Wirral University Teaching Hospital NHS Foundation Trust

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 28 January 2026
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.	Staff Story	Carla Burns	
6.	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 Audit and Risk Committee	Meredydd David	
17.	WUTH Research and Innovation Committee – **Verbal**	Steve Igoe	
18.	WUTH Finance Business Performance Committee	Meredydd David	
19.	WUTH Quality Committee	Dr Steve Ryan	
20.	WUTH People Committee	Debs Smith	
21.	WCHC Finance and Performance Committee	Meredydd David	
22.	WCHC Quality and Safety Committee	Professor Chris Bentley	
23.	WCHC People and Culture Committee	Debs Smith	
Regulatory Reports			
24.	WUTH Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 7 Annual Declaration)	Julie Roy	Jo Lavery
25.	WUTH Gender Pay Gap Report	Carla Burns	
26.	WUTH Freedom to Speak Up Biannual Report	Carla Burns	
27.	WUTH Guardian of Safe Working Report Q3 2025/26	Dr Nikki Stevenson	
28.	WUTH Learning from Deaths Report Q2 2024/25	Dr Nikki Stevenson	
29.	WCHC Learning from Deaths Report Q2 2024/25	Dr Nikki Stevenson	
30.	WCHC Care Quality Commission (CQC) Reports of Eastham Walk-in Centre and Urgent Treatment Centre	Claire Wedege/Ali Hughes	
Governance and Assurance			
31.	WUTH Charity Annual Report and Accounts 2024/25 – **To follow**	Ali Hughes	
Closing Business			

32.	Questions from Governors and Public	Steve Igoe	
33.	Meeting Review	Steve Igoe	
34.	Any other Business	Steve Igoe	
Date and Time of Next Meeting			
Wednesday 1 April, 09:00 – 12:30			

Meeting	WUTH Board of Directors in Public
Date	Wednesday 3 December 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
HS	Haris Sultan	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
NS	Dr Nikki Stevenson	Joint Chief Medical Officer & Deputy CEO
HK	Hayley Kendall	Joint Executive Managing Director
DS	Debs Smith	Joint Chief People Officer
MS	Matthew Swanborough	Joint Chief Strategy Officer
MC	Mark Chidgey	Joint Chief Finance Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications
JR	Julie Roy	Interim Chief Nurse

In attendance:

CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
CM	Chris Mason	WUTH Chief Information Officer
CW	Claire Wedge	WCHC Interim Chief Nurse
SH	Sheila Hillhouse	WUTH Lead Public Governor
PB	Phillipa Boston (until	WUTH Staff Governor
SPW	Sue Powell-Wilde (until 09:45)	WUTH Appointed Governor

Apologies:

JC	Joanne Chwalko	Joint Chief Integration and Partnerships Officer

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.	
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 5 November were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story highlighting the pre-hospital integration pathway, specifically in relation to the clinical assessment service of category 3-5 diverts to urgent care response. The video story described the experience of a resident in a care home in Upton. The Board **NOTED** the video story.	
6	**Acting Joint Chair Update** SI provided an update on recent matters and highlighted that the financial position remained challenging and both WUTH and WCHC continued to be fully engaged in financial turnaround of Cheshire and Merseyside. SI explained he had met with the Chair of the Countess of Chester to discuss the collaboration opportunities given the close proximity to each other and neighbouring patients. SI added he had also met with MC and AH to discuss the Trusts digital agenda, and a new Digital Committee was being explored. SI also thanked Rosie Cooper who was stepping down as Chair of Mesey Care and welcomed Lisa Greenhalgh who was underdoing the appointment process to become a new Joint Non-Executive Director. SI noted that a new single Executive Team was now in place, and this would be helpful to drive forward the strategic transaction to become a single organisation. The Board **NOTED** the verbal update.	
7	**Joint Chief Executive Officer Report** JH stated the WUTH Charity Tiny Stars Appeal would formally close on 30 November and had raised a total of £1.1m since 2019 and a new fundraising appeal was being developed. JH added the opening of the refurbished Neonatal Unit using these funds would open in early December. JH advised the critical incident declared in October 2025 affecting	

	surgical instruments was stood down in early November and services are now returning to normal. JH highlighted Sexual Health Wirral had been among the finalists in the recent Health Service Journal awards, this was for the Innovation and Improvement in Reducing Health Inequalities Award. JH stated she and the Interim Chief Nurse had held a number of listening events with Clinical Support Workers (CSWs) to discuss plans to review the approach to ongoing organisational change. JH gave an update regarding Better Together - Journey to Integration, highlighting the appointment of a single Executive Team, the TUPE transfer of corporate staff from WCHC had taken place and the ongoing development work of the new Joint Strategy. JH summarised the Cheshire and Merseyside Provider Collaborative meeting in November, noting the discussions around the digital programme, 2026/27 planning and other wider system issues including industrial action. JH provided an overview of the various national developments in the last month, noting the publication of the strategic commissioning framework and the advanced Foundation Trust programme. JH reported at WUTH in October there was four RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework. JH referenced various joint activity undertaken across both Trusts, including safeguarding adults' week and marking Remembrance Day. JH highlighted the various WUTH and WCHC employee of the month and standout winners for October. HS queried how clinical teams were able to contribute to the development of the new Joint Strategy. JH advised the strategy team engaging with staff through open sessions and direct interviews and noted development of the clinical service strategies would begin early next year which were more relevant to clinical teams. MS agreed and stated the strategy team would make themselves available to clinicians to ensure they had opportunity to contribute as this was important.	

	The Board **NOTED** the report.	
8	**Integrated Performance Report** DS stated appraisal compliance was below Trust target but continuing to increase towards threshold. DS highlighted sickness absence remained high but continued to show improvement from the same period in the previous year. SR queried the flu uptake so far. DS reported uptake for WCHC was 44% and WUTH was 38%. SI highlighted the importance of business continuity planning in the event of increased sickness absence due to flu. SI emphasised the risk of low uptake. HK noted a live exercise was scheduled in December across WUTH/WCHC, with revamped flu plans. FITT testing risks for masks was identified, with a need to refocus on providing these for frontline staff. MD queried the barriers preventing staff from coming forward for vaccination. DS explained uptake is consistent with other Trusts and not an outlier. Barriers include vaccine fatigue and myths, requiring a myth-busting approach and behaviour change. SI asked whether staff turnout was linked to redundancy concerns. DS clarified that uptake was not due to redundancy fears but acknowledged fewer NHS jobs overall and vacancy controls in Cheshire and Merseyside impacting staff perceptions. LD queried the workforce performance metrics for Estates and Facilities, noting the presentations at People Committee earlier in the year. DS stated this Division remained challenged. JR stated there had been 13 incidents of C Diff and 6 hospital acquired category 3 pressure ulcers. There was a continued focus on these areas to reduce the number of incidents. JR reported a further reduction in Friends and Family Test (FTT) for ED, inpatients, and outpatients. The number of informal concerns and formal complaints had also increased.	

	NS explained NEWS2 compliance had further reduced and continued to be monitored operationally through Divisional governance structures. The Board **NOTED** performance to the end of October 2025.	
9	**Joint Chief Finance Officer Report** MC reported at the end of October, month 7, the Trust is reporting a deficit of £17.6m which excluding Deficit Support Funding (DSF) is a £8.8m adverse variance to plan. MC added this variance was driven by industrial action, pay award pressures, system stretch target and the Sterile Services critical incident which impacted on the Trusts elective programme. MC noted to date, £8.5m of non-recurrent mitigations have been used to support delivery against plan and offset the key risks. MC 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 MC 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. MC added the cash balance at the end of month 7 was £0.31m and a cash mitigation plan has been implemented in September but remains a significant issue until the Trust has returned to a sustainable financial position. MC noted a revenue support application for November had been approved and a December application was in progress. MC 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. MD noted the significantly low cash balance given the size of the Trust and queried the risk that revenue support was not provided in December. MC stated in the event an application be rejected the Trust had a cash management policy and would prioritise payments accordingly. MC noted the options available to the Trust regarding other sources of revenue support also changed as the risk deteriorates.	

	Members acknowledged the financial position remained challenging and that there was an opportunity to discuss this and the 2026/27 – 2028/29 plan during the Private meeting. 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** 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; and • **APPROVED** the increase in the capital budget of £0.069m for retinal imaging.	
10	**Joint Executive Managing Director Report** HK reported October elective activity performance was 97.5% for outpatients and 80% for elective admissions, noting the sterile service critical incident had a significant impact on activity. HK highlighted because of the critical incident the referral to treatment position had deteriorated, resulting in total caseload increasing by 1022 patients and 52-week waiters increasing by 118 across the period of the incident. HK explained the 28 day Faster Diagnostic Standard (FDS) remained challenging due to the pathway changes and AI implementation. HK advised additional funding had been provided for insourcing to deal with the backlog and an additional consultant was being sought temporary on a zero hour contract. HK noted this was planned to be resolved for end of January. HK highlighted type 1 performance in the Emergency Department (ED) was 43.83% and focus remains on reducing 12-hour waits. HK added the Trust continued to be supported by ECIST who had made improvements relating to streaming pathways from ED and improving triage waits. HK stated the number of patients with no criteria to residue was stable at 12.2%, demonstrating positive movement towards achieving the Trust's local trajectory of 10% by March 2026. HS queried the impact of the recent resident doctor strike. HK reported improvements in 4-hour performance and a reduction in patients waiting for a bed. LD asked whether removing dermatology cases would meet compliance with 28 day Faster Diagnostic Standard. LD also asked how many patients were affected by this change.	

	HK confirmed resolution of the dermatology issue would meet Faster Diagnostic Standard. HK added that 80 patients were waiting over 60 days compared to 5 previously, with an eight-week backlog following the decision to treat. SR enquired about the future of no criteria to reside if occupancy reached 10 percent and the implications for the model of care. HK highlighted the CICC as an opportunity to expand criteria safely while reducing general and acute beds. Risks were identified regarding local authority cash withdrawal and prolonged hospital stays. CB enquired the closure of virtual wards. HK explained that funding withdrawal was anticipated, and modelling was under review to assess projected demand. HK added opportunities exist to manage patients differently via Same Day Emergency Care. SI asked about measures to improve 12 Emergency Department performance. HK reported adjustments included changing the footprint to expedite patient assessment and better utilisation of the medical intake team, though medical wait times remain a significant concern, and this needed to be addressed. The Board **NOTED** the report.	
11	**Board Assurance Framework (BAF)** AH provided an overview the changes to the BAF, noting the Quality Committee had met and agreed to included additional updates regarding the recent CQC report, the impact of the SSD critical incident and the on-going FRPM programme across Cheshire & Merseyside. AH noted the upcoming Committee meetings in December and January where the relevant strategic risks will be discussed and update provided to Board next month. AH advised of the 12 strategic risks, 6 were currently scoring 15 or above and no changes to the scores were proposed at this time. Members discussed the BAF and agreed it accurately reflected the current position. Members also agreed that there was good triangulation of the BAF driving the Board meeting agendas. The Board:	

	• **NOTED** the position reported in relation to the strategic risks; and; • **APPROVED** the strategic risk positions	
12	**Lead Governor Report** SH provided a verbal update, noting Governors from both Trusts had been involved in the appointment of the substantive Joint Chair and the recruitment of a new Joint Non-Executive Director. The Board **NOTED** the verbal update.	
13	**Committee Chairs Report – Estates and Capital Committee** SI alerted members that reactive maintenance performance had deteriorated and that a further deterioration was anticipated due to reduced overtime available, in line with the Trust's financial mitigation plan. SI also referenced the deep dive presentation provided relating to fire safety. Committee 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. SI alerted members that the Committee discussed the Frontis Building and had agreed with the recommendation to demolish this. A longer-term proposal for the redevelopment of the site had been requested. SI summarised the various "Advise" and "Assure" matters from the meeting on 3 November. The Board **NOTED** the report.	
14	**Committee Chairs Report – Charitable Funds Committee** LD alerted members that discussions were underway to agree the Charity's next significant campaign. LD also alerted members to the upcoming fund-raising activities planned for the rest of the year, including the winter ball, hospital carol service, an evening with Paul Burrell and book signing and an Abseiling event. LD summarised the various "Advise" and "Assure" matters from the meeting on 11 November. The Board **NOTED** the report.	
15	**Committee Chairs Report – Quality Committee**	

	SR alerted members that the Committee continued to have strong oversight of infection prevention and control, and discussion occurred surrounding the clinical areas with the highest incidences and the controls in place. SR also alerted members that there was a focus on ensure that all staff in relevant areas are being fit-tested for respiratory masks. SR added Committee also noted the risk regarding the vacancy rate for speech and language therapists for outpatient services and discussed the integration opportunities with WCHC. SR alerted members to the less positive Friends and Family Test responses and a higher level of informal concerns in the Emergency Department, relating to waiting times especially. NS advised the reference to internal audit report of the ward accreditation system was currently draft and a final report was due in January. SR summarised the various "Advise" and "Assure" matters from the meeting on 24 November. The Board **NOTED** the report.	
16	**Committee Chairs Report – Finance Business Performance Committee** SR noted that the Committee reviewed the month 7 financial position and the Trust's cash position, and this would be reported in the Chief Finance Officer Report. SR alerted members that the Committee also reviewed the 28 day Faster Diagnostic Standard, noting the challenges related to dermatology due to a new digital pathway which had led to increased referrals. SR added additional funding has been received from the Cancer Alliance and is expected to allow the standard to be met by the end of January 2026. SR also alerted members that the Committee discussed the impact of the critical incident in the Sterile Services Department, noting the financial impact had been significant and an elective recovery plan was in place to address the postponed procedures. SR summarised the various "Advise" and "Assure" matters from the meeting on 27 November. The Board **NOTED** the report.	
17	**Quarterly Maternity and Neonatal Services Report**	

	JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of non-compliance for October. JL stated there were no Patient Safety Investigation Incidents (PSIIs) declared for Maternity Services or Neonatal Services in October. JL gave an update on the Maternity Incentive Scheme (MIS) Year 7 and the ten safety actions, noting progress to date and that this was being routinely tracked through the Divisional Quality Assurance meeting. A presentation will be given to Quality Committee and Board in January 2026 with the LMNS present. JL referenced the Perinatal Mortality Reviews Summary Report (PMRT) for quarter 3 2025/26 which summarised the number of stillbirths and perinatal deaths. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 96% compliance against the 6 elements based on evidence as of 30 September 2025. JL added the Trust continued to work towards full implementation of this. JL summarised the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services. JL provided an update on the midwifery workforce using the Birth Rate + workforce tool, noting the Board had recently approved an increase in the establishment to meet the safe staffing levels. JL set out the progress of the Maternity Portal Online Programme (MPOP), Maternity Self-Assessment Tool and noted the annual maternity and neonatal culture report had been provided for assurance. JL highlighted the NHSE and LMNS annual maternity visit had been postponed from October to March 2026. JL added the neonatal refurbishment was due to complete and open later this month. SR commented as Maternity Safety Champion he attended the quality assurance meeting regarding MIS and noted the robust approach for gathering and presenting evidence. SR added the approval to increase the establishment had been received positively from maternity and neonatal nurses.	

	JH noted in the report it was referenced that the neonatal unit was being expanded, and this was not the case and requested JL make clear it was being refurbished. JL agreed to amend the report. The Board: • **NOTED** the report and associated appendices. • **NOTED** the Perinatal Clinical Surveillance Assurance report. • **NOTED** the position of the Maternity and Newborn Safety Investigations (MNSI) and declaration of one PSII for Neonatal Unit. • **NOTED** the position with the Maternity Incentive Scheme Year 7 requirements. • **NOTED** the PMRT reports for Q2 25/26. • **NOTED** the progress of the Trust's position with Saving Babies Lives v3. • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals;" and • **NOTED** the progress with the Maternity Portal Online Programme.	
18	**Organ Donation Annual Report 2024/25** NS noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the chairs report. NS explained organ donation takes place from referrals within the Intensive Care Unit or Emergency Department. NS added 11 life-saving organ transplants took place during 2024/25 and there were 3 missed potential donations. NS highlighted work was continuing on the design and creation of a permanent memorial at the Trust to recognise and raise awareness of organ donation. The Board **NOTED** the report.	
19	**Learning from Deaths Report Q1 2025/26** NS noted this report had been considered and discussed in detail at the recent Quality Committee with assurance included in the chairs report. NS provided a summary of adult in patient deaths and case reviews, noting of the 430 deaths 15 cases were escalated for review by the Medical Examiner and the Mortality Review Group reviewed a random selection of deaths to identify learning. No care issued had been identified.	

	NS added a CUSUM alert had been identified for deaths due to other disorders of the stomach and duodenum and 6 patients were being reviewed to see if any lessons could be learned. AH stated there was a discussion in the Committee regarding the publication of this report and the Corporate Governance team were reviewing the guidance to ensure this was aligned across both Trusts. MD enquired about the HSMR coding issue previously discussed and if this had been resolved. MC advised during 2025/26 the Trust had not fully coded every episode and prioritised elective activity and deaths, noting there was no impact on finance but there was an impact on performance. MC added in 2026/27 there would be on impact on both finance and performance and Executives had requested a plan be developed to code to 100%. The Board **NOTED** the report.	
20	**Questions from Governors and Public** SH queried the outcome of the Mutually Agreed Resignation Scheme across both Trusts. DS stated less than 50 applications had been approved across both Trusts, a number of staff had already left and more were planned over the next few months due to various notice periods. DS added closure reports had been provided to both People Committees. SH also queried the opportunities for collaborating with the Countess of Chester. JH advised this was influenced by Cheshire and Merseyside and the requirement for providers to collaborate on services. JH stated both Executive teams were focussing on fragile services and exploring how these could be delivered together for the benefits of patients.	
21	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute. Members also agreed the BAF continued to drive the agenda, and this was positive in line of wide ranging risks.	
22	**Any other Business** No other business was raised.	

(The meeting closed at 11:30)

Wirral Community Health and Care NHS Foundation Trust

Meeting	WCHC Board of Directors in Public
Date	Wednesday 3 December 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
HS	Haris Sultan	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
JH	Janelle Holmes	Joint Chief Executive
NS	Dr Nikki Stevenson	Joint Chief Medical Officer & Deputy CEO
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DS	Debs Smith	Joint Chief People Officer
MS	Matthew Swanborough	Joint Chief Strategy Officer
MC	Mark Chidgey	Joint Chief Finance Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications
CW	Claire Wedge	Interim Chief Nurse

In attendance:

CH	Cate Herbert	WUTH Board Secretary
JJE	James Jackson-Ellis	WUTH Corporate Governance Officer
CM	Chris Mason	WUTH Chief Information Officer
JR	Julie Roy	WUTH Interim Chief Nurse
SH	Sheila Hillhouse	WUTH Lead Public Governor
PB	Phillipa Boston (until	WUTH Staff Governor
SPW	Sue Powell-Wilde (until 09:45)	WUTH Appointed Governor

Apologies:

JC	Joanne Chwalko	Joint Chief Integration and Partnerships Officer

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	surgical instruments was stood down in early November and services are now returning to normal. JH highlighted Sexual Health Wirral had been among the finalists in the recent Health Service Journal awards, this was for the Innovation and Improvement in Reducing Health Inequalities Award. JH stated she and the Interim Chief Nurse had held a number of listening events with Clinical Support Workers (CSWs) to discuss plans to review the approach to ongoing organisational change. JH gave an update regarding Better Together - Journey to Integration, highlighting the appointment of a single Executive Team, the TUPE transfer of corporate staff from WCHC had taken place and the ongoing development work of the new Joint Strategy. JH summarised the Cheshire and Merseyside Provider Collaborative meeting in November, noting the discussions around the digital programme, 2026/27 planning and other wider system issues including industrial action. JH provided an overview of the various national developments in the last month, noting the publication of the strategic commissioning framework and the advanced Foundation Trust programme. JH reported at WUTH in October there was four RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive and no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework. JH referenced various joint activity undertaken across both Trusts, including safeguarding adults' week and marking Remembrance Day. JH highlighted the various WUTH and WCHC employee of the month and standout winners for October. HS queried how clinical teams were able to contribute to the development of the new Joint Strategy. JH advised the strategy team engaging with staff through open sessions and direct interviews and noted development of the clinical service strategies would begin early next year which were more relevant to clinical teams. MS agreed and stated the strategy team would make themselves available to clinicians to ensure they had opportunity to contribute as this was important.	

	The Board **NOTED** the report.	
8	**Integrated Performance Report** DS highlighted sickness absence remained an area of concern, however due to robust controls the seasonal increase experienced last year had not occurred, and the position was being maintained. DS suggested the new controls in place would reduce sickness absence, but this would take a period of time. LD queried how the culture relating to sickness absence was being addressed. DS advised the current focus was on getting the basis right and this would lead to changing the culture. DS added regarding long term sickness absence this was being managed but return to work plans were not routinely in place and this was being addressed and lead to an improved culture. HS queried the anxiety of staff following the TUPE of corporate services to WUTH. DS advised whilst staff in both corporate services teams are likely to feel anxious due to the upcoming organisational change period, this isn't currently resulting in sickness absence. HK explained operational performance remained consistent, noting urgent community response and Community Intermediate Care Centre (CICC) performance was strong. HK added waiting lists for dental and cariology remained areas of concern and remedial actions plans were in place to address this. CW reported 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. CW added 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. A data analysis has identified learning opportunities. CW referenced the appended presentation relating to the action log from October, noting this provided a summary of patient experience/quality outcomes post a GP Out-of-Hours Service interaction. HS queried the accessibility format for patients to contribute to the Friends and Family Test. HS also queried how the Trust was sharing learning with system partners if areas for improvement had been identified.	

	CW advised electronic format, including large text was available and the where possible the Trust would share any learning with wider system partners. SR noted that a theme identified as very poor/poor for GP out of hours related to sensory issues and queried if this would be addressed as part of the service integration between WUTH and WCHC. HK agreed to review the sensory environment provision for adults and children in the new ED facility. MC reported 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. The Board **NOTED** performance to the end of October 2025.	Hayley Kendall
9	**Board Assurance Framework (BAF)** AH provided an overview the changes to the BAF, noting the Quality and Safety Committee had agreed an additional gap to be noted reflecting the GA capacity impact on waiting lists for the dental service, particularly for paediatrics. AH noted the upcoming Committee meetings in December and January where the relevant strategic risks will be discussed and update provided to Board next month. AH advised of the 9 strategic risks, ID07 was currently scoring at a high level and no changes to the scores were proposed at this time. The Board **NOTED** the position reported in relation to the strategic risks.	
10	**Lead Governor Report** AH provided a verbal update on behalf of Lead Governor, noting Governors from both Trusts had been involved in the appointment of the substantive Joint Chair and the recruitment of a new Joint Non-Executive Director. AH added Governor elections closed today, the results would be shared shortly, and new Governors will be inducted in January. The Board **NOTED** the verbal update.	
13	**Committee Chairs Report – Quality and Safety Committee**	

	CB alerted members that the Committee discussed the clinical and professional supervision internal audit, noting there was one high risk, and 3 medium RAG rated recommendations, and it was agreed that a risk would be added on the operational risk register. CB also alerted members that the Committee received a Duty of Candour benchmarking report from internal audit and explained the Trust had good compliance for this, but areas of improvement were identified to strengthen practice. CB referenced the EPRR Core Standards Annual Self-assessment which the Committee received with good assurance and was included on the agenda for this meeting. CB summarised the various "Advise" and "Assure" matters from the meeting on 24 November. The Board **NOTED** the report.	
14	**Learning from Deaths Report Q1 2025/26** NS noted this report had been considered and discussed in detail at the recent Quality and Safety Committee with assurance included in the chairs report. NS reported during the quarter 8 deaths were investigated through the mortality group structure, noting only 1 occurred in a patient under the care of the Trust and the others were deaths that occurred in the community. NS added after investigation, none of these were caused by gaps or omissions in care provided by the Trust. AH stated there was a discussion in the Committee regarding the publication of this report and the Corporate Governance team were reviewing the guidance to ensure this was aligned across both Trusts. The Board were **ASSURED** by the content of the report and approved it for publication.	
15	**Controlled Drugs Annual Report 2024/25** NS noted this report had been considered and discussed in detail at the recent Quality and Safety Committee with assurance included in the chairs report. NS highlighted there was a total of 59 controlled drug incidents reported during 2024/25 (compared with 43 reported 2023/24). NS added these incidents were low or no harm and the most common theme reported were incidents involved documentation errors with no actual loss of controlled drugs.	

	The Board were **ASSURED** that controlled drugs were handled safely across the organisation.	
17	**EPRR Core Standards Annual Self-Assessment** HK noted this report had been considered and discussed in detail at the recent Quality and Safety Committee with assurance included in the chairs report. HK stated 56 of the 58 EPRR core standards identified full compliance and partial compliance against the remaining 2. This provides an assessment rating of "Substantial Compliance" with a 97% compliance score. The Board were **ASSURED** that the Trust has completed the annual EPRR core standards process.	
18	**Questions from Governors and Public** SH queried the outcome of the Mutually Agreed Resignation Scheme across both Trusts. DS stated less than 50 applications had been approved across both Trusts, a number of staff had already left and more were planned over the next few months due to various notice periods. DS added closure reports had been provided to both People Committees. SH also queried the opportunities for working collaboratively with the Countess of Chester. JH advised this was influenced by Cheshire and Merseyside and the requirement for providers to collaborate on services. JH stated both Executive teams were focussing on fragile services and exploring how these could be delivered together for the benefits of patients.	
19	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute. Members also agreed the BAF continued to drive the agenda, and this was positive in line of wide ranging risks.	
20	**Any other Business** No other business was raised.	

(The meeting closed a 11:30)

Action Log
Board of Directors in Public
28 January 2026

WUTH						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1			No actions due			

WCHC						
No.	**Date of Meeting**	**Minute Ref**	**Action**	**By Whom**	**Action status**	**Due Date**
1	3 December 2025	8	To review the sensory environment provision for adults and children within UECUP	Hayley Kendall	Complete. The current UECUP plan will provide sensory equipment that moves to patients. We are exploring options to create a customised space.	January 2026

Board of Directors in Public **Item 7**
28 January 2026

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** Urgent and emergency care performance at WUTH continues to be challenged and focussed improvement work continues with specific actions on 4 & 12 hour standards.

	At WCHC operational performance remains strong in urgent community response and Community Intermediate Care Centre (CICC). GP out of hours and 4 hour performance remains below target and remedial action plans are in place to support improvements. Further detail regarding both Trust's performance is available in the Integrated Performance Reports.
1.2	**Local News and Developments** **Thank you to colleagues during an exceptionally busy period** We acknowledge the current pressures across our hospital sites and want to thank staff for all the hard work in caring for our patients. This is an exceptionally busy time for the NHS both locally and nationally and we recognise the impact this is having on staff and patients. Safe care continues to be our top priority as ever, and in response to the current demand we have taken several actions to manage the pressures experienced. These include: • All available inpatient beds have been opened where it is safe to do so. • Some non-urgent elective procedures are being rearranged to create capacity for the sickest patients. • Staff are being redeployed to areas of greatest need. • Additional staffing in place when required. • We are working closely with NHS and social care partners to support timely and safe discharges. • Diagnostic capacity is being prioritised to support patient flow. • Senior operational, clinical and executive teams are closely monitoring the position and remain on site and available to support services as required. We know this continues to be a challenging period, and we want to thank staff for their professionalism, teamwork and continued commitment to patient care during sustained pressure. Thank you again for everything you are doing. **Executive Team - Chief Nursing Officer** Following the announcement of the single Executive Team in mid-November 2026 I am pleased to advise that with effect from 1 February 2026, Christine Douglas will join both Trusts on a secondment from the ICB as interim Joint Chief Nurse. Chris is a highly experienced nurse leader having worked in both acute and community providers and more latterly as Chief Nurse of the Cheshire & Merseyside ICB. Chris will work alongside and be supported by Claire Wedge and Julie Roy, Directors of Nursing who have been appointed as respective interim Chief Nurses until the end of January 2026. Chris will be the registered manager for CQC and that the statements of purpose for both Trusts have been updated. **New Monthly All Staff Briefing**

In January 2026, we launched a new All Staff Briefing for staff across both WUTH and WCHC to attend. This replaces previous arrangements in each Trust through the monthly Leaders In Touch and Get Together.

This new briefing recognises the path to integration, following the TUPE transfer of corporate staff and importantly the opportunities that exist between clinical and non-clinical teams in both Trusts to learn from each other and improve the way we deliver our services to our local populations.

Each meeting will include updates from the Executive Team on quality, performance, finance and workforce sharing key metrics, priorities and good news stories. An update on the statutory transaction as part of the Better Together programme will also be shared, along with case studies of where services are already working together to improve service delivery and patient experience.

The monthly briefing will be open to all staff across both Trusts and we encourage as many staff as possible to attend to hear the latest news from the Trusts and to share messages in teams.

Financial Recovery Performance Management (FPRM) process

We continue to engage with the NHSE regional team and PWC in the FPRM process which includes monthly meetings to review the financial position of both Trusts, and specifically actions to address financial recovery.

This process is rigorous however despite significant challenges, we are demonstrating grip and control, and progress on the implementation of actions to the national team.

It is undeniable that there are difficult decisions to be made and as such additional control measures have been put in place, but patient safety and the quality of our services will always be our number one priority.

NHS Oversight Framework

The NHS Oversight Framework was published in September and most recently updated in November 2025. The position remains that WCHC is in segment 1 - NOF Mental Health Dashboard - NHS England Data Dashboard and WUTH is in segment 4 - NOF Acute Dashboard - NHS England Data Dashboard.

With effect from January 2026, the Integrated Performance Reports to the public Board will include a NOF dashboard highlighting the position for each Trust against each of the relevant metrics.

New Resident Doctor Peer Lead Appointed at WUTH

We are delighted to announce the appointment of Tracey Livingstone, Specialty Registrar in Urology, as our new Resident Doctor Peer Lead. This is an important role for the Trust, strengthening our commitment to delivering NHS England's 10-point plan to improve resident doctors' working lives.

Tracey will work closely with Dr Nikki Stevenson, Chief Medical Officer and Board Lead for Resident Doctor Experience, to ensure resident doctors' voices are heard at the

highest level and that WUTH continues to build strong, transparent, and accountable systems of support.

This appointment reinforces the Trust's dedication to ensuring the NHSE 10-point plan is implemented on issues including enhancing wellbeing, improving working environments, ensuring fair processes, and reducing the pressures associated with training rotations.

Tracey's leadership will be central to driving these national priorities forward at WUTH and in this influential role she will help to ensure our resident doctors feel valued, supported, and empowered throughout their training.

Resident Doctor Industrial Action

Resident Doctors undertook industrial action form 17-22 December. As with previous periods of industrial action the Trust implemented robust operational planning and oversight to ensure safe services were maintained. All emergency and urgent care services remained fully operational during the period of action, with staffing maintained by permanent medical staff and non-striking resident doctors.

Overall, 841 outpatient appointments, of which 5 were cancer related, were cancelled during the period of industrial action. A total of 28 day case procedures, of which 1 was cancer related were cancelled. No inpatient procedures were cancelled and all cancer patients cancelled for operation have been treated.

Transforming Urgent Care: Keeping Patients Closer to Home with the Clinical Assessment Service

WCHC, WUTH and North West Ambulance Service (NWAS) are working in partnership to deliver a Clinical Assessment Service (CAS) that supports Wirral residents to receive the right care, at the right time, in the right place, every time with the aim of avoiding hospital admissions where possible.

Since its launch on 29 October 2025, the service has already made an impact. The team has helped avoid 205 ambulance callouts, easing pressure on emergency services, and safely diverted 156 patients to appropriate community services instead of the emergency department. This is particularly significant as our Emergency Department, as is the case at hospitals across the country, continues to experience extremely high demand, with at times during December, up to a 30% increase in attendances on expected levels.

The Urgent Community Response (UCR) team is able to accept lower acuity ambulance calls (category 3 and 4) via NWAS. Through enhanced clinical triage, clinicians can determine whether patients require acute hospital care or whether safe, effective treatment can be provided in their own homes, within an Urgent Treatment Centre, or through referral to another WCHC community service.

National Joint Registry's Quality Data Audit Results

The National Joint Registry's Quality Data Provider audit for the 2024-2025 financial year has been successfully completed and I'm proud to say that the results show outstanding achievements.

Both Arrowe Park Hospital and Clatterbridge Hospital have achieved the prestigious Gold Standard Certification for Data Submission & Quality. This signifies that an exceptional 100% compliance rate has been achieved to earn this esteemed recognition.

This remarkable success is a testament to the excellent level of compliance achieved in gaining consent from patients to allow their personal details to be held on the National Joint Registry when undergoing elective arthroplasty. It also reflects the diligent efforts made by the surgical team, nursing and administrative staff in ensuring accurate data capture and coding.

Better Together - Journey to Integration

Since the last report to the Board of Directors, I am pleased to confirm that the TUPE transfer of corporate staff from WCHC to WUTH was completed successfully on 1 December 2025. Thanks to staff across both Trusts who led the various elements of the transfer and to all staff who actively engaged in the process.

The teams across corporate services are continuing to support each respective Trust and during Q4 we plan to commence a programme of organisational change to establish single corporate teams with effect from Q1, 26-27. This process will have Executive oversight as per the new single Executive Team.

The Integration Management Board continues to meet monthly and governance arrangements across both Trust are 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 proceeding to develop the Outline Business Case for the statutory transaction. We are also seeking to move to Group Governance arrangements with effect from the start of the new financial year to support the streamlining of reporting arrangements where practical and appropriate.

Our new Joint Trust strategy remains in development following successful engagement sessions and meetings with key stakeholders. This is also on track for presentation to the Board in April 2026.

Stakeholder Newsletter from WCHC and WUTH - December 2025

In December the Stakeholder Newsletter was issued and from January 2026 this will be issued quarterly.

The December issue included updates on the appointment of the Single Executive Team and Non-Executive appointments, Joint strategy development and the refurbished Neonatal Unit opened at Arrowe Park Hospital.

The newsletter also had a feature on Sexual Health Wirral, which was a finalist at the HSJ Awards 2025 and included a campaign urging young people to get tested for Chlamydia.

2025 NHS Staff Survey

A big thank you to the 892 staff at WCHC who completed the NHS Staff Survey, which represents a 52% response rate. At WUTH 2825 staff also completed the survey which represents a 42% response rate.

The results will be available in the spring and further information about the next steps will be shared shortly.

Cheshire and Merseyside Provider Collaborative Updates

Friday 5th December

The Leadership Board reviewed a comprehensive digital transformation agenda intended to reposition digital as a system wide driver of clinical and operational improvement. The Board endorsed the direction of travel, including establishment of a Digital Centre of Excellence, development of shared architecture, and accelerated progress on key priorities. The Board agreed in principle to incorporate ICB digital functions into a shared collaborative model and requested a concise plan on a page summarising vision, milestones, and governance.

A strategic discussion on collaborative procurement highlighted £1.2bn annual addressable non pay spend and substantial efficiency opportunities. The Board endorsed progressing toward a single system wide procurement service, supported by phased implementation, and an accelerated business case.

Operational updates noted that Cheshire & Merseyside remains an outlier on 65 week elective waits. Workforce matters included agreement on a target of 95% attendance threshold. Decisions on visas and recruitment freezes were deferred pending further guidance from a scheduled NHSE webinar.

Friday 19th December

The CMPC Leadership Board convened to review system wide progress, organisational pressures, and future strategic direction. The meeting opened with an update from Liz Bishop, ICB CEO, highlighting rapid development of a commissioning strategy due in January, with a renewed focus on prioritised pathways, prevention, and a more standardised approach across Cheshire and Merseyside. ICB governance structures are under review, with executive appointments expected by the end of January.

A substantial portion of the meeting focused on in year delivery and planning, including discussion of the recent NHS England Undertakings issued to several providers. The Board agreed on the need to focus on a three year planning horizon supported by a small number of credible transformation schemes including workforce reduction strategies, corporate services consolidation, productivity improvements, and potential estate rationalisation.

The Board discussed workforce productivity tools, including acuity based rostering tools and redesign of outpatient provision.

Friday 9th January 2026

The Leadership Board met on 9th January 2025 to review key programmes and system priorities. The Board approved continuation of the Dermatology AI – Skin Analytics programme, noting its strong clinical performance, and contribution to increased efficiency by reducing consultant appointments and biopsy rates.

The Board endorsed the proposed methodology for identifying fragile services across

	Cheshire & Merseyside, which applies a structured scoring matrix across quality, workforce, standards, and financial measures. This process will support the development of a prioritised shortlist by March. A detailed update was provided on the LAASP business case. The work demonstrates a rigorous approach to assessing integration options across Liverpool providers. Key objectives include economies of scale, clinical pathway integration, improved workforce models and strengthened system working. Updates on diagnostics and community capital planning highlighted tight national deadlines, with £41m available for diagnostics in 2026/27 and £14m across three years for community investment. Work is progressing to align a shared prioritisation matrix and to shift towards a more strategic system wide approach to capital planning. The ICB's financial planning for 2026–28 indicates an early ICB draft position of £9.4m surplus and a £74.8m CIP requirement., noting this position will change as plans iterate. Concerns were raised regarding the sustainability of incremental growth models and the need for a strategic resource allocation framework aligned with the Blueprint. The system remains broadly on track for delivery of the 65 week wait target, though immediate action is required to address residual cases. Trusts are encouraged to engage with Q4 outpatient sprint opportunity and RTT improvement funding to maximise activity delivery before year end. Finally, the Board discussed the need for strengthened oversight of service changes to avoid unintended system impacts, agreeing to refine processes for reviewing ICB Service Change Panel outputs, and welcomed the decision of the ICB to reconsider the previously proposed decommissioning of virtual ward beds. **NHS Cheshire and Merseyside appoints Interim Executive Director of Strategy and Transformation (Turnaround)** NHS Cheshire and Merseyside appoints Interim Executive Director of Strategy and Transformation (Turnaround). NHS Cheshire and Merseyside confirmed the appointment of Jude Adams as Interim Executive Director of Strategy and Transformation (Turnaround). Jude joins the Integrated Care Board on secondment from her role as Executive Chief Delivery Officer at Northern Care Alliance NHS Foundation Trust and will strengthen NHS Cheshire and Merseyside's leadership team at a time of system-wide financial recovery.
1.3	**National News and Developments** **Menopause and prostate conditions prioritised for NHS's new online hospital** The NHS has selected nine common conditions which will be the first to be treated by the NHS Online service, providing faster access to specialist care. Launched by the Prime Minister in September 2025, today's announcement sees the first step in delivering the new NHS Online hospital, which will transform how healthcare is delivered, allowing patients to be triaged quickly through the NHS App, speak to doctors via video consultation, and monitored in the comfort of their home, saving

	unnecessary trips to hospital. NHS Online is a flagship reform programme at the heart of efforts to modernise the health service. It will harness digital technology to fundamentally change how people are able to access healthcare for generations to come, ensuring it is more personalised, more convenient and more democratic. While patients will always have the option of in-person appointments, NHS Online will help tackle deep rooted inequalities in the healthcare system by ending the postcode lottery of care and help make getting treatment as easy as online banking. **Mental Health Bill receives Royal Assent** The Mental Health Bill has received Royal Assent to modernise outdated mental health laws and improve care for seriously ill patients. Patients with severe mental illness are to be better protected thanks to landmark new legislation. The new Mental Health Act has received Royal Assent, meaning it is now law. It will reform the outdated Mental Health Act of 1983, which provides the legal framework to detain and treat people in a mental health crisis who are at risk of harm to themselves or others. The modernised act will implement urgent reforms which experts have been calling for almost a decade, bringing mental health care into the 21st century and empowering patients to take charge of their treatment. **Messages from NHS England chief executive** An end of year message from Sir Jim Mackey, Chief Executive, NHS England was published in December and is available here. A further new year message was published in January and is available here.
1.4	**WUTH Health and Safety** There was two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in December. 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 December 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. • **Age UK - Age UK publishes data of impact of corridor care.** New analysis by Age UK has revealed that more than 100,000 elderly individuals endured waits of up to three days in A&E corridors and waiting rooms last year before finally being moved to a hospital ward. The research found that over half of these patients

	were aged 80 or over, with some reportedly forced to lie on the floor and wash in toilet sinks during their prolonged waits. https://www.ageuk.org.uk/our-impact/campaigning/corridor-care/ • **NHS Confederation - The state of integrated care systems 2024/25: delivering through change.** This annual report on the state of integrated care systems (based on a survey of ICS leaders) examines systems' progress, how they are responding to the changing policy landscape and their role in implementing the 10 Year Health Plan: The state of integrated care systems 2024/25 | NHS Confederation • **Nuffield Trust - District nursing: understanding the decline and mapping the future.** District nurses, who provide care to people in homes all over the country and operate all hours of the day, are fundamental to the government's plans to shift more care from hospital to the community. But this new research report shows those plans are unlikely to be achievable unless action is taken to address the state of the district nursing profession. As demand for their care rises, and is set to rise further, an estimated one in four district nurses are leaving the profession and there has been a 43% decline in overall numbers since 2009. https://www.nuffieldtrust.org.uk/research/district-nursing-understanding-the-decline-and-mapping-the-future • **HFMA Briefing - Summary of medium-term planning guidance 2026/27 to 2028/29.** NHS England published planning guidance over the course of October and November 2025. Integrated care boards (ICBs), and NHS trusts and foundation trusts (providers) must now work with this planning guidance to develop medium-term plans. This briefing pulls out key points from the planning guidance, as relevant to NHS finance staff. https://www.hfma.org.uk/publications/summary-medium-term-planning-guidance-202627-202829 • **NHS Providers - Beyond the hospital: how boards can lead the digital shift to neighbourhood working.** This report examines the role that digital transformation will play in the creation of a Neighbourhood Health Service and what NHS boards need to know in order to realise these ambitions. https://nhsproviders.org/resources/beyond-the-hospital-how-boards-can-lead-the-digital-shift-to-neighbourhood-working • **Royal College of Nursing - Bracing for winter: a close look at NHS emergency and elective care in England and its implications for corridor care.** This report examines the increasing pressures on the NHS in England and its implications for corridor care as the winter period begins. It explores how rising demand, pressures, and challenges with patient flow for emergency and elective services has contributed to the persistence of corridor care, and why winter pressures risk making the situation worse. RCN Bracing for winter | Publications | Royal College of Nursing • **National Audit Office - Primary and community healthcare support for people living with frailty.** This report examines the effectiveness of the government's approach to identifying and managing frailty in non-hospital based services in England. The report sets out the growing problem of frailty, the government's approach to frailty, supporting people living with frailty, and frailty and the new neighbourhood health service. https://www.nao.org.uk/reports/primary-and-community-healthcare-support-for-people-living-with-frailty/?nab=0
1.6	**Communications and Engagement**

Photographer Returns to Arrowe Park's Neonatal Unit 40 Years After Her Own Premature Birth

A professional photographer whose life was saved at Arrowe Park Hospital's Neonatal Unit returned four decades later to offer free photographs to families in memory of her mum, Pat.

Joanna Bray, age 40, spent the first weeks of her life on the same unit she visited in November. Born several months early at just 25 weeks, following a sudden accident involving her mum, Joanna arrived tiny, fragile and fighting for survival. Family members recall her being "the size of her dad's palm", and they have often spoken about the determination she showed from her earliest moments.

Her aunt also passed down a story that has stayed with Joanna all her life. The night before she began breathing independently, doctors were preparing to withdraw support. Her family asked for 24 more hours, and by the following day, Joanna took her first breaths on her own.

Joanna visited the Neonatal Unit on World Prematurity Day to offer complimentary photo sessions to families. Each received five professional images and access to a secure private gallery. Joanna dedicated the project to her mum, who passed away when she was 16.

10th annual International Best Care of the Dying Conference

Congratulations to Jess Thompson, End of Life Care Lead Practitioner and Charlotte Botes, Community Specialist Palliative Care and End of Life Team Manager, who presented their work at the International Best Care of the Dying Conference in Liverpool in November.

Together with Gilbert Ngatia, Services Director for Nursing, they attended The Spine in the Knowledge Quarter for the international conference, together with colleagues and peers, from Liverpool to Australia.

Presenting their work on Single Registered Practitioner for Syringe Drivers in the Community, their poster brought about constructive questioning and feedback from peers. Their work has been published in the Abstract Book – page 30.

A fond farewell to Eileen and Spartacus

A final thank you and farewell was given to Eileen and Spartacus on Friday 12 December. Colleagues and friends who have had the pawsome pleasure of meeting Spartacus over the years, came together to celebrate his amazing career.

From ambulance stations to Amazon warehouses, Spartacus has visited numerous organisations, offering wellbeing visits and a wagging tail to frontline workers, students, and employees alike. His favourite destinations remain St. Catherine's Health Centre, Clatterbridge, and Victoria Central Hospital in Wallasey, where treats and smiles abound.

Therapy Dogs Nationwide is a charity powered by 2,250 volunteers and their temperament-assessed dogs, offering comfort and support across the country. Spartacus

	is a shining example of the incredible work these dogs do, demonstrating the profound "power of the dog" to heal and inspire. Bailey and handler (and owner) Angela will now follow in Spartacus's pawsteps. **WCHC Standout Winner** Congratulations to our November Standout winner, The Ageing Well and Frailty Service. The Ageing Well and Frailty Service (formerly ICCT) has achieved 100% positive patient feedback over the last six months, with heartfelt comments praising the compassionate support and of community matrons, advanced practitioners and NPOPs. Feedback highlights exceptional, person-centred care and the vital impact the team has on older people and their carers, evening inspiring a poem of gratitude. Despite service transformation and challenges, the team continues to deliver outstanding care and truly deserves recognition. **WUTH Employees of the Month Winners** Congratulations to Hannah Harper, Neonatal Unit Ward Manager, who was announced as Employee of the Month for Patient Care at Leaders in Touch in December. Hannah was nominated for her exceptional leadership, compassion and unwavering commitment to both staff wellbeing and patient safety. She leads with kindness and calm, supports teams clinically when needed, and consistently champions high-quality care for babies and families. Her inclusive leadership and dedication make a real difference every day. Congratulations also to Stuart Jones and the Clatterbridge Maintenance Team, who were announced as our Support Services Employee and Team of the Month at Leaders in Touch. The team were nominated for consistently going above and beyond to keep the Clatterbridge site safe, warm and welcoming, particularly during the most challenging winter months. From responding to urgent repairs to working through cold nights to grit roads and pathways, their dedication often goes unseen but makes a real difference every day. Congratulations finally to Steven Taylor, Advanced Nurse Practitioner in Emergency Medicine, who was presented with the CEO Star Award by Janelle Holmes, Chief Executive. Steven is recognised for being consistently supportive and bringing exceptional knowledge, experience and passion to delivering high quality patient care in ED. His commitment to developing others is evident in the way he supports the learning of colleagues, students and patients while continuing to advance his own practice.

Board of Directors in Public **Item 8**

28 January 2026

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 December 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 December 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.

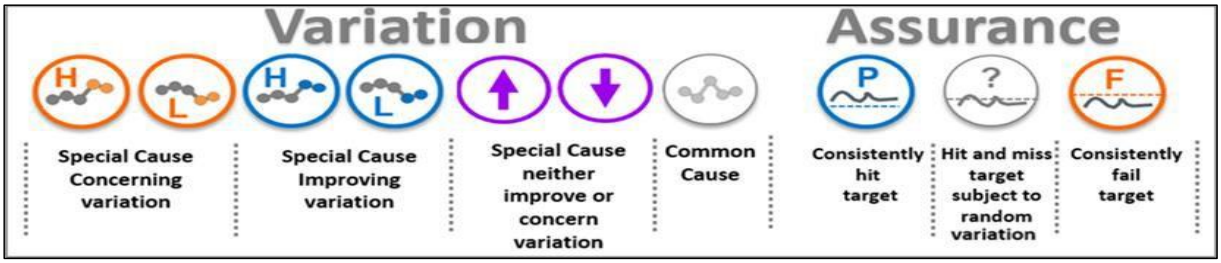
Key Risks
Strategic (Board Assurance Framework- BAF) and operational Risk and opportunities: The Board reviews the Trust's performance at every meeting together with the risks both operational and strategic in the Board Assurance Framework (BAF). The Board seek opportunities to continuously improve the 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.

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.

