Wirral Community Health and Care
NHS Foundation Trust

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Group Board of Directors in Public
Date	Wednesday 3 June
Time	09:00 – 12:30
Location	Hybrid

	Agenda Item	Lead	Presenter	Action
1.	Welcome and Apologies for Absence	Chair		Note
2.	Declarations of Interest	Chair		Note
3.	Minutes of the Previous Meeting	Chair		Approve
3.	Action Log	Chair		Note
	Standing Items			
4.	Patient Story	Chief Nursing Officer		Note
5.	Chair Update – **Verbal**	Chair		Note
6.	Chief Executive Officer Report	Chief Executive Officer		Note
7.	Joint Integrated Performance Report	Executive Directors		Note
8.	Board Assurance Framework (BAF)	Director of Corporate Affairs & Communications		Approve
9.	Lead Governor Report – **Verbal**	Lead Governor		Note
	Joint Committee Chairs Reports			
10.	Joint Quality and Safety Committee – **Verbal**	Dr Steve Ryan, Non-Executive Director		Note
11.	Joint Digital Committee	Haris Sultan, Non-Executive Director		Note
12.	Joint Finance and Performance Committee	Meredydd David, Non-Executive Director		Note
13.	Joint Finance and Performance Committee – **Verbal**	Meredydd David, Non-Executive Director		Note

14.	Joint People Committee – **Verbal**	Lesley Davies, Non-Executive Director		Note

WUTH and WCHC Statutory Board Committee Chairs Reports

15.	WUTH Audit and Risk Committee	Lisa Greenhalgh, Non-Executive Director		Note
16.	WCHC Audit and Risk Committee	Lisa Greenhalgh, Non-Executive Director		Note
17.	WUTH Charitable Funds Committee – **Verbal**	Lesley Davies, Non-Executive Director		Note

Regulatory Reports

18.	WUTH Quarterly Maternity and Neonatal Services Report	Chief Nursing Officer	Divisional Director of Nursing & Midwifery	Assure
19.	WUTH Biannual Establishment Review	Chief Nursing Officer		Note
20.	Joint Patient Safety Incident Response Policy and Framework Plans	Chief Nursing Officer		Approve
21.	WCHC Infection Prevention and Control Annual Report	Chief Nursing Officer		Approve
22.	WUTH Guardian of Safe Working Annual Report (including Q4 2025/26)	Trust Medical Director	Guardian of Safe Working	Note
23.	WUTH Mortuary Services Annual Report 2025/26	Trust Medical Director	Cellular Pathology Manager & HTA Designated Individual	Assure

Governance and Assurance

24.	WUTH Registers of Interest and Hospitality Annual Update	Director of Corporate Affairs & Communications	Board Secretary	Note
25.	Modern Slavery Statements	Director of Corporate Affairs & Communications	Board Secretary	Approve

Closing Business

26.	Questions from Governors and Public	Chair
27.	Meeting Review	Chair
28.	Any other Business	Chair

Date and Time of Next Meeting

Wednesday 2 September, 09:00 – 12:30

Meeting	Group Board of Directors in Public
Date	Wednesday 1 April 2026
Location	Hybrid

Members present:

SI	Steve Igoe	Joint Chair
SR	Dr Steve Ryan	Joint Non-Executive Director
MD	Meredydd David	Joint Non-Executive Director
CB	Professor Chris Bentley	Joint Non-Executive Director
LG	Lisa Greenhalgh	Joint Non-Executive Director
LD	Lesley Davies	Joint Non-Executive Director
HS	Haris Sultan	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
MS	Matthew Swanborough	Joint Chief Strategy Officer
MC	Mark Chidgey	Joint Chief Finance Officer
JC	Dr Joanne Chwalko	Joint Chief Integration & Partnerships Officer
CD	Chris Douglas	Joint Chief Nursing Officer
DS	Debs Smith (from 10:45)	Joint Chief People Officer
AH	Ali Hughes	Joint Director of Corporate Affairs & Communications

In attendance:

CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 23
GG	Gary Grady	WCHC Governor
EH	Eileen Hume	WCHC Governor
LC	Lynn Collins	WCHC Governor
SH	Sheila Hillhouse	WUTH Lead Public Governor
RT	Robert Thompson	WUTH Deputy Lead Public Governor
MT	Mark Taylor	Member of the Public

Apologies:

CM	Chris Mason	Chief Information Officer
GR	Gareth Robinson	Joint Director of Transformation & Turnaround

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed members to the meeting. No apologies were received.	

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 WUTH and WCHC meetings held on the 28 January were **APPROVED** as an accurate record.	
4	**Action Log** The Group Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story highlighting a mum's story of her bereavement journey after unexpectedly losing her 22 year old son. The video story described the excellent clinical care, however the bereavement experience in terms of information and making memories did not meet the mum and her family's expectation. CB reported that considerable work had been undertaken in this area, with support from the individual in the patient story, while recognising that further development is required. CD highlighted the importance of alignment with the national framework, noting that the Bereavement Strategy is due to be launched later in the year and that the Bereavement Suite has now been relocated to improve accessibility. LD queried whether volunteers could provide additional support. CD advised that this could be explored with a focus on identifying appropriate individuals, confirming that staff are already involved as part of the improvement plan. SI reflected that the patient story shared was powerful and welcomed that actions were already being progressed. SR noted that paediatrics and maternity services are more advanced in managing deaths within maternity, and suggested drawing on their valuable learning. CD acknowledged that there are lessons to be learned across Divisions, including the role of bereavement midwives, and advised that opportunities to utilise charitable funds could also be explored. HS highlighted the potential for collaboration with hospices to inform development of this strategy. MD emphasised the complexity of navigating bereavement processes within the hospital setting, as well as other situations noting that clearer information and support, such as leaflets or face-	

	to-face guidance, could benefit patients and families beyond end-of-life situations. JH referenced the Patient Experience Strategy, which included the use of video resources to support patients prior to procedures, and emphasised the importance of continued learning and improvement to enhance end-of-life care and ensure patients feel supported, while recognising that further opportunities for development remain. The Group Board **NOTED** the video story.	
6	**Joint Chair Update** SI reported that finalisation of financial plan was progressing well and thanked the team for their continued work. SI commented about the importance of delivering the agreed plans both at Trust and system level. SI added he had undertaken service visits across both Trusts, with particular praise for digital developments within orthopaedics, which have received an HSJ award, alongside positive observations regarding therapeutics within WCHC, including speech and language services. SI highlighted a number of upcoming meetings, including with the Countess of Chester to discuss horizontal integration and meetings with the ICB regarding the financial plan submission. The Group Board **NOTED** the verbal update.	
7	**Joint Chief Executive Officer Report** JH gave an update regarding Better Together - Journey to Integration, highlighting the statutory transaction remained ongoing and the new Joint Strategy would launch in April. JH reported NHSE and the Local Maternity and Neonatal System (LMNS) Annual Maternity Visit took place on 5 March and initial verbal feedback had been positive. JH added the Digitally Supported Arthroplasty Service team at WUTH had been shortlisted for the HSJ Digital Awards 2026 in the category Empowering Patients Through Digital. JH stated WUTH had welcomed and received a visit from the President of the British Geriatrics Society and positive feedback had been received regarding the progress and the collaborative approach demonstrated by the teams. JH referenced a number of appointments to NHS Cheshire and Merseyside and NHS England North West.	

	JH provided an overview of the various national developments since the last meeting, including the publication of the national cancer plan for England, changes to nursing graduate pay and job progression, and the publication of the 2026/27 NHS Standard Contract. JH reported at WUTH in January and February there were three RIDDORs (Reporting of Injuries, Diseases and Dangerous Occurrences) reported to the Health and Safety Executive. No Patient Safety Incident Investigations were opened under the Patient Safety Incident Response Framework. JH stated a quality priority collaboration event was held in March for WUTH and WCHC staff to discuss our first joint quality priorities for 2026/27. The four priorities are falls, pressure ulcers, medications, and discharge. JH highlighted the various WUTH and WCHC employee of the month and standout winners for January and February and explained a staff recognition week took place during March to celebrate and thank the various award winners. The Group Board **NOTED** the report.	
8	**WCHC Integrated Performance Report** HK explained 4-hour performance for the Urgent Treatment Centre and Walk In Centres was on target at 95.3% in month, however high-level risks remain regarding workforce. Resilience is improving with reductions in sickness absence; however some challenges remain, particularly in the Minor Injuries Unit which may have to temporarily close. Eastham WIC re-opened on 9 February after a temporary closure due to safe staffing levels. HK added the dental waiting list remained a concern due to demand and ongoing staffing challenges. Options were being explored to increase capacity. HK explained CICC occupancy for M11 was well above target at 97.7% and length of stay at 18 days against a 21-day target. LD queried what the driver was regarding the Minor Injuries Unit. HK explained this was due to Advanced Nurse Practitioner sickness absence and workforce challenges. SR enquired about the dental waiting list, suggesting liaising with the ICB regarding this as they had recently launched a children's dental campaign.	

	HK agreed, stating this was a new 10 year contract and the team would review the available options with the clinical lead. SI queried the 2026/27 performance targets and the achievability of these. HK stated the Trust finished 2025/26 in line with the agreed trajectories and was in a strong position to continue deliver into the new financial year. CD highlighted there has been a reduction in incident and patient safety incident reporting during M11, resulting in concerning special cause variation for overall incident reporting. Further analysis is in progress to understand the reason for this reduction and to identify which incident codes have been subject to reduced reporting. MC reported at the end of February, the Trust is reporting a surplus of £4.8m against a planned deficit of £0.067m, a positive variance to plan of £4.867m. At M11 the Trust has transacted £4.9m of CIP against a full year target of £6.6m. This shortfall will be fully mitigated by additional CIP and non-recurrent underspends. The Group Board: • **NOTED** performance to the end of February 2026 (or latest available months data); and • **NOTED** the summary position reflecting the latest publication of the NOF is also included in the IPR	
9	**WUTH Integrated Performance Report** DS reported sickness absence levels are above the Trust's 5% threshold but continue to demonstrate improvement. DS added mandatory training compliance dipped below target in January 2026 due to a risk identified during alignment with Core Skills Training Framework relating to fire awareness. DS explained targeted action throughout January and February has resulted in a 22.26% increase to almost 70% for fire awareness level 1. MD queried the timeframe for achieving the mandatory training compliance target. DS stated the Trust is aiming to reach 90% overall compliance for mandatory training by the end of April 2026. CD reported in February there were 16 C Diff cases, which is the same as last month. CD added at least 6 of these patients were on a Norovirus outbreak ward at the time of diagnosis. 4 patients were known to have a history of C Diff. CD stated there was 1 Hospital Acquired Pressure Ulcer Category 3 and 4 (Category 3 and above) Pressure Ulcers that worsened in our care.	

CD highlighted the Trust recorded 284 informal concerns (Level 1) and 28 formal complaints (Level 2). Both figures represent a modest reduction from January, with informal concerns down 6% and formal complaints down 15% month-on-month. Despite this improvement, activity remains above historical averages.

Members discussed the difference in the number of complaints compared to WCHC, noting a significant number originated from the Emergency Department which was operationally very challenged. The nature of complaints was also more complex. Members acknowledged a new Divisional Director of Nursing was in place and the Governance Support Unit had been asked to provide additional support to deal with the number of open complaints.

LG suggested the Trusts should also consider recording and publishing compliments.

MD queried the increase in pressure ulcers.

CD advised this reflects normal variation, with ongoing collaborative work likely to identify underlying causes and potential spikes in reporting. It was noted that tissue viability services exist across both Trusts, with opportunities to strengthen joint working being explored.

HK reported that mattress management has been a challenge, with 70 specialist mattresses purchased to improve access and support regular checks.

SI queried if a mattress replacement programme was in place.

HK confirmed a rolling programme is not yet established but is in development, with audits ongoing and scope for strengthening this area.

NS stated NEWS2 compliance was slightly below target. Ongoing work on areas of non-compliance is monitored through Divisional DPRs, with live reporting on BI portal accessible to all ward managers. NS added the 4 Never Events occurred in 2025/26 and this KPI would be reset as of 1 April.

MC stated that the Trust is reporting a deficit of £36m, which, excluding DSF, is a £15.2m adverse variance to plan. Non recurrent mitigations have been deployed to support delivery against the plan, including £2.6m of income in respect of Industrial Action, which has helped to partially mitigate the variance.

MC stated that the Trust is on track to deliver the revised forecast and there are no risks highlighted to impact this. The risk ratings for the financial targets on financial stability, sustainability, and

	efficiency are red, while the agency spend and capital are green. Cash is amber for M10 and red for the full year forecast, and it should be noted that the cash position has been supported by NHSE through cash applications. There is no guarantee that this support will continue. The Group Board: • **NOTED** performance to the end of February 2026 (or latest available months data); • **NOTED** the summary position reflecting the latest publication of the NOF is also included in the IPR; • **NOTED** the Trust has reported an adverse variance to plan; • **NOTED** that the Trust's most immediate finance risk remains the cash position and **APPROVED** that the CFO submits additional applications based on confirmed need; and • **NOTED** that, as approved by the Board, the Trust has confirmed to NHSE a revised forecast outturn for 2025/26 of a £49.5m deficit, representing a £27.4m adverse variance against the plan	
10	**Executive Managing Director Report** HK reported in February that the Trust attained an overall performance of 108% against plan for outpatients and an overall performance of 99.5% against plan for elective admissions. HK added the national outpatient sprint continues in quarter 4, where Trusts will receive income for over delivering against quarter 4 outpatient plan in order to increase referral to treatment performance above March 2026 target levels. HK explained in February the Trust achieved trajectory for RTT caseload but was over trajectory for percentage of patients waiting 18 weeks or under, and the number and percentage of 52-week waiters. HK stated the Trust did not meet the national cancer standards for January and explained a robust mitigation plan was in place at Divisional level. HK highlighted for unscheduled care in February, type 1 performance was reported at 46.18% and the number of patients waiting over 12 hours reduced compared to the previous month, however, it remained above trajectory. HK added corridor care reduced during the month and there was a further increase in the proportion of patients in acute beds with no criteria to reside. SR queried the impact of mental health patients on the running of the department.	

	HK advised that work undertaken over winter with the Director of Operations and CWP which has resulted in a significant reduction in patient volumes MD acknowledged the improvements delivered through the recent sprint and queried whether these were driven by additional funding, or renewed focus, and how they could be sustained. HK advised that continued focus will be required to sustain improvements for the benefits of both patients and staff. HK added from a planned care perspective, previous funding had ceased but RTT requirements remain and a business case under review to explore alternative options. HS queried whether delays in unscheduled care were cultural or operational. HK advised this is primarily cultural, particularly within ED and reset was underway involving the medical team. HS sought clarity regarding mental health provision, including first aiders, and whether a crisis centre is being built. HK confirmed that space has been built and is expected to be completed in 2026/27, in addition to currently available rooms. DS stated that WUTH had 130 mental health first aiders and WCHC had 54. The Group Board **NOTED** the report.	
11	**WUTH Board Assurance Framework (BAF)** AH provided an overview of the year-end position of the strategic risks, noting the BAF has tracked 12 strategic risks during the year. AH added of the 12 strategic risks, 6 are scored 15 or above - ID1, 2, 3, 4, 6 and 11, and 2 risks have achieved their target risk rating in year - ID10 and 12. AH provided an overview of the new BAF, noting the new 12 strategic risks have been aligned to the new strategic objectives as described in the new Joint Strategy. AH added these new strategic risks were aligned to Joint Committees and had a responsible Executive Director lead. AH referenced the new BAF template, which was in progress and would continue to be developed with a full review of the current actions and controls.	

	Members discussed the BAF and agreed the position and controls were accurate reflected the current environment. Members also welcomed the new strategic risks and the alignment in the new Joint Strategy. The Group Board: • **APPROVED** the year-end position on each of the strategic risks as reviewed by the sub-committees of the Board; • **APPROVED** the recommendations for strategic risks for 2026-27; and • **NOTED** the completion of the Assurance Framework Review 25-26 which will be reported in full to the Audit & Risk Committee	
12	**WCHC Board Assurance Framework (BAF)** AH presented the BAF, noting the year-end position showed nine strategic risks tracked during 2025/26 and a position was provided for each, including the proposed year-end position following review by the relevant sub-committees of the Board. AH added at year-end there remained one high-level risk - ID07 - which was monitored via the People & Culture Committee. No risk had achieved its target risk rating, but each had been tracked for gaps and completion of actions. Any outstanding actions would be reviewed and aligned with the new strategic risks for 2026-27. AH set out the same strategic risks for 2026/27 as mentioned in the previous agenda item. Members discussed the BAF and agreed the position and controls were accurate reflected the current environment. The Group Board: • **APPROVED** the year-end position on each of the strategic risks as reviewed by the sub-committees of the Board; • **APPROVED** the recommendations for strategic risks for 2026-27; and • **NOTED** the completion of the Assurance Framework Review 25-26 which will be reported in full to the Audit & Risk Committee	
13	**Lead Governors Reports** SH welcomed the reduction in corridor care. SH expressed a keenness for Governors to be part of future walkabouts which will enhance engagement with individual NEDs. SH also referenced the work ongoing regionally and nationally regarding the future role of the Governors and any future public accountability model.	

