 2025 included updates in relation to finance, performance and workforce strategic risks.

The Quality & Safety Committee met on 24 November 2025 and approved the position as reported acknowledging the high-level organisational risks mapped to ID01 and agreed an additional gap to be noted reflecting the GA capacity impact on waiting lists for the dental service, particularly for paediatrics. The committee agreed the current position in relation to risk ratings and risk appetite.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks

Key Risks

This report relates to the following key risks:

The BAF records the principal risks that could impact on the Trust's ability in achieving its strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trust not being able to achieve its strategic objectives or its statutory obligations. There are opportunities through the effective development and use of the BAF, to enhance the delivery of the Trust's strategic objectives and effectively mitigate the impact of the principal risks contained within the BAF.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives:	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	Yes
People	
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Yes
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
19/02/25	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the MIAA Assurance Framework Report 2024/25.
19/03/25	Informal Board	BAF	The members of the Board supported an informal discussion to review current and emerging risks for 2025-26 and to inform the position presented to the committees and the Board in April and May 2025.
23/04/25	Board of Directors	BAF	The Board of Directors approved the recommendation for new risks for 2025-26.
04/06/25	Board of Directors	BAF	The Board of Directors received the update provided on the current position in relation to

			the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress. It was noted in particular that the meeting of the Finance & Performance Committee and the People & Culture Committee would take place (the following week) to review relevant risks.
03/09/25	Board of Directors	BAF	The Board received the updates provided on the current position in relation to the strategic risks and approved the proposed change to the risk appetite for ID06 from Cautious to Moderate as recommended by the Finance & Performance Committee. The Board also noted inclusion of the new risk (ID05) associated with cyber security and EPRR monitored by the Finance & Performance Committee.
01/10/25	Board of Directors	BAF	The Board **NOTED** the updates provided on the current position in relation to the strategic risks; and **APPROVED** the addition of a new risk - ID11 related to integration noting continued oversight by the Integration Management Board.
05/11/25	Board of Directors	BAF	The Board received the update provided on the current position in relation to the strategic risks and **APPROVED** a recommendation from the People & Culture Committee to increase the risk rating of ID07 to RR16.

1	Narrative
1.1	The Board has in place a full Board Assurance Framework which is reviewed annually to reflect the strategic priorities of the Trust. Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the committee.
1.2	At the meeting of the Board of Directors in October 2025 an update was provided on each of the strategic risks.

1.3	The summary table at **appendix 1** confirms the current position of strategic risks as reviewed during November 2025.
1.4	The BAF includes 9 strategic risks, and ID07 is currently scoring at a high-level. No risk has achieved its target risk rating.
1.5	It is anticipated that as the development of the Joint Strategy progresses, shared strategic risks and Board Assurance Frameworks between WCHC and WUTH will emerge.
1.6	**Wirral Place Delivery Assurance Framework** The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF was last presented to the Place Based Partnership Board in November 2025, and can be accessed via the following link - (Public Pack)Agenda Document for Wirral Place Based Partnership Board, 20/11/2025 10:00

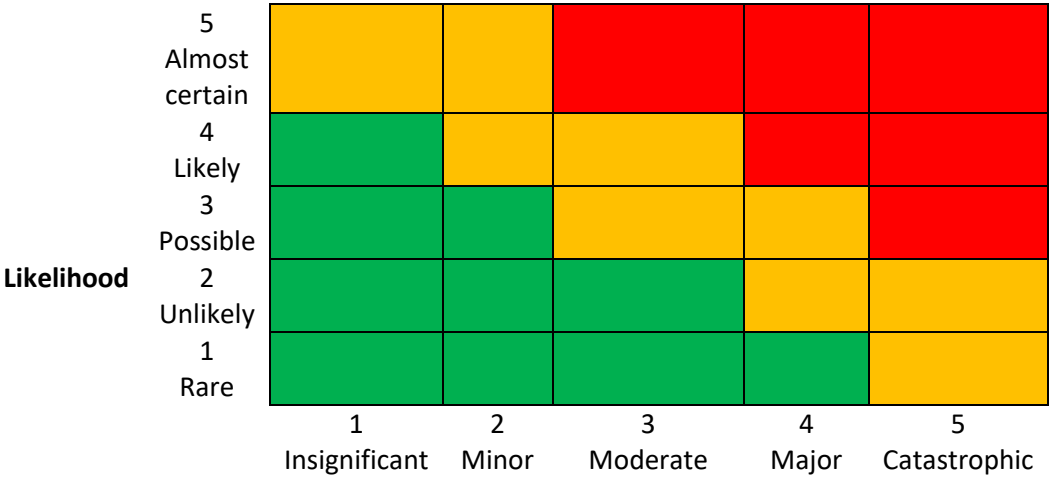
2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF is key to effective governance and is subject to an annual Assurance Framework Review as per internal audit standards in order to inform the Head of Internal Audit Opinion (HOIA) each year. The strategic risks tracked through the BAF are reported annually through the Annual Governance Statement.

3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Not applicable If Yes, please select all of the social value themes that apply: **Community engagement and support** ☐ **Purchasing and investing locally for social benefit** ☐ **Representative workforce and access to quality work** ☐ **Increasing wellbeing and health equity** ☐

Strategic risk summary 2025-26

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC) (November 2025)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Averse
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change.	Quality & Safety Committee	Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Averse
Previous ID03 archived at end of 2023-24.						
ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 3 (9)	3 x 4 (12) ↔	2 x 4 (8)	Cautious
ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber-attack impacting on the quality of patient care	Finance & Performance Committee	Safe care and support every time Make most efficient use of resources to ensure value for money	3 x 3 (9)	3 x 4 (12) ↔	2 x 4 (8)	Cautious
ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Moderate
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.	People & Culture Committee	Improve the wellbeing of our employees	2 x 4 (8)	4 x 4 (16) ↑	1 x 4 (4)	Moderate

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC) (November 2025)	Target risk rating (LxC)	Risk Appetite
		Better employee experience to attract and retain talent				
ID08 - Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12) ↔	1 x 4 (4)	Moderate
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee	Grow, develop and realise employee potential. Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8) ↔	1 x 4 (4)	Open
ID11 - Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce, financial and patient experience/outcomes) not being realised	Integration Management Board	Delivery sustainable health and care services	3 x 3 (9)	3 x 3 (9) ↔	2 x 3 (6)	Open



Consequence

Averse	Prepared to accept only the very lowest levels of risk
Cautious	Willing to accept some low risks
Moderate	Tending always towards exposure to only modest levels of risk
Open	Prepared to consider all delivery options even when there are elevated levels of associated risk
Adventurous	Eager to seek original/pioneering delivery options and accept associated substantial risk levels

Board Assurance Framework 2025-26

Strategic risks with oversight at Quality & Safety Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the quality governance framework in place across the Trust.

Corporate Governance

- The Quality & Safety Committee meets on a bi-monthly schedule with an agreed annual workplan in place.
- The committee has Terms of Reference in place, reviewed annually.
- The Chief Nurse is the Executive Lead for the committee.
- The Chief Nurse is also the Trust Lead for addressing health inequalities.
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee.
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF.
- The committee receives an update on trust-wide policies related to the duties of the committee and on the implementation of recommendations from internal audit reviews
- The Chair of the committee meets with the governor chair of the Governor Quality Forum to provide a briefing after each meeting of the committee.
- Governance arrangements of oversight groups reporting to IPB tested through internal audit in 2023-24 providing Substantial Assurance.

Quality Governance

- Year 1 and Year 2 of the Quality Strategy Delivery Plan implemented successfully with committee oversight.
- The quality governance structure in place provides clarity on the groups reporting to the committee.
- The committee receives the Terms of Reference for the groups reporting to it and minutes/ decisions from the groups for noting.
- The committee contributes to the development of the annual quality strategy delivery plan and priorities and receives bi-monthly assurance on implementation.
- The committee contributes to the development of and maintains oversight of the implementation of the annual quality priorities.
- The committee reviews and approves the Trust's annual quality report.
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from incidents, complaints, patient/client feedback and learning from deaths.
- The fortnightly Clinical Risk Management Group (CRMG) meetings are in place to monitor incidents and learning.
- SAFE system in use trust-wide for audits (e.g., hand hygiene, medicines management, IG, team leader)
- SAFE Operations Group (SOG) reports directly to the Integrated Performance Board
- Regular formal and informal engagement with CQC
- CQC inspection rating of Good with Outstanding areas.

- The Trust has implemented a health inequalities stratification waiting list tool - Joint AIS and Health Inequalities Waiting List Tool questionnaire now live in System one with all fields mandated
- Just and Learning culture supported by FTSU framework allowing staff to openly raise concerns.

PSIRF

- Patient Safety Specialist in post and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation reported to the committee
- PSIRF policies and procedures developed and implemented to promote sustainability.
- PSIRF stakeholder group established.
- Robust gantt chart aligned to the national PSIRF implementation timeframes, reporting to POG monthly by exception.
- High-level of compliance with patient safety training.
- Clinical protocol for Clinical Supervision (CP95)
- Patient Safety Incident Response Plan (GP60) approved

FTSU

- FTSU Guardian appointed.
- FTSU Executive Lead is a member of the committee.
- FTSU NED Lead identified and attends committee
- FTSU Steering Group reporting to the committee.

Safeguarding governance

- Safeguarding executive lead is member of committee
- Quarterly Safeguarding Assurance Group established to oversee compliance with legislative and regulatory safeguarding standards reporting directly to QSC
- Place based Safeguarding Assurance Partnership Boards and subgroups are supported through strong presentation of WCHC safeguarding specialists
- Safeguarding Supervision Policy (SG04)

Infection prevention and control governance

- Director of Infection Prevention and Control is member of committee
- Quarterly IPC group established to oversee compliance with legislative and regulatory IPC standards reporting directly to QSC
- Place based IPC and Health Protection Boards attended by IPC specialists
- Member of NW IPC forum

Medicines governance

- Executive lead for medicines governance and Controlled Drugs Accountable Officer is member of committee
- Medicines governance group established which reports directly to QSC

Safe Staffing (the following mitigations have been moved from the detail of ID01 recognising implementation during 2023-24)

- Safe staffing model on CICC supports professional judgement by maximising use of available staffing resource, implementing a holistic multidisciplinary team model including the use of therapies staff.
- Enhanced reporting through the governance agreed via PCC and QSC.
- Metrics and measures developed to monitor, analyse and review and report against e-rostering system use and performance *(MiAA recommendation completed)*
- Reporting timetable developed to ensure regular, timely updating to PCOG and SOG including any trends or areas for improvement *(MiAA recommendation completed)*
- Trust engaged in national pilot of Community Nursing Safer Staffing Tool (CNSST) - the first cohort of community trusts to collect safe staffing data

System Governance

- Wirral Place Quality Performance Group established with CNO as member
- Partnership working with Local Authorities and other stakeholder organisations via Place (e.g., Quality & Performance Group, Safeguarding Children Partnerships, Safeguarding Adults Partnership Board) and regional (e.g., C&M Chief Nurse Network, MHLDC Provider Collaborative) meetings
- Joint Establishment & Pay Control Panel established with WUTH (weekly)
- Chief Nurse participating in system recovery meetings with turnaround Director

Monitoring quality performance

- The committee receives a quality report from TIG providing a YTD summary (via SPC charts) of all quality performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway to monitor quality performance and to access the Audit Tracker Tool to monitor progress.
- The committee contributes to and receives the annual quality improvement audit programme and tracks implementation.
- The committee receives updates live from the system on regulatory compliance including local audits and procedural documents.
- SAFE mechanism for recording clinical and professional supervision captures method of delivery to include peer, group and 1:1 delivery
- Management Supervision procedure (HRP07)
- Transferrable learning from Shanley Review to WCHC identified across 7 recommendations
- Assurance review process of the recommendations from the Shanley Review focused on 1) Assurance Tools, 2) Governance Processes, 3) Alignment to Trust Strategies

QEIA process

- Standard Operating Procedure for the completion and approval of QEIA/EIA/QIA in place and available on Staff Zone
- Stage 1 and stage 2 templates available on Staff Zone

ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.	Quality & Safety Committee oversight

Link to 5-year strategy - Safe care and support every time

Organisational risks - ~~**ID3137 (RR16 - 4 x 4)** - CICC call bells, **ID3201 (RR16 - 4 x 4)**~~ ID2769 (RR15), ID3209 (RR15) and ID3228 (RR15) - see high level risk report.

Consequence;

- Poor experience of care resulting in deterioration and poor health and care outcomes
- Non-compliance with regulatory standards and conditions
- Widening of health inequalities

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)**
May 25	**July 25**	**Sept 25**	**Nov 25**	**Jan 26**	**Mar 26**	**Averse**	2 x 4 (8)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)				

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)**	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure safe care and support every time to prevent variation of standards across localities and teams. - NOF segment 1 Headline measures in-month (M06) - 0 never events - QUAL05 - 0 MRSA incidents - QUAL16 - 0 C.Diff incidents - QUAL15 - 0 fall (moderate & above harm) (YTD = 1) - QUAL17 - 86.1% FFT (YTD 90.6%) - QUAL22 - 1 complaint received (YTD = 19) - QUAL08	- MIAA Clinical and Professional Supervision Assignment Report - *Moderate Assurance* - **Deputy Chief Nurse** - Supervision Training Strategy - **Head of L&OD** - PSIRF learning cafes roll-out Q4 - delayed to 25-26 *(included in Delivery Plan - wider roll out to teams will commence during 2025/26 and have an emphasis on system learning with WUTH*	- NOF rating / segmentation - Sustained performance against quality metrics - FFT response rate and satisfaction rate - Low number of complaints - Mandatory training sustained compliance maintained at 90% - Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee	- Supervision Training Strategy approved - **TBC** - Completion of action plan to address recommendations associated with the MIAA Clinical and Professional Supervision - **March 2026** - ~~Reporting on expected outcomes from 4 joint high priority clinical risk areas (based on PSIRF analysis) - **October 2025**~~ **COMPLETE**

- 415 incidents reported - QUAL02 *(0.4% moderate and above harm - QUAL18)*
- 174 patient safety incidents - QUAL03
- Mandatory training compliance trust-wide achieved target - 94.7% (vs 90% target)
- Indicators within the Quality Dashboard have been refreshed to reflect the Patient Safety Incident Response Framework and systems-learning
- The following indicators have been added;
  - QUAL25: Number of reported no and low harm patient safety incidents
  - QUAL26: Number of After-Action Reviews (AAR) requested
  - QUAL27: Number of patient safety incident investigations (PSII) requested
  - QUAL28: Number of patient safety incident investigations (PSII) completed in 3 months
- Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC
- ~~4 agreed clinical safety improvement priorities for 2025-26 agreed with WUTH aligned to shared priorities (Quality Goal 1)~~
- Monitoring of impact of 4 safety focussed quality improvement programmes will progress throughout 2025/26, via dashboards containing relevant quality metrics to develop a single accessible position statement from the Frontline to Board. **Expected outcome measures*
	and beyond) - **Head of Quality & Patient Experience**
	- QI programme to address waiting lists in specialist speech and language and ND assessments *(aligned to Ofsted/CQC Wirral SEND inspection report established) (Quality Goal 4)* - **Deputy Chief Nurse**
	- A reduction in FFT score was evident during August, with performance being -2 standard deviations from the mean. Further analysis has highlighted that there has been an increase in the number of FFT responses utilising the 'don't know' option, this is supporting targeted quality improvement - **Head of Quality & Patient Experience**
	- Capacity for general anaesthetic services does not meet demand for dental service resulting in waiting list of patients (raised as an organisational risk - ID2769) - **Deputy Chief Operating Officer**
		- ~~Role essential training compliance achieved and maintained at 90%~~
		- ~~12% of staff to be trained in Tier 2 Oliver McGowan mandatory training~~
		- ~~QI summary reports with measured impacts from 4 x QI programmes and with actions for improvement~~
		- ~~20 members of staff trained in QSIR-P (5-day course now concluded with positive evaluation)~~
		- ~~80 members of staff trained in QSIR-F *(2 session for Quality Champions in Q4)*~~
		- ~~Quarterly patient safety champions meetings with attendance monitored to ensure continued appropriate staff engagement across services~~
		- ~~PSIRF learning cafes~~
			- Delivery of 4 joint QI programmes based on high priority clinical risks - **March 2026**
			- Quarterly patient safety champion meetings - **December 2025**
			- Delivery of two patient safety champion training sessions - **March 2026**
			- Implement 'What matters to you' campaign in 2 more WCHC services **- December 2025**
			- 'What matters to you' campaign day - **March 2026**
			- ~~12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training **- June 2025**~~
			- 65% of eligible staff trained in QI - ~~July 2025~~ **March 2026**
			- ~~PSIRF actions to further embed in the process and culture *(quality goal 2)* **- Q1, 2025-26**~~

include and will build on progress during 24/25: • Reduction in pressure ulcers (all categories) • Reduction in falls at CICC • Reduction in medication incidents • Improved quality of care for patients who are end of life - LFPSE (Learning from Patient Safety Events) launched including quarterly reporting to the committee (Q1 report - September 2025. - Enhanced PSIRF training delivered (over 425 staff trained exceeding target of 250) (Quality Goal 2) - Joint Quality improvement work to be undertaken in partnership with Wirral University Teaching Hospital to maximise system learning, with the aim of delivering seamless, safe care across shared clinical pathways. - PSIRF champions identified and communicated on Staff Zone (Quality Goal 2) - 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) - Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4) - Internal governance structure to support collaborative working *(aligned to*			

Ofsted/CQC Wirral SEND inspection report established) (Quality Goal 4) - 25-26 plan for QI curriculum training with focus on foundation training including flexible options to support compliance (Quality Goal 5) - District nursing development work underway, including engagement with frontline rearms to take forward improvement ideas - currently PAUSED awaiting consultation to commence. - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year end position of 8.6% of eligible staff trained against a target of 12%. 1 session planned for June 2025 and if all staff attend, this will take position to 10.1%. - Professional Nurse Advocate (PNA) programme in place - Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated **Actions to ensure safe mobilisation of new services.** - Business decision making process aligned to strategic objectives. - Establishment of mobilisation project at the commencement of new contracts - Mobilisation projects monitored at POG. - SRO and Project Lead identified. - New tender evaluation process agreed at private Board (July 2025) including the			

establishment of new BDIG with WUTH - Business Development & Investment Group **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles.** - Health Inequalities & Inclusion Strategy developed and approved. - Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC – see mitigations above related to each quality goal. - Mechanism in place to ensure involvement of people always included within PSII's (agreed at CRMG) - Participation in C&M Prevention Pledge programme agreed with identified. - Chief Nurse = Prevention Pledge Executive Lead - Inclusion dashboard developed. - Partnership forum established. - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Silver award in the Armed Forces Covenant Employer Recognition Scheme - Veteran Aware accreditation achieved for the Trust. - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. Included as an action from EDS domain 1.	- Share findings from the review of the NHS Providers guide on reducing health inequalities - **Chief Nurse**	- Sustained performance against inclusion metrics - Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data	

Actions to ensure safe demobilisation of services. - Corporate Services Transfer to WUTH overseen via IMG and IMB - SLA in place to provide services back to WCHC clinical services			

ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change	Quality & Safety Committee oversight

Link to 5-year strategy - Safe care and support every time

Consequence;

- Inequity of access and experience and outcomes for all groups in our community
- Poor outcomes due to failure to listen to people accessing services
- Reputation impact leading to poor health and care outcomes

Current risk rating (LxC)						**Risk appetite**	**Target risk rating (LxC)**
May 25	**July 25**	**Sept 25**	**Nov 25**	**Jan 26**	**Mar 26**	**Averse**	2 x 4 (8)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)				

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure collaboration and co-design with community partners. - EDI training compliance - 96.8% - Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC - Inclusion Annual Report 24-25 published - 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) - Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4)	- Lack of staff confidence in accessing and interpreting health inequalities data - **Head of Inclusion** - Digital version of AIS and Health Inequalities Waiting List Tool questionnaire in multiple languages - **Head of Inclusion** - Embed use of paper forms of questionnaire for those impacted by digital	- Sustained performance against inclusion metrics - Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee - Measures of equity of access demonstrated through patient/service user data and experience. - Staff confident in delivering culturally sensitive care.	- Implement 'What matters to you' campaign in 2 more WCHC services **- December 2025** - 'What matters to you' campaign day - **March 2026** - 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **June 2025** - 65% of eligible staff trained in QI - ~~July 2025~~ **March 2026**

- Inclusion Principle 1 - Positive action for inclusive access. Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated. - 6000 public members sharing their experience and inspiring improvement. - Level 1 Always Events accreditation focussing on what good looks like and replicating it every time. - Complaint's process putting people at the heart of learning. - QIA and EIA SOP refreshed and approved - Recruitment of Population Health Fellow role - Experience dashboard built on TIG. - Partner Safety Partners recruited. - Re-balancing of resources in community nursing to support caseload in PCNs underway. - 5 community partners recruited. - Completion of all actions agreed following MIAA review to address variation in practice and incomplete data. **Actions to address health inequalities by hearing from those with poorer health outcomes, learning and understanding the context of people's lives and what the barriers to better health might be** - On-going work with system partners (system health inequalities group) to improve identification of minority and vulnerable groups within the population, ensuring that we reach into these communities and make it as easy as possible for people to access appropriate care when required.	exclusion - **Head of Inclusion**	- All reasonable adjustments are made to facilitate most effective care delivery. - Staff will report increased skill, knowledge and confidence in quality improvement methodology. - Further embed health inequalities waiting list tool - Regular reporting to the Trust Board on health inequalities data through the Integrated Performance Report.	- Achievement of 90% completion rate of AIS and inclusion template across all services - **March 2025** *(Inclusion principle 1)* - locality completion rates range from 47% - 80%; monitoring at SOG.