NHS
Wirral Community Health and Care
NHS Foundation Trust

Integrated Performance Report – December 2025

Dashboard	Workforce
Lead	Chief People Officer

Chief People Officer Update

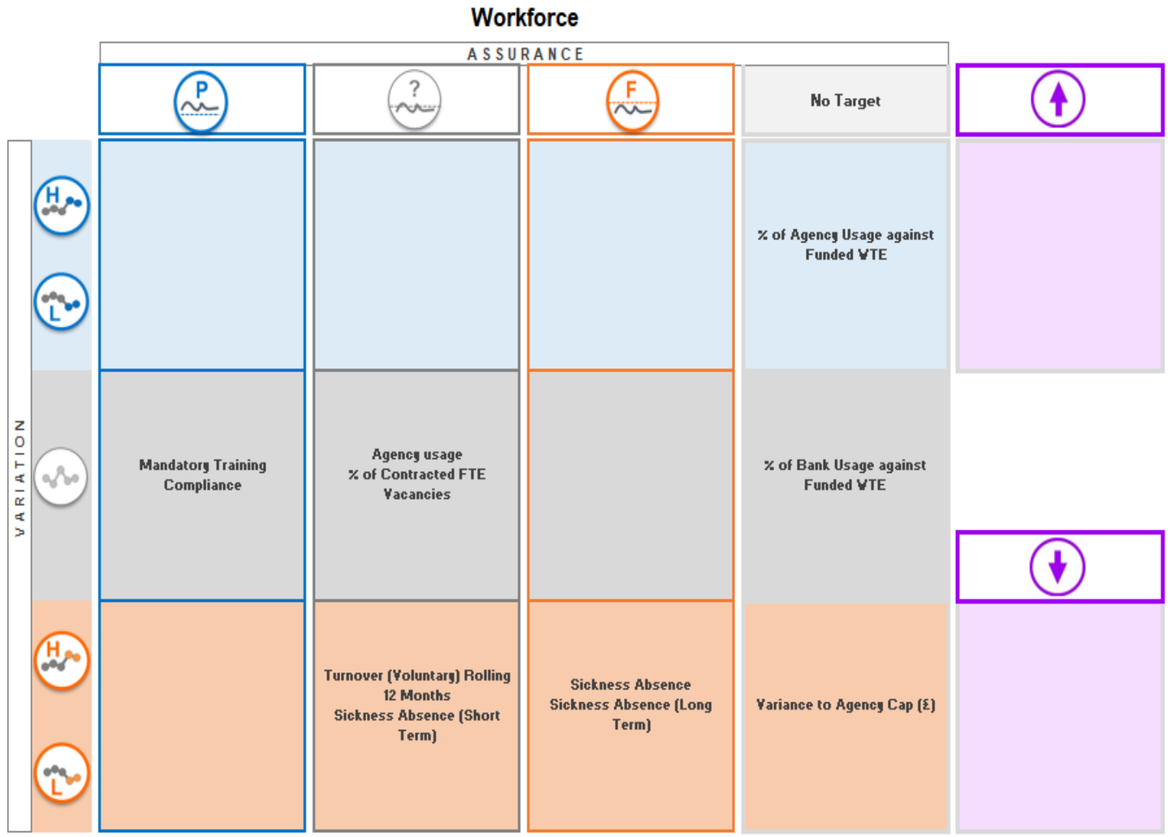
Voluntary Turnover dropped slightly to 9.3% (12 month average), from 9.5% in December, currently there is a review of Turnover metrics to report total turnover including involuntary attrition.

Mandatory training remained above target at 95.10% which shows a month on month improvement of 0.7% The trend is consistent and stable, and all localities are reporting over 90% target.

Agency expenditure has remained low in December at 0.1%. This is significantly below the regional 3.2% target. With the single expenditure in Ophthalmology (1 WTE)

Sickness absence levels continue to be above the Trust ≤5% tolerance. There is a high impact action plan in place ,which has been focused on the high levels of long-term absence. Sickness absence has been an area of concern for several months and latest performance is 7.98% The Trust threshold of ≤5% was last achieved in August 2023. The absence challenges are driven mainly by long term sickness at 5.02%. Long term sickness rates have reduced month on month from 6.26% in August to 5.02% in December reflecting the extensive work undertaken in the action plan. Short term sickness has been increasing and spiked in December at 2.96%.

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, in line with current reporting, however this is likely to increase in line with plans to review turnover rates.

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% however in December percentage of total pay bill was 3.9% which is over the target of 3.2%. This was driven from Specialist Medical, Community Response and Nursing.

Areas of Concern

Sickness absence remains a cause for concern as it is above the Trust ≤5% target at 7.95% in December.

The top 3 reasons remain:

- Mental health (anxiety, stress, depression) (41.34%)
- Gastro (11.77%)
- Cold, cough, flu (10.61%)

Localities with the highest sickness absence were Corporate Services (12.92%), Community Response (9.05%), Children's (8.64%), Specialist Medical (7.99%) and Nursing 7.26%.

Corporate Services rose from 6.55% in Nov to 12.92%.

Recorded RTW discussion dipped to 73% in Nov but were back up at 80% for December.

The risk score on the register is rated at 12.

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:

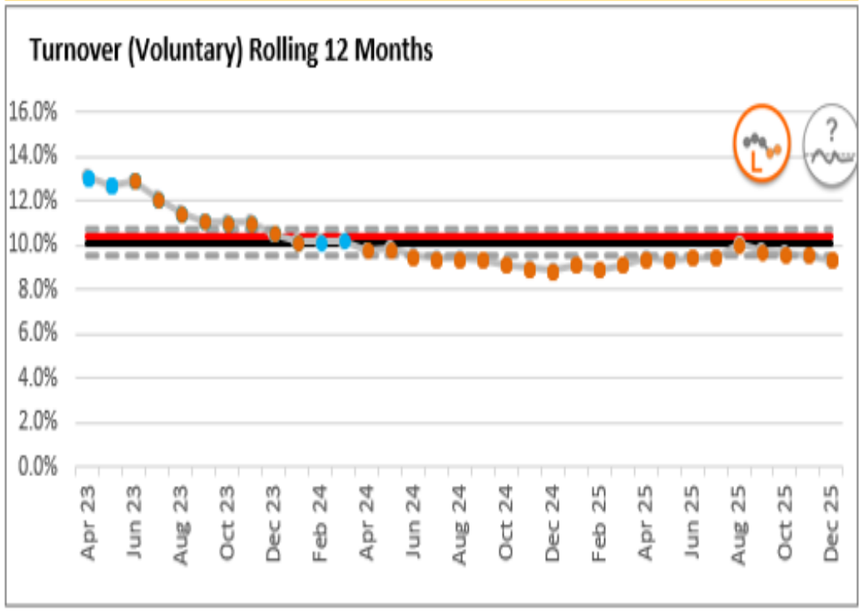
- Continuation of communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness.
- Continuation of the flu programme to prevent increase in flu related absence.
- Designing a new meningitis contact tracing proforma to ensure consistency and timely prophylaxis (antibiotics) treatment.
- A listening event will be undertaken for Urgent Care Centre staff.
- Latest Well WUTH & WCHC programme in progress with 15 attendees in total, from both Trusts.
- New Well WUTH & WCHC promotional video to increase uptake through both powerful individual stories and increased awareness.
- Wellbeing Surgeries held in January focused on mental health and further surgeries scheduled for February.
- New process, support and training being designed for managers to help staff who report suicidal intentions, training dates to be set.
- Mental Health First Aid support session undertaken for MHFA Trained staff at both Trusts.
- Additional Mental Health First Aid training scheduled for February.

Managing Absence:

- The return-to-work programme Well WUTH has been renamed as Well WUTH & WCHC and has been operationalised following the pilot. The pilot evaluation demonstrated strong measurable improvements in participants' emotional, psychological and physical wellbeing. The pilot was validated and the programme established.
- Contract variation and resolution of the OHIO access issues following the TUPE transfer of WCHC staff to WUTH. Access reinstated for the HR Team to support the effective management of cases.
- 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).
- Sickness Audits reported through PCOG.
- Active utilisation of the Health Indicators Report 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

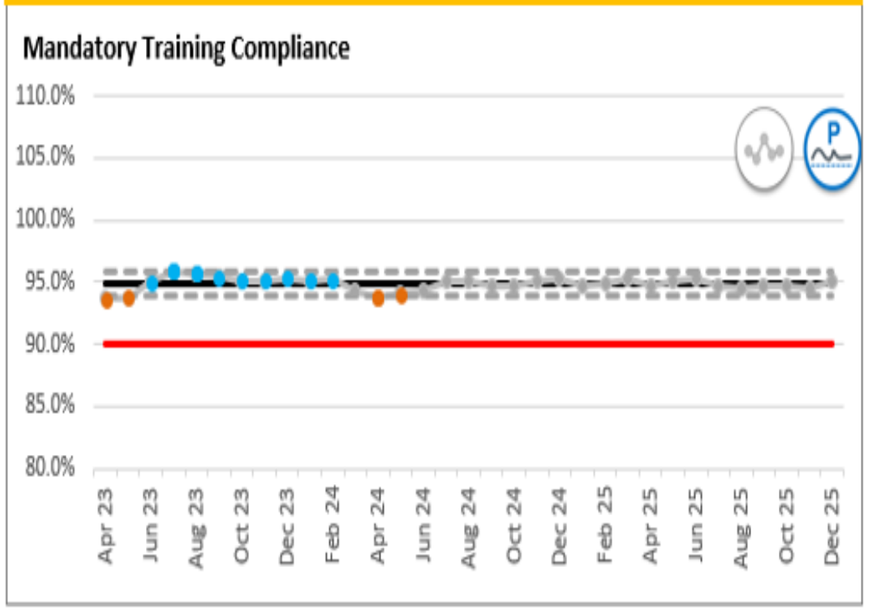
CQC Domain : Safe



Dec-25
9.3%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Hit & miss target subject to random variation

Mandatory Training Compliance

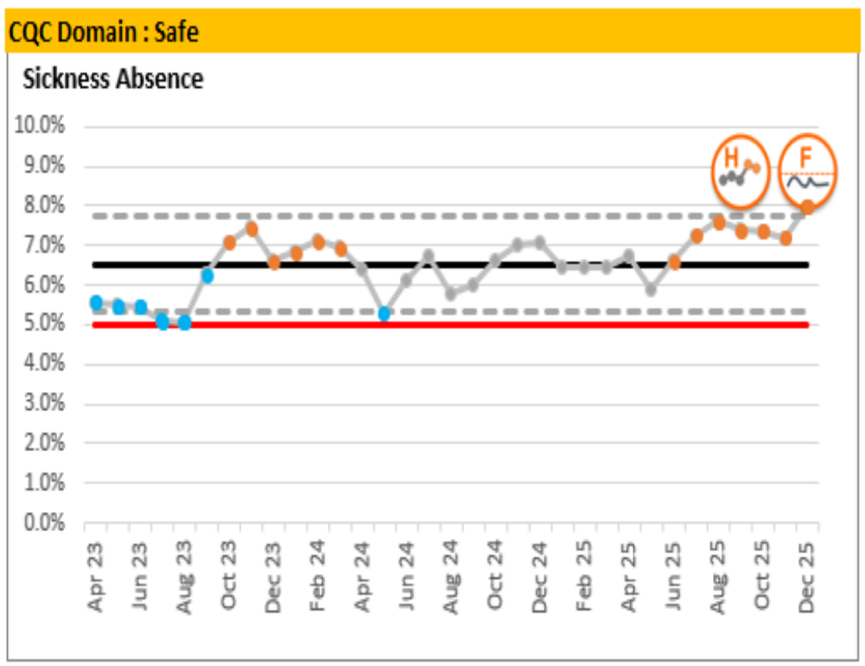
CQC Domain : Safe



Dec-25
95.1%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target

Sickness Absence

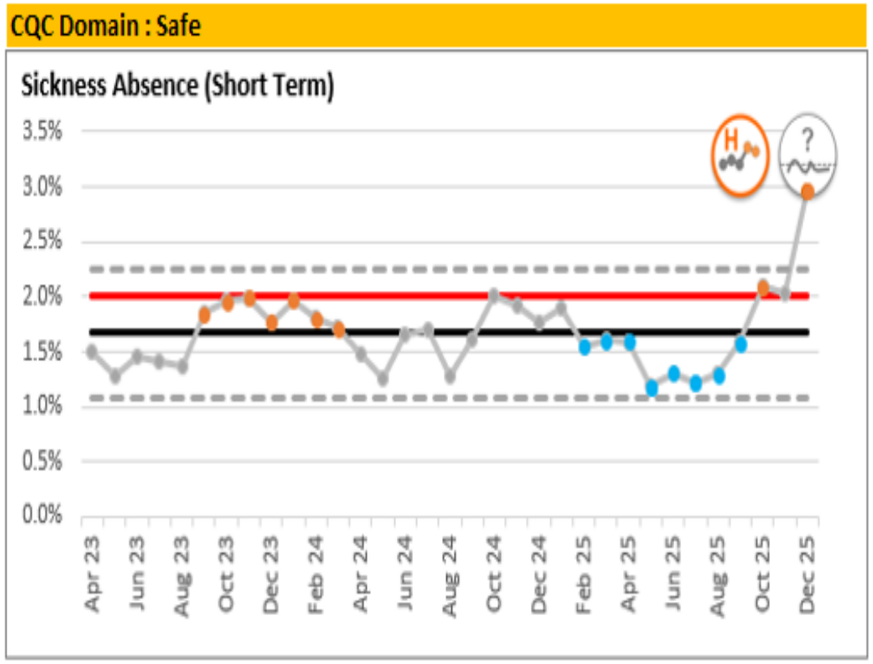
CQC Domain : Safe



Dec-25
8.0%
Variance Type
Special cause variation - Concerning
Threshold
≥5%
Assurance
Performance consistently fails the target

Sickness Absence (Short Term)

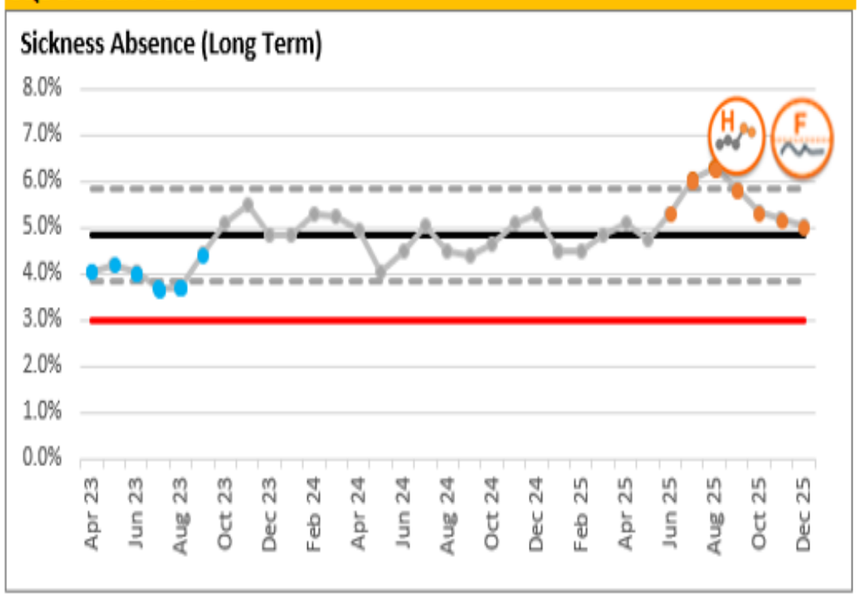
CQC Domain : Safe



Dec-25
3.0%
Variance Type
Special cause variation - Concerning
Threshold
≥2%
Assurance
Hit & miss target subject to random variation

Sickness Absence (Long Term)

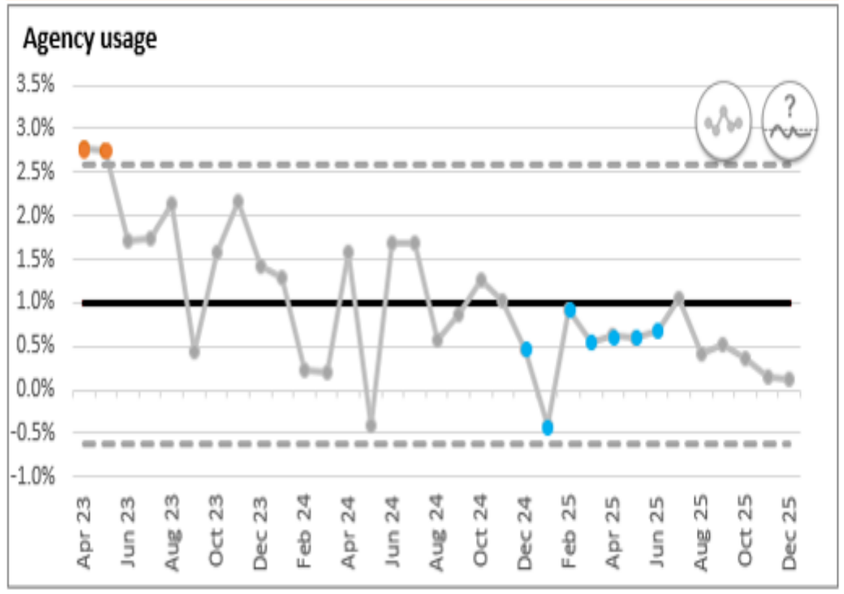
CQC Domain : Safe



Dec-25
5.0%
Variance Type
Special cause variation - Concerning
Threshold
≥3%
Assurance
Performance consistently fails the target

Agency usage

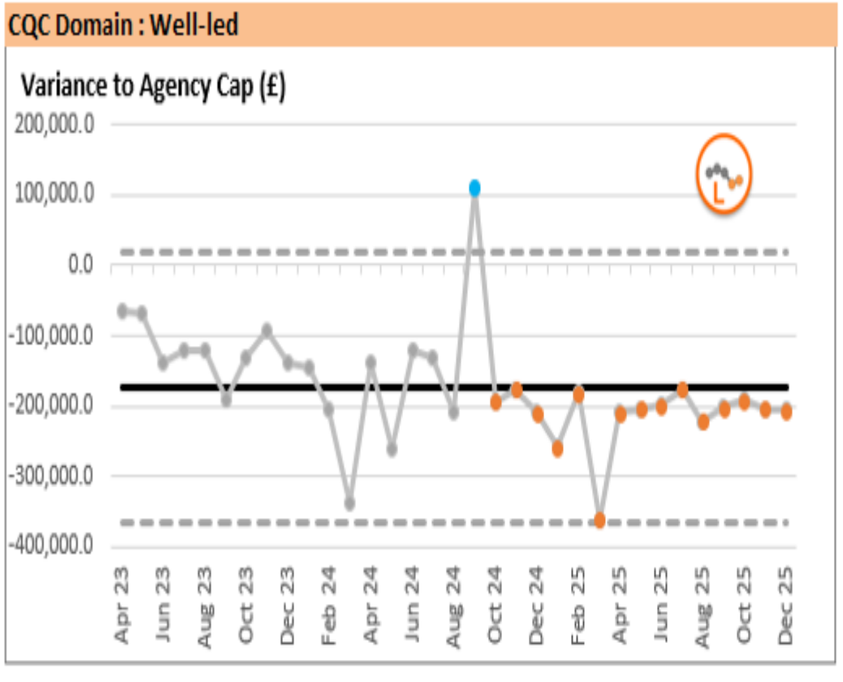
CQC Domain : Well-led



Dec-25
0.1%
Variance Type
Common cause variation
Threshold
≥1%
Assurance
Hit & miss target subject to random variation

Variance to Agency Cap (£)

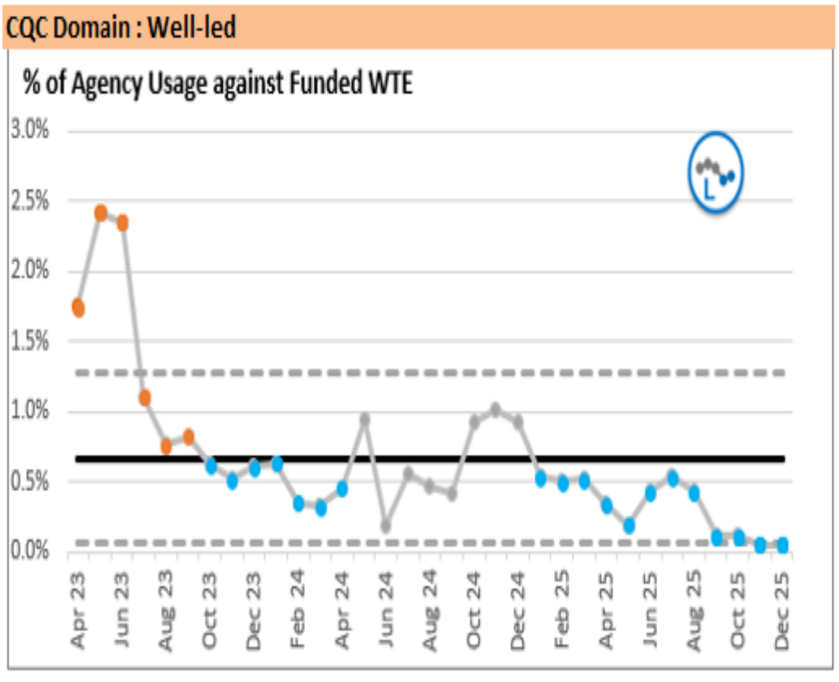
CQC Domain : Well-led



Dec-25
-£205,626.02
Variance Type
Special cause variation - Concerning
Threshold
Assurance

% of Agency Usage against Funded WTE

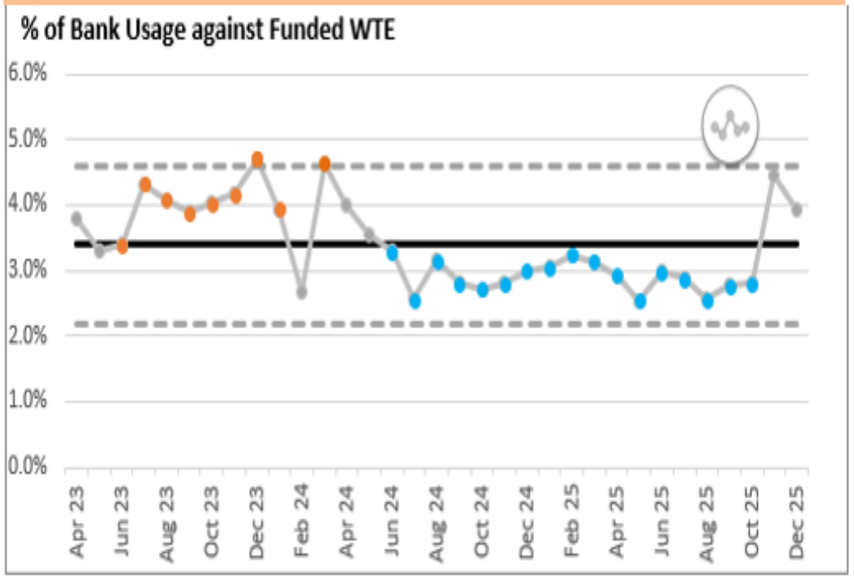
CQC Domain : Well-led



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

% of Bank Usage against Funded WTE

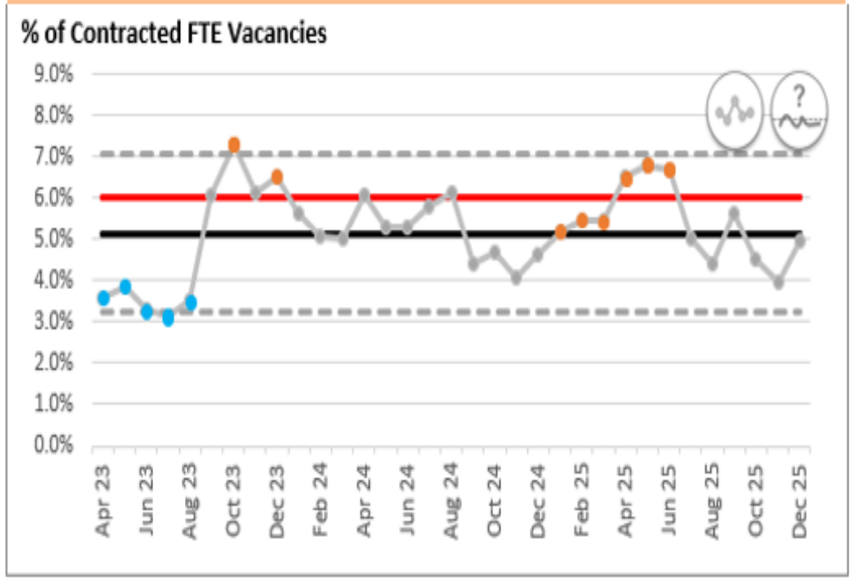
CQC Domain : Well-led



Dec-25
3.9%
Variance Type
Common cause variation
Threshold
Assurance

% of Contracted FTE Vacancies

CQC Domain : Well-led



Dec-25
5.0%
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. The position for M9 25-26 is:

- 83 Green KPIs
- 4 Amber KPIs
- 6 Red KPIs

Highlights by exception:

- UCR performance 84.4% against a 70% target and high volume of activity.
- Intermediate care - CICC occupancy for M9 was well above target at 96% and length of stay at 15.6 days against a 21-day target
- 0-19/25 services –all 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. 4 hour performance for UTC/WICs remains below the 95% target at 92% and GPOOH CAS response times for 20 minute, 2-hour response and NHS 111 also below target. However, notable improvements in UCAT 15 minute, 30 minute and 60 minute response times.

  Significant workforce challenges remain due to sickness and unexpected staff absence (risk 3214). Further staffing challenges in Month 9 have resulted in service continuity plans to be enacted to safely consolidate the UTC/WIC service to APH and VCH, with Eastham WIC closing temporarily.

  CAS 2 hour and NHS 111 performance impacted by staffing challenges. Service clinically prioritises more urgent presentations/response time requirements with staff available (i.e. UCAT, CAS20) which unfortunately impacts ability to meet less urgent targets such as CAS 2 hour and NHS 111.

  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 identifying learning opportunities.

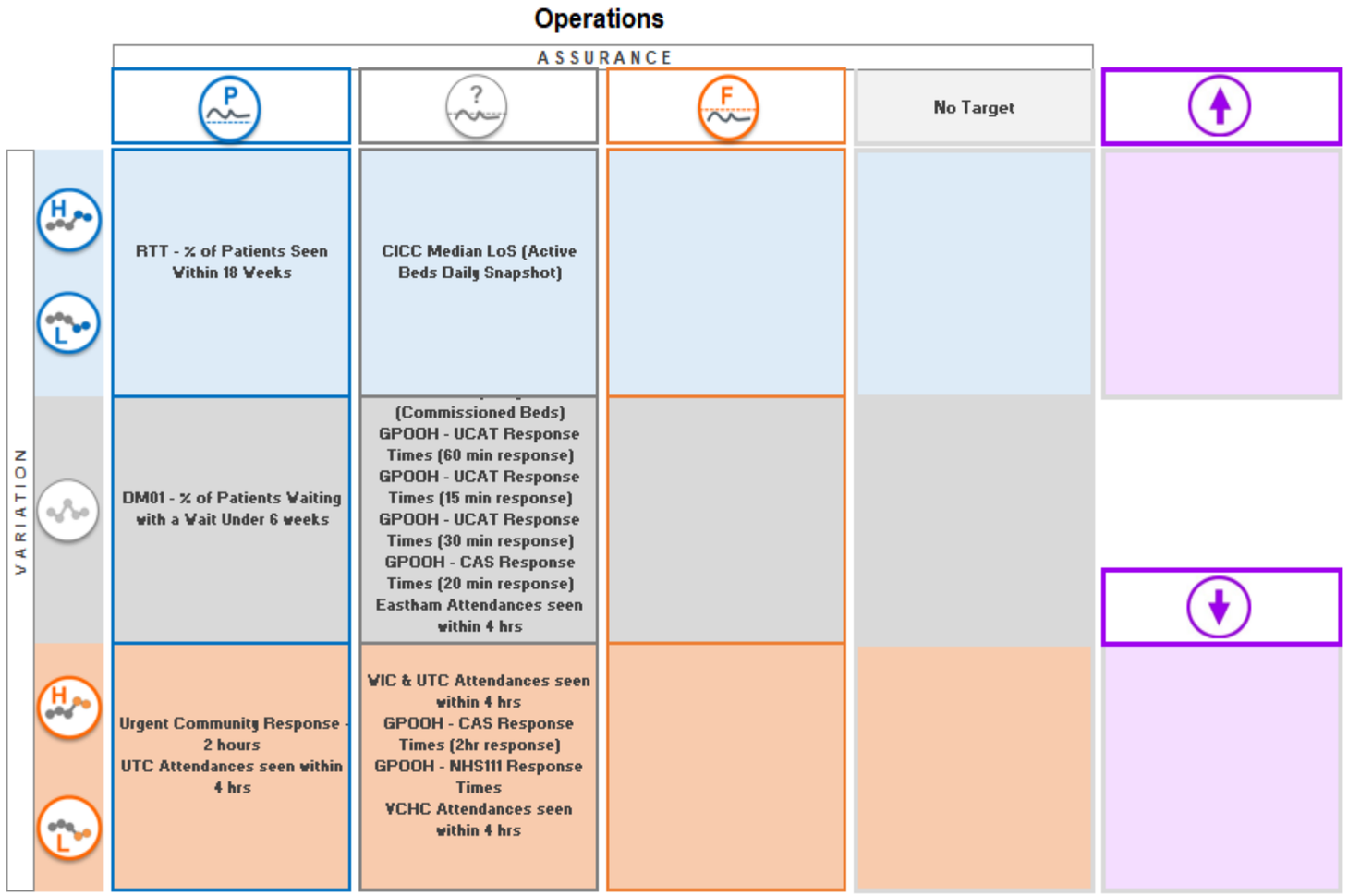
- Waiting lists: remedial action plans in place for Dental and Cardiology services.

  Dental waits are related to volume of patients awaiting paediatric exodontia (Risk 2769). Achievement of the recovery plan is dependent on sufficient additional theatre capacity at WUTH. Internal and external meetings in place to monitor.

  Cardiology challenges related to the volume of outstanding resting ECGs and the substantial increase in referrals because 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



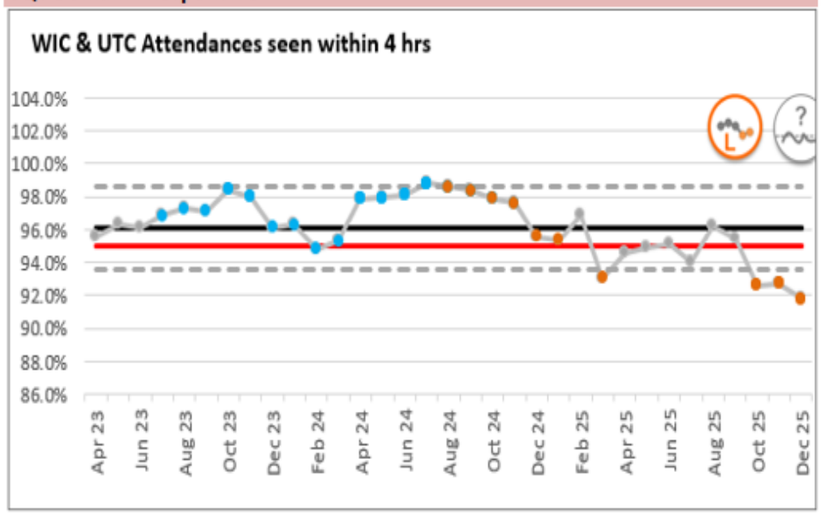
Operations Summary

Highlights	Areas of Concern	Forward Look (Actions)
• UCR performance 84.4% against a 70% target and a significant increase in of activity • Intermediate care - CICC occupancy continues above 90% at 96% and length of stay remains strong at 15.6 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.	• 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). Bladder and Bowel under active monitoring.

• 0-19/25 services – all key metrics across the four regional teams performing above target		

WIC & UTC Attendances seen within 4 hrs

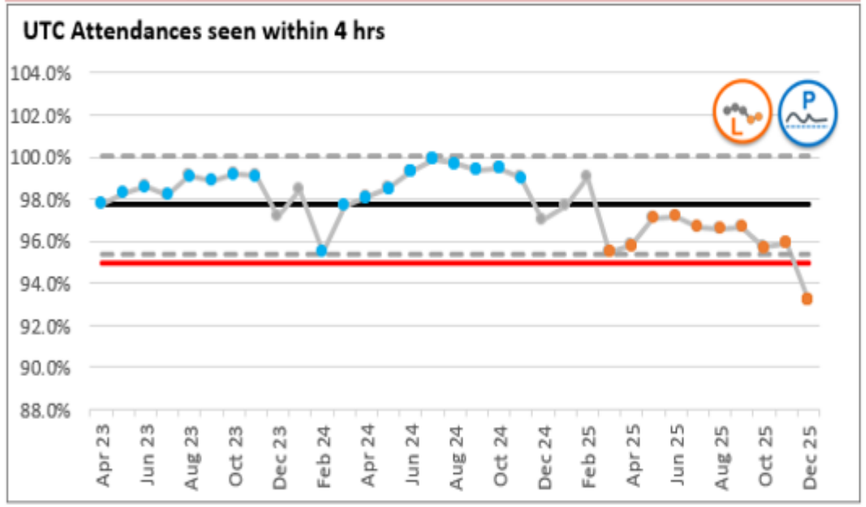
CQC Domain : Responsive



Dec-25
91.8%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

UTC Attendances seen within 4 hrs

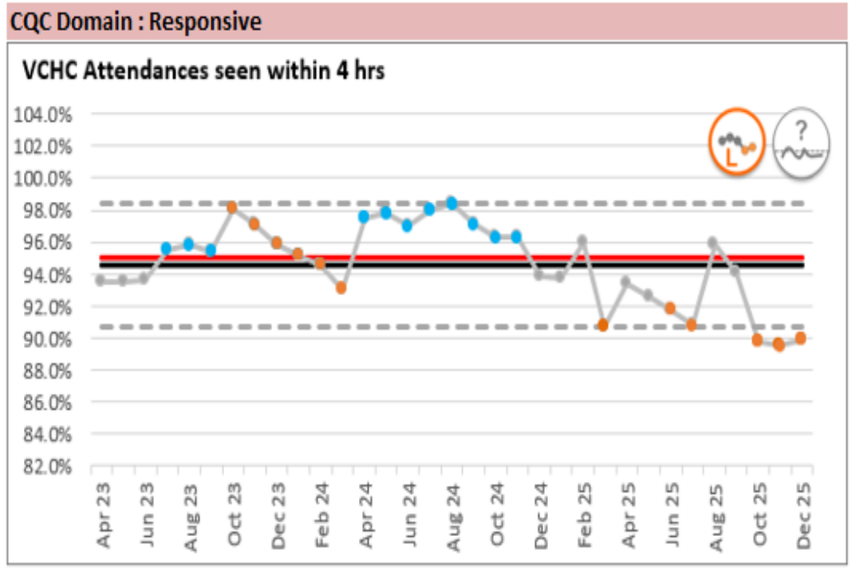
CQC Domain : Responsive



Dec-25
93.2%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Consistanly hit target

VCHC Attendances seen within 4 hrs

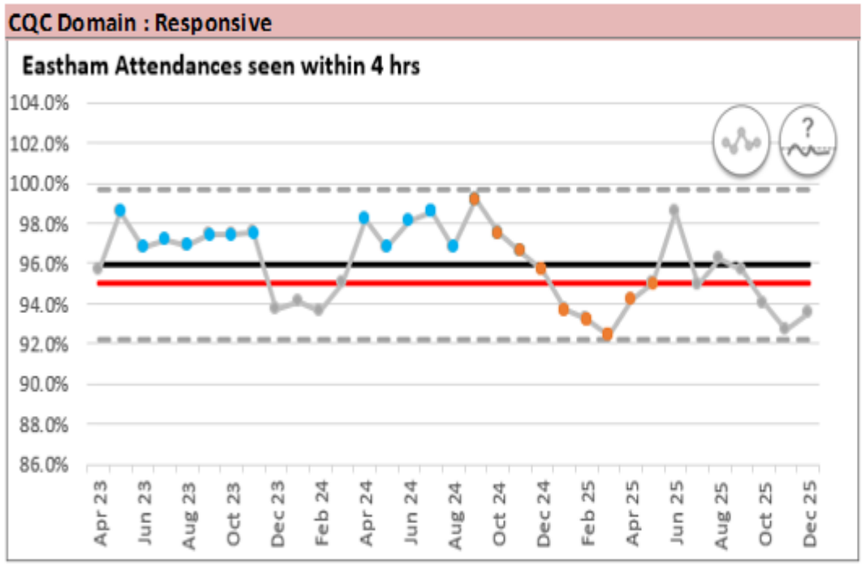
CQC Domain : Responsive



Dec-25
89.9%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Eastham Attendances seen within 4 hrs

CQC Domain : Responsive



Dec-25
93.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

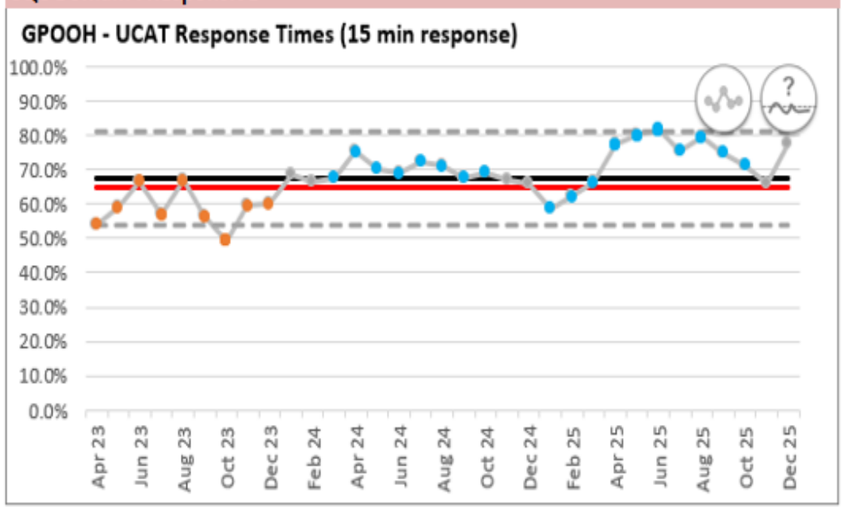
Commentary

4-hour performance overall is 91.8% against the 95% target. YTD performance at 94.2%. Now include 4 hour performance split by site, VCH site (Minor Injuries Unit) particularly challenged. Unprecedented workforce challenges due to sickness and unexpected staff absence (Risk ID: 3214, rated 16) and service enacted business continuity plans to maintain safe staffing across VCH and APH sites, with Eastham WIC closing temporarily. Reviewing staffing position weekly with the aim to re-open Eastham WIC as soon as possible. Remedial action plan for performance remains in place also. Plans include reviewing and

improving the operational service models (current model and 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

GPOOH - UCAT Response Times (15 min response)

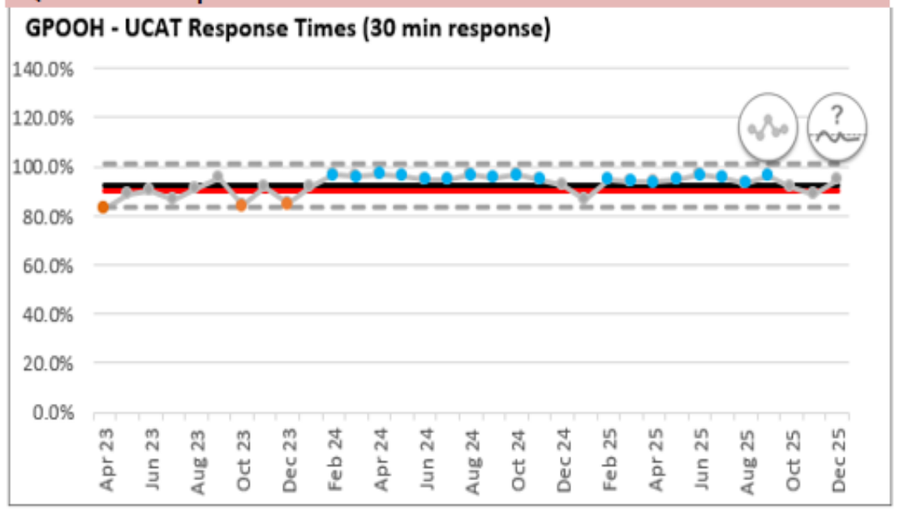
CQC Domain : Responsive



Dec-25
77.3%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (30 min response)

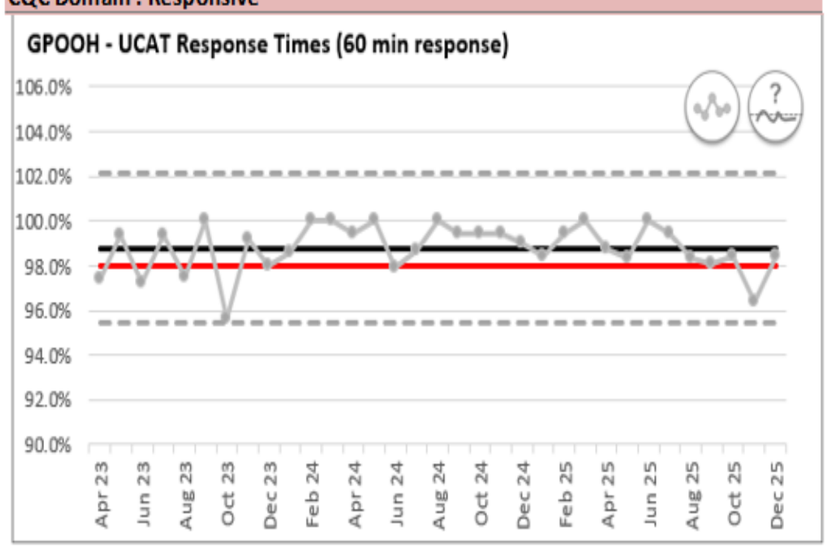
CQC Domain : Responsive



Dec-25
94.3%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

GPOOH - UCAT Response Times (60 min response)

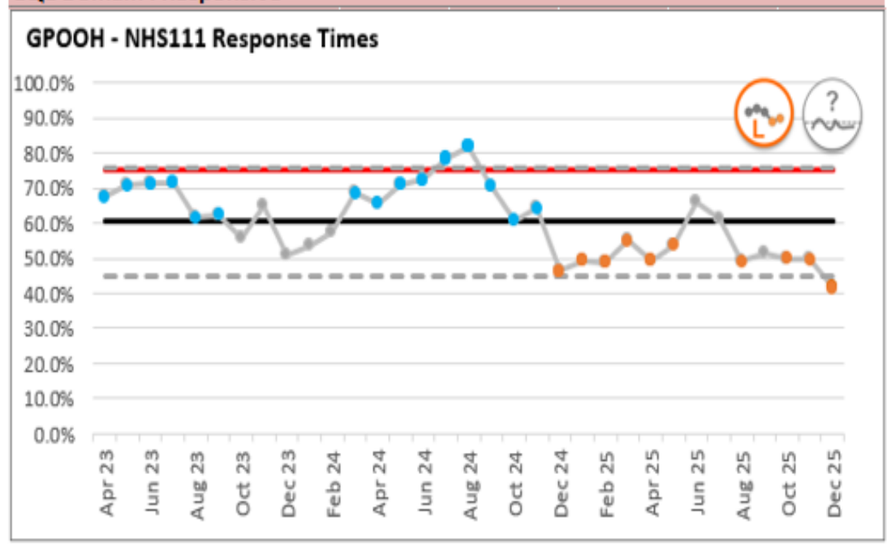
CQC Domain : Responsive



Dec-25
98.5%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation

GPOOH – NHS 111 Response Times

CQC Domain : Responsive



Dec-25
41.5%
Variance Type
Special cause variation - Concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Commentary

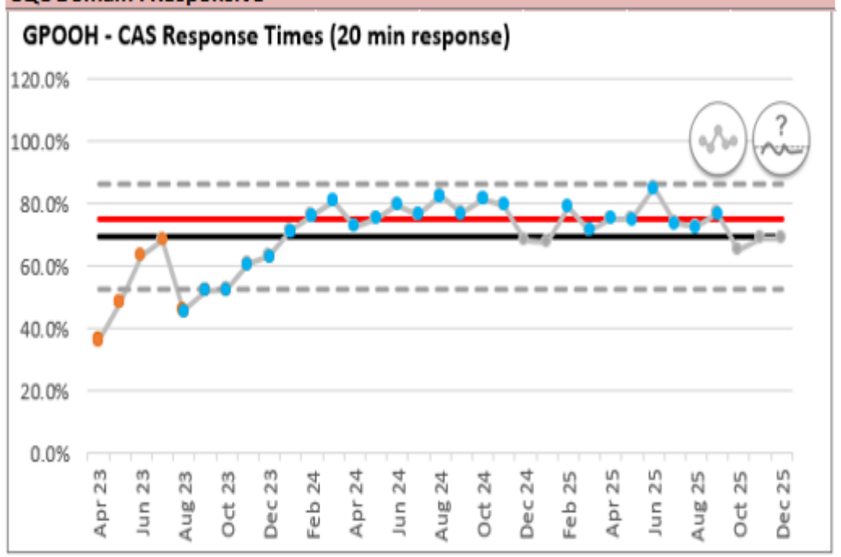
GPOOH CAS and 111 response times.

Continued improved performance for UCAT 15-minute, 30-minute, and 60-minute response times, all now above target. However, performance against CAS 20-minute, 2-hour response times and NHS 111 response times remain outside target. Performance impacted by workforce challenges across urgent care and increased demand. The risk is reflected on the operational risk register (ID 3227). Action plans actively in place and progress monitored through daily oversight and monthly reporting.