	LC reported that recent Governor elections had been positive, with strong attendance at induction sessions, and confirmed that a Council of Governors meeting will take place in April. The Group Board **NOTED** the verbal updates.	
14	**Committee Chairs Reports – WUTH Audit and Risk Committee** LG alerted members that the Committee noted the increase in ID05 reflecting staff experience and the impact of organisational change on morale and culture. This would be discussed at People Committee. The Committee endorsed the risk and associated rating. LG also alerted members that the Committee noted that the revised finance forecast represented a significant update to the position but did not change the risk score which was already high. LG alerted members that the Committee approved the Joint Standing Financial Instructions (SFIs) and recommended the SFI's to Group Board for approval. LG summarised the various "Advise" and "Assure" matters from the meeting on 13 February. The Group Board **NOTED** the report.	
15	**Committee Chairs Reports – WUTH Finance Business Performance Committee** MD alerted members that the Committee reviewed the month 10 position, noting the Trust reported a deficit of £32.3m to date which excluding Deficit Support Funding (DSF) which is £13.6m adverse variance to plan with the most significant change compared to month 9 being the recognition of the loss of income due to the impact of the Sterile Services critical incident. MD also alerted members that as approved by the Board, the Trust has confirmed to NHSE the revised forecast outturn for 2025/26, and the most immediate risk remains the cash position. MD alerted members that urgent care performance particularly 4hr and 12hr has been significantly challenging during this period due to increased flow with this compounded due to the UECUP capital and refurbishment work underway. MD summarised the various "Advise" and "Assure" matters from the meeting on 21 January. The Group Board **NOTED** the report.	
16	**Committee Chairs Reports – WUTH Quality Committee**	

	SR alerted members that the Trust had breached its agreed annual trajectory for Clostridioides difficile (C diff) infections, noting the need for continued focus on fundamental infection control procedures in addition to improving patient flow. SR also alerted members that higher-grade tissue ulcers remain a concern and, as such, will be a key component of both Trusts' quality improvement plans for 2026/27, lead through a "fundamentals of care" group. SR stated there continued to be oversight, with a weekly executive-led meeting focusing focus on patients with no criteria to reside at the Trust. SR summarised the various "Advise" and "Assure" matters from the meeting on 25 March. The Group Board **NOTED** the report.	
17	**Committee Chairs Reports – WUTH People Committee** LD explained the Deputy Chief People Officer provided a verbal update at the last meeting and that this report summarised that update. The Group Board **NOTED** the report.	
18	**Committee Chairs Reports – WCHC Audit Committee** LG alerted members that risk ID07 remains high and has continued oversight by the People and Culture Committee. LG also alerted members that the Committee approved the Joint Standing Financial Instructions (SFIs) and recommended the SFI's to Group Board for approval. LG summarised the various "Advise" and "Assure" matters from the meeting on 13 February. The Group Board **NOTED** the report.	
19	**Committee Chairs Reports – WCHC Finance and Performance Committee** MD alerted members that the Committee reviewed the month 10 position, noting a reported surplus of £4.4m ahead of plan. There was confidence that the Trust would achieve its target outturn. MD also alerted members that the Committee discussed the 2026–29 financial plan, which set out a compliant position anchored by a £0.9m surplus in 26/27 which was the same level of surplus for 25/26. The efficiency requirement totalled £5.0m in year one and £2.18m in subsequent years.	

	MD added that working figures are required by the plan to move from 1,507 whole time equivalents to 1,348. This was primarily through infrastructure and support roles with bank and agency usage falling year on year. The biggest financial risks were the deconstructing of the block contract and delivery of the CIP. MD summarised the various "Advise" and "Assure" matters from the meeting on 20 February. The Group Board **NOTED** the report.	
20	**Committee Chairs Reports – WCHC Quality and Safety Committee** CB stated there are no issues to alert to from the last meeting of the Committee recognising that the position in relation to all high-level risks and strategic risks was discussed and mitigations reviewed, and a number of important reports were received by the Committee for assurance. CB added that the issues previously raised as alerts have been followed up through reports and updates to the last meeting, namely the CQC reports of the UTC and Walk-in Centre and the internal audit on Clinical Supervision. CB summarised the various "Advise" and "Assure" matters from the meeting on 25 March. The Group Board **NOTED** the report.	
21	**Committee Chairs Reports – WCHC People and Culture Committee** LD explained the Deputy Chief People Officer provided a verbal update at the last meeting and that this report summarised that update. The Group Board **NOTED** the report.	
22	**Committee Chairs Reports – Joint People Committee** LD provided a verbal update on the 30 March meeting and alerted members that sickness absence had improved overall, although the estates staff group remained a concern. LD also alerted members that recent staff survey results had showed a decrease in satisfaction reported across several areas, and it was agreed that the action plan would be updated to reflect the shared responsibility of all Divisional teams instead of only Workforce.	

	LD advised members that the Committee received two internal audit reports on recruitment processes and payroll transitional arrangements. LD assured members that the Committee received a detailed deep dive into CSW banding following organisational change, noting an overall reduction in sickness absence and that of the 100 CSWs initially expected to move, only five had transferred across wards, with learning identified in relation to workforce transformation. LD also assured members that good progress was also noted in relation to sexual health safety changes, with assurance provided, and it was suggested that a future Board seminar be arranged to cover this area alongside employment law. The Group Board **NOTED** the verbal update.	
23	**WUTH 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 two areas of partial compliance. These were related to midwifery staffing below Birth Rate+ acuity and recommendations from national reports not implemented. JL added the business case approved by Board continued to be recruited to and work to address recommendations related to estates and triage was underway. JL stated there were no Patient Safety Investigation Incidents (PSIIs) or Newborn Safety Incidents (MNSI) declared for Maternity Services or Neonatal Services in January and February. JL gave an update on the Maternity Incentive Scheme (MIS) Year 8, noting no technical guidance had been released yet and this was expected in the spring. 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 97% compliance against the 6 elements based on evidence as of 31 December 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 and recruitment was underway. JL set out the annual Maternity CQC survey results, noting the improved position and positive results. JL highlighted the NHSE and LMNS annual maternity visit had taken place on 5 March and summarised the key strengths identified. SR commented from a recent maternity safety walkabout that there was a noticeable positive difference in the environment, with staff experiencing increased capacity to provide care, taking time to reflect, and considering opportunities for further service improvement enabled by the additional time available. Members thanked JL for their continued hard work, strengthened by good triangulation and consistency of high quality reporting. The Group 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 any declared PSII's; • **NOTED** the submission of the Trust's position with Maternity Incentive Scheme Year 7 and potential changes for MIS Year 8; • **NOTED** the summary of expected reports for maternity and neonates in 2026; • **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"; • **NOTED** the progress with the Maternity Portal Online Programme; • **NOTED** the results of the CQC 2025 maternity survey; • **NOTED** the outcome of the UNICEF accreditation; and • **NOTED** the feedback of the joint NHSE and Northwest Regional visit in March 2026	
24	**WUTH Learning from Deaths Report Q3 2025/26** NS summarised the mortality comparators, stating for the reporting period the Summary Hospital Level Mortality Indicator (SHMI) was within the expected range.	

	NS added Hospital Standardised Mortality Ratio (HSMR) had increased and remains in the above expected range, noting this was due to the impact of coding backlogs during 2025 which members had previously been made aware of. NS provided a summary of adult in patient deaths and case reviews, stating that, of the 441 deaths, 19 cases were escalated for review by the Medical Examiner and the Mortality Review Group reviewed a random selection of deaths to identify learning. NS also provided a summary of the perinatal and neonatal deaths and the outcome of the PRMT reviews. NS stated general learning from mortality reviews included lack of treatment escalation planning/lack of recognition of dying phases as well as copying and pasting medical records in the EPR and prescribing errors, noting these did not result in harm. NS indicated regarding external benchmarking respiratory failure has been flagged as requiring further review and an audit of those deaths was underway and will be reported back through the Morality Review Group. The Group Board **NOTED** the report.	
25	**WCHC Learning from Deaths Report Q3 2025/26** NS reported during the quarter 4, deaths were investigated through the mortality group structure. This includes a total of 7 child deaths. NS added of the 7 child deaths, 1 occurred in a patient who had received an element of care by the Trust and on review the death was not related to the care provided by the Trust. The other 6 were deaths that occurred in the community. The Group Board **NOTED** the report.	
26	**WUTH Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2025 Assessment** DS gave an overview of the 2025 Equality Delivery System (EDS) self-assessment and the ratings for domain 1, 2 and 3, noting the proposal was to maintain the same ratings for domain 2 and 3 similar to last year as achieving activity. DS advised for domain 1, commissioned or provided services a different service was assessed each year, indicating it was MSK services this year and does not represent a like for like comparison. This was rated as developing activity. DS stated due to this this change the Trust was proposing to the rated as developing activity instead of achieving activity.	

	The Group Board: • **NOTED** the report; and • **RATIFED** the EDS recommended rating	
27	**WCHC Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2025 Assessment** DS advised an identical process was undertaken for WCHC and similar to WUTH the proposal was to be rated as developing activity, due to the changes in domain 1 rating. The Group Board: • **RECEIVED** assurance regarding the content of the report in relation to the Trust being an inclusive place to work and receive treatment; and • **RATIFED** the EDS recommended rating	
28	**Staff Survey Results** DS provided an overview of the presentation, noting the WUTH response rate decreased to 42%, below both its 2024 position and the national average (47%) and WCHC maintained a 51% response rate, but this remains below the national average (62%). DS explained of the 9 People Promise elements, 5 were significantly lower for WUTH based on statistically significant changes and for WCHC 3 were significantly lower based on the 2024 score. DS set out the key areas for improvement for both Trusts and the next steps, including engagement and involvement with staff to lead and shape key actions as well feedback and action on “free text” comments. Members commented that upcoming year and the 2026 staff survey results were likely to be challenging and may deteriorate further. DS commented that organisational pressures and the merger was creating an uncertain environment for staff, while emphasising areas within both Trusts’ control and the need to deliver the merger at pace. JH observed that other NHS providers are experiencing similar levels of demand and change, noting the importance of understanding why some providers appear to perform better. SR raised the importance of career progression opportunities for staff and queried this.	

	DS stated this would be looked at in further detail, noting there had been feedback regarding perceptions of unfairness in promotion processes and concerns regarding equitable access. LD emphasised the importance of consistent recruitment practices and documentation to improve perceptions. DS noted that some improvements have been implemented, including enhanced interview feedback, acknowledging that previous feedback had not always supported development. The Group Board: • **NOTED** the decline in staff satisfaction and the statistically significant different decline in a number of areas; and • **NOTED** the key areas for improvement and focus on ensuring basics which should be applied locally and across the organisation.	
29	**WUTH Charity Annual Report and Accounts 2024/25** AH stated the WUTH Board of Directors had approved this electronically and had been submitted to the Charity Commission in line with the 31 January deadline.	
30	**Group Governance Manual** AH stated this document had been approved by the Group Board in Private in March and subsequently approved by both Council of Governors. The Group Board **NOTED** the Group Governance Manual.	
31	**Questions from Governors and Public** No questions were raised.	
32	**Meeting Review** Members agreed it had been a good meeting, and everyone had the opportunity to contribute.	
33	**Any other Business** There was no other business.	

(The meeting closed at 12:15)

Action Log
Group Board of Directors in Public
3 June 2026

No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1			No actions due			

Group Board of Directors in Public **Item 7**

03 June 2026

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

Purpose of the Report and Recommendation	
Report For	Information
It is recommended that the Board: • Note the report	

Key Points to Note
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.

Key Risks
This report relates to these key risks: • No key risks identified.

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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

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

1	Narrative
1.1	**Performance** Both Trusts continue to operate in the context of continued demand on services, but positive performance with recovering referral to treatment standards, 4 hour accident and emergency, cancer waits and sustained performance across community services. This reflects the continued commitment, professionalism and flexibility of staff working in both Trusts with teams responding proactively to demand and working collaboratively to support the delivery of care for the Wirral population. Performance across both Trusts is also actively monitored through the National Oversight Framework (NOF) and a summary of the position is included in the Joint Integrated Performance Report. We understand that the NOF for 26-27 will be revised and we are actively engaging with NHSE to ensure that we implement appropriate monitoring and reporting against relevant metrics for both Trusts. Further detail regarding both Trust's performance is available in the Joint Integrated Performance Report.
1.2	**Local News and Developments** **Response to Hantavirus** We were asked by NHS England and the UK Health Security Agency (UKHSA) to house UK citizens repatriated from the MV Hondius cruise ship in the accommodation block on the Arrowe Park Hospital site to provide them with a safe place for their isolation period, following cases of Hantavirus. Both NHSE and the UKHSA recognised how quickly and positively we responded to and supported the repatriation of British nationals from Wuhan and the Diamond Princess prior to the COVID-19 pandemic. We welcomed the guests on Sunday 10 May 2026 and nobody showing any symptoms was transferred to the site. Our role has been to provide a safe place for the residents to isolate, and I am very proud of the way our organisation once again stepped up to respond to a national incident. The pace at which teams mobilised to ensure our guests had a safe place to return to in the UK has been exceptional and the work of our staff was been widely recognised and praised by national and regional colleagues, as well as key local stakeholders, including Members of Parliament and Steve Rotherham, the City Region Mayor Our strong partnership working with colleagues across local, regional and national agencies has been particularly impressive and should not be underestimated. **WUTH and WCHC Corridor Care Summit brings teams together**

	Colleagues from WUTH and WCHC came together in April for a Corridor Care Summit at Floral Pavilion to focus on what all teams can do to maintain patient flow in our hospitals and in the community and to eliminate corridor care. The event was hosted by members of the Executive Team. It brought together colleagues from services across both WUTH and WCHC for a day of shared learning, reflection and action. The summit began by setting the context, exploring the reality of corridor care across the system, including its impact on patients, staff and services. Colleagues heard powerful patient and staff stories, highlighting real experiences and reinforcing the importance of driving change. Throughout the day, teams took part in group discussions to explore the national definition of corridor care, review national and local action plans, and reflect on what changes are needed within services. In the afternoon, colleagues worked in divisional and specialty groups to identify practical actions to improve patient flow, reduce delays and enhance patient experience. These actions will now be developed further, with clear ownership and next steps. The summit provided an important opportunity to come together, strengthen shared understanding and focus on collective solutions to eliminate corridor care across our services. **Better Together - Journey to Integration** The Better Together programme continues to make strong progress across both strategic and operational priorities. The Joint Strategy was launched in April 2026 bringing together the collective strengths of both organisations and sets out a shared vision to improve services, outcomes and experiences for patients, residents and staff. Focused on collaboration and long-term impact, the strategy builds on strong existing partnerships and provides a clear framework for delivering more integrated, accessible and person-centred care. It represents an opportunity to further align priorities and ensure services continue to meet the evolving needs of local communities. A coordinated internal communications campaign has been rolled out, including screensavers and supporting engagement materials to reinforce shared priorities and the new vision across teams. Work is now ongoing on the enabling strategies including clinical services. Work on the Corporate Services organisational change programme remains on track, with consultation underway as part of the phased approach. Integration of clinical services is also advancing, particularly within MSK and Cardiology. **WUTH Charity announced as Merseyrail Charity of Year** We are delighted that Merseyrail has chosen WUTH Charity as its Charity of the Year this year. Over the next two years, WUTH Charity will benefit from support led by Merseyrail's community involvement team.

Collection buckets are now available across Merseyrail stations and recently, WUTH Charity volunteers joined Merseyrail staff at Aintree Railway Station during the Aintree Races to raise funds.

This exciting partnership will create many opportunities for WUTH staff and volunteers to get involved.

NHS Cheshire and Merseyside Provider Collaborative Updates

CMPC Leadership Board 17th April

CEOs received an update from Liz Biship on the ICB programme of management of change and financial recovery, the Board were advised that PWC support will remain throughout Q1. Jude Adams outlined emerging proposals for a single, joint oversight model, reducing duplication between contract, regional, and regulatory forums.

Clare Watson provided an overview of the national neighbourhood health framework. A discussion took place on the left shift funding CEOs requested clarity of governance arrangements relating to funding allocation, and more detailed information on the process/decision making.

Updates were received on the UEC strategy and a presentation on the proposed system-wide digital platform (Blinks Paco) to support integrated neighbourhood working.

An update on year-end performance demonstrated significant improvement across elective, diagnostics, cancer and community services, with the system now the highest performing in the Northwest for elective recovery.

CEOs reflected on emerging contracting principles and agreed to develop a coordinated CMPC wide response to strengthen the system negotiating position.

CMPC Leadership Board 1st May

CEOs received an update on the year end outturn position. The need for consistent reporting of industrial action was agreed with a coordinated CFO approach to protect system credibility.

The Integrated Referral Model was presented and agreed as a core strategic priority, representing a fundamental shift in outpatient delivery rather than incremental change. The Board supported development of a business case for care coordination hubs to improve community alternatives to ED, subject to clear return on investment and alignment with wider transformation programmes. More broadly, members emphasised the need to tightly coordinate left shift and neighbourhood initiatives, focusing on a small number of outcome-driven priorities and avoiding fragmented delivery.

The discussion reflected a clear national expectation for systems to deliver demonstrable transformation at scale, with CMPC's elective and community proposals aligned to this direction. In this context, the Board agreed to focus on a limited number of high impact "big bets," with opportunity for further discussion at the next CEO and Chair session.

1.3	**National News and Developments**

NHS England (NHSE) - 1 April 2026 next steps on planning and priorities for 2026/27

This letter from Sir James Mackey, Chief Executive, NHS England set out collective priorities for the NHS and looks ahead for the new financial year. NHS England » 1 April 2026 next steps on planning and priorities for 2026/27.

The letter outlines eight key areas where, collectively, we can make a big difference this year and beyond:

- **Outpatient transformation** – shifting away from traditional outpatient models through a major expansion of Advice and Guidance and a reduction in unnecessary follow-ups.
- **A step-change in reducing hospital bed-days for highest-risk cohorts** – with neighbourhoods playing a central role in implementing proactive care models for high-risk groups.
- **Scheduling and access reform for urgent care** – making it easier for patients to book urgent care appointments in GP practices, urgent treatment centres, or other appropriate settings, reducing avoidable ED attendances.
- **Technology-enabled productivity improvements** – expanding the deployment of Ambient Voice Technology and a suite of tools to improve theatre utilisation, discharge flow, RTT validation, community waiting lists, Advice and Guidance, electronic prescribing in all trusts, and crisis response.

Nationally, we will be taking action to support these and related improvement efforts, including:

- **The NHS App** – accelerating efforts to expand the role of the App as the digital front door into the NHS, supporting more convenient and effective triage and navigation for patients.
- **Payment reform** – realigning the payment system to the service changes you are seeking to deliver, including new payment models for urgent and emergency care.
- **Quality** – putting quality back at the heart of everything we do, including the publication of a new quality strategy, the development of modern service frameworks focused on cardiovascular disease, sepsis, serious mental illness, frailty and dementia, children and young people, and palliative and end-of-life care, and testing new delivery models for secondary prevention to tackle variations in the uptake of high-impact CVD and diabetes interventions.
- **Capability building and a focus on our people** – launching the new Leadership College, which will be the most radical change to leadership development and talent management that the NHS has seen in over a decade.