- Quality Strategy - *quality goal 6* - 5 co-designed care pathways identified - *NPOP and referral pathway to memory clinic, translation and interpretation, Long Covid and rehabilitation, Rehab @ Home and home hazards checklist, FNP-Improving accessibility of information for first time parents.* **Actions to ensure that all voices, including under-represented groups can be heard and encouraged to influence change.** - Active engagement through the Partnership Forum with multiple groups/agencies across Wirral (e.g., Wirral Change, Mencap, LGBT, veterans) supporting close links with our communities and positively influencing participation and involvement. - Veteran Aware accreditation (Bronze and Silver) achieved for the Trust. ~~- EDS 2022-23 published on public website with actions identified.~~ - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year-end position of 8.6% of eligible staff trained against a target of 12%. 1 session planned for June 2025 and if all staff attend, this will take position to 10.1%. - 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) ~~- Trust active involvement in system-wide preparation for re-inspection of SEND.~~			

- TIG dashboard updated to show new AIS compliance monitoring, targets and agreed trajectories **Actions to ensure children and families living in poverty in all our places are engaged to improve outcomes and life chances.** - Established service user groups including Involve, Your Voice and Inclusion Forum with a commitment to co-design. - Participation in Local Safeguarding Children Partnerships across all Boroughs where 0-19/25 services are delivered. - Good partnerships with other agencies - Locality governance reflects trust-wide governance across different geographies with any variation related to specific service specification (i.e., different 0-19 services)			

Board Assurance Framework 2025-26

Strategic risks with oversight at Finance & Performance Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the financial and performance governance framework in place across the Trust.

Financial Governance

- The Finance & Performance Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually (last reviewed in August 2024)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in August 2024)
- The interim Chief Finance Officer is the Executive Lead for the committee
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- The Finance & Resources Oversight Group (FROG) reports to the IPB on all matters associated with financial and contractual performance and the Safe Operations Group (SOG) reports to the IPB on all matters associated with operational performance
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the TIG on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF
- The committee receives an update on the status of trust-wide policies (related to the duties of the committee) at every meeting
- The committee receives an update on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool) at every meeting
- The committee receives assurance reports in respect of the Data Security & Protection Toolkit submission
- The committee receives an IG /SIRO Annual Report
- The committee reviews and approves the Trust's financial and operational plans prior to submission to the Board of Directors and relevant regulators
- The committee contributes to the development of the annual financial plan (including oversight of CIP and capital expenditure) and the Digital Strategy Delivery Plan and receives quarterly assurance on implementation
- The committee receives the Terms of Reference for the groups reporting to it and decision and action logs from each meeting for noting
- Joint governance arrangements established between WCHC and WUTH for CIP tracking, monitoring and oversight (including WCHC CIP assurance group and joint Programme Improvement Board)

System Governance

- Wirral Place Finance, Investment and Resources Group established with CFO as member
- Trust involvement in system planning sessions for 2025-26
- Integration Management Board (IMB) established between WCHC and WUTH to oversee integration

Monitoring performance

- The committee receives a finance report providing a summary of YTD financial performance metrics at each meeting (via TIG)
- The committee receives a report on progress to achieve CIP targets across the Trust

- The committee receives a YTD operational performance report providing a summary of all operational performance metrics (national, regional and local) at each meeting with TIG dashboards allowing tracking of performance
- The members of the committee have access to the Trust Information Gateway to monitor performance

ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.	Finance & Performance Committee oversight

Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Poor financial performance in the Wirral health and care system leads to a negative impact and increased monitoring and regulation

Organisational risk - **ID3192 (RR9 - 3 x 3)** - *Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full* and **ID3186 (RR12 - 3 x 4)** - *A significant underlying deficit financial position at both North West and C&M ICB has been reported. The ask of each system is to deliver financial balance within 3 years. C&M currently has a deficit plan of £178m. The Trust has submitted a £0.9m surplus plan for 25-26 which includes at £5.7m CIP that will be challenging making the delivery of the 25-26 financial plan a risk.*

Consequence;

- Financial sustainability impact
- Negative reputational impact for the Trust and system
- Enhanced financial control from ICB and NHSE

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Cautious**	2 x 4 (8)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)				

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• NOF segment 1 • Board approval of financial plan 2025-26 and subsequent revised forecast (18.7.25) linked back to current run rate and extrapolates current financial position to year-end	• Impact of ICB turnaround process is not clear - expectation to improve forecast to mitigate the risk associated with WUTH forecast. • NHSE approval of C&M financial plan	• Delivery of recurrent CIP to achieve the target for 2025-26 • Delivery of revised financial forecast 2025-26	• CIP stretch target delivered - **March 2026** • Financial plan delivered or mitigated position with ICB - **March 2026**

• Full participation in C&M ICS reviews - ICS Director Turnaround, NHSE review of CIP and establishing forecast risk for 25-26 and PWC/Stephen Hay diagnostic / financial governance • Bi-monthly updates to Finance & Performance Committee • Monthly oversight at Finance, Resources Oversight Group, chaired by interim CFO • Financial plan delivery (at M4) in line with plan • Robust CIP plan in place for 2025-26 with identification of recurrent schemes • Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board • CIP workstreams established with SRO Leads at Executive level • Trust continued engagement in ICB turnaround process (NOTED as an emerging issue at private board on 4.6.25) • M5 financial plan - reported surplus of £0.5m; an improvement on plan for M5 but no change to the project year end surplus of £0.9m. • M5 CIP position - £4.98m of CIP in year transacted - £5.051m FYE (v's revised target of £6.6m)	• Delivery of CIP stretch target - **Chief Finance Officer** • Further implementation and use of model health data in clinical and corporate services - **Chief Strategy Officer / Interim Chief Finance Officer** • Develop 3-year rolling capital programme - **Chief Finance Officer** • Conclusion of negotiations on 0-19 contracts - Chief Operating Officer /interim Chief Finance Officer		

• Membership and participation in Place Finance and Investment Group • System collaboration across NHS provider organisations • Relevant organisational risks (e.g., CIP, Capital, Financial Performance) tracked on Datix and through governance structures (as per Risk Policy) • EPCP process established jointly between WCHC and WUTH • Enhanced controls established for vacancy control and non-pay discretionary spend and communicated trust-wide with supporting SOP - improved position reported in two months since established.			

NEW ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.	Finance & Performance Committee oversight

Link to 5-year strategy - Make most efficient use of resources to ensure value for money
Link to PDAF - Wirral system partners are unable to deliver the priority programmes within the Wirral Health and Care Plan which will result in poorer outcomes and greater inequalities for our population (RR8).

Organisational risk - **ID3192 (RR9 - 3 x 3)** - *Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full*

Consequence;

- Poor service user access, experience and outcomes
- Poor contract performance - financial implications (Trust and system)
- Negative reputational impact

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Moderate**	2 x 4 (8)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)				

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• NOF segment 1 • Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board • CIP workstreams established with SRO Leads at Executive level	• CIP delivery to support delivery of improved position - **Chief Finance Officer** • Community Nursing Development Programme to commence consultation and progress - **Chief Nurse**	• Delivery of the benefits of integration as described for each service • Staff experience and staff morale	• Implementation of new Community Nursing model - **Q4 2025-26** • Key deliverables for Y1 of 2-year integration plan achieved - **March 2026**

• Programme of Quality Improvement Training and Events available across the Trust (including WUTH staff) • Community Nursing Development Programme determined and scoped • WCHC COO / Director of Integration & Partnerships leading programmes of work associated with clinical services integration • 2-year integration plan developed for clinical and corporate services with oversight at Integration Management Group (IMG) and Integration Management Board (IMB) • MSK clinical service review in progress between WCHC and WUTH as part of the 2-year integration plan • UEC service review in progress between WCHC and WUTH as part of the 2-year integration plan • Workforce Sharing Agreement in place to support flexibility of wokforce between Trusts *(to maximise transformation opportunities)*	• Phase Two MSK clinical services review - **Chief Strategy Officer** (to IMG) • UEC integration programme - **COO/Director of Integration & Parternships** (to IMG)	• Patient experience and feedback • Delivery of recurrent CIP to achieve the target for 2025-26 • Delivery of revised financial forecast 2025-26	• CIP target delivered - **March 2026** • Financial plan delivered or mitigated position with ICB - **March 2026**

NEW ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber attack impacting on the quality of patient care	Finance & Performance Committee oversight

Link to 5-year strategy - (Populations) Safe care and support every time, (Place) Make most efficient use of resources to ensure value for money

Consequence;

- Delivery of patient care and patient experience
- Staff morale
- Financial impact
- Negative reputational impact for the Trust and system

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	Cautious	2 x 4 (8)
-	-	3 x 4 (12)	3 x 4 (12)				

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• EPRR arrangements in place including business continuity plans for all services • EPRR lead reporting to COO • Annual EPRR report presented to Board with regular monitoring at FPC • Major Incident Plan approved by Board • EPRR work plan agreed and endorsed by Board	• Achievement of substantial compliance against the EPRR core standards self-assessment - **Chief Operating Officer** • Alignment of EPRR functions with WUTH - **Chief Operating Officer** • Implementation of recommendations from DSPT/CAF	• EPRR core standards self-assessment - substantial compliance	• EPRR core standards self-assessment - substantial compliance - **March 2026** • Implementation of all recommendations from DSPT/CAF audit review - **Q1, 26-27**

• 2024 EPRR core standards self-assessment confirmed 86% compliance (partial compliance) • MiAA audit provided 'substantial assurance' • EPRR governance through HSSR group reporting to FPC • SIRO appointed • DSPT/CAF completed and submitted to NHSE, following audit review • 12 outcomes reviewed across the 5 objectives, including 8 NHSE mandated outcome and 4 identified by the Trust - *11 outcomes = met the minimum achievement level* - *1 outcome = not meeting the minimum achievement level* - *Overall assurance rating = moderate risk.* - *Overall assessment of the veracity of self-assessment = High confidence* • Action plan developed to track implementation of recommendations from DSPT/CAF • Cyber and IG governance through IGDS reporting to FPC • Multi-Factor Authentication in place across the Trust	audit review - **Chief Digital Information Officer**		

Board Assurance Framework 2025-26

Strategic risks with oversight at People & Culture Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the quality governance framework in place across the Trust.

Corporate Governance

- The People & Culture Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually (last reviewed in August 2024)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- The Chief People Officer is the Executive Lead for the committee. A Joint CPO has been appointed between WUTH and WCHC as part of the recommendations from the Wirral Review.
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee.
- The PCOG (People & Culture Oversight Group) reports to the IPB on all matters associated with people and workforce performance.
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks and can access all operational risk status through the Datix on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF.
- The committee receives an update on trust-wide policies (related to the duties of the committee and on the implementation of recommendations from internal audit reviews.
- The Chair of the committee is also the NED health and wellbeing lead for the Trust.

Workforce Governance

- Joint Leadership Team across the People Directorates in WUTH and WCHC established
- Year 1, 2 and 3 of the People Strategy Delivery Plan implemented successfully with committee oversight.
- The PSDP has been reviewed and actions consolidated with a focus on management training and development, clinical career pathways and apprenticeships, rotational posts and RPA.
- Other actions have been held as paused and will be carried over into future plans under a joint WCHC/WUTH People Team which will address the capacity issues preventing delivery.
- The governance structure in place provides clarity on the groups reporting to the committee.
- The committee contributes to the development of the annual People Strategy Delivery Plan and priorities and receives bi-monthly assurance on implementation.
- The committee receives the Terms of Reference for the groups reporting to it and decision and action logs from each meeting for noting.
- The committee reviews and approves the EDS (workforce domains), WRES and WDES annual reports and associated action plans.
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from staffing incidents and employee relations cases.
- The committee receives and approves the Trust's workforce plan.
- The FTSU Executive Lead is a member of the committee.
- People Governance structure reviewed during 2023-24 to ensure effective monitoring of workforce and L&OD metrics.

- Quarterly People Pulse Survey process embedded with reporting to PCC and to staff via Get Together
- National NHS Staff Survey reporting via PCC and to Board of Directors.

System Governance

- Wirral Place Workforce Group established with CPO as member
- CPO Chair of NHS national community providers COP meeting
- Workforce Sharing Agreement approved between WCHC and WUTH
- Integration Management Board (IMB) established between WCHC and WUTH to oversee integration

Monitoring workforce performance

- The committee receives a workforce report from TIG providing a YTD summary (via SPC charts) of all workforce performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway, to monitor workforce performance and to access the Audit Tracker Tool to monitor progress
- Recruitment and Retention Group established
- Recruitment and retention action plan delivered with improved tracking of key metrics
- The committee receives updates on regulatory and legislative compliance including procedural documents

ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised	People & Culture Committee oversight

Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent

Consequence;

- Low staff morale - increase in sickness absence levels and reduced staff engagement
- Poor staff survey results
- Poor staff retention
- Reputation impact leading to poor health and care outcomes
- Increase in staff turnover and recruitment challenges

Current risk rating (LxC) *(by committee by month)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Moderate**	1 x 4 (4)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	4 x 4 (16)				

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• NOF segment 1 – NHS staff survey engagement theme sub-score 2.8 in NOF • People Strategy Delivery Plan Year 4 developed and includes; – Actions deferred from Year 3 – Alignment to existing national priorities – Key themes of the People Promise	• Impact of AFC review of nursing role profiles to be reviewed (plan in place aligned to WUTH) - **Chief People Officer** • Sickness absence rates increasing - flagged in IPR at Board of Directors and monthly Get Together. Sickness rates impacting on	• Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v's 2024 results 7.02 • NSS uptake Year 4 target ≥ 55% v's 2024 result 51% • Q25c in NSS *"I would recommend my organisation as a place to work"* Year 4 target ≥ 63% v's 2024 result 63.21%	See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success. - Completion of actions in Year 4 PSDP 'Looking after our people' - **March 2026** - Roll-out of OD programme to support integration of services between WCHC and WUTH - **on-**

• 9 x actions in Year 4 delivery plan aligned to ambition 1 'Looking after our people'
• NHS staff survey 2024 results published
  – Overall, a decline in all 9 scores, only two decreases were statistically significant
  – Best score for Community Trusts for *staff having an appraisal*
  – Key overview - comparison to 2023 - 1 significantly better, 8 significantly worse, 91 no significant difference.
• Wellbeing Champions in services across the Trust
• Wellbeing conversation training for managers and uptake monitored at PCOG.
• Wellbeing (including financial wellbeing) information on Staff Zone for all staff.
  – Wagestream available for all staff
  – Vivup staff benefits platform launched.
• FFT results providing high satisfaction levels from service users (>90%)
• Leadership Qualities Framework in place and supporting development of leadership skills *(LQF under review to identify any gaps in current behavioural statements)*
• System Leadership Training for senior leaders
• Staff Voice Forum
• Managers briefings in place and issued to support with the dissemination of key
	People & Workforce domain of NOF - **Chief People Officer**
	• Implementation of workplace sexual safety measures - **Head of HR**
	• Appraisal compliance 2025 – (80%) **- Deputy Chief People Officer**
	• Manager training to support staff mental health and wellbeing **- Head of HR**
	• Delivery of People Management Skills **- L&OD**
	• Deliver Leadership for All programmes with alignment between WCHC and WUTH **- L&OD**
		• Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target ≤ 28.0% v's 2024 result 33.23%
		• Improve staff retention Year 4 target ≤12% v's 8.9% in 2024-25
		• We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63%
		• Positive FFT results at 'very good' or 'good' Year 4 target 93%
		• 'Morale' sub-score in NSS Year 4 target ≥6.1 v's 2024 result 5.84%
		• 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target ≥7.30 v's 2024 result 7.30
		• 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target ≥7.20 v's 2024 result 7.28
		• Targeted culture interventions *'We are safe and healthy'* Year 4 target ≥6.3 v's 2024 result 6.20
			going and aligned to 2-year integration plan

messages (to be enhanced through staff engagement plan)
• Senior Leaders Briefings established monthly to support dissemination of messages
• Appraisal window 2025 opened and extended to September 2025
• Training packages in place via ESR to support managers to undertake effective appraisals.
• Freedom To Speak Up Guardian and >100 champions.
• Organisational-wide recruitment and retention (R&R) group reporting to PCOG
• Reduction in vacancy rates (data on TIG)
• Refresh and relaunch of MDT preceptorship programme.
• Behavioural standards framework launched trust-wide
• Internal and external communications plans to support integration developed - Better Together branding launched
• Workforce Sharing Agreement agreed between both Trusts
• Engagement plan developed for staff as part of the integration plan
  – Corporate Services Transfer briefings to managers and staff
  – Update FAQs available to all staff
• OD plan developed including managers 'toolkit' to support service integration			

• Joint Strategy development between WCHC and WUTH to include staff engagement - underway • Better Together - case for change document published internally and externally • Multiple channels for staff to ask questions - Ask ELT, monthly Get Together, monthly Leaders In Touch, Senior Leaders Briefing • CPO weekly meetings with Staff Side reps in both Trust supporting communication of messages • NHSE Staff Experience Assessment Framework implemented • Implementation of the NHS Sexual Safety Charter			

ID08 Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population	People & Culture Committee oversight

Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent

Consequence;

- Poor outcomes for the people working in the Trust
- Reduced staff engagement
- Failure to meet the requirements of the Equality Act 2010
- Increase in staff turnover and recruitment challenges

Current risk rating (LxC) *(by committee by month)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Moderate**	1 x 4 (4)
3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)				

Measures remain under review and in development following committee discussions in August 2024.

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• NOF segment 1 - NHS staff survey engagement theme sub-score 2.8 in NOF • Inclusion Annual Report • People Strategy Delivery Plan Year 4 developed and includes; - Actions deferred from Year 3	• Roll out cultural competence training - **Head of Inclusion** • EDI dashboard to PCC - **Head of Inclusion** • Implement regular cultural assessment at Trust and divisional level - **Deputy CPO**	• Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v's 2024 results 7.02 • NSS uptake Year 4 target ≥ 55% v's 2024 result 51% • Q25c in NSS *"I would recommend my organisation as a place to*	See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success. • Completion of actions in Year 4 PSDP 'Culture and Belonging' - **March 2026**

- Alignment to existing national priorities - Key themes of the People Promise • 8 x actions in Year 4 delivery plan aligned to ambition 1 'Culture and Belonging' • NHS staff survey 2024 results published - Key overview - comparison to 2023 - 1 significantly better, 8 significantly worse, 91 no significant difference. • Inclusion and Health Inequalities Strategy published with a commitment to empowering and upskilling our people. • Staff network groups established for BAME, LGBTQ, Ability and Carers, Menopause and Armed Forces - Executive sponsorship of all staff networks refreshed and agreed. • Staff Voice Forum • WRES and EDS completion with oversight at PCC • Trust adopted NorthWest BAME Assembly anti-racist statement • C&M NHS Prevention Pledge – 14 commitments to deliver • Gender pay gap report to PCC • Wellbeing and Inclusion Champions in services across the Trust • Representatives of BAME staff network supporting the development of more inclusive recruitment practices.	• Further develop staff network - **Head of Inclusion** • Increase coaching activity	*work"* Year 4 target ≥ 63% v's 2024 result 63.21% • Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target ≤ 28.0% v's 2024 result 33.23% • Improve staff retention Year 4 target ≤12% v's 8.9% in 2024-25 • We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63% • Positive FFT results at 'very good' or 'good' Year 4 target 93% • 'Morale' sub-score in NSS Year 4 target ≥6.1 v's 2024 result 5.84% • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target ≥7.30 v's 2024 result 7.30 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target ≥7.20 v's 2024 result 7.28 • Targeted culture interventions *'We are safe and healthy'* Year 4 target ≥6.3 v's 2024 result 6.20 • Number of people supported on pre-employment programmes Year 4 target 10 v's 2024 achievement of 9	• Deliver all actions from the WDES action plan - **April 2026** • Deliver all actions from WRES action plan - **April 2026**

• Organisational-wide recruitment and retention (R&R) group reporting to PCOG • R&R group developed recruitment and retention action plan with improved monitoring of leaver data and improved exit processes. Plan closed following sustained decrease in turnover to below target levels. • NHS Rainbow Pin Badge scheme - achieved bronze status • Armed Forces Covenant community inclusion initiatives - covenant signed, silver DERS achieved and VCHA accreditation achieved • Recruitment and Retention Policy includes positive action in respect of increasing diversity at senior roles (8a and above). • Chief executives, chairs and board members have specific and measurable EDI objectives to which they are individually and collectively accountable (6 high impact actions for EDI) • Behavioural standards framework launched trust-wide • EDS 2024 completed (jointly with WUTH) with Board approval in February 2025 - Overall attainment level = **Achieving**		• Delivery of NHSE EDI High Impact Actions (included in both WRES and WDES) • Achieve Bronze Level status for the NW BAME Assembly Anti-Racist Framework	

ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee oversight

Link to 5-Year strategy - Grow, develop and realise employee potential
Better employee experience to attract and retain talent
Link to PDAF - The Wirral health and care system is unable to recruit, develop and retain staff to create a diverse health and care workforce with the skills and experience required to deliver the strategic objectives (RR12).

Consequence;

- Poor outcomes for the people working in the Trust
- Reduced staff engagement
- Increase in staff turnover and recruitment challenges

Current risk rating (LxC) *(by month by committee)*						**Risk appetite**	**Target risk rating (LxC)**
April 25	**June 25**	**Aug 25**	**Oct 25**	**Dec 25**	**Feb 26**	**Open**	1 x 4 (4)
2 x 4 (8)	2 x 4 (8)	2 x 4 (8)	2 x 4 (8)				

Measures remain under review and in development following committee discussions in August 2024.