CAS 2 hour and NHS 111 performance impacted by urgent care staffing challenges. Service clinically prioritises more urgent presentations/response time requirements with staff available (i.e. UCAT, CAS20) which unfortunately impacts ability to meet less urgent targets such as CAS 2 hour and NHS 111

GPOOH - CAS Response Times (20 min response)

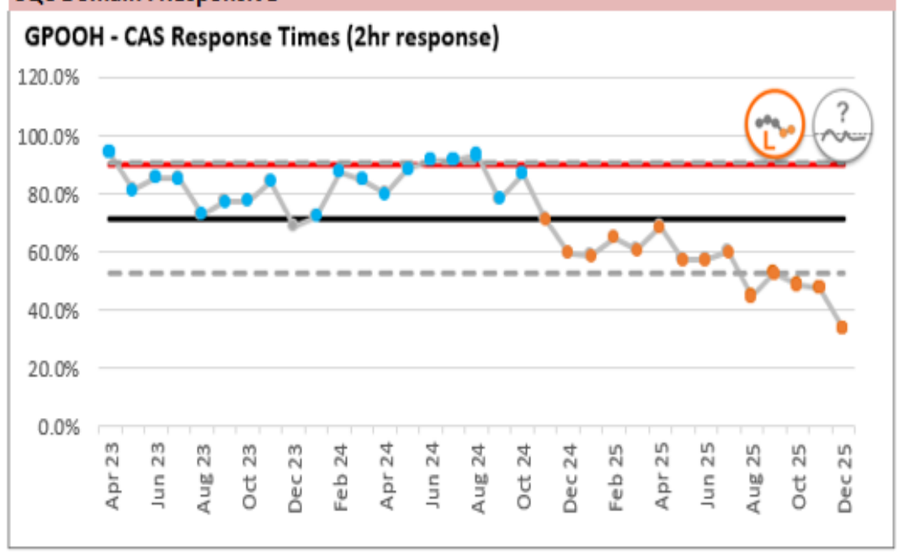
CQC Domain : Responsive



Dec-25
68.8%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

GPOOH - CAS Response Times (2hr response)

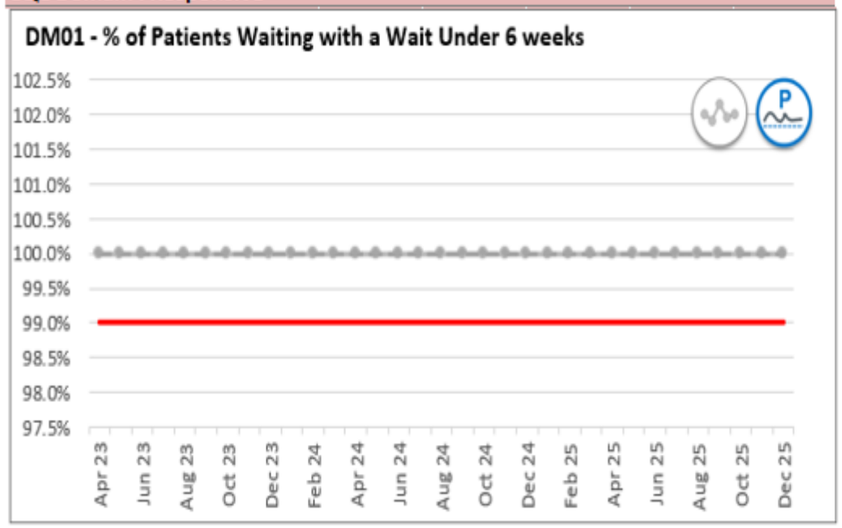
CQC Domain : Responsive



Dec-25
33.3%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

DM01 - % of Patients Waiting under 6 weeks

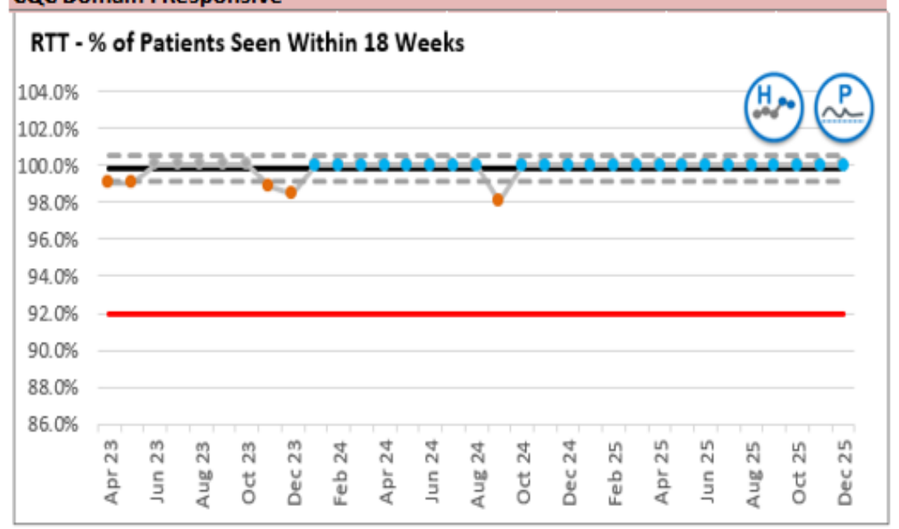
CQC Domain : Responsive



Dec-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



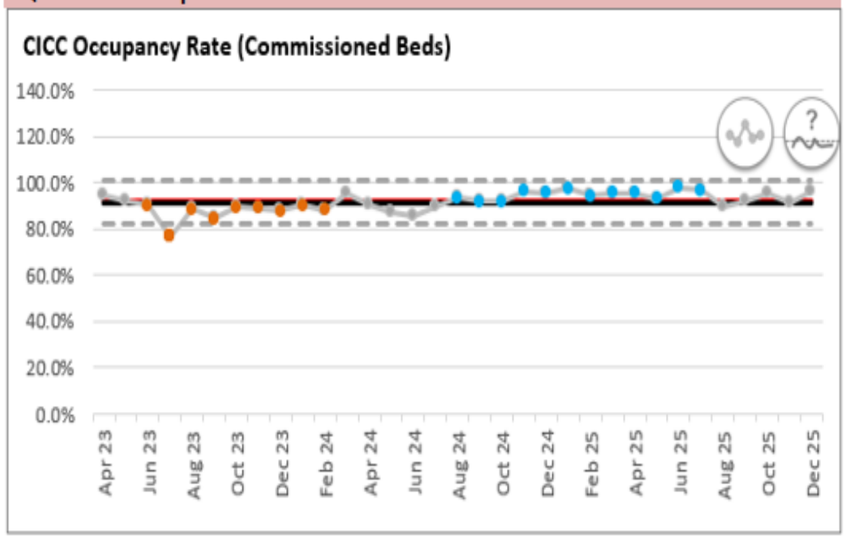
Dec-25
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target

Commentary

DM01/RTT - 100% no concerns

CICC Occupancy Rate (Commissioned Beds)

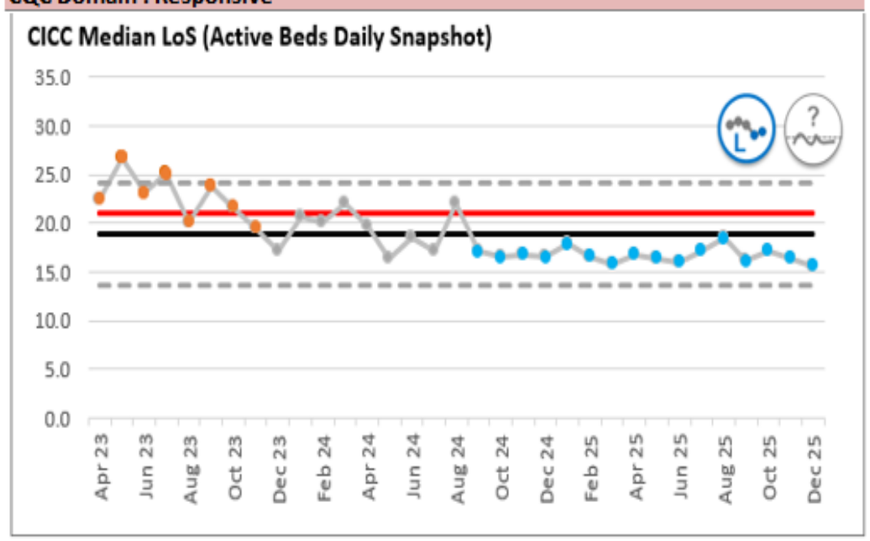
CQC Domain : Responsive



Dec-25
96.0%
Variance Type
Common cause variation
Threshold
≥92%
Assurance
Hit & miss target subject to random variation

CICC Median LoS (Active Beds Daily Snapshot)

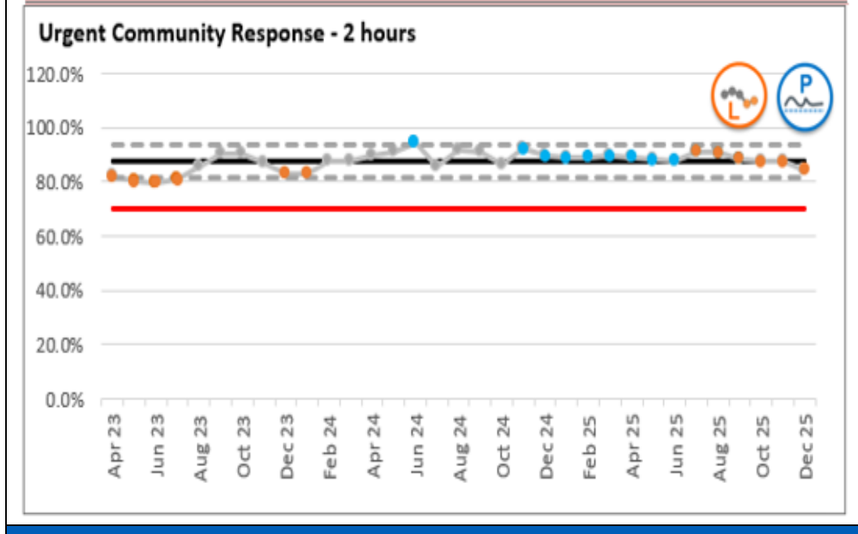
CQC Domain : Responsive



Dec-25
16
Variance Type
Special cause variation - Improving
Threshold
21
Assurance
Hit & miss target subject to random variation

Urgent Community Response - 2 hours

CQC Domain : Responsive



Dec-25
84.4%
Variance Type
Special cause variation - Concerning
Threshold
≥70%
Assurance
Consistanly hit target

Commentary

CICC achieving performance against targets, no concerns
UCR achieving performance against targets, no concerns

Waiting Lists

Waiting list movement in Month - December 2025				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	69% (-9%)	96% (-1%)	100% (0%)	513 (7)
Specialist Medical	91% (-3%)	100% (0%)	100% (0%)	1863 (407)
Specialist Medical - Dental	30% (8%)	50% (8%)	66% (5%)	312 (-18)
Therapies	48% (-11%)	76% (-6%)	90% (-2%)	4408 (407)

0-19/25 Performance

0-19/25 Services - December 25								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	91.1%	89.0%	91.2%	87.6%	94.1%	93.5%	95.9%	94.9%
12 month reviews	90.4%	89.9%	93.0%	90.3%	94.9%	96.1%	90.4%	90.9%
2.5 year reviews	85.9%	88.2%	90.6%	89.8%	93.3%	93.6%	87.6%	89.5%
Breastfeeding 6-8 weeks	56.3%	56.5%	34.0%	37.6%	38.3%	40.2%	49.7%	45.6%

Commentary

Waiting Lists. The average waiting time for all services is below 18 weeks and most services are demonstrating improvements in year-to-date performance for the volume of patients waiting.

Notable YTD performance improvements in Paediatric SALT, and Podiatry. Overall reduction in Waiting List size of 22.9% YTD.

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 SSD incident at WUTH with lost capacity and cancellations. SSD issue is now resolved and the 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 because 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. Bladder and Bowel services are under active monitoring by the Waiting List Management Group.

0-19/25 services. All key metrics across the four regional teams performing above target. Knowsley birth visits returned to Green RAG rating in month following new starters taking up post in November (91.2% against and 85% target).

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 M9 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. In relation to overall incident reporting, there have been eight successive data points below the mean, resulting in a M9 position of special cause variation – concerning. Patient safety incident reporting, however, remains within common cause variation. Further data analysis is in progress to explore the reasons for the reduction in overall reporting; this will progress to the Trust's SAFE Operational Group (SOG) in accordance with Trust governance, to identify learning opportunities. 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 M9, 90.5% of patient safety incidents reported were no or low harm incidents.

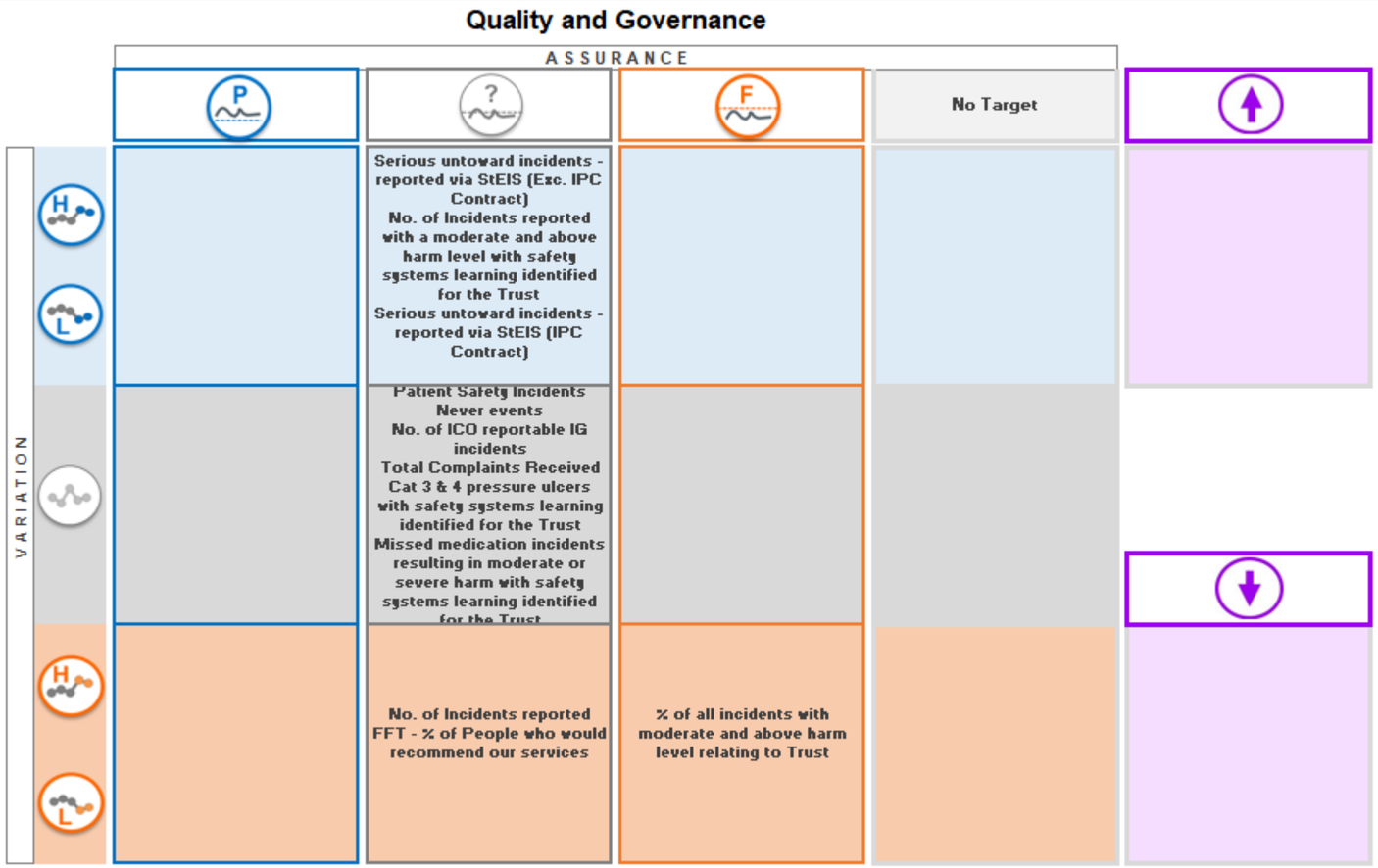
Board is asked to note that there was one ICO reportable incident reported during M8. This incident relates to a data breach involving the recording of information on the incorrect patient record. The information was reported to the ICO in a timely manner and a permanent removal requested and completed, evidencing responsiveness. The incident remains under review by the ICO.

During the M9 reporting period, there has been one fall at CICC resulting in moderate harm; the year-to-date position is two moderate harm falls. 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.

The Trust's overall Friends and Family Test score remains stable at 88.2% for M9 based on 1,697 positive responses, however, this remains below the Trust's standard of 90% and continues to evidence concerning special cause variation. Of the remaining feedback, 4.8% was neither positive or negative and 7% of feedback was negative. In month data analysis continues to reflect learning previously presented to Board in relation to urgent care services.

Four complaints have been received by the Trust during M9, reflecting common cause variation resulting in a red RAG rating for this indicator. The four complaints received relate to four separate services which do not include Walk-in-Centres or GP Out of Hours Services. The reported complaints have progressed to investigation to identify learning.

Quality and Governance Domain Matrix

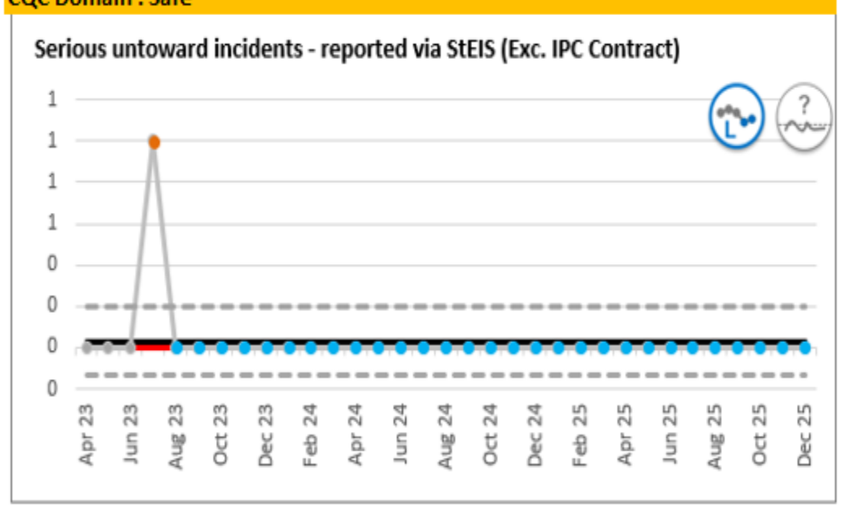


Quality and Governance Summary

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.	In relation to overall incident reporting, there have been eight successive data points below the mean, resulting in a M9 position of special cause variation – concerning. Patient safety incident reporting remains within common cause variation. This is subject to close monitoring. During the M9 reporting period, there has been one fall at CICC resulting in moderate harm, this will progress to review at the Trust's Clinical Risk Management Group (CRMG). The M9 Friends and Family Test score and complaints received are both red RAG rated.	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)

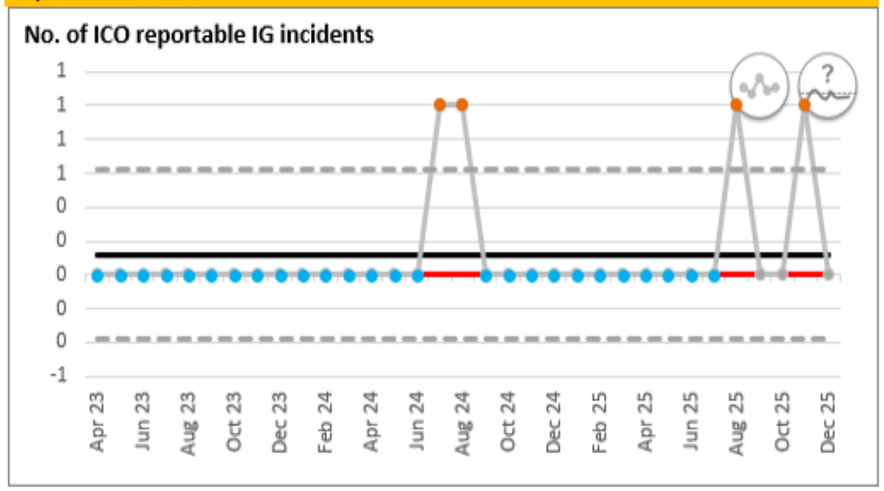
CQC Domain : Safe



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

No. of ICO reportable IG incidents

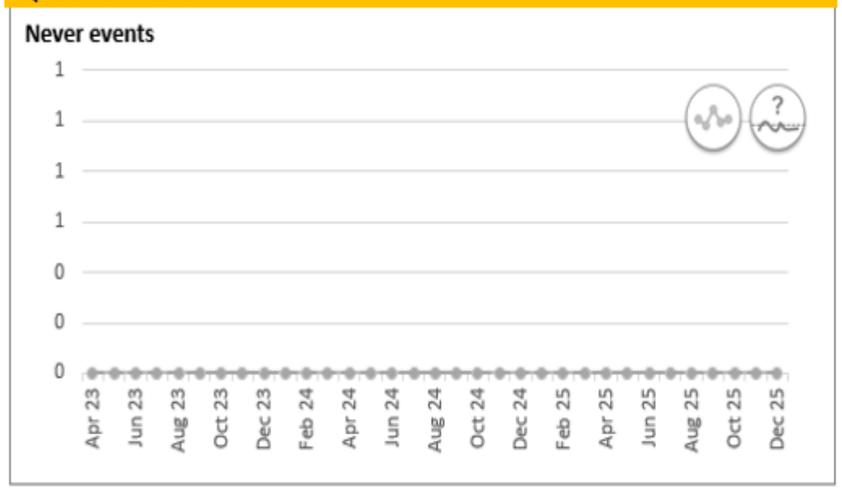
CQC Domain : Safe



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

Never events

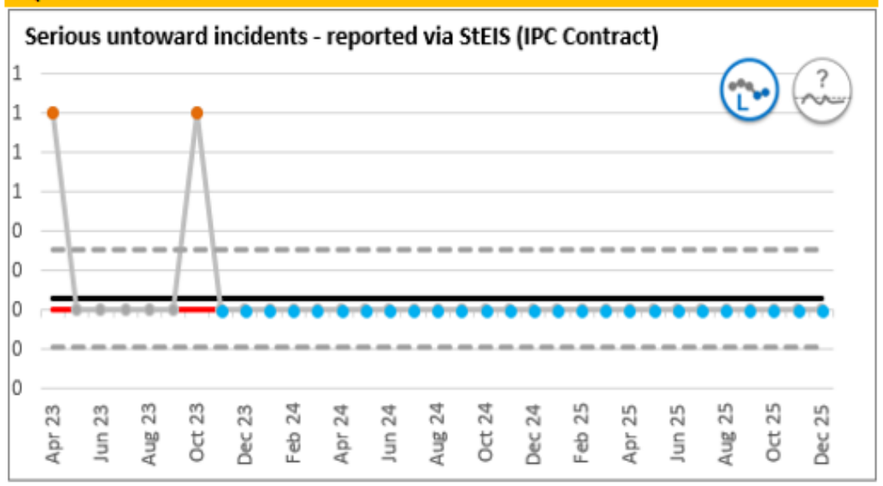
CQC Domain : Safe



Dec-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)

CQC Domain : Safe



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

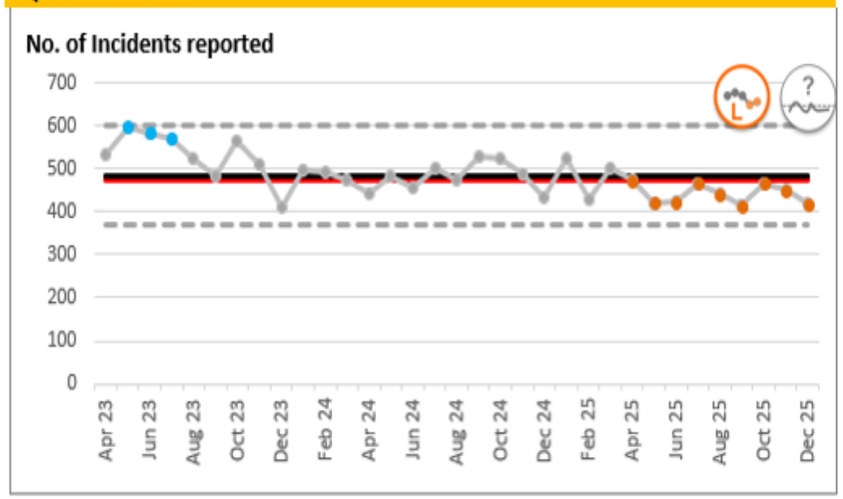
Commentary

The above indicators all have tolerances of zero.

During the M9 reporting period, there have been no reported incidents relating to any of these indicators, however, during M8 there was one ICO reportable incident to highlight to Board. This incident relates to a data breach involving the recording of information on the incorrect patient record. The information was reported to the ICO in a timely manner and a permanent removal requested and completed, evidencing responsiveness. The incident remains under review by the ICO.

Number of Incidents reported

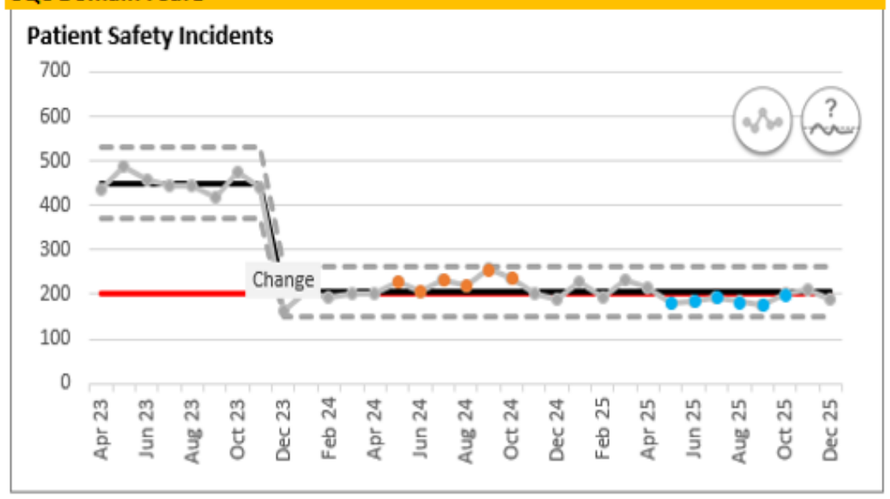
CQC Domain : Safe



Dec-25
419
Variance Type
Special cause variation - Concerning
Threshold
475
Assurance
Hit & miss target subject to random variation

Patient Safety Incidents

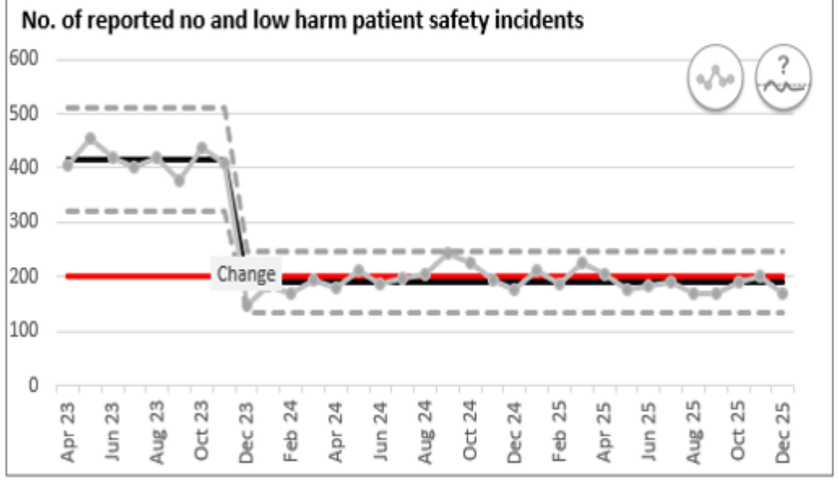
CQC Domain : Safe



Dec-25
188
Variance Type
Common cause variation
Threshold
200
Assurance
Hit & miss target subject to random variation

No. of reported no and low harm patient safety incidents

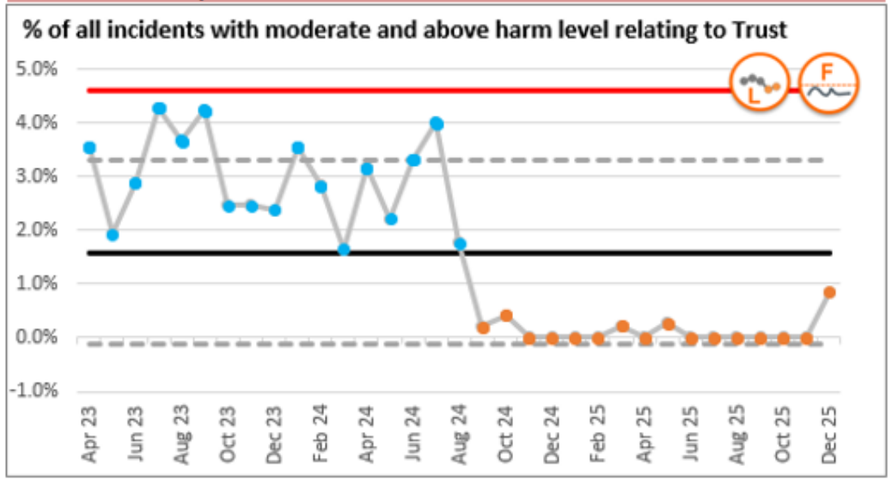
CQC Domain : Safe



Dec-25
170
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



Dec-25
0.9%
Variance Type
Special cause variation - Concerning
Threshold
2.2%
Assurance
Performance consistently fails the target

Commentary

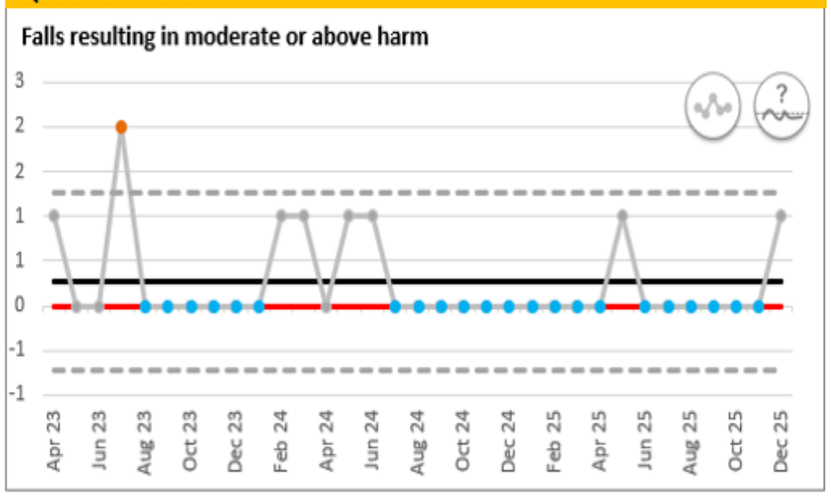
Incident reporting is an effective measure of safety culture across an organisation. In relation to overall incident reporting, there have been eight successive data points below the mean, resulting in a M9 position of special cause variation – concerning. Patient safety incident reporting, however, remains within common cause variation. Further data analysis is in progress to explore the reasons for the reduction in overall reporting; this will progress to the Trust's SAFE Operational Group (SOG) in accordance with Trust governance, to identify learning opportunities. This is aligned to the principles of the Patient Safety Incident Response Framework.

During M9, 0.9% of all incidents reported were categorised as resulting in moderate harm, which is slightly higher than the annual reporting period, but remains below the Trust's threshold. All moderate and above harm incidents are reviewed at the appropriate governance group to identify learning.

The number of low and no harm incidents remains within common cause variation and represents 90.5% of patient safety incidents reported during M9.

Falls resulting in moderate or above harm

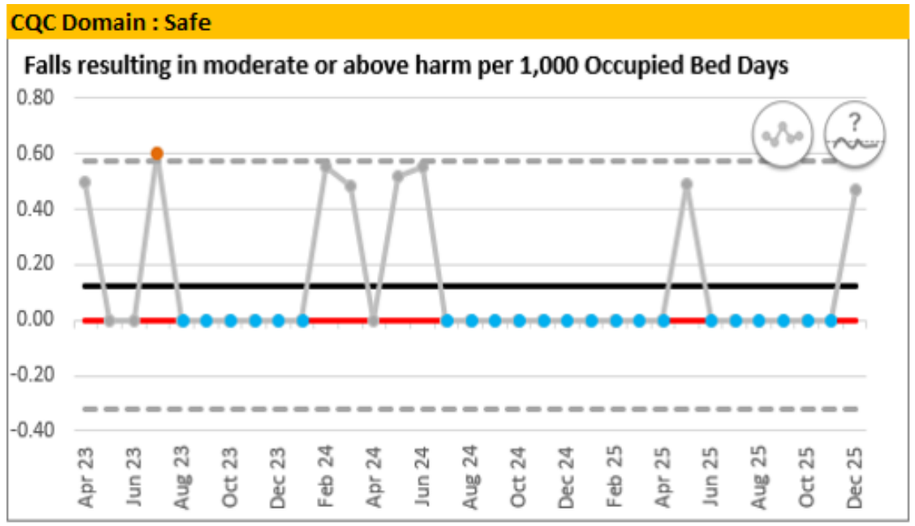
CQC Domain : Safe



Dec-25
1
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

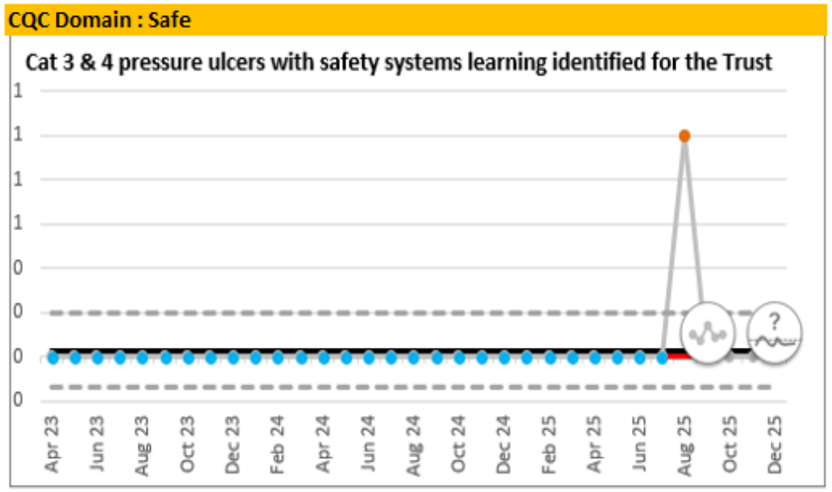
CQC Domain : Safe



Dec-25
0.90
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

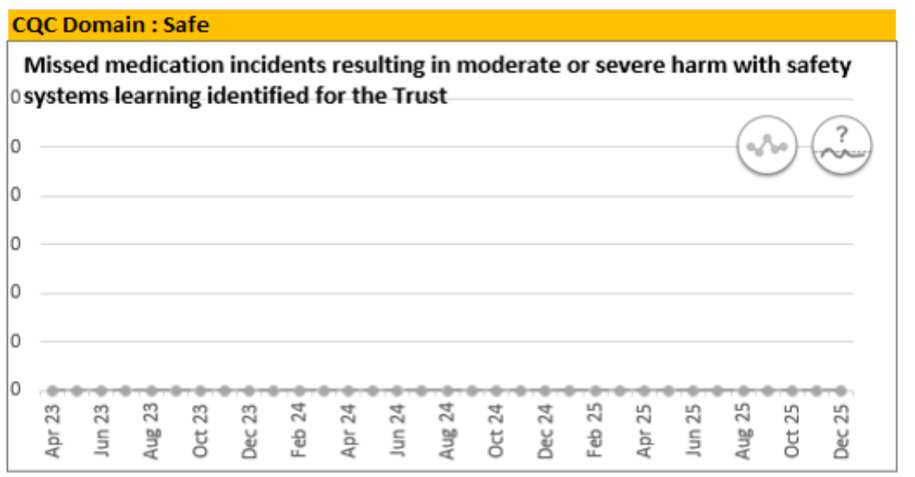
CQC Domain : Safe



Dec-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



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

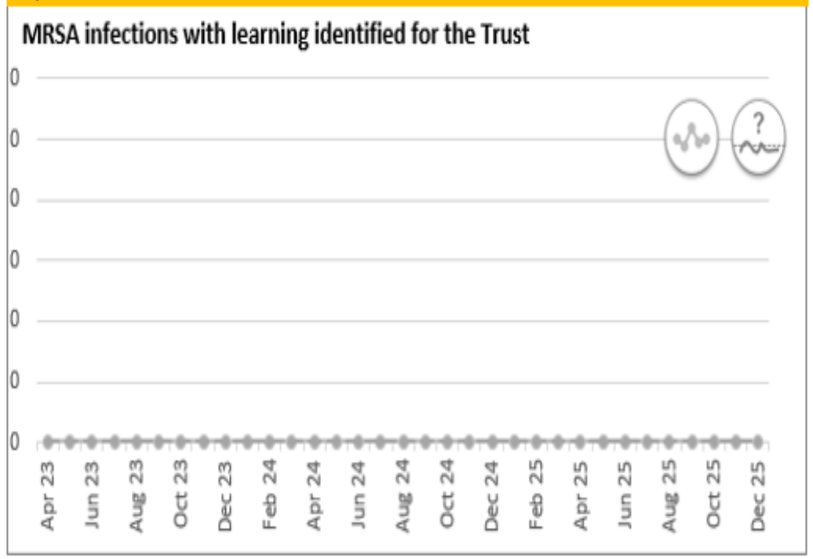
Commentary

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 M9 reporting period, there has been one fall at CICC resulting in moderate harm; the year to-date position is two moderate harm falls. 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.

MRSA infections with learning identified for the Trust

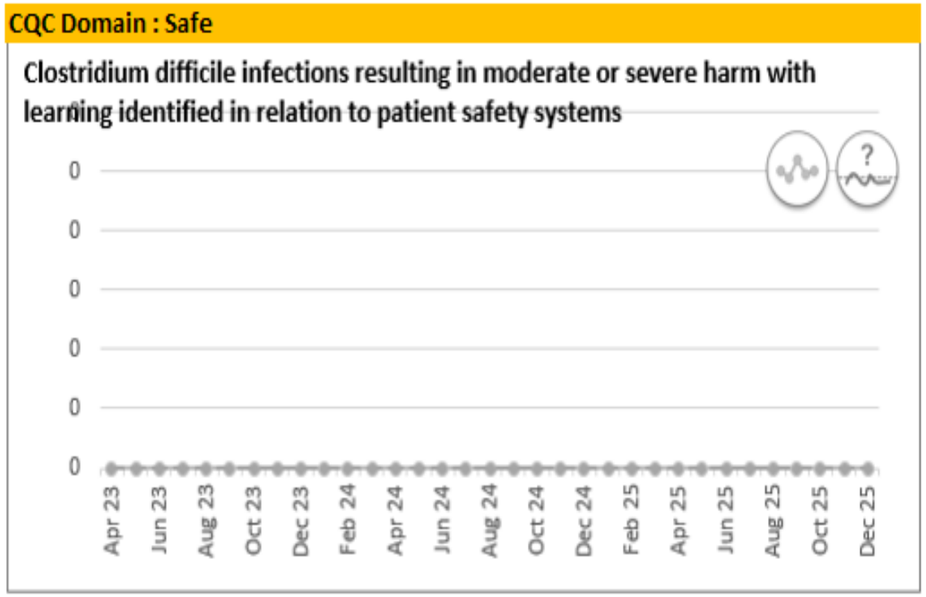
CQC Domain : Safe



Dec-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

CQC Domain : Safe



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

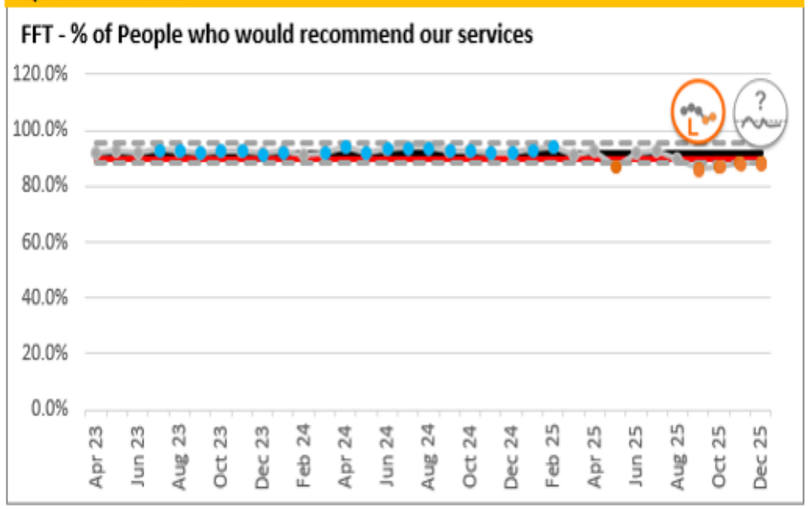
Commentary

During M9, 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

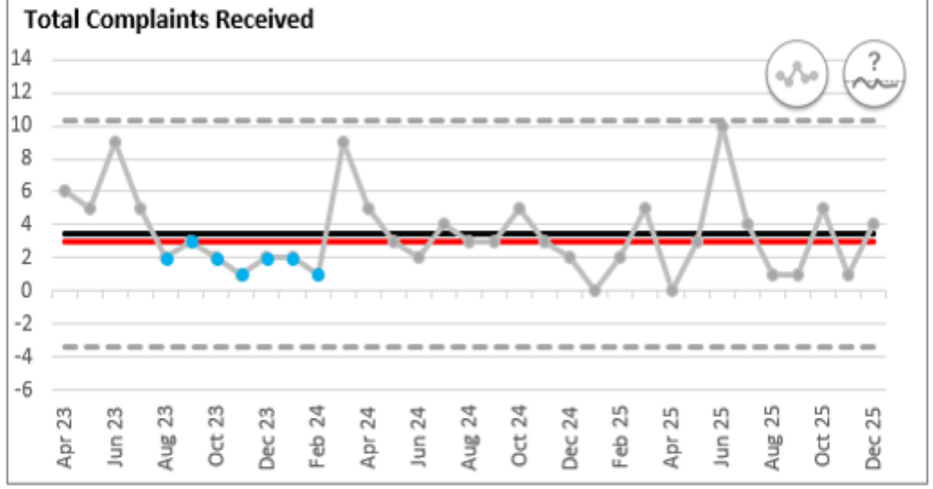
CQC Domain : Safe



Dec-25
88.2%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Total Complaints Received

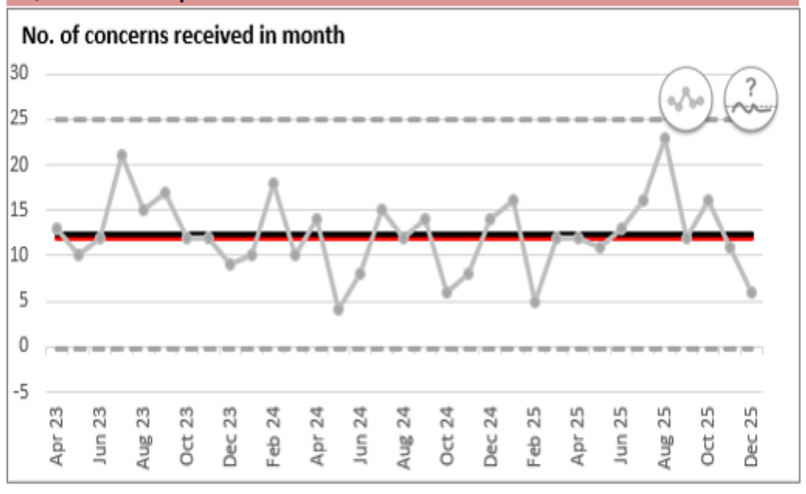
CQC Domain : Responsive



Dec-25
4
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month

CQC Domain : Responsive



Dec-25
6
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

Commentary

The Trust's overall Friends and Family Test score remains stable at 88.2% for M9 based on 1,697 positive responses, however, this remains below the Trust's standard of 90% and continues to evidence concerning special cause variation.

Of the remaining feedback, 4.8% was neither positive or negative and 7% of feedback was negative. In month data analysis continues to reflect learning previously presented to Board in relation to urgent care services.

Four complaints have been received by the Trust during M9, reflecting common cause variation resulting in a red RAG rating for this indicator. The four complaints received relate to four separate services which do not include Walk-in-Centres or GP Out of Hours Services.

Dashboard	Finance
Lead	Chief Finance Officer

Chief Finance Officer Update

At the end of December the Trust is reporting a surplus of £1.6m against a planned deficit of £0.2m, a positive variance to plan of £1.8m. At M9 the Trust has transacted £5.2m of recurrent CIP against a full year target of £6.6m, this shortfall will be fully mitigated by additional CIP and non-recurrent underspends.

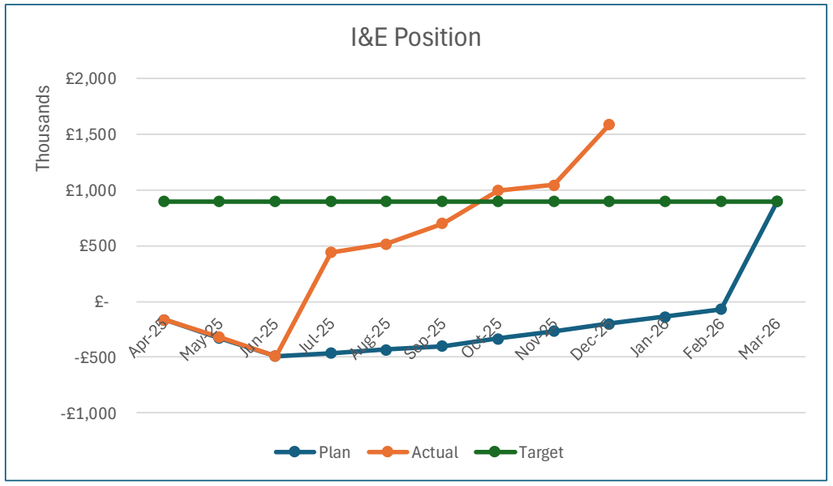
Finance Domain Matrix

Statutory Financial Targets	RAG (M9)	RAG (Forecast)
Financial stability	🟢	🟢
Agency spend	🟢	🟢
Financial sustainability	🟢	🟢
Financial Efficiency	🟡	🟢
Capital	🟢	🟢
Cash	🟡	🟢

Finance Summary

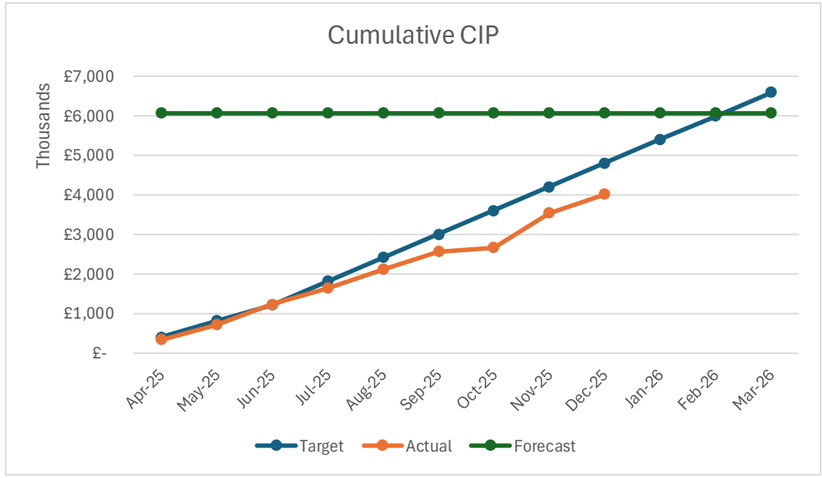
Highlights	Areas of Concern	Forward Look (Actions)
The Trust is ahead of plan at M9. Income is behind plan but this is fully offset by underspends in both pay and non-pay.	The key risk facing the Trust remains the CIP stretch target and delivery off this.	The Trust continues to look at identify additional CIP schemes.

I&E Position



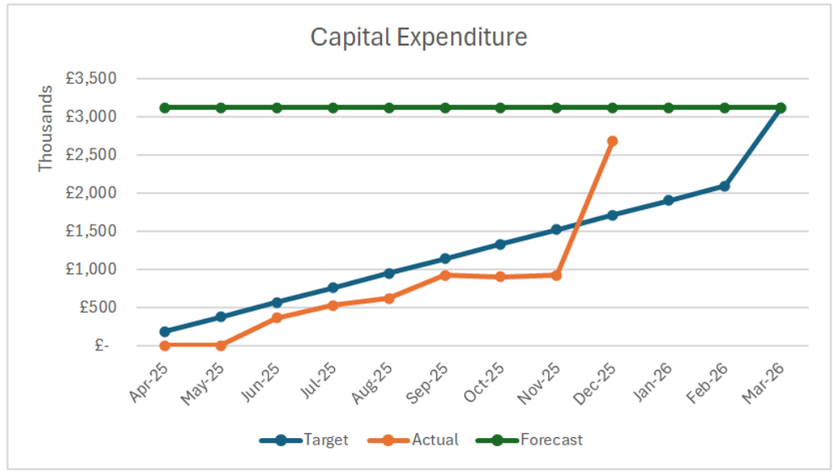
Dec-25
£1,594k
Variance
Position better than plan
Target
£900k

Cumulative CIP



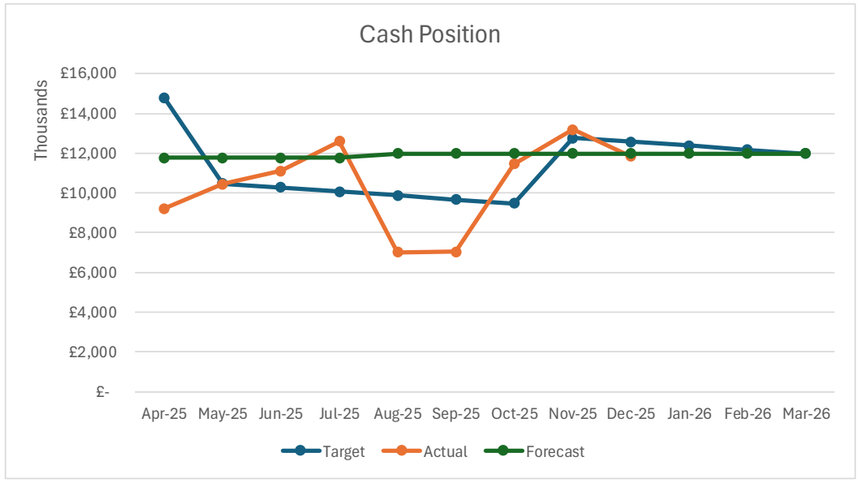
Dec-25
£4,016k
Variance
Position worse than plan
Target
£4,805k

Capital Expenditure



Dec-25
£2,689k
Variance
Position better than plan
Target
£1,713k

Cash Position



Dec-25
£11,845k
Variance
Position worse than plan
Target
£12,571k

Commentary

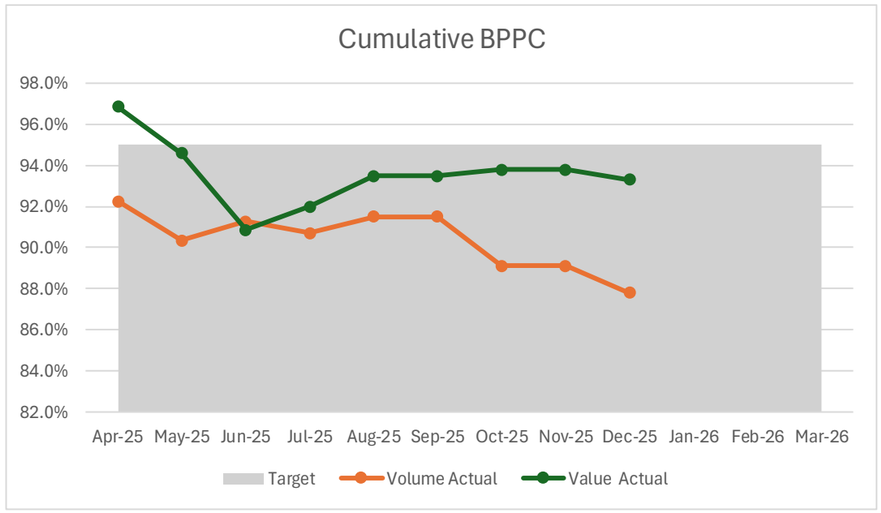
The Trust is performing ahead of plan at M9.

Although patient care income is currently below plan, this is expected to recover in Month 10 due to the catch-up on 0–19 income. Non-pay and finance costs remain broadly in line with plan, and the underspend on pay continues to contribute positively to the overall position.

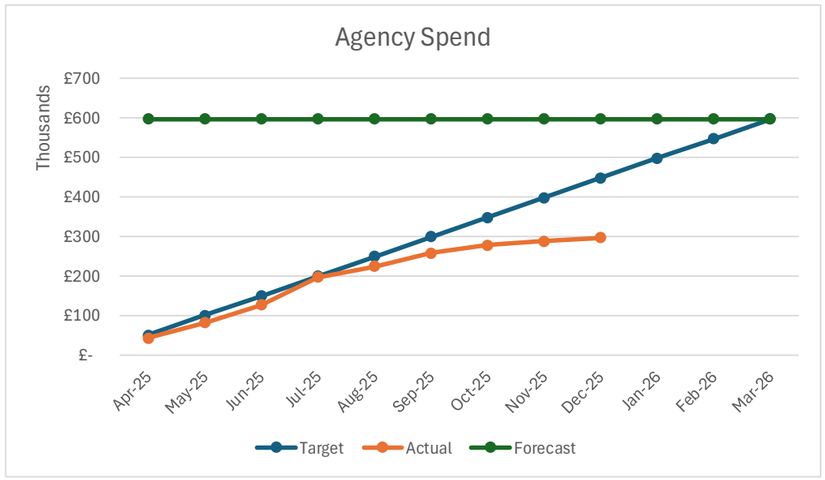
At M9, CIP delivery is £0.452m behind plan but is fully offset by non-recurrent underspends.