NHS Cheshire and Merseyside publishes Clinical and Strategic Commissioning and Population Health Improvement Plans

	NHS Cheshire and Merseyside is the statutory body responsible for planning, funding and overseeing NHS services for our 2.7 million residents. Their 2026–31 Clinical and Strategic Commissioning and Population Health Improvement Plans set out the shared ambitions for the years ahead. Aligned with the NHS 10-Year Health Plan, the strategy focuses on transforming services to improve outcomes while ensuring long-term financial sustainability. The ICB will target resources to deliver the three key shifts in care: • Hospital to community • Sickness to prevention • Analogue to digital **NHS University Hospitals of Liverpool Group** James Sumner, Chief Executive of NHS University Hospitals of Liverpool Group has announced that he will be leaving in the coming months once a successor has been appointed. James joined the organisation as Chief Executive of Liverpool University Hospitals NHS Foundation Trust in April 2022. **North Cheshire and Mersey NHS Foundation Trust** As of 1 April 2026, Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust have officially come together as a single organisation. Together we will be known as North Cheshire and Mersey NHS Foundation Trust.
1.4	**WUTH Health and Safety** There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported between March and April. 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 zero Patient Safety Incident Investigations (PSII) opened in March and April 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. • **Department of Health and Social Care - Neighbourhood health framework.** This framework defines neighbourhood health and sets out the challenges neighbourhood health and care services should address. It aims to establish clear metrics for success and maps out the process systems should go through to establish local metrics. It also defines the roles of integrated care boards, local authorities, health and wellbeing boards, and other partners in neighbourhood health's development and implementation. https://www.gov.uk/government/publications/neighbourhood-health-framework

	• **NHS England (NHSE) - Fit for the future: towards population health delivery models.** To realise the ambitions set out in the 10 Year Health Plan, services must be delivered in new ways that better meet patients' needs, and provide care as close to home as possible. As set out in the Neighbourhood Health Framework, this means improving routine health care services, moving to a more proactive care model for people with multiple long-term conditions and delivering better alternatives to hospital care. This publication sets out new population health delivery models to facilitate these changes, supporting integrated care boards (ICBs) to commission providers around the needs of defined populations. ICBs – working with partners, including local authorities and health and wellbeing boards – will agree neighbourhood footprints that form clearly defined populations. Single neighbourhood, multi-neighbourhood and integrated health organisation contracts will be commissioned around these populations. https://www.england.nhs.uk/long-read/fit-for-the-future-towards-population-health-delivery-models/ • **NHSE - Corridor care definition.** To ensure consistency in reporting of activity in relation to corridor care, this definition has been developed by NHSE to allow acute hospitals to accurately record and count corridor care. The guidance sets out a definitions for ED and, general and adult beds, together with a table describing key criteria. These 'worked examples' support acute hospitals to operationalise the corridor care definition. https://www.england.nhs.uk/long-read/corridor-care-definition/ • **National Maternity and Neonatal Investigation - Independent investigation into maternity and neonatal services in England: interim report.** This report sets out the background and changing context in which maternity and neonatal care is provided. It examines six factors that could be contributing to the pressures on the maternity and neonatal system. These are: capacity pressures; culture and leadership; racism and discrimination; poor responses and lack of accountability when things go wrong; the quality of estates; and workforce. The report concludes with next steps. https://www.matneoinv.org.uk/updates/independent-investigation-into-maternity-and-neonatal-services-in-england-interim-report/ • **NHSE - Neighbourhood health centre guidance for regions and integrated care boards.** This guidance is both a statement of policy intent and a practical planning instruction for neighbourhood health centre (NHC) development in the current planning period. It sets out the strategic framework for how integrated care boards (ICBs) and NHS England regions, working with providers, should identify and develop NHC schemes to support neighbourhood health: the archetypes to consider, estate planning, pipeline development and funding routes. https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/ • **NHSE - The future of Freedom to Speak Up.** Following the Dash review of patient safety across the health and care landscape, the government has agreed that the National Guardian's Office will close at the end of June 2026. From 1 July 2026, NHSE will deliver some activities previously undertaken by the National Guardian's Office, and healthcare organisations will take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements. This document sets out the revised responsibilities for Freedom to Speak Up across the NHS. https://www.england.nhs.uk/publication/the-future-of-freedom-to-speak-up/
1.6	**Communications and Engagement**

Monthly All Staff Briefings

Since The Monthly All Staff Briefing launched in January 2026, around 400 colleagues across both Trusts attend each briefing either in person or online.

A monthly opportunity to bring colleagues together and hear from the joint Executive Team with a standard agenda focusing on Quality, Operational Performance, Better Together, People, Finance, Spotlight on Services, and Q&A. Questions can be asked in advance or during the briefing.

The briefing concludes with a section on Recognition where we celebrate the Monthly Standout (WCHC) and Employee/Team of the Month (WUTH) who are presented with a certificate and hamper.

World Administrative Day: Celebrating Our NHS Administrative Staff

In April we marked World Administrative Day across both Trusts, this was an opportunity to recognise and celebrate the invaluable contribution of administrative staff across the NHS. Their work is at the heart of our services, supporting service users and patients, enabling clinical teams, and keeping everything running smoothly behind the scenes.

International Nurses Day

In May, we also marked International Nurses Day across both Trusts, a moment to recognise and celebrate every nurse working across our two Trusts for their unwavering dedication to the people of Wirral and our communities.

This year's theme of 'empowering nurses' recognises the important role nurses play in supporting and uplifting one another, while also helping patients to feel informed and involved in their own care. Nurses are at the heart of healthcare, empowering themselves and others through compassion, leadership and advocacy every day.

Empowerment also means creating opportunities for learning, development and career progression, enabling nurses at every stage of their journey to grow their skills, share their expertise and reach their full potential.

Dying Matters Week

Our annual recognition of Dying Matters Awareness Week focused on students for the 2026 campaign, with the key message, *'Let's talk about death and dying'.*
The objective was to support students to feel informed and empowered around death and dying. Students were invited to a training event held by the End-of-Life Care Team, to promote the importance of clear communication and use of terminology with patients and their families, as well as respecting wishes – whether practical or spiritual.

For the wider workforce, the campaign offered practical steps such as discussing will-writing with a partner, and emotional support, for example the benefits of talking about grief.

A key takeaway from the campaign was the importance of compassionate care across all services. The internal campaign was promoted across the staff Facebook group, StaffZone, screensavers, items in The Update, and a dedicated Special Edition.

Major estates upgrades improving safety across our sites

WUTH has secured NHS England Estates Safety Funding to support essential upgrades to critical infrastructure across its sites. The funding, awarded in late 2025 to 2026, is being used on a priority risk basis to upgrade or replace critical systems, including ventilation plant, potable water systems and electrical supplies. In many cases, this infrastructure has been in place since the hospital was first built, making these improvements vital to ensure ongoing safety and compliance.

WUTH shortlisted for national biomedical science award

Colleagues from the Immunohistochemistry team at WUTH have been shortlisted for a 2026 Institute of Biomedical Science award for partnership working. Working with NHS laboratories across Cheshire and Merseyside, the team has helped improve quality and consistency in testing, which is vital for diagnosing conditions such as cancer.

Enhanced Macmillan Information Centre opens at Arrowe Park Hospital

During April the Macmillan Cancer Services team celebrated the opening of a new enhanced Macmillan Information Centre at Arrowe Park Hospital, marking a significant commitment to supporting the wellbeing of people affected by cancer across Wirral.

The centre was opened by Chris Douglas, Joint Chief Nurse, who thanked everyone involved in bringing the project to life and highlighted the vital role the service plays for patients and their loved ones.

Funded through a £160,000 investment from Macmillan Cancer Support, the new centre is now centrally located within the hospital and offers a welcoming space with a private area for confidential conversations.

WUTH May Employee / Team of the Month for Patient Care - Anaesthetic Team

Congratulations to the Anaesthetic Team, who have been recognised as WUTH Employee/Team of the Month for Patient Care. The team was nominated for their exceptional dedication, compassion and commitment to delivering outstanding care to patients across the Trust.

Supporting some of the hospital’s sickest patients, the team provides specialist care not only in theatres, but across areas including MRI, Endoscopy, A&E and ITU, as well as supporting transfers between departments and other trusts. Colleagues praised the team’s expertise, innovation and patient-centred approach, highlighting the reassurance and support they provide to patients during some of their most vulnerable moments. Their nomination described them as a team whose care, professionalism and commitment consistently make a difference every day.

WUTH May Employee/Team of the Month for Support Services - Andrew Sutcliffe

	Congratulations to Andrew Sutcliffe, Programme Manager within the Service Improvement Team, who has been recognised as WUTH Employee / Team of the Month for Support Services. Andrew was nominated for his outstanding contribution to the Wirral One Plan Improvement Programme, helping improve patient flow through the Emergency Department and hospital wards. Colleagues praised his professionalism, positivity and willingness to always go above and beyond to support teams across the organisation. While working behind the scenes, Andrew's work has a direct impact on improving patient care, reducing delays and supporting safer, more efficient pathways. Alongside his role, Andrew has also recently qualified as a QSIR trainer, helping strengthen the Trust's culture of continuous improvement and supporting colleagues to develop improvement skills. **WUTH April Employee/Team of the Month for Support Services - Arrowe Park Hospital Estates Electrical Team** Congratulations to the Arrowe Park Hospital Estates Electrical Team at WUTH, named Employee/Team of the Month for Support Services. The team was recognised for their exceptional response to a recent generator failure, ensuring patient and staff safety while maintaining critical services. Their professionalism, rapid action and dedication highlight the vital role support services play across the Trust. **WUTH April Volunteer Making a Difference Award - Charlie Hollywood** Well done to Charlie Hollywood from the Therapies team at WUTH, who has received the Volunteer Making a Difference Award. Charlie was recognised for bringing joy to patients through weekly activities, supporting rehabilitation and contributing to new ideas that enhance patient experience. His dedication and positivity make a real difference to both patients and staff. **WCHC Standout Winners** Congratulations to Clare Slack at Claughton Community Nursing Team, our Standout winner for April! Clare demonstrated exceptional professionalism and leadership during a recent road traffic accident. Despite being newly qualified, Clare demonstrated a level of confidence, leadership, and clinical skill far beyond her experience. Clare was one of the first healthcare professionals on the scene and immediately took control in an incredibly challenging and high-pressure situation. She provided emergency care to those involved, calmly assessing needs, prioritising interventions, and ensuring that everyone remained safe until emergency services arrived. Clare also organised members of the public who were present, giving clear instructions and creating order in what could easily have become a chaotic environment.

Group Board of Directors in Public **Item 7**

03 June 2026

Title	Joint Integrated Performance Report
Area Lead	Executive Directors
Author	Executive Directors

Purpose of the Report and Recommendation	
Report For	Information

It is recommended that the Board:

- Note performance to the end of April 2026 (or latest available months data).
- Note the summary position reflecting the latest publication of the NOF is also included in the IPR.

Key Points to Note

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of April 2026 (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.

Key Risks

This report relates to these key risks:

- All BAF 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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes

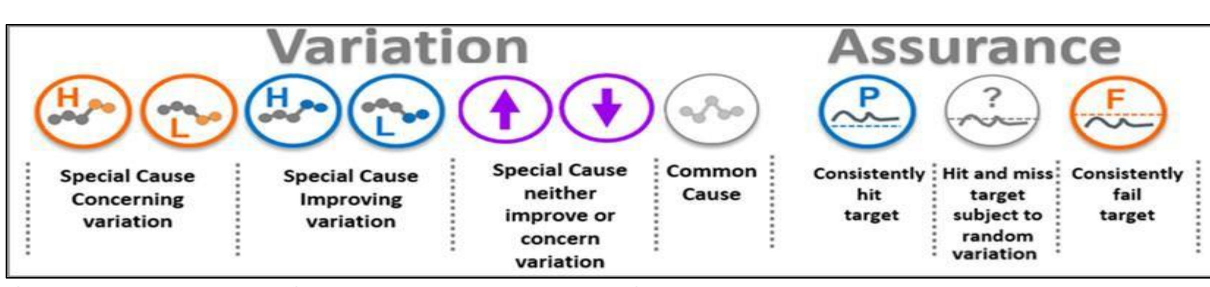
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
n/a			

1	Narrative
1.1	This is the first joint Integrated Performance Report for the Board, bringing together the two Trust's performance reports. A few amends have been made to the format, including an overall matrix for both Trusts showing all indicators, rather than individual portfolio matrices, and each Executive Director's portfolio now includes a section for WUTH and WCHC, where relevant. This report also replaces the historic WUTH COO and WUTH CFO reports, and the detail within those reports will now be included in this Joint IPR to support triangulation. Further work is being undertaken on the IPR and it is anticipated that additional indicators will be included in the next iteration of this report. This includes the development of indicators for the CMO WCHC section, and further indicators for the CPO section to triangulate with the financial plan requirements, and the addition of indicators to align with the NOF metrics. No existing indicators are planned for removal or amend. It should also be noted that the EMD portfolio indicators are also reported against the agreed national trajectories, rather than year-end targets.

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.

WUTH Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Apr 26	5.53%	≤5%			5.94%
Staff turnover % - in-month rate	Apr 26	0.62%	≤1%			87.73%
Mandatory training % compliance	Apr 26	88.82%	≥90%			92.05%
Appraisal % compliance	Apr 26	87.33%	≥88%			0.83%
4-hour Accident and Emergency Target (including APH UTC)	Apr 26	62.55%	≥57.63%			61.1%
Number of inpatients not meeting the Criteria to Reside	Apr 26	182	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Apr 26	735	≤0			651
Proportion of patients more than 12 hours in ED from time of arrival	Apr 26	18.07%	≤20.84%			18.3%
Ambulance Handovers: % < 30 mins	Apr 26	65.77%	≥95%			54.7%
Ambulance Handovers: % < 45 mins	Apr 26	85.64%	≥100%			73.4%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Apr 26	65.42%	≥63.88%			59.1%
Referral to Treatment - total open pathway waiting list	Apr 26	43867	≤46923			45238
Referral to Treatment - cases exceeding 52 weeks	Apr 26	283	≤429			1421
Referral to Treatment - cases waiting 78+ wks	Apr 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Mar 26	50	≤50			136
Cancer - Faster Diagnosis Standard	Mar 26	84.05%	≥77.73%			73.0%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Mar 26	91.83%	≥91.39%			91.4%
Cancer Waits - 62 days to treatment (monthly)	Mar 26	75.86%	≥75.51%			74.5%
Diagnostic Waiters, 6 weeks and over - DM01	Apr 26	92.04%	≥94.5%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Apr 26	186	≤79			168
Clostridioides difficile (healthcare associated)	Apr 26	14	≤8			12
Pressure Ulcers - Hospital Acquired Category 3 and above	Apr 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Apr 26	0	≤0			0
Patient Safety Incidents	Apr 26	1333	-			1222
FFT Overall experience of very good & good: ED	Apr 26	73.3%	≥95%			75.7%
FFT Overall experience of very good & good: Inpatients	Apr 26	96.9%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Apr 26	97.0%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Apr 26	96.9%	≥95%			96.1%
Patient Experience: concerns received in month - Level 1 (informal)	Apr 26	283	≤173			233
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Apr 26	3	≤3			3
Falls – Moderate to Severe Harm	Apr 26	0.14	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Apr 26	92.0%	≥90%			89.1%
WUTH Average RN Night Staffing Fill Rates	Apr 26	95.0%	≥90%			90.8%
WUTH Average CSW Day Staffing Fill Rates	Apr 26	91.0%	≥90%			87.2%
WUTH Average CSW Night Staffing Fill Rates	Apr 26	104.0%	≥90%			99.8%
MRSA Cases	Apr 26	0	≤0			0
MSSA Cases	Apr 26	2	≤0			2
% of adult patients VTE risk-assessed on admission	Apr 26	96.4%	≥95%			97.2%
Never Events	2026/27	0	≤0			
NEWS2 Compliance	Apr 26	90.4%	≥90%			89.3%
Mortality (SHMI)	Dec 25	1.060	>=0.95			1.024
Agency spend	Apr 26	1.5%	≤1%			2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

WUTH Scorecard Matrix

Variation	Assurance: Consistently Hits Target	Hit and Miss Target, subject to random variation	Consistently Fails Target	No target set/insufficient data points
Special Cause improving		- Duty of Candour compliance – breaches of DoC standard for serious incidents - FFT Overall Experience of very good & good : Inpatients - WUTH Average RN Day Staffing Fill Rates - WUTH Average RN Night Staffing Fill Rates - Never Events - Staff turnover % in month rate - RTT – cases waiting 78+ wks	- Agency Spend - 18 week RTT - Incomplete pathways < 18 wks - RTT - cases exceeding 52 wks - Cancer waits – reduce number waiting 62 days +	- FOI – Completed - Pay – Run Rate
Common Cause	- WUTH Average CSW Night Staffing Fill Rates	- Clinical coding completeness (Freeze) - Pressure Ulcers – Hospital Acquired Cat 3 and above - FFT Overall Experience of very good & good : Outpatients - FFT Overall experience of very good & good: Maternity - Patient Experience: Concerns received in month – Level 1 (informal) - Patient Experience – complaints in month per 1000 staff – Level 2 (formal) - Falls – Moderate to Severe Harm (per 1000 bed days) - WUTH Average CSW Day Staffing Fill rates - MRSA Cases - MSSA Cases - NEWS2 Compliance - Appraisal % Compliance - 4-hour ED Target (including APH UTC) - 12 hr waits from arrival in ED - RTT – total open pathway waiting list - Cancer waits - % receiving first definitive treatment within 31 days of decision to treat - Cancer waits – 62 days to treatment (monthly) - Cancer – Faster Diagnosis Standard - Diagnostic Waiters, 6 weeks and over – DM01	- FFT Overall experience of very good & good: ED - Sickness absence % - in month rate - 12 hr waits from decision to admit in ED - Ambulance Handovers % <30mins - Ambulance Handovers % <45 mins - Cancer waits – 2 week referrals (monthly)	- Non-pay run rate - Non-contract income – Run Rate - Number of inpatients not meeting the criteria to reside
Special Cause Concerning	- % of adult patients VTE risk-assessed on admission	- Mortality (SHMI) - Mandatory Training % compliance	- Staff Vacancy as % of workforce - Long length of stay – number of patients in hospital for 21 or more days	- FOI – Waiting List - Patient Safety Incidents