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Strategy Delivery Plan Year 4 developed and includes; - Actions deferred from Year 3 - Alignment to existing national priorities - Key themes of the People Promise • 4 x actions in Year 4 delivery plan aligned to ambition 1 'Growing for the Future'	• Review operational service requirements in relation to career pathways, clinical apprenticeships and advanced practice **- L&OD**	• Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v's 2024 results 7.02 • NSS uptake Year 4 target ≥ 55% v's 2024 result 51% • Q25c in NSS *"I would recommend my organisation as a place to work"* Year 4 target ≥ 63% v's 2024 result 63.21%	See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success. • Completion of actions in Year 4 PSDP 'Growing for the Future' - **March 2026**

• Positive student experience and methods of fast-track recruitment • Low staff turnover • Apprenticeship plan in progress (task & finish group established) - *'grow our own'* - clinical career pathways • Joint Head of L&OD role now in place to support joint working and policy implementation • Social value metrics related to recruitment agreed • Internal and external communications plans to support integration developed - Better Together branding launched • Workforce Sharing Agreement agreed between both Trusts • Engagement plan developed for staff as part of the integration plan • OD plan developed including managers 'toolkit' to support service integration • Joint Strategy development between WCHC and WUTH to include staff engagement		• Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target ≤ 28.0% v's 2024 result 33.23% • Improve staff retention Year 4 target ≤12% v's 8.9% in 2024-25 • We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63% • Positive FFT results at 'very good' or 'good' Year 4 target 93% • 'Morale' sub-score in NSS Year 4 target ≥6.1 v's 2024 result 5.84% • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target ≥7.30 v's 2024 result 7.30 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target ≥7.20 v's 2024 result 7.28 • Targeted culture interventions *'We are safe and healthy'* Year 4 target ≥6.3 v's 2024 result 6.20 • 'Development' sub-score 'We are always learning' Year 4 target ≥6.6% v's 2024 result 6.33% • Social value metric - % of apprenticeship levy used for entry level roles Year 4 target ≥5% v's	

		2024 position 5.7% (90 live apprenticeships) • Social value metric - % of workforce on an apprenticeship programme Year 4 target ≥5% • Number of people supported on pre-employment programmes Year 4 target 10 v's 2024 achievement of 9 • Develop and pilot at least 1 pre-employment programme	

Board Assurance Framework 2025-26

The below risk is as a shared strategic risk between WCHC and WUTH and whilst this will be reflected on each respective organisational BAF, the mitigations and controls will be aligned across both organisations reflecting the work of the Integration Management Board.

The status of the strategic risk will be shared with the IMB bi-monthly reflecting the timetable for the presentation of the 2-year integration plan.

Failure to effectively deliver the 2-year integration plan including delivery of the transaction between WCHC and WUTH, resulting in the benefits of integration (clinical, operational, workforce, financial and patient experience/outcomes) not being realised	Integration Management Board
Link to WCHC and WUTH strategies – *WCHC – Delivering sustainable health and care services, WUTH – Provide seamless care working with our partners*	
Risk category – Reputational, Operational, Strategic, Compliance, Financial	
Consequence; • Failure to realise the benefits of integration • Poor staff and patient experience • Poor reputation	

Current risk rating (LxC) *(by month of committee)*						**Risk appetite**	**Target risk rating (LxC)** *(by end of 25-26)*
May 25	**July 25**	**Sept 25**	**Nov 25**	**Jan 26**	**Mar 26**	**Open** *Prepared to consider all delivery options even when there are elevated levels of associated risk*	2 x 3 (6)
-	-	3 x 3 RR9	3 x 3 RR9				

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)**	**Trajectory to mitigate and achieve target risk rating**
• Partnership Agreement (PA) agreed and approved by both statutory boards • Joint functions and delegated functions described in the PA	• ~~Agreement of costs to support the necessary resources associated with the statutory transaction - **Chief Strategy Officer**~~	• Delivery of key milestones in the 2-year project plan for integration • Transfer of Corporate Services from WCHC to WUTH	• Case for change to be presented to the ICB Board on 25.09.25 - **September 2025** - **COMPLETE AND ACCEPTED**

• Integration Management Board (IMB) established as a special purpose Joint Committee with Terms of Reference • IMB reporting to both statutory boards via Chair's AAA report • Integration Management Group (IMG) established reporting to the IMB • 2-year project plan developed for integration with oversight at IMG (and bi-monthly reporting to IMB) • Transaction type approved by IMB following consideration of multiple options and risk/benefit analysis • Active engagement with the ICB and NHSE on the transaction timeline and process • Internal communications and staff engagement plans developed • TUPE transfer of Corporate Services from WCHC to WUTH agreed and project group established and reporting to IMG • Councils of Governors of both Trusts engaged with regular briefings • Development of Joint Strategy commenced with workshops and focus groups with staff across both Trusts • ICB approval of the case for change • TUPE transfer of corporate services • Corporate Services Collaboration Agreement / SLA for Corporate Services approved by IMB and Boards of Directors	• ~~ICB approval of the case for change – **Chief Strategy Officer**~~ • EQIA(s) to be completed for organisational change process – **Executive Leads / PMO** • See ID07 increase related to increase sickness absence • Appointment of transaction support (consultancy and legal) - **Chief Strategy Officer**	• Completion of the statutory transaction as per agreed timeline for 25-26 • Staff experience and feedback • Delivery of financial plans in both Trusts including CIP targets for the integration of services • Patient experience	• Transfer of Corporate Services from WCHC to WUTH to be completed – **COMPLETE** • Corporate Services organisational change – **April 2026** • Completion of all agreed steps for 25-26 in the statutory transaction timeline - **March 2026**

• Group Governance Manual to support revised governance arrangements with effect from April 2026			

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 16**
3 December 2025

Report Title	Committee Chairs Report – Estates and Capital Committee
Date of Meeting	3 November 2025
Author	Steve Igoe, Chair of Estates and Capital Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Estates and Capital Update summarised estates statutory compliance figures, reactive maintenance performance, facilities compliance and health and safety reporting. Members discussed reactive maintenance performance, acknowledging this was decreasing and that a further deterioration was anticipated due to reduced overtime available, in line with the Trust's financial mitigation plan. ○ A deep dive presentation was provided relating to fire safety. Members acknowledged the significant improvements made since 2021 to improve compliance but noted some residual risks remained and requested that mitigation for these risks be provided to the next meeting. ○ Following the acquisition of the Frontis building on the Arrowe Park site earlier in the year the Committee discussed the future use of the building. Committee agreed with the recommendation to demolish the building and requested that a timeline for this and longer-term proposal for the redevelopment of the site be provided to Committee in due course.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Violence and aggression continued to be the highest non-clinical incident reported with a total of 206 in Q1 2025/26 which was an increase of compared to Q1 2024/25. Committee were assured that new arrangements introduced by the Head of Security were beginning to reduce the risk and targeted efforts had already shown early positive impact. ○ The Trusts capital programme totalled £26.105m for this financial year and at month 5 spend remained below plan. Committee acknowledged there was a risk that some schemes will not be complete by year end and work was underway to complete a capital reforecast. ○ Phase 4 of the Urgent & Emergency Care Upgrade Programme (UECUP) was complete and operational, and phase 3 was now underway. The costed risk register had been reduced by £900k, however various phase 3 challenges had become visible due to the condition of the existing building and equalled £900k. The revised planned completion date was now August 2026.
Assure	• The Committee wish to assure members of the Board of Directors that:

	○ Fire Safety Level 2 compliance across all the Divisions has improved, however Emergency Care, Medicine, Surgery and Women's and Children's Divisions remain below the 90% compliance target. An improvement plan remains in place to meet compliance. ○ Significant progress has been made in the delivery of the larger capital scheme's such as Neonatal Unit and Sterile Services performing to both delivery and financial plans.
Review of Risks	• Committee discussed the Board Assurance Framework and agreed the risks relating to its portfolio appeared accurate and reflected the current position.
Other comments from the Chair	• No other comments

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 17**
3 December 2025

Report Title	Committee Chairs Report – Charitable Funds Committee
Date of Meeting	11 November 2025
Author	Lesley Davies, Joint Non-Executive Director & Committee Chair

Alert	The Committee wish to alert members of the Board of Directors that: ○ **Tiny Stars Appeal** A press release has been produced in readiness of the closure of the Tiny Stars appeal. Discussions are underway to agree the Charity's next significant campaign and, in the meantime, fund raising activities will be allocated to the remaining restricted funds. ○ Future fund-raising activities planned for the rest of the year include the Winter Ball, Hospital Carol Service, an evening with Paul Burrell and book signing and an Abseiling event.
Advise	The Committee wish to advise members of the Board of Directors that: ○ The Committee was updated on the Charity's fund-raising activities and current income to date. Patient Wish and Tiny Stars remain the largest funds. The Committee also discussed the pressures on fund raising income and donations given the economic climate and competition from other charities. Without new income streams, the cost of running the charity would disproportionately impact smaller funds. For 2025/26 the fixed costs recharge to WUTH for running the Charity stands at an estimated £161k per annum and the Charity has a stretch income target of £242k in order to secure a return on investment. ○ Funds are currently behind forecasts, but the main fund-raising activities are planned over the new few months with the aim to achieve the targets set ○ The Committee was provided with a verbal financial update
Assure	The Committee wish to assure members of the Board of Directors that: ○ Good progress is being made with the neonates redevelopment and the expected completion and launch of the new ward is planned for early December. Cot space has been increased by removing a theatre, and infrastructure upgrades have been completed, including new pipes, ventilation and generators. The Committee was given assurance that the project will also be delivered within budget
Review of Risks	• The Committee reviewed the Charity's strategic risks. Two historical risks (added in 2003 and 2006) have now been closed following significant improvements. These risks were originally raised during a period when the charity was in a very different position, and the mitigating actions taken have removed the likelihood of recurrence. The remaining two risks were reviewed and mitigation discussed

Other comments from the Chair	The Committee noted the good progress being made and the planned activities for the rest of the year

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
3 December 2025

Item No 18

Report Title	Committee Chairs Report – Quality Committee
Date of Meeting	24 November 2025
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It continues to keep a strong oversight of infection and prevention and control arrangements, given number of patients with Clostridioides difficile infection; 16 in September- with a set monthly threshold of no more than 8. Our discussion focus was on clinical areas of the highest incidence -caring for the patients at highest risk. Whilst it was felt that some controls, such as antimicrobial stewardship were where we wanted them to be, others needed to achieve greater reliability. Work was underway with the estates team to ensure that no opportunities were missed there, given the outdated nature of our isolation facilities. ○ Despite better recording of patients arriving at the hospital with extant tissue ulcers, there was still more work to ensure that all such patients had their skin condition reviewed and recorded in a timely way within the emergency department. ○ There is focussed work on ensuring that all staff in relevant areas are being fit-tested for respiratory masks. This is especially important given the high level of respiratory infections at present and also since the national Covid enquiry has thrown a light the need for effective pandemic planning. ○ There is currently a 100% vacancy rate for speech and language therapists for outpatient services. The Committee discussed opportunities arising out of our integration to support patient's access to SLT. ○ It noted the potential impact on patient outcomes of the sterile services incident and that the relevant patients would be monitored for any resulting harm. Cancer patients have been prioritised during the initial recovery phase. ○ We are continuing to see less positive Friends and Family Test responses and a higher level of informal concerns in the Emergency Department, relating to waiting times especially.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ A review of our Patient Safety Incident Response Framework is underway to improve timeliness, learning and reporting and importantly getting back to patients and families. Timescales for full (PSII) investigations were sometimes lengthy. The Board will be updated with a report in the New Year. ○ Progress with the immediate actions from the CQC (March) inspection of medicine and emergency care was progressing

	well and leaders were looking to ensure that actions were embedded and permanent. ○ The Committee received the Patient Experience Strategy Annual Report which demonstrated a wide range of activities of interaction and engagement with communities, service users and staff to help understand and shape our offer to them. Taken with our response to the new national Experience of Care Framework, we will build on the first 2 years of the strategy to review and reshape our strategy to further enhance our patient's experience. ○ The Committee also received the biannual Mortuary Services Report which continued to provide good assurance that the processes and governance in the mortuary were robust and compliant. Committee received a gap analysis in relation to the Fuller Inquiry Phase 2 recommendations and acknowledged the Trusts strong position. Members were also pleased to hear that the Mortuary team had access to health and wellbeing support, which was important when dealing with upsetting circumstances in the morgue.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ A Mersey Internal Audit Agency review of our ward accreditation system (WISE) is feeding into our review and updating of WISE. The review found positive evidence of a "robust, consistent and patient-centred WISE assessment process". Examples of maintaining and improving accreditation levels on a number of wards was presented. ○ The Committee received number of reports, where it judged that gave good assurance on the quality of care and its governance, with number being on this Trust's Boards Agenda. These included. ▪ Learning from Deaths Report ▪ Organ Donation Annual Report
Review of Risks	• The Committee reviewed Board Assurance Framework risk 3 (Failure to ensure adequate quality of care, safety and patient experience resulting gin adverse patient outcomes and increase in patient complaints). It felt that the current risk score should remain at 16. It did note a gap around the increase in scheduled care demand (for acute macular degeneration for example).
Other comments from the Chair	• The Committee benefitted from receiving clear and helpful reports that enabled it to conduct its business.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 19**
3 December 2025

Report Title	Committee Chairs Report – Finance Business Performance Committee
Date of Meeting	27 November 2025
Author	Dr Steve Ryan, Joint Non-Executive Director & Meeting Chair

Alert	• The Committee wishes to alert members of the Board of Directors that: ○ At the end of October 2025 (M7) the Trust is reporting a deficit of £17.6m which is £8.8m adverse to plan. The Committee received a detailed paper of the drivers of this deficit down to the level of individual services within divisions. The Committee noted effective oversight of any budget's over-runs and under-delivery of cost improvement plans and was able to confirm the actions necessary to identify actions to recover the agreed financial position for 2025/2026. As an example, it was able to note the annual round of appointment of newly qualified nurses had led to an increase in workforce numbers, since these nurses initially undertake supernumerary duties so that they can begin work safely. It also noted the good work in using "deep dives" into services with budget variations. ○ Concerns remain around patients' access to the faster diagnostic standard at 28 days. This principally relates to dermatology services through a new regional digital access pathway which has seen a significant increase in referrals and the need for on-going clinical scrutiny while the system beds in. Additional funding from the Cancer Alliance has been received and is expected to allow the standard to be met by the end of January 2026. This is significantly impacting the Trust's 28-day performance which has a high risk of external scrutiny. ○ The Trust's cash position has continued to be supported with access to national support funding and will continue to do so into Quarter 4 (Q4). ○ The impacts of the critical incident in the Sterile Services Department (SSD) were noted. The financial impact has been substantial. Dealing with delays to the 65-week waiting standard is a risk to achieve zero waits by the end of December. The biggest on-going challenge is orthopaedic surgery. This is because the number and range of instruments required is substantial and work is required with manufacturers to bring all the equipment back into use. Arrangements are being made to swap operating and clinic time, so that backlogs can be caught up in Q4.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ It was pleased to note the recovery of the Diagnostic DM01 Performance to 95% in October, against a standard of 90% ○ It noted that the issues with dermatology cancer waiting times performance masked really good progress with waiting times in Urology, Breast, Colorectal, Head and Neck and Gynaecology ○ It received an update on the Unscheduled Care Improvement Plans, where the Trust is being supported but the Emergency care

	Improvement Support Team (ECIST) to meet national improvement trajectories (such as more than 78% of emergency department patients being seen within 4 hours) by March 2026. With ECIST a "SMARTer" plan, with improved clinical engagement is showing early signs of traction. For example, focus on the quality and number of "huddles" is helping. There is still a very high demand for access to the Emergency Department with up to 330 patients a day attending. ○ The Trust will be required to submit its 3-year financial and activity plan for 2026 through 2029 by the 15th of December. The Committee received a presentation from the Chief Financial Officer outlining the underlying financial position from 2022/23, including a persistent negative exit run rate. Increasingly strong performance in delivering recurrent cost improvement had enabled the Trust to meet inflation and other national income reductions of £46.3 M but had not allowed it to yet address the underlying deficit. The Board will be required to ensure appropriate scrutiny prior to the submission.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ It was assured through the papers it received that there is evidence of planning and action in relevant areas of financial concern and access performance, and it was able to gain further assurance in its enquiries. ○ There is continued oversight work being undertaken to continue to recover activity lost through the sterile service department critical incident.
Review of Risks	• The Committee noted that there are risks to the delivery of the agreed year-end financial position and will continue to focus on going assurance on plans to mitigate these risks. The risks to dermatology cancer performance were highlighted and have an appropriate mitigation plan. The risks following the SSD incident are also being actively managed.
Other comments from the Chair	• The Committee benefitted from receiving clear and helpful reports that enabled it to conduct its business.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 19**
3 December 2025

Report Title	Committee Chairs Report – Quality & Safety Committee
Date of Meeting	24 November 2025
Author	Professor Chris Bentley, Chair of Quality & Safety Committee

Alert	QSC wish to alert members of the Board that the committee of the following: • **MIAA Clinical and Professional Supervision Assignment Report 2025/26:** to review systems and processes in place to ensure controls were in place and operating effectively. This had been requested having been a Committee concern, with trends varying over time depending on timing of improvement initiatives. The overall assurance opinion was 'moderate' with recommendations to mitigate areas of risk. There were areas of good practice, but with **1 area of high risk and 3 medium**. It was agreed to open an operational risk (3 X 4), with mitigations overseen by Chief Nurse, and working through Clinical Risk Management Group and Safe Operations Group (SOG). This should be mirrored by a Gap identified in BAF ID01. • **MIAA Duty of Candour Benchmarking Report:** This general learning report had produced 5 recommendations, which have been reviewed on behalf of both Trusts. The self-assessment for WCHC reported good compliance, with some areas of possible further improvement. It was noted that DoC was built into core processes e.g. PSIRF; Learning from Deaths; Complaints. • **Emergency Preparedness Resilience and Response (EPRR) Core Standards Self-Assessment:** updated action plan now assured with assessment rating 'Substantial Compliance' – 97% completion. Confirmed by C & M ICB EPRR Team, comment *'documentation supplied is of consistently good standard. It is clear significant time and effort has been dedicated to continuously improving EPRR processes across Wirral Community.'* Thanks to Emergency Planning Lead, Mick Blease. Approved to proceed to Board.
Advise	QSC wish to advise members of the Board that the committee: received several updates to the integration and joint working processes including: • **Committee organisational changes:** it was noted that new scheduling aligned the Quality Committee of both Trust meetings onto the same day. A new membership resulted from the appointment of a single executive group across Trusts. • **Corporate Services transfer:** the transfer of services will occur on 1st December. Key elements relevant to QSC monitoring include IPC; Safeguarding; Tissue Viability services.

	• **Quality Governance:** is another element overseen through Corporate Services. The focus will be on bringing operational systems of governance together below Committee level. MIAA will be supporting with a mapping exercise, supporting a process for an advisory piece on a combined governance and assurance structure. It was confirmed that NEDs, with their governance and assurance remit, would be involved early in the process. • **Joint pathway development:** a very positive theme that emerged across the meeting was the real potential now to develop strategies and processes on a Wirral population basis, rather than organisational silos. Areas discussed, including in agenda items in Quality Strategy and Patient Experience report, included managing: falls; pressure ulcers; infectious disease e.g. C. Diff., and joint discussions are already underway on each of these and more. • **Provider Alliance:** this will be central to Wirral population-based approaches through work with other partners including primary care, local authority/public health and VCFSC representation. A good update on progress was brought to Committee. • **District Nurse Transformation:** process to review clinical pathways to simplify recording care templates and workforce models has been paused currently. Appointment of a new SRO is awaited to restart this important work.

Assure	QSC wish to assure members of the Board that it signed off:
	• **Quality Strategy Delivery Plan 2025/26**: the developed robust delivery plan was reported to be progressing well. Highlights included:
	  ○ SALT have been successful in recruiting a significant number of therapists, with resulting reductions in waiting times for assessment, and a decline in complaint numbers. There was a good discussion on sharing learning for WUTH processes, as well as other joint working benefits.
	  ○ Discussion about sharing QI processes and learning across the Trusts. Also, discussion about joint approaches to active research engagement. Trust NED (MD) had offered to provide link into Chester University and a joint meeting had happened.
	• **Quality and Patient Experience Report:** good performance overall to end of September. Exceptions of note:
	  ○ Falls in the numbers of incidents (low/no harm). Being examined for possible reasons. Want to maintain numbers to learn from 'near misses'.
	  ○ Deep dive into moderate/severe incidents. 25/25 reviewed were pressure ulcers

	○ Slight fall in Friends and Family Test positives. Under review • **Infection, Prevention and Control Q2 Report 2024/25:** Received for assurance. Of note: ○ 4/10 IPC BAF criteria are amber. Action noted that 2 of these have active plans to go green before year end. 2 have extended target dates to allow cross working with WUTH ○ Within this, an area of risk relates to FIT testing in some areas. WUTH has similar risks, and action being considered together • **Learning from Deaths**: report approved to proceed to Board, and for (Q1) report to be published on website. Agreed from Q3 WCHC and WUTH Reports to be reported at same time. • **Controlled Drugs Annual Report:** received for assurance including compliance with updated controlled drug legislation. Approved to proceed to Board. • **Medicines Optimisation Mid-Year Assurance Report 2024/25**. Two-part report considering a) CICC and b) Trust wide. Detailed report discussed and received with assurance. • **Audit reviews:** Nil outstanding • **Policy schedule:** 61/62 policies for QSC in date. 1 approved and ready to publish.
Review of Risks	**High-level operational risks** which had been discussed at the (operational) IPB were brought to QSC for information and discussion in accordance with the Risk Policy: • Risk ID 3137 (RR16) Call bell system on Bluebell ward of CICC. Review carried out by Joint Chief Nurse and Deputy Chief Nurse. Satisfied with clinical mitigations, but technical and leasehold problems still outstanding. • Risk ID 2769 (RR15) Increased from RR12 waiting in children's Dental due to anesthesia capacity and aseptic systems problem. Review if still contemporaneous as very longstanding. Review prioritisation across dental waiting lists. • Risk ID 3209 (RR15) due to psychosexual therapy services and increasing waiting lists • Risk ID3228 (RR15) related to the Wheelchair service and impact of reduced admin levels on referrals • Risk ID 3124 Urgent Care staffing in Urgent Treatment Centre, Walk in Centre and GP Out of Hours under review from CQC site visit. Pending report **Board assurance framework (BAF)** reviewed and approved to proceed to Board with two additions: ○ Add reference to the MIAA Clinical Supervision Report as a Gap in both ID01 and ID07

	○ Add reference to the paediatric dental waits as a Gap in ID01
Other comments from the Chair	This was a good meeting, welcoming the perspectives from several Joint Executives and the WUTH Quality Committee NED Chair. Time was necessarily given to explaining systems and processes and immediately drawing comparisons. The conversations were naturally drawing towards how things could be drawn together – possibilities and challenges. Echoed in the afternoon by my joining the WUTH Quality Committee. Good first steps.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 20**

03 December 2025

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2025 with extended monthly reports in October and November 2025. The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (October 2025) key quality and safety metrics and the position of patient safety incidents.