The cash balance at M9 is slightly behind plan, primarily due to the catch-up in Accounts Payable payments following the ledger transfer.

Cumulative BPPC



Agency Spend



Dec-25
£296k
Variance
Position better than plan
Target
£448k

Commentary

At M9, the Trust remains below the national BPPC target. This is linked to the ledger migration and the subsequent need to cleanse and reconcile data received from SBS. Work continues to address these issues and improve performance against the target.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

28 January 2026

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 December 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	**3**	**1**	**-**	**4**
Operations	**2**	**15**	**1**	**18**
Quality and Safety	**12**	**8**	**4**	**24**

All Metrics For latest available data, where agreed targets have been defined, 19 metrics were achieving the agreed target and 31 were not achieving target.
N.B. There are 7 metrics without target at present.

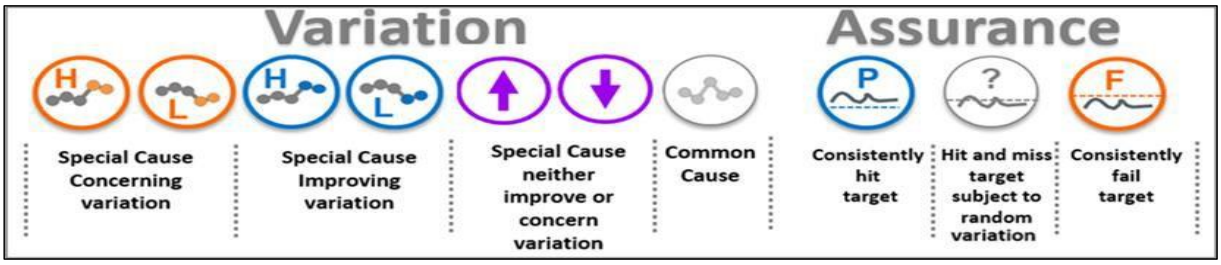
It is recommended that the Board:

- Note performance to the end of December 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

1	Implications
1.1	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 reports by each Executive Director.

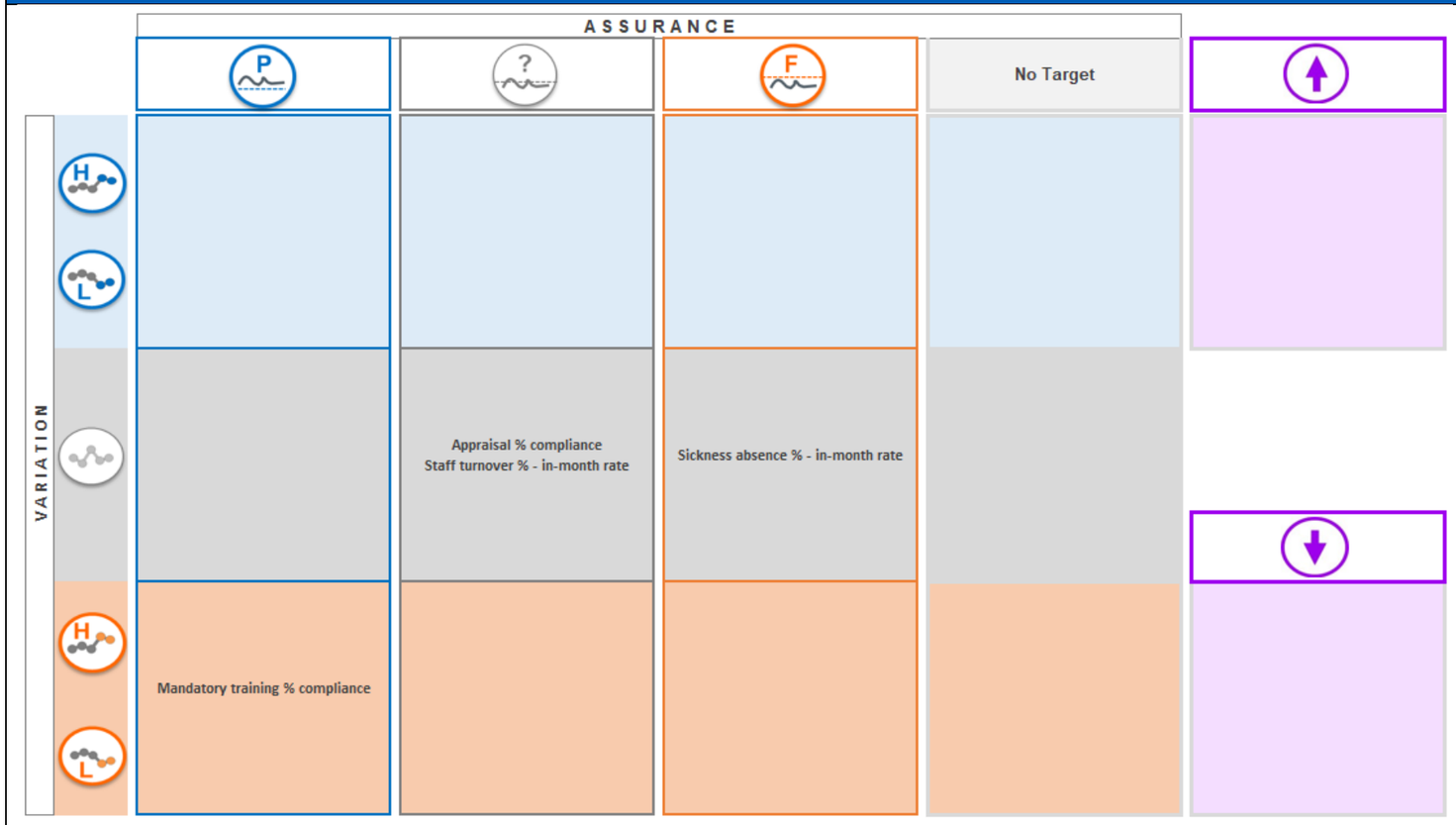
2	General guidance and Statistical Process Charts (SPC)
2.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high 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	Dec 25	6.30%	≤5%			5.98%
Staff turnover % - in-month rate	Dec 25	0.82%	≤1%			87.76%
Mandatory training % compliance	Dec 25	91.72%	≥90%			92.59%
Appraisal % compliance	Dec 25	88.32%	≥88%			0.86%
4-hour Accident and Emergency Target (including APH UTC)	Dec 25	58.37%	≥95%			61.2%
Number of inpatients not meeting the Criteria to Reside	Dec 25	120	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Dec 25	897	≤0			634
Proportion of patients more than 12 hours in ED from time of arrival	Dec 25	21.16%	≤0%			18.1%
Ambulance Handovers: % < 30 mins	Dec 25	58.71%	≥95%			54.3%
Ambulance Handovers: % < 45 mins	Dec 25	76.77%	≥100%			72.8%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Dec 25	59.34%	≥92%			58.7%
Referral to Treatment - total open pathway waiting list	Dec 25	47125	≤47941			45265
Referral to Treatment - cases exceeding 52 weeks	Dec 25	1046	≤668			1514
Referral to Treatment - cases waiting 78+ wks	Dec 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Nov 25	161	≤77			137
Cancer - Faster Diagnosis Standard	Nov 25	67.14%	≥77%			72.9%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Nov 25	87.82%	≥96%			91.4%
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)	Nov 25	73.19%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Sep 25	75.36%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Dec 25	90.75%	≥95%			92.9%
Long length of stay - number of patients in hospital for 21 or more days	Dec 25	189	≤79			166
Clostridioides difficile (healthcare associated)	Dec 25	7	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Dec 25	6	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Dec 25	0	≤0			0
Patient Safety Incidents	Dec 25	1314	-			1202
FFT Overall experience of very good & good: ED	Dec 25	73.7%	≥95%			76.0%
FFT Overall experience of very good & good: Inpatients	Dec 25	95.2%	≥95%			95.5%
FFT Overall experience of very good & good: Outpatients	Dec 25	98.0%	≥95%			95.4%
FFT Overall experience of very good & good: Maternity	Dec 25	100.0%	≥95%			96.2%
Patient Experience: concerns received in month - Level 1 (informal)	Dec 25	214	≤173			226
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Dec 25	2	≤3			3
Falls – Moderate to Severe Harm	Dec 25	0.18	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Dec 25	90.0%	≥90%			88.8%
WUTH Average RN Night Staffing Fill Rates	Dec 25	94.0%	≥90%			90.4%
WUTH Average CSW Day Staffing Fill Rates	Dec 25	87.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Dec 25	99.0%	≥90%			99.6%
MRSA Cases	Dec 25	1	≤0			0
MSSA Cases	Dec 25	0	≤0			2
% of adult patients VTE risk-assessed on admission	Dec 25	95.9%	≥95%			97.3%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Dec 25	88.6%	≥90%			89.3%
Mortality (SHMI)	Aug 25	1.039	0.95-1.05			1.021
Number of studies open	Dec 25	42				
% of current studies meeting recruitment target	Dec 25	26.2%				
% of open studies with a commercial sponsor	Dec 25	4.8%				

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	Dec 25	6.30%	≤5%			5.98%
Staff turnover % - in-month rate	Dec 25	0.82%	≤1%			87.76%
Mandatory training % compliance	Dec 25	91.72%	≥90%			92.59%
Appraisal % compliance	Dec 25	88.32%	≥88%			0.86%

Areas of Concern

Sickness

Sickness absence levels continue to improve but remain above the Trust's 5% target.

Latest performance is 6.30% in-month which is an increase since Nov but an improved position compared to both Dec'24 (6.68%). The rolling absence reduced for the sixth consecutive month and currently stands at 6.03%.

The top 3 reasons are cold, cough, flu, Gastro and mental health (anxiety/ stress/depression). Notably cold, cough and flu were up by 5.46% from Nov.

The LT sickness reduced to 1.46% and ST increased to 4.84%.

Clinical Support Division (4.44%) and Corporate Support (4.55%) were below target. Surgery Division was the highest at 7.97%, followed by Estates, Facilities and Capital 7.56% and ED 6.85%.

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

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

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.

The Trust has a robust Attendance Management Policy which is working well however, we recognise that some staff groups (Estates and Ancillary, Additional Clinical Services (CSWs) and Nursing and Midwifery) are more affected that others. The Trust continues to implement a wide range of supportive interventions as well as robust application of the policy.

Forward Look (Actions)

Sickness

Proactively supporting physical health and wellbeing:

- Continuation of the communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness.
- Continuation of the flu programme focusing on both targeted areas and outbreak wards to prevent increase in flu related absence.
- Updated return to work Covid guidance re staff testing.
- Designing a new meningitis contact tracing proforma to ensure consistency and timely prophylaxis (antibiotics) treatment.
- Designing a 12-month wellbeing plan for ED.
- Latest Well WUTH & WCHC programme in progress with 15 attendees in total, from both Trusts.
- New Well WUTH and WCHC intranet site in development
- New Well WUTH & WCHC promotional video to increase uptake through both powerful individual stories and increased awareness.
- Wellbeing Surgeries took place in January focused on mental health and further surgeries scheduled for February.
- New staff smoking cessation clinic commenced in January.
- Cervical Screening Living Well Bus (mobile clinic) attended 7 January and is scheduled to return in February and March. Early screening is key to prevent cancers and promote health.
- Wellbeing featured at Leaders in Touch and the Well WUTH & WCHC video will be played as part of a future Monthly All Staff Briefing.
- Mental Health First Aid support session undertaken for MHFA Trained staff at both Trusts.
- Professional Nurse Advocate wellbeing session undertaken.

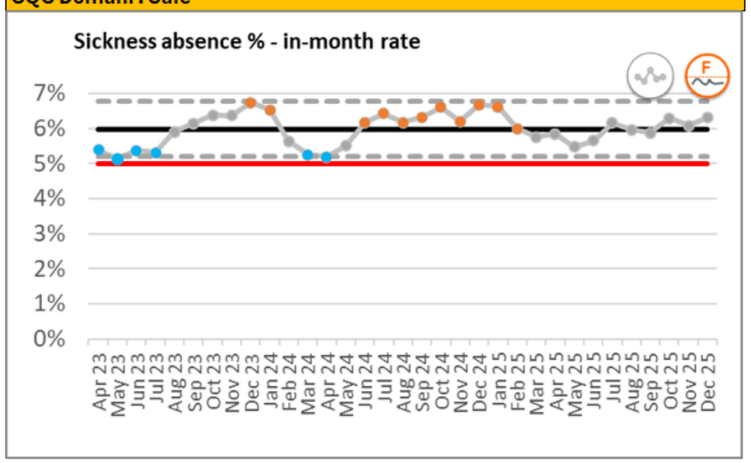
Managing Absence:

- The return-to-work programme Well WUTH has been renamed as Well WUTH & WCHC and has been operationalised following the pilot. The pilot evaluation demonstrated strong measurable improvements in participants' emotional, psychological and physical wellbeing. The pilot was validated and the programme established.
- New Sickness Transformation Project 'Shaping the Plan' sessions undertaken and further session planned to increase stakeholder buy in, shared accountability and action focused.
- Both OHP and OHA waiting times have reduced.
- Focus on Resident Doctors' sickness and new RTW SOP agreed at JLNC.

		• Continuation of sickness absence training. • High impact action plans for each Division focused on hot spots. • 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 Performance Report.

Sickness absence % in month rate

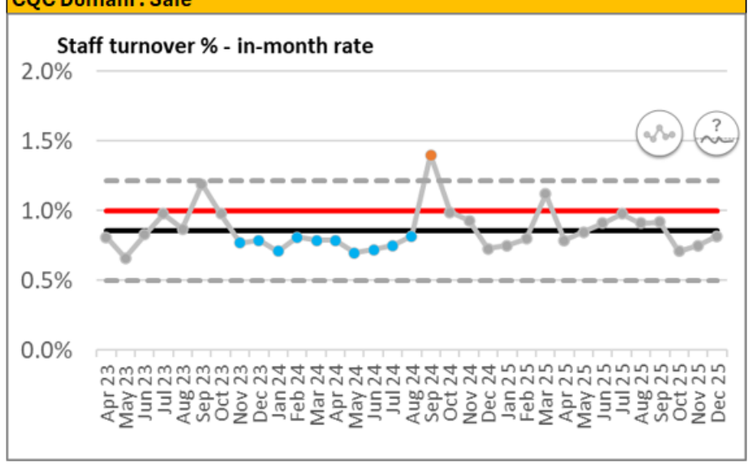
CQC Domain : Safe



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

Staff turnover % in month rate

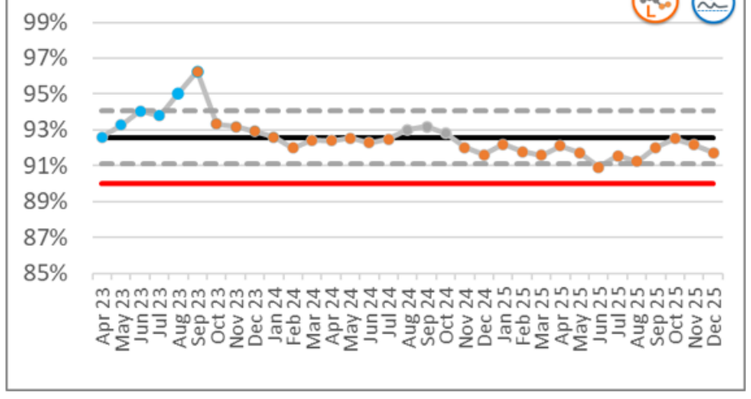
CQC Domain : Safe



Dec-25
0.8%
Variance Type
Common cause variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation

Mandatory training % compliance

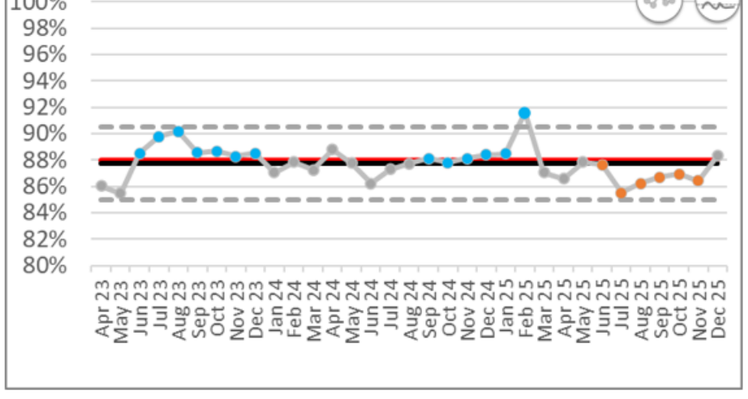
CQC Domain : Safe



Dec-25
91.7%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Consistently hit target

Appraisal % compliance

CQC Domain : Well-led

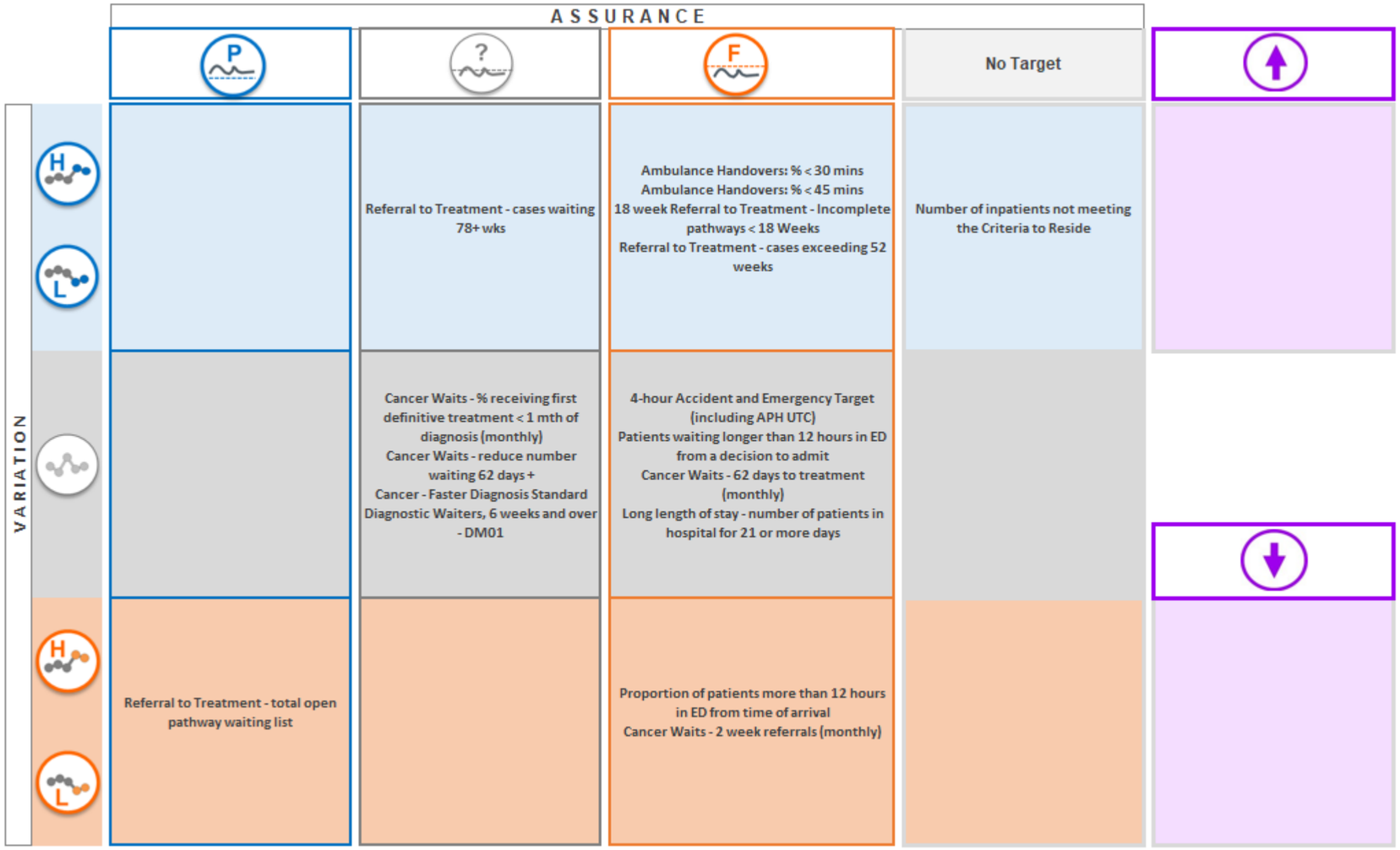


Dec-25
88.3%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Commentary

Dashboard	Operations
Lead	Executive Managing Director

Operations Domain Matrix



Operations Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Dec 25	58.37%	≥95%			61.2%
Number of inpatients not meeting the Criteria to Reside	Dec 25	120	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Dec 25	897	≤0			634
Proportion of patients more than 12 hours in ED from time of arrival	Dec 25	21.16%	≤0%			18.1%
Ambulance Handovers: % < 30 mins	Dec 25	58.71%	≥95%			54.3%
Ambulance Handovers: % < 45 mins	Dec 25	76.77%	≥100%			72.8%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Dec 25	59.34%	≥92%			58.7%
Referral to Treatment - total open pathway waiting list	Dec 25	47125	≤47941			45265
Referral to Treatment - cases exceeding 52 weeks	Dec 25	1046	≤668			1514
Referral to Treatment - cases waiting 78+ wks	Dec 25	0	≤0			6
Cancer Waits - reduce number waiting 62 days +	Nov 25	161	≤77			137
Cancer - Faster Diagnosis Standard	Nov 25	67.14%	≥77%			72.9%
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)	Nov 25	87.82%	≥96%			91.4%
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)	Nov 25	73.19%	≥85%			74.7%
Cancer Waits - 62 days to treatment (quarterly)	Sep 25	75.36%	≥85%			75.0%
Diagnostic Waiters, 6 weeks and over - DM01	Dec 25	90.75%	≥95%			92.9%
Long length of stay - number of patients in hospital for 21 or more days	Dec 25	189	≤79			166

Areas of Concern

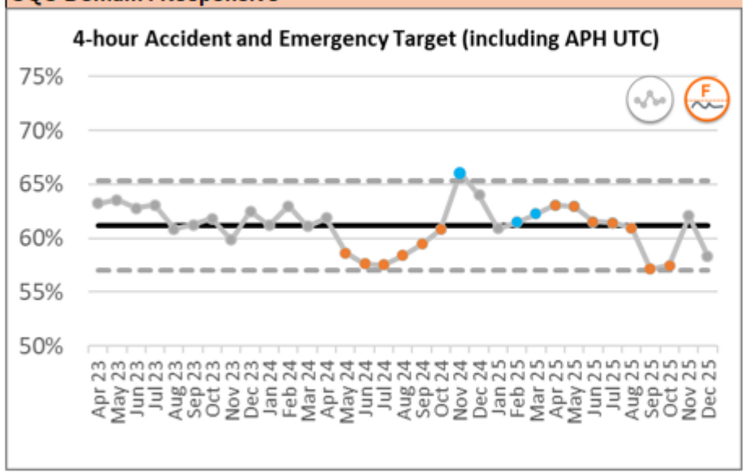
- 4 hour performance
- Patients spending more than 12 hours in ED
- Cancer faster diagnosis standard
- Long length of stay of 21 days or more

Forward Look (Actions)

- Early improvements in 4 hour performance w/c 19th January
- Expected improvements in 28 day faster diagnostic Standard by the end of February
- Improved 12 hour in department performance

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

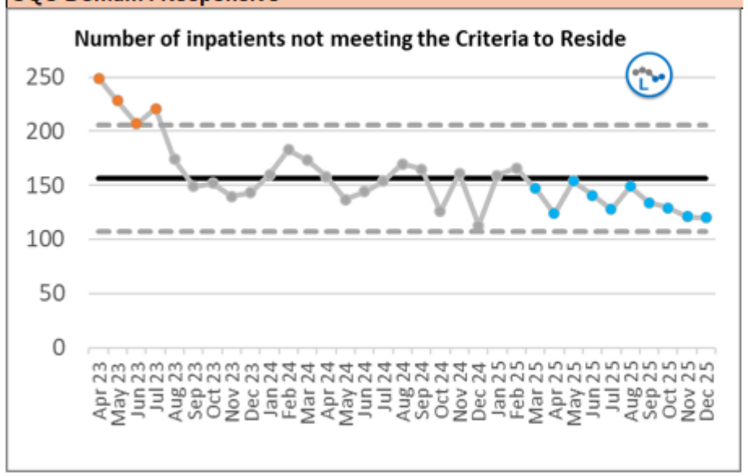
CQC Domain : Responsive



Dec-25
58.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

Number of inpatients not meeting the Criteria to Reside

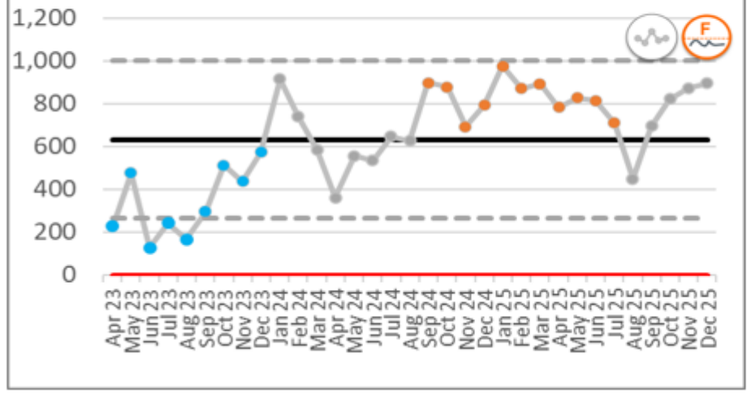
CQC Domain : Responsive



Dec-25
120
Variance Type
Special cause improving variation
Threshold
-
Assurance
Not applicable

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

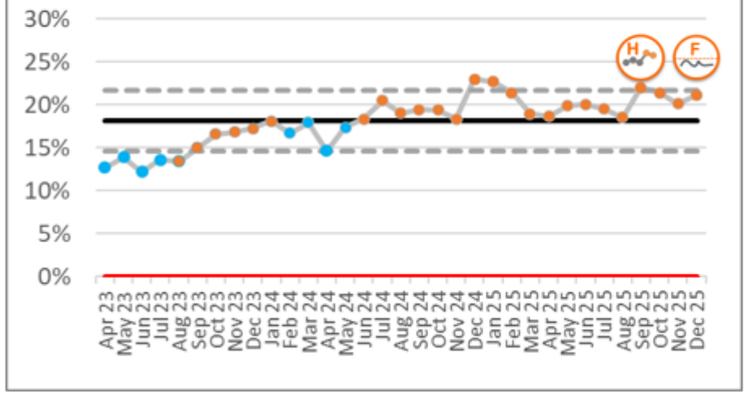
CQC Domain : Responsive



Dec-25
897
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



Dec-25
21.2%
Variance Type
Special cause concerning variation
Threshold
≤0%
Assurance
Consistently fail target

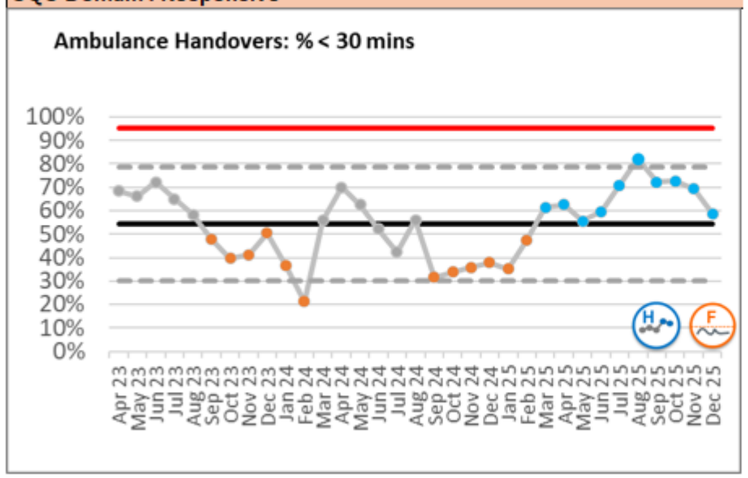
Commentary

4 hour- Some improvements seen in Type 1 performance September to November, with a significant deterioration in December secondary to increased demand. Staffing challenges within UTC across August to October impacted performance. Actions in place to improve tracking of patients and number of ED doctors on shift overnight to support type 1 4 hour performance.

12 hour DTA and LoS- There has been an increase in the number of 12 hour DTA breaches August to December. 12 hour LoS in the Emergency Department remains above 20%. Review of function of escalation spaces in ED and assessment area reconfiguration are in progress to support performance improvement.

Ambulance handover % < 30 minutes

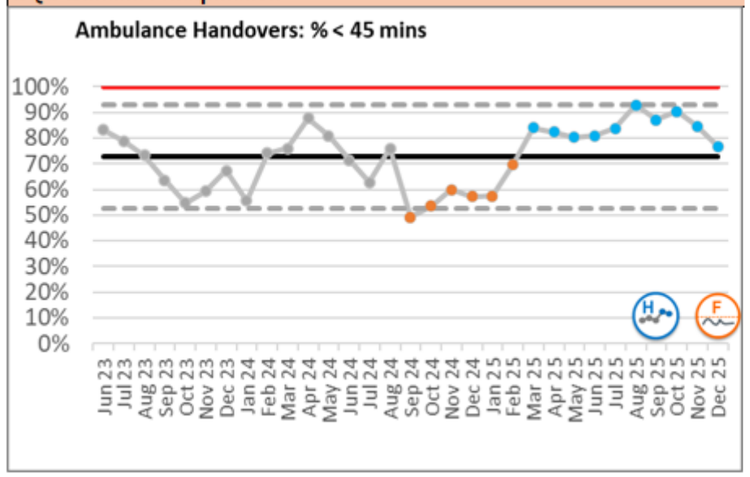
CQC Domain : Responsive



Dec-25
58.7%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Consistently fail target

Ambulance handover % < 45 minutes

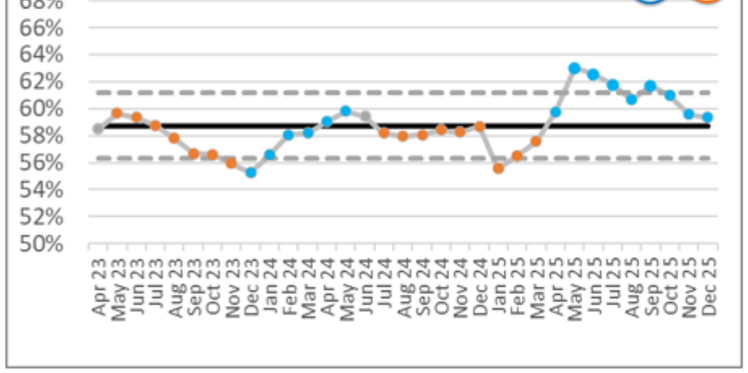
CQC Domain : Responsive



Dec-25
76.8%
Variance Type
Special cause improving variation
Threshold
≥100%
Assurance
Consistently fail target

18 week Referral to Treatment – incomplete pathways < 18 weeks

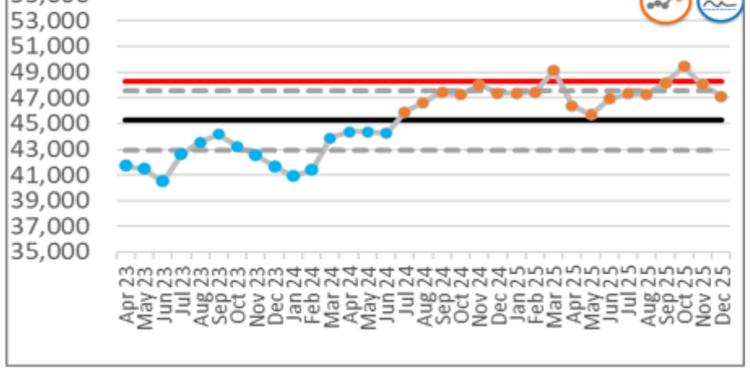
CQC Domain : Responsive



Dec-25
59.3%
Variance Type
Special cause improving variation
Threshold
≥92%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive



Dec-25
47125
Variance Type
Special cause concerning variation
Threshold
≤47941
Assurance
Consistently hit target

Commentary

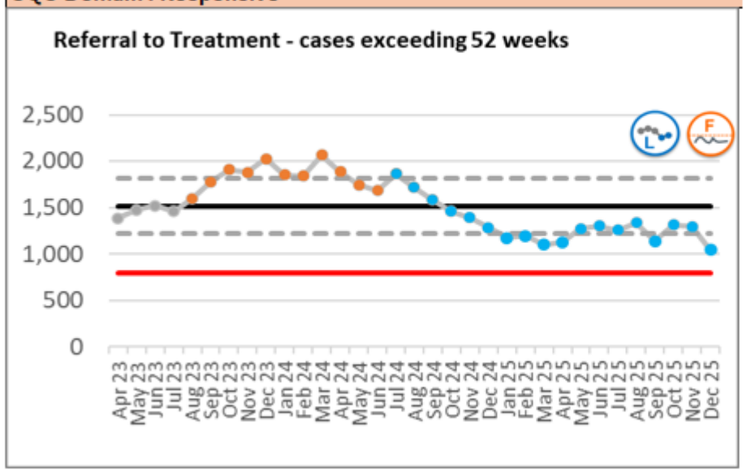
Ambulance Handover- Handover performance against 30 and 45 minutes remain above the mean but have deteriorated since October. However, performance remains significantly better than the same period in Winter 24/25 and ongoing focus to get the department back to delivering handover within 15 minutes when not in surge.

RTT - The Trust achieved trajectory for RTT caseload in December, but was over trajectory for percentage of patient waiting 18 weeks or under.

RTT % within 18 weeks for December was impacted by the sterile services incident as patients waiting for TCI were delayed. Continuation of the national validation sprint, outsourcing within ENT and the commencement of insourcing in Dermatology will all support continued reduction in RTT caseload. Sterile service recovery will support improvements in % RTT as will ongoing increased validation. To further support improvements in RTT performance, the Trust has received external funding to provide additional new outpatient activity as part of a national outpatient sprint, along with Cheshire and Mersey funded triage of referrals in Dermatology and ENT.

Referral to Treatment – cases exceeding 52 weeks

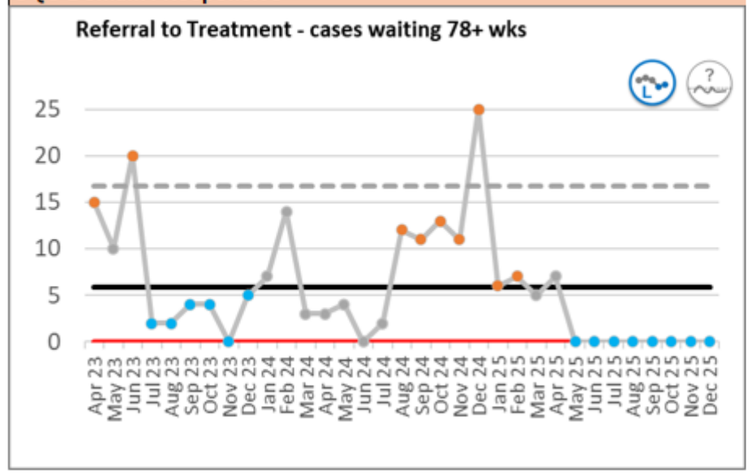
CQC Domain : Responsive



Dec-25
1046
Variance Type
Special cause improving variation
Threshold
≤668
Assurance
Consistently fail target

Referral to Treatment – cases waiting 78+ weeks

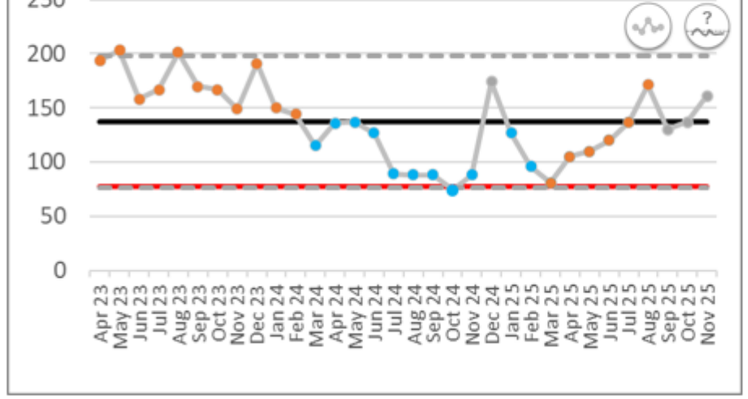
CQC Domain : Responsive



Dec-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 +

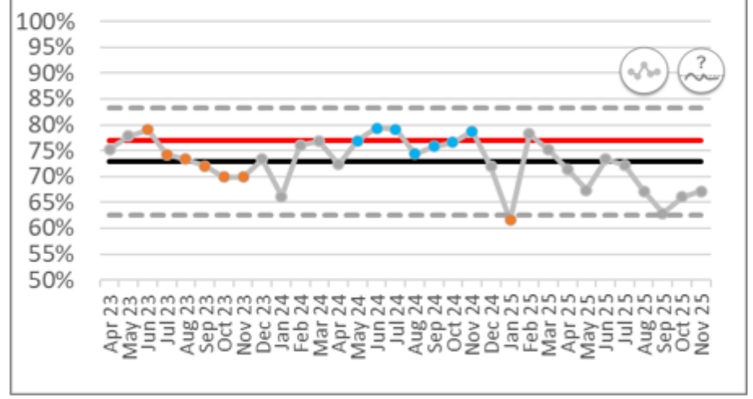
CQC Domain : Responsive



Nov-25
161
Variance Type
Common cause variation
Threshold
≤77
Assurance
Hit and miss target subject to random variation

Cancer – Faster Diagnostic Standard

CQC Domain : Responsive



Nov-25
67.1%
Variance Type
Common cause variation
Threshold
≥77%
Assurance
Hit and miss target subject to random variation

Commentary

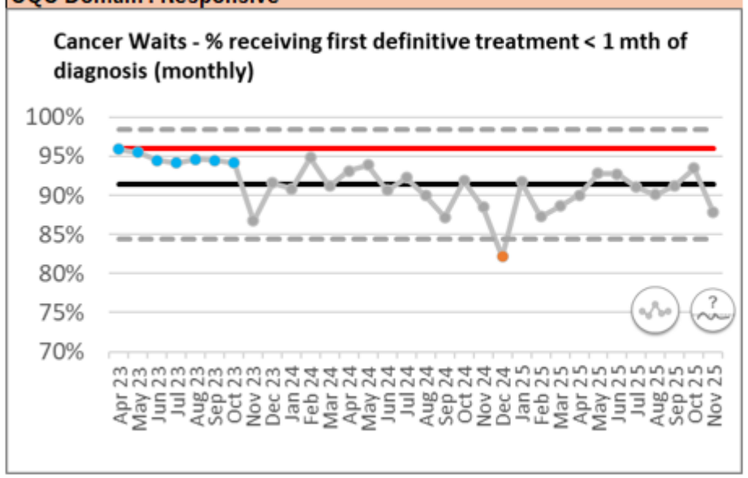
RTT - The Trust achieved the important milestone of 0 x 65-week waiters in December. Achievement of 0 x 65-week waiters was closely monitored regionally and nationally and reflects significant amount of work from divisional and supporting teams on tracking and managing long waiting patients. The number of 52-week waiters increased due to sterile services incident. Following the achievement of 0 x 65-week waiters, teams are focused on delivery of the March 2026 Trust target of no more than 1% of caseload waiting over 52 weeks.

Cancer – The Trust didn't meet the local trajectory for the Faster Diagnosis Standard (FDS), with November performance at 67.14% versus trajectory of 79.08%. Improved performance was maintained in Gynaecology, Urology, Lower GI and more recently in Breast following change in pathway following improvements in tracking and improved cross-Divisional working. Despite the pressures in Skin, these improvements have seen performance rise from the September position of 62.88%. Skin cancer performance remains impacted by regional ceasing of funding for tele-dermatology, alongside regional implementation of an AI pathway. Insourcing (funded by the Cancer Alliance) in Dermatology has commenced in December to support recovery of FDS performance. Whilst monthly data provided is from November, weekly tracking of performance through December and January demonstrates the positive impact insourcing is having on Dermatology performance.

The rise in 62-day waiters is also attributed to Dermatology, because of delays early in the pathway. Waiting times for first appointment in Dermatology decreased in January, allowing capacity to be targeted at reducing the number of 62 waiters, which had continued to increase significantly beyond the reported November position. The Trust has been successful in receiving approval from Cancer Alliance to continue insourcing capacity beyond January.

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

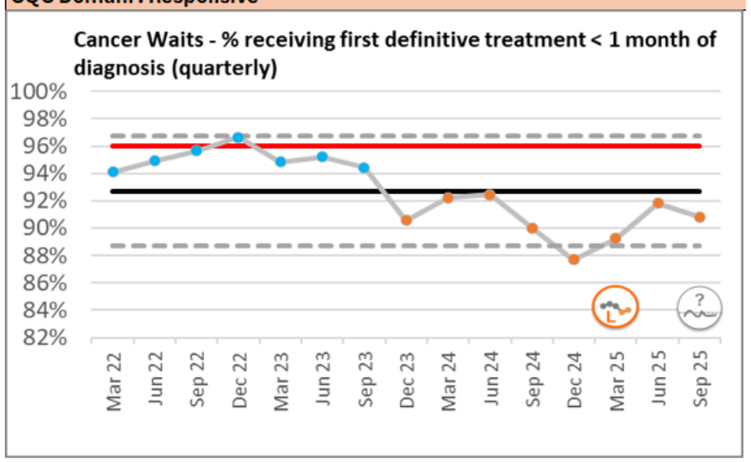
CQC Domain : Responsive



Nov-25
87.8%
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)

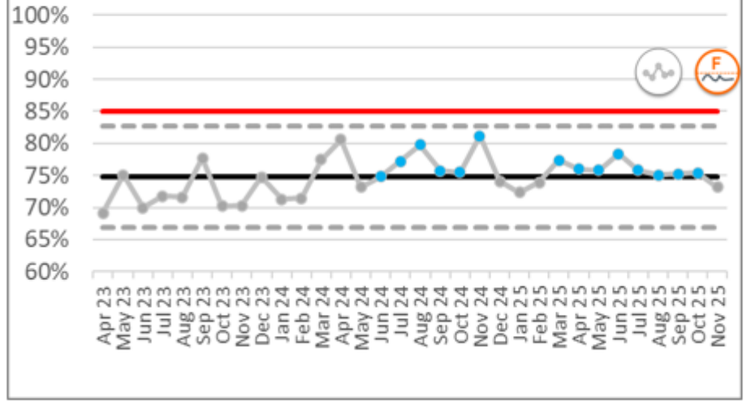
CQC Domain : Responsive



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)

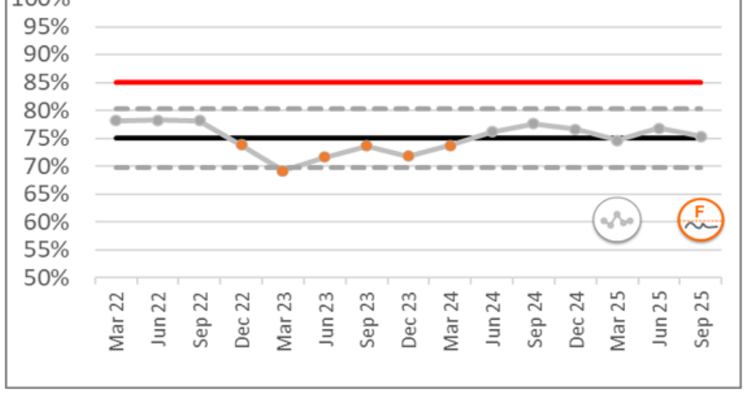
CQC Domain : Responsive



Nov-25
73.2%
Variance Type
Common cause 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

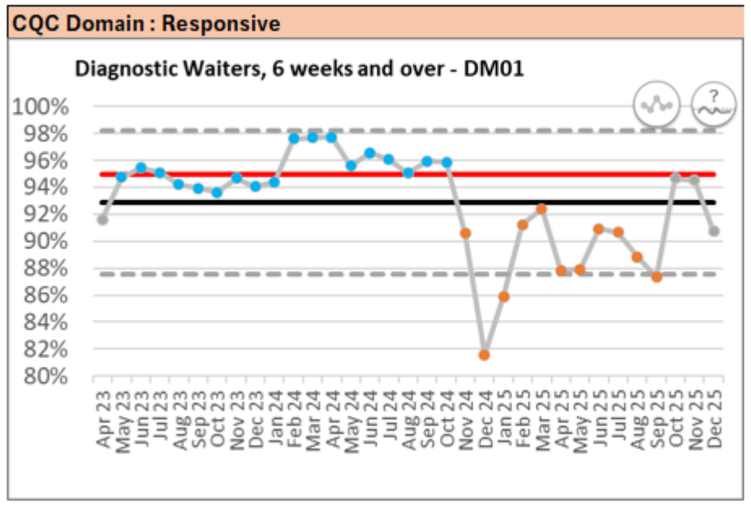
Commentary

31 Day Treatment Standard - The Trust failed to achieve local trajectory in November 2025 at 87.82% versus trajectory of 93.69%.

62 Day Treatment Standard - The Trust failed to achieve local trajectory in November 2025 at 73.19% versus trajectory of 77.09%. 62-day performance is noted as impacted by reduction in 28-day performance in earlier months. As noted above, the Trust has received further additional funding from the Cancer Alliance to support Dermatology, extending insourcing beyond January and allowing additional capacity to be target at the reduction in over 62-day waiters.

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive



Dec-25
90.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

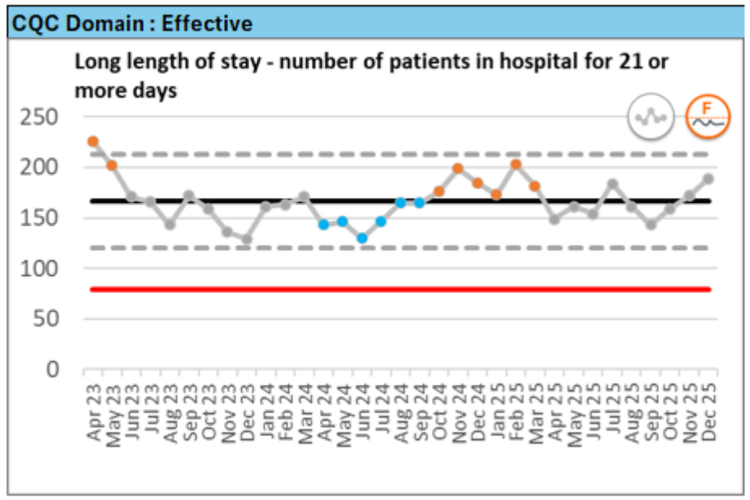
Commentary

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 90.7% for December.

December performance is a reduction in levels achieve in October and November. December saw an increase in direct access referrals in non-obstetric ultrasound and a reduction in performance in endoscopy. Additional capacity in non-obstetric ultrasound has been identified in January, plus further capacity from February.

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

CQC Domain : Effective



Dec-25
189
Variance Type
Common cause variation
Threshold
≤79
Assurance
Consistently fail target

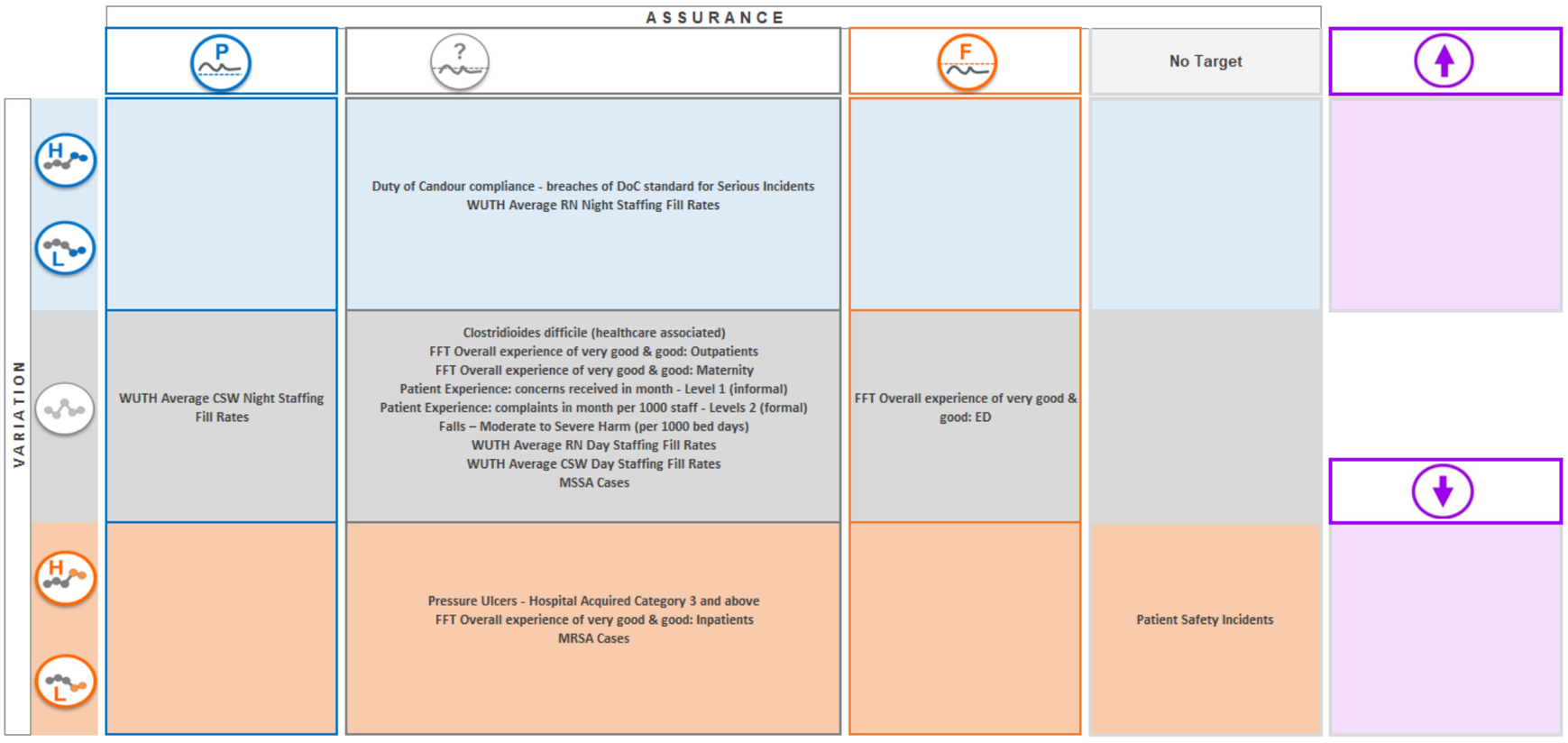
Commentary

Significant work has been undertaken in the division of medicine in reviewing all patients with a length of stay of over 21 days. In the majority of cases medical care was still ongoing and thus deemed to be appropriate.