NHS Oversight Framework (NOF) Dashboard Q3, 25-26

Wirral University Teaching Hospital

TABLE 1: SCORED METRICS (Contributing to Segmentation

		2025/26 - Qtr 3 Metric Performance					Metric Value Quartiles 2025/26 Q3					Domain Performance Qtr 3		2025/26 - Qtr 2 Metric Performance				Domain Performance Qtr 2	
Metric	**Type**	**Metric Value**	**Provider Rank**	**Time Period**	**Performance Trajectory**	**Metric Target**	**Quartile 1**	**Quartile 2**	**Quartile 3**	**Quartile 4**	**Quartile Threshold *(Improve to the left)***	**NOF Score**	**Segment Quartile**	**Metric Value**	**Provider Rank**	**Time Period**	**Metric Value Quartiles**	**NOF Score**	**Segment Quartile**
ACCESS TO SERVICES DOMAIN																			
% patients waiting <18 weeks (absolute)	Acute	59.30%	81/131	Dec-25	↓	61.70%			59.30%		60.9% to 57.45%	3.13	4	61.70%	61/131	Sep-25	2	2.51	3
% patients waiting <18 weeks (vs plan)	Acute	-2.36%	82/131	Dec-25	↓	0%			-2.36%		-1.82% to -3.82%			1.57%	36/131	Sep-25	2		
% patients waiting >52 weeks	Acute	2.22%	87/131	Dec-25	↓	1.39%			2.22%		1.56% to 2.43%			2.36%	74/131	Sep-25	3		
% patients waiting >52 weeks (community)	Community	*	-	-	☒	-					-			*	-	-	*		
% urgent referrals diagnosed within 28 Days	Acute	67.72%	107/118	To Dec 2025	↑	79.34%				67.72%	74.84% to 0%			67.54%	101/118	Q2 2025/26	4		
% patients treated within 62 days	Acute	72.86%	51/118	To Dec 2025	↓	77.26%		72.86%			77.92% to 71.48%			75.36%	34/118	Q2 2025/26	2		
% A&E patients seen within 4 hours	Acute	70.83%	87/123	To Dec 2025	↓	63.89%			70.83%		73.05% to 70.07%			72.10%	88/123	Q2 2025/26	3		
% A&E attendances >12 hours	Acute	22.74%	122/123	To Dec 2025	↓	21.71%				22.74%	10.58% to 100%			21.93%	116/119	Q2 2025/26	4		
EFFECTIVENESS & EXPERIENCE DOMAIN																			
Summary Hospital Level Mortality Indicator	Acute	2	-	Oct24 - Sep25	⇔							1.94	2	2		Jul-24- Jun-25		2	2
Discharge delays (bed days lost) - including zero days	Acute	0.54	35/127	Dec-25	↑	-		0.54			0.51 to 0.83			0.63	39/126	Jun-25	New Q3		
CQC inpatient satisfaction	Acute	2	-	2024	⇔									2	2	Dec-25			
PATIENT SAFETY DOMAIN																			
Staff survey - raising concerns	Acute	6.17	113/134	2024	⇔					6.17	6.24 to 0	3.04	4	6.17	113/134	2024	4	3.22	4
MRSA infections (rate)	Acute	2	-	To Dec 2025	⇔	0		2			1.25 to 3			2	39/134	Oct-24-Sep 25	2		
C-Difficile infections (rate)	Acute	1.22	-	To Dec 2025	↑	<1			1.22		1.12 to 1.31			1.5	116/134	Oct-24-Sep 25	4		
E-Coli infections (rate)	Acute	1.12	-	To Dec 2025	↑	<1		1.12			1.06 to 1.17			1.16	63/134	Oct-24-Sep 25	2		
PEOPLE & WORKFORCE DOMAIN																			
Sickness absence rate	Acute	6.03%	123/134	To Sep 2025	↓	-				6.03%	5.5% to 100%	3.54	4	5.74%	120/205	Q1 2025/26	4	3.54	4
Staff survey engagement score	Acute	6.56	119/134	Dec-24	⇔	-				6.56	6.71 to 0			6.56	119/134	Dec-24	4		
FINANCE & PRODUCTIVITY DOMAIN																			
Combined finance score (planned vs variance)	All Trusts	4	-	Q3 2025/26	⇔					4		3.47	4	4		Q2 2025/26	4	3.33	4
Planned surplus/deficit	Acute	-4.45%	104/134	Apr-25	⇔	Breakeven/ Surplus				-4.45%	-3.99% to 100%			-4.45%	104/134	Apr-25	4		
Variance YTD to plan	Acute	-3.62%	125/134	Dec-25	↑	>0%				-3.62%	-3.62% to 100%			-3.69%	130/134	Sep-25	4		
Implied productivity level	Acute	1.50%	87/134	Sep-25	↑				1.50%		2.6% to 0.75%			1.06%	75/134	Jun-25	3		

*** Data not submitted for % patients waiting >52 weeks (community) due to data quality issues and services changes**

WCHC Indicators Dashboard

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	Apr 26	12.8%	10.4%			12.5%
Mandatory Training Compliance	Apr 26	94.8%	90.0%			95.0%
Sickness Absence	Apr 26	6.4%	5.0%			6.5%
Sickness Absence (Short Term)	Apr 26	1.2%	2.0%			1.6%
Sickness Absence (Long Term)	Apr 26	5.2%	3.0%			4.9%
Agency usage	Apr 26	0.3%	1.0%			0.9%
Variance to Agency Cap (£)	Apr 26	-203784.4	-			-175005.4
% of Agency Usage against Funded WTE	Apr 26	0.00%	-			0.6%
% of Bank Usage against Funded WTE	Apr 26	4.40%	-			3.4%
% of Contracted FTE Vacancies	Apr 26	3.8%	6.0%			5.1%
WIC & UTC Attendances seen within 4 hrs	Apr 26	96.8%	95.0%			96.1%
CICC Occupancy Rate (Commissioned Beds)	Apr 26	97.3%	92.0%			92.2%
CICC Median LoS (Active Beds Daily Snapshot)	Apr 26	16.3	21.0			18.7
Urgent Community Response - 2 hours	Apr 26	88.3%	70.0%			87.5%
GPOOH - UCAT Response Times (60 min response)	Apr 26	98.4%	98.0%			98.7%
GPOOH - UCAT Response Times (15 min response)	Apr 26	73.4%	65.0%			68.4%
GPOOH - UCAT Response Times (30 min response)	Apr 26	91.5%	90.0%			92.8%
GPOOH - CAS Response Times (20 min response)	Apr 26	69.4%	75.0%			69.5%
GPOOH - CAS Response Times (2hr response)	Apr 26	68.6%	90.0%			69.8%
GPOOH - NHS111 Response Times	Apr 26	66.4%	75.0%			60.2%
RTT - % of Patients Seen Within 18 Weeks	Apr 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	Apr 26	99.5%	99.0%			100.0%
UTC Attendances seen within 4 hrs	Apr 26	96.9%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	Apr 26	95.9%	95.0%			94.4%
Eastham Attendances seen within 4 hrs	Apr 26	98.6%	95.0%			93.6%
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)	Apr 26	0	0			0
No. of incidents reported	Apr 26	416	475			477
Patient Safety Incidents	Apr 26	174	200			201
Never events	Apr 26	0	0			0
No. of ICO reportable IG incidents	Apr 26	0	0			0
Total Complaints Received	Apr 26	4	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	Apr 26	0	0			0
Missed medication incidents resulting in moderate or severe harm with safety syster	Apr 26	0	0			0
No. of incidents reported with a moderate and above harm level with safety systems	Apr 26	0	0			0
Clostridium difficile infections resulting in moderate or severe harm with learning ide	Apr 26	0	0			0
MRSA infections with learning identified for the Trust	Apr 26	0	0			0
Falls resulting in moderate or above harm	Apr 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	Apr 26	0.0%	4.6%			1.4%
No. of concerns received in month	Apr 26	11	12			12
FFT - % of People who would recommend our services	Apr 26	90.1%	90.0%			91.6%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	Apr 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	Apr 26	0	0			0
No. of reported no and low harm patient safety incidents	Apr 26	166	200			189
I&E Position	Apr 26	£0.2m	£1.9m			
Cumulative CIP	Apr 26	£0.2m	£6m			
Capital Expenditure	Apr 26	£0.1m	£4.8m			
Cash Position	Apr 26	£17.5m	£9m			
Agency usage	Apr 26	0.3%	0.1%			

WCHC Scorecard Matrix

		Assurance			
		Consistently Hits Target	Hit and Miss Target, subject to random variation	Consistently Fails Target	No target set/insufficient data points
Variation	Special Cause improving	RTT - % of Patients Seen Within 18 Weeks	CICC Median LoS (Active Beds Daily Snapshot) Serious untoward incidents – reported via StEIS (Exc. IPC Contract) Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust Serious untoward incidents – reported via StEIS (IPC Contract) Agency Usage		% of Agency Usage against Funded WTE
	Common Cause	Urgent Community Response – 2 hours Mandatory Training Compliance	WIC & UTC Attendances seen within 4 hrs CICC Occupancy Rate (Commissioned Beds) GPOOH – UCAT Response Times (60 min response) GPOOH – UCAT Response Times (15 min response) GPOOH – UCAT Response Times (30 min response) GPOOH – CAS Response Times (20 min response) GPOOH – NHS111 Response Times VCHC Attendances seen within 4 hrs Eastham Attendances seen within 4 hrs Patient Safety Incidents Never events No. of ICO reportable IG incidents Total Complaints Received Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust No. of Incidents reported with a moderate and above harm level with safety systems learning identified for the Trust Clostridium difficile infections resulting in moderate or severe harm with learning identified in relation to patient safety systems MRSA infections with learning identified for the Trust Falls resulting in moderate or above harm No. of concerns received in month Falls resulting in moderate or above harm per 1,000 Occupied Bed Days No. of reported no and low harm patient safety incidents Sickness Absence (Short Term) % of Contracted FTE Vacancies	Sickness Absence Sickness Absence (Long Term)	% of Bank Usage against Funded WTE
	Special Cause Concerning	DM01 - % of Patients Waiting with a Wait Under 6 weeks UTC Attendances seen within 4 hrs	No. of Incidents reported FFT - % of People who would recommend our services	GPOOH – CAS Response Time (2hr response) % of all incidents with moderate and above harm level relating to Trust Turnover Rolling 12 Months	Variance to Agency Cap (£)

NHS Oversight Framework (NOF) Dashboard Q3, 25-26

Wirral Community Health and Care NHS Foundation Trust

TABLE 1: SCORED METRICS (Contributing to Segmentation)

		2025/26 - Qtr 3 Metric Performance					Metric Value Quartiles 2025/26 Q3					Domain Performance Qtr 3		2025/26 - Qtr 2 Metric Performance				Domain Performance Qtr 2	
Metric	**Type**	**Metric Value**	**Provider Rank**	**Time Period**	**Performance Trajectory**	**Metric Target**	**Quartile 1**	**Quartile 2**	**Quartile 3**	**Quartile 4**	**Metric Quartile Threshold *(Improve to the left)***	**NOF Score**	**Segment Quartile**	**Metric Value**	**Provider Rank**	**Time Period**	**Metric Value Quartiles**	**NOF Score**	**Segment Quartile**
ACCESS TO SERVICES DOMAIN																			
% patients waiting >52 weeks (community)	Community	0.0%	1/41	Q3 2025/26	⇔	-	1				0 to 0.02	1	1	0.0%	1/41	Q2 2025/26	1	1	1
EFFECTIVENESS & EXPERIENCE DOMAIN																			
Urgent Community Response 2-hour performance	Community	85.92%	21/38	Q3 2025/26	↓	70%			2.11		88.86% to 79.80%	2.11	2	90.17%	13/38	Q2 2025/26	2	1.68	1
PATIENT SAFETY DOMAIN																			
Staff survey - raising concerns	Acute/Community	6.94	18/61	2024	⇔	-		1.85			6.95 to 6.81	1.85	1	6.94	18/61	2024	1	1.93	1
CQC safe inspection score	Acute/Community	2	2	2023	⇔	-		2						2	2	2023	2		
PEOPLE & WORKFORCE DOMAIN																			
Sickness absence rate	Acute/Community	7.45%	58/61	Q2 2025/26	↓	-				3.94	6.52% to 7.95%	3.37	4	6.46%	54/61	Q1 2025/26	3	3.13	4
Staff survey engagement score	Acute/Community	7.02	37/61	Dec-24	⇔	-			2.8		7.08 to 6.95			7.02	37/61	Dec-24	3		
FINANCE & PRODUCTIVITY DOMAIN																			
Planned surplus/deficit	Acute/Community	0.85%	6/61	Q3 2025/26	⇔	Breakeven/ Surplus	1				2.39 to 0	1.09	1	0.85%	6/61	Q2 2025/26	1	1	1
Variance YTD to plan	Acute/Community	2.27%	1/61	Dec-25	↑	-	1				2.27 to 0.21			2.04%	2/61	Sep-25	1		

CMO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
% of adult patients VTE risk-assessed on admission	Apr 26	96.4%	≥95%			97.2%
Never Events	2026/27	0	≤0			
NEWS2 Compliance	Apr 26	90.4%	≥90%			89.3%
Mortality (SHMI)	Dec 25	1.060	>=0.95			1.024

Highlights

Percentage of adult patients having a completed VTE risk assessment on admission remains within target with 96.4 % compliance in month and a mean of 97.2%

There are no reported Never Events for this financial year. The last reported Never Event was in June 2025

NEWS 2 compliance at 90.4% in month with mean at 89.3%

SHIM remains in as expected range, although there has been an upward trend due to coding backlog issues

Areas of Concern

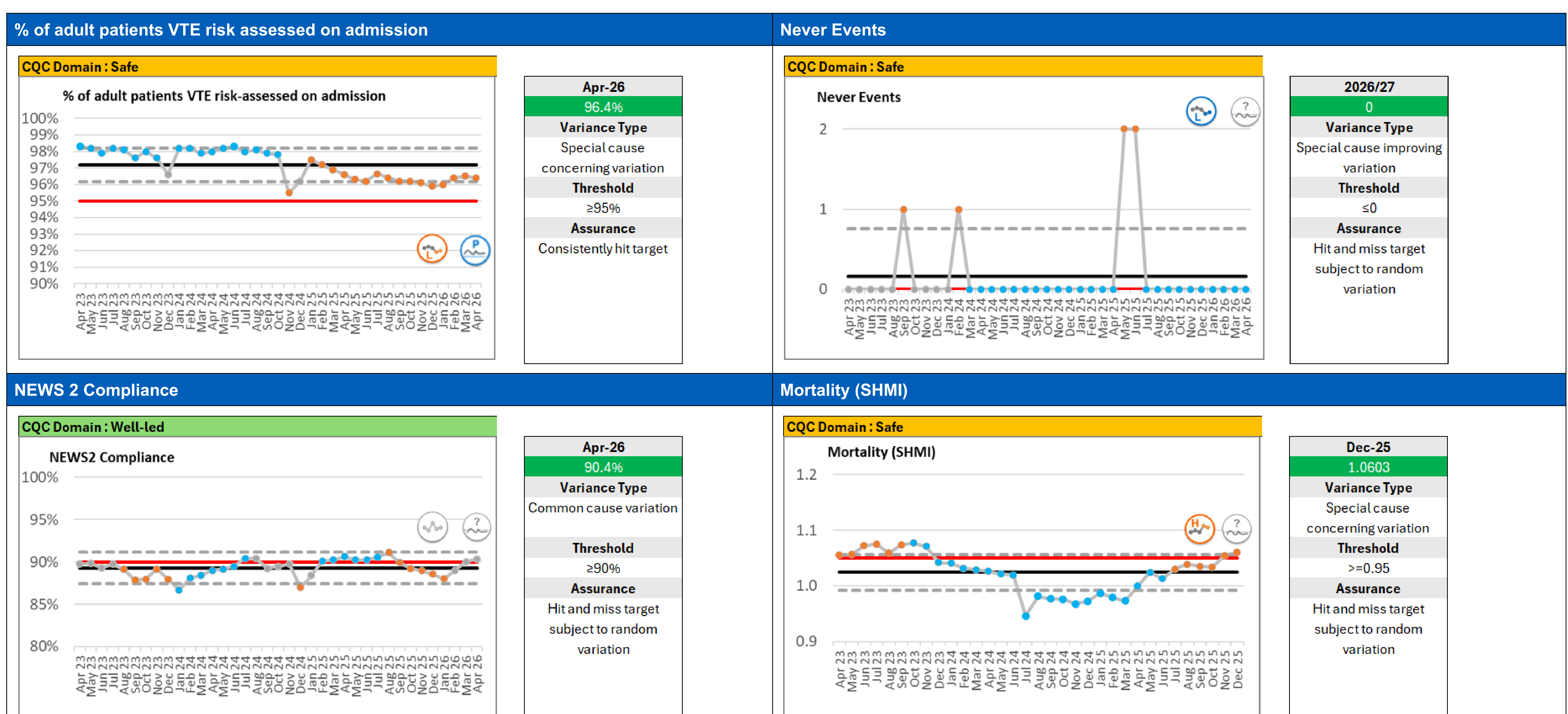
Forward Look (Actions)

Continued focus on areas of lower compliance.
Planned move to new risk assessment tool in January 2027
Will strengthen prescription of VTE prophylaxis

Electronic LocSSIP to be introduce from June, completing the final open action on the LocSSIP action plan

Ward level breakdown of compliance available on live dashboard and monitored at DQB and DPR

Continued monitoring of mortality trends through MRG .
Coding backlog now cleared