This paper provides a specific update regarding MIS Year 7, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, together with a progress update on MPOP, Neonatal Unit Expansion. The report also includes an update on

It is recommended: -

- Note the report and associated appendices.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of the Maternity and Newborn Safety Investigations (MNSI) and declaration of one PSII for Neonatal Unit.
- Note the position with the Maternity Incentive Scheme Year 7 requirements.
- Note the PMRT reports for Q2 25/26.
- Note the progress of the Trust's position with Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the progress with the Maternity Portal Online Programme.

Key Risks

This report relates to these key Risks:

- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes

Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
December 2025	Divisional Quality Board	Quarterly Maternity and Neonatal Services Report	For information
December 2025	Maternity and Neonatal Assurance Meeting	Quarterly Maternity and Neonatal Services Report	For information
December 2025	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (October) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services.

2	Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in October 2025 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there is one active cases. There was one Patient Safety Investigation Incidents (PSII's) declared in May 2025 for Neonatal services. The incident has also been declared as a Never Event as it related to the displacement of a Nasogastric tube. The incident has been correctly classified as a never event according to NHS England criteria and a PSII has been commissioned

	in, line with the PSIRF Policy and approved. The Maternity and Neonatal Assurance Board has tracked progress by reviewing the investigation, root causes and identified contributing factors identified along with corrective measures and learning. There have been no further Patient Safety Investigation Incidents (PSII's) declared in October 2025.

3	Maternity Incentive Scheme (MIS) Year 7
	Now in its seventh year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. Provider compliance with the ten Safety Action Standards across C&M has been closely monitored by the LMNS/ICB. The request to sign off will be presented to Board of Directors on 28th January 2026 with the LMNS present.

4	PMRT Reports
	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 3**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in Quarter 3 25/26 period. .

5	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS Year 7 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management

	of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 30th September 2025 the Trust achieved 96% compliance against the 6 elements included at **Appendix 4**. This was an increase from the previous quarter and the Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper. Quarter 3 25/26 evidence has been submitted and under review by the LMNS for compliance of a updated version and changes to the required interventions and evidence requirements.

6	**Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations**
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. A full review has been undertaken, and the gap analysis is included at **Appendix 5** and remains in the same RAG rated position as fully compliant.

7	**Three Year Delivery Plan – Maternity and Neonatal**
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 6** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

8	**Midwifery Workforce and update on Birth Rate**
	As previously presented to Board of Directors a full workforce review is required to be undertaken every 3 years in line with Ockenden utilising the Birth Rate + workforce tool. There is a requirement to meet required staffing levels in line with Safety Action 5 of the Maternity Incentive Scheme (MIS). Following approval from the Board of Directors to increase the establishment to meet safe staffing levels all actions within the action plan have been instigating for action and recruitment processes are underway to meet the standard.

9	MPOP
	There is a requirement by the LMNS to report the progress of the Maternity Portal Online Programme (MPOP) to the Board of Directors and it is included at **Appendix 7.**

10	NHSE and LMNS Annual Maternity Visit
	An annual visit was scheduled by WUTH for 22nd October 2025 by the Northwest Chief Midwifery officer and team on behalf of NHSE, accompanied by the LMNS. Due to the declaration of a critical incident this has been postponed to March 2026,

11	NNU Expansion
	From 2018/19 to present, the Trust Charity, along with Incubabies Charity, have fundraised approximately £1m for the redevelopment of the Neonatal Unit at Arrowe Park Hospital. Across 2023 and 2024, the Estates Team, with the support of Day Architectural examined a range of design options to support the redevelopment of the unit. The expansion of the Neonatal Unit footprint to comply with the British Association of Perinatal Medicine (BAPM) commenced in June 2025 and completion is delayed with an expected date for the beginning of December 2025. The NNU is temporary relocated to an alternative ward area within the Women's and Children's division and building.

12	Conclusion
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The Board is asked to note the assurance on Safety Action 7 compliance and endorse the continued resourcing and involvement of the Maternity and Neonatal Partnership (MNVP) and service users in governance processes. The Board is asked to support the recommendations in the following reports:- • Gap analysis and Trust readiness to the Maternity and neonatal inquiry. • Midwifery staffing paper and action plan to meet the midwifery workforce establishment. • Maternity and Neonatal Culture Annual report. • Board Assurance MIS Year 7, Action 4 and compliance with the RCOG guidance. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

12	Implications
12.1	**Patients**

	• The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
12.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 9 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. Safety Action 1 noncompliance has no impact on quality and safety of maternity services and is a data transcription error. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Progress with sustainability of Ockenden. • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
12.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity workforce is required and funding options continue to be explored. A paper will be submitted to BDISC for approval to increase establishment and maintain compliance with Safety Action 5. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels.
12.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 22**

3 December 2025

Title	Organ Donation Annual Report 2024-25
Area Lead	Dr Nikki Stevenson, Joint Chief Medical Officer & Deputy CEO
Author	Dr Rosie Holmes, Clinical Lead for Organ Donation Angela Campion-Sheen, Specialist Nurse Organ Donation
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide a detailed account of organ donation activity within Wirral University Teaching Hospital (WUTH) for the period 1st April 2024 – 31st March 2025. Organ donation activity is monitored via the Potential Donor Audit (PDA) through NHS Blood and Transplant (NHSBT) and overseen locally by the Organ Donation Committee (ODC), which meets quarterly. Lead members of the committee are:

Dr. Steve Ryan - Chair (Non-Executive Director) WUTH
Dr. Rosie Holmes - Clinical Lead for Organ Donation (CLOD) WUTH
Angela Campion-Sheen - Specialist Nurse – Organ Donation (SNOD) NHSBT/WUTH

Organ donation takes place mainly within the Intensive Care Unit (ICU), with some within the Emergency Department (ED) at WUTH. There are two groups of patients who can donate solid organs after death:

1) patients who have been pronounced dead using neurological criteria and are ventilated on a life support machine. This is known as Donation after Brain Stem Death (DBD).
2) patients who are mechanically ventilated with overwhelming single organ failure (usually brain) and a decision has been made to withdraw life-sustaining treatment (WLST). This is known as Donation after Circulatory Death (DCD).

Organ donation is a complex process requiring multi-disciplinary co-operation. Potential organ donors are identified by medical and nursing staff in the above units and subsequently referred to the on-call organ donation team. It is imperative that potential donors are identified and referred to NHSBT in a timely manner.

All organ donor activity, including potential donors, is monitored via the PDA. This national audit commenced in 2003 as part of a series of measures to improve the rates of organ donation. The principal aim of the audit is to determine the number of potential solid organ donors in the UK, and to provide information about the hospital practices surrounding donation and how local teams are contributing to this. It provides a breakdown of information, including reasons why some potential donors do not go on to become solid organ donors. All deaths in the Critical Care Unit and Emergency Department are included in the audit which is input to the NHSBT databases for analysis.

It is recommended that the Board:

- Note the report

Key Risks
This report relates to these key risks: • Board Assurance Framework risk 3 - Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
November 2025	Quality Committee	As above	As above
August 2025	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	**Key Issues** The following statistics represent data obtained by Angela (SNOD) for the National PDA. It includes all deaths within the ICU and the ED. The column on the right of the table shows comparator data from the National PDA across the UK. Please note that this data excludes patients over 80 years of age, despite patients aged up to 85 (but not actually 85) being eligible. **Key Figures: Key numbers comparison with National Rates, 1st April 2024 – 31st March 2025**

	DBD	DCD	UK wide PDA data 2024 – 2025
Patients meeting OD referral criteria	7	28	6880
Referred to NHSBT	7	27	6486

Referral rate %	100	96	94
Neurological death tested	2	-	1356
Testing rate %	29	-	72
Eligible donors	1	8 (3 missed referrals, the rest unsuitable)	4982
Family approached	1	5	2911
Collaborative approach with SNOD	1	4	2672
% collaborative approaches	100	80	92
Consent ascertained	1	3	1713
Consent rate	100	80	59
Actual donors	1	3	1398
% of consented that became actual donors	100	100	82
Missed potential	0	3	-

As shown in the table above 35 patients met the criteria for referral to NHSBT. Considering absolute contraindications, a known expressed decision of opt-out on the organ donation register (ODR), screening out on assessment by the SNOD team and clinical deterioration post consent, meant 9 patients were potentially eligible donors. Of these, 4 patients went on to have their end-of-life decisions to donate honoured. This resulted in 11 life-saving transplants:

- 1 person received a heart transplant
- 3 people received a liver transplant
- 6 people received a kidney transplant
- 1 person received a rare multi-visceral transplant, including: stomach, pancreas, spleen, small bowel and colon
- 1 person donated their heart for valves
- 3 people donated their corneas (6 in total)

The figures include all possible patients from the ICU and ED; all referrals came via the critical care team. The numbers highlight the successful collaboration between the ICU team, SNOD and Transplant Teams. The previous introduction of a referral reminder in the ICU morning safety huddle continues to maintain our high referral rate. Local consent rate figures are adjusted to account for known decisions not to donate and identify when deemed consent has been obtained.

The low rate of neurological death testing (NDT) is multifactorial. 1 family did not want to wait for testing, 1 patient was too unstable to test, in 1 case ancillary testing was inconclusive, 1 patient had an absolute contra-indication and in the final case, the patient was declined by the SNOD team and the family did not then want to wait for testing.

There have been 3 missed potentials over the previous year, all via the DCD pathway and all from ED although in all instances the ICU team were involved. In one instance there were no beds available on either ICU on theatre recovery to offer neuro-prognostication. In another instance the decision to withdraw life sustaining treatment (WLST) was made by an ICU consultant on the information received from the neurosurgeons at The Walton Neuro Centre in the setting of bed pressures on ICU. This patient was referred to NHSBT after WLST and although they were unable to be considered for solid organ donation, they were referred to Tissue Donation services and went onto donate their corneas. In the case of the third missed potential donor,

	there was no clear documentation as the decision-making process with regards to referral to NHSBT prior to WLST. There are no specific learning points identified, other than to continue to promote awareness of OD in both ICU and ED and to empower all grades of doctors from all involved specialties (ICM, ED and anaesthetics) to challenge decisions to WLST of potential patients prior to referral to NHSBT.
1.2	**Organ Donation Committee** The Organ Donation Committee meets quarterly and is chaired by Dr Steve Ryan. This gives strategic direction to organ donation activity. Angela continues to recruit new ICU link nurses who endeavour to attend meetings, however it can prove difficult for many to attend and so we plan to carry out future meetings both face-to-face and via Microsoft Teams to facilitate attendance. The link nurses play a key role in promoting education and awareness amongst their colleagues and have attended OD study days to increase their knowledge. We continue to raise the public profile of organ donation at WUTH mainly through the ongoing efforts of Paul Dixon, our volunteer. He has continued to raise awareness, promote discussion and increase the numbers of people signing up to the Organ Donor Register on the Wirral. Organ Donation Week runs from Monday 22nd to Sunday 28th September 2025. There will be a stall in the main entrance for the week which Paul will kindly set up and he will see if there are any other NHSBT ambassadors who might be willing and able to help man the stand. We are aiming to run the 'Find the Pink' campaign again. This is a social media-oriented promotion whereby anyone can photograph anything pink and link it to the campaign via multiple social media forums. We will fly the OD flag over the hospital again, as well as having the main entrance lit up pink. Once again, we will liaise with Wirral Borough Council to try and arrange having a council building lit up pink, most likely Wallasey Town Hall. The Race 4 Recipients National Campaign that has run for the last two years is not being run this year. We are continuing to work on the design and creation of the permanent memorial to publicly recognise and acknowledge the patients and families who have generously given the gift of life through organ donation within WUTH. We are working closely with Paul Mason, Director of Estates and Facilities, to pick the location that will best show this memorial off within the setting of the new development at the front of the hospital. We have a local artist whom we have met several times and a provisional design with costings has been suggested. We are planning on meeting with the artist in her studio to finalise the design and costs before putting it to the ODC for sign off. This continues to be supported by the Trust's Chief Executive.
1.3	**Clinical Guidelines** The WUTH Organ Donation Guideline was reviewed and updated, with minimal change, in November 2024. It continues to reflect current national guidance. It is awaiting ratification via the Policy Review Group in October before going live.

2	Implications
2.1	**Patients** At the heart of every potential donation there is a patient. Their wishes, and that of their family's journey and care remains the top priority even after referral to the Organ Donation team. The process is clearly explained, and the family are involved from the very start. They receive support not only from the Critical Care team but also the SNOD involved in the case. They are free to change their mind about whether they would like to explore organ donation at any point, and their wishes are always honoured and respected. A safety huddle occurs every morning on the Intensive Care Unit. It is usually at this point that any patients who may fulfill Brain Stem Death criteria or whom may have treatment withdrawn are identified. Nursing staff as well as doctors are closely involved in the process and if someone requests not to be involved, that is facilitated.
2.2	**People** Organ donation is acknowledged to be a difficult process for staff to go through. It can be extremely lengthy and is usually highly emotive. As such, support is given throughout the entire process by the SNOD involved in each case. There is an opportunity for a debrief after donation and the SNOD and/or CLOD endeavour to liaise with individual members involved in the process. It is recognized that from referral to donation can be well over 24 hours. This in itself is a huge resource requirement as it requires a dedicated Critical Care nurse and bed for the duration, as well as time in theatre if the donation proceeds. The Critical Care Unit and Trust support and help facilitate every donation.
2.3	**Finance** Funding is currently through NHSBT; the SNOD is employed through NHSBT and the CLOD's PAs are funded by NHSBT. The Trust receives a donation from NHSBT for proceeding donors. Funds are currently held in a separate account, spending from which is authorized by the Organ Donation Committee.
2.4	**Compliance** WUTH continues to follow Best Practice Guidance for organ donation and is audited annually via the NHSBT PDA.

3	Conclusion
3.1	Performance in organ donation is compliant with CG135 and is within acceptable national targets in many of the key metrics measured. There continues to be a small number of missed potential donors, however there is no recurrent theme, and the overall referral rate is comparable to National rates and once consent is obtained all our patients went on to donate.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 23**
3 December 2025

Title	Learning from Deaths Report (Q1 2025-2026)
Area Lead	Dr Nikki Stevenson, Joint Chief Medical Officer & Deputy CEO
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q1 2025-26.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to May 2025 is 1.02 (within expected range)
- HSMR on the latest available data is 104.2 (within expected range)
- Telstra Health have flagged a CUSUM Alert for deaths "Other disorders of the stomach and duodenum"
- The Mortality review group (MRG) is a multidisciplinary group that meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstra Health data to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and via the Divisional Quality Boards. Specific learning points are also fed back to relevant Trust wide steering groups.

It is recommended that the Board:

- Note the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.

Key Risks

- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

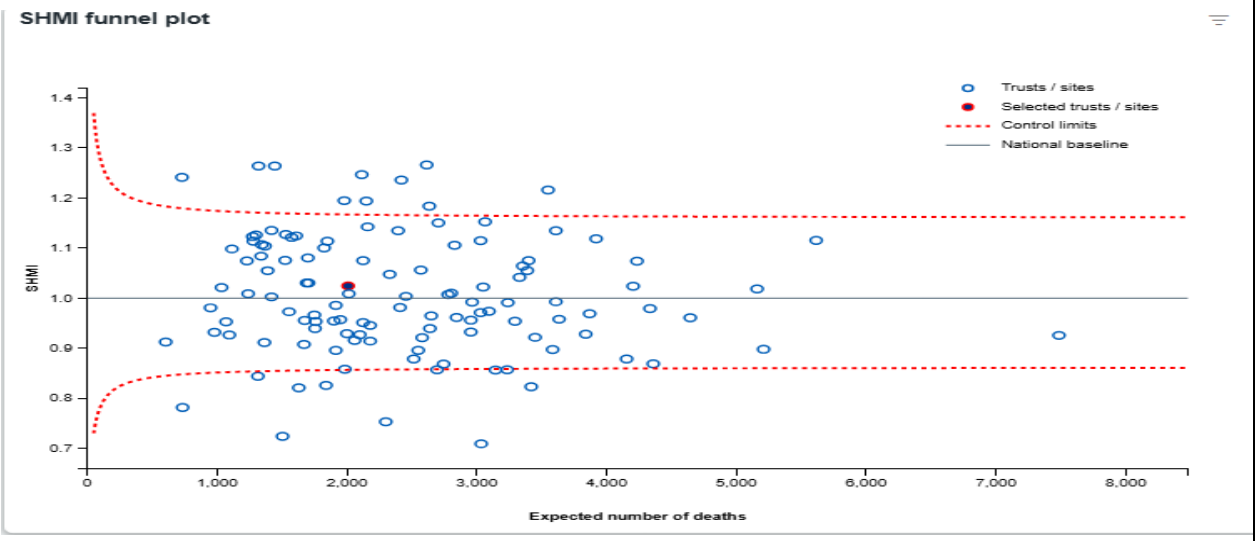
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes

Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospital NHS Foundation Trust over Quarter 1 2025-26. It aims to identify key learning points, trends, and areas for improvement to enhance patient safety and care quality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare and benchmark against mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide an indication of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random sample of non-escalated deaths (approx. 5% per quarter) are selected for a “quality assurance” mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group, and by the circulation of this report through Divisional Quality Boards. **Patient demographics** There was a total of 430 deaths in Q1 25-26. Most recorded deaths are in the over 70 age group and the vast majority fall into the “White British” Ethnic band. This is in keeping with previous quarters. **Mortality Comparators** Summary Hospital Level Mortality Indicator (SHIMI)

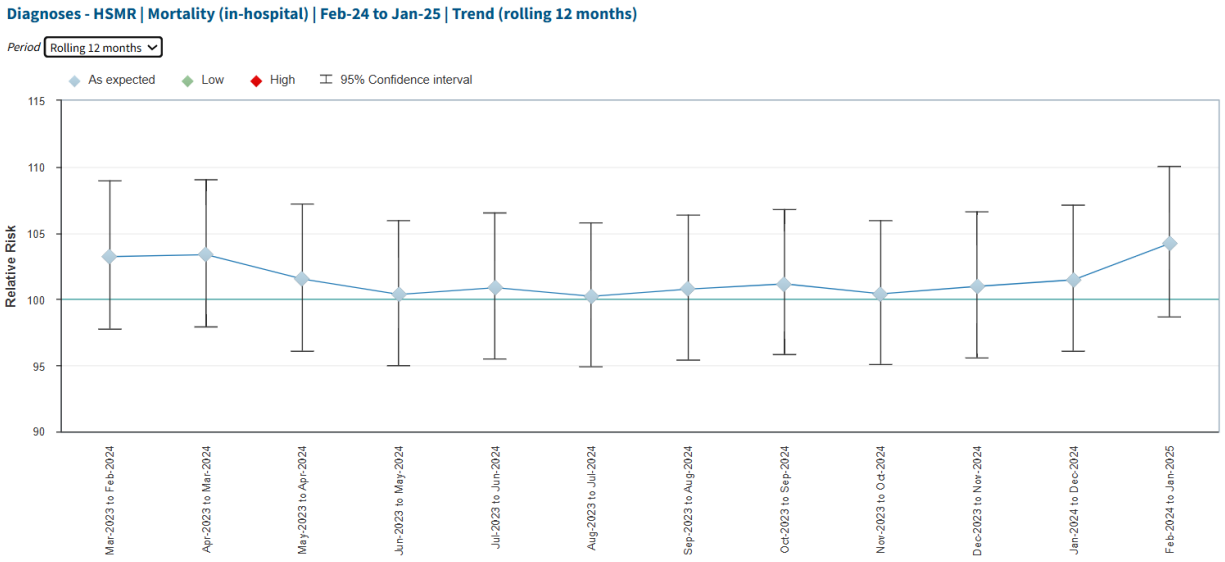
The overall SHIMI for WUTH on the latest available data (12 months to January 2025) is 1.02 which is within the “as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

There are no individual diagnostic groups highlighted as statistical outliers for the latest reporting period



<u>Hospital Standardised Mortality Ratio (HSMR)</u>

The HSMR on the latest 12 months rolling trend is at 104.2 This is in the expected range, but there has been an upward trend over the past 2 quarters (to Feb 25)



Further analysis of HSMR has show 3 main areas that are contributing to this upward trend

1. Palliative care coding is higher for WUTH than peers
2. Lower than expected coding for “Frailty” that impacts HSMR
3. Deaths in the diagnostic group “ Other disorders of the stomach and duodenum” are higher than expected for the prevous 12 months. Deaths in this group are being reviewed by MRG

Mortality Dashboard

The medical examiners (MEs) continue to maintain scrutiny of all WUTH deaths and escalate cases where potential concerns are identified.