The Wirral One Improvement Plan will continue to focus on longer length of stay.

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix



Quality and Safety Care Summary

Highlights

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Dec 25	7	≤8			11
Pressure Ulcers - Hospital Acquired Category 3 and above	Dec 25	6	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Dec 25	0	≤0			0
Patient Safety Incidents	Dec 25	1314	-			1202
FFT Overall experience of very good & good: ED	Dec 25	73.7%	≥95%			76.0%
FFT Overall experience of very good & good: Inpatients	Dec 25	95.2%	≥95%			95.5%
FFT Overall experience of very good & good: Outpatients	Dec 25	98.0%	≥95%			95.4%
FFT Overall experience of very good & good: Maternity	Dec 25	100.0%	≥95%			96.2%
Patient Experience: concerns received in month - Level 1 (informal)	Dec 25	214	≤173			226
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Dec 25	2	≤3			3
Falls – Moderate to Severe Harm	Dec 25	0.18	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Dec 25	90.0%	≥90%			88.8%
WUTH Average RN Night Staffing Fill Rates	Dec 25	94.0%	≥90%			90.4%
WUTH Average CSW Day Staffing Fill Rates	Dec 25	87.0%	≥90%			87.1%
WUTH Average CSW Night Staffing Fill Rates	Dec 25	99.0%	≥90%			99.6%
MRSA Cases	Dec 25	1	≤0			0
MSSA Cases	Dec 25	0	≤0			2

Areas of Concern

Forward Look (Actions)

Areas of Concern

Hospital acquired pressure ulcers – category 3 and above – 7

FFT overall experience ED
Complaints in month

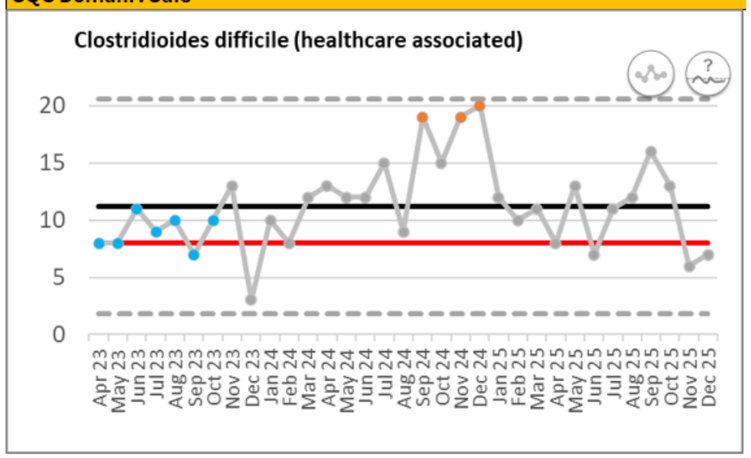
MRSA bacteraemia – 1 case

CSW day staffing fill rates

Actions as below

Clostridioides difficile (healthcare associated)

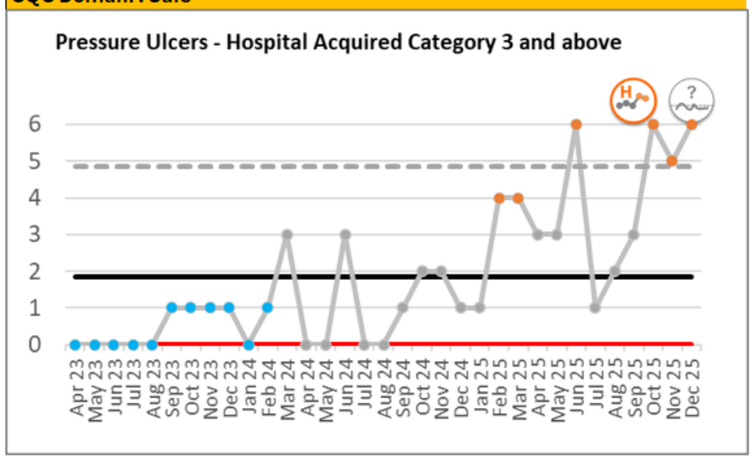
CQC Domain : Safe



Dec-25
7
Variance Type
Common cause variation
Threshold
≤8
Assurance
Hit and miss target subject to random variation

Pressure Ulcers – Hospital Acquired Category 3 and above

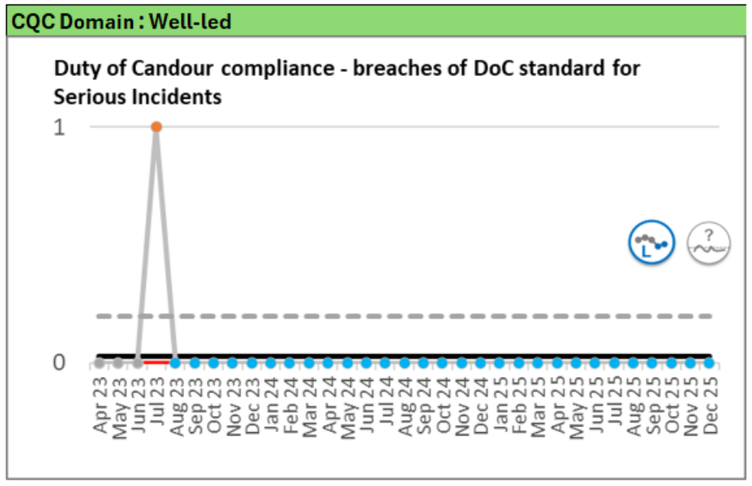
CQC Domain : Safe



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

Duty of Candour Compliance

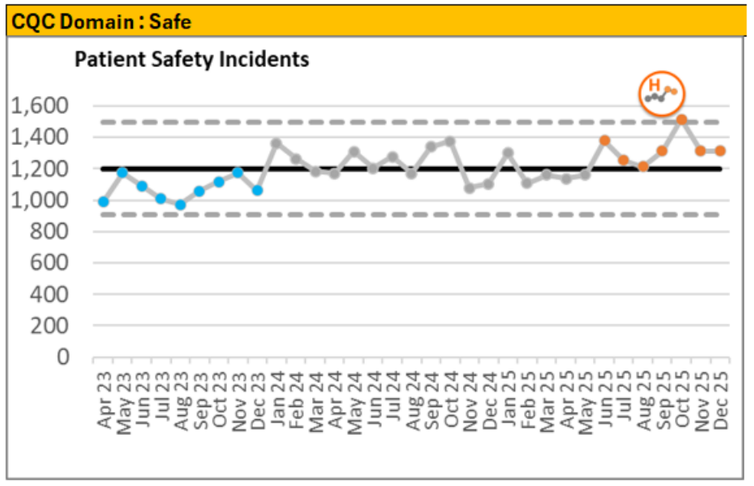
CQC Domain : Well-led



Dec-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



Dec-25
1314
Variance Type
Special cause concerning variation
Threshold
-
Assurance
Not applicable

Commentary

C Diff

In December there have been 5 HOHA and 2 COHA CDTs, this is the second consecutive month below the monthly threshold. One COHA CDT patient had not been in hospital in the previous 28 days but had been on the Virtual OPAT ward, and therefore is classed as healthcare associated.

One patient had previously had CDI this year, and 5 patients had been nursed on a ward at the same time 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 reactive Misting of bays following CDT /CDE
- Promote use of side rooms with ensuite facilities for isolating patients with CDT / CDE
- Key messaging related to preventing CDI included in IPC Daily Update email
- Evaluate impact of the Wirral CDT Strategy with system partners

Hospital Acquired Pressure Ulcers (HAPU) category 3 and above

In November, there were five Hospital-Acquired Pressure Ulcers (HAPU) Category 3 reported. Of these, three existing pressure ulcers (Category 3 or above) deteriorated while in our care, and two were newly acquired during admission.

In December, seven HAPU Category 3 cases were reported. Six were newly acquired in our care, and one existing ulcer worsened. All incidents have been or are currently under investigation.

Areas affected:

- W19 – 1 (Nov)
- W36 – 2 (1 Nov / 1 Dec)
- W14 – 1 (1 Nov)
- A&E – 2 (1 Nov / 1 Dec)
- W22 – 1 (Nov)
- M1 – 2 (same patient, Dec)
- W31 – 1 (Dec)
- W21 – 1 (Dec)
- AMU – 1 (Dec)

Actions:

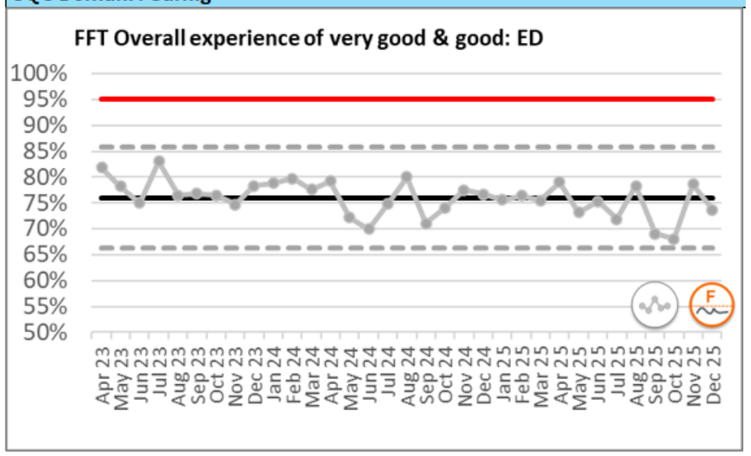
- Implementing updates in Cerner to ensure documentation is accurate, comprehensive, and legally defensible.
- Held meetings with the Interim Chief Nurse and Medical Division Matrons to identify strategies for enhancing pressure area care.
- Tissue Viability team delivering targeted education at ward level and organisation-wide on pressure ulcer prevention, wound assessment, and documentation standards.
- Creating practical guides to support mattress selection, including user instructions and fault-finding guidance.
- Introducing bedside repositioning clocks to promote regular patient repositioning.
- Assigning divisional Matrons responsibility for Tissue Viability, working in collaboration with the Tissue Viability Team to drive improvements.
- Targeted support for ED with use of newly purchased pressure relieving trolley ‘toppers’

Risks to position and/or actions:

- Part-time Tissue Viability Lead – opportunities for re-structure with WCHC integration

FFT Overall experience of very good & good – ED

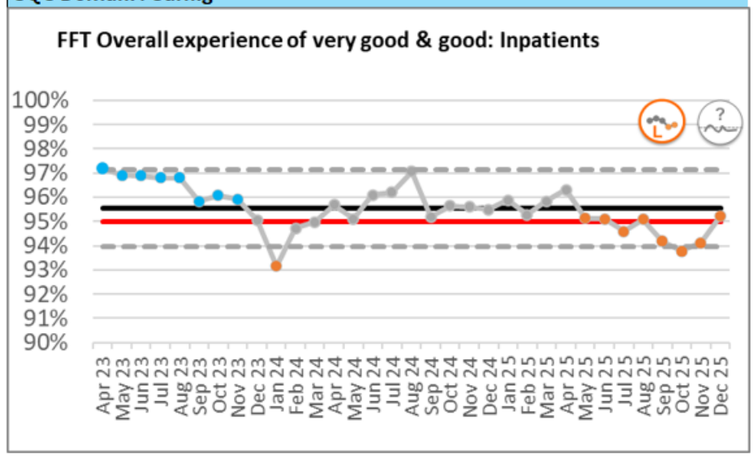
CQC Domain : Caring



Dec-25
73.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

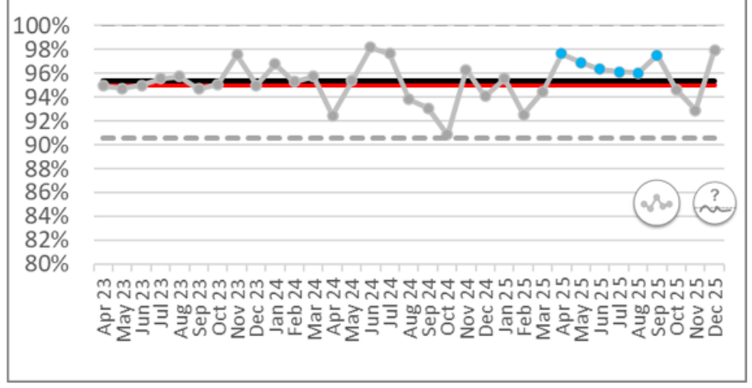
CQC Domain : Caring



Dec-25
95.2%
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

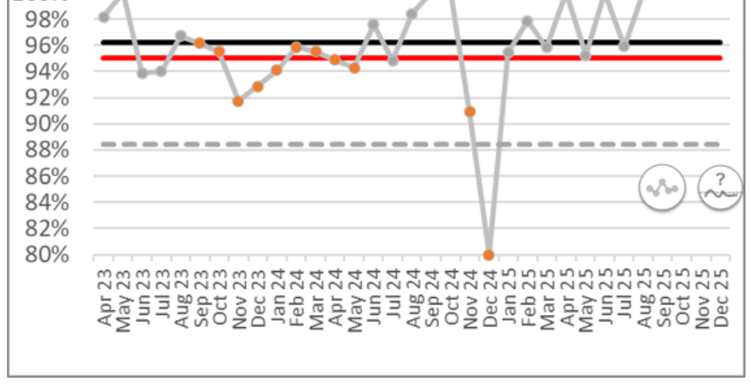
CQC Domain : Caring



Dec-25
98.0%
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



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

Commentary

FFT ED

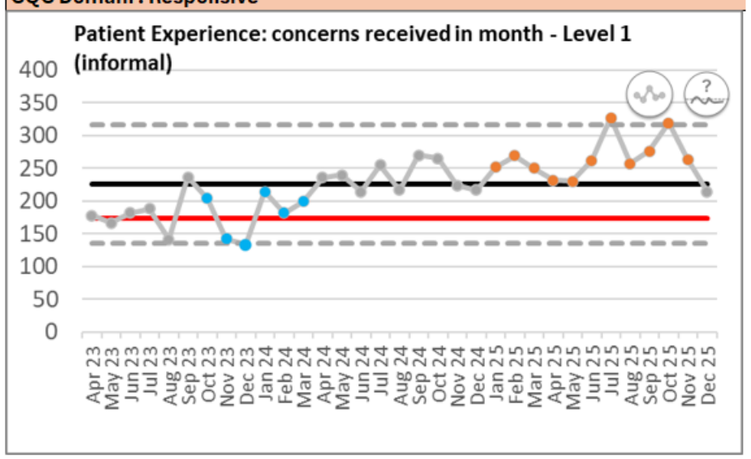
December ED FFT score was 73.7% which was a 5% decline on November's score 78.6% . It is acknowledged that there has been increased activity within ED during December which aligns with the continuation of comments in relation to ED overcrowding, waiting times and expectations in relation to pain management and communication in relation to investigations influencing the main reasons for experiencing a poor experience.

Actions

Commencement of a further 2 new ED Volunteers, totalling 7 ED Volunteers. Additional temporary volunteers support offering drinks rounds in waiting areas. Appointment of a new Divisional Director of Nursing. Continuation of improvement plans to support increased compliance with intentional rounding and ED checklist.
Focus on improving experience and communication in temporary ED waiting room

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

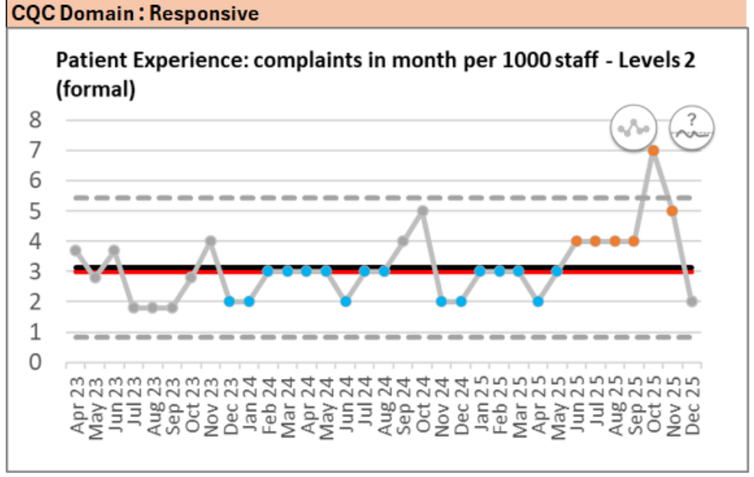
CQC Domain : Responsive



Dec-25
214
Variance Type
Common cause 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)

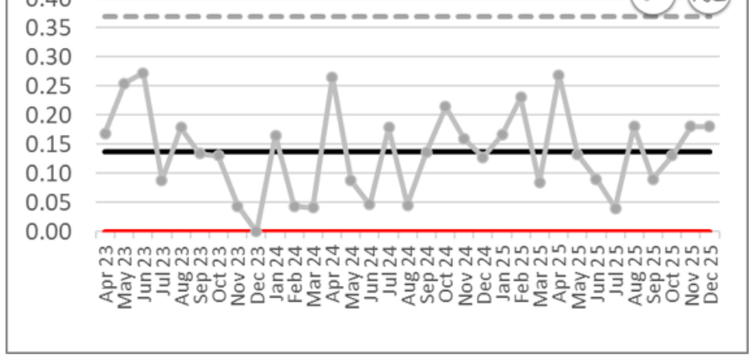
CQC Domain : Responsive



Dec-25
2
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit and miss target subject to random variation

Falls – Moderate to Severe Harm

CQC Domain : Safe



Dec-25
0.18
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 December 2025, the Trust recorded 215 informal concerns (Level 1) and 14 formal complaints (Level 2). Both figures represented substantial reductions compared with November, with informal concerns down 18.9% (from 265) and formal complaints down 44.0% (from 25). December volumes were below both the 2024/25 monthly averages and the 2025/26 year-to-date averages, indicating a seasonal easing of patient concern and complaint activity.

Informal concerns were highest in Surgery (63) and Medicine (59), with Emergency Care (31) and Women & Children's (35) also prominent. Formal complaints were concentrated in Medicine (5), Emergency Care (5), and Surgery (3), with most other departments recording isolated cases. Thirteen departments generated both informal and formal feedback, with the Emergency Department accounting for the largest combined volume.

Key themes continued to focus on clinical care, communication, and access. Informal concerns were dominated by access & admission, communication, and treatment & procedure, all lower than November, while formal complaints mainly concerned treatment & procedure and communication. Notably, complaints relating to diagnosis and access increased relative to the previous month.

Timeliness remained a challenge, with only 27% of formal complaints responded to within 40 working days and an average response time of 65 days. At month-end, 78 complaints were open, including 33 breaches. Targeted oversight, weekly divisional meetings, and staff training continue to support structured management, but operational pressures, sustained complaint volumes, and variability in investigation quality remain key risks to timely resolution.

Actions
Daily performance reporting and weekly divisional meetings with the Complaints Team continue to provide oversight, structured support, and escalation where required.
Targeted training sessions remain in place to support staff undertaking complaint investigations and improve consistency, timeliness, and quality of responses.
Improvement plan – with oversight by WCHC Interim Chief Nurse

Risks to Position and/or Actions
Persistent operational pressures and sustained complaint volumes may continue to limit the Trust's capacity to respond within 40 working days, maintaining variability in timeliness.
Seasonal or unexpected surges in complaints (e.g., sudden peaks like October 2025) could overwhelm capacity if mitigation measures are not actively maintained, scaled, and resourced.

Falls
There were 5 falls with short-term harm reported in December: these consisted of traumatic subarachnoid bleed, fractured elbow, Fractured neck of femur and fracture to the right occipital bone, Fractured pubic rami

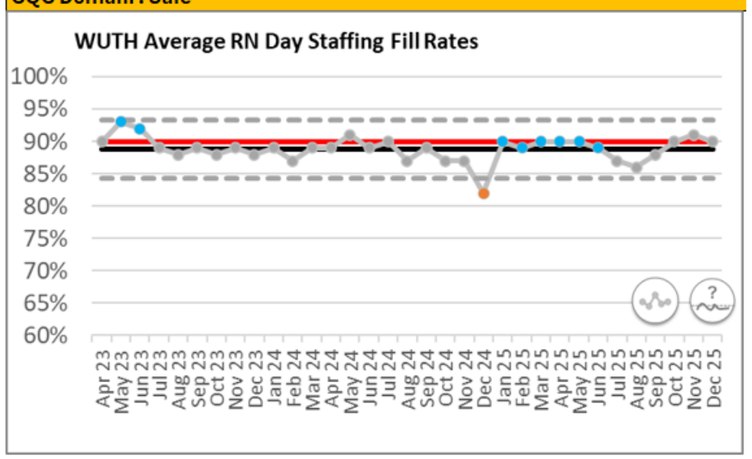
60% of falls recorded were found on the floor
48% of falls occurred at night
21% of falls occurred at the weekend.

Of the moderate falls in December – 30% had assistive technology in place and 65% of patients who fell were assessed to be independent (Level 1 Supervision).

Actions
For the short-term harms identified in December – RECs have been undertaken with the respective ward areas and any learning has been identified and shared locally with cross- divisional learning shared through the Trust's Fundamentals of Care meeting
There is a monthly rolling training programme in place at both sites to educate staff with regards to the correct use of equipment following a fall.
Falls training is delivered on IMPACT, WEPP and CSW training.
Proposals to establish a falls champion network within ward areas being developed with associated training options via an external training provider which will support this.

Average Registered Nurse Day Staffing Fill Rates

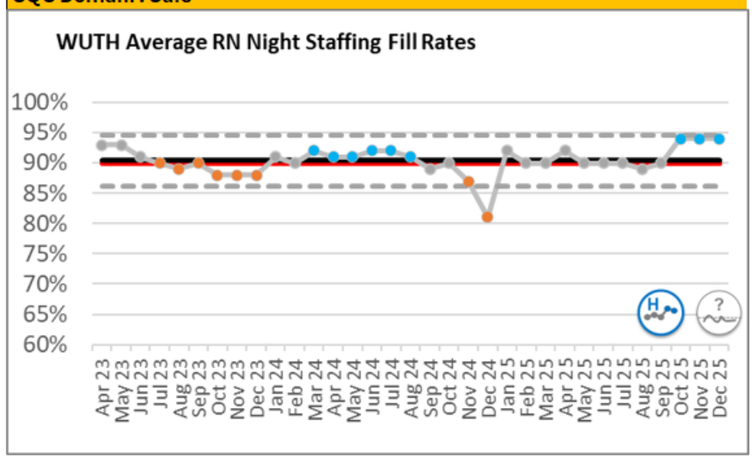
CQC Domain : Safe



Dec-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

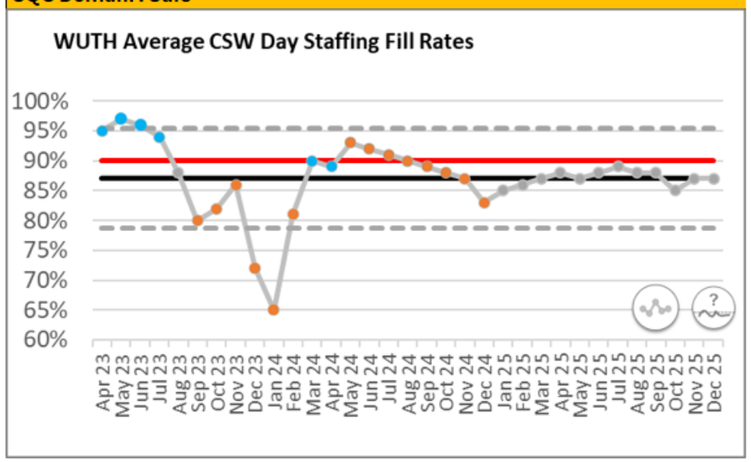
CQC Domain : Safe



Dec-25
94.0%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Average Clinical Support Worker Day Staffing Fill Rates

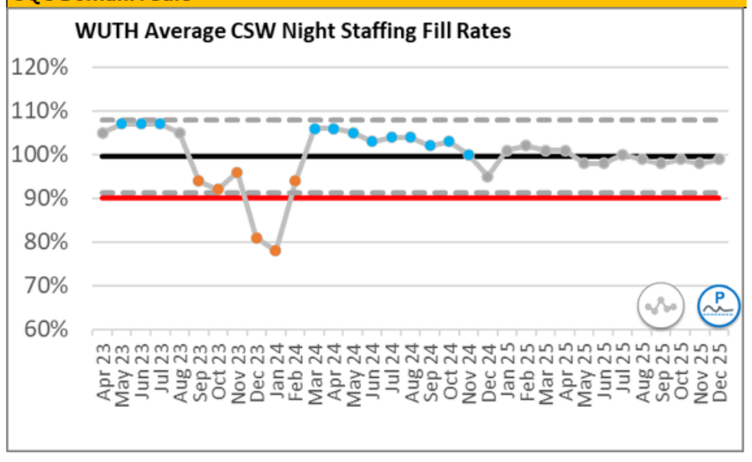
CQC Domain : Safe



Dec-25
87.0%
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



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

Commentary

CSW day staffing fill rates

CSW fill rates on day shifts remain below 90%

Actions

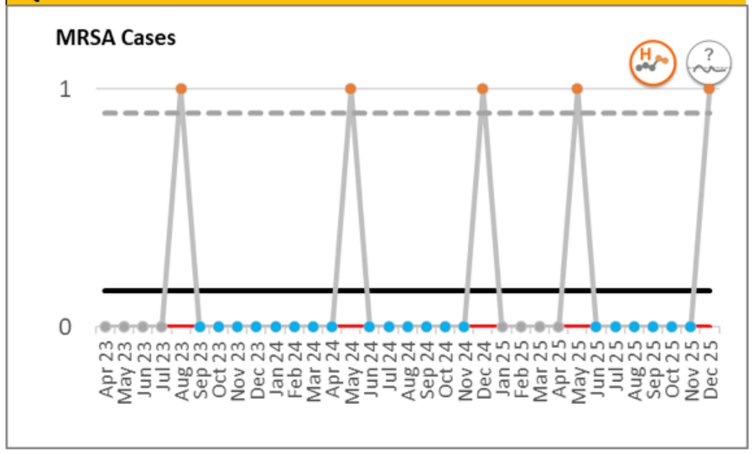
Successful Trust wide CSW recruitment event in December- new format piloted, support from system partners

Significant work undertaken to refresh CSW organisational change plans – meetings held with all areas and CSW representatives. Revised models agreed and implementation plans in progress with associated training and development plans.

Focussed ED CSW recruitment planned.

MRSA Cases

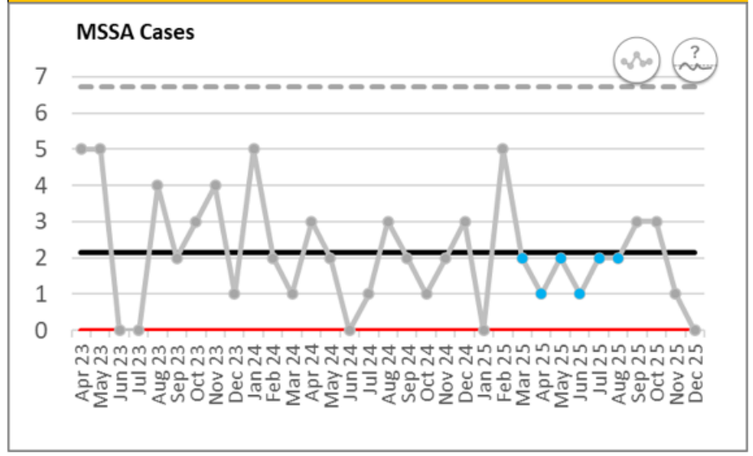
CQC Domain : Safe



Dec-25
1
Variance Type
Special cause concerning variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

MSSA Cases

CQC Domain : Safe



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

Commentary

MRSA

In December there has been one HOHA MRSA Bacteraemia reported. The patient was known to be have been previously colonised with MRSA. A post infection review is currently underway, however there was no record that Octenisan washes had been given for the first 5 days of admission and there was a delay in commencing decolonisation treatment.

Actions:

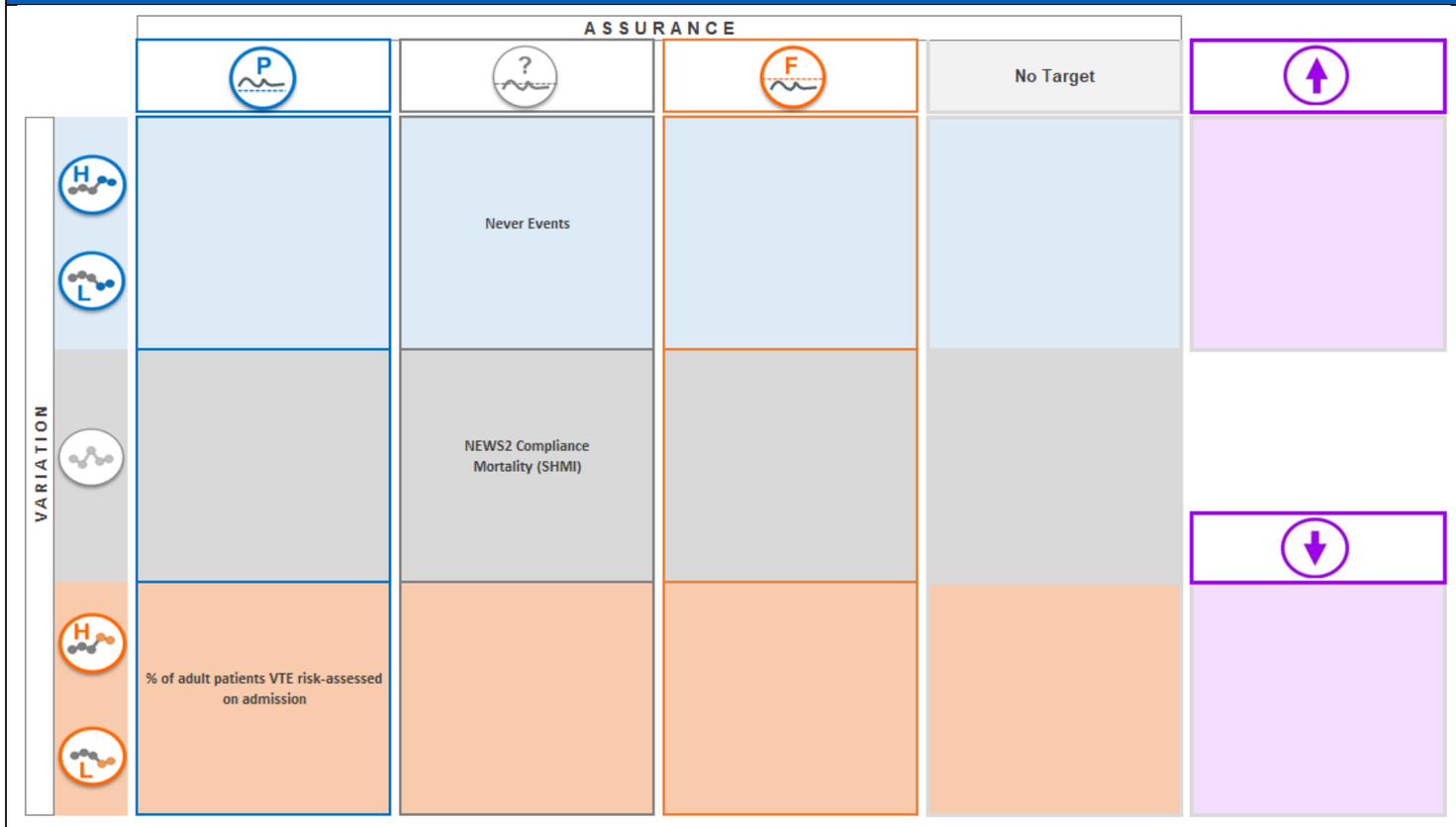
- Complete post infection review with multi-disciplinary team
- Learning to be presented to Infection Prevention and Control Group
- Octenisan washes for the first 5 days of admission to be recorded in CERNER interactive view
- MRSA decolonisation treatment dates are included on the IPC daily update

MSSA

There have been no MSSA blood stream infections reported in December.

Dashboard	Quality and Safety
Lead	Chief Medical Offier

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	Dec 25	95.9%	≥95%			97.3%
Never Events	2025/26	4	≤0			
NEWS2 Compliance	Dec 25	88.6%	≥90%			89.3%
Mortality (SHMI)	Aug 25	1.039	0.95-1.05			1.021
Number of studies open	Dec 25	42				
% of current studies meeting recruitment target	Dec 25	26.2%				
% of open studies with a commercial sponsor	Dec 25	4.8%				

Areas of Concern

4 Never Events reported during Q1

Reduction in NEWS 2 compliance

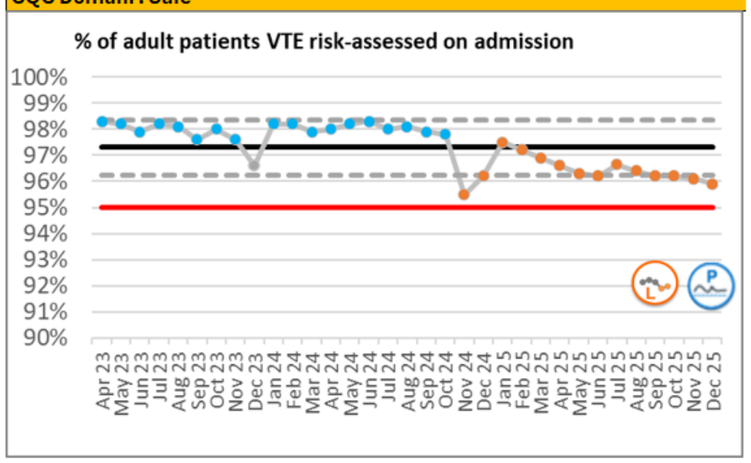
Forward Look (Actions)

Work around LocSSIPs continues with new e-learning package in place for all clinical staff. Electronic LocSSIP to be developed once Cerner upgrade completed

Compliance dropped in Dec 2025, related to a drop in compliance for acute areas. Live compliance on BI portal by area. Focused actions in place with individual areas to improve compliance. This is monitored through DQB and DPRs

% of adult patients VTE risk assessed on admission

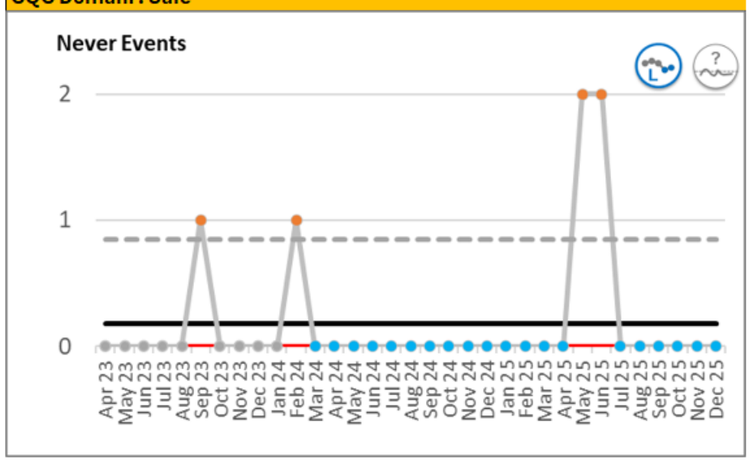
CQC Domain : Safe



Dec-25
95.9%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target

Never Events

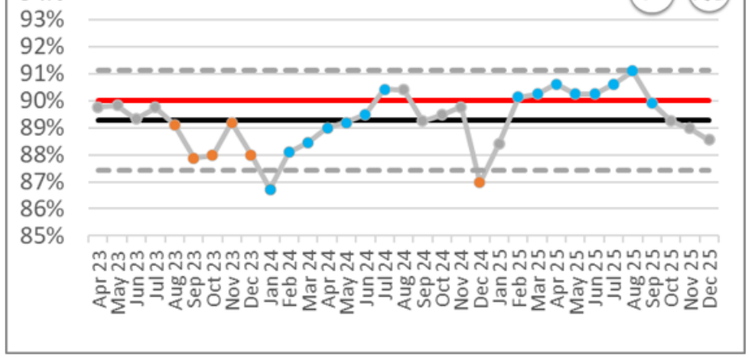
CQC Domain : Safe



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

NEWS 2 Compliance

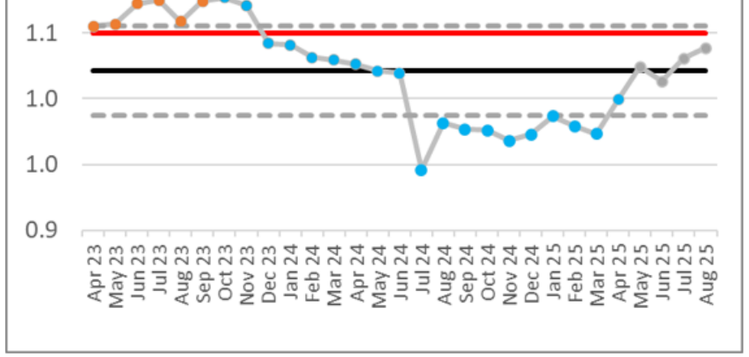
CQC Domain : Well-led



Dec-25
88.6%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation

Mortality (SHMI)

CQC Domain : Safe



Aug-25
1.0387
Variance Type
Common cause variation
Threshold
0.95-1.05
Assurance
Hit and miss target subject to random variation

Commentary

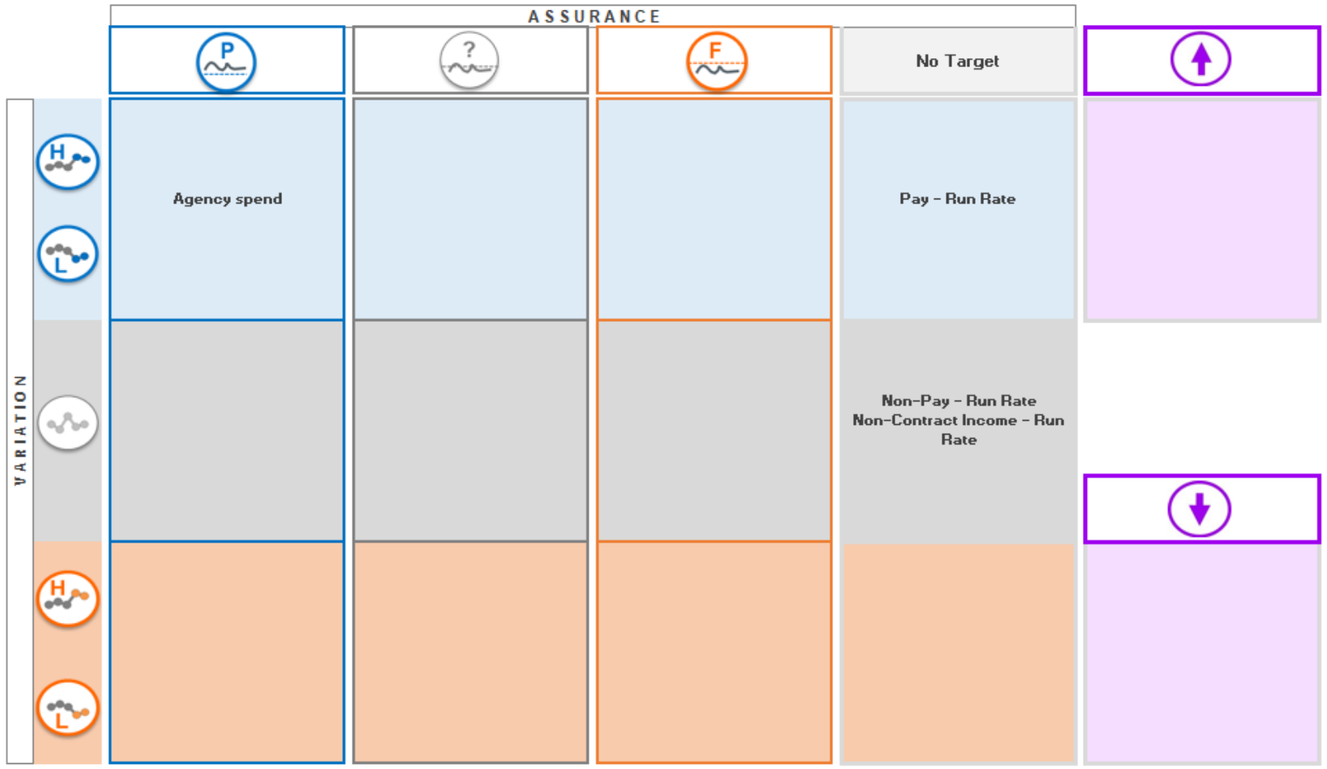
Number of studies open – Snapshot position	% of current studies meeting recruitment target – Snapshot position
42	26.2%

% of open studies with a commercial sponsor – Snapshot position
4.8%

Commentary

Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix



Finance Summary

Highlights

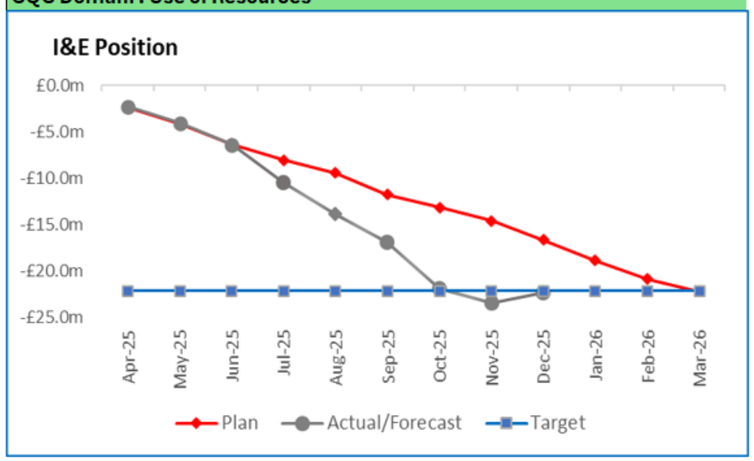
KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Dec 25	1.5%	≤3.2%			2.6%
I&E Position	Dec 25	-£22.3m	-£22.1m			
Cumulative CIP	Dec 25	£24.0m	£24.0m			
Capital Expenditure	Dec 25	£16.8m	£26.1m			
Cash Position	Dec 25	£0.1m	£2.7m			

Areas of Concern

Forward Look (Actions)

I&E Position

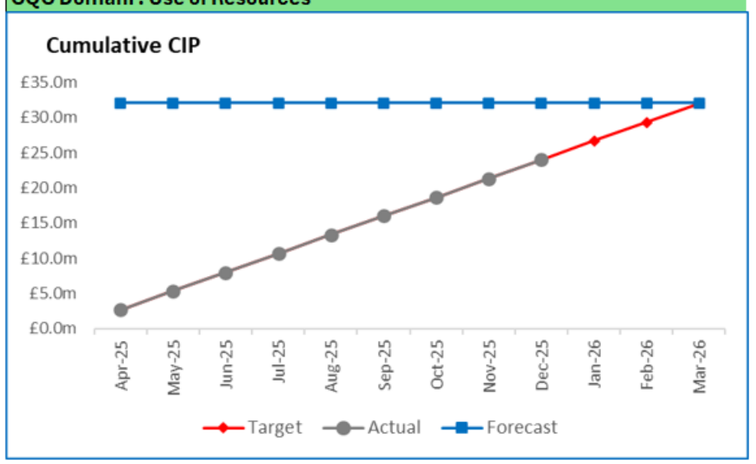
CQC Domain : Use of Resources



Dec-25
-£22.3m
Variance Type
Position doesn't meet the plan
Target
-£22.1m

Cumulative CIP

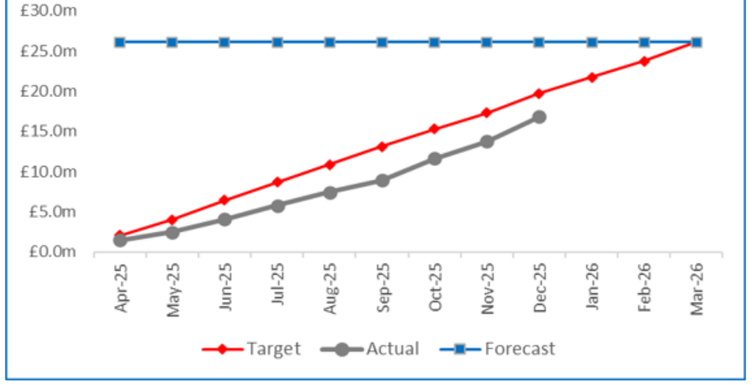
CQC Domain : Use of Resources



Dec-25
£24.0m
Variance Type
Position meets the plan
Target
£24.0m

Capital Position

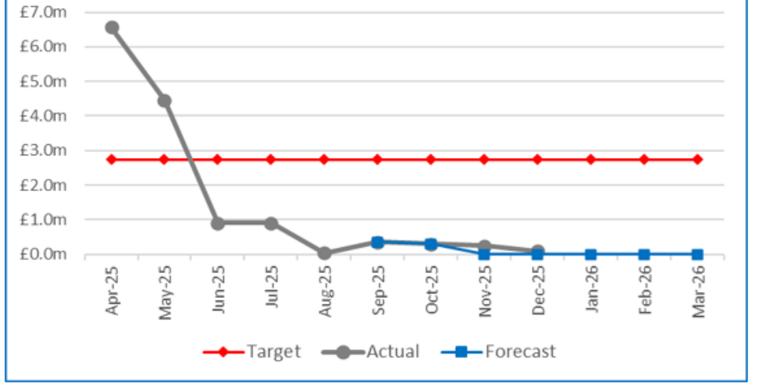
CQC Domain : Use of Resources



Dec-25
£16.8m
Variance Type
Position meets the plan
Target
£26.1m

Cash position

CQC Domain : Use of Resources

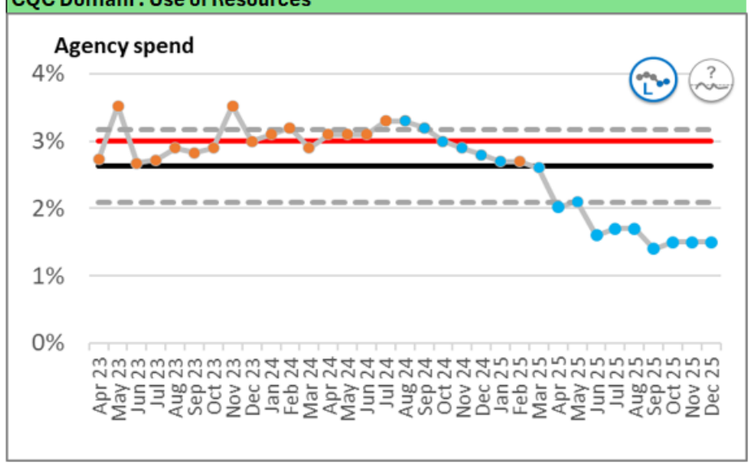


Dec-25
£0.1m
Variance
Position doesn't meet the plan
Target
£2.7m

Commentary

Agency spend %

CQC Domain : Use of Resources



Dec-25
1.5%
Variance Type
Special cause improving variation
Threshold
≤3.2%
Assurance
Consistently hit target

Commentary

Executive Summary

At the end of December 2025 (M9) the Trust is reporting a deficit of £22.3m which excluding DSF is a £5.7m adverse to plan. This is driven by; industrial action, pay award pressures, the level of efficiency target challenge and the Sterile Services (SSD) critical incident which has impacted the Trusts elective programme. Non-recurrent mitigations have been utilised to support delivery against plan and partially offset the key risks outlined below.