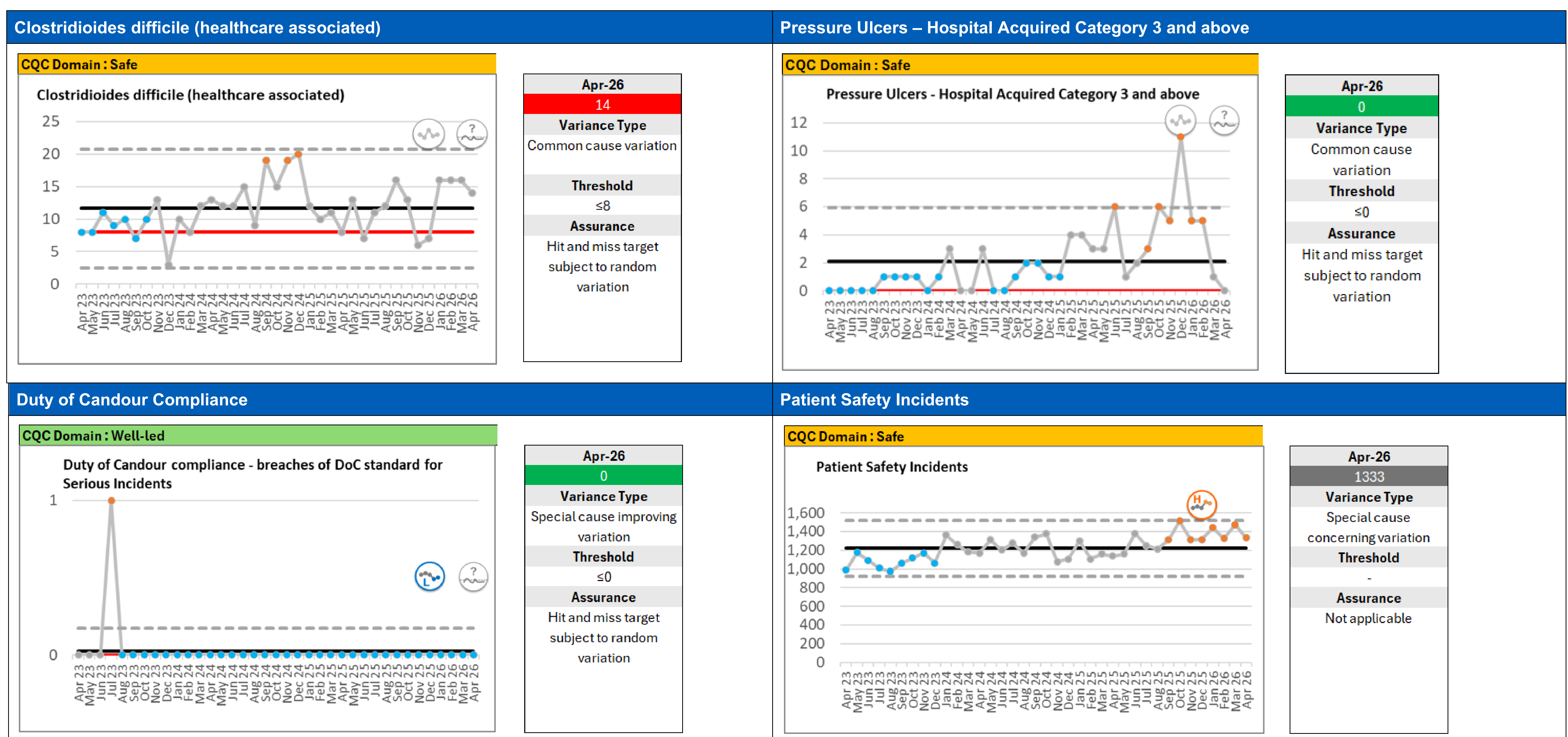

% of adult patients VTE risk assessed on admission
CQC Domain : Safe
% of adult patients VTE risk-assessed on admission
100% 99% 98% 97% 96% 95% 94% 93% 92% 91% 90%
Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26 Mar 26 Apr 26
Apr-26
96.4%
Variance Type
Special cause concerning variation
Threshold
≥95%
Assurance
Consistently hit target
Never Events
CQC Domain : Safe
Never Events
2 1 0
Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26 Mar 26 Apr 26
2026/27
0
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation
NEWS 2 Compliance
CQC Domain : Well-led
NEWS2 Compliance
100% 95% 90% 85% 80%
Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26 Feb 26 Mar 26 Apr 26
Apr-26
90.4%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation
Mortality (SHMI)
CQC Domain : Safe
Mortality (SHMI)
1.2 1.1 1.0 0.9
Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25
Dec-25
1.0603
Variance Type
Special cause concerning variation
Threshold
>=0.95
Assurance
Hit and miss target subject to random variation

CNO Quality and Safety Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Clostridioides difficile (healthcare associated)	Apr 26	14	≤8			12
Pressure Ulcers - Hospital Acquired Category 3 and above	Apr 26	0	≤0			2
Duty of Candour compliance - breaches of DoC standard for Serious Incidents	Apr 26	0	≤0			0
Patient Safety Incidents	Apr 26	1333	-			1222
FFT Overall experience of very good & good: ED	Apr 26	73.3%	≥95%			75.7%
FFT Overall experience of very good & good: Inpatients	Apr 26	96.9%	≥95%			95.6%
FFT Overall experience of very good & good: Outpatients	Apr 26	97.0%	≥95%			95.5%
FFT Overall experience of very good & good: Maternity	Apr 26	96.9%	≥95%			96.1%
Patient Experience: concerns received in month - Level 1 (informal)	Apr 26	283	≤173			233
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)	Apr 26	3	≤3			3
Falls – Moderate to Severe Harm	Apr 26	0.14	≤0			0.14
WUTH Average RN Day Staffing Fill Rates	Apr 26	92.0%	≥90%			89.1%
WUTH Average RN Night Staffing Fill Rates	Apr 26	95.0%	≥90%			90.8%
WUTH Average CSW Day Staffing Fill Rates	Apr 26	91.0%	≥90%			87.2%
WUTH Average CSW Night Staffing Fill Rates	Apr 26	104.0%	≥90%			99.8%
MRSA Cases	Apr 26	0	≤0			0
MSSA Cases	Apr 26	2	≤0			2

Clostridioides difficile (healthcare associated)		
Highlights In April there were 14 cases of *C.diff* which is a slight reduction from previous months. Of the 14 cases, there were 11 HOHA and 6 COHA CDTs. 1 patient was known to have a history of CDT/CDE, and 7 patients had known exposure to CDT/CDE.	**Areas of Concern** • Ward outbreak detected from sentinel surveillance on ward 25 • Delay in obtaining stool samples • Delay in isolation due to high levels of occupancy	**Forward Look (Actions)** • Task & Finish Group planned for May to discuss reactive use of HPV in place of Misting for CDT/CDE patients • Development of a Trust wide CDI improvement plan
Pressure Ulcers Hospital acquired Category 3 and above		
Highlights There have been no Category 3 or 4 pressure ulcers reported in April 2026	**Areas of Concern** • Incomplete Purpose T on admission • Documentation on description of pressure ulcer (wound assessment completed) • Categorisation of pressure ulcers • Correct use of equipment and availability • Use of Medical Photography on detection of pressure damage or ongoing monitoring.	**Forward Look (Actions)** • Quality Improvement Project- collaborative with • focus areas. • Review of pressure relieving equipment usage and availability • Review of education and delivery.
Friends and Family Test		
Highlights Overall experience in ED remains consistently below target	**Areas of Concern** • Themes related to waiting times and poor experience/; environment whilst waiting	**Forward Look (Actions)** • Opening of new department planned for July 26 with improved waiting area • Corridor Care Summit held with overarching action plan

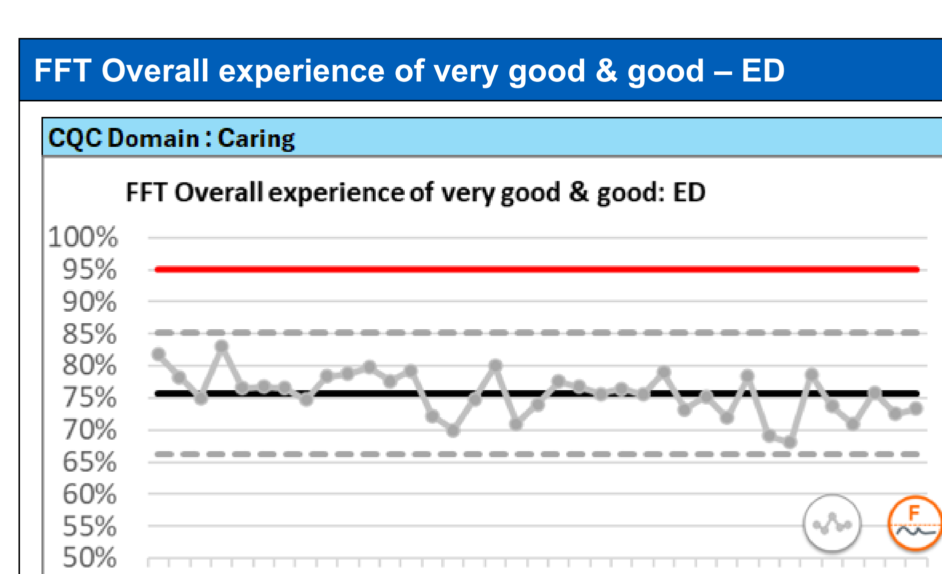
<table>
<tr><th>Complaints</th><th></th><th></th></tr>
<tr><td>Highlights
• Reduction in both informal concerns (289 vs 310) and formal complaints (20 vs 30), indicating a moderation in activity at the start of 2026/27.
• Overall activity remains above historical norms, with informal concerns continuing to represent sustained pressure across services.
• Backlog position improved, with open complaints reduced (87 vs 100) and overdue cases decreasing (39 vs 47).
• Emergency Department remains the most significant single hotspot across both reporting routes, although activity is broadly distributed across services.</td><td>Areas of Concern
• Timeliness performance deteriorated significantly, with compliance within 40 working days falling to 15% (from 32%) and average response times increasing to 76 days.
• Despite reduced caseload, backlog pressures persist, indicating ongoing challenges in case complexity and flow through the system.
• Variability in divisional performance and investigation quality continues to impact consistency and prolong resolution times.
• Elevated activity remains concentrated in Access & Admission, Communication, and Treatment & Procedure themes, reflecting continued operational pressure.</td><td>Forward Look (Actions)
• Maintain focus on increasing weekly closure rates and improving consistency of case progression to reduce overdue complaints further.
• Continue delivery of the Complaints Improvement Plan, including strengthened divisional ownership and governance arrangements.
• Sustain targeted training and performance oversight to improve investigation quality, timeliness, and standardisation.
• Prioritise clearance of older and high-risk cases to support recovery in 40-working-day compliance and reduce average response times.</td></tr>
<tr><th>Falls – Moderate to Severe Harm</th><th></th><th></th></tr>
<tr><td>Highlights
Good uptake with face to face hoverjack training by ward areas and staff are using it more frequently than they previously had</td><td>Areas of Concern
3 falls with harm reported over April – 2 fractured neck of Femur and 1 subdural haematoma
38% of patients who fell had assistive technology in place
Neurological observations not being undertaken as per policy.</td><td>Forward Look (Actions)
New falls policy has been written and incorporates NICE guidance giving clearer direction for neurological observations as current policy is ambiguous – awaiting review at fundamentals of care.
Awareness of neurological observations has been added to the patient safety study days.</td></tr>
<tr><th>Staffing</th><th></th><th></th></tr>
<tr><td>Highlights
All fill rates above threshold for CSW and RN day and night.</td><td>Areas of Concern
Although improving position for CSW day fill rate- remains area of focus.
Successful ED CSW recruitment event
Staffing escalation areas outside of core establishment an ongoing challenge.</td><td>Forward Look (Actions)
Support for ongoing CSW recruitment events planned
Training / progression plans to support CSW retention
Plan for recruitment of newly qualified RNs in progress</td></tr>
<tr><th>MRSA/MSSA Cases</th><th></th><th></th></tr>
<tr><td>Highlights
In April, there were 0 cases of MRSA bloodstream infections reported. 2 MSSA bloodstream infections were reported in April, both community onset hospital associated (COHA). Of the 2 cases, 1 infection was potentially line related in a child with complex medical needs, the child was known to have had a previous bloodstream infection.</td><td></td><td></td></tr>
</table>

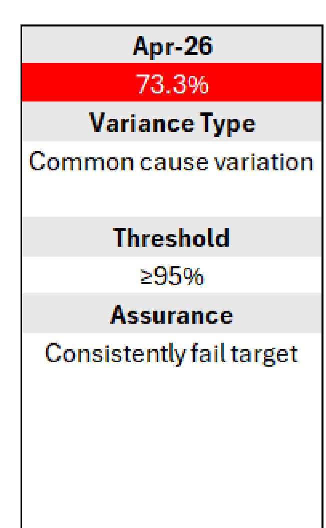


Clostridioides difficile (healthcare associated)
CQC Domain : Safe
Clostridioides difficile (healthcare associated)
Apr-26
14
Variance Type
Common cause variation
Threshold
≤8
Assurance
Hit and miss target subject to random variation
Pressure Ulcers – Hospital Acquired Category 3 and above
CQC Domain : Safe
Pressure Ulcers - Hospital Acquired Category 3 and above
Apr-26
0
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation
Duty of Candour Compliance
CQC Domain : Well-led
Duty of Candour compliance - breaches of DoC standard for Serious Incidents
Apr-26
0
Variance Type
Special cause improving variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation
Patient Safety Incidents
CQC Domain : Safe
Patient Safety Incidents
Apr-26
1333
Variance Type
Special cause concerning variation
Threshold
-
Assurance
Not applicable

FFT Overall experience of very good & good – ED

CQC Domain : Caring

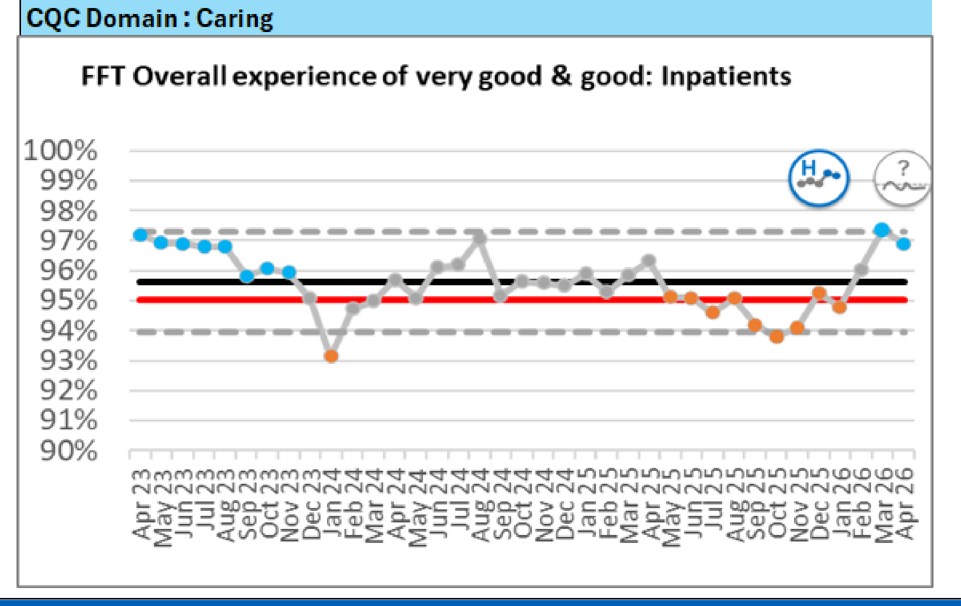


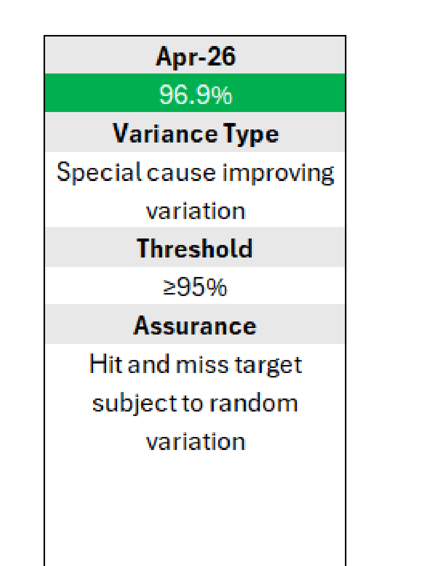


Apr-26
73.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Consistently fail target

FFT Overall experience of very good & good – Inpatients

CQC Domain : Caring

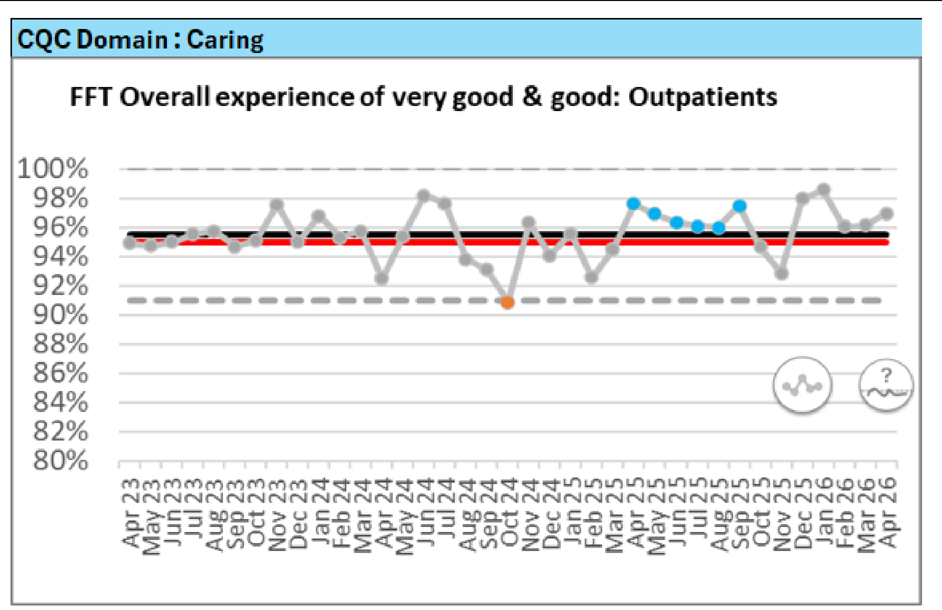


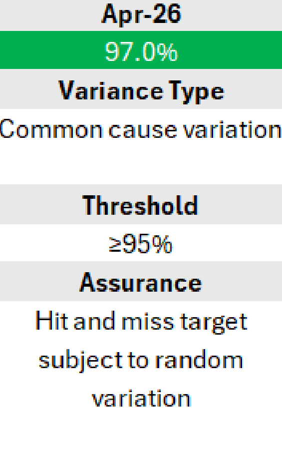


Apr-26
96.9%
Variance Type
Special cause improving variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