15 cases escalated by the ME service during Q1 have been allocated for review using our Mortality Review form. 6 of these cases were in deaths in patients with a recorded Learning Disability.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 28 deaths were allocated for review in Q1 (6%) using the PMR template.

Summary of all Adult in patient deaths and case reviews					
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q2 (24-25)	436	100%	16	32	48
Q3 (24-25)	471	100%	14	27	41
Q4 (24-25)	487	100%	15	26	41
Q1 (25-26)	430	100%	15	28	43

Grading of Adult Care and avoidability following review in Q1 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, affected outcome
Number of cases	19	3	0	0

During Q1 21 reviews were discussed at MRG and graded as above.

During Q1 there were 6 deaths reported for patients with a recognised learning disability. All 6 will be reviewed through MRG as well as being referred to the national LeDeR programme.

Learning Disability Mortality Reviews			
	Total No. of LD Deaths	No. reviewed	Referred to National LeDeR Programme
Q2 (24-25)	5	5	5
Q3 (24-25)	1	1	1
Q4 (24-25)	4	4	4
Q1 (25-26)	6	4	6

Perinatal and Neonatal deaths

All Neonatal deaths are discussed in a monthly neonatal mortality review meeting attended by Consultants, Nurse Managers, Advanced Neonatal Nurse Practitioners, trainee doctors and senior neonatal nurses. A standardised review template is used to

collate information relating to the inpatient care. The deaths are then further reviewed using the PMRT which is a review that supports external attendance from Obstetricians, Neonatologists and Midwives.

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q2 (24-25)	0	3	3	3
Q3 (24-25)	4	5	4	9
Q4 (24-25)	2	2	0	4
Q1 (25-26)	1	2	4	3

All neonatal deaths and stillbirths will be reviewed using the PMRT process
The 3 of the 4 paediatric deaths were out of hospital unexpected deaths, and all 3 are being investigated under the SUDIC process

Outcome of PMRT reviews reported in Q1 (each PMRT is graded for 3 elements)				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	2	4	2	1

3 PMRT reviews were finalised during Q1 and graded as above.

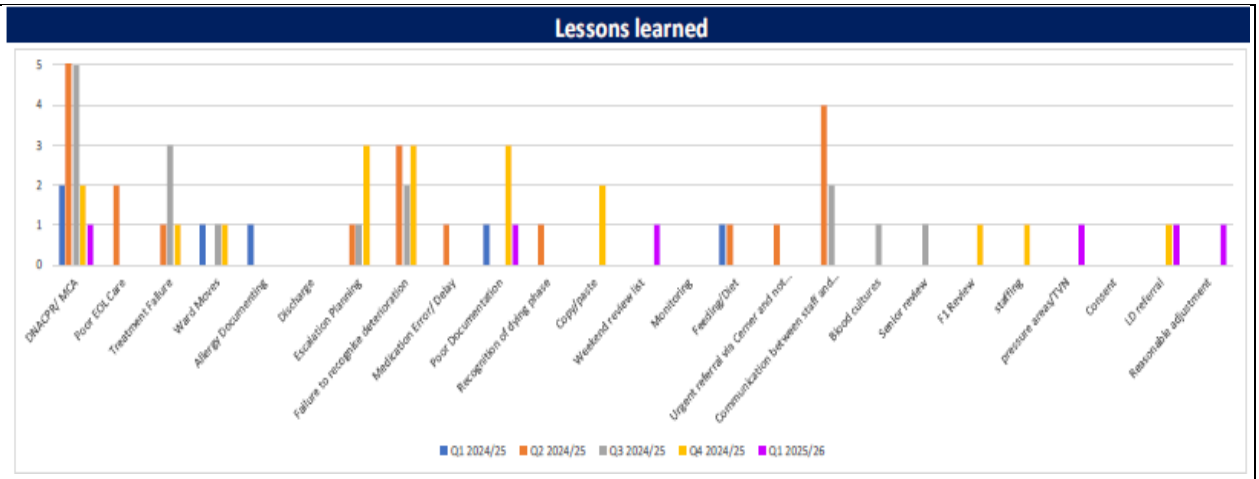
The C/D elements relate to care in another organisation prior to transfer to WUTH, and delays in NWAS transferring a patient to a maternity unit. There was one element related to bereavement care provided on maternity ward rather than the bereavement suite. This has been shared with the department and an action plan developed to monitor the required improvements

Learning identified through review of mortality reviews during Q1.

Learning for mortality is derived from 3 main sources.

- Mortality reviews (collated into a learning log)
- Themes and trends escalated from the Medical Examiner
- Learning identified through the PSIRF process.

General learning themes from mortality reviews are collated on a learning tracker and shared across Divisions for learning



External Benchmarking Data

Telstra Health Data

The Telstra Health (formerly Dr Foster) dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality.

During Q1 a CUSUM alert was generated for deaths due to “other disorders of the stomach and duodenum”. Six patients are being reviewed to see if any lessons learnt. This is being coordinated through MRG

Conclusion

- Mortality Indicators remain in the “as expected” category, although HSMR has shown an upward trend in recent months.
- MRG continues to meet every 2 weeks to scrutinise and review mortality across the Trust
- The Medical examiner service continues to provide 100% scrutiny of all inpatient and Emergency Department deaths
- A CUSUM alert was generated in disorders of the stomach and duodenum. This will be further investigated through MRG

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Board of Directors in Public **Item 24**

03 December 2025

Title	Learning from Deaths Report for Quarter 1 2025-26
Lead Director	Dr Nikki Stevenson, Chief Medical Officer
Author	Dr Ranjeev Mehra, Interim Medical Director
Report for	Approval

Executive Summary and Report Recommendations
The purpose of this paper is to assure the Board of Directors regarding the quality governance systems regarding learning from deaths and to seek approval in relation to the publication of the learning from deaths appendix on the Trust website. The report details the number of cases reviewed and any relevant learning identified.
It is recommended that the Board of Directors: • Is assured by the content of the report and approves it for publication

Key Risks
This report relates to the following key risks: Strategic Risk ID01 – Failure to deliver services safely and responsively to inclusively meet the needs of the population.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives	
Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	No

People	Choose an item.
Improve the wellbeing of our employees	No
Better employee experience to attract and retain talent	No
Grow, develop and realise employee potential	No
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
24/11/2025	Quality Committee	Learning from Deaths Report Q1 2025-26	Approved for progression to Board of Directors

1	**Narrative**
1.1	This quarterly report provides evidence that learning from deaths is embedded as a priority across the Trust, ensuring full adherence to the NQB Learning from Deaths framework. It provides anonymised details of the numbers of unexpected deaths which have occurred within the Trust throughout Q1 2025-26, along with a summary of any thematic learning identified during investigation into these cases. All deaths reported to the Trust in Q1 have flowed through the Trust's governance processes. There were no deaths that were associated with gaps or omissions in care delivery. Learning was identified and actions plan developed in lines with safety systems learning.

2	**Implications**
2.1	**Quality/Inclusion** Identification of learning and assurance around robust quality processes to review mortality.
2.2	**Finance** Not applicable.
2.3	**Compliance** This report ensures compliance with NQB Learning from Deaths framework.

3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Not applicable If Yes, please select all of the social value themes that apply: Community engagement and support ☐

	Purchasing and investing locally for social benefit ☐ Representative workforce and access to quality work ☐ Increasing wellbeing and health equity ☐ Reducing environmental impact ☐

Wirral Community Health and Care NHS Foundation Trust

Mortality Report: Learning from Deaths
Quarter 1: 01 April 2025 – 30th June 2025

Purpose

1. The purpose of this paper is to provide assurance to the members of the Quality and Safety Committee in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. During Q1 there were a total of 8 deaths investigated through the mortality group structure at WHCT. This includes a total of 5 child deaths, all of which were reviewed using SUDIC methodology.

3. Of the 8 deaths only 1 occurred in a patient under the care of WHCT. The others were deaths that occurred in the community.

4. During Q1 there were 0 deaths which met the criteria for StEIS reporting.

5. Each death investigated during Q1 has been analysed to identify if any care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

6. Of the total deaths reported in Q1, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Learning was identified as a result of safety systems review; this was discussed and shared at service level and reported to Clinical Risk Management and Mortality Review Groups, with any learning shared wider as appropriate.

Background

7. Wirral Community Health and Care NHS Foundation Trust (WCHC) Board recognises that effective implementation of the Learning from deaths framework (National Quality Board, March 2017), is an integral component of the Trusts' learning culture, driving continuous quality improvement to support the delivery of high-quality sustainable services to patients and service users.

8. The National Quality Board (NQB) Learning from Deaths framework (2017) exists with the specific aim to address the key findings of the CQC report, ensuring a consistent approach to learning from deaths across the NHS, assuring a transparent culture of learning by delivering a commitment to continuous quality improvement, particularly in relation to the care of vulnerable people.

9. The key findings of the CQC report were as follows:

   - Families and carers are not treated consistently well when someone they care about dies.
   - There is variation and inconsistency in the way that system partners become aware of deaths in their care.
   - Trusts are inconsistent in the approach they use to determine when to investigate deaths.
   - The quality of investigations into deaths is variable and generally poor.
   - There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

10. Since 2017 the focus on learning from preventable deaths and unexpected deaths has continued to strengthen and the NHSE developed the Patient Safety Strategy in 2019 which describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

11. The National Safety Strategy has been pivotal introducing a Patient Safety syllabus, Patient Safety Specialists, and Patient Safety Partners. All of which have been embedded within the governance of the Trust.

12. Patient Safety and Incident Reporting Framework (PSIRF) is embedded within our Trust. It sets out the NHS approach for effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is embedded within our Clinical Risk Management group and Mortality Review group.

13. Learning From Patient Safety Events (LFPSE) is designed to capture events where:

    - A patient was harmed or could have been harmed
    - there has been a poor outcome, but it is not yet clear whether an incident contributed or not
    - risks to patient safety in the future have been identified
    - good care has been delivered that could be learned from to improve patient safety.

WCHC Learning from deaths governance framework

Policies

14. Learning from Deaths Policy (GP58); It provides a framework for how the Trust will evaluate those deaths that form part of our mortality review process, the criteria for review and quarterly and annual reporting mechanisms.

15. Incident Management Policy (GP08). This cross-references the Learning from Deaths Policy, ensuring a consistent approach to implementation, and includes the process to follow in the event of an unexpected death of a patient.

16. The Trust's Datix incident reporting system has been aligned to the Learning from Deaths Policy to ensure prompt communication to the Executive Medical Director, Chief Nurse and Deputy Chief Nurse for all reported unexpected deaths.

Process

17. All reported deaths which have occurred in a place where we are commissioned to deliver services, are discussed at both the Quality and Governance Safety Incident Review Group (SIRG) and the fortnightly Clinical Risk Management Group (CRMG). Further investigations are commissioned based on the events surrounding the death and the results of the Mortality Screening Tool. The principles around Duty of Candour are also overseen within this group.

18. The Mortality Screening Tool considers whether a variety of factors were present. Examples include:
    - Receipt of an End-of-Life advance care plan (PACA)
    - Presence of a DNACPR form
    - Association with failed visits
    - Association with rescheduled visits
    - Concerns raised by any party regarding the care provided prior to death
    - The involvement of other services involved prior to death
    - Medical Cause of death (if known)

19. Commissioned investigations are monitored at CRMG against progress and timelines. Any investigation reports and associated action plans are approved at CRMG. This includes cases which are under investigation by the coroner.

20. Thematic learning from Learning from Deaths cases is reviewed at the Trust's quarterly Mortality Review Group which is chaired by the Executive Medical Director and who is responsible for the Learning from Deaths agenda.

21. Minutes from the Mortality Review Group are submitted to the Quality and Safety Committee and to the Board by exception.

22. A report is produced which summarises the details of the deaths which have occurred within the preceding quarter, along with details of any thematic learning. This is ratified by the Quality and Safety Committee prior to being presented to Public Board, again on a quarterly basis.

23. The Trust continues to work with our system partners to devise systems whereby Learning from Deaths can take place in a consistent way across all major health and social care providers. This includes working with the UK Health Security Agency and the Local Authority to analyse the effect of COVID-19 by utilising a population-based approach to identify areas of inequality and its association with deaths due to this disease.

24. The Learning from Deaths report is based on the template devised by the National Quality Board. This report will be published on the Trust's website in keeping with our statutory obligations.

Child Deaths

25. Given the extensive geography that WCHC delivers Children and Young People's services, there are now robust processes in place which enable every unexpected child death to be identified within all the localities we deliver care. This includes Wirral, East Cheshire, St Helens & Knowsley.

26. The membership of the Mortality Review Group includes the Trust's Child Death Overview Panel (CDOP) representative and the Trust's Head of Safeguarding enabling, the visibility of any thematic learning across the whole of Cheshire and Mersey. The membership is regularly reviewed to ensure it contains a variety of skills and knowledge to maximise the identification of learning.

27. The Trust has links with each Place-based Child Death governance structures, which facilitates the identification of themes over a large geography and then uses this data to reflect on how WCHC can continuously improve the delivery of its Children and Young People services. Services.

28. The Trusts Named CDOP representative is an active participant of the multi-agency Place-based Sudden Unexpected Death in Childhood (SUDIC) meetings and feeds any intelligence and learning into the Mortality Review Group. When our representative has any concerns then these are escalated and raised with system partners.

29. The Mortality Review Group will receive the Child Deaths Annual reports when they become available.

Bereaved Families

30. Families will be treated as equal partners following a bereavement and will always receive a clear, honest, compassionate and sensitive response in a supportive environment and receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.

31. Families are informed of their right to raise concerns about the quality of care provided to their loved one and their views help to inform decisions about whether a review or investigation is needed.

32. Families will receive timely, responsive contact and support in all aspects of an investigation process, in line with duty of candour and with a single point of contact and liaison.

33. Families are partners in an investigation to the extent, and at whichever stages, that they wish to be involved and voice their experiences of the death of their loved one, as they offer a unique and equally valid source of information and evidence that can better inform investigations.

National Medical Examiners

34. Medical Examiner officers at hospital trusts now provide independent scrutiny of almost all non-coronial deaths occurring in hospitals. All deaths in England and Wales are independently reviewed either by a Medical Examiner or a coroner. Medical Examiners provide an important safeguard.

35. The Department for Health and Social Care (DHSC) published details of the death certification reforms and are now in place since April 2024. Primary legislation was commenced on 1 October 2023. The new death certification process requires all deaths in England and Wales to be independently reviewed either by a medical examiner or a coroner.

36. Our local NHS host trust for this function is Wirral University Teaching Hospital NHS Trust. We have created agile and secure access for medical records to allow the Medical Examiner to fulfil their role.

Q1 25-26 WCHC Reported deaths (Datix incident reporting)

37. During Q1 there were a total of 8 deaths reviewed, including 5 child deaths. Only one of these deaths occurred in a patient under direct care of WHCT services (CICC)

38. During Q1 there were 0 deaths which met the criteria for StEIS reporting.

Structured Judgement Reviews:	
Total Number of Deaths in scope	8
There are no outstanding cases from the previous quarter (Q1)	
Total Number of Deaths considered to have more than 50% chance of being avoidable	0
LeDeR reviews: - Please note that these are undertaken by the mental health trust	
Total Number of Deaths in scope	0
Total Deaths reviewed through LeDeR methodology	0
Total Number of deaths considered to have been potentially avoidable	0
SUDIC reviews:	
Total Number of Child Deaths	5
Total Deaths reviewed through SUDIC methodology	5

Summary of thematic / other Learning for Q1

39. Each death reported during Q1 has been analysed and investigated appropriately, to identify if care provided by the Trust resulted in harm or contributed to the death, and if any relevant learning exists for the Trust and the wider health and social care system.

40. There were no trends or themes identified during the review of deaths. Of the total deaths reported in Q1, after investigation, none of these were caused by gaps or omissions in care provided by the Trust. Each death was reviewed at service level and via the Clinical Risk Management Group (CRMG), and Mortality Review Group. Learning opportunities were highlighted, discussed and shared. This included:

- Review of action cards for CICC when patient is deceased

Recommendations for Quality and Safety Committee

41. The Quality and Safety Committee is asked to be assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy.

42. The Quality and Safety Committee is asked to be assured the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths.

Dr Ranjeev Mehra
Interim Medical Director WHCT

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Board of Directors in Public **Item 25**

03 December 2025

Title	Controlled Drug Accountable Officer's Annual Report 1 April 2024- 31 March 2025
Lead Director	Dr Nikki Stevenson, Chief Medical Officer
Author	Ranjeev Mehra - Interim Medical Director & Trust CDAO With contributions from Lisa Knight- Lead Pharmacist
Report for	Assurance

Executive Summary and Report Recommendations

This report from the Trust's Controlled Drugs Accountable Officer (CDAO) covers the period 1 April 2024 to 31 March 2025 and provides assurance that the Trust is compliant with updated controlled drug legislation and that controlled drug systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs safety and governance.

This Controlled Drug Annual Report is required, as the Trust Board is accountable for the safe management of controlled drugs via the CDAO. It is therefore essential that the Board receives assurance.

The report outlines:

- Standard operating procedures are in place and based on best practice surrounding the management and control of Controlled Drugs (CDs)
- CD prescribing is audited, and appropriate challenges are in place
- The handling of CDs within services is audited
- Incidents involving CDs are investigated and learning is put in place
- Incidents are reported to the regional CDAO via the local intelligence network to which the Trust is an active member

It is recommended that the Board of Directors:

- Is assured that controlled drugs are handled safely across the organisation.

Key Risks
This report relates to the following key risks: During the reporting period there was one risk on the Trust risk register that related to CDs ID 3167. This risk related to the unavailability of over-labelled medicines for end-of-life symptom control to supply to patients in the community. The current risk score has reached its target of 6 (unlikely likelihood, moderate consequences). The risk is now archived. This is because the Trust has procured suitable over-labelled stock of medicines for end-of-life care.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

Contribution to WCHC strategic objectives	
Populations	Choose an item.
Safe care and support every time	Yes
People and communities guiding care	No
Groundbreaking innovation and research	No
People	Yes
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	No
Place	Choose an item.
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
24 November 2025	Quality & Safety Committee	Controlled Drug Accountable Officer's Annual Report 1 April 2024-31 March 2025	Assured

1	Narrative
1.1	Accountability for the safe management of controlled drugs sits with the Trust Board via the Controlled Drugs Accountable Officer (CDAO). This report from the Trust's CDAO provides assurance that the Trust is compliant with updated controlled drugs legislation

	and that controlled drugs systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs safety and governance.

2	Implications
2.1	**Quality/Inclusion** This report is designed to assure the Quality and Safety Committee and the Board, that CDs are handled appropriately throughout Trust Services.The report lists the Trust policy and medicines related procedures which when followed will optimise patient care for all patients including those in protected groups.
2.2	**Finance** n/a
2.3	**Compliance** This report will not affect compliance with legislation, however following the listed policy and procedures will promote compliance with legislation surrounding controlled drugs.

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Not applicable If Yes, please select all of the social value themes that apply: Community engagement and support ☐ Purchasing and investing locally for social benefit ☐ Representative workforce and access to quality work ☐ Increasing wellbeing and health equity ☐ Reducing environmental impact ☐

Wirral Community Health and Care
NHS Foundation Trust

Controlled Drug Accountable Officer's Annual Report

1 April 2024- 31 March 2025

Introduction

1. Accountability for the safe management of controlled drugs sits with the Trust Board via the Controlled Drugs Accountable Officer (CDAO). This report from the Trust's CDAO provides assurance that the Trust is compliant with updated controlled drugs legislation and that controlled drugs systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs safety and governance.

Responsibilities

2. The 2013 Controlled Drugs (Supervision of Management and Use) Regulations outlined the requirement for NHS Trusts to appoint a Controlled Drug Accountable Officer. The Controlled Drug Accountable Officer (CDAO) is a statutory role responsible for ensuring the following:

   - Standard operating procedures are in place, based on current legislation and best practice surrounding the management and use of controlled drugs (CDs).
   - Adequate destruction and disposal arrangements are in place for CDs.
   - CDs are used safely and effectively throughout the Trust.
   - The management and use of CDs is audited.
   - Relevant individuals receive appropriate training surrounding the use and handling of CDs.
   - A system is in place to assess and investigate incidents regarding the use and handling of CDs and appropriate action is taken.
   - CD incidents are reported to the regional CDAO via the local intelligence network to which the Trust is an active member.

The next sections describe activity relating to each of these duties.

Standard operating procedures are in place, based on current legislation and best practice surrounding the management and use of controlled drugs (CDs).

3. The policy for the Safe Handling and Administration of Medicines (GP11) is applicable to all Trust services that are involved in the handling of medicines. This policy includes sections outlining safe handling of CDs within Trust Services.

4. In addition, the Trust has a suite of procedures that outline expected standards for handling of CDs within Community Nursing, GP Out of Hours, Community Dental Service, Community Intermediate Care Centre (CICC), Teletriage, Community Integrated Response Team (CIRT) and the Community Specialist Palliative Care Team.

5. The procedures incorporate best practice as outlined by NICE guidance NG46, Controlled Drugs: Safe Use and Management 2016. This guidance outlines expected standards for storing, transporting, disposal, prescribing, supply and administration of CDs.

   All the guidance documents are in date.

   A full list of Trust procedures relating to CDs can be found in appendix 1

Current legislation surrounding safe handling of CDs is considered and incorporated into Trust guidance if applicable.