The Trust agreed additional actions to support delivery of the agreed plan which excluding DSF is a £22.1m deficit. These include enhanced controls across variable pay, non-core spend, discretionary non pay, elective income and a non-clinical vacancy freeze - all agreed controls have been enacted. These measures 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 – After adjusting for the impact of IA and CSSD incident elective income is below plan at M9.
- 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 M9 was £0.1m. The Trust is following the agreed cash mitigation plan but until a sustainable financial position is achieved this significant issue will continue. Further revenue support applications made for December and January have been approved and February's application is 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 the Trust has submitted the first cut of the 3 year plan starting 2026/27.

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

Statutory Financial Targets	RAG (M9)	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 revised capital budget of £24.812m.

I&E Position

Narrative:

The table below summarises the M9 position:

	In Month			Year to Date			Forecast		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£39.0m	£41.7m	£2.6m	£351.1m	£352.3m	£1.2m	£468.1m	£469.8m	£1.7m
Other Operating Income	£3.0m	£6.3m	£3.3m	£26.6m	£28.7m	£2.2m	£35.2m	£36.6m	£1.4m
Total Income	**£42.0m**	**£48.0m**	**£6.0m**	**£377.6m**	**£381.0m**	**£3.4m**	**£503.3m**	**£506.4m**	**£3.1m**
Employee Expenses	-£31.7m	-£33.1m	-£1.5m	-£285.3m	-£290.2m	-£4.8m	-£380.0m	-£388.5m	-£8.4m
Operating Expenses	-£13.0m	-£13.0m	-£0.0m	-£115.5m	-£115.9m	-£0.4m	-£153.7m	-£155.8m	-£2.1m
Non Operating Expenses	-£0.4m	-£0.7m	-£0.3m	-£3.7m	-£4.2m	-£0.6m	-£4.9m	-£5.5m	-£0.6m
Recurrent CIP	£1.0m	£0.0m	-£1.0m	£10.3m	£0.0m	-£10.3m	£13.2m	£1.2m	-£12.0m
Non Recurrent Mitigations	£0.0m	£0.0m	£0.0m	£0.0m	£7.0m	£7.0m	£0.0m	£7.0m	£7.0m
Total Expenditure	**-£44.0m**	**-£46.8m**	**-£2.8m**	**-£394.2m**	**-£403.3m**	**-£9.0m**	**-£525.5m**	**-£541.6m**	**-£16.1m**
Month 9 position excluding DSF	**-£2.1m**	**£1.1m**	**£3.2m**	**-£16.6m**	**-£22.3m**	**-£5.7m**	**-£22.1m**	**-£35.1m**	**-£13.0m**

Key variances within the YTD position are:

Clinical Income – £1.2m positive variance, the positive movement reflects funding for the impact of M8/M9 Industrial Action. Elective underperformance prior to M7, industrial action and loss of DSF are all included in the year to date position but at this stage the exceptional income impact of the CSSD critical incident is excluded

Employee Expenses - £4.8m adverse variance relates to use of bank, agency, industrial action and undelivered vacancy factors.

Operating expenses – £0.4m adverse variance relates clinical supplies and depreciation.

Cost Improvement Programme – £3.3m underdelivered at month 10 which includes £7.0m of non-recurrent mitigations.

The Trust's agency costs remained at 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 £29.6m at M9 of which, £7.0m has been delivered non-recurrently. The Trust has identified recurrent CIP with a full year effect of £31.7m, however, this figure reduces to £26.9m once risk adjusted reflecting a risk adjusted shortfall of £5.1m. Review of the CIP position is ongoing through fortnightly 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: Across Q3 the Trust elective programme has been significantly impacted by the CSSD critical incident. This was stepped down to a business continuity incident in November with the majority of specialties able to return to normal activity levels during December.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2025/26 at M9:

Description	Approved Budget at M1	Revision to budget M2	Revision to budget M5	Revision to budget M6	Revision to budget M7	Revision to budget M8	Revision to budget M9	Revised Budget
CDEL								
Internally Generated	**£9.765m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£9.765m**
ICB/PDC/WCHC	**£14.550m**	**£0.516m**	**£0.034m**	**£0.058m**	**£0.069m**	**-£1.424m**	**£0.144m**	**£13.947m**
Charity	**£1.100m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£1.100m**
Confirmed CDEL	**£25.415m**	**£0.516m**	**£0.034m**	**£0.058m**	**£0.069m**	**-£1.424m**	**£0.144m**	**£24.812m**
Total Funding for Capital	**£25.415m**	**£0.516m**	**£0.034m**	**£0.058m**	**£0.069m**	**-£1.424m**	**£0.144m**	**£24.812m**
Capital Programme								
Estates, facilities and EBME	**£3.100m**	£0.516m	£0.034m	£0.000m	£0.000m	£0.782m	£0.000m	**£4.432m**
Operational delivery	**£8.440m**	£0.000m	£0.000m	£0.000m	£0.069m	£0.000m	£0.144m	**£8.653m**
Medical Education	**£0.080m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£0.080m**
Transformation	**£0.250m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£0.250m**
Digital	**£0.750m**	£0.000m	£0.000m	£0.058m	£0.000m	£0.000m	£0.000m	**£0.808m**
UECUP	**£7.800m**	£0.000m	£0.000m	£0.000m	£0.000m	-£2.100m	£0.000m	**£5.700m**
PDC commitments	**£0.304m**	£0.000m	£0.000m	£0.000m	£0.000m	-£0.106m	£0.000m	**£0.198m**
ICB hosted	**£3.591m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£3.591m**
Charity	**£1.100m**	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	**£1.100m**
Approved Capital Expenditure Budget	**£25.415m**	**£0.516m**	**£0.034m**	**£0.058m**	**£0.069m**	**-£1.424m**	**£0.144m**	**£24.812m**
Total Anticipated Expenditure on Capital	**£25.415m**	**£0.516m**	**£0.034m**	**£0.058m**	**£0.069m**	**-£1.424m**	**£0.144m**	**£24.812m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**
Approved Capital Expenditure Budget	**£25.415m**	**£25.931m**	**£25.965m**	**£26.023m**	**£26.092m**	**£24.668m**	**£24.812m**	**£24.812m**

In M8 and M9 the following revisions to capital funding and budgets are:

- Estates Safety totalling £0.782m. This is to fund six backlog maintenance projects.
- Confirmation of national funding for urgent care of £4.9m, therefore there is a reduction of £2.1m in CDEL.

- An adjustment to the physiological sciences schemes - national funding has been reduced by £0.067m
- CDC equipment – additional equipment of £0.105m.

Cash Position

Narrative:

The cash balance at the end of M9 was £0.18m. This includes the impact of £8.4m withheld Deficit Support Funding. 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.

The Trust's cash mitigation actions are consistent with the NHS cash regime confirmed in "2025/26 Financial management expectations, tools, interventions and oversight". These include:

- 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 reduced cash balance presents daily challenges with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 11**
28 January 2026

Title	Executive Managing Director Report
Area Lead	Executive Managing Director
Authors	Hayley Kendall, 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	Local focus remains on recovering elective and cancer waiting times following the impact of the Covid-19 pandemic on planned care services and clinical services have performed well in this regard. There are robust processes in place to monitor and track patients through elective care pathways. 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. The Trust has also been supported by the Emergency Care Intensive Support Team (ECIST) in improving urgent and emergency care delivery across the Trust.

2	Planned Care
2.1	**Elective Activity** In December 2025, the Trust attained an overall performance of 104% against plan for outpatients (101% for new outpatient attendances), and an overall performance 87% against the plan for elective admissions, as shown in the table below: **Activity Type / Target for November / Actual for November / Performance** Out pt New: 11,309 / 11,519 / 101.9% Out pt Follow up: 24,388 / 25,655 / 105.2% Out pt procedures: 3,638 / 3,731 / 102.6% Total Out pts: 39,335 / 40,905 / 104.0% Day case: 4,333 / 3,847 / 88.8% Inpatients: 533 / 368 / 69.0% Total - Elective and Daycase: 4,866 / 4,215 / 86.6% The Trust achieved plan for outpatients and underachieved elective/daycase, with activity impacted by the sterile service incident. Underachievement for elective / daycase activity was seen in Medicine, Surgery and Women's and Children's. The sterile services incident impacted elective activity in November as forecast whilst the team work on building on the good progress made so far in restoring services.
2.2	**Referral to Treatment (RTT)** The Trust's performance at end of December 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	Nov-25	Dec-25
Total RTT Caseload	46,400	45,691	46,939	47,312	47,271	48,195	49,453	48,066	47,125
% RTT	59.74%	63.01%	62.54%	61.80%	60.68%	61.70%	60.96%	59.58%	59.34%
52 weeks	1,128	1,272	1,302	1,255	1,335	1,138	1,313	1,296	1,046
52 weeks % of caseload	2.43%	2.78%	2.77%	2.65%	2.82%	2.36%	2.66%	2.70%	2.22%
104+ Week Wait Performance	0	0	0	0	0	0	0	0	0
78+ Week Wait Performance	7	0	0	0	0	0	0	0	0
65+ Week Wait Performance	24	22	13	16	7	4	26	25	0

In December the Trust achieved trajectory for RTT caseload but was over trajectory for percentage of patients waiting 18 weeks or under, and number and percentage of 52-week waiters. The Trust achieved 0 x 65-week waiters in line with national requirements.

Whilst overall caseload has reduced through November and December, the percentage of patients waiting under 18 weeks has decreased (i.e. it did not improve, as seen with earlier reductions in caseload).

Due to the effectiveness of additional validation reducing RTT caseload nationally, the national validation sprint (provision of additional funding for non-activity related clock stops) has been extended through to the end of March 2026. This allows additional validation resource to be deployed within the Trust to help reduce and maintain overall caseload numbers.

In addition, to a continuation of ENT outsourcing, Dermatology insourcing (see section 2.3 Cancer Performance) commenced in December, which will have a positive impact on caseload. Regionally funded triage of referrals has also commenced in ENT and Dermatology as part of regional efforts to support RTT performance.

There were 0 x patients waiting 78+ weeks at the end of December 2025, this position has been maintained since May 2025. The Trust achieved the important milestone of 0 x 65-week waiters in December. Achievement of 0 x 65-week waiters was closely monitored regionally and nationally and reflects significant amount of work from divisional and supporting teams on tracking and managing long waiting patients.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 3:

Quarter	3
Period	01/10/2025 - 31/12/2025

National Standards:

Standard	Indicator	Threshold	October-25	November-25	December-25
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	77.00%	66.11%	67.14%	N/A
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	93.51%	87.82%	N/A
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.39%	73.19%	N/A

Sub Standards:

Standard	Indicator	Threshold	October-25	November-25	December-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	66.11%	67.14%	N/A
28 Day Wait	Breast >=90%	90.00%	90.98%	94.19%	N/A
28 Day Wait	Skin >=90%	90.00%	27.40%	33.62%	N/A
31 Day Wait	Individual Trust Provider Trajectory	Per Month	93.51%	87.82%	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.39%	73.19%	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	October-25	November-25	December-25
14 Day Wait	GP USC Referral to First Appointment	93.00%	68.60%	64.34%	N/A
14 Day Wait	GP Breast Symptomatic Referral to First Appointment	93.00%	85.71%	80.00%	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the trajectory for the FDS standard for November 2025. Dermatology performance continues to have a significant impact on the overall Trust, following regional ceasing of A&G / introduction of AI. Improvement is seen in number of tumour sites including Breast, Gynaecology and Urology. The forecast is to improve performance by the end of February.
- *62-day treatment* - The Trust did not achieve trajectory in November 2025 with performance of 73.19% versus trajectory of 77.09%. The impact of pressures on 28-day performance is seen to impact 62-day treatment delivery in particular relating to Dermatology.
- *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 and pressures in Dermatology.

	07/04	05/05	02/06	07/07	04/08	01/09	08/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11	01/12	08/12	15/12
Actual 25/26	81	105	110	120	137	171	156	130	140	144	132	137	132	147	153	161	164	179
Trajectory 25/26	105	98	91	84	77	69	69	61	61	61	61	53	53	53	53	45	45	45
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104-day long waiters* – the number of waiters has decreased across December but remains above trajectory.

	07/04	05/05	02/06	07/07	04/08	01/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11	01/12	08/12	15/12
Actual 25/26	26	21	26	28	32	45	31	30	26	32	35	28	25	27	24	24	22
Trajectory 25/26	22	21	19	17	15	13	11	11	11	11	9	9	9	9	7	7	7
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

Performance in Dermatology continues to have a significant impact on overall 28-day FDS performance at Trust level.

Improved performance was maintained in Gynaecology, Urology, Lower GI and more recently in Breast, following a change in pathway following improvements in tracking and improved cross-divisional working. Despite the pressures in Dermatology, these improvements have seen performance rise from the September position of 63% to 67%.

Dermatology cancer performance remains impacted by regional ceasing of funding for tele-dermatology, alongside regional implementation of an AI pathway. There is a recovery plan in place to ensure performance improves by the end of the financial year.

Additional activity in Dermatology targeted at improving cancer performance commenced in December, following confirmation of funding from the Cancer Alliance. Weekly tracking of performance through December and January demonstrates that insourcing is having a positive impact on Dermatology performance. Further funding has subsequently been secured in January, from the Cancer Alliance, to allow the continuation of insourcing.

A large rise in 62-day waiters is also attributed to Dermatology, due to delays earlier in the pathway. As waiting times for first appointment in Dermatology have decreased in January, it has allowed capacity to be targeted at reducing the number of 62 waiters, which had continued to increase significantly beyond the reported November position.

2.4 **DM01 Performance – 95% Standard**

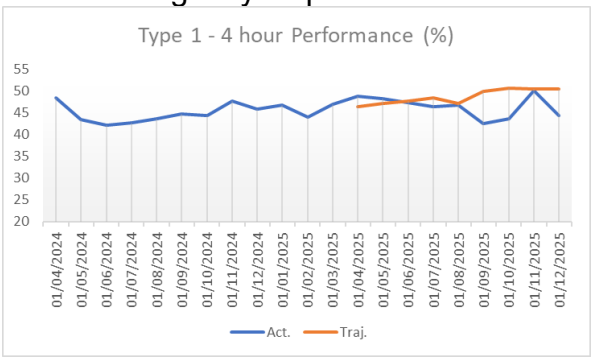
The Trust achieved 90% of patients had been waiting 6 weeks or less for their diagnostic procedure, for those modalities included within the DM01 seeing performance at 90.7% for December.

	This is a reduction in levels achieved in October and November. December saw an increase in direct access referrals in non-obstetric ultrasound and a reduction in performance in endoscopy. Additional capacity in non-obstetric ultrasound has been identified in January, plus further capacity from February.
2.5	**Risks to recovery and mitigations** The main areas of concerns are recovery of cancer performance and maintaining 0 x 65 weeks / achieving 1% of patents waiting 52 weeks by end of March 2026. 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 for November, with the exception of Dermatology which remains the most significant risk to Trust performance. Additional funding has been received to support insourcing of additional capacity from December in Dermatology. More recently we have seen the introduction of regionally funded RTT referral triage in Dermatology and ENT as areas of know pressure and approval of funding for additional outpatient new attendances to see improvements in RTT performance.

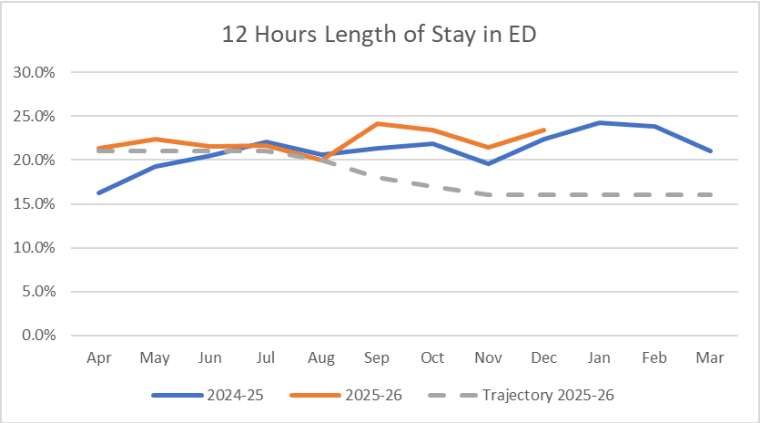
3.0	**Unscheduled Care**
3.1	**Performance** In December, Type 1 performance was reported at 44.08%, with a combined performance across all Wirral sites reaching 69.62%. This was small improvement from previous month.

Type 1 ED attendances: • 8,090 in November (avg. 279/day) • 7,893 in December (avg. 255/day) • 6% decrease in attendances from previous month	Type 3 ED attendances: • 2,903 in November (avg. 97/day) • 3,241 in December (avg. 105/day) • 11.64% increase in attendances from previous month

In December, the daily demand for ED decreased compared to the previous month along with the 4-hour Type-1 performance, reverting to a similar level observed in December 2024. Despite the overall drop in attendances for the month, the Trust faced exceptionally high demand on several days, including a peak of 350 attendances in one day, compared to the yearly daily average of 250. This surge in attendances on a single day impacts subsequent days due to the time required to recover from the resulting overcrowding in the Emergency Department.



Similar to the 4-hour performance, the number of patients waiting in ED for over 12 hours also declined. This was a consequence of the surges in demand and challenges with the number of patients requiring admission to a bed.



In response to this demand, the Trust implemented several actions to create additional capacity and ensure patient safety was maintained. The initiatives agreed as part of the Wirral Winter Plan were implemented, some of which included:

- Reducing triage waiting time in ED by providing early oversight of acuity in the waiting room.
- Embedding streaming pathways from the ED direct to specialties.
- Expanding the Frailty Same Day Emergency Care unit to operate 7 days per week.
- Reconfiguring the medical short stay ward, expanding the acute medical unit model to focus on reducing length of stay and providing early flow from ED.
- Opening additional escalation bed capacity.
- Reconfiguring a temporary escalation space to a medical reverse cohort area.
- Conducting a System MADE event pre-Christmas period.

However, pressures with demand, acuity and flow continued throughout the month.
The improvement work with GIRFT (ECIST) continued throughout December.
The review of the ED medical rotas and increase in out-of-hours coverage, with the rota are set to go live in January. This will help ensure that the medical model meets the peaks in demand and reduces waiting times to be seen.

The team also spent time with the ED triage nurses to ensure that the new triage model is embedded as standard practice before proceeding with the next stage of improvements with the acuity tool.

Work continues on a group of wards focusing on standardised board rounds and implementing criteria-led discharge. The plan is that this could increase early discharges from the wards and support an increase in weekend discharge numbers.

The 12-hour improvement action plan is making good progress with the Divisions. The table summarises actions completed in month and actions planned to be completed in January.

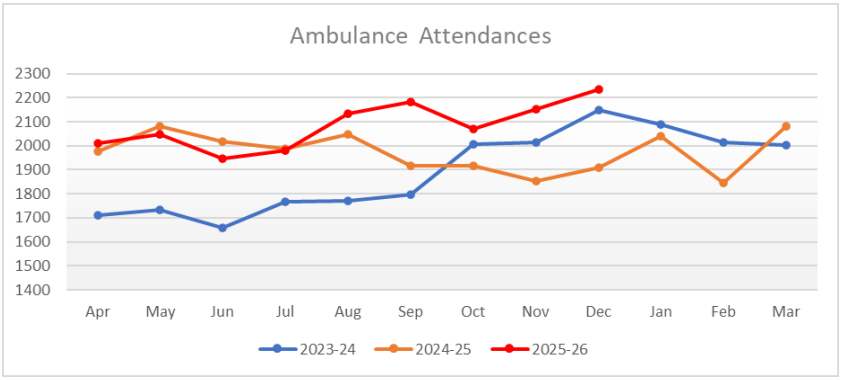
12-hour action plan - Completed

Action	Completion Date
Implementation of extended hours for Frailty SDEC 7 day service for winter.	Dec-25
Implementation of extended AMU footprint into MSSW.	Nov-25
Increase baseline for Post Take Ward Round capacity	Nov-25
Provide an additional ward round (ED3) at the weekend.	Nov-25
Visibility of ambulatory clinics for medicine and wait times	Nov-25
Increase cardiology in-reach/RACPC capacity following pilot.	Nov-25
Programme of early discharge focus at ward level, directorates to focus on changes at ward level to improve early discharge.	Ongoing
Prospective coordination of consultant and resident capacity	Dec-25
Long Length Of Stay reviews by senior Medical Consultant Team – focus on 21 day + Length Of Stay with Criteria To Reside	Dec-25
Follow streaming criteria and process ED to specialties	Dec-25
Escalation of specialty breaches in real time to speciality leads	Dec-25
Drive improvements in Inter-Professional Standards (IPC) across all specialities	Dec-25
Ensure live 12 hour LoS performance visible on BI portal	Nov-25

12-hour action plan – Planned for January

Action	Planned Completion
Change of Tier 1 Medical rota in ED to increase coverage evening and overnight	Jan-26
Improve communication and isability of improvement work with staff - showcase successes and highlight areas of focus for further improvement	Jan-26
Zoning of the ED with Senior Decion Makers	Jan-26
Complete daily point prevalence of key areas in ED to allow earlier decisions, identify opportunties for discharge with community services or flow to SDEC areas	Jan-26
Utilise GPs in ED to support peaks in demand	Jan-26

The average ambulance handover times increased in December, as observed across most Trusts in Cheshire and Merseyside. However, the overall average remained below 45 minutes. The demand for ambulance conveyances continues to exceed previous years' activity, reaching the highest number of conveyances in December, despite the Trust's efforts to offer alternative services to the Emergency Department for patients contacting the ambulance service.



Discussions will continue within the Cheshire and Merseyside Ambulance Improvement Group into January, and a local review of the current service offer for the ambulance service will be conducted internally across the Acute and Community Trust.

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

In December, the position remained stable, with 12.5% of patients occupying acute beds despite having no criteria to reside (NCTR). Often, the NCTR increases over winter so this sustained position demonstrates significant progress in the improvement work completed across Wirral, ensuring patient discharge pathways are streamlined,

	delays are reduced, and having the appropriate skilled workforce in place to enable patients to be discharged to the most appropriate destination in a timely manner. The Trust continues to perform strongly compared to neighbouring Trusts in relation to NCTR, maintaining its position as one of the highest performing Trusts in the system. Winter planning with system partners ensured that a MADE event was scheduled in the month prior to Christmas. The event focused on specific cohorts of patients to reduce delays and ensure that all capacity was utilised going into the festive period. As part of the 2026/27 planning, the system will review additional actions that can be taken to work towards the locally set 10% target. **Provider** ▲ / **Current** Countess 19.5% East Cheshire 13.0% LUHFT 19.9% Mid Cheshire 15.4% MWL 17.4% W&H 19.4% WUTH 12.5% **Total 17.4%**
3.3	**Mental Health** Long waits for Mental Health patients in the Emergency Department (ED) have improved, reducing the need for senior teams to enact the Mental Health escalation route through the action cards. Ongoing discussions are taking place regarding the potential offer of capital funding to support the establishment of a section 136 suite outside of the ED, along with some clinic spaces to support patients presenting to the ED with Mental Health needs. Cheshire and Merseyside are continuing to work towards developing a pathway for patients requiring conveyances on a section 136 by the police to the nearest place of safety and how to respond when at full capacity. The plan is for this to be in place from April 2026.
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 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 continues to experience challenges with the number of patients presenting with respiratory illnesses including influenza and norovirus which has resulted in limiting flow on wards.

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery in line with national trajectories. The paper also details the extra actions introduced recently to improve UEC performance given the longer lengths of stay in the department and the impact on patients.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • The cost of delivering elective performance is contained within the financial forecast. There are premium costs associated with the delivery of Trust UEC services over and above the original 25/26 plan.
4.4	**Compliance** • The paper outlines the achievement of the compliance standards for elective care by the end of this financial year but flags risks around UEC 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 and improvements continue, in particular recovering the 28 day faster diagnostic standard by month 11.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

28 January 2026

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 on the management of strategic risks through the Board Assurance Framework (BAF) for 2025-26.

This update provides the position following review during December 2025 and January 2026 at the sub-committees of the Board.

- The Finance, Business & Performance Committee met on 15 December 2025.
- The Quality Committee met on 21 January 2026.
- The People Committee met on 22 January 2026.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks with assurance on the oversight from the sub-committees of the Board
- Note the position in relation to the six strategic risks scoring as high-level
- Approve the increase in risk rating for ID5 from RR9 to RR12
- Approves the position for all other 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.
December 2025	Board	Board Assurance Framework	The Board noted and approved the position reported in relation to the strategic risks.
December 2025	Finance, Business & Performance Committee	Board Assurance Framework	The Committee noted the position for the relevant risks and approved onwards reporting to the Board of Directors.
January 2026	Quality Committee	Board Assurance Framework	The Committee noted the position for the relevant risk and approved onwards reporting to the Board of Directors.
January 2026	People Committee	Board Assurance Framework	The Committee noted the position for the relevant risks and approved onwards reporting to the Board of Directors.

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 maintains oversight of strategic risks relevant to the duties and responsibilities of the committee.
1.2	At the meeting of the Board of Directors in December 2025 an update was provided on each of the strategic risks.
1.3	The dashboard at **appendix 1** confirms the current position of strategic risks as reviewed during December 2025 and January 2026. Of the 12 strategic risks, 6 are scored 15 or above - *ID1,2,3,4,6 and 11.* The People Committee agreed a recommendation to increase risk ID5 - *Failure to have the right culture, staff experience…* to RR12 (from RR8) recognising current pressures and triangulation with key workforce metrics particularly in relation to sickness and staff engagement. There are no further proposed changes to risk ratings this month, and all committees of the Board acknowledge the alignment of key papers and performance reporting to the highest scoring strategic risks. The Audit & Risk Committee will meet on 13th February 2026 to have oversight of all strategic risks and progress to mitigation and achievement of target risk ratings. The IMB maintains oversight of the risk related to integration with WCHC with good progress being made. The IMB will review this risk on 11th February 2026.
1.4	It is anticipated that with the launch of the new Joint Strategy in Q1,26-27 a revised BAF with shared strategic risks will be developed reflecting the position for both Trusts.
1.5	**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	**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		Jan 26
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)	↑	12 (3 x 4
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**

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	

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. • Additional actions have been taken to improve UEC performance, i.e., a different allocation of senior decision makers, tracking and executive daily huddles to remove obstacles • Improvement plan actions have been modelled and shared through Tier 1 meetings, with the expected impact on 4 and 12 hours. Revised trajectories for 4 hours have been submitted to NHSE	• 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 (Q2 25-26) - 4 (unchanged from Q1; ranking position 110/134) • NOF domain score - Access to Services - Q2 - 3, *(Q1 - 2.57)* • NOF metric score - UEC 4 hours - Q2 - 3.1, *(Q1 - 2.7)* • NOF metric score - UEC 12 hours - Q2 - 3.92 *(Q1 - 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. • Staffing pressures in UTC and WICs potential impact on ED

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.	Exec MD	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 on-site	Exec MD	December 2025 - COMPLETE
Full engagement with the national Tier 1 process for UEC performance (engaging in fortnightly calls)	Exec MD	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 • Critical incident to be formally stood down with forecast and plan to recover all elective activity	• 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 (Q2 25-26) - 4 (unchanged from Q1; ranking position 110/134)
- NOF domain score - Access to Services - Q2 - 3, *(Q1 - 2.57)*
- NOF metric score - UEC 4 hours - Q2 - 3.1, *(Q1 - 2.7)*
- NOF metric score - UEC 12 hours - Q2 - 3.92 *(Q1 - 3.95)*
- Business continuity plans for SSD services
- Recent critical incident related to SSD has impacted elective surgery timescales with potential consequential impact on patient experience
- 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.
- Reduction in skin cancer 28-day performance (see action)
- 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*	**Exec MD / Chief Finance Officer**	**COMPLETE**
Delivery of recovery plan to address skin cancer 28-day performance	Exec MD	January 2026
Continue with delivery of mitigation plans for scheduled care,	Exec MD	March 2026
Utilisation of premium time capacity to bridge gaps in capacity and demand	Exec MD	March 2026
Delivery of forecast and plan to recover all elective surgery activity (following SSD critical incident)	Exec MD	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.

		Initial Score	Previous month	Current	Target
Strategic Priority	**Outstanding Care**				
Risk Appetite	**Minimal**				
Review Date	**Q3 2025/26**				
Lead	**Chief Medical Officer and Chief Nurse**	**16 (4 x 4)**	**16 (4 x 4)**	**16 (4 x 4)**	**12 (4 x 3)**

Controls	Assurance
• Action plan agreed following CQC inspection of UEC & Medicine • 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	• CQC report of UEC (1 out of 5 rated 'good') & Medicine (3 out 5 rated 'good') • EDS report – domain 1 (reported to committee in January 2026) • Cancer Annual Report (reported to committee in January 2026) • 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

- 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	COMPLETE

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.

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

Controls	Assurance
• Focus on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy. • 'Well WUTH' Programme launched to support return to work from absence (with positive feedback) • 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	• Workforce Steering Board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring as Workforce Steering Committee

• Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • 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 - 'Everyday 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 sickness absence rates related to stress and anxiety. • Impact of organisational change in corporate services

Action	**Responsible**	**Deadline**
Wellbeing Surgeries across sites	Chief People Officer	March 2026
OH Capacity and Demand Review	Chief People Officer	**Complete**
Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing	Chief People Officer	March 2026
Talent mapping exercise for senior leaders	Chief People Officer	26/27
Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months.	Chief People Officer	**Complete**
The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.	Chief People Officer	March 2026

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)**	**12 (3 x 4)**	**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 reviews. • 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	March 2026
Develop and implement the WUTH Perfect Start	Chief People Officer	March 2026
Work ongoing to resolve dispute in theatres	Chief People Officer	**Complete**
Working in progress to progress the settlement for CSWs – led by DCN	Chief People Officer	**Complete**
Q1 project planned for Q3 to address team working – led by CN	Chief People Officer	March 2026

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 • Board engagement in development of MTFP and planning submission for 26-27 and beyond • Review of Board Assurance Statements to support annual planning submissions	• 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 (Q2 25-26) - 4 (unchanged from Q1; ranking position 110/134) • NOF domain score - Finance and Productivity - Q2 - 4.00, *(Q1 - 2.36)* • NOF combined finance metric score - Q2 - 4.00, *(Q1 - 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
Review of digital governance arrangements and establishment of sub-board Digital Committee	Chief Finance Officer / Chief Information Officer/ Director of Corporate Affairs	April 2026

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
• Board engagement in development of MTFP and planning submission for 26-27 and beyond
• Review of Board Assurance Statements to support annual planning submissions
• 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 - in progress.
• 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	**Executive Managing Director**	**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	Executive Managing Director	March 2026
Heating and ventilation programme completion	Executive Managing Director	March 2026
Replacement of generators and ventilation systems	Executive Managing Director	March 2026
Delivery of 2024/25 Capital Programme to plan and budget allocation.	Chief Finance Officer	March 2026
Development of bids in preparation for potential NHSE Capital Grants for 2024/25 and 2025/26	Executive Managing Director	March 2026
Examination of options to relocate corporate and clinical functions to community	Executive Managing Director	March 2026

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.

		Initial Score	Previous month	Current	Target
Strategic Priority	**Infrastructure**				
Risk Appetite	**Open**				
Review Date	**Q3 2025/26**				
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. • Issues log to Board identifying any emerging risks

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
- Review of Digital Governance and establishment of Digital Committee for Board oversight

Action	Responsible	Deadline
Continue with the actions highlighted in the core standards peer review assessment.	Chief Finance Officer	March 2026
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	February 2026
Operational Cyber programme addressing the risks raised within the Dionach, Penetration test.	Chief Information Officer	March 2026
Working with suppliers to irradicate legacy connections, expressing importance of the standards.	Chief Information Officer	March 2026
Cyber incident action plan	Chief Information Officer	March 2026

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 • 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~~ March 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.

Public Board of Directors **Item 13**

28 January 2026

Title	WCHC Board Assurance Framework 2025-26
Lead Director	Alison Hughes, Director of Corporate Affairs
Author	Alison Hughes, Director of Corporate Affairs
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 December 2025 and January 2026 at the sub-committees of the Board.

- The Finance & Performance Committee met on 15 December 2025.
- The Quality Safety Committee met on 14 January 2026.
- The People & Culture Committee met on 22 January 2026.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks with assurance on the oversight from the sub-committees of the Board
- Notes the high-level risk (ID07)
- Approves the position for all other 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 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.
03/12/25	Board of Directors	BAF	The Board received the update provided on the current position in relation to the strategic risks.

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 maintains oversight of strategic risks relevant to the duties and responsibilities of the committee.

1.2	At the meeting of the Board of Directors in December 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 December 2025 and January 2026.
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	There are no proposed changes to any other risk ratings. The Quality & Safety Committee noted a reference to the CQC inspection of the Eastham WIC and UTC related to both ID01 and ID02. Since the meeting of the committee, the reports have been published, and action plans are now in progress to be completed at pace. The People & Culture Committee agreed that a further review of risk ratings will be completed in March 2026 to determine any impact following the release of the national staff survey (NSS) results, recognising that a number of the outcomes to mitigate each of the risks are linked to the results of the NSS. The Finance & Performance Committee noted reference to the NOF rating at segment 1 for WCHC, and there were no further proposed changes to the risks.
1.6	It is anticipated that with the launch of the new Joint Strategy in Q1,26-27 a revised BAF with shared strategic risks will be developed reflecting the position for both Trusts.
1.7	**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

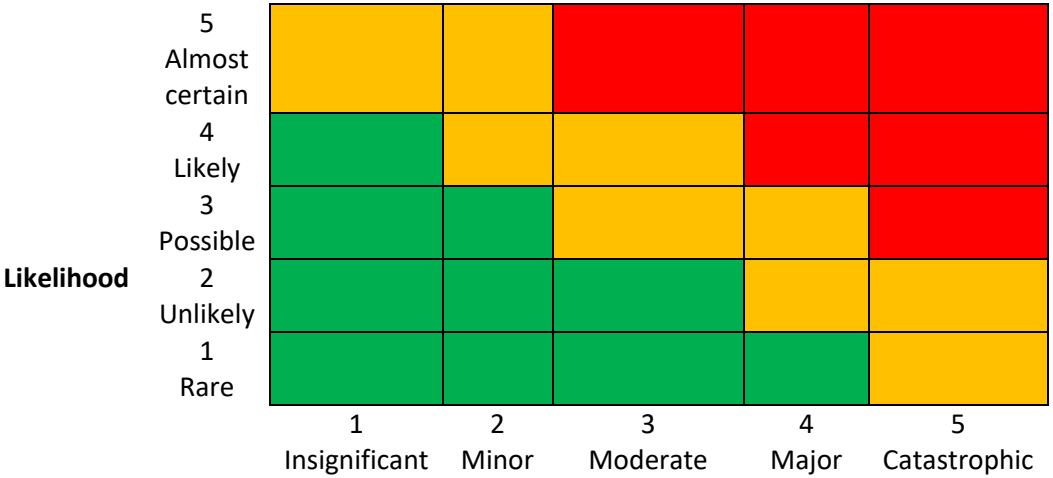
2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF 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) (January 2026)	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 Better employee experience to attract and retain talent	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) (January 2026)	Target risk rating (LxC)	Risk Appetite
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 meets on the same day as the corresponding WUTH committee with joint NEDs.
- The committee has Terms of Reference in place, reviewed annually *(2025 review pending due to integration programme).*
- 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 *(2025 review pending due to integration programme).*
- 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.

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

<table>
<tr><td colspan="5">ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - Safe care and support every time

Organisational risks - ID2769 (RR15), ID3209 (RR15), ID3228 (RR15), ID3242 (RR15) and ID3243 (RR16) - reported via the high level risk report as per Risk Policy.</td></tr>
<tr><td colspan="6">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</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td colspan="2" rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">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 (M08)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 0 fall (moderate & above harm) (YTD = 1) - QUAL17
- 88.7% FFT (YTD 96.1%) - QUAL22
- 1 complaint received (YTD = 25) - QUAL08</td><td>- Final reports following CQC inspection of Eastham WIC and UTC - interim Chief Nurse
- Temporary closure of Eastham WIC - Exec MD / Deputy COO
- MIAA Clinical and Professional Supervision Assignment Report - Moderate Assurance - Deputy Chief Nurse (Risk ID3240 - RR12)
- Supervision Training Strategy - Head of L&OD</td><td>- 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</td><td>- 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</td></tr>
</table>

- 451 incidents reported - QUAL02 *(0.4% moderate and above harm - QUAL18)*
- 212 patient safety incidents - QUAL03
- Mandatory training compliance trust-wide achieved target - 94.5% (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*
	- 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 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 - **Complete**
			- Delivery of two patient safety champion training sessions - **March 2026**
			- Implement 'What matters to you' campaign in 2 more WCHC services - ~~**December 2025**~~ **March 2026**
			- '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 - Corporate Services Collaboration Agreement in place to provide services back to WCHC clinical services, monitored via IMB			

<table>
<tr><td colspan="6">ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Safe care and support every time</td></tr>
<tr><td colspan="7">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</td></tr>
<tr><td colspan="6">Current risk rating (LxC)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td rowspan="2">Averse</td><td rowspan="2">2 x 4 (8)</td></tr>
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<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">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)</td><td colspan="2">- Final reports following CQC inspection of Eastham WIC and UTC - interim Chief Nurse
- Temporary closure of Eastham WIC - Exec MD / Deputy COO
- Lack of staff confidence in accessing and interpreting health inequalities data - Head of Inclusion
- Digital version of AIS and Health Inequalities</td><td>- 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.</td><td colspan="2">- 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</td></tr>
</table>

- 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.	Waiting List Tool questionnaire in multiple languages - **Head of Inclusion** - Embed use of paper forms of questionnaire for those impacted by digital 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)	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 (Q2 published) • 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) • M7 financial plan - reported surplus of £1.0m; £1.3m ahead of plan • M7 CIP position - £400k behind plan • 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	• 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 Finance Officer**		

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)	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 (Q2 published) • 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** - delayed and position reported to the QSC in November 2025

• Programme of Quality Improvement Training and Events available across the Trust (including WUTH staff) • Community Nursing Development Programme determined and scoped • Joint Chief Integration & Partnerships Officer 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 • Cardiology service review in progress between WCHC and WUTH as part of the 2-year integration plan • Corporate Services TUPE transfer completed with Organisational Change during Q4 26-27	• 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	• Key deliverables for Y1 of 2-year integration plan achieved - **March 2026** • CIP target delivered - **March 2026** • Financial plan delivered or mitigated position with ICB - **March 2026**

<table>
<tr><td colspan="5">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</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - (Populations) Safe care and support every time, (Place) Make most efficient use of resources to ensure value for money</td></tr>
<tr><td colspan="6">Consequence;
• Delivery of patient care and patient experience
• Staff morale
• Financial impact
• Negative reputational impact for the Trust and system</td></tr>
<tr><td colspan="5">Current risk rating (LxC)
(by month of committee)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Cautious</td><td rowspan="2">2 x 4 (8)</td></tr>
<tr><td>-</td><td>-</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td></tr>
<tr><td colspan="2">Mitigations
(i.e. processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">• Annual self-assessment against 58 core standards attributed to community providers completed with 97% overall compliance (substantial compliance) – reported to QSC and Board in November & December 2025
• EPRR arrangements in place including business continuity plans for all services</td><td colspan="2">• ~~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 audit review (extensions to 30</td><td>• EPRR core standards self-assessment - substantial compliance
• DSPT / CAF compliance</td><td>• ~~EPRR core standards self-assessment - substantial compliance - March 2026 - COMPLETE and ACHIEVED~~
• Implementation of all recommendations from DSPT/CAF audit review - Q1, 26-27</td></tr>
</table>

• 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 • MiAA audit provided 'substantial assurance' • EPRR governance through HSSR group reporting to QSC • 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	June 2026 requested) - **Chief Finance Officer / SIRO** • Digital Integration Plan with WUTH - **Chief Finance Officer / SIRO**		

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 meets on the same day as the corresponding WUTH committee with joint NEDs.
- The committee has Terms of Reference in place, reviewed annually *(2025 review pending due to integration programme)*
- The Joint Chief People 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 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

<table>
<tr><td colspan="5">ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent

High-level organisational risks - ID3214 (RR16) - related to UTC/WIC/MIU/OPD sickness absence rate at 11.6% - as reported in high-level risk report as per Risk Policy.</td></tr>
<tr><td colspan="6">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</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by committee by month)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Moderate</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>4 x 4 (16)</td><td>4 x 4 (16)</td><td></td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">TUPE transfer of corporate staff completed on 1 December 2025
Standardised approach to assessing and enhancing employee experience using NHSE staff experience assessment framework
NOF segment 1
NHS staff survey engagement theme sub-score 2.8 in NOF</td><td colspan="2">Final reports following CQC inspection of Eastham WIC and UTC - interim Chief Nurse
Temporary closure of Eastham WIC – Exec MD/ Dep COO</td><td>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”</td><td>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</td></tr>
</table>

• 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 • 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	• Impact of AFC review of nursing role profiles to be reviewed (plan in place aligned to WUTH) - **Chief People Officer** • Sickness absence rates increasing (7.98% - M9) - flagged in IPR at Board of Directors and monthly Get Together. Sickness rates impacting on People & Workforce domain of NOF - **Chief People Officer** • Increasing turnover rates above the Trust target of 10% - 12-month rolling at 13.22% - **Chief People Officer** • ~~Implementation of workplace sexual safety measures - **Head of HR - Complete**~~ • Increase compliance of staff training in sexual misconduct – **Head of HR** • Appraisal compliance 2025 - (91.24%) **- Deputy Chief People Officer - Complete** • Manager training to support staff mental health and wellbeing **- Head of HR - on track** • Delivery of People Management Skills **- L&OD**	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	- Roll-out of OD programme to support integration of services between WCHC and WUTH - **on-going and aligned to 2-year integration plan** - Staff training in Sexual Misconduct to achieve 90% compliance (72.6% at M9) - **March 2026**

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 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	• Deliver Leadership for All programmes with alignment between WCHC and WUTH - **L&OD**		

• 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 - 'Understanding Sexual Misconduct in the workplace' manager training compliance at 91.8%.			

<table>
<tr><td colspan="6">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</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="7">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</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by committee by month)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Moderate</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td></tr>
<tr><td colspan="8">Measures remain under review and in development following committee discussions in August 2024.</td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">TUPE transfer of corporate staff completed on 1 December 2025
Standardised approach to assessing and enhancing employee experience using NHSE staff experience assessment framework
WUTH Leadership for All offering available to all WCHC staff</td><td colspan="2">Roll out cultural competence training - Head of Inclusion - Complete
EDI dashboard to PCC - Head of Inclusion - Complete
Implement regular cultural assessment at Trust and divisional level - Deputy CPO</td><td colspan="2">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</td><td colspan="2">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</td></tr>
</table>

• EDI dashboard produced and reviewed at EDI steering group and via PCOG • Wirral Coaching Hub with Local Authority Coaching Hub established. • 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 - 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	• Further develop staff network - **Head of Inclusion** • Increase coaching activity - **L&OD Team** - **Complete** • Submission of application for Anti-Racist Framework bronze level accreditation - **Head of People Experience**	*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** • Staff network development (L&D offer and revised governance) - **March 2026**

• 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. • 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)		• 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	

• Behavioural standards framework launched trust-wide • EDS 2024 completed (jointly with WUTH) with Board approval in February 2025 - Overall attainment level = **Achieving**			

<table>
<tr><td colspan="6">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.</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">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).

High-level organisational risks - ID3214 (RR16) - related to UTC/WIC/MIU/OPD sickness absence rate at 11.6% - as reported in high-level risk report as per Risk Policy.</td></tr>
<tr><td colspan="7">Consequence;
Poor outcomes for the people working in the Trust
Reduced staff engagement
Increase in staff turnover and recruitment challenges</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by month by committee)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Open</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td>2 x 4 (8)</td><td></td></tr>
<tr><td colspan="8">Measures remain under review and in development following committee discussions in August 2024.</td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">TUPE transfer of corporate staff completed on 1 December 2025
Standardised approach to assessing and enhancing employee experience using NHSE staff experience assessment framework</td><td colspan="2">Final reports following CQC inspection of Eastham WIC and UTC - interim Chief Nurse
Temporary closure of Eastham WIC – Exec MD/ Dep COO</td><td colspan="2">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%</td><td colspan="2">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</td></tr>
</table>

• WUTH Leadership for All offering available to all WCHC staff • 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' • 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	• Review operational service requirements in relation to career pathways, clinical apprenticeships and advanced practice **- L&OD**	• Q25c in NSS *"I would recommend my organisation as a place to 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 • '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	

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 16**
28 January 2026

Report Title	Committee Chairs Reports – Audit and Risk Committee
Date of Meeting	10 December 2025
Author	Meredydd David, Chair of Audit and Risk Committee

Alert	The Audit and Risk Committee wish to alert members of the Board to: • This year's core standards assessment has been assessed as compliant with this area being reviewed by MIAA and assurance levels reported are moderate. • There are large backlogs with responding to subject access requests (SARs), which is an area impacted by vacancies and long-term sickness coupled with high demand. There is a risk of enforcement action from the ICO due to the backlog, and a business case has been developed to deal with this. • Clinical coding backlog has improved and recent performance has been stronger than previous months, and there are mitigation plans to try to continue this. This is still a risk area and the Trust's mortality rates have been affected by this because the Trust has uncoded activity, but is prioritising all deaths, which means that mortality rates only appear to have increased. This is now being addressed. • Cyber security and the gaps in controls which were seen through the cyber incident, including password control contributed to the learning identified and these actions need to be implemented, but team capacity is impacting the timely delivery of this.
Advise	The Audit and Risk Committee wish to advise members of the Board that: • It was noted that of the key business continuity risks on the register all other than the critical care air handling unit failure has been addressed. This particular risk has not been addressed with capital spend because there are suitable alternatives available in the event of a business continuity issue • The financial assurance report showed solid performance. Future reports would include aged debt comparison • Internal Audit follow up report indicated that some LocSSips recommendations have been delayed. It was agreed that this should be referred to the Quality Committee so they are sighted on this delay. • It has been decided the annual review of the Standing Financial Instructions will be held back to allow the incorporation of the revised procurement thresholds available from January 2026 and will include any relevant delegations to a Group Board to allow this to be used from the point that a group governance model is constituted.

	• An update was received on the significant risks on the Trust risk register which relate to cyber, and noted that in addition to these, there are 7 rated as high and 2 as moderate. Progress made to date, including the removal of generic accounts, segmenting medical equipment, and commencing integration work with WCHC was outlined.
Assure	The Audit and Risk Committee wish to assure members that: • There were no issues to escalate from the meeting held with internal audit after the Audit Committee • The Head of Security has been fully engaged on both lockdown incidents and other EPRR matters and has significant experience in this area. Further work is being done in preparation for the introduction of Martin's Law and the Audit Committee will receive a further update on its implementation. • The trust meets or exceeds model health benchmarks for procurement waivers and has increased its control measures for non-pay spend. • The Internal Audit Anti-Fraud progress report showed eleven components as green and one as amber which was due to the fraud risk assessment requiring a refresh this year. This amber rating has been implemented across all MIAA client Trusts to reflect the requirements. • Internal Audit provided substantial assurance on the Recruitment Process and Procurement Process audits.
Review of Risks	• Of the 12 risks on the BAF, 6 are scoring high and there are no proposed changes to the scoring. • It was agreed to review how the audit recommendations are managed, monitored and escalated through the appropriate Committees, including via EARC.
Other comments from the Chair	• The impact of the financial pressures and workload peaks on various teams is beginning to manifest in delays in some actions and recommendations being delivered. Thus the referral of action plans and recommendation from Internal Audit to relevant sub-committees for more timely monitoring.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
28 January 2026

Item No 18

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	15 December 2025
Author	Meredydd David, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ at the end of November, month 8, the Trust is reporting a deficit of £23.3m which, excluding Deficit Support Funding (DSF), is a £8.9m adverse variance to plan. ○ at month M8 the Trust is forecasting a £13.1m adverse variance to plan under the mid case scenario. The Trust has agreed a series of turnaround actions which If implemented in full would be sufficient to deliver the approved plan of £22.1m under a best case scenario. ○ the Trust's exit run rate deficit for 2025/26 stands at £40.9m, compared to a required underlying deficit of £22.1m. The modelled Cost Improvement Programme (CIP) level of 5% would need to increase to approximately 10% to deliver a compliant plan. ○ the Committee recognised the significant challenges associated with delivering the 2026/27 control total of £9.1m, including a CIP target of 10%. The Trust's MTFP is clear on the drivers of deficit and the improvement programmes required to address these ○ the referral to treatment position for October was significantly impacted by the sterile services incident which resulted in the cancellation of 1,378 elective cases in October and November
Advise	• The Committee wish to advise members of the Board of Directors that: ○ the revenue support application for December had been received, and the Trust requires a further £11.5m between January and March 2026. It was noted future applications were not guaranteed and that the Trust has a cash mitigation plan which outlines the actions the Trust will take to preserve cash. ○ the Committee received an update on the first-cut plan due for submission and the risks and challenges to complying with the nationally required control total of £9.1m. Trusts that do not submit compliant plans would not be eligible for Deficit Support Funding in 2026/27 which in WUTH's case would be £9.1m ○ the Committee endorsed the net reduction to the 25/26 Capital plan of £1.388m. This is primarily an adjustment to realign to the NHSE approved business case for urgent care. ○ the number of patients waiting 65+ weeks has increased to 26 from 4 between September and October due to the sterile services incident.