FFT Overall experience of very good & good – Outpatients

CQC Domain : Caring

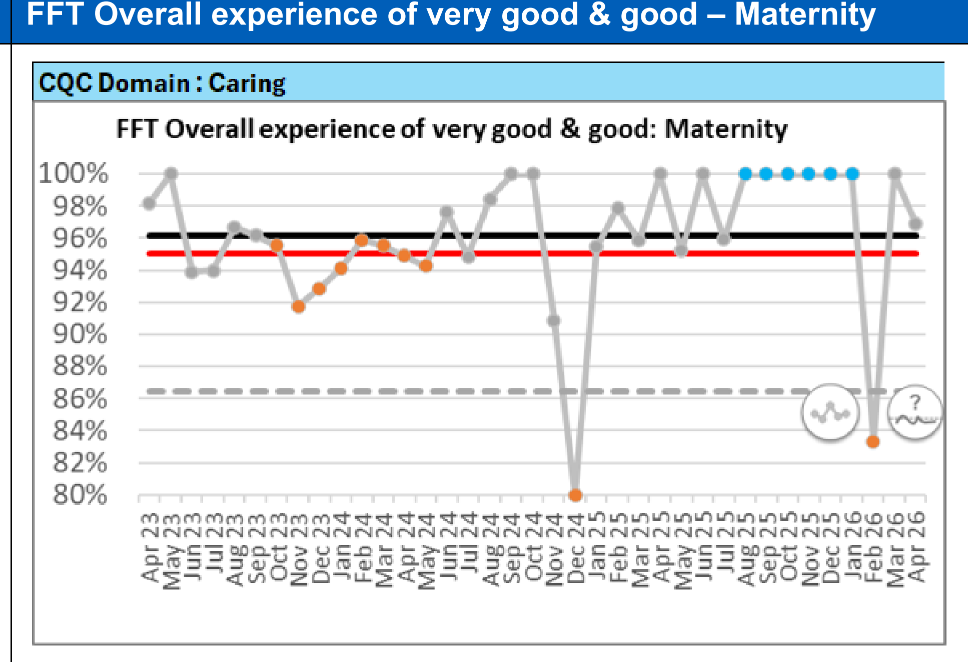


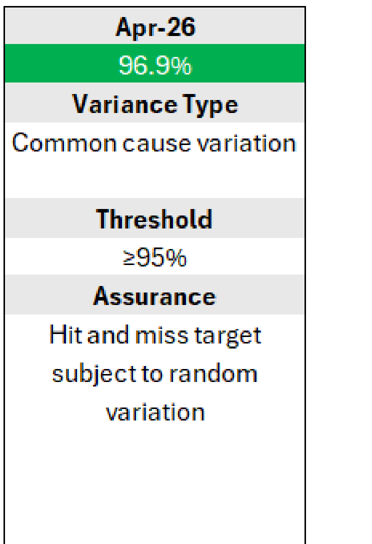


Apr-26
97.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation

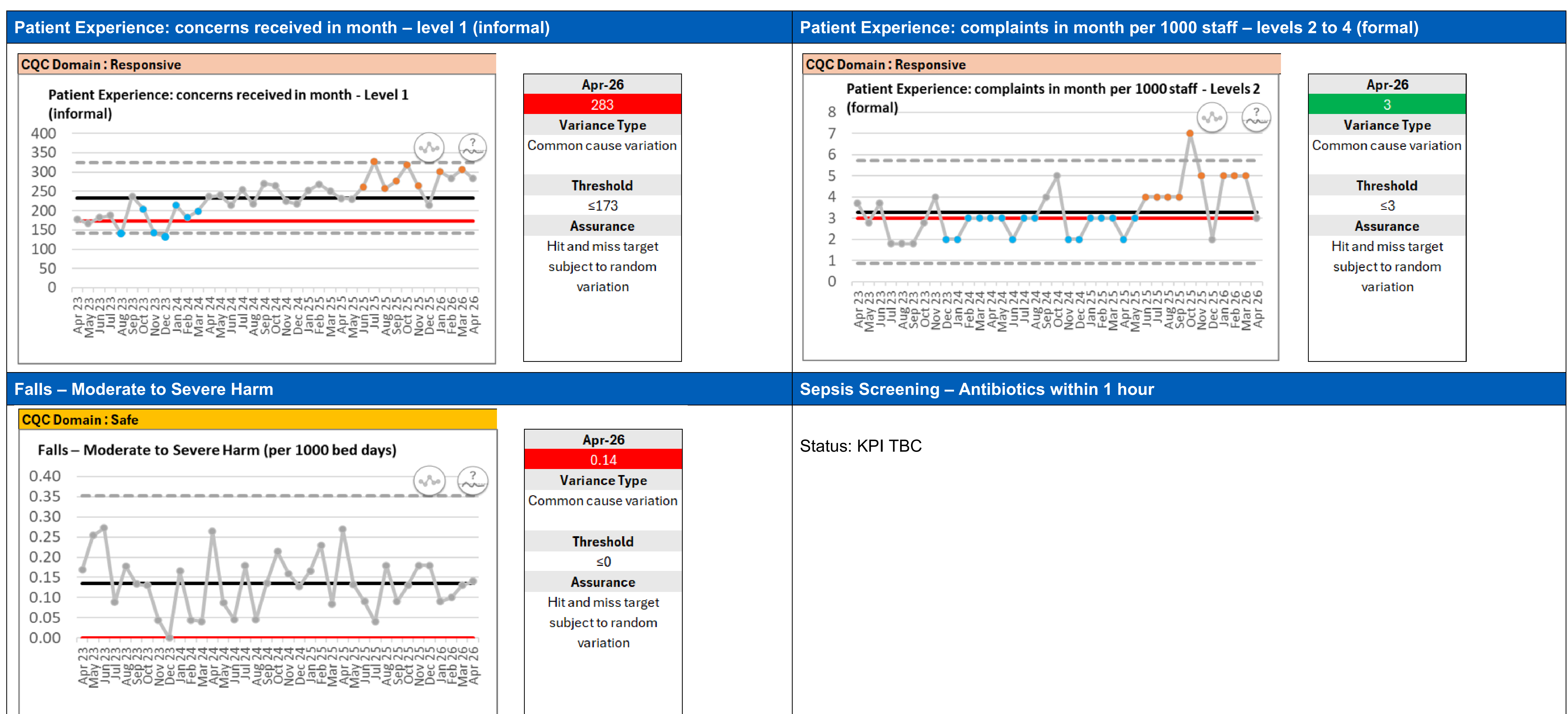
FFT Overall experience of very good & good – Maternity

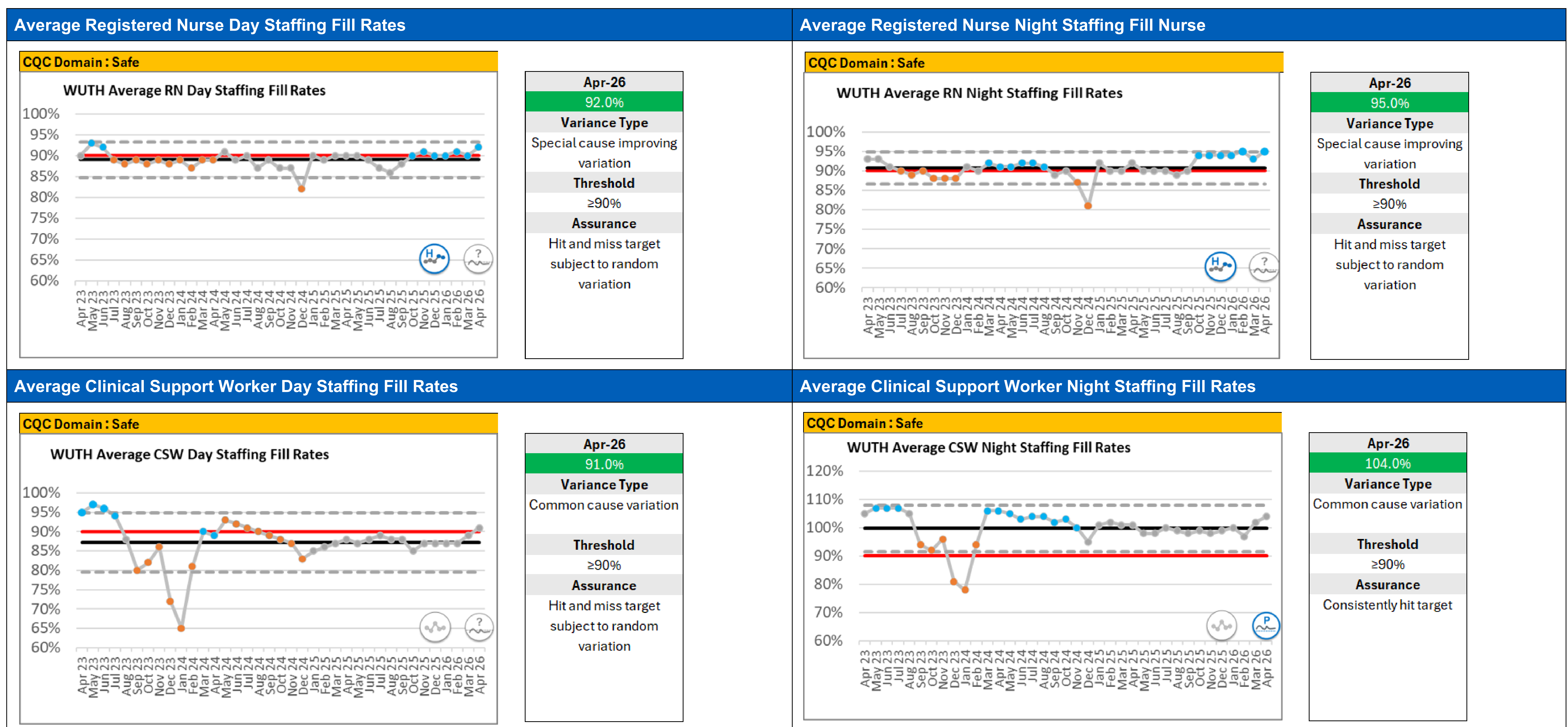
CQC Domain : Caring

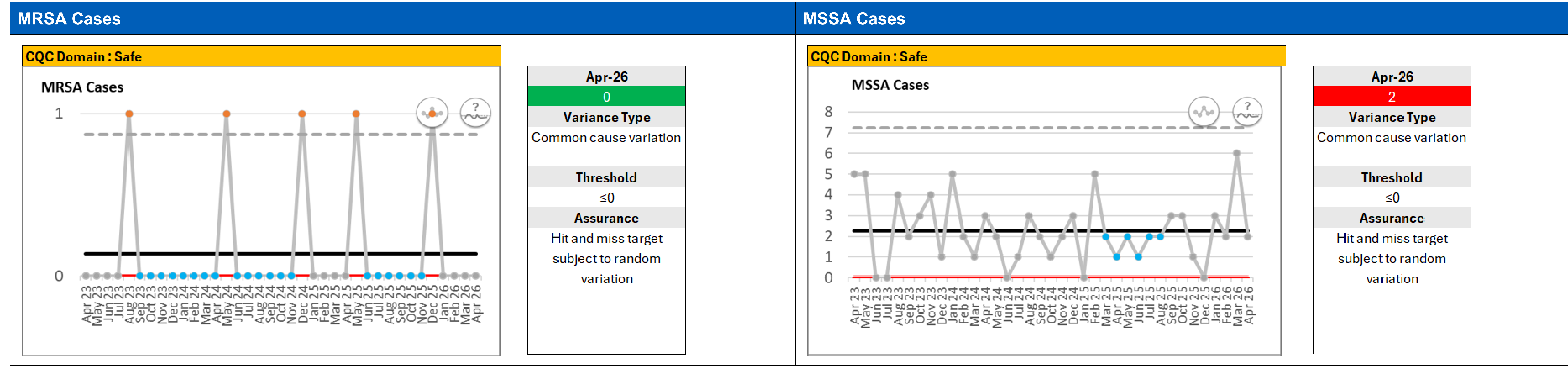




Apr-26
96.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit and miss target subject to random variation


Patient Experience: concerns received in month – level 1 (informal)
CQC Domain : Responsive
Patient Experience: concerns received in month - Level 1 (informal)
Apr-26
283
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
Patient Experience: complaints in month per 1000 staff - Levels 2 (formal)
Apr-26
3
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit and miss target subject to random variation
Falls – Moderate to Severe Harm
CQC Domain : Safe
Falls – Moderate to Severe Harm (per 1000 bed days)
Apr-26
0.14
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


Average Registered Nurse Day Staffing Fill Rates
CQC Domain : Safe
WUTH Average RN Day Staffing Fill Rates
Apr-26
92.0%
Variance Type
Special cause improving variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation
Average Registered Nurse Night Staffing Fill Nurse
CQC Domain : Safe
WUTH Average RN Night Staffing Fill Rates
Apr-26
95.0%
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
WUTH Average CSW Day Staffing Fill Rates
Apr-26
91.0%
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
WUTH Average CSW Night Staffing Fill Rates
Apr-26
104.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Consistently hit target



MRSA Cases
CQC Domain : Safe
MRSA Cases
1
0
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
Apr 26
Apr-26
0
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation
MSSA Cases
CQC Domain : Safe
MSSA Cases
8
7
6
5
4
3
2
1
0
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
Apr 26
Apr-26
2
Variance Type
Common cause variation
Threshold
≤0
Assurance
Hit and miss target subject to random variation

Quality and Governance Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)	Apr 26	0	0			0
No. of Incidents reported	Apr 26	416	475			477
Patient Safety Incidents	Apr 26	174	200			201
Never events	Apr 26	0	0			0
No. of ICO reportable IG incidents	Apr 26	0	0			0
Total Complaints Received	Apr 26	4	3			3
Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust	Apr 26	0	0			0
Missed medication incidents resulting in moderate or severe harm with safety s	Apr 26	0	0			0
No. of Incidents reported with a moderate and above harm level with safety sys	Apr 26	0	0			0
Clostridium difficile infections resulting in moderate or severe harm with learnin	Apr 26	0	0			0
MRSA infections with learning identified for the Trust	Apr 26	0	0			0
Falls resulting in moderate or above harm	Apr 26	0	0			0
% of all incidents with moderate and above harm level relating to Trust	Apr 26	0.0%	4.6%			1.4%
No. of concerns received in month	Apr 26	11	12			12
FFT - % of People who would recommend our services	Apr 26	90.1%	90.0%			91.6%
Falls resulting in moderate or above harm per 1,000 Occupied Bed Days	Apr 26	0.00	0.00			0.13
Serious untoward incidents - reported via StEIS (IPC Contract)	Apr 26	0	0			0
No. of reported no and low harm patient safety incidents	Apr 26	166	200			189

Highlights

The matrix provides assurance that a positive patient safety system exists across the Trust delivered through a robust quality governance framework. This is evidenced by the patient safety outcomes achieved. The following quality and safety metrics are **all reporting zero** for April 2026:

- Serious untoward incidents
- Never events
- ICO reportable IG incidents
- Category 3 & 4 pressure ulcers with safety systems learning identified for the Trust
- Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust
- IPC incidents with safety systems learning identified for the Trust
- Falls resulting in moderate or above harm

The Trust's FFT score for M1 is green RAG rated at 90.1%.

Areas of Concern

During M1, the following areas are reporting a red RAG rated position:

- Number of incidents reported
- Number of patient safety incidents reported
- Total complaints received

Total number of incidents is reporting a position of concerning special cause variation; however, this is improving, with incident reporting increasing over the last two consecutive months. Communications across Trust services continue to be disseminated, highlighting the importance of incident reporting to support a learning culture.

Patient safety incident reporting and complaints received are both reporting common cause variation. Robust monitoring remains in place, with no new themes or trends identified.

Forward Look (Actions)

The red RAG rated areas continue to be closely monitored throughout the Trust's governance framework to identify action to deliver improvement.

Clinical Risk Management Group continue to track improvement plans, with new quality improvement driver diagrams for 2026/27 being developed for the following joint quality priorities:

- Pressure Ulcers
- Falls
- Medications
- Discharge
- Infection prevention and control

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

CQC Domain : Safe

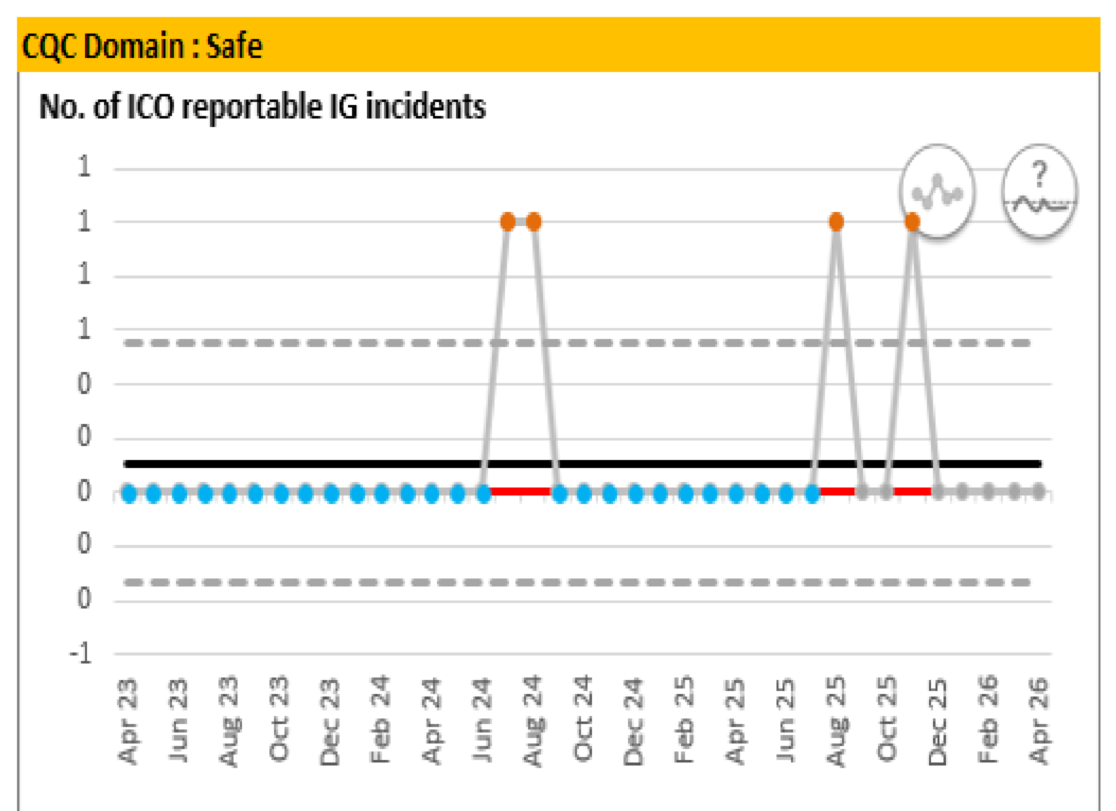
Serious untoward incidents - reported via StEIS (Exc. IPC Contract)

1 1 1 1 0 0 0 0

Apr 23 Jun 23 Aug 23 Oct 23 Dec 23 Feb 24 Apr 24 Jun 24 Aug 24 Oct 24 Dec 24 Feb 25 Apr 25 Jun 25 Aug 25 Oct 25 Dec 25 Feb 26 Apr 26