6. The Trust is required to comply with current legislation surrounding safe use and handling of CDs. The Controlled Drugs (Supervision of Management and Use) Regulations 2013, outlines how CDs should be handled throughout the organisation. (NICE Guidance NG46, Controlled Drugs: Safe Use and Management 2016 is in line with these regulations.) There were no changes in legislation during the reporting period that required amendment to Trust policies or procedures.

Adequate destruction and disposal arrangements are in place for CDs

7. The Trust has two current procedures specifically for disposal of CDs:

   MMSOP28 - Standard Operating Procedure for Witnessing the Destruction of Controlled Drugs within Community Trust Services.

   MMSOP17 - Destruction of Patients' Own Controlled Drugs in the Community.

   In addition, MMSOP56 - Safe Handling and Administration of Medicines within Community Intermediate Care Centre includes specific guidance on disposal of patients' own CDs that are no longer required and have not been returned to the patient on discharge.

   MMSOP59- Safe Handling and Administration of Medicines within Urgent Community Response and Wirral Frailty Ward also includes a section on CDs, instructing practitioners to never remove CDs from patient's homes and only in exceptional justifiable circumstances to destroy CDs in line with MMSOP17.

   Guidance for removal and destruction of illicit substances, is included in the Trust' security management policy HS18.

   These procedures provide staff with guidance which when followed, ensures CDs are denatured prior to appropriate destruction. The procedures are compliant with current legislation and best practice.

The Management and Use of CDs is Audited to Evidence the Safe Use of CDs

8. In June 2018 the government published the findings of investigations into the earlier than expected deaths of patients within a community hospital in Hampshire, “The Gosport Independent Panel”. The report identified that patients had received inappropriately high doses of opioids delivered via syringe driver. Since the publication of this report, the CQC has required healthcare organisations to evidence that their patients only receive appropriate opioid dosing, titrated to each individual patient’s needs.

9. Opioid medication administered within community nursing is prescribed by the patients’ GP. Community nurses are responsible for reporting inappropriate dosing and titrating doses to individual patient needs. During 2024, a member of the specialist palliative care team performed a retrospective review of 40 patient records who received end of life care via community nursing in 2023. Records were scrutinised to identify if initial doses were appropriate and if escalating doses were within the recommended maximum of up to the equivalent of 30% of the previous daily dose. The audit findings showed that patients generally received dosing in line with guidance. No major concerns were identified. The Specialist Palliative Care Service plan to repeat this audit during 2025 to ensure continued safe use of opioids.

10. A member of the Medicines Management Team conducted face-to-face audits of the handling of CDs within services that held stocks of CDs. In addition, the in-patient wards at CICC were audited (CICC do not hold stock CDs, but store controlled drugs that have been individually prescribed for patients). The audits identified that services generally followed agreed procedures, completion of the few actions identified were monitored via the Medicines Governance Meeting.

11. Controlled drug prescribing continued to be audited by reviewing ePACT prescribing data. Controlled drug prescribing data for the Trust was presented each quarter at the Medicines Governance Group. Most controlled drug prescribing occurred within GP Out of Hours and the Urgent Treatment Centre. Trust procedure dictate that quantities should be sufficient only to allow the patient time to obtain further supplies from their own GP. ePACT data was therefore reviewed to identify any prescribing of larger than expected quantities which were then challenged and fed back to the prescriber via line management.

12. ePACT data was also reviewed to identify any prescribing that was out of scope for the service or individual prescriber. During the reporting period a prescription for methadone was identified as been prescribed by a doctor within GP Out of Hours. Trust Urgent Primary Care services are not commissioned to prescribe medication for drug dependent patients as this is provided by a specialist service external to the Trust. Following the audit, all prescribers within GP Out of Hours were reminded that GP Out of Hours should not prescribe methadone or other medication for addiction but rather signpost patients to the specialist service.

13. There were anecdotal reports of community pharmacies directing out of hours requests for methadone to GP Out of Hours, the Tust were able to share information with community

pharmacies instructing them how to correctly signpost opioid dependent patients in need of support.

14. The quantity of CDs prescribed within the Trust was also compared to the prescribing of CDs in other community trusts by utilising CD benchmarking data. It was noted that the Trust was not an outlier for the prescribing of controlled drugs.

15. ePACT data does not include information on individual consultations therefore, to scrutinise the controlled drug prescribing data further, bi-monthly audits of SystmOne records were undertaken to ensure appropriate quantities were prescribed and the prescribing was appropriate for the indication.

16. During the reporting period, there were two audits of gabapentinoids (gabapentin and pregabalin), three of co-codamol. The main findings noted that there were occasions when prescribers prescribed more than the recommended duration of treatment. However, during the second gabapentinoid audit, the pharmacist identified a historic prescribing error that had been continued by the patient's own GP, where a patient with a history of drug misuse was prescribed a total daily dose of 900mg of pregabalin (300mg over the usual maximum dose). On investigation, the dose should have been a total daily dose of 450mg. The patient's GP was alerted to ensure the patient received a medication review.

17. In February 2025, the Medicines Management Team completed the annual CD LIN Assurance framework self-assessment. The framework allowed organisations to reflect on their arrangements for CDs. Following the self-assessment, actions were identified and completed: to update the overarching policy for handling medicines GP11 to include a requirement for the CDAO to share personal identifiable information of individuals of concern where diversion of CDs is suspected with the police, professional regulators or NHS England. In addition, training and procedures were strengthened to ensure all staff were advised how to report concerns of possible diversion of CDs.

Relevant individuals receive appropriate training surrounding the use and handling of CDs

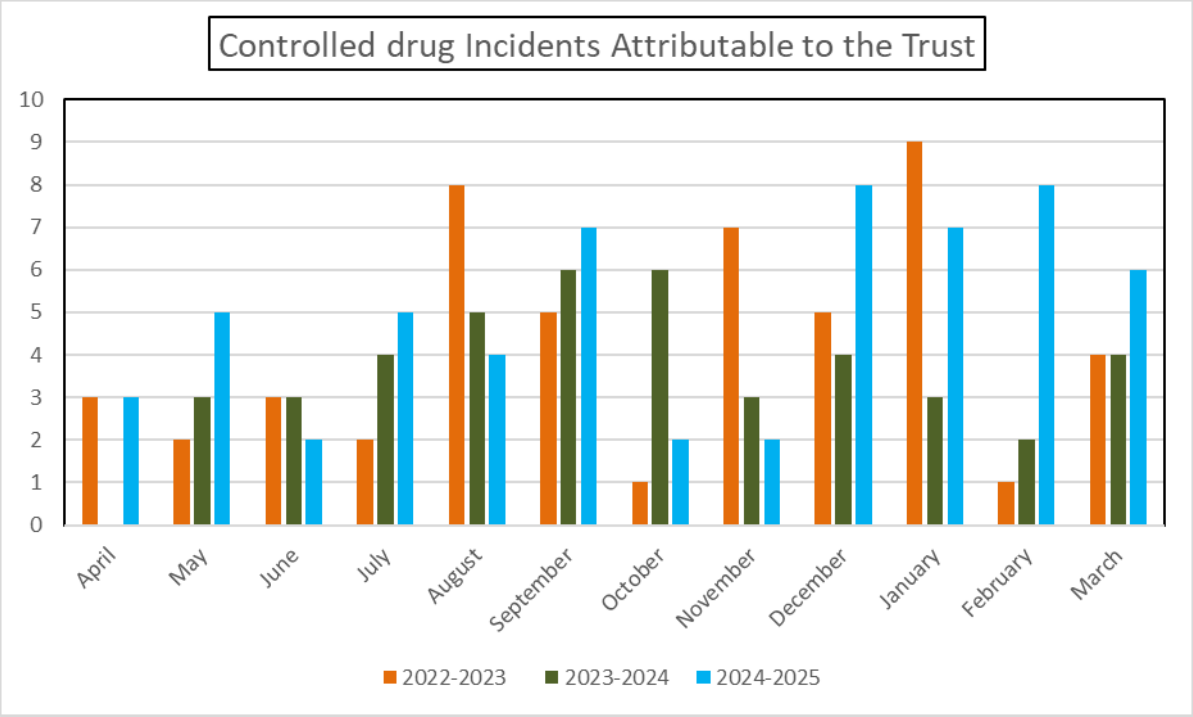
18. Community Nurses when joining the Trust attended end of life training, regular updates on palliative care were also available to staff. Nursing staff were trained to convert oral doses of opioids to equivalent subcutaneous doses and were therefore able to challenge inappropriate dosing. In addition, the handling of controlled drugs was incorporated into mandatory refresher Medicines Management training for community nurses.,

19. The Trust's CDAO and/or a pharmacist from the Trust's Medicines Management Team attended Mersey Regional Local Intelligence Network (LIN) meetings. These meeting are a forum for different health care providers to meet and discuss controlled drug incidents with a view to implement lessons learnt throughout the region. The Trust was therefore kept up to date with current best practice surrounding the handling of CDs.

A system is in place to assess and investigate incidents regarding the use and handling of CDs and appropriate action is taken

20. All medication incidents including controlled drug incidents were monitored via the Medicines Governance Meeting, any outstanding actions following investigations were also monitored via this group.

    The graph below indicates the number of controlled drug incidents reported as being attributed to Trust Services during 2024-2025, Incidents reported 2022-2023 and 2023-202 are included for comparison.



21. There was a total of 59 controlled drug incidents reported during 2024 /2025 (compared with 43 reported 2023 /2024, and 50 reported 2022/ 2023). All the reported CD incidents were low or no harm. The most common theme reported were incidents involved documentation errors with no actual loss of controlled drugs.

22. There were two incidents reported involving continuous subcutaneous infusion of end-of-life medication (CSCI) where there was an underdose of opioid in the syringe driver. In both cases learning was shared with the nursing team. In addition, for widder organisational learning, the procedure for administration of opioids within community nursing was updated to include worked examples of conversions of oral opioid to subcutaneous doses and an article was written in the Trust's Medicines Management Bulletin including further worked examples of dose conversions.

23. In a further incident, a patient was initiated onto CSCI on the same day as starting an opioid transdermal patch of buprenorphine. National and local guidelines state that transdermal patches should not be initiated in patients with unstable pain. Following this incident learning was also circulated via the monthly Medicines Management Bulletin.

CD incidents are reported to the regional CDAO via the local intelligence network (LIN) to which the Trust is an active member

24. The criteria for reporting incidents to CD LIN changed in December 2022. Incidents and concerns were only be reported if the following criteria was met:
    - Real or perceived staff diversion of CDs
    - Real or perceived staff substance misuse of CDs
    - Patients with drug seeking behaviours that might require an NHSE alert to be issued to health and care settings.
    - Severe harm issues

There were two incidents reported to CD LIN during the reporting period:

25. A patient's granddaughter informed community nurses that her boyfriend had stolen some codeine and Lorazepam tablets. The Trust security manager provided a safe to store the patient's medication. The family did not want to report to the incident to police.

26. GP Out of Hours provided end of life medication to a care home where the ampoules were not labelled. The medication was prescribed and supplied for end-of-life care. The patient received appropriate care. Although this incident did not fulfil the criteria for reporting, the lack of labelling contravened the Human Medicines Regulations 2012 and was therefore reported. The incident highlighted a need for appropriately over-labelled packs of ampoules of medicines used for end-of-life care. These packs were sourced from a licensed over-labelling unit and GPs were instructed on their use.

National Recommendations from CQC

27. CQC's Controlled drugs annual update report for 2024, "The safer management of controlled drugs 2024" published July 2025 gives an outline of themes regarding controlled drugs that were identified by CQC inspectors during the calendar year of 2024. The report was scrutinised for relevance to Trust services.

    The following areas were considered relevant to the Trust:

    Recording medicines in patients' own homes

28. The report noted, "There have been instances over the last year of healthcare professionals visiting patients in their own homes but not recording the administration of controlled drugs." The Community Nursing Service regularly administers controlled drugs in patients' homes. There is a robust system in place where any medicines that the service is responsible for administering is stored in a tamper evident Envopak with a numbered tag. Community nurses keep a record of end-of-life medicines received into the home and those administered. This

process is outlined in Trust procedure MMSOP04 Clinical Procedure for McKinley T34 and BD Bodyguard T Syringe Drivers.

Self-prescribing of controlled drugs

29. The report reminded organisations, “Prescribing controlled drugs for personal use or to people who are known personally to the prescriber should not happen apart from in exceptional circumstances.” The Trust procedures currently in place, SOP10 for prescribing within GP Out of Hours and MMSOP14 for non-medical prescribing and safe handling of prescriptions both remind prescribers not to prescribe for themselves, their family or friends. To strengthen further a reminder will be written in the Trust’s Medicines Management Bulletin.

Sharps bins and diversion

30. The CQC report highlighted instances where used sharps bins had been stolen in order to extract any part-used controlled drugs that may have been disposed of in the bin. Trust procedures dictate that unused doses of controlled drugs should be denatured prior to disposal. This means that controlled drugs could not be extracted easily from sharps bins. In addition, Trust advice for disposal of part used doses and ampoules was added to procedures. On the advice of NHS England, staff are now advised to add washing up liquid to the bottom of sharps bins to make it more difficult to extract any controlled drugs. The Medicines Management Team will review where full and part filled sharps bins are stored prior to being picked up by the waste management company as part of their 2025 2026 audit cycle.

Conclusion

31. This report provides an overview of how the Trust has engaged fully with the local healthcare community and the Mersey Regional Local Intelligence Network and carefully considered national learning from CQC inspections, ensuring the governance arrangements surrounding the handling of controlled drugs comply with best practice.

Ranjeev Mehra - Interim Medical Director & Trust CDAO

Lisa Knight - Lead Pharmacist

September 2025

References

Controlled drugs annual update report for 2024 published - Care Quality Commission

The Gosport Independent Panel

Appendix 1

STANDARD OPERATING PROCEDURES (SOPS) AND POLICIES OUTLINING HANDLING OF CONTROLLED DRUGS

The following procedures and policies are available to all staff via the Staff Zone of the Wirral Community NHS Foundation Trust's website

General Policies:

- GP11 Policy for the Safe Handling and Administration of Medicines is applicable to all trust services who are involved in the handling of medicines. The policy includes sections on the following:

    - Administration of Controlled Drugs
    - Disposal of Controlled Drugs
    - Ordering Controlled Drugs from Wirral University Teaching Hospital
    - Receipt of Controlled Drugs
    - Storage of Controlled Drugs
    - Controlled Drugs stock reconciliation
    - Procedure for missing Controlled Drugs

Community Nursing Procedures:

- MMSOP04 Standard Operating Procedure for McKinley Syringe Driver for Administration of Palliative Care Medicines

- MMSOP09 Standard Operating Procedure for Transport of Prescribed Controlled Drugs

- MMSOP17 Standard Operating Procedure for Destruction of Patients' Own Controlled Drugs in the Community

- MMSOP18 Standard Operating Procedure for Administration of Opioid Medicines

GP Out of Hours

- MMSOP34 Standard Operating Procedure for the Management of Controlled Drugs within Primary Care Division

- SOP10 GP Out of Hours Prescribing Policy (This procedure outlines appropriate prescribing of controlled drugs within GP Out of Hours)

Specialist Palliative Care Team

- MMCP07 Clinical Protocol for Providing Specialist Palliative Care Medicines Advice from the Integrated Specialist Palliative Care Team

- MMCP13 Clinical Protocol for Non-Medical Prescribing within Palliative Care

Community Dental Services

- MMSOP21 Standard Operating Procedure for the Administration of Intravenous Midazolam for Conscious Sedation.

- MMSOP41 Procedure for the Administration of Oral, Buccal or Intranasal Midazolam for Premedication prior to Dental Conscious Sedation

- MMSOP37 Standard Operating Procedure for the safe and secure management of Midazolam within Community Dental Services

Community Integrated Care Centre (CICC)

- MMSOP56 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Care Centre. This procedure includes a section on the management of controlled drugs within the centre. All controlled drugs are prescribed for individual patients, there are no stock controlled drugs held on the unit.

Community Intermediate Response Team (CIRT)

- MMSOP59 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Response Team (CIRT). This procedure includes a section on CDs highlighting the fact that CDs must never be removed from patient's homes.

Trust Wide

- MMSOP28 Standard Operating Procedure for witnessing the destruction of Controlled Drugs within Community Trust Services

- MMSOP120 Remote Prescribing Policy

Compassion Open Trust

NHS
Wirral Community Health and Care
NHS Foundation Trust

Board of Directors in Public **Item 26**

03 December 2025

Title	EPRR Core Standards Annual Self-Assessment Assurance Process
Lead Director	Hayley Kendall – Joint Executive Managing Director
Author	Mick Blease – LSMS/Emergency Planning Lead.
Report for	Assurance

Executive Summary and Report Recommendations

The Trust is required to complete an annual self-assessment against 58 core standards that are attributed to community providers. This process has now been completed and provides an overall percentage compliance of 97% with an overall assessment of "Substantial Compliance

It is recommended that the Board:

- To provide assurance to Board of Directors that the Trust has completed the annual EPRR core standards assurance process.

Key Risks

There are no risks associated with this report.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	No
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	No

People	
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	
Improve the health of our population and actively contribute to tackle health inequalities	No
Increase our social value offer as an Anchor Institution	No
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
24 November 2025	Quality & Safety Committee	EPRR Core Standards Annual Self- Assessment Assurance Process	Assured

1	Narrative
1.1	The annual EPRR core standards self-assessment process has been completed by the EPRR lead. The process identified full compliance against 56 of the 58 assessed standards and partial compliance against the remaining 2. This provides an assessment rating of “Substantial Compliance” with 97% compliance. The self-assessment process has been subject of a check and challenge process with the C&M ICB EPRR team who have confirmed the self-assessment.
1.2	An action plan has been developed to address the two standards assessed as partial compliance.

2	Implications
2.1	**Quality/Inclusion** The core standards self-assessment process does not differentiate between individuals including any of the protected groups.
	Quality & Equality Impact Assessment completed and attached Not applicable
2.2	**Finance** There are no financial implications to this policy.
2.3	**Compliance** This policy supports the Trust Compliance with the following legislation:- The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England

3	The Trust Social Value Intentions
3.1	Does this report align with the Trust's social value intentions? Not applicable If Yes, please select all of the social value themes that apply: Community engagement and support ☐ Purchasing and investing locally for social benefit ☐ Representative workforce and access to quality work ☐ Increasing wellbeing and health equity ☐ Reducing environmental impact ☐

Wirral Community Health and Care
NHS Foundation Trust

EPRR – Core Standards

Annual Self Assessment - 2025

Purpose

To provide assurance to the Quality and Safety Committee that the Trust has completed the annual core standards assurance process and to report that a rating of **"Substantially Compliant"** has been reached in the process.

Compliance level	Definition
Fully Compliant 100%	The Trust is fully compliant with all core standards – No actions required
Substantially Compliant 89% - 99%	The Trust is compliant with 89% - 99% of the assessed core standards. – For each non-compliant core standard, the Trust board has agreed an action to meet compliance within the next 12 months.
Partially Compliant 77%-88%	The Trust is compliant with 77% - 88% of the assessed core standards. – For each non-compliant core standard, the Trust board has agreed an action to meet compliance within the next 12 months.
Non-Compliant <77%	The Trust is compliant with 89% - 99% of the assessed core standards. – For each non-compliant core standard the Trust board has agreed an action to meet compliance within the next 12 months. This action plan will be monitored on a quarterly basis to demonstrate progress towards compliance.

Background

NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The assurance process requires the Trust to undertake a self-assessment against the core standards.

As a community provider the Trust is asked to self-assess against 58 pre-determined standards.

Self-Assessment Process 2024

The self-assessment process for 2024 provided an overall assessment of "Partial Compliance" and an overall compliance rating of 86%. An action plan was developed in order to address the 8 standards that were not fully compliant. This action plan has been subject to oversight by the Quality and Safety Committee.

Self-Assessment Process 2025

The self-assessment process for 2025 has now been completed by the EPRR lead. The initial self-assessment has been subject of a check and challenge process conducted by the Cheshire and Merseyside ICB EPRR Team prior to submission to NHS England.

As a result of the self-assessment submitted and the associated evidence provided, the ICB has agreed that WCHC has an overall assessment of "Substantially Compliant" and an overall compliance percentage of 97%.

The below table outlines the self-assessed compliance status of the 58 core standards that are applicable to a community trust and which domain the standard belongs.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	10	10	0	0
Total	58	56	2	0

There are two standards that have been assessed as "**Partially Compliant".**

Standard 33 relates to Warning and Informing and specifically to identify how the Trust will provide 24-hour communication and support to On Call managers.

This is a standard that many providers are unable to evidence full compliance with as it requires on on-call mechanism for communication staff. Work will continue with other providers to ascertain if something can be done on a system based footing to provide that 24-7 support that the standard dictates.

Standard 49 states that the Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

MIAA has conducted its annual assessment of the Trust to certify the toolkit. The assessment identified a small amount of improvement required to achieve full compliance. An action plan has been developed to address these areas in order to achieve full compliance at the next assessment which will take place in June 2026.

A new action plan to address these two core standards has been developed by the EPRR lead that will address these standards to ensure that Wirral Community Health and Care

NHS Foundation Trust is fully compliant for the 2026 process. This action plan will be monitored through the Quality and Safety Committee. The action plan is included at **Appendix A**

A summary of the Cheshire and Merseyside area performance is included at **Appendix B**

The full self-assessment process is included at **Appendix C** (Excel).

ICB Check and challenge process findings is included at **Appendix D** (Adobe)

Deep Dive

There was no Neep Dive element to this year's core standards assurance process.

Recommendation

1. The quality and Safety Committee is assured that the trust has completed the annual EPRR core standards self-assessment assurance process and that an overall compliance of "**Substatial Compliance"** has been agreed with the ICB which equates to a level of 97%.