	○ there was significant discussion on digital innovation, staff training and expertise and that investment in this area is required and will be a challenge due to financial pressures. ○ there had been a positive change in 4 hour performance, noting type 1 increased from 42.83% to 50.82% in month. ○ approval to award a contract for a one-off capital purchase of an MRI scanner was agreed and would progress to Board. ○ a full Business Case for Optimising Patient Flow for Acute Medicine and Frailty Same Day Emergency Care (SDEC) and a case for Reconfiguration of Patient Flow were recommended for Board approval
Assure	• The Committee wish to assure members of the Board of Directors that: ○ completed Subject Access Requests (SARs) have improved month on month since February but remain below the target completion rate. The volume of requests received are consistent with previous months in the calendar year ○ coding completions by the freeze date in September was marginally below target which is an improved outcome. ○ the Trust is in a good position regarding cloud and networking, though a refresh would be required within 2–3 years
Review of Risks	• Noted the RAG rating for risks highlighted that financial stability, financial sustainability, and financial efficiency were red, cash was amber, and agency spending, and capital was green. Noted that the Trust's most immediate risk remains the cash position. • It was agreed to review risk rating for 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" with to understand this further and update the BAF accordingly.
Other comments from the Chair	• The Trust faces significant financial challenges which are being addressed in detail, strategically and robustly whilst maintaining focus on clinical performance and improvements. The monthly PWC challenge meetings are helpful as the Trust can also demonstrate its "grip and control" in these sessions. The cash position is critical and is the major immediate financial risk.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 19**
28 January 2026

Report Title	Committee Chairs Reports – Quality Committee
Date of Meeting	21 January 2026
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ It received a verbal report from the Chair of the Patient Safety Quality Board (PQSB). A key area of concern was highlighted by a narrative received by the PQSB from a relative about the unscheduled care that their family member had received on the corridor used as an overflow from the emergency department. This was a deeply impactful story and gave the staff from the department the opportunity to voice their concerns, that this was not where and how they wanted to deliver care to anyone. Subsequently senior colleagues held a meeting to agree actions to address specific issues raised about the care this patient received. ○ Wider impacts of high levels of patient attendance in the Emergency Department (up to 370 per day) included seeing clinical staff having to be moved from their usual place of work to support the teams in the emergency department. It was clear that clinical leaders did not wish to "normalise" corridor care but needed to arrange for appropriate resources to be deployed to provide the best care possible in the circumstances. ○ In response a total of ninety-nine escalation beds had been opened to address the high level of inpatient need. The investment to increase qualified nurses in the emergency department was nearly complete, but the need to recruit more clinical support workers remains. ○ The Trust had reached its annual threshold for cases of hospital acquired Clostridiodes difficile by the 21st of January and very likely will pass the threshold. This will negatively impact its scoring & ranking on the National Outcomes Framework.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ It received the Learning from Deaths report that provided assurance on mortality review processes and outlined learning opportunities arising from the reviews. An update was given on the increase in Hospital Standardised Mortality Rate (HSMR) identified in the first half of 2025. This was associated with significant problems with clinical coding at the time. There is an opportunity to correct the relevant codes which will be

	completed by May, when we should have an accurate figure for the HSMR for that period. Given the pressures on the coding service this was felt to be a reasonable timeframe. ○ Compared to planned timescales, the review of the Patient Safety Incident Response Framework (PSIRF) has been delayed. However, an update indicated the principle direction of travel; quicker, less bureaucratic reviews prompting faster learning and dissemination. Themes from PSIRF activity such as tissue ulcers have been identified and will from part of our integrated quality improvement programme for 2026/2027
Assure	• The Committee wish to assure members of the Board of Directors that: ○ It received the high-quality Cancer Services Annual Report which gave assurance that cancer care is underpinned by continued progress in improvement, personalisation and framed against the Trust's values. There is continued progress in improving cancer waiting times. There is strong collaboration with partners including the McMillan Cancer Information and Support Centre. A year-on-year increase in cancer diagnoses being made (4,626 in 2024/25) was particularly evident in urology with an increase over 4 years from around 800 to around 1350 diagnoses. The national patient cancer experience survey had highlighted urology as an area where patients reported a less good experience than expected and the Committee asked for a deep dive into this area. ○ The monthly Maternity and Neonatal Service Report (including the Maternity Incentive Scheme Year 7 declaration) was provided. The Committee was able to receive the details of compliance with each element and sub-element of the scheme and recommends that the Board gives its approval for the Chief Executive Officer sign-off the relevant submission to NHS Resolution. The level of compliance has been supported by the review of the Local Maternity and Neonatal System who will attend this Board meeting. ○ The Committee received its part of the report on the Trust's progress with the Equality Delivery System-Domain 1 relating to clinical services. The report had also been received at the Wirral Community Health and Care Trust since this was a review of musculoskeletal service provided collaboratively. The Committee was assured that the rating of achievement of the 4 sub-domains was appropriate.
Review of Risks	• The Committee reviewed BAF risk 3 (the delivery of outstanding care) and determined there was no need to advise modifying the risk rating. Actions to mitigate gaps in controls which were noted at

	the meeting, will be added to the template (e.g. maternity, equality delivery and cancer services)
Other comments from the Chair	• The Committee benefitted from receiving really 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 21**
28 January 2026

Report Title	Committee Chairs Reports – Finance and Performance Committee
Date of Meeting	15 December 2025
Author	Meredydd David, Chair of Finance and Performance Committee

Alert	• The Committee wishes to alert members of the Board of Directors that: ○ The first submission of the financial plan was to be made in late December 2025 with a second submission in the New Year after further scrutiny by the Board in January 2026. ○ The main risk (£3m) to achieving the control total would be unwinding of the block contract income which is not expected to be transacted in 2026/27.
Advise	• The Committee wishes to advise members of the Board of Directors that: ○ The Trust is likely to transact £5.7m of CIP this financial year with remaining schemes continuing to deliver in 2026/27. ○ The CIP target for 2026/27 was set at 4.7% which is c£5m and schemes to this value had already been identified and the Trust surplus was to be £0.9m ○ The Trust is significantly ahead of the financial plan at month 8 ○ There were 123 WTE less than funded WTE reported in month 8. ○ GPOOH metrics remained below target due to significant workforce challenges which was listed as risk ID:3214. Remedial action plans remain in place.
Assure	• The Committee wishes to assure members of the Board of Directors that: ○ The Trust is in a good position this financial year and moving forward into 2026/27. ○ In month 7, of the 93 operational KPI's reportable to commissioners 79 are were green, 4 amber and 10 red which was noted as strong performance. ○ Internal Audit reviews on four areas resulted in one substantial and three moderate assurance ratings for Critical Application Review Electronic Patient Record; Contract Management; Cyber Assessment Framework; and Data Quality Community Cardiology, respectively. Updated action plans would be brought to the next committee for scrutiny and assurance.
Review of Risks	• The committee received the report providing assurance that all high-level organisational risks were effectively managed. There were 74 organisational risks that had been subjected to a health check score and were all scoring 100% which confirmed all risks on the register were reviewed monthly. • There was one high-level risk to escalate to the committee as follows: ID3125 (RR16) - related to the delivery of the pre-diagnostic

	element of the ND pathway due to lack of available funding from the ICB. The scope of this risk is currently being reviewed to also recognise the integration plans with WUTH.
Other comments from the Chair	• The Trust continues to deliver strong performance in financial and clinical areas including the majority of KPI's with risks regularly reviewed and managed.

Wirral Community Health and Care NHS Foundation Trust

Board of Directors in Public **Item No 22**
28 January 2026

Report Title	Committee Chairs Reports – Quality and Safety Committee
Date of Meeting	14 January 2026
Author	Professor Chris Bentley, Chair of Quality and Safety Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ A Draft Report had been received concerning the recent **CQC inspection of the Urgent Treatment and Care Centre (UTC) at APH and Eastham Walk-in Centre (WiC):** the report had not been circulated, pending the opportunity for factual accuracy check and initial feedback**.** Some clarity is required before being clear on learning/strengthening for the Trust. There are some initial areas for local action while waiting for the final report, and then there will be consideration of wider application of learning. Eastham Centre is temporarily closed due to staffing problems. The pending Report is captured as a Gap on the Trust BAF related to Risks ID01 and ID07 ○ A second area now covered in the ID01 of the BAF covers the mitigations required following **MIAA Audit on Clinical Supervision**, which while finding Moderate Assurance identified that there were some gaps.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ **Quality Strategy Delivery Plan 2025/26:** the action plan, which is reported at each QSC meeting, provided assurance that it is on track for delivery. There were 2 exceptions for which extensions were requested and approved until 31 March 2026 which brings the Plan to completion. The Plan centres around the requirement to set a number of Quality Goals for the Trust. These were set based on the enabling Quality Strategy as part of the Trust's 5 Year Plan, although modified appropriately to reflect the process towards merger with WUTH. Looking forward to setting Goals for 2026/27, Committee began to consider how these would now reflect the 2 year and 5 year joint strategies being developed but with Goals that could still be reported legitimately for the continuing separate Trust entities through to formal merger. ○ **Quality and Patient Experience Report (QPER):** an overview of the up-to-date metrics from the Trust Information Gateway for 1 October – 31 December evidenced a positive position across key quality and safety metrics giving assurance across these measured priority issues. The report included a requested review of incidents coded as moderate and above harm incidents in October and November. Of these 24/24 were pressure ulcers referred into the Trust. These are not reported

	in the same way in WUTH. This data confirmed the need to consolidate reporting in terms of referral source to enable a more population level approach to the problem and its management, ○ **Equality Delivery Systems (EDS) Report:** this was received for assurance that a robust review has been conducted for Domain 1 in accordance with national standards. Domains 2 and 3 will proceed to People and Culture Committee for assurance. The composite must be approved by Board and published by end of February 2026. All three domains have been worked on jointly with WUTH. This year, the Domain 1 topic was MSK. Good evidence was provided to confirm action and Committee was assured. There was a useful discussion about the value of comparing access and outcomes systematically in relation to multiple deprivation score of residence, and this will be pursued separately.
Assure	○ The Committee wish to assure members of the Board of Directors of: ○ **Infection Prevention and Control (IPC) Assurance Report for Q3:** Of the 10 Criteria in the IPC BAF, 6 are fully compliant, 2 are on track for completion, and 2 have agreed extensions as joint work with WUTH is being carried out. Work continues collaboratively at system level to support a reduction in C.diff infections as part of Wirral's 12 month C. diff Strategy. The Team continue to provide a service to the wider Wirral community as part of the Local Authority commissioned service. ○ **Safeguarding Assurance Report Q2:** strong assurance was received based on the extensive and detailed report, which provided monitoring of adult and 0 – 19/25 children's safeguarding activity, as well as report on the the Safeguarding Strategic Plan. All required training was fully compliant, except for the area of executive /Board training. The differences between WCHC and WUTH requirements for training, and the situation of now having a single joint Board are now under review. The management of children in care placed out of Borough and from outside looked after in Borough in Wirral is being reviewed to assure standards of care. ○ **Patient Safety Incident Review Framework (PSIRF) Implementation Assurance Report:** Committee continues to be assured by the now embedded processes, and that the priorities, now aligned with WUTH, are being monitored, and reviewed going forward, with an eye to joint pathway development ○ **Complaints and Concerns Mid-year assurance Report:** 19 complaints had been received in the reporting 6 month period and 17 had been closed. No PHSO requests received. Analysis of the complaint by theme; service and demographic were clearly recorded in the report. Lessons learned were included in the report; but CQC feedback to further strengthen local internal learning is now in progress.

	○ **Learning from Deaths Q2 Report;** this was approved to proceed to Board, and for publication on the Trust website. Aligning the timing and process for this with WUTH reporting was confirmed, and agreement to clarify in the text how the published report could be easily accessed by the public. ○ **Progress on Internal Audit Reviews:** nothing to report by exception ○ **Policy schedule update:** 61/62 policies with QSC oversight are in date. 2 policy extensions were approved to March 31st.
Review of Risks	There were 5 high level risks scoring RR 15/16 identified and discussed at Committee: ○ The need for regular checks of call bells at CICC during out of hours periods. This newly focused risk replaces the former more general one. ○ Increasing waiting lists in Dental due to anesthesia availability ○ Impact of reduced admin staffing on referrals to the Wheelchair service ○ Increasing waiting lists related to the psychosexual therapy service. There was some discussion around the fragility of this service depending on a 'singleton' professional in the establishment. What possibilities in terms of mitigation? Report requested for the next Committee ○ A new risk related to staffing levels within the Parkinsons Disease service These were all registered as risks on ID01 of the BAF, but it was not considered to require an adjustment to the BAF risk score.
Other comments from the Chair	An outstanding item from the QSC Action log related to a mitigation in BAF ID02, related to the Board Self-Assessment against the NHS Providers Guide on Health Inequalities. An Assessment had been drafted for discussion at WCHC Board, but this had been deferred as major contextual changes occurred. It was suggested that this exercise would now be more relevant in the context of the joint working towards merger. Chair would discuss its possible place in relation to the consultations on Joint Strategy.

Wirral University Teaching Hospital
NHS Foundation Trust

Item 24

Board of Directors in Public
28 January 2026

Title	Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 7 Annual Declaration)
Responsible Director:	Julie Roy, Interim Chief Nurse
Presented by:	Jo Lavery, Director of Nursing & Midwifery – Women & Children's Division

Executive Summary and Report Recommendations
This paper includes the Board of Directors report and associated appendices which will be presented on 28th January 2026 with a focus on Maternity Incentive Scheme Year 7. It is recommended that the Board: • Note the content of the paper and prior to Board of Directors approve compliance for sign off to NHS resolution with the Maternity Incentive Scheme (MIS Year 7).

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

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**
January 2026	Quality Committee	As above	As above

1	**Implications**
1.1	**Patients**

	• The report and appendices outline the standards we adhere to deliver a safe service, with excellent patient care. • The increase in maternity workforce establishment to ensure patient safety and quality as a core requirement of national policy, professional standards and the Maternity Incentive Scheme.
1.2	**People** • Maternity services at Wirral University Teaching Hospital (WUTH) continue to deliver high quality patient care to the women and birthing people we care for. • Collaboration and co-production with the Maternity and Neonatal Voices Partnership (MNVP) Lead has promoted the voices and experiences of women, birthing people and families to the ongoing improvement of maternity and neonatal services.
1.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) investment into the maternity workforce is required to support safe staffing maternity levels, funding is being identified through budget setting processes.
1.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 7

Prepared and Presented by:
Jo Lavery (Director of Midwifery) & Mustafa Sadiq (Clinical Director for Maternity Services)
9th January 2026 - Maternity and Neonatal Assurance Meeting
15th January 2026 - Patient Safety Quality Board (PSQB)
21st January 2026 - Quality Committee
29th January 2026 - Board of Directors

Introduction to MIS Year 7

- To provide an oversight of how the ten safety actions have been achieved at Wirral University Teaching Hospital and details of the evidence
- To demonstrate overall assurance to the Board of Directors compliance with the ten CNST Safety Actions detailed in the Maternity Incentive Scheme (Year 7)
- To seek Board of Directors approval today and permission to support the sign off before the final submission to NHS Resolution by 12 noon on 3rd March 2026. The following conditions apply:-
    - Trusts must achieve all ten safety actions
    - The declaration form is submitted to the Trust Board today with this presentation detailing position and progress with the maternity safety actions by the Director of Midwifery and Clinical Director
    - The LMNS/ICB representation will be in attendance to confirm oversight by the governance structure/BoD
    - The Board of Directors give permission following today's meeting to the CEO to sign the Board declaration form prior to submission to NHS Resolution
    - In addition to the CEO of the Trust the accountable officer for the ICB will also apprise the safety actions evidence and declaration form
- To provide an update to Board on the MIS scheme in Year 8 and any potential changes

Safety Actions Summary Table

Safety Action	Detail	RAG Rate
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all six elements of the Saving Babies' Lives Care Bundle Version Three?	
7	Can you demonstrate that you Listen to women, parents and families using maternity and neonatal services and coproduce services with users?	
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?	
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	
10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	

- All notifications are made, and surveillance forms submitted using the MBRRACE-UK reporting website
- The service is using the PMRT tool to review the care and all reports are generated via the PMRT
- Reports are available via the Women and Children's Divisional Clinical Governance Team.
- The Trust board has received updates via the quarterly report evidencing that PMRT has been used to review eligible perinatal deaths and that all required Safety Actions have been met
- NHS Resolution will use data from MBRRACE-UK/PMRT to cross reference again the Trusts certification

Safety Action 2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

MSDS (Available Live):-

Confirmation of a Maternity Information System & framework reported to NHSE using the self-declaration form

1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).
2. 2. July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional

- The submission return has been confirmed as compliance and live evidence reviewed

Safety Action 3 - Can you demonstrate that you have Transitional Care (TC) services in place and undertaking quality improvements to minimise separation of parents and their babies

Safety Action Met

- Transitional Care (TC) was implemented in 2018 jointly both the maternity and neonatal team with a focus on minimising separation of mother and babies with both teams involved in decision making and care planning
- Local polices and pathways based on BAPAM framework have been reviewed and signed off by the LMNS
- There is an explicit staffing model
- The policies have been fully embedded with auditable Safety Actions and quarterly audits
- An explicit staffing model is in place to ensure TC has 24/7 cover with a Band 4/NNU support on the maternity ward. Local policy of TC admission criteria is based on BAPM framework
- By 6 months into the MIS year 7 scheme (end of September 2025) a quality improvement project has been registered with WUTH and the LMNS
- Updates have been provided to the LMNS and Safety Champions regarding development and progress

Safety Action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety Action Met

a) Obstetric medical workforce
   - Commitment to the RCOG workforce document is demonstrated within the Obstetric Staffing Levels policy
   - The trust is monitoring attendance of consultants for appropriate clinical situations as outlined by the RCOG through monthly audits

b) Anaesthetic medical workforce
   - A duty Anaesthetist is available for the obstetric unit 24 hours a day as evidenced in rosters

c) Neonatal medical workforce
   - The neonatal unit required improvement to meet BAPM national standards of medical staffing in MIS Year 5/6; an action plan was developed and implemented to ensure 24/7 consultant cover on site

d) Neonatal nursing workforce
   - The neonatal unit meets the service specification for neonatal nursing as evidence via workforce and evidenced within rosters and neonatal workforce report presented to BoD

Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety Action Met

- Birth-rate plus was completed to calculate midwifery staffing establishment and identified an increase in midwifery levels was required
- The Board of Directors via reports has been provided evidence of midwifery staffing recommendations from Ockenden and funded establishments; current budgets and establishments reflect the findings of BR Plus
- A statement of case and timeline to achieve have been approved by the Board of Directors
- The delivery suite co-ordinator has supernumerary status to ensure there is oversight of all birth activity within the service at the start of each shift. Clear escalation plans are available and have been reported to BoD via the workforce report
- All women in active labour receive one-to-one care (reported 100%)
- A midwifery staffing oversight report that covers staffing and safety issues has presented to the Board at least every 6 months during the MIS Year reporting period (presented to BoD Feb 2025 and September 2025)

Safety Action 6 - Can you demonstrate that you are on track to fully implement all elements of the Saving Babies Lives Care Bundle Version Three

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing six elements of care together:-

- Assurance has been given to the BoD via the implementation tool on at least two (included three times in the quarterly update) occasions the compliance with SBLv3 and identified quality improvement discussions
- Quarterly meetings have been held with the LMNS/ICB and utilisation of the new national implementation tool with evidence uploaded via the NHS Future Platform
- Using the national implementation tool and following review of all evidence by the LMNS/ICB WUTH have demonstrated implementation of 94-97% interventions across all 6 elements overall

Safety Action 7 – Listen to women, parents and families using maternity and neonatal services to coproduce services with users (MNVP)

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

Close relationship with maternity team and MNVP lead – weekly meetings	Quarterly meetings and annual report	Action plan co-produced following CQC maternity survey
Direct communication pathway with senior midwifery team	MNVP Chair is member of safety champions and progress monitored via forum	15 steps annually with service users
Remuneration and expenses paid; budget income managed via MNVP lead	Action plan and work plan jointly produced; CQC noted outstanding practice as part of inspection	Supporting women and families receiving bereavement and neonatal care as well as BAME background

WIRRAL MVP

together we will

Safety Action 8 - Can you evidence the three elements of local training plans and in house one day multi-disciplinary training?

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- A local training plan is in place to ensure that all six core modules of the Core Competency Framework (V2) and has been agreed with all stakeholders
- Fetal monitoring surveillance (antenatal and intrapartum):- WUTH has demonstrated >90% compliance for 2025
- Maternity emergencies and multi-professional training:- WUTH has demonstrated >90% compliance for 2025
- Neonatal Lift Support:- WUTH has demonstrated >90% compliance for 2025

Safety Action 9 - Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal quality safety issues?

Safety Action Met

NHS Wirral University Teaching Hospital NHS Foundation Trust

- The dashboard is produced locally monthly and includes; the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance
- The Perinatal Quality Surveillance Model is reported as evidence monthly at Trust Board
- Perinatal deaths are reported in the quarterly learning from death reported to Trust Board
- A comprehensive maternity report is reported to the Board of Directors monthly and monitors trends including PSIRF framework, MNSI and PSII's
- Safety Board Champions undertake quarterly engagement sessions to include a visible Maternity and Neonatal Board Safety Champion supporting the leadership team

Safety Action 10 – Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to the NHS Resolution's Early Notification (EN) scheme from 1 December 2024 to 30 November 2025?

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- All qualifying cases have been reported to MNSI from 1/12/24-30/11/25
- Report from HSIB / MNSI evidences the safety action has been met
- All qualifying EN cases have been reported to NHS from 1/12/24-30/11/25
- The Trust Board has had sight of details for all qualifying cases via the quarterly maternity update report along with evidence that families have received information on the role of MNSI and EN scheme
- No cases are currently reporting exceptions
- Compliance with duty of candour can be evidenced and promoted with openness and honesty at all levels as an integral part of safety culture

Conclusion

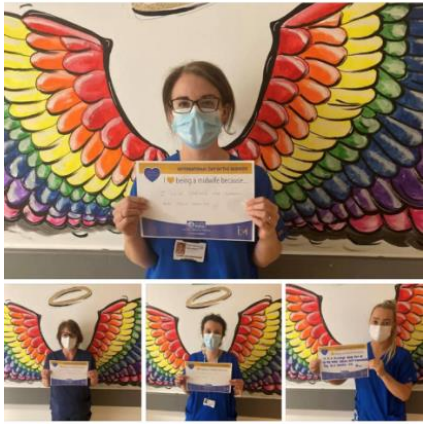
- Wirral University Teaching Hospital (WUTH) is compliant with MIS Year 7 and demonstrates all the Safety Actions have been met
- The Women's & Children's divisional clinical governance and wider identified team members have collated all the evidence for each of the ten Safety Actions and can be accessed/reviewed providing assurance of compliance. All evidence has been reviewed by the LMNS/ICB on the NHS Future Platform and confirmed written compliance
- The frequency of board assurance for compliance with the scheme has been demonstrated via the Maternity Quarterly Reports to the Board of Directors
- The process to demonstrate compliance has been fulfilled including:-
  - Maternity and Neonatal monthly assurance meetings: Interim Chief Nurse and Non-Exec Maternity Safety have been present and provided assurance of all the evidence collated
  - Presented at Patient Safety Quality Board (PSQB)
  - Presented at Divisional Quality Board (DQB)
  - Presented at Quality Committee followed by Board of Directors with the ICB/LMNS present
- The declaration form to be signed by both CEO and the Accountable Officer of ICB before submission by 12 noon on 3rd March 2026

Recommendations

The Board of Directors approve and give permission for the Trust to sign off compliance with Year 7 of the scheme

Final submission of all the evidence supporting and demonstrating compliance with all 10 Safety Actions will be by 12 noon on 3rd March 2026 using a specific notification template which will be signed off by the Chief Executive Officer

I being a midwife....



Thank You – Any Questions?

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	Yes
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	N/A
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
12	Was the above action plan shared with the LMNS?	N/A
13	Was the above action plan shared with the Neonatal ODN?	N/A
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Yes
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
17	Was the above action plan shared with the LMNS?	N/A
18	Was the above action plan shared with the Neonatal ODN?	N/A

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	Yes
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	Yes
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	Yes

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Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	N/A
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes

9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes

21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	Yes
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

NHS Resolution

Section A : Maternity safety actions - Wirral University Teaching Hospital NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	7	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	11	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	5	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	20	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	0		
	Number of neonatal deaths (before 28days) at WUTH	0		
	Number of maternal deaths (up to 28 days following delivery)	0		
	Post partum haemorrhage >1500mls	6		x 6 reported; all have had full reviews via the CIF process and have been managed in line with policy
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 7
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report received in March 2025 and staffing levels suboptimal; business case required to support an increase in establishment; recruitment underway
	Midwifery staff absence rate in month (sickness)	4.08%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target; national rate 5.0% and reported as below
	Midwifery vacancy rate	5.00%		All posts out for recruitment including increasing establishment posts to meet BR plus compliance as action plan and SA5 of the MIS Year 7 Scheme
	Midwife : Birth ratio	01:27		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0		Nil
	BAPM compliance - Neonatal medical staff	Yes		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil; mutual aid requested
	Total number of Red Flags reported	8		Theme: delay in providing pain relief; improvement noted from previous months
Service user /	Staff survey	47%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, required improvement; action plan produced with key priorities; 2025 staff survey increased response rate >47% for the division
	CQC National survey	Yes		Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
	SCORE Survey	Yes		Participated in 2024; facilitated workshops and ongoing action plan
	Feedback via Deanery, GMC, NMC	No		Nil of note
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Leadership and relationships	New leadership within or across maternity and/or neonatal services	No		All posts etsablished and recruited to
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 7 to be submitted March 2026, sign off by BoD to be requested in Jan 2026
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	No		Nil of note
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	No		Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No		Robust governance processes
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	No		Learning shared internally and via MNSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No		Nil of note
	Maternity/Neonatal Safety Champion concern; negative feedback; escalation	Nil		Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes		CQC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Incident reporting	Number of PSIRF reported incidents graded moderate or above	3		
	Number of Maternity or Neonatal PSII's	0		No new PSII's for maternity; x 1signed off for NNU
	Number of cases referred to MNSI	1		x 1 referral in Month of December 2025; cooling case and was accepted
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Reported Never Events	0		Nil for maternity
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safery action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governanc e processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	No		Post critical incident resumed to business contunuity; mutal aid stood down
	Number of maternity/neonatal risks on the risk register overdue	0		Nil overdue
	Number of maternity/neonatal risks on the risk register with a score >12	43		NNU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions; 6 monthly risk review underway
CQC inspection and DHSC or NHS(E) request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No		Nil to report this month
	Coroner Regulation 28 made direct to Trust	No		CQC reports published in April 2023 'GOOD' for maternity services
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No		N/A
	CQC Rating overall	GOOD		N/A
	Been issued with a CQC warning notice	No		N/A
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No		N/A
	Been identified to the CQC by MNSI with concerns	No		N/A

Board of Directors in Public **Item 25**
28 January 2026

Title	Gender Pay Gap Report
Area Lead	Debs Smith, Chief People Officer
Author	Sharon Landrum, Head of People Experience
Report for	Approval

Executive Summary and Report Recommendations

The gender pay gap is the difference between the average pay of men and women in an organisation.

Gender pay gap legislation was introduced in April 2017 requiring UK employers with 250+ employees to publish data about their gender pay gap on an annual basis. Data must be based on a snapshot date of 31st March each year (for the public sector) and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017:

1. mean (average) gender pay gap using hourly pay
2. median gender pay gap using hourly pay
3. percentage of men and women in each hourly pay quarter
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

Information contained within this report is therefore based on 31st March 2025 and must be reported nationally, with a narrative report, by no later than 30th March 2026.

In summary, the 2025 gender pay gap reporting key findings are:

1) Increased mean gender pay gap from 20.1% to 20.9% this year, continuing to be in favour of males
2) Increased median gender pay gap from 2.8% to 4.4% this year.
3) Significant reduction in mean bonus pay gap from 30.1% to 10.2% this year.
4) Continued 0% median bonus pay gap.
5) 4.6% reduction in proportionately of bonus, with 0.4% of females receiving bonus pay this year, compared with 4.3% of males (1.8% females in 2024 and 10.3% of males).
6) Reduced number of male staff from 22.4% to 21.8% this year. Number of male staff still remains significantly lower than females overall.
7) Reduction in the females in the upper pay quartile this year (from 69.5% in 2024 to 69% this year).

A number of steps have been taken across the organisation over the last few years to support workforce wellbeing and worker experiences and support development and personal growth for staff.

Gender pay gaps at Wirral University Teaching Hospital have shown a reducing trend since reporting commenced, however this is the second time since commencement that the mean

gap has increased.

Mean averages can fluctuate year on year due to the recruitment and loss of experienced high earning staff, which appears to be the case this year. Data shows a reduction in the number of females within the upper pay quartile, which would impact the overall mean average.

Bonus gender pay gaps have however significantly improved, largely due to changes in awarding of clinical excellence awards (CEA) and discretionary points for medical staff.

2019 Government recommendations identified key areas that would work to reduce the gender pay gap and women's progression in the workplace and these are:

- create an inclusive culture
- support women's career development
- progression for part-time workers
- improve recruitment and promotion processes
- measure and evaluate policies to support diversity and inclusion

Further work is therefore required this year to understand experiences of female staff at Wirral University Teaching Hospital to support a reverse in results next year. 2024 staff survey results for female staff will therefore be reviewed and analysed to understand potential areas of priority.

A review of pay gaps within Divisions will also be considered, to identify any areas of additional concern / priority.

Ethnicity, disability and sexual orientation pay gaps are also monitored and include gender pay gaps.

Key findings by protected characteristic are:

1) A 23.8% ethnicity pay gap in favour of Black, Asian and Minority Ethnic (BAME) staff, with a higher average earning for both male and female BAME staff when compared with white colleagues.
2) A 12.0% disability pay gap in favour of non-disabled staff, with a higher average earning for both male and female non-disabled staff when compared with disabled colleagues.
3) A 5.09% sexual orientation pay gap in favour of heterosexual or straight staff, with a significantly higher average earning for male heterosexual or straight staff, when compared with male LGB colleagues and a higher average earning for female LGB staff when compared with heterosexual / straight colleagues.

Detailed findings of all elements are contained within the report attached at appendix A.

It is recommended that the Board:

- Approve the report, which will be shared on the Trust's public facing webpage, with data submitted to a national portal.

Key Risks
None

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	No

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	No
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	No
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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
18 Dec 25	Workforce Steering Board	As above	As above
15 Jan 26	EDI Steering Group	As above	As above
22 Jan 26	People Committee	As above	As above

1	Summary and Conclusion
1.1	There are a mixture of results this year with increases in mean and median gender pay gaps; however a reduction can be seen in the mean bonus pay gaps. Reductions in bonus pay gaps have however been largely affected by national changes in awards given to medical staff and therefore not necessarily as a result of Trust cultural improvements. The Trust has a People Strategy and ED&I Strategic Commitment "***To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated".*** Trust strategies are under review and findings from this report will be taken into consideration as part of setting the EDI strategic direction moving forwards***.*** Key deliverables are currently under discussion to ensure delivery of the ED&I strategic commitment which seeks to ensure ED&I is embedded as a golden thread across our people processes. Key actions identified to support improvements for 2026/7 are: 1) Continued implementation of the Trust's People Strategy, Engagement Framework and ED&I strategic commitment deliverables. 2) Review of demographic monitoring data with staff networks and relevant staff groups i.e. WUTH Sunflowers and Rainbow Alliance staff network members, to understand additional areas of support and development opportunities. 3) Review of staff survey data for female workers, to understand any areas of priority 4) Explore pay gap data by Division.

2	Next Steps
2.1	• Upload data to the national portal by 30/3/25. • Upload the narrative report (appendix A) to the Trust public section of the website

	by 30/03/25.

3	Implications
3.1	**Patients** • Outline the impact on patient safety, patient experience and any mitigations required • Outline the impact on EDI and how this activity/proposal maximises opportunities for inclusion
3.2	**People** • Outline the impact on people. Consider resource requirements, capacity, impacts on wellbeing and employee experience, and any mitigations required • Outline the impact on EDI and how this activity/proposal maximises opportunities for inclusion • Consider impact on stakeholders – both internal and external
3.3	**Finance** • Outline the financial impact, including on the CIP programme, any impacts on future budgets (i.e. invest to save)
3.4	**Compliance** • Outline how this supports statutory and/or regulatory compliance

Wirral University Teaching Hospital NHS Foundation Trust

Gender Pay Gap Report 2025

Sharon Landrum, Head of People Experience

December 2025

Contents

1.0 Executive Summary

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March each year for the public sector. Information contained within this report is therefore based on 31st March 2025 data in line with national reporting requirements.

In summary, key findings are:

8) Increased mean gender pay gap from 20.1% to 20.9% this year, continuing to be in favour of males
9) Increased median gender pay gap from 2.8% to 4.4% this year.
10) Significant reduction in mean bonus pay gap from 30.1% to 10.2% this year.
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12) 4.6% reduction in proportionately of bonus, with 0.4% of females receiving bonus pay this year, compared with 4.3% of males (1.8% females in 2024 and 10.3% of males).
13) Reduced number of male staff from 22.4% to 21.8% this year. Number of male staff still remains significantly lower than females overall.
14) Reduction in the females in the upper pay quartile this year (from 69.5% in 2024 to 69% this year).

A number of steps have been taken across the organisation over the last few years to support workforce wellbeing and worker experiences and support development and personal growth for staff.

Gender pay gaps at Wirral University Teaching Hospital have shown a reducing trend since reporting commenced, however this is the second time since commencement that the mean gap has increased.

Mean averages can fluctuate year on year due to the recruitment and loss of experienced high earning staff, which appears to be the case this year. Data shows a reduction in the number of females within the upper pay quartile, which would impact the overall mean average.

Bonus gender pay gaps have however significantly improved, largely due to changes in awarding of clinical excellence awards (CEA) and discretionary points for medical staff.

2019 Government recommendations identified key areas that would work to reduce the gender pay gap and women's progression in the workplace and these are:

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- improve recruitment and promotion processes
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Further work is therefore required this year to understand experiences of female staff at Wirral University Teaching Hospital to support a reverse in results next year. 2024 staff survey results for female staff will therefore be reviewed and analysed to understand potential areas of priority. A review of pay gaps within Divisions will also be considered, to identify any additional priority areas.

2.0 Background and Introduction – reporting requirements

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March for the public sector).

The gender pay gap shows the difference between the **average** (mean or median) earnings of men and women and is expressed as a percentage of men's earnings.

This report is therefore based on the snapshot date of 31st March 2025 and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 applicable to the public sector:

1. mean (average) gender pay gap using hourly pay
2. median gender pay gap using hourly pay
3. percentage of men and women in each hourly pay quarter
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

Wirral University Teaching Hospital WUTH) is committed to ensuring that the principles of the Public Sector Equality Duty (PSED) are upheld and that we eliminate discrimination and ensuring working towards advancing opportunities and fostering good relations. This report is therefore vital not only to ensure compliance with national requirements, but to support the Trust in identifying where any gaps my lie and what actions are required to create improvements.

The Trust views analysis of any gaps in gender pay as a valuable tool in identifying levels of equality in the workplace, female / male participation and how effectively talent is being maximised.

The gender pay gap differs from equal pay (which deals with the pay difference between men and women who carry out the same or similar jobs, or work of equal value). Wirral University Teaching Hospital pays staff of different genders equally if they perform the same job or work of similar value.

2.1 Staff included in the gender pay gap data

Data is based on full-pay relevant employees at the snapshot date of 31st March 2025.

2.2 What counts as pay?

The gender pay gap **includes** basic pay, paid leave, allowances, pay for any piecework and bonus pay and **excludes** overtime pay, expenses, pay in lieu of notice, the value of salary sacrifice, redundancy or termination payments, arrears of pay, shift premiums and benefits in kind.

2.3 Median and Mean

The mean hourly rate is the average hourly wage across the entire organisation so the mean gender pay gap is a measure of the difference between women's mean hourly wage and men's mean hourly wage.

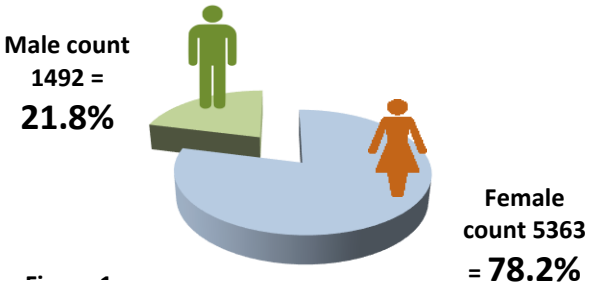
The median hourly rate is calculated by ranking all employees from the highest paid to the lowest paid, and taking the hourly wage of the person in the middle; the median gender pay

gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man).

3.0 Wirral University Teaching Hospital Demographics

The overall gender split within WUTH is shown in figure 1, with data as at 31 March 2025.

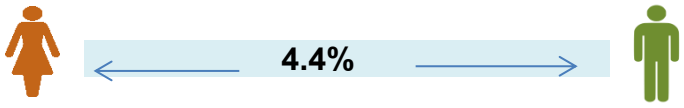
The number of female employees significantly outweighs the number of male employees however the % of males has reduced this year from 22.4% in 2024 to 21.8% in 2025.



4.0 Wirral University Teaching Hospital's Gender Pay Gap

Gender pay gap calculations are based on the reporting requirements listed above and include bonus pay.

4.1 Median gender pay gap (%)



4.2 Mean gender pay gap (%)

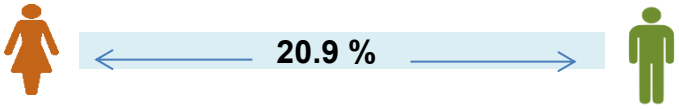
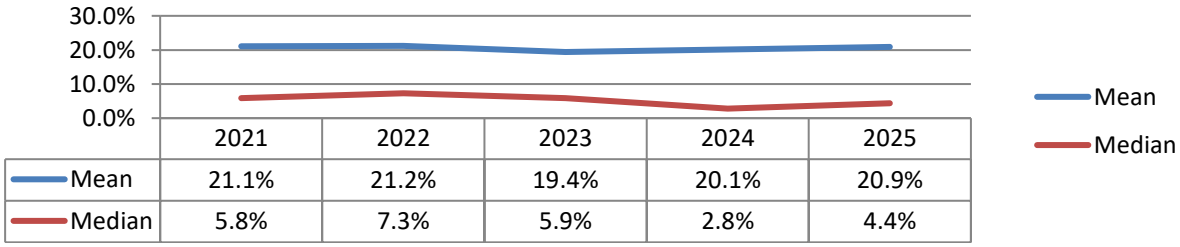


Fig. 2 Gender Pay Gap Annual Comparison



	2021	2022	2023	2024	2025
Mean	21.1%	21.2%	19.4%	20.1%	20.9%
Median	5.8%	7.3%	5.9%	2.8%	4.4%

Summary of Findings

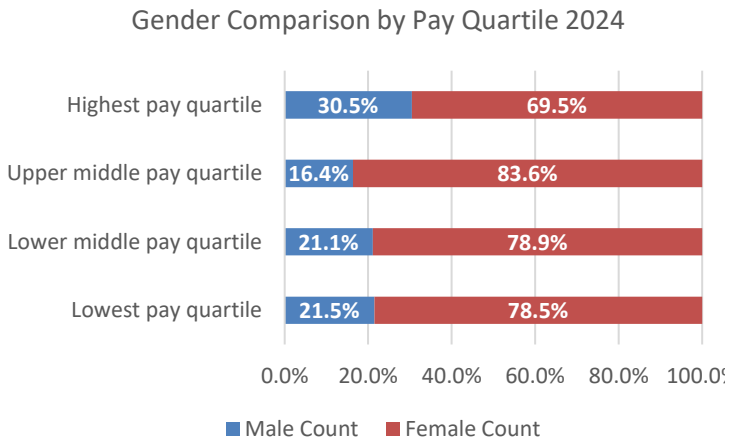
Increases can unfortunately be seen in both the median and mean gender pay gaps this year. Whilst the mean gap remains lower than 2021; this is the second year that an increase can be seen.

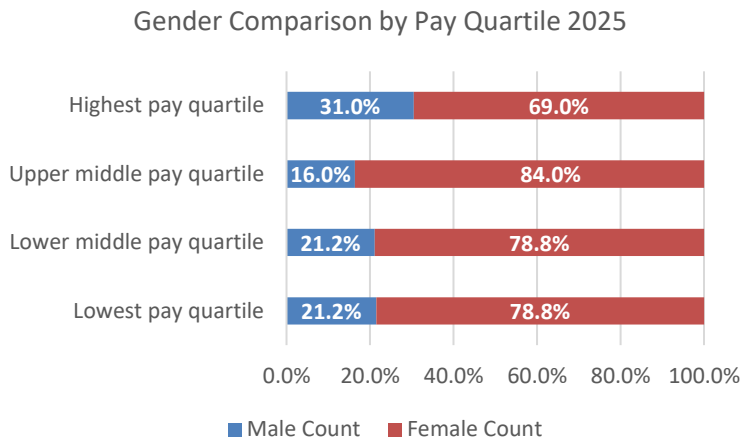
5.0 Salary

WUTH salary quartiles

Females are in the majority in all pay quartiles however there is a lower proportion of females in the highest pay quartile.

The Upper middle and lowest quartiles have seen an increase in female %'s however there has been a reduction in the highest and lower middle pay quartiles.

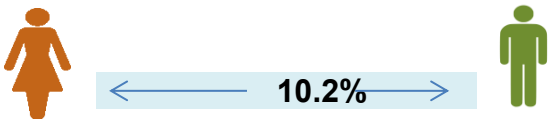




6.0 Bonus pay gender gap

Bonus pay includes clinical excellence awards and discretionary points. Significant improvement can be seen in the mean bonus pay gap this year, reducing from 30.1% to 10.2%. The median bonus gap continues to remain at 0%.

6.1 Mean bonus gap (%)



6.2 Median bonus gap (%)

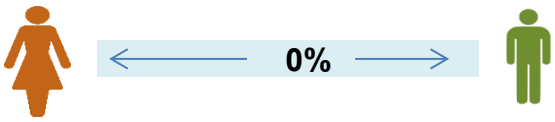
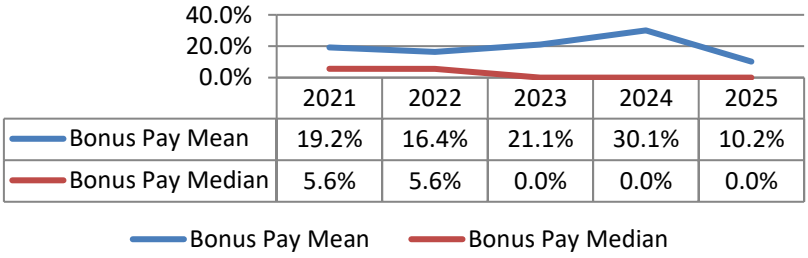


Fig. 3 Bonus Pay Gender Pay Gap Annual Comparison



	2021	2022	2023	2024	2025
Bonus Pay Mean	19.2%	16.4%	21.1%	30.1%	10.2%
Bonus Pay Median	5.6%	5.6%	0.0%	0.0%	0.0%

Clinical excellence award (CEA) payments previously increased up an agreed framework as service continued. The Trust had a number of male employees with long service that received a higher scale of award and as such, resulted in a wider gender pay gap.

Mean figures varied significantly from year to year due to recruitment and loss of long serving staff.

Due to the impact of COVID-19 on the service, in line with national guidance and agreed at JLNC, CEAs began to be evenly distributed to all eligible colleagues and not linked to an application process. 2024 was the last year of distribution in this manner.

7.0 Bonus pay proportions

There is a 4.6% reduction in proportionately of bonus pay this year, with 0.4% of females receiving bonus pay this year, compared with 4.3% of males. In 2024, 1.8% of females received bonus pay compared with 10.3% of male colleagues

8.0 Additional Data – Data by Pay Bands

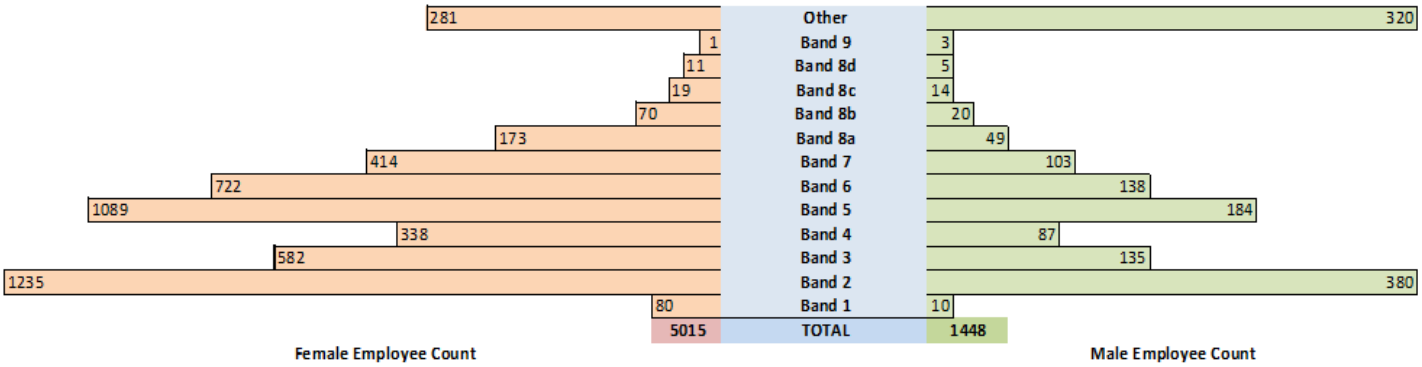
In addition to the legislative requirements and in order to further analyse data and seek improvements, WUTH have decided to further breakdown data collected per pay bands as follows:

Gender count and mean averages per pay grade

	Female		Male		
Grade	**Employee Count**	**Average Hourly Rate**	**Employee Count**	**Average Hourly Rate**	**Difference in hourly rate**
Band 1	80	£ 17.12	10	£ 15.51	**£1.61**
Band 2	1235	£ 13.60	380	£ 13.58	**£0.03**
Band 3	582	£ 13.89	135	£ 14.11	**-£0.21**
Band 4	338	£ 14.55	87	£ 15.02	**-£0.47**
Band 5	1089	£ 18.97	184	£ 18.71	**£0.26**
Band 6	722	£ 22.51	138	£ 21.66	**£0.85**
Band 7	414	£ 25.70	103	£ 25.83	**-£0.13**
Band 8 - Range A	173	£ 28.91	49	£ 29.70	**-£0.79**
Band 8 - Range B	70	£ 33.85	20	£ 32.08	**£1.76**
Band 8 - Range C	19	£ 40.08	14	£ 37.58	**£2.50**
Band 8 - Range D	11	£ 43.84	5	£ 45.94	**-£2.10**
Band 9	1	£ 50.45	3	£ 57.72	**-£7.26**
Other	281	£ 44.62	320	£ 49.42	**-£4.80**
Grand Total	**5015**	**£ 19.93**	**1448**	**£ 25.18**	**-£5.25**

The chart shows bands are broadly similar, with the exception of Bands 1, 8B and 8C which have a wider gender pay gap in favour of females which was the reverse in 2024 and bands 8D and above and also other (which includes medical and dental staff) which all have a wider gender pay gap in favour of males.

Fig 4. Gender count per banding



9. Demographic Monitoring of Gender Pay Gaps

Wirral University Teaching Hospital is keen to understand the experiences of staff in all aspects and as such, has commenced monitoring of gender pay gap information in the following areas:

1) Ethnicity
2) Disability
3) Sexual orientation

Table 1 – *Mean Gender Pay Gap Information comparing Black, Asian and Minority Ethnic (BAME) staff and white colleagues.*

	2024				2025			
Ethnicity	**Male & Female**	**Female**	**Male**	**Pay Gap**	**Male & Female staff**	**Female**	**Male**	**Pay Gap**
Total White staff average hourly pay	£21.31	£18.99	£26.78	**29.1%**	£20.32	£21.93	£27.71	**20.86%**
Total BAME staff average hourly pay	£24.48	£23.49	£26.68	**8.0%**	£25.15	£24.44	£27.88	**12.34%**
Mean pay gap	**-14.9%**	**-23.7%**	**0.4%**		**-23.8%**	**-11.45%**	**-0.61%**	

Ethnicity Bonus Pay Gap reporting

An additional report has been produced this year for the first time, providing data on the Trust's ethnicity bonus pay gap.

Key Findings

Data shows the following key findings:

- There is a 23.8% pay gap between Black Asian and Minority Ethnic (BAME) staff and white colleagues, in favour of BAME staff. This has increased further this year from 14.9% in 2024.
- There is a median pay gap of 15.8% between Black Asian and Minority Ethnic (BAME) staff and white colleagues, in favour of BAME staff.
- The ethnicity pay gap has increased from 14.9% to 23.8% this year, in favour of BAME staff.
- The ethnicity pay gap between female BAME and female white colleagues has reduced this year, from 23.7% to 11.45%, remaining in favour of BAME females.
- The pay gap between male BAME staff and white male colleagues remains broadly similar this year, with a 0.61% gap in favour of BAME male staff.
- The gender pay gap for white staff has reduced slightly from 29.1% to 20.86% this year, continuing to be in favour of males.
- The gender pay gap for BAME staff has increased this year, from 8.0% to 12.34% also in favour of males.
- There is a mean ethnicity bonus pay gap of 21.11% in favour of BAME staff and a median ethnicity pay gap of 0.0% due to the even split of bonus pay across all staff.