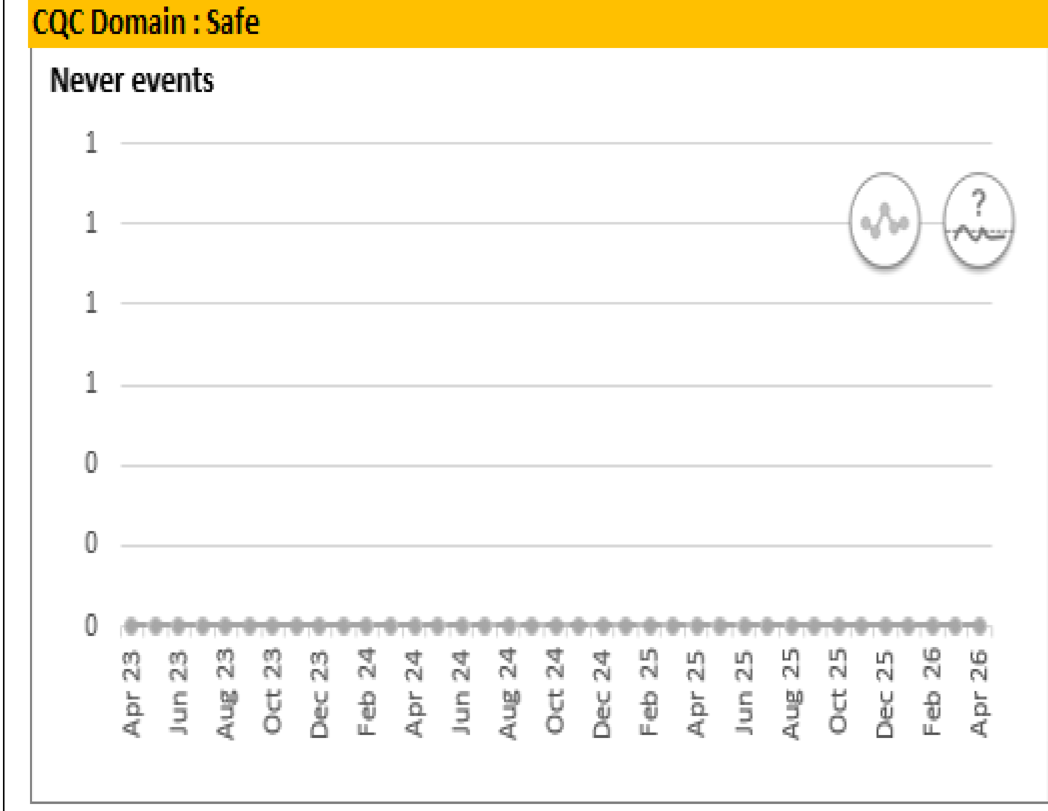
Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

No. of ICO reportable IG incidents



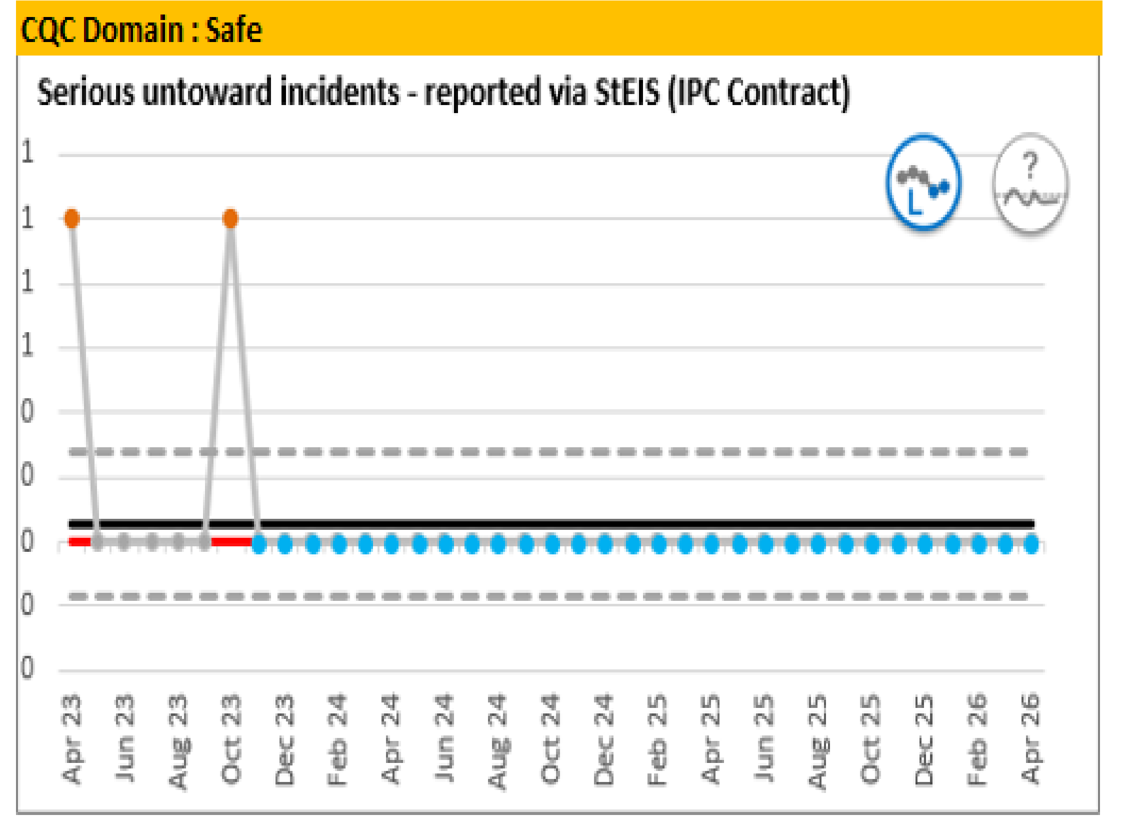
Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Never events



Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

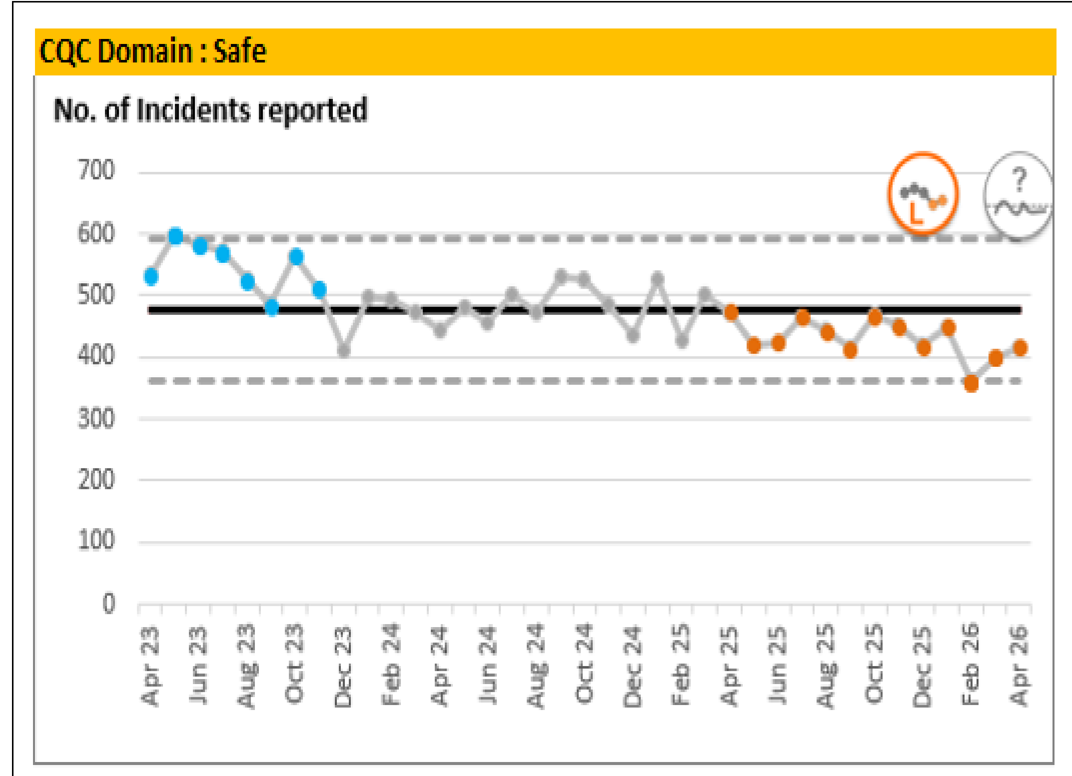
Serious untoward incidents – reported via StEIS (IPC Contract)



Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Number of Incidents reported

Patient Safety Incidents



Apr-26

416

Variance Type

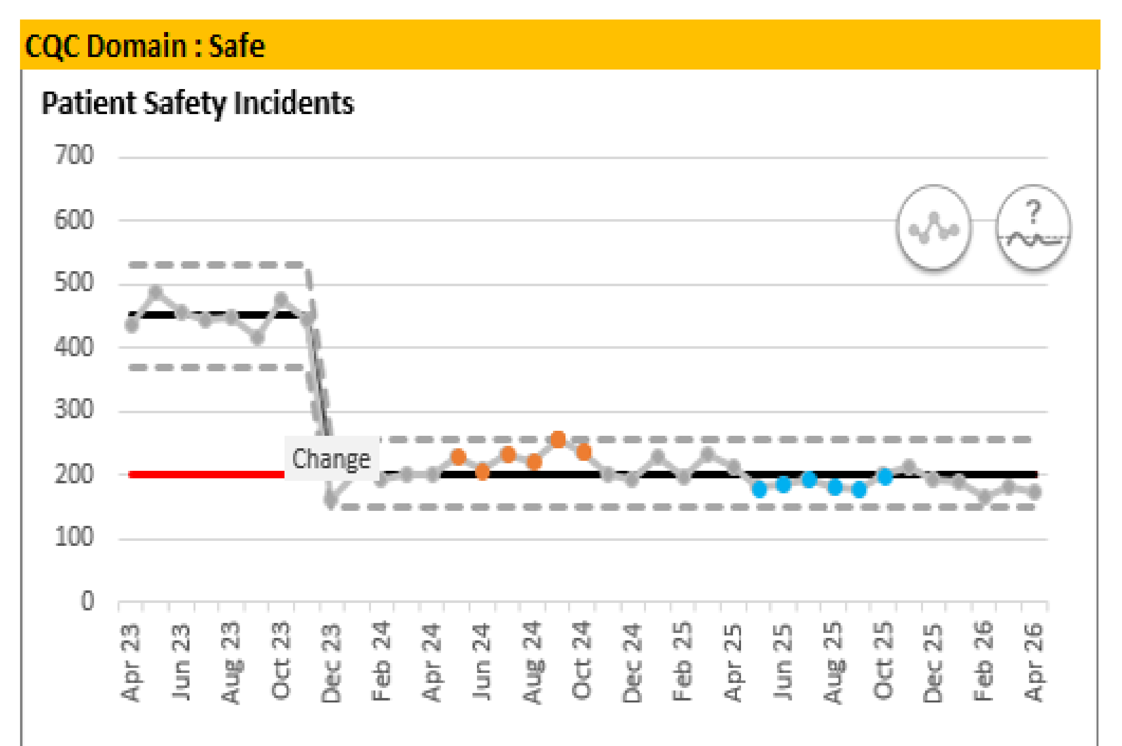
Special cause variation - Concerning

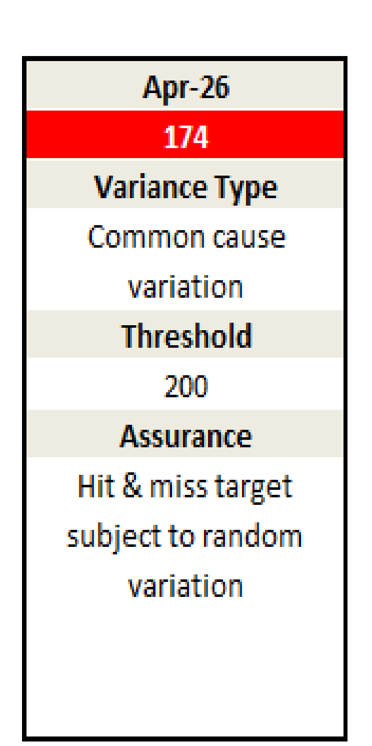
Threshold

475

Assurance

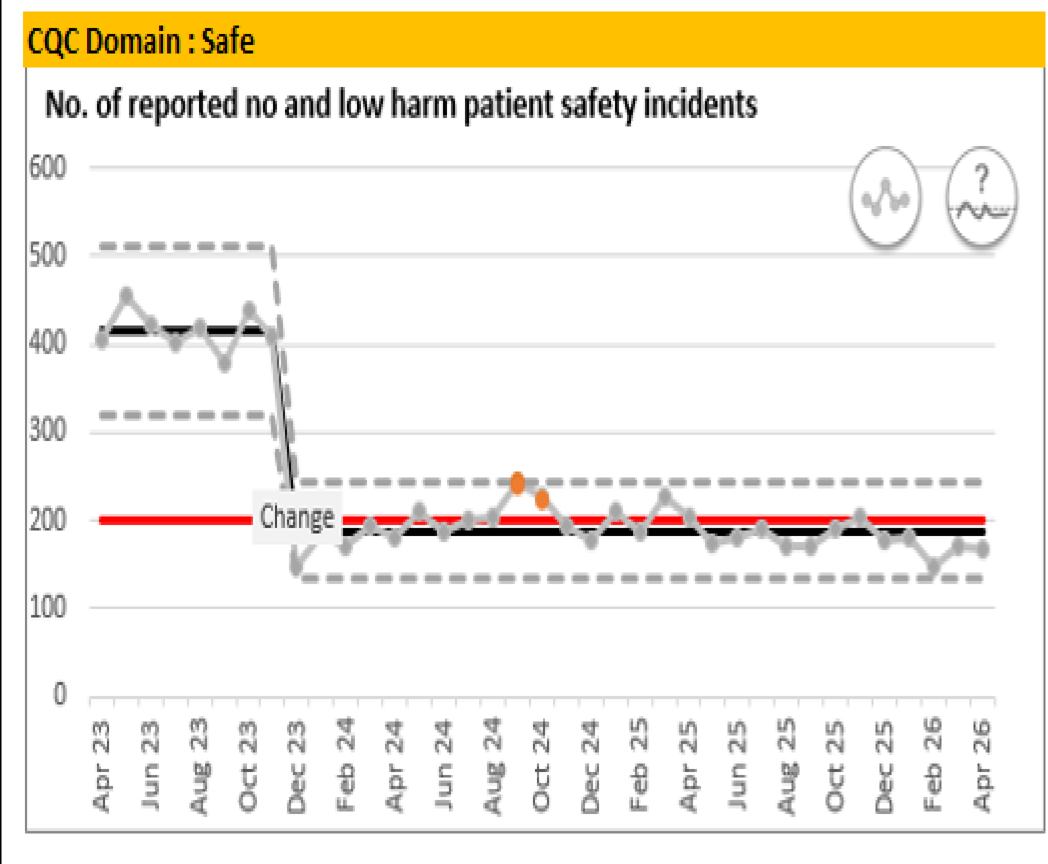
Hit & miss target subject to random variation

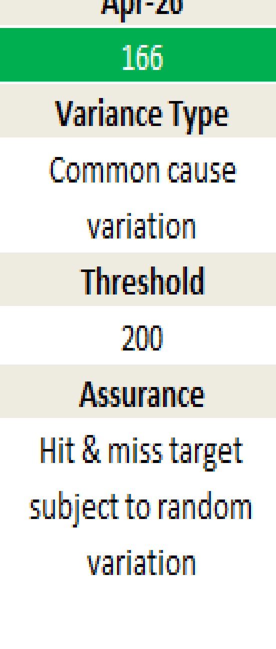


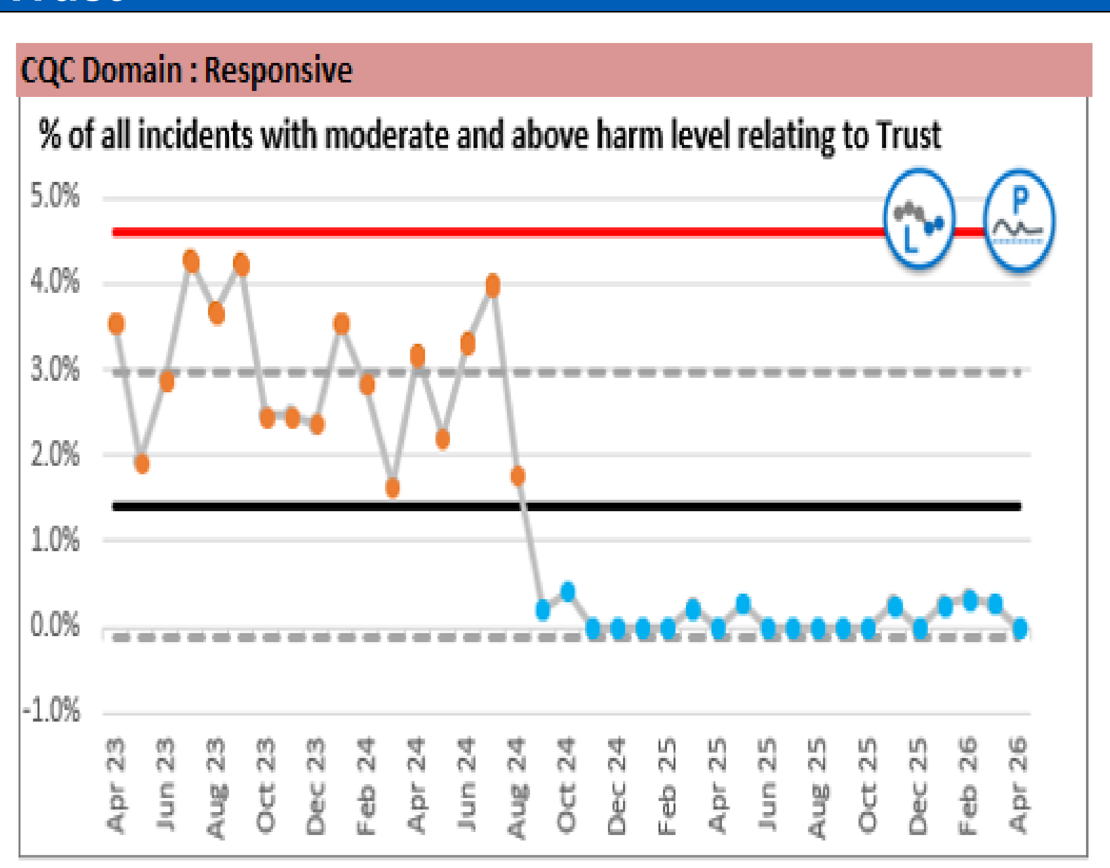


No. of reported no and low harm patient safety incidents

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







Apr-26

0.0%

Variance Type

Special cause variation - Improving

Threshold

2.2%

Assurance

Consistanly hit target

Falls resulting in moderate or above harm

CQC Domain : Safe

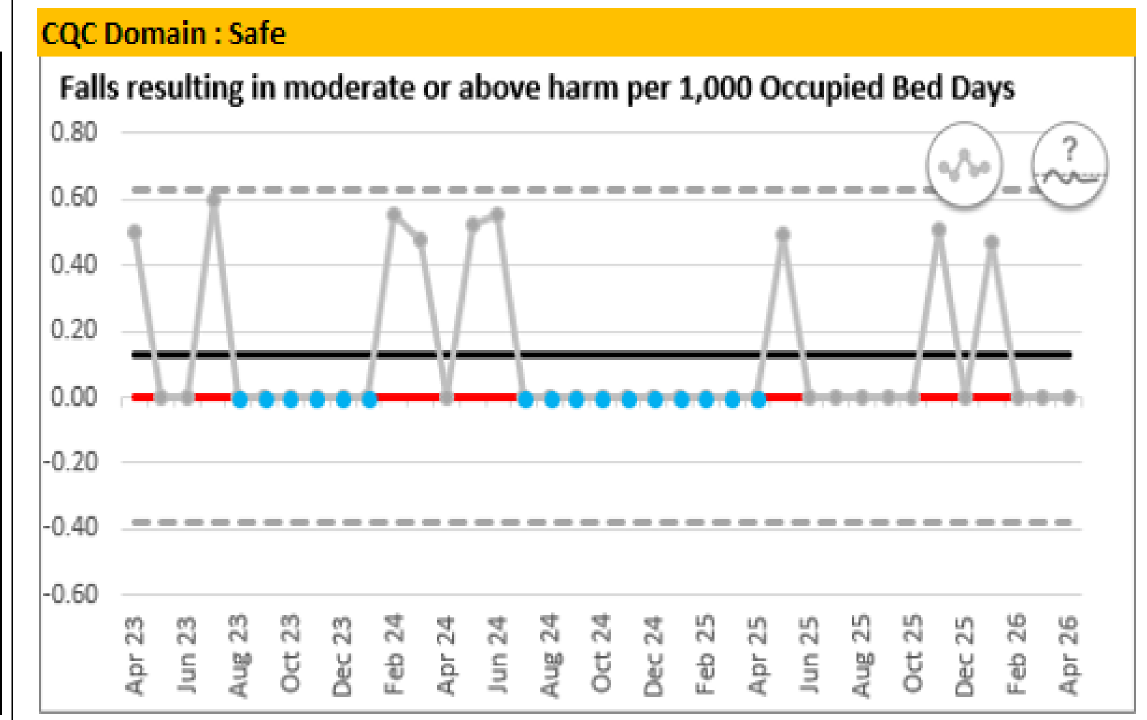
Falls resulting in moderate or above harm