Name: **Mick Blease**

Job Title: **LSMS/EPRR Lead**

Date: **20th October 2025**

Appendix A

Wirral Community Health and Care NHS Foundation Trust

Action Plan Template
KEY (Change status)

1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented

Action plan lead	EPRR Core Standards 2025/26– Mick Blease

	Actions required and Core Standard Targeted	Completion date	Person responsible	Change stage	Description of current position	Evidence of Completion
1	Explore any integration merger opportunities with WUTH to support a 24/7 trained support for On call Managers. Liaise with other providers in the Wirral place to identify what other Comms support systems are in place and possibilities of a place response. **CS33**	01.03.2026	MB/FF			
2	Complete DSPT Toolkit Improvement plan as developed following the MIAA DSPT audit conducted June 2025 **CS 49**	01.06.2026	KC/PL			

Appendix B

Trusts	Compliance Level	Compliance Trend from 2024/25	Fully compliant standards	Partially compliant standards	Non-compliant Standards	Overall compliance percentage
Alder Hey	Partial	Increased	50	12	0	81%
Countess of Chester	Substantial	Increased	56	6	0	90%
East Cheshire	Partial	Maintained	49	13	0	79%
Liverpool University	Substantial	Maintained	58	3	1	94%
Mersey & West Lancashire	Substantial	Increased	60	2	0	97%
Mid Cheshire	Substantial	Increased	60	2	0	97%
Warrington and Halton	Partial	Increased	53	9	0	85%
Wirral University Hospitals	Substantial	Increased	59	3	0	95%
Specialist Trusts						
Clatterbridge Cancer Centre	Substantial	Maintained	57	2	0	97%
Liverpool Heart and Chest	Substantial	Increased	56	3	0	95%
Liverpool Women's Hospital	Partial	Increased	51	7	1	86%

The Walton Centre	Non	Decreased	37	17	5	63%
Community and Mental Health Trusts						
Bridgewater	Partial	Maintained	48	10	0	83%
Cheshire and Wirral Partnership	Substantial	Increased	53	5	0	91%
Mersey Care	Substantial	Maintained	57	1	0	98%
Wirral Community ICB	Substantial	Increased	56	2	0	97%
NHS Cheshire and Merseyside	Substantial	Increased	43	4	0	91%

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	1, 2,	Fully compliant				The Trust has appointed Dr Joanne Chwalko as the Accountable Emergency Officer. Joanne is the Chief Operating Officer for the Trust. The Trust is currently engaged in major change process with a "Merger by Acquisition" (WUTH) under way . The role of AEO is outlined in the JD (1) of the CFO, however as a result of the aforementioned process the CFO role is now a joint role across both organisations and the AEO responsibilities passed to the COO as an interim measure. New executive roles including the AEO will be announced in Mid-October 2025. The role of the AEO is also outlined in the Trust EPRR Policy GP52 at item 5.6 of the policy. (2).
The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	2	Fully compliant				The Trust EPRR Policy was Reviewed February 2025. (2) The Policy outlines Roles and Responsibilities including AEO in Section 5. The Trust governance structure model is included at Appendix 5. Page 1 and 2 outlines the review schedule and version control. Section 6 of the policy outlines the process including risk assessment. Section 8 of the policy references EPRR Training and Exercising requirements. Following the review of core standard submission 2024 the role of Head of rocurement has been enhanced at section 5.13. The role of the Operation Cammander Role is included at section 6.5 and Appendix 6 includes the HSSR TOR dated January 2025.
The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	3, & 4	Fully compliant				The EPRR Lead presented the EPRR Annual Report to Public Board on the 4th June 2025. Item 30 is referenced in the Agenda (4) for that meeting. The Annual Report (3) outlines in section 2 of the report summarises training and exercising that staff have participated in during the year. Section 3 of the report outlines the response to incidents and the lessons identified during those incidents.
The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	2, & 3	Fully compliant				The Trust EPRR Training and Exercise programme is included in the Annual EPRR Report (3) and commences on Page 14 of that report. Exercising and Training is referenced in the Trust EPRR Policy at Section 8. (2)

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	2 & 3	Fully compliant				The Annual Board Report (3) at section 1.8 advises the board on the EPRR Trust resources and budgets and that they are continually being assessed. The Trust EPRR Policy (2) at Section 5 outlines the roles and responsibilities of EPRR Resources. Section 5.19 of the policy references EPRR governance Structure. The Trust Governance Structure, including EPRR, is included at Appendix 5 of the Policy. The Health Safety Security and Resilience Group Terms of Reference is included at Appendix 6 of the report. EPRR Financing covered at section 6.7 of the EPRR Policy
The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	2,5,6 and 7.	Fully compliant				Section 8 of the EPRR Policy (2) discusses capturing lessons identified from incidents and exercises etc. A monitoring tool is included at Appendix 4 of the policy. The EPRR lead attends the tactical LHRP meetings for C&M and contributes towards the continuous improvement programme. (5) Evidence to support WCHC involvement is included in a Lessons Identified Tracker. Following the Core Standards submission for 2024 the Trust EPRR lead completed an Action Plan to address areas where issues were identified. That plan has been monitored through Quality and Safety Committee on a bimonthly basis (6). Further evidence to support the Trust commitment to continuous improvement is included in the Debrief reports prepared and submitted at regional exercises. An example is produced in response to Exercise Kaus Austailis. (7)
The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	2, 8, 9, and 10.	Fully compliant				The Trust has a policy which outlines Risk Identification and Management, GP45. (9) The policy describes the Trust's approach to the timely and effective management of Risks across the organisation, including EPRR risks. Section 5.17 of the policy outlines the EPRR Risk Management process. The policy is due for review February 2028. All risks are included on the Trust Datix System and managed through this system. EPRR specific and Inherent Risks are included in this system. Cognisance of the community Risk Register is taken which forms the basis of the inherent risks. Included in the evidence bundle are screen shots from the front page (10) of the following Inherent Risks for Adverse Weather Risk ID 2990 and Cyber Security Risk ID 2844. Section 6.1 of the Trust EPRR Policy GP52, (2) references the Risk Assessment process. All risks are subject to a monthly audit Tracker that identifies compliance. The monthly report is shared with the chairs of the Trusts four oversight groups. The August Monthly tracker is included as evidence (12)

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	2, 8 & 10.	Fully compliant				The Trust has a policy which outlines Risk Identification and Management, GP45. (8) The policy describes the Trust's approach to the timely and effective management of Risks across the organisation, including EPRR risks. Section 5.17 of the policy outlines the EPRR Risk Management process. Section 6.1 of the Trust EPRR Policy GP52, (2) references the Risk Assessment process. All risks are subject to a monthly audit Tracker that identifies compliance. The monthly report is shared with the chairs of the Trusts four oversight groups. The August Monthly tracker is included as evidence for April 2025 (10)
Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	2, 11, &13	Fully compliant				The EPRR Policy GP52 (2) clearly describes at section 6.2 that In developing organisational plans consideration will be given to the Local Resilience Forum community risk register and associated plans, the scope of operational delivery considering resource and capacity requirements of the organisation and the wider heath economy. And that consultation with both internal and external stakeholders relevant to the scope of the plan. Evidence of Collaborative Planning is provided with the signed MOU (11) between the Chair and Co Chairs of the LHRP and all 15 AEO's from the Cheshire and Merseyside ICB. The MOU key principle states that NHS Cheshire and Merseyside is empowered to use and or call upon such relevant resources as may be necessary from any one or all eighteen of the signatories within the Local Resilience Forum areas of Cheshire and Merseyside, in response to a Business Continuity, Critical or Major Incident. Further evidence of collaboration is provided by the Wirral Place Winter Planning Slide Deck from January 2024 (16). The presentation evidence collaborate partnership working between WCHC, WUTH, NWAS, Primary Care, and the Local Authority led care market. The Trust Major Incident Plan (18)

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In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	13, 14, 15, & 16	Fully compliant				The Trust Major Incident Plan (13) is reviewed annually. The reviewed document forms part of the Trust annual EPRR report where Quality and Safety Committee are asked to approve the document. The latest version of the plan was approved in June 2025. V15 and outlines the Command-and-Control structures for the Trust. All aspects of compliance are referenced in the document. Comments from the NHSE Core Standards Check and Challenge process have been reflected in this latest version and action cards have been updated to reflect updated terminology. The plan has also been updated to include reference to Joint Decision Model. The latest evidence where the Major Incident Plan was tested is provided during exercise Coborn 30th May 2025. The slide deck for the exercise is located at (14) In addition, evidence is provided on how the Trust supports acute discharges. The Home First Daily Sitrep (19) identifies where the Home First team supports the discharge process. The Trust is represented on the Daily System call that discusses system pressures. The Trust supports the system by advising on bed spaces in the Community Integrated Care Centre and home first spaces. Email (20)
In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	.0. 17, 18, 19, 20, 21, 22,& 23	Fully compliant				The Trust has an Adverse Weather Heather Plan (21) and is aligned to National guidelines. The plan was reviewed June 25 Exercise Niveous that was conducted on the 5th December 2023. The plan is linked to risk 2990 (9) Included in the evidence bundle for this care standard is the Exercise Niveous Slide Deck (18) Planning document (19) Attendance Sheet (20) Trust Exercise Planning Guide (21) Example of Ex Niveous Feedback form(22) and Ex Niveous Action Plan (23).
In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	24, 25, 26, 27, 28 & 29	Fully compliant				The Trust has an overarching Infection Prevention and Control Operational Policy IP01 (24). The policy sets out the Trust's approach to IPC and to support maintaining High Standards of infection prevention, reducing the risk of infections to HCAI's and eliminate avoidable infections. The policy was due for review in March 2025 but Quality and Safety Committee have extended this to 01.10.25 in order to maxmise integration opportunities. In Addition to this document the Trust has developed an additional policy Outbreak Management and Isolation Policy(25) . One of the tactics utilised in outbreak management is to establish an Outbreak Control Team. Outbtraks are managed locally in the IPC Database. Screenshots of the database are included as evidence (26)The policy is further supported with UKHSA Community Outbreak Plan (27) and the Trust community Outbreak Plan (28)The plan is a generic plan on how the Trust would support a community outbreak and describes how the Trust would access necessary medicines/vaccinations through WUTH as part of the contract that is in place between WCHC and WUTH. Individual outbreaks may require additional guidance outside the scope of the previously mentioned documents. The latest

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In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	30, 31, & 32	Fully compliant				The Pandemic Response Plan (30) has been reviewed in August 2025. The review takes cognisance of lessons learnt during the covid19 Pandemic and includes reference to the use of Social Distancing. The plan also refers to the NHSE Framework for managing the response to pandemic diseases, produced in July 2024. The WHO state that the world is still in a pandemic (Covid19) although this was scaled (31) from an emergency in May 2023 and as a result the Trust is still in a pandemic response state. FFP3 stocks and trained Fit Testers are continually being reviewed. On 6th August 2025 8 members of Trust staff have been trained to FFP3 Fit Testing capabilities. The Trust EPRR lead and an IPC representative attended the system wide exercise Nexus. This was a community outbreak exercise set in an asylum seeking hostel. (32)
In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	13, 27, 28, 33, 34, & 35	Fully compliant				The Trust has developed a Community Outbreak Plan (28) which was last reviewed August 2024. The Plan is generic plan and outlines how the Trust will support the Local Authority, UKHSA etc in the response to an outbreak. The UKHSA C&M Outbreak Plan (27) will support the Trust response to an outbreak plan. The plan highlights that the Trust has a contract (33) with WUTH Pharmacy to provide prophylaxis/vaccinations as and when required. Please see email from Trust Contracts Manager . Guidance on how to access CBRN Countermeasures in included at section 5.11 of the Trust Major Incident Plan (13) . Elements of the Community Outbreak Plan have been tested during 2025 with regards to the Trust Response to a regional measles outbreak plan. Please see Trust Measles Trust Wide Action Plan (34) and Measles preparedness meeting Agenda (35)
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	11, 13, & 36	Fully compliant				As a small Community Trust the response to a mass casualty event is one of a supportive nature. The Trust has two walk in centre's and an Urgent Treatment Centre. The three are not specifically referenced in the NWAS Regional Mass Casualty plan (36). The three locations would support with the reception of P3 patients and self presenters. The Major Incident Plan (13) outlines our mutual aid response at section 1.6.4. The Trust is a signatory to the recently produced Cheshire and Mersey EPRR MOU (11) which has its key principle as NHS Cheshire and Merseyside is empowered to use and or call upon such relevant resources as may be necessary from any one or all eighteen of the signatories within the Local Resilience Forum areas of Cheshire and Merseyside, in response to a Business Continuity, Critical or Major Incident of which would include a Mass Casualty event.

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In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	37, 38,39, 110, 111	Fully compliant				The Trust has an Evacuation and Shelter Standard Operating Procedure reviewed July 2024 (37). The review included the inclusion of a Patient Tracker Form and the latest guidance issued 2023. The evacuation element is tested regularly as port of the Fire Safety strategy. The latest evacuation was tested as part of a table top exercise at the CICC on the 21st March 2025 (38) This was done in line with the Fire Risk Assessments for the three wards at CICC. (39). In addition to this all staff are required to complete a fire safety induction process which outlines the ecvacuation process. Please see example at (111). Each of the three wards has a
In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	40,41	Fully compliant				The Trust has a lockdown Plan (40) The plan was tested in December 2024 at St Catherines Health centtre. An After-Action Review was conducted of the exercise (41) The Lockdown plan is owned by the Local Security Management Specialist.
In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	42	Fully compliant				VIP visitor Plan in place (42) This was developed and first approved July 2024 in consultation between LSMS and Communications team. The document has been reviewed in July 2025 and no ammendments have been necessary.The plan includes VIP's and other individuals that may attract a media interest who are patients.
The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	43,44 & 11	Fully compliant				WCHC is a small community Trust and has no direct involvement in the regional management of mortuaries as described in the Mortuary Capacity and Contingency Plan etc and does not have a specific role in the multiagency arrangements for excess deaths and mass fatalities. During a surge in deaths the Trust will support the system by alleviating the pressures on others with our verification of deaths process. Clinical Procedure 50 (43) outlines the process to verify the expected death of an adult in a community setting. This procedure was last reviewed June 2024. Training is provided to all community nursing teams in order to proficient in this process. (43) The Trust is a signatory to the recently produced Cheshire and MERSEY EPRR MOU (11) which has its key principle as NHS Cheshire and Merseyside is empowered to use and or call upon such relevant resources as may be necessary from any one or all eighteen of the signatories within the Local Resilience Forum areas of Cheshire and Merseyside, in response to a Business Continuity, Critical or Major Incident of which would include an excess death event. We will support accelerated discharges from acute settings into the community to free up capacity and support flow through the ED and into the acute setting. As

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The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	2, 13, 44,45,46,47,48,49,50,51,52	Fully compliant				he On Call Mechanisms are fully described in the Trust EPRR policy at section 6.6 (2) and describes the two tier On call Mechanisms with the first port of call being the Tactical On Call Manager and the Strategic on call acting as the escalation level of the On Call. The mechanisms are further described in the Major Incident Plan at sections 2.6.3 and 4.3 (13). ICB Escalation details are also included in the MIP at section 4.7.1. The Trust has conducted two On Call communication exercises during the past year. The exercises are entitled Exercise Alexander and tested all On Call arrangements in the Trust and were conducted in December 2024 and June 2025. Please see evidence which includes Exercises Planning documents (45, 48) Exercise Debrief reports (47) (50) Exercise performance (46) (49). All On Call support documentation is included in the Trust on call pack which includes rotas which are managed by the EPRR lead. Please see screen shots at Evidence (51). On Call Managers utilise the Trust Datix system to record and manage on call incidents. On Call Log screenshot (52)
Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	2, 13, 53, 54, 55, 56	Fully compliant				The Trust utilises an EPRR Training Needs Analysis (53)This captures the training required for On Call Managers, Strategic and Tactical in line with the National Minimum Occupational Standards. The TNA also captures the training for other roles including the EPRR lead and staff involved in decontamination procedures. All On call managers are provided with On Call training delivered by the EPRR lead prior to the commencement of performing the role. The latest On Call Manager recruited to the Strategic Rota is Robbie Chapman who received training on the 6th June. (54) The On Call Training slides are included at (55). All On Call Managers have attended the Training session "Principles of Health Command". Please see example of attendance certificate. (56) Attendance details included in TNA. The EPRR Policy (2) includes a full list of EPRR Skills for Justice NOS requirements at Appendix 1. The Policy also includes at section 6 Command and Control arrangements which includes On Call procedures. Training and Exercising is included at section 8. The Major Incident Plan (13) discusses the role of Incident Commander at Section 2.6.1. Section 5 outlines the ICC process including the establishing, staffing, and

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The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	2, 3, 53, 54, 55, 59, 60, 61, 62,	Fully compliant				Section 8 of the Trust EPRR Policy (2) outlines the EPRR Training and Exercising requirements for the Trust to remain enabled to deal with an emergency and to continue to deliver the services it is employed to do so. The Policy at Appendix 1 also includes Skills For Justice National Occupational Standards relevant to EPRR roles. This is supported by the EPRR Training Needs Analysis (53) The TNA amongst other training requirements includes Decontamination Training. Please see the Training slides (62) which is delivered to likely first responders to a CBRN/HAZMAT incident delivered by the EPRR lead. An example training attendance record is included at (61). On Call Manager training slides are included at (55). This training is delivered by the EPRR lead. Please see example attendance sheet at (54). Loggist training is also delivered by the EPRR lead. On 30th July 2025 a loggist refresher training session was conducted. Please see training slide deck at (59) & Loggist attendance sheet (60). All Trust On call managers have received Training on the Principles of Health Command. Details included in the TNA (53) and Example certificate at (56) The Trust Annual EPRR Board report (3) informs Board on the training and exercising that has
In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	3, 7, 14, 41, 45, 46, 47, 48, 49, 50, 63, 64, 65,	Fully compliant				The Trust has conducted two communication exercises in the past year. Exercise Alexander Dec 24, The planning, Ex Report and debrief can be found at (45, 46, & 47) and Exercise Alexander June 25 The planning, Ex Report and debrief can be found at (48, 49, 50). The Trust conducted aCBRN Table Top Exercise Coborn in June 2025 2023. The Exercise Planning document, presentation and debrief sheet is included at (14, 57 & 58) The Trust conducted a live Lockdown Exercise at its St Catherines Health Centre in December 2024. The after Action Review is included at (41). The Trust Command Post was tested as part of its response to the Industrial action that affected the Trust in January 2023. (63). The Trust participated in Exercise Kaus Australis (July 2025) a table top exercise to test the Business Continuity Plans in response to a National Power Outage. A pre exercise workbook session was facilitated by the EPRR lead with On Call managers which highlighted current responses and lessons idetified. The completed workbook can be found at (64). Th planning document and exercise debrief report can be found at (65 & 7) The Trust Exercise schedule is include in the Annual EPRR board report. (3)

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The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	2, 3, 53, 54, 56, 59, 60, 61, 62	Fully compliant				Section 8 of the Trust EPRR Policy (2) outlines the EPRR Training and Exercising requirements for the Trust to remain enabled to deal with an emergency and to continue to deliver the services it is employed to do so. The Policy at Appendix 1 also includes Skills For Justice National Occupational Standards relevant to EPRR roles. This is supported by the EPRR Training Needs Analysis (53) The TNA amongst other training requirements includes Decontamination Training. Please see the Training slides (62) which is delivered to likely first responders to a CBRN/HAZMAT incident delivered by the EPRR lead. An example training record is included at (61). On Call Manager training slides are included at (55). This training is delivered by the EPRR lead. Please see example attendance sheet at (54). Loggist training is also delivered by the EPRR lead. A loggist refresher training course was delivered on the 30th July 2025 (59 & 60) . All Trust On call managers have received Training on the Principles of Health Command. Details included in the TNA (53) and Example certificate at (56) The Trust Annual EPRR Board report (3) informs Board on the training and exercising that has taken place during the previous 12 month. The report also includes the
There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	66	Fully compliant				As a result of a gap identified in this core standard for the 2024 self assessment it was necessary to review the Trust induction Toolkit. The induction process supports the EPRR programme and ensures that staff are aware of their role in an emergency and where to find plans that are relevant to their own area of work or department. Specific reference is also mention of the service Business Coninuity Plan and reference to relevant policies.
The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	2, 13, 66, 67,	Fully compliant				The Trust has a Main ICC located at SCHC and a backup ICC located at Albert Lodge at VCHC. The ICC is referenced in the EPRR Policy GP52 (2) at section 6.5. There is a dedicated Standalone ICC Development Plan (70) which included all the details necessary to set up the ICC. This includes Maps/plans of the ICC's and testing and training. The main ICC has been located at SCHC as these premises have a power back up in the form of a generator and can continue to operate in the time of a loss of power. The ICC provision also has a dedicated section within the Trust Major Incident Plan (18). Monthly checks are conducted in the ICC on equipment (71).