Table 2 *– Gender Pay Gap Information comparing Disabled and non-disabled staff*

	2024				2025			
Disability Pay Gap	**All staff**	**Female**	**Male**	**Pay Gap**	**All staff**	**Female**	**Male**	**Pay Gap**
Total disabled staff average hourly pay	£17.73	£17.51	£18.22	**3.9%**	£18.60	£18.62	£18.60	**-0.11%**
Total non-disabled staff average hourly pay	£19.74	£18.72	£23.31	**19.7%**	£21.13	£19.96	£25.16	**20.67%**
Pay gap	**10.2%**	**6.5%**	**21.8%**		**12.00%**	**6.71%**	**26.07%**	

Key Findings

Data shows the following key findings:

- There is a 12% pay gap between disabled and non-disabled colleagues, which has increased from 10.2% last year, in favour of non-disabled staff.
- There is a pay gap in favour of non-disabled males, whereby non-disabled males earn more than disabled males. The gap has increased this year from 21.8% to 26.07%.
- The pay gap between disabled and non-disabled females has remained broadly similar at 6.71% this year compared to 6.5% in 2024.
- There is no disabled gender pay gap, as disabled male and females earn similar.
- The pay gap for non-disabled staff has increased this year from 19.7% to 20.67%, in favour of males.

Table 3 *– Gender Pay Gap Information comparing Lesbian, gay, bisexual and non-binary staff (LGB+) staff with heterosexual or straight colleagues.*

	2024				2025			
Sexual Orientation Pay Gap	**All staff**	**Female**	**Male**	**Pay Gap**	**All staff**	**Female**	**Male**	**Pay Gap**
Total Heterosexual or straight staff average hourly pay	£19.66	£18.66	£23.25	**19.7%**	£21.04	£19.88	£25.21	**21.14%**
Total LGB+ staff average hourly pay	£18.47	£19.09	£16.59	**-15.1%**	£19.97	£20.46	£18.63	**-9.82%**
Pay gap	**6.1%**	**-2.3%**	**28.6%**		**5.09%**	**-2.92%**	**26.1%**	

Key Findings

Data shows the following key findings:

- There is a 5.09% pay gap between LGB+ and heterosexual / straight staff. This gap has continued to reduce, from 6.1% in 2024 to 5.09% this year.
- The gap between LGB+ and heterosexual / straight males has also reduced this year, from 28.6% in 2024 to 26.1% this year.
- Female LGB+ staff continue to earn more than male LGB+ staff, however the gap has reduced from 15.1% in 2024 to 9.82% this year.
- The gender pay gap of heterosexual / straight staff has increased this year from 19.7% in 2024 o 21.14% this year, in favour of males.
- The gender pay gap between LGB+ staff has reduced this year from 15.1% to 9.82% and continues to be in favour of females.

10. Actions Undertaken to Reduce Pay Gaps

The Trust has implemented a number of actions over the last few years to support reduction in pay gaps and these include:

- **Removal of personal identifiable information** from clinical excellence awards (CEA) and discretionary points applications to support removal of any conscious / unconscious bias from the process.
- **Additional engagement and support with female Consultant colleagues** regarding application for CEA and support offered as necessary.
- **Promotion of male and female role models** – the Trust continues to promote and celebrate the achievements of our staff including as part of International Mens and Womens Day and continues to share stories and experiences of female colleagues in Trust communications.
- **Leadership qualities framework** launched with a suite of "leadership for all" programmes offered for staff at all levels.
- Springboard and Navigator (**personal and professional development programmes for women and men**) have been completed.
- The Trust developed a new **People Strategy** (2022 – 2026), with engagement from a variety of staff across the Trust.
- A new **equality, diversity and inclusion (EDI) strategic commitment** was developed (2022 – 2026), to underpin the People Strategy and ensure an EDI lens is placed on key deliverables.
- A focus was also placed this year on **ensuring the Trust is positively anti-racist** and in further **understanding the experiences of Black, Asian and Minority Ethnic staff**, with high impact actions identified to support improvements.
- A review has been undertaken of **flexible working** within the Trust, with stakeholder groups held, flexible working Ambassadors identified and a series of key actions undertaken to ensure improvements moving forwards.
- A new **engagement framework** launched in 2024, with new reward and recognition schemes launched and opportunities to ensure staff have a voice that counts.
- A **menopause staff network** established with a range of activities and guidance developed, including new webpages offering advice and support to staff. A dedicated staff menopause clinic has been established and specialists offering information and support sessions for staff.
- Establishment of an **armed forces network** to support forces families.
- A **Strategic Trustwide Retention Group** was launched, with a variety of actions completed to support retention of our staff, including career clinics; listening events; exit survey process review and a new Band 5 Registered Nurse transfer process. Whilst this has now concluded, previous work has supported improvements in experiences for staff.
- **Review of Trust policies** has been undertaken to ensure best practice is adhered to with regards to **family friendly** policies and a more **flexible approach**
- **New appraisal and check-in processes** to include **wellbeing conversations** with enhanced compliance monitoring.
- Trust sign up to the **sexual safety charter**, with a series of actions undertaken to promote key messages of support to staff, development and launch of a new policy and introduction of mandatory training for staff.

11.0 Summary

In summary, key findings are:

1) Increased mean gender pay gap from 20.1% to 20.9% this year, continuing to be in favour of males
2) Increased median gender pay gap from 2.8% to 4.4% this year.
3) Significant reduction in mean bonus pay gap from 30.1% to 10.2% this year.
4) Continued 0% median bonus pay gap.
5) 4.6% reduction in proportionately of bonus, with 0.4% of females receiving bonus pay this year, compared with 4.3% of males (1.8% females in 2024 and 10.3% of males).
6) Reduced number of male staff from 22.4% to 21.8% this year. Number of male staff still remains significantly lower than females overall.
7) Reduction in the females in the upper pay quartile this year (from 69.5% in 2024 to 69% this year).

Key findings by protected characteristic are:

4) An 23.8% ethnicity pay gap in favour of Black, Asian and Minority Ethnic (BAME) staff, with a higher average earning for both male and female BAME staff when compared with white colleagues.
5) A 12.0% disability pay gap in favour of non-disabled staff, with a higher average earning for both male and female non-disabled staff when compared with disabled colleagues.
6) A 5.09% sexual orientation pay gap in favour of heterosexual or straight staff, with a significantly higher average earning for male heterosexual or straight staff, when compared with male LGB colleagues and a higher average earning for female LGB staff when compared with heterosexual / straight colleagues.

12.0 Next steps

Key actions for 2026/7 will therefore be:

5) Continued implementation of the Trust's People Strategy, Engagement Framework and ED&I strategic commitment deliverables.
6) Review of demographic monitoring data with staff networks and relevant staff groups i.e. WUTH Sunflowers and Rainbow Alliance staff network members, to understand additional areas of support and development opportunities.
7) Review of staff survey data for female workers, to understand any areas of priority
8) Explore pay gap data by Division.
9) Trust strategies are under review and findings from this report will be taken into consideration as part of setting the EDI strategic direction moving forwards.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 26**
28 January 2026

Title	Freedom to Speak Up 6 Month Report
Area Lead	Deb Smith – Chief People Officer / Executive Lead for FTSU
Author	Tracey Nolan FTSU Guardian/People Experience Lead
Report for	Information

Executive Summary and Report Recommendations

National Guardians Office (NGO) guidance ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should be on a bi-annual basis. The purpose of this report is to therefore provide a biannual update on Freedom to Speak Up (FTSU) activity in line with the NGO guidance.

The report includes data for Q1 and Q2 25/26 reporting periods.

A summary of FTSU activity detailed in the report is**:**

- The number of people speaking up to FTSU Guardians in Q1 and Q2 2025/26 decreased compared to the same period last year, with 24 people speaking up compared to 50 in the previous year. Q1 2024/25 did however see inflated numbers due to a large group of staff reporting from a specific area.
- Concerns raised by theme show a decrease in bullying and harassment concerns, although attitudes and behaviours along with bullying and harassment account for 84% of all concerns raised.
- No patient safety concerns were raised via FTSU Guardians within Q1 and Q2 2025/26.
- Surgery staff raised the most concerns, accounting for 59% of the total concerns raised.
- Admin and clerical staff accounted for 32% of all concerns raised.
- 8% of staff raising concerns were Black, Asian, and Ethnic Minority, with one concern citing racism.
- 8% of staff were neurodiverse, with concerns citing a lack of understanding and appreciation of neurodiversity in the workplace.
- Current levels of non-compliance with speak-up eLearning are of particular concern within the Estates, Facilities, and Capital Planning Division at 46.4% compliance with level 1.

It is recommended that the Board:

- Note the report

Key Risks
This report relates to key Board Assurance Framework (BAF) Risks: BAF 5: Failure to have the right culture, staff experience, and organisational conditions to delivery our priorities for our patients and service users. NOTE: Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary.

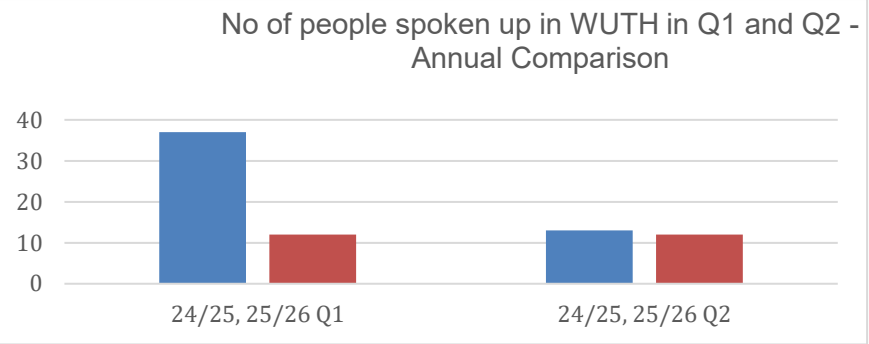
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
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**
January 2026	People Committee	As above	As above

1	Update from the National Guardians Office
	NHS England and the Department of Health and Social Care have confirmed that the role of Freedom to Speak Up Guardian will remain part of NHS Standard Contract for 2026/27, providing crucial certainty about the future of the guardian role. This announcement addresses concerns raised following news of the National Guardian's Office closure in 2026. The commitment demonstrates ongoing support for guardians' vital work in ensuring workers' voices are heard. NHS England will take over responsibility for national support and guidance of guardians from 2026/27 onwards, as functions transfer from the National Guardian's Office. Until then, the National Guardian's Office remains the primary point of contact and support for all guardians. The confirmation reinforces the essential role guardians play in developing safer, fairer, and more transparent healthcare systems throughout England.
2	**FTSU Activity**
	2.1 Number of People Speaking Up Data is submitted to the National Guardians Office (NGO) on a quarterly basis and whilst this report usually provides a comparison of data between regional and national Trusts of a similar size, unfortunately comparative data for Q1 and Q2 is currently unavailable

from the NGO. This has been escalated as a concern to the NGO and will be reported on as soon as data becomes available.

The number of people speaking up to FTSU Guardians in the first quarter has decreased in comparison to the same period last year; with 24 people speaking up in Q1 and Q2 2025/26 compared to 50 staff speaking up in Q1 and Q2 2024/25. The chart below does however show a spike in people speaking up in Q1 2024/25 which was related to a large group of staff within a specific area.



Whilst this report is focused on Q1 and Q2 2025/26, increased visibility around the hospital and promoting the service within induction as well as all managers training events has seen speak up numbers rise in Q3 with 28 concerns raised.
Full details of Q3 data will however be included within the next FTSU Biannual report.

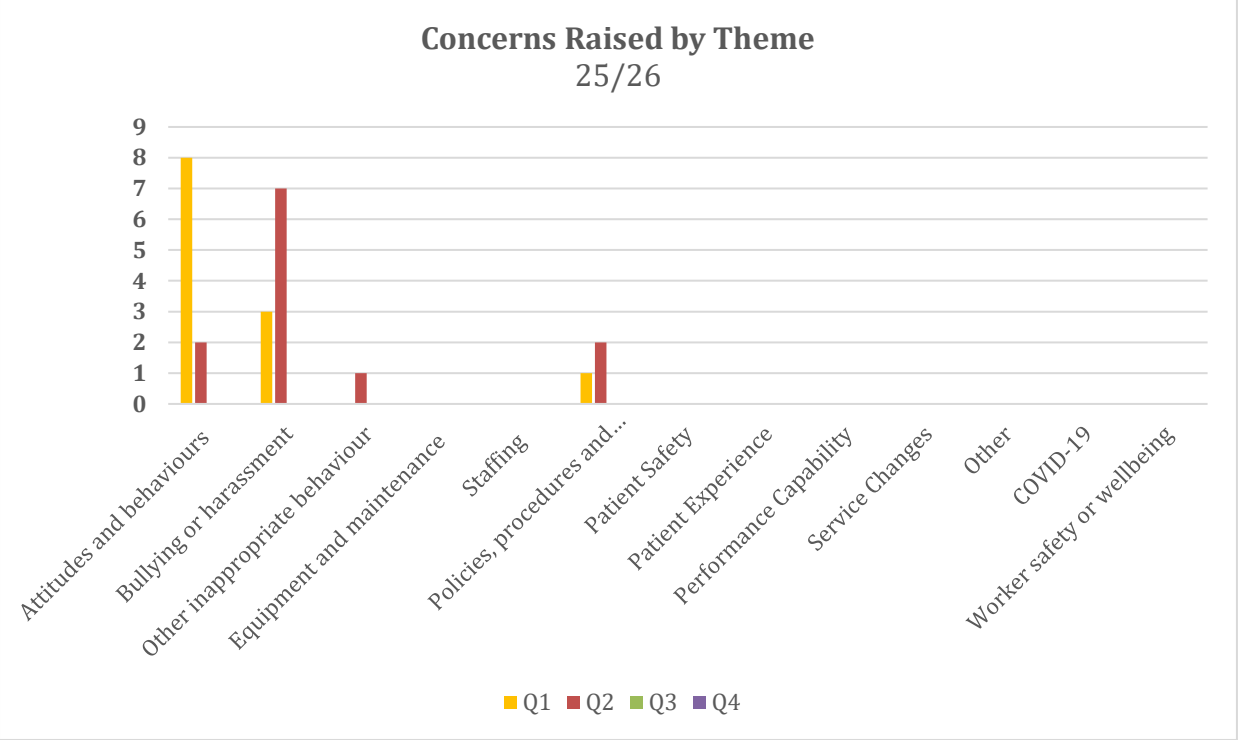
Improvements continue to be seen in staff saying they feel able to raise concerns with their line manager themselves, which is positive and suggests that staff feel they are working within a psychologically safe environment.

2.2 Concerns Raised by Theme

The table below sets out the concerns raised during Q1 and Q2 25/26 by theme. This 6 month period has seen a decrease in bullying and harrasment concerns which is bositive, however attitudes and behaviours along with bullying and harrasment account for 84% of all concerns raised within Q1 and Q2.

During Q1 and Q2 25/26 there was a total of 24 FTSU cases (individuals) who raised concerns. When staff members speak up there is often several elements associated with their specific case. Each element is then grouped under one of thirteen national guidance reporting themes. Moving forward The National Guardians office has grouped some categories together for reporting purposes which will enable guardians to place concerns more accurately – this should allow for clearer reporting.

It is important to note that as per the NGO guidance, “bullying or harassment” is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case.



A coded triangulation exercise was conducted last year showed that tensions often exist between staff, rather than direct or indirect bullying and harassment. Poor communication and incivility was the primary driver causing upset to either or both parties.

Staff continue however to raise concerns around incivility and rudeness and were saddened on occasion at the manner in which they had been spoken to. A common theme amongst staff raising concerns with the FTSU Guardians is that whilst “the outcome would have been the same”; the way that managers’ had spoken to staff had caused the concern, with significant upset caused with some staff reporting rude, aggressive management styles when instructions or requests were being given.

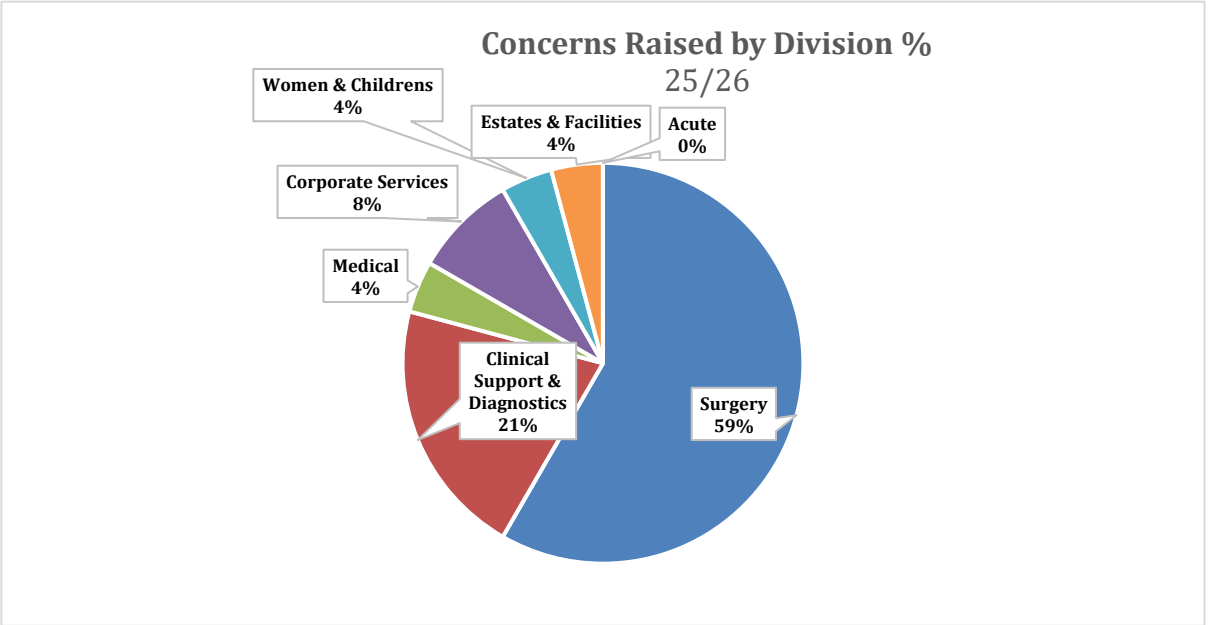
This feedback is included within development programmes for all staff and particularly too for staff undertaking any of the Leadership for all sessions.

2.3 FTSU Patient Safety Data

No patient safety concerns were raised via FTSU Guardians within Q1 and Q2 25/26.

2.4 Concerns Raised by Division

The chart below shows the concerns raised by division. Surgery have raised the most concerns



Divisional Reporting

Surgery staff have raised the most concerns this year – accounting for 59% of the total concerns raised. Significant work has focused on surgery which may have account for staff feeling able to speak up as they have done over the last 12 months.

Managers have encouraged staff to speak up as concerns were raised that staff felt unable to speak up through a survey monkey that was undertaken across the division. Listening events have taken place with surgery staff across both sites, which has encouraged staff to speak up and raise themes however staff did not want to be identified when raising concerns.

A team around the team approach was undertaken with various key stakeholders providing offers of support and help for Perioperative Medicine, within Surgery. This included support to increase the number of FTSU Champions; face to face speak up awareness sessions for staff and separate sessions for managers to support them in responding to concerns. Actions selected by the Division will move forward into this year.

WUTH continues to try and increase the number of FTSU champions across divisions and this will continue moving forwards. Medicine and Surgery have the highest number of champions to date.

Estates and facilities continue to have the lowest number of champions and links have therefore been made with management teams and staff within these areas to identify more, however work remains ongoing.

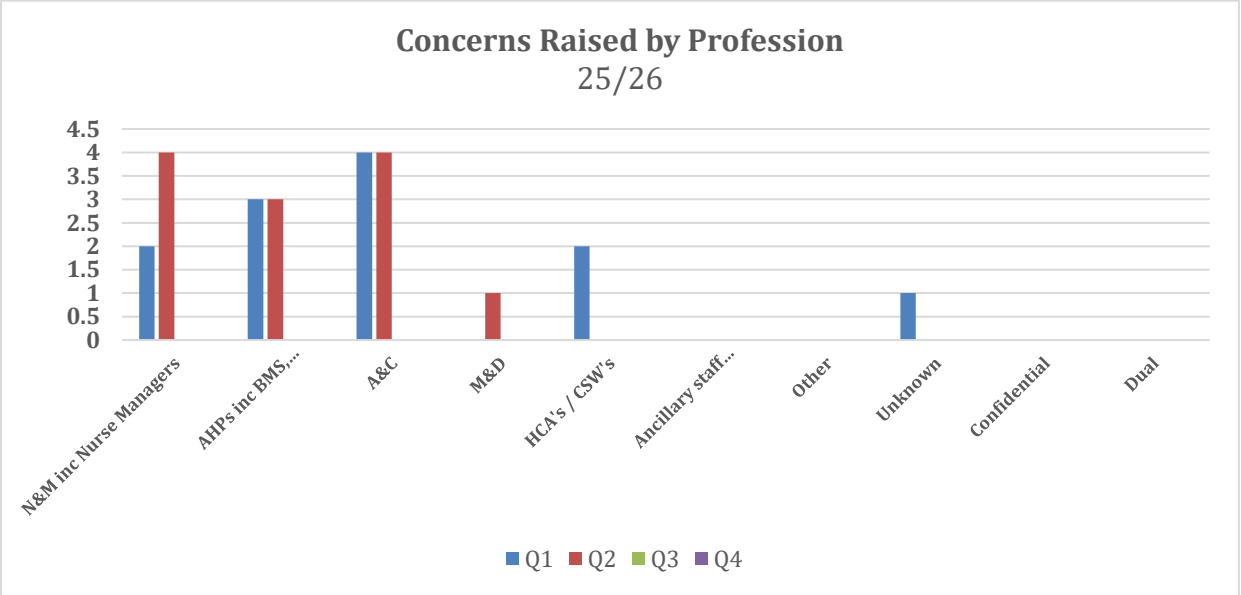
The FTSU Guardian held drop-in sessions across Estates and Facilities focussed on understanding any concerns relating to staff safety and further drop-in sessions are scheduled to promote speaking up and understand staff experiences. Plans are underway to pilot face to face training support sessions to increase uptake of speaking up, sexual misconduct and respect at work training compliance. All sessions to be facilitator led and to include the FTSU Guardian.

Work has been undertaken in conjunction with HR Business Partners to support enhanced FTSU reporting to Divisional management teams. **Quarterly reports** will now be sent to each division updating them on:

- Number of FTSU cases in their area
- Themes within the division
- Training compliance for FTSU level 1 and 2
- Number of Champions in the division

2.5 Concerns Raised by Professional Group

The following table highlights the concerns raised by professional group.



The highest group of staff raising concerns across the 12-month period are from Admin and clerical staff accounting for 32% of all concerns raised.

2.6 Anonymous Concerns

1 anonymous concern was received throughout the year, this was about bullying. Anonymous reporting along with confidential reporting continues to remain low which is pleasing to see. Staff are encouraged in the first instance to discuss their concerns with their line manager where possible.

2.7 Demographics

24 staff raised concerns.

8% of staff were Black, Asian and Ethnic Minority staff. 1 of these concerns cited racism in the department.

8% of staff were neurodiverse, with all of those concerns citing lack of understanding and appreciation of neurodiversity in the workplace.

An increase can also be seen in the level of seniority of staff reporting to FTSU Guardians. The speak up process and access to support remains the same regardless of the staff seniority.

2.8 Disadvantageous or Demeaning Treatment as Result of Speaking Up

No cases were reported across the 12-month period (from Q2 2024/25 to Q2 2025/26).

2.9 Time Taken to Close Cases

The average time taken to close cases across the year was 5 days – most cases are quickly resolved resulting in staff feeling happy with an outcome and managers being receptive to the concern being raised. This figure has decreased from 2 weeks from the previous year. The National Guardians office along with Guardians feel that time taken to close cases is rarely relevant and it is likely that this recording may cease.

2.10 Lessons Learned

The staff survey last year has demonstrated that staff feel able to speak up however they have little faith in the process and are not confident that anything will be done once they have spoken up.

It is vital that managers play a significant role in the speaking up process to demonstrate and build staff confidence in knowing that when they do speak up that they will be listened to, and action will be taken. Moving forward a timely response is expected from managers once a concern has been raised, with revised monitoring and escalation processes in place with Trust senior leaders; to review cases and highlight areas of concern.

Themes throughout the year have demonstrated that the way we talk to each other is important and the way that we ask people for help or to change can impact people significantly, both positively and negatively. Kindness can make a huge difference to people and can have a significant impact on individuals and divisions. Kindness can create a more positive and supportive environment.

2.11 Triangulation of Data

New methodology has been developed this year to support greater understanding of staff experiences. FTSU data has been included as part of a number of triangulation exercises including understanding numbers of staff experiencing incidents of a sexual nature and cases of bullying and harassment. This provides an opportunity to further understand staff experiences and identify and potential themes or trends and areas for additional focus.

A summary of speak up data and themes is now included within the biannual people experience report that is shared and reviewed as part of the workforce governance structure.

WUTH is also working with WCHC to understand areas of best practice, WUTH now has plans in place to mirror triangulation meetings.

2.12 Additional Highlights

- **Development of staff safety engagement sessions**
  The Guardian has worked closely with Andrew Holvey, Head of Security/Violence Prevention Reduction Lead to support improvements in **Staff Safety** this financial year. Engagement events were developed and promoted to support greater understanding of staff experiences with violence, aggression and challenging behaviours in the workplace. Sessions are however to be readvertised due to a lack of uptake.

- **Deep dive into FTSU bullying and aggression cases**

A deep dive was undertaken in conjunction with HR, to look at FTSU bullying and aggression cases. This was an interesting piece of work as it highlighted that most cases raised around bullying and harassment do not follow a formal process which is positive and less stressful for those involved.

- **Listening events with Black, Asian and Ethnic Minority (BAME) Staff**
  Further listening events have been undertaken which have been positively received and informative. This has allowed greater insight into the experience of BAME staff at WUTH and Wirral Community Health Care Trust and changes have already been made as a result of the events.

- **CSW support**
  The FTSU Guardian has spent time engaging with CSW staff across the Trust to understand experiences relating to the ongoing CSW organizational change process. Discussions focused on experiences relating to current bandings and understanding any staff concerns.

  During these walkabouts, staff raised other concerns as a result of spending time with the Guardian. This group of staff have notoriously been difficult to engage with and raise very few concerns via FTSU route. The time spent with them was therefore extremely valuable.

- **Review of 2025 staff survey data**
  Initial findings from the 2025 staff survey have now been received and reviewed by the FTSU Guardian in conjunction with the wider People experience team to understand Trustwide findings and those specifically related to the speak-up culture in WUTH.

  Results are currently under embargo until mid-March/April however steps are in place for the FTSU Guardian to support workshops scheduled with Divisional management teams and staff networks. A dedicated workshop will also be held with FTSU Champions to understand areas of progress and further attention. Findings will be included in the next FTSU update report.

- **FTSU Policy review**
  WUTH adopted the nationally recommended FTSU policy, however the policy is now due for review. Whilst an initial review has been undertaken with minimal changes identified, it is recognised that as WUTH and Wirral Community Healthcare Trust (WCHC) work towards integration, both WCHC and WUTH FTSU policies will require further review and harmonization.

- **Speak up eLearning training compliance**
  As 31 December 2025, 86.22% of staff have completed their level 1 Speak up training**.** Whilst compliance levels are above the overall Trust compliance level for role specific training; unfortunately levels continue to remain below the Trusts 90% target.

  The following table provides a breakdown of Divisional compliance with role specific speak up eLearning compliance:

Division	**Level 1 compliance**	**Level 2 compliance**
Corporate Services	93.95%	96.21%
ED	78.65%	92.59%

Estates, Facilities & Capital Planning	46.40%	91.30%
Diagnostics and Clinical Support	97.87%	85.39%
Medicine	92.12%	93.02%
Surgery	93.90%	97.04%
Women and Childrens	94.97%	94.20%

Following a review of compliance data, three areas are currently below Trust target. However, Estates, Facilities and Capital planning are significantly below, with 439 staff remaining non-compliant. This is therefore a particular area of concern. On wider review of data, compliance for this area also remains low across a number of role specific sessions and as such, further discussions have taken place with management teams, HR and OD colleagues to escalate concerns and explore options to support improvements,

Steps are currently being taken to create a face-to-face event where eLearning modules can be shown in a group setting, thus supporting a number of staff to complete a series of sessions. Suggested sessions include speak up level 1; respect at work level 1 and sexual misconduct in the workplace.

Compliance for the level 3 speak up eLearning programme “follow up” is 100%.

3 Conclusion

3.1 The number of people speaking up to FTSU Guardians has decreased when compared to the same time period last year, although numbers within Q1 2024/25 were inflated due to a large group of staff reporting from within a specific area.

Work continues to be undertaken to support a healthy speak-up culture and to support staff raising concerns.

Whilst work is being undertaken to support increases in speak up eLearning compliance, current levels of non-compliance are of concern within the Estates, Facilities and Capital Planning Division.

FTSU data is being triangulated with wider workforce metrics to seek further understanding of staff experiences and identify areas requiring further attention.

Additional walkabouts and promotion of FTSU have taken place, which have already resulted in increases in the number of staff speaking up in Q3.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 27**

28 January 2026

Title	Guardian of Safe Working Report
Area Lead	Dr Nikki Stevenson, Chief Medical Officer
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to give assurance to the board that doctors and dentists in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS).

This report covers the period 1st October to 31st December 2025 (Q3 2025) and outlines the following:

- Actual number of doctors in training.
- Exception reports submitted for the reporting period by specialty and grade.
- Breaches of safe working hours and fines incurred.

There are a small number of exception reports outstanding which will be closed with the support of the newly appointed Guardian of Safe Working. The Trust continues to support junior doctors to complete exception reports as it gives a greater understanding of workforce and training issues.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: 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	No

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	No
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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
January 2026	People Committee	As above	Ass above

1 Narrative

To monitor compliance with the working hours directive, Doctors/Dentists in Training (DIT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service.

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 293 (272.8 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 293 (272.8 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the guardian (if any): Access to 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by Department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident and emergency	0	5	4	1
Otolaryngology (ENT)	0	7	7	0
General Medicine	0	56	54	2
Obstetrics and gynaecology	0	1	1	0
General Surgery	0	13	11	2
Traumatic and Orthopaedic Surgery	0	1	1	0

Urology	0	1	0	1
Total	0	84	78	6

Exception reports by Grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	37	31	6
F2	0	5	5	0
CT1-2 / ST1-2	0	34	34	0
ST3-8	0	8	8	0
Total	0	84	78	6

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E 20 per cent Fellow 2025 Work Sched 6m plus	0	1	0	1
A and E SHO 2025 LTFT 0.6 MTW	0	1	1	0
A and E SpR 2025 26 LTFT 0.8 Flexi	0	3	3	0
ENT General Template for RT4	0	7	7	0
GPST 2025	0	2	2	0
GPST 2025 LTFT 0.8 TWTF	0	1	1	0
Medicine F1 2025	0	22	21	1
Medicine F1 2025 LIFT MT	0	1	0	1
Medicine IMY2 2025	0	2	2	0
Medicine IMY3 2025	0	1	1	0
Medicine SHO 2025	0	4	4	0
Medicine SHO 2025 9 to 5	0	2	2	0
Medicine SHO 2025 LTFT 0.5 MTW slot share	0	3	3	0
Medicine SHO 2025 LTFT 0.8 TWTF	0	13	13	0
Medicine SpR 2025 LTFT 0.8 MTWF aa	0	3	3	0
O and G T1 2025	0	1	1	0
Renal	0	2	2	0

Surgical F1 2022	0	2	2	0
Surgical F1 2022 LIFT MT	0	2	2	0
Surgical F1 2022 LIFT W F	0	3	3	0
Surgical F1 2026	0	5	3	2
Surgical SpR 2025	0	1	1	0
T and O SHO 2020 LTFT 0.8 MTWT	0	1	1	0
Urology Junior rota 2025	0	1	0	1
Total:	0	84	78	6

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	27	6	3	3	3	6
F2	0	0	2	0	0	0
SHO	6	6	9	2	0	0
SpR	7	1	0	4	0	0
Total	40	13	14	9	3	6

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
ENT General Template for RT4	0	6	6	0
GPST 2025 LTFT 0.8 TWTF	0	1	1	0
Medicine F1 2025	0	4	4	0
Medicine F1 2025 LIFT MT	0	1	0	1
Medicine IMY2 2025	0	2	2	0
Medicine SHO 2025	0	1	1	0
Medicine SpR 2025 LTFT 0.8 MTWF	0	3	3	0
Surgical F1 2026	0	2	1	1
Total	0	20	18	2

Exception Reports

	As is usual the majority of exceptions raised during this period are from the Medical Division and from more junior staff, particularly the F1s. Although there were remaining outstanding exception reports at the end of the period the exception reports for Hours have all been completed by the time of submitting this report. During this quarter, and in the run up to the new framework for exception reporting to be rolled out on 4th February 2026, we have been working with the trainees on ensuring that they are providing all of the information required for the Central Resourcing Team to be able to process and complete the exception reports at Stage 0 of the new framework where possible. There have also been exception reports due to running departments at minimum staffing and the impact this can have on being able to complete tasks, there is an ongoing review of minimum staffing levels which may go some way to resolve this issue going forwards. There were a number of exception reports from Education relating to loss of educational opportunities due to rota issues. These are being addressed where possible. Some were due to acuity and some to rota design or staffing. We have been communicating with staff to try to optimise rotas to facilitate a reduction in missed educational opportunities. **Work schedule reviews** There have been no formal work schedule reviews enacted during the quarter. **Vacancies** There continue to be a number of vacancies in rotas which are unfilled, and equivalent FTE vacancies as not all LTFT posts are post shared. **Fines** There have been a small number of fines raised for working hours breaches during the quarter. Some of these have been due to not having secured locum cover for shifts. These have been addressed with Medical Staffing to try to ensure they do not recur.

2	Implications
2.1	**Patients** • The role of the safe working hours is designed to reassure junior doctors and the Trust that rotas and working conditions are safe for doctors and patients.

2.2	**People** • The Guardian ensures that issues of compliance with safe working hours are addressed by the doctor and the Trust as appropriate. It provides assurance to the board of the employing organization that doctors' hours are safe. • The guardian works in collaboration with the Director of Medical Education and Local Negotiating Committee to ensure that the identified issues within exception reports, concerning both working hours and training hours, are properly addressed by the Trust.
2.3	**Finance** • The Guardian distributes monies received as a consequence of financial penalties to improve the training and working experience of all doctors. There have been no financial penalties this quarter.
2.4	**Compliance** • This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
28 January 2026

Item 28

Title	Learning from Deaths Report (Q3 2025-2026)
Area Lead	Dr Nikki Stevenson, Joint Chief Medical Officer & Deputy CEO
Author	Dr Ranjeev Mehra, Trust Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Quality Committee with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q2 2024-2025.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to June 2025 is 1.01 (within expected range)
- HSMR has increased in Q2 and is now in the “above expected” range. Review of this has highlighted the impact of coding backlogs for the months of April- Sept 2025
- 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

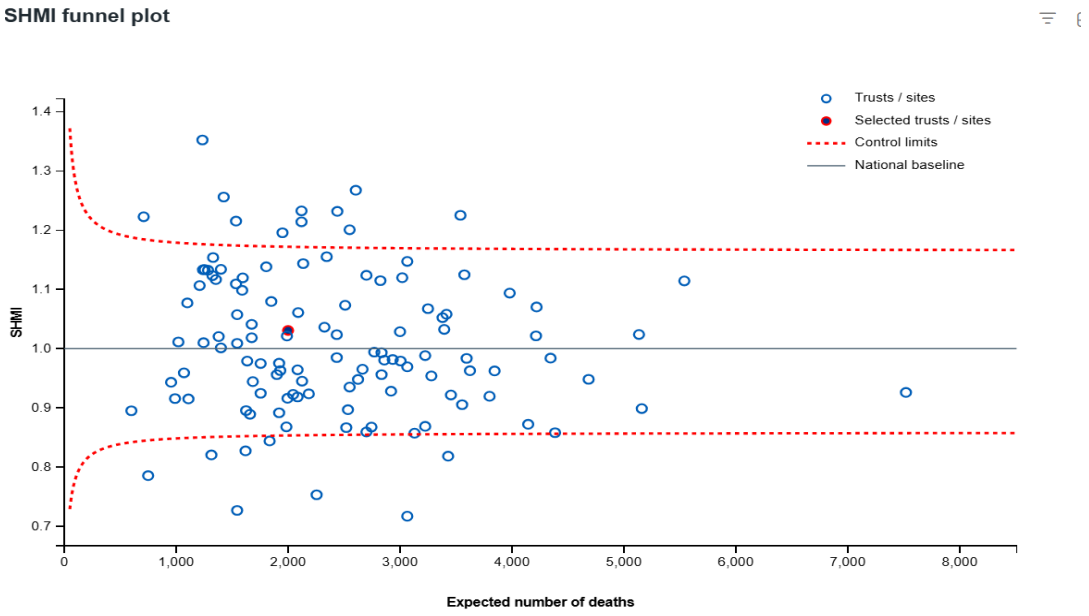
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working 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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
January 2026	Patient Safety Quality Board	As above	As above
January 2026	Quality Committee	As above	As above

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospitals NHS Foundation Trust over Quarter 2 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 412 deaths in Q2 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)

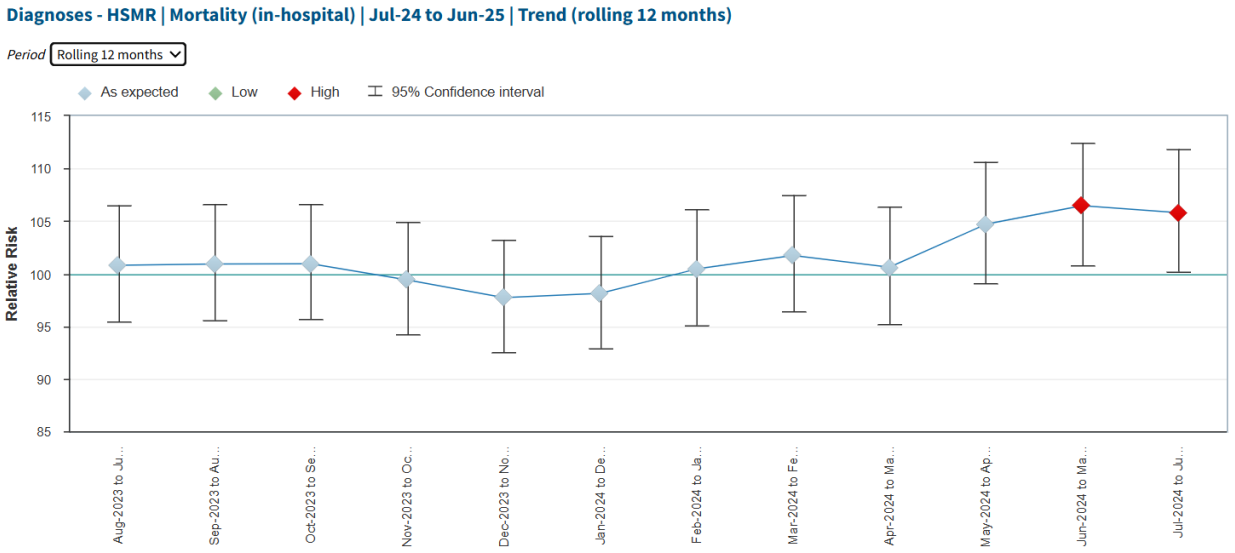
The overall SHIMI for WUTH on the latest available data (12 months to June 2025) is 1.01 which is within the “as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

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

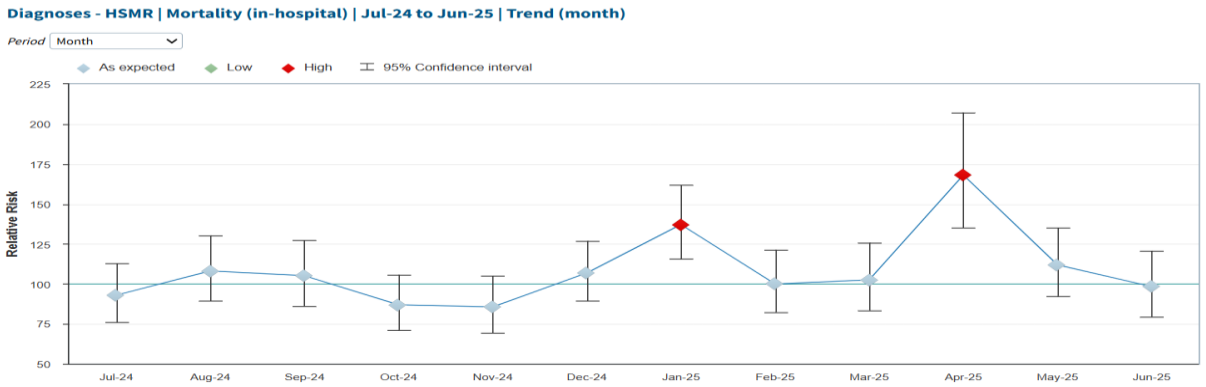


Hospital Standardised Mortality Ratio (HSMR)

The HSMR on the latest 12 months rolling trend is now in the “above expected” range)



There has been a steady rise in HSMR from Q1 onwards. Analysis of monthly trends has shown a spike in April (168.1) and a fall in subsequent months.



Analysis of the data by Telstra Halth has shown that the rise in April is due to a low number of coded episodes. This is due to a backlog in coding patient encounters.

The impact of the spike will cause a rise in the rolling 12 month HSMR position unless the data is coded and resubmitted. There is a plan to catch up with coding backlog during Q4 and this will allow us to resubmit data and correct the HSMR.

Analysis of individual diagnostic groups has not shown any statistical outliers, but coding issues are apparent across several dignostic groups (Sepsis, Pneumonia and congestive heart failure)

Mortality Dashboard

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

20 cases escalated by the ME service during Q2 have been allocated for review using our Mortality Review form. 5 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 30 deaths were allocated for review in Q2 (7%) 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
Q3 (24-25)	471	100%	14	27	41
Q4 (24-25)	487	100%	15	26	41
Q1 (25-26)	430	100%	15	28	43
Q2 (25-26)	412	100%	20	30	50

Grading of Adult Care and avoidability following review in Q2 (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
Escalated review	4	5	4	0
QA review	20	3	0	0

During Q2 36 reviews were discussed at MRG and graded as above.

During Q2 there were 5 deaths reported for patients with a recognised learning disability. All 5 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
Q3 (24-25)	1	1	1
Q4 (24-25)	4	4	4
Q1 (25-26)	6	4	6
Q2 (25-26)	5	5	5

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
Q3 (24-25)	4	5	4	9
Q4 (24-25)	2	2	0	4
Q1 (25-26)	1	2	4	3
Q2 (25-26)	5	3	3	8

All neonatal deaths and stillbirths will be reviewed using the PMRT process
3 paediatric deaths occurred during Q2. 2 of these deaths are being investigated under the SUDIC process. One is planned for a Coroners inquest in March 2026.

Outcome of PMRT reviews reported in Q2 (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
	5	2	1	1

	3 PMRT reviews were finalised during Q2 and graded as above. The main learning from the PMRTs is summarised below • Delay in ambulance transferring patient to hospital (Grade D) • Sub optimal temperature management in theatre (a new policy for thermoregulation has been launched since this review) • Delay in consultant attendance following stillbirth (guidelines for management of stillbirth has been reviewed and updated) **Learning identified through review of mortality reviews during Q2.** 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. Analysis of thirteen escalated reviews and twenty-three quality assurance reviews identified several themes. • MCA documentation and assessment • Documentation of MCA in DNACPR documentation • Delay in structured medication reviews following falls • Prescribing errors (not resulting in harm) • Copy and pasting of medical records in the EPR (not resulting in harm) The above themes are fed back to Divisions through the relevant mortality leads and picked up through relevant trust wide groups (Eg Medicines Safety and optimisation group). Additionally, if mortality reviews identify individual learning points rather than themes these are fed back to the relevant teams. **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 Q2 there were no individual groups flagged as statistical outliers, but Sepsis, Pneumonia and congestive heart failure are trending higher. Analysis of HSMR has suggested this is due to the coding issues identified earlier in the report.
	Conclusion • SHIMI remains in the “as expected” category. • HSMR has risen to the “above expected” range. Analysis has shown this to be due to coding backlog issues. Work is underway to code this this backlog • 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

Board of Directors in Public **Item 29**

28 January 2026

Title	Learning from Deaths Report for Quarter 2 2025-26
Lead Director	Dr Nikki Stevenson, Chief Medical Officer
Author	Dr Ranjeev Mehra, Trust Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this paper is to assure the Board of Directors of 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:

- Note the report

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**
14/01/2026	Quality & Safety Committee	Learning from Deaths Q2	Assurance and approval

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 Q2 2025-26, along with a summary of any thematic learning identified during investigation into these cases. All deaths reported to the Trust in Q2 have flowed through the Trusts 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 ☐

Mortality Report: Learning from Deaths
Quarter 2: 01st July 2025 – 30th Sept 2025

Purpose

1. The purpose of this paper is to provide assurance to the members of the Board of Directors in relation to the implementation of the Learning from Deaths framework.

Executive Summary

2. During Q2 there were a total of 10 deaths investigated through the mortality group structure at WCHC. This includes a total of 8 child deaths, all of which were reviewed using SUDIC methodology.

3. Of the 8 child deaths, 2 occurred in a patient who had received an element of care under WCHC. Neither death was related to the care provided by WCHC. The other 6 were deaths that occurred in the community.

4. During Q2 there were 0 deaths which met the criteria for StEIS reporting.

5. Each death investigated during Q2 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 Q2, 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.

Q2 25-26 WCHC Reported deaths (Datix incident reporting)

37. During Q2 there were a total of 10 deaths reviewed, including 8 child deaths. Only one of these deaths occurred in a patient under direct care of WCHC services (CICC)

38. During Q2 there were 0 deaths which met the criteria for StEIS reporting.

Structured Judgement Reviews:	
Total Number of Deaths in scope	10
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	8
Total Deaths reviewed through SUDIC methodology	8

Summary of thematic / other Learning for Q2

39. Each death reported during Q2 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 Q2, 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. Any learning opportunities were highlighted, discussed and shared.

Recommendations for the Board of Directors

41. The Board 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 Board 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
Trust Medical Director

Public Board of Directors **Item 30**

28 January 2026

Title	CQC reports of Eastham WIC and the Urgent Treatment Centre
Lead Director	Claire Wedge, Interim Chief Nurse
Author	Alison Hughes, Director of Corporate Affairs
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with the links to the final CQC inspection reports following the inspections of Eastham Walk-in Centre and the Urgent Treatment Centre in September 2025.

Both reports have now been published on the CQC website

- Eastham Walk In Centre HTML report for assessment AP14668 - Care Quality Commission
- Arrowe Park Urgent Treatment Centre - Care Quality Commission

It is recommended that the Board:

- Notes the publication of the reports
- Receives assurance that the Trust has action plans in place to address the findings and recommendations from the report

Key Risks

This report relates to the following key risks:

Strategic risks ID01, ID02 and ID07 on the BAF record the CQC inspection reports in the context of ensuring the continued provision of safe care and supporting staff wellbeing and experience.

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	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	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**
No previous reporting history			Both reports were published on 20 January 2025 on the CQC website.

1	Narrative
1.1	Following a CQC inspection of Eastham Walk-in Centre and the Arrowe Park Urgent Treatment Centre (UTC) in September 2025, the final reports have now been published. The reports cite areas of Good practice, with the UTC rated as Good in the CQC key questions of Effective, Caring and Responsive, and Eastham Walk-in Centre rated as Good in Effective and Caring. The reports state that; - Staff treated patients with kindness and respect, protecting their privacy. - They prioritised care for clinically vulnerable patients and worked with other professionals to deliver appropriate treatment. - The culture and ethos of service was to ensure a high level of patient satisfaction. - Staff worked well as a team to meet patient need and support each other in their roles. - Key performance indicator for 4 hours treatment and discharge ranged between 92% and 99% with an average of 94% achievements

	- Staff understood the diverse health and care needs of people and their local communities, so they delivered care that was joined-up, flexible, and supported choice and continuity. The reports also highlight feedback from patients who said staff were 'patient, excellent, kind, and informative.' This supports our Friends and Family Test results, which for the last year has shown that 85% or more of our patients would recommend the service as a place to receive treatment or care.
1.2	Whilst it is disappointing that these services have been given an overall rating of Requires Improvement, the report reflects the position at the end of September 2025 and work to address the improvement areas identified is in progress with a robust action plan in place. The action plan will be submitted to the CQC by the requested deadline of 28 February 2026.

2	**Implications**
2.1	**Quality/Inclusion** The CQC reports identify areas of good practice and areas of improvement which are being addressed with robust action plans in place.
2.2	**Finance** There are no financial implications associated with the publication of the reports.
2.3	**Compliance** The CQC reports identify areas for improvement aligned to Regulation 18 which are being addressed with robust action plans in place.

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** ☐