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Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	2, 69, 70, 71,	Fully compliant				All Planning Documents are included on the Staff Intranet Known as StaffZone. (70) In Addition plans are included in the On Call pages as part of the On Call Pack. (Please see screenshot (69). Hard copies of the MIP are included in the ICC. Photograph (71). The EPRR Policy (2) at Sections 6.4 describes how plans are available on the staff Intranet and in the ICC. all EPRR exercises OCM's Are encouraged to download plans to desktop on laptop computers to add additional resillience in this area.
In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	13, 72,	Fully compliant				The Major Incident Plan (13) Section 7 discusses how the Trust Maintains BC and provides an Overview of BC. The Business Continuity Policy has been produced. (69) The Policy references the ISO 22301 (Plan Do Check Act) as its basis for BC Planning. The Policy references Escalation at 7.8 and Recovery at 7.9. It also covers responsibilities at section 6.
To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	13, 46, 49, 59, 60, 73	Fully compliant				The role of record keeping and the role of a Loggist is included at section 5.7 of the Major Incident Plan (13) The details and phone numbers of trained Loggists are included in the On Call Pack (73). loggists are included in communication exercises conducted in November 2024 and June 25 during exercise Alexander (46) (49). The EPRR lead is a qualified trainer and regularly conducts Loggist training and refresher training. The latest training was conducted on 30th July 2025 which was in the form of a refresher training session. . The attendance sheet is included at (60) The Training slides delivered are included at (59).
The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	13	Fully compliant				The Trust Major Incident Plan (13) Discusses Situation Reports at section 8.2.1 . In summary the Business Operations Team will support with the development of a situation report specific to the incident being experienced at the time. An example of a Situation Report is included at Appendix 4 of the Plan..

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The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	13, 53, 74	Partially compliant	explore any integration merger opportunities with WUTH to support a 24/7 trained support for On call Managers. Liaise with other providers in the Wirral place to identify what other Comms support systems are in place and possibilities of a place response.	Mick Blease	01st January 2026	A Trust Incident Response Communications Plan has been developed. (74) The Plan includes a roles and responsibilities of the Communications and Marketing team at section 5 of the plan. The Structure of the team is outlined at Appendix 4 of the plan. A Communication lead action card is included in the plan at Appendix 1. The plan outlines the role of the Strategic On Call Manager who will be the SPOC for communication issues during out of hours. A number of the Strategic On Call managers have been trained in media skills. This is outlines in section 8 of the plan along with other training requirements. The Trust EPRR Training Needs (53) Analysis (outlines the communication training requirements for On Call staff. The role of ICB Communications is included at section 6.10 of the plan. In Addition to the above there is an action card outlining the role of communications in a Major Incident included in the Major Incident Plan (13). A media enquiry form is included at appendix 2 of the plan. This is utilised to record any media enquiry and to track and record the response to that enquiry.
The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	1, 49, 50, 58, 74	Fully compliant				The Incident Response Communications Plan (74) includes the roles of the communication team at section 5 of the Plan and section outlines the process to be adopted. A Communication lead action card is included in the plan at Appendix 1. Appendix 7 and 8 of the Plan includes prepared "Holding" statements for Patients and Public and for staff. Section 6.11 outlines the role of regional communication teams and how they can support the Trust in the response to an emergency. The plan also includes details for On Call managers on how to access Stakeholders contact details via the Trust T Drive at section 6.7. of the plan. As part of Exercise June 2025 thre Trust head of communications and Marketing was successfully contacted. They were also willing to come to site to form part of an IRT if the exercise dicated (49) and (50) . The Communication and Marketing lead was present during Exercise Coborn and contributed to the exercise with advice and Comms actions (58). In Addition to the Action Card described in the IRCP the role of the Communications in an Incident Management Team is outlined in an action card included in the Major Incident Plan (13)

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The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	74	Fully compliant				The Incident Response Communications Plan (74) includes at section 6 the process in communicating with staff and stakeholders. It outlines on how staff should be updated as soon as possible and the options available on how to communicate including internal methods and social media platforms. Examples of Website and StaffZone alerts are included at Appendix 5 and 6 of the plans. The Communication Lead Action Card at Appendix 1 describes how the lead should ensure (as far as practicable) that Patients, their Relatives and carers should be kept informed about an incident and how it may affect them prior to learning about it in the media. A full list of stakeholders and partner organisations is included in the On Call pack for managers to access as and when required. The link is included in the IRCP at section 6.7. As part of the response to any emergency incident he Communications team will link in with other communication teams with in the region, including the ICB in order to ensure, that where applicable, consistent communications are being delivered during an incident.
The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	53, 74, 75, 76	Fully compliant				The use of social media in the Trust is governed by the Social Media Standard Operating Procedure SOP 59 (75) and further governed by the Media Standard Operating Policy SOP58(76). These SOPs describe how social media should be used by all employers of the Trust and how it is monitored. Both of these SOP's are in date with review dates of August 2025. The Incident Response Communications Plan (74) provides specific details at section 6.6 of the accounts relevant to the Trust that can be used as communication platform during a major incident including X formerly known as Twitter, and Facebook accounts. The Plan states that the Strategic on call managers will be the identified SPOC for requests to comment or interview during an incident. The Trust has developed a pool of Trust spokes people who form part of the Strategic On Call and have received Media Skills Training. (53)
The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	77	Fully compliant				During the year the AEO role Changed from the CFO post to the COO. This is reflected in the COO JD. The Trust has achieved a 100% attendance record for all Strategic LHRP's during the past year. (77)
The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	78, 79	Fully compliant				The Trust is represented at the Merseyside LRF by a member of the C&M ICB EPRR Team. All relevant information is cascaded back to the Trust EPRR lead in a timely fashion. The ICB EPRR team produces a weekly update to EPRR leads providing highlights their engagement with the Local Resilience Forums. Please see Weekly updates for 04th July and 01st August. (78) and (79).

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The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	11, 13, 80, 81	Fully compliant				EPRR Mutual Aid arrangements are included in the Trust Major Incident Plan (13) at section 1.6.4. The recently developed C&M EPRR MOU (11) signed by all Trust AEO's underpins how and when the Trust will provide and request that additional Mutual Aid. Further evidence is included in the C&M Mutual Aid Agreement process (80) The agreement outlines the process to be adopted by commanders, Tactical or Strategic, to request additional support during an emergency. This process was tested sucessfully when a request was made by Alder Hey EPRR team to support the Measles outbreak June 2025. WCHC were able to assist with the loan of a Fit Testing portacount device. (81)
The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	82, 83, 84, 85, 86, 87	Fully compliant				The Trust has a number of policies that support information sharing including the overarching Information Governance Policy IG01 (85), Freedom of Information Policy IG09 (86) and the Data Protection Impact Assessment IG21 (87). For sharing with none NHS organisations we will complete a DPIA and ISA if its us sharing. For NHS organisations where we are sharing information as a data set or for non direct care purposes we will complete a DPIA as the legally required document but not an ISA. Example DPIA (83)– . Pop Health (working in GP practices as part of a MDT to provide care to individuals identified as high risk frailty and 2. a pilot between our Home First Service and INW (82). Example ISA (84)– 1. between ourselves and WUTH as we share care so share information of a specific cohort of patient routinely when we are providing dental surgery after WUTH have provided general anaesthetic and 2. St Helens Family Hubs sharing (safeguarding)
The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	88	Fully compliant				The Trust has a Business Continuity Policy - GP62 (88). The Policy includes a strategy statement at section 2 of the policy which outlines the commitment of the Trust in having in place robust Business Continuity Management Systems in order to minimise any disruption to its services. The process for BC utilises the Plan Do Check Act methodology and references ISO 22301 at Section 7 of the Policy. Section 6 of the Policy outlines the responsibilities and accountabilities which includes the CEO and Board of Directors.

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The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	88	Fully compliant				The Trust Business Continuity Policy (88) fully outlines its approach to the Business Continuity Management process that establishes, implements, operates, monitors, reviews, maintains and improves business continuity. The policy identifies the prioritised activities which include Community Nursing, Urgent Treatment Centre and Walk-In Centre's, the Community Integrated Care Centre and the Community integrated Response Team. The BCM processes are fully outlined in Section 7 of the Policy. The roles, responsibilities and Accountabilities in the business continuity management are included at Section 6 of the Policy. That process includes the development of service level Business Continuity Plans at Section 7.6 of that Policy. The service level plans are signed off by the Service Level Directors. The risk assessment element of the policy is included at 7.6 and stresses the duty that on the Trust to continually assess the risk of business continuity interruption. Each BCP includes details of who is responsible for invoking a BCP. The escalation process is included at 7.8 of the policy. Section 9.1 of the policy outlines the training and support in relation to BCMS and specifically references how all new recruits will be made aware of the Trusts BCM arrangements.
The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially	88	Fully compliant				The Trust Business Continuity Policy (88) references the prioritised services it delivers at Section 4 of the policy under the Business Impact Analysis and includes Community Nursing, Urgent Treatment Centre and Walk-In Centre's, the Community Integrated Care Centre and the Community integrated Response Team. Each service produces a business continuity plan which includes the assessment of the services it delivers and if critical or not. Section 7.10 of the Policy highlights the requirement of an annual review process as a minimum and also to review if a plan has been invoked, Significant changes to staff, change in the service being delivered and/or the location in which it is being delivered from.

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The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	88, 89, 90, 91, 92, 93, 94	Fully compliant				The Trust BC Policy GP62 (88) outlines thoroughly at section 7 the process to be adopted when developing service level BCP,s referencing the ISO 22301, Plan do check Act ethos. Section 7 also describes the management process of a BC incident and the invoking of a BC plan including the Triggers for activation, Escalation Process and recovery. Section 9.3 outlines the requirement of the EPRR lead to support Service Level Business Continuity Leads in the development of BC Plans. A training session was delivered to BC Leads in January 2024. Please see Training Slides at (089) and Lesson Plan at (090) . The BC Policy includes at Appendix A the BC Template to be adopted by all services. This template was modified by the EPRR lead for 2024 and includes a section to declare if the service is described as a Critical Service. All plans are included in the On call managers Pack. The monitoring of the BC Policy is included at section 10. All plans are reviewed annually and this process is managed by the EPRR lead. Example service Level BC Plans are included at (91) the Dental BCP 2025 and (92) The Community Nursing BC Plan 2025. Business Continuity Management is also included in Section 7 of the Major Incident Plan. (13) A
The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	2, 3, 7, 14, 40, 41, 46, 47, 48, 49, 50, 57, 58, 64, 65,94,	Fully compliant				The EPRR Policy GP52 (2) Outlines the Trust Training and Exercising requirements at Section 8 of the Policy and at 8.3 the specific details to achieve compliance in this area. Performance against these standards are included in the Trust Annual EPRR Report (3) at Section 2. Exercises included in the past 12 months include Exercise Coborn that tested the Trust CBRN(e) plan and service level BCP's Please see evidence at (14, 57 , & 58) this includes the debrief documentation . The Trust also participated in the exercise Kaus Austrailis which was an exercise to test the response to a National Power Outage. Please see vidence at (7, 64 and 65). A live lockdown exercise was conducted in December 2024 (40 & 41). Two in house Trust Communication Exercises were conducted during the year under the title of Exercise Alexander. Please see evidence at (45, 46, 47, 48, 49 and 50) MIAA conducted a full review of WCHC EPRR arrangements in February 2025. The overall assurance opinion showed a substantial rating and the statement " There is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently. (94)
Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	99	Partially compliant	Complete DSPT Toolkit Improvement plan	Dave Murphy.	01..06.2026	MIAA has conducted an audit of the WCHC DSPT toolkit which was completed 30th June 2025. Although the Trust was compliantr with the majority of the toolkit there were some areas specifically around procurement and contracts. An improvement plan has been developed in order to address these identified arteas and is included at (99). The rarget date for completion of these actions is in line with the 2026 DSPT toolkit audit.

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The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	3, 88, 93, 94, 101	Fully compliant				The Annual EPRR Report (3) submitted to board includes reference to BC Performance and Exercising Compliance at Section 2 of the Report and also plan status at Section 1.7 of the report. The Business Continuity Policy (88) GP62 outlines the monitoring process of the policy at Section 10 and a Monitoring tool is included at Appendix C of the policy. The BC Audit process is outlined in the 2024/25 Audit report at (101). MIAA conducted a full review of WCHC EPRR arrangements in February 2025. The overall assurance opinion showed a substantial rating and the statement " There is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently. (94) The Service level BCP Compliance table is prodiced (93)
The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	88, 93, 94, 101,	Fully compliant				The BC Policy (88) outlines the audit requirements at Section 7.10 of the policy. A full BCP Audit was copleted in December 2024 and the report is included at (101). MIAA conducted a full review of WCHC EPRR arrangements in February 2025. The overall assurance opinion showed a substantial rating and the statement " There is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently. (94) The Service level BCP Compliance table is prodiced (93). Performance in thjis area is included in the annual EPRR board report. (3)
There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	2,7, 14, 41, 45, 46, 47, 48, 49, 50, 57, 58, 64, 65, 94	Fully compliant				The Trust EPRR Policy (2) t section 8.4states how the Trust will capture lessons identified from Incidents and Exercises. The Policy also discusses the roles and Responsibilities of the Health Safety Security and Resilience Group in the monitoring of this area at Section 5.5. The Business Continuity Policy (88) also discusses Lessons identified at section 9.4. At 7.10 of this policy the reviewing process of the individual BCP.s Examples of Action plans and debriefs following Incidents and exercises can be seen as follows. A lockdown exercise took place in December 2024. A debrief took place following the exercise and an After Action Review is produced (41) Exercise Coborn that tested the Trust CBRN(e) plan and service level BCP's Please see evidence at (14, 57 , & 58) this includes the debrief documentation . The Trust also participated in the exercise Kaus Austrailis which was an exercise to test the response to a National Power Outage. Please see vidence at (7, 64 and 65). Two in house Trust Communication Exercises were conducted during the year under the title of Exercise Alexander. Please see evidence at (45, 46, 47, 48, 49 and 50) MIAA conducted a full review of WCHC EPRR arrangements in February 2025. The overall

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The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	88, 94, 95, 96, 102, 103	Fully compliant				The Trust Procurement Process includes the request for Business Continuity Plans from prospective suppliers as part of any Tender process prior to the award of any contract. Examples include the BCP for Eric Wright who provide the Trust's Soft Facilities Management. (102) and Arrowe Security Servies who provide manned guarding technical security support and alarm response. (96). The process is supported by the Procurement Supplier Questionnaire (103). Section 4.14 Part 3 of the questionnaire relates to Business Continuity Plans. Section 6.14 of the Business Continuity Policy (88) outlines the responsibilities of the Head of Procurement service in seeking assurance of those supplier BC Plans. An audit was completed 28.08.25 on the BCP process for Arrowe Security Service for assurance purposes. That audit provided the necesaary assurance. (95). MIAA conducted a full review of WCHC EPRR arrangements in February 2025. The overall assurance opinion showed a substantial rating and the statement " There is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently. (94)
The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	104, 105	Fully compliant				The Trust has developed a CBRN/HAZMAT plan (104) in line with the CBRN Risk Assessment (105). The Plan identifies the roles and responsibilities at section 5 of the plan which includes reference to the role of AEO. The plan identifies its processes at section 6. The 9itial operational response arrangements are included at Section 8 of the plan. Training and exercising is refenced at section 14 of the plan. The Response maintenance Checklist is included at Appendix 6 of the plan. This is checked on a monthly basis.
Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	105	Fully compliant				A CBRN Risk assessment has been completed (105). The Trust is a small community provider and as such it has not been provided with specific decontamination resources such as suits and structures. The Risk assessment has identified trust premises where there is a potential for self presenters attending who may have been subjected to a CBRN or HAZMAT type incident.
Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	104	Fully compliant				Key and critical specialist advice is included in the CBRN/Hazmat Plan at Appendix 5. (104)

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The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	104, 105	Fully compliant				The Trust has completed a CBRN Risk assessment (105) and identified premises where persons potentially subject of a HAZMAT contamination may present and a plan to address has been developed (104). This Plan was reviewed in June 2025. The plan outlines the decontamination processes to be adopted. The Trust is a small community Trust and as such the CBRN focuses on the risk of self presenters potentially subjected to contamination by a Hazmat. The Trust does not have the facilities available to larger acute settings which is corroborated by the CBRN Risk assessment. The aim of the plan is to respond to CBRN/HAZMAT incidents whilst simultaneously protecting other patients and staff from contamination whilst maintaining the delivery of services. The plan would be supported by Service Business Continuity Plan and Trust Lockdown Plans . The plan acknowledges guidance with regards to Wet v Dry decontamination. As there are no facilities to conduct wet decontamination in the premises identified guidance is followed with the utilisation of Wet Wipes as a substitute. Wet Wipes are included in the Hazmat Response Bags. Waste management is included at section 10 of the plan.
The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	104	Fully compliant				The CBRN/HAZMAT Plan (104)focuses on the new 2023 Initial Operation Response and the Remove, Remove Remove principles. The Trust does not have access to any PRPS suits or, Decontamination/Disrobing Structures or other water outlets to assist with the Decon process. The plan utilises CBRN/HAZMAT response box that contains all the required equipment that would support the decontamination process. The response box checklist is included at Appendix 6 of the plan. A photograph of the response bag and checklist is included at (93)
There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	104, 106	Fully compliant				The Trust has a CBRN/HAZMAT plan (104) that addresses the issue of self presenters at Trust premises who may have been contaminated as a result of a CBRN or HAZMAT incident. The Plan focuses on the new 2023 Initial Operation Response and the Remove, Remove Remove principles. The Trust does not have access to any PRPS suits or, Decontamination/Disrobing Structures or other water outlets to assist with the Decon process. The plan utilises CBRN/HAZMAT response box that contains all the required equipment that would support the decontamination process. The response box checklist is included at Appendix 6 of the plan. A photograph of the response bag and checklist is included at (106)

Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	14,53, 57, 58, 62, 107	Fully compliant				The Trust has completed a CBRN Risk assessment (105) and identified premises where persons potentially subject of a HAZMAT contamination may present. The CBRN9e)/ Hazmat Plan(105) has taken this risk assessment into consideration during its development and subsequent review. A training programme has been developed by the EPRR lead that supports this plan. The Training slides are included at (62) The EPRR Lead has delivered this training to all relevant staff employed in the areas identified as part of the risk assessment . Please see attendance sheet at (61). This training requirement is included in the Trust EPRR TNA (53). The training (62) also formed part of the training delivered to On Call managers and operational staff during exercise Coborn (14, 57, 58). The Trust EPRR lead attended a HAZMAT/CBRN Decontamination training programme delivered by NWAS August 2024 (107)
The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	53, 61, 62, 104, 107.	Fully compliant				The EPRR lead attended face to face decontamination training presented by NWAS on the 22nd August 2024 addressing the latest IOR principles . Certificate of attendance (107) The Trust has a PLAN FOR THE INITIAL MANAGEMENT OF SELF PRESENTERS FROM INCIDENTS SUSPECTED TO INVOLVE HAZARDOUS MATERIALS .(104) A training programme has been developed by the EPRR lead that supports this plan. The Training slides are included at (62) The EPRR Lead has delivered this training to all relevant staff employed in the areas identified as part of the risk assessment . Please see attendance sheet at (61). This training requirement is included in the Trust EPRR TNA (53).
Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	104, 106	Fully compliant				The Trust has a PLAN FOR THE INITIAL MANAGEMENT OF SELF PRESENTERS FROM INCIDENTS SUSPECTED TO INVOLVE HAZARDOUS MATERIALS .(104) This Plan includes details of what is included in Hazmat Incident Response bag. The bag includes all the PPE a responder is likely to require when dealing with a HAZMAT incident. The bags are placed in premises which have been risk assessed as potential locations where individuals may self present who may have been subjected of a HAZMAT contamination incident. Please see image of a bag and its contents at (106). Contents of these bags are checked on a monthly basis.
Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	14, 57, 58.	Fully compliant				CBRN Exercising is included in the Annual EPRR board report (3) The Trust HAZMAT/CBRN self Presenters plan (104) has been reviewed. This plan was tested as part of Exercise Coborn on 30th June 2025. The exercise was delivered to On Call Managers, Operational Staff and support staff including Estates and Comms. The exercise was in a WIC setting and addressed both a HAZMAT incident and a CBRN incident. Please see associated paperwork (14, 57, 58)

NHS
Cheshire and Merseyside

To:
Joanne Chwalko
Accountable Emergency Officer (AEO)
Wirral Community Health and Care NHS Foundation Trust

Date: 20th October 2025

Dear Joanne,

NHS Cheshire and Merseyside are responsible for gaining assurance on the preparedness of the NHS Trusts within Cheshire and Merseyside, to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the NHS EPRR Annual Self-Assessment Assurance process, which was reviewed by the NHS Cheshire and Merseyside EPRR Team, with the aim to provide constructive feedback to allow for continuous development. This process was achieved by reviewing the evidence submitted for 5 randomly selected core standards from your Trust.

The 5 core standards that were randomly selected for your Trust were:

Core Standard:	Title:	Standard detail:
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
17	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
29	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker

Core Standard:	Title:	Standard detail:
55	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented

The outcome of the review can be found in appendix 1, whereby we agree with the self-assessment rating based on the evidence supplied.

The documentation supplied is of a consistently good standard. It is clear that significant time and effort has been dedicated to continuously improving EPRR processes across Wirral Community.

Next Steps:

1. The AEO is asked to note the outcome of the review and ensure learning is incorporated within the EPRR Work Programme.
2. The AEO is asked to present the results of the annual EPRR assurance process and compliance position to the organisations Public Board.

The final detail will be included within the Cheshire and Merseyside Assurance Report which will be presented at the Strategic Local Health Resilience Partnership meeting on Tuesday 11th November 2025, prior to submission to NHS England North West.

Yours sincerely

Anthony Middleton
Director of Performance and Planning / AEO
NHS Cheshire and Merseyside

Appendix 1

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Agree	Appendix 2 footer onwards states V1 - be mindful when editing documents and formatting that updates run throughout them.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required	Agree	Substantial evidence supplied to support.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
				to use them • outline any equipment requirements • outline any staff training required		
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Agree	Please be mindful that Trusts links and escalation should be via NHS Cheshire and Merseyside, and not 'NHS England Local Area Team' as they no longer exist. These are referenced in the action cards in the Major Incident Plan. Please update.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Agree	Substantial evidence supplied to support.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Agree	Please note the CBRN risk assessment date shows completed in 2028.