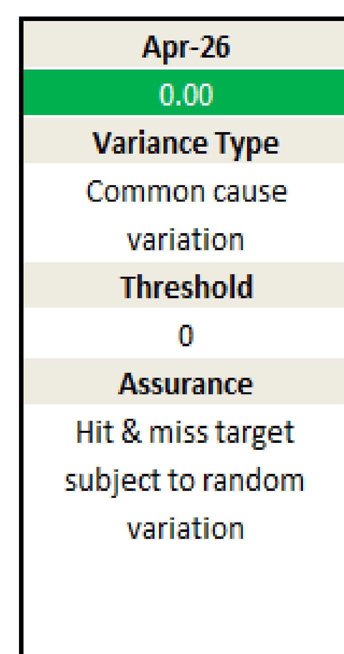
3
2
2
1
1
0
-1
-1

Apr 23 Jun 23 Aug 23 Oct 23 Dec 23 Feb 24 Apr 24 Jun 24 Aug 24 Oct 24 Dec 24 Feb 25 Apr 25 Jun 25 Aug 25 Oct 25 Dec 25 Feb 26 Apr 26

Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

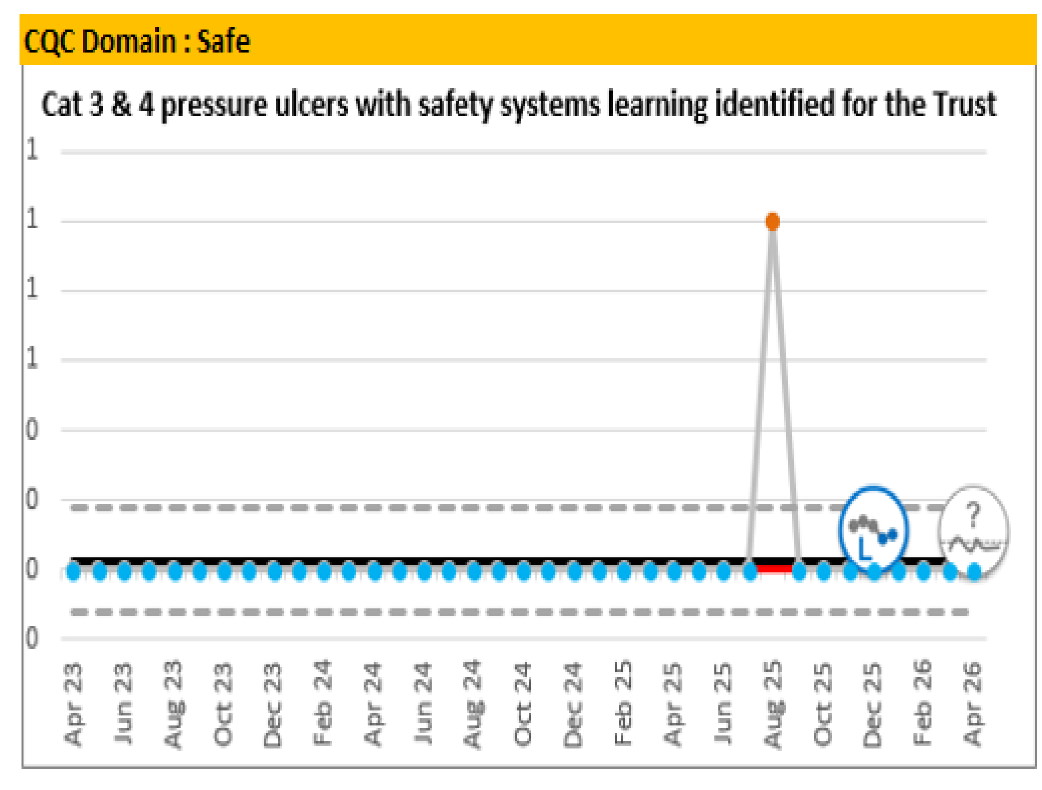
Falls resulting in moderate or above harm per 1,000 occupied bed days





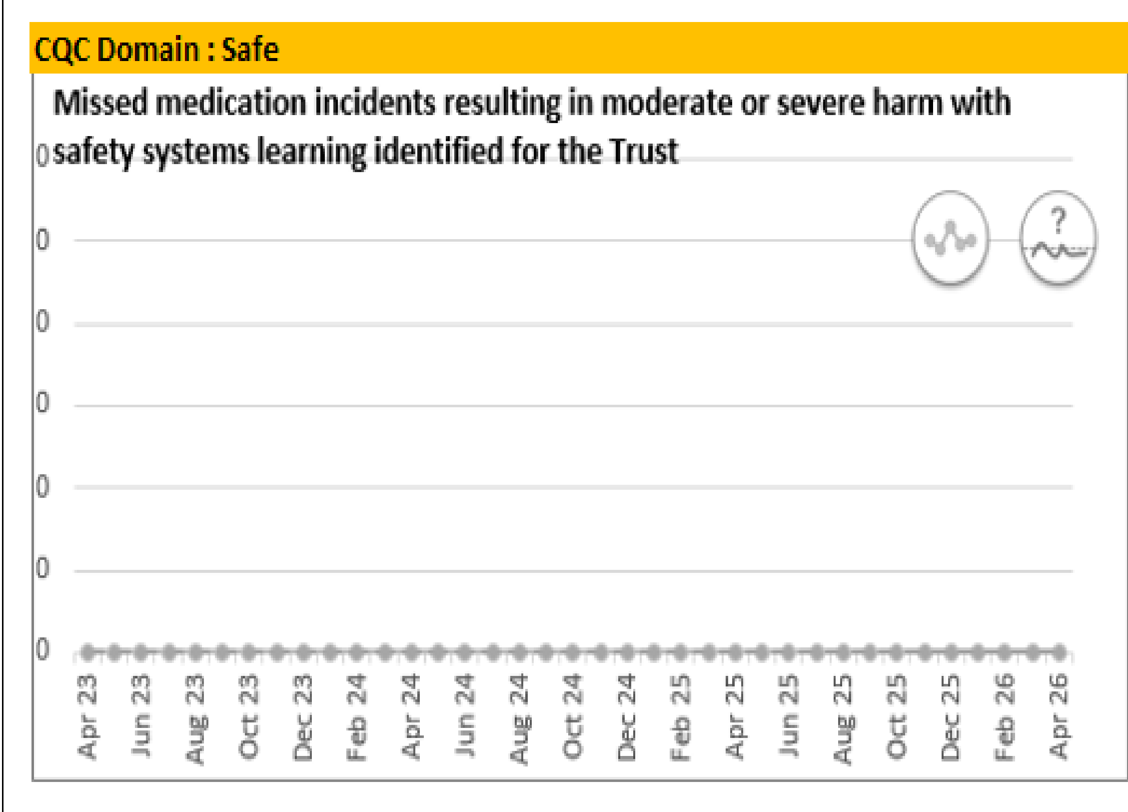
Apr-26
0.00
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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



Apr-26
0
Variance Type
Special cause variation - Improving
Threshold
0
Assurance
Hit & miss target subject to random variation

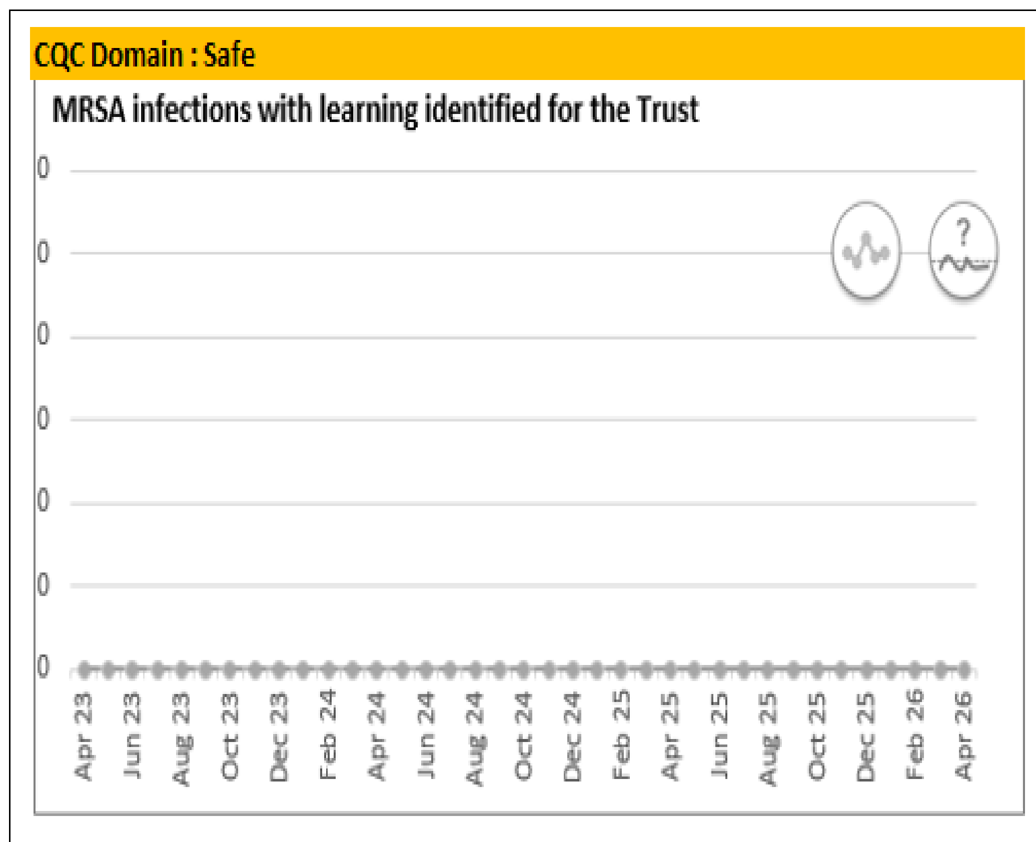
Missed medication incidents resulting in moderate or severe harm with safety systems learning identified for the Trust



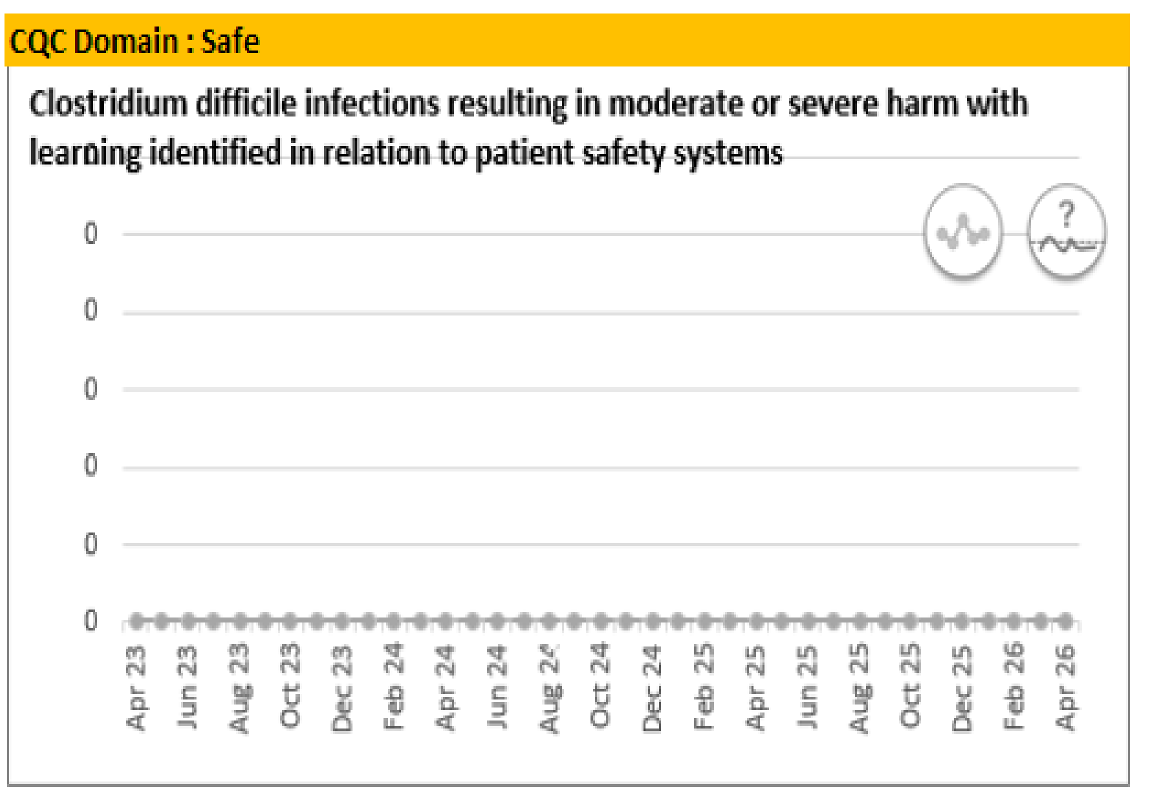
Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

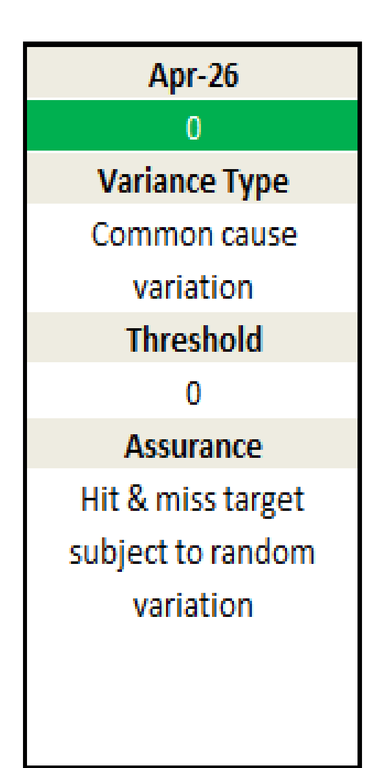
MRSA infections with learning identified for the Trust

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



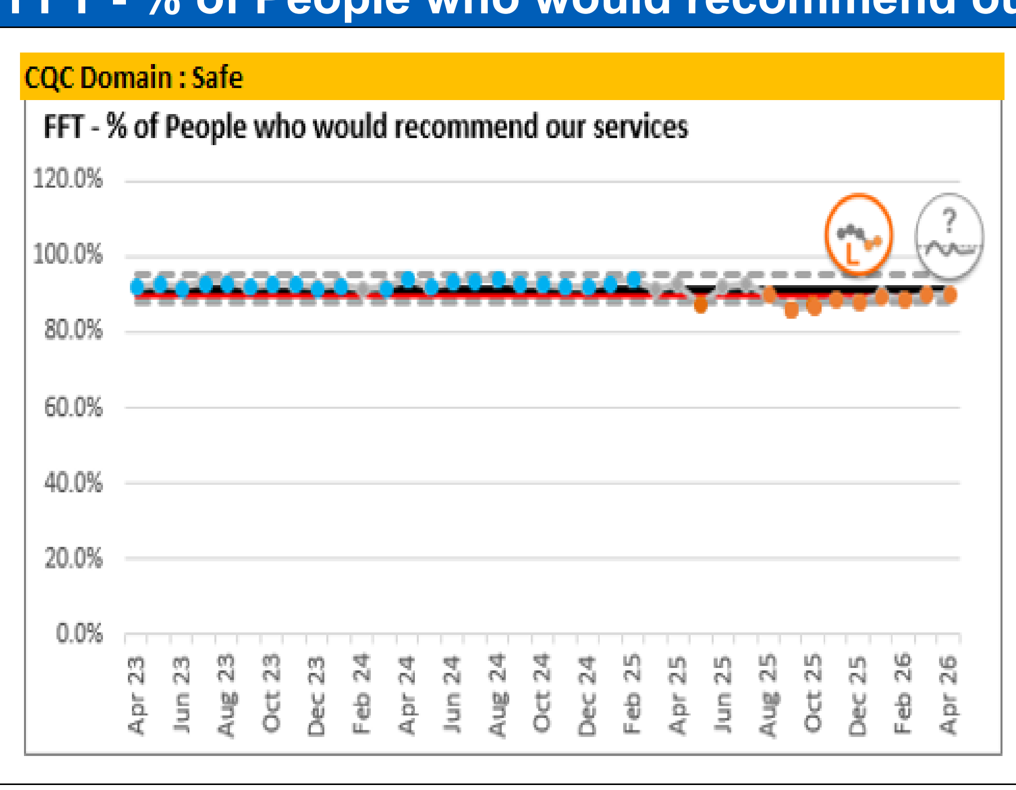
Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

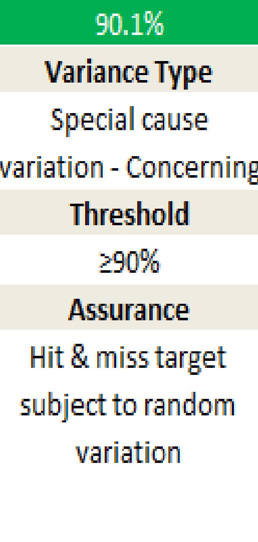




Apr-26
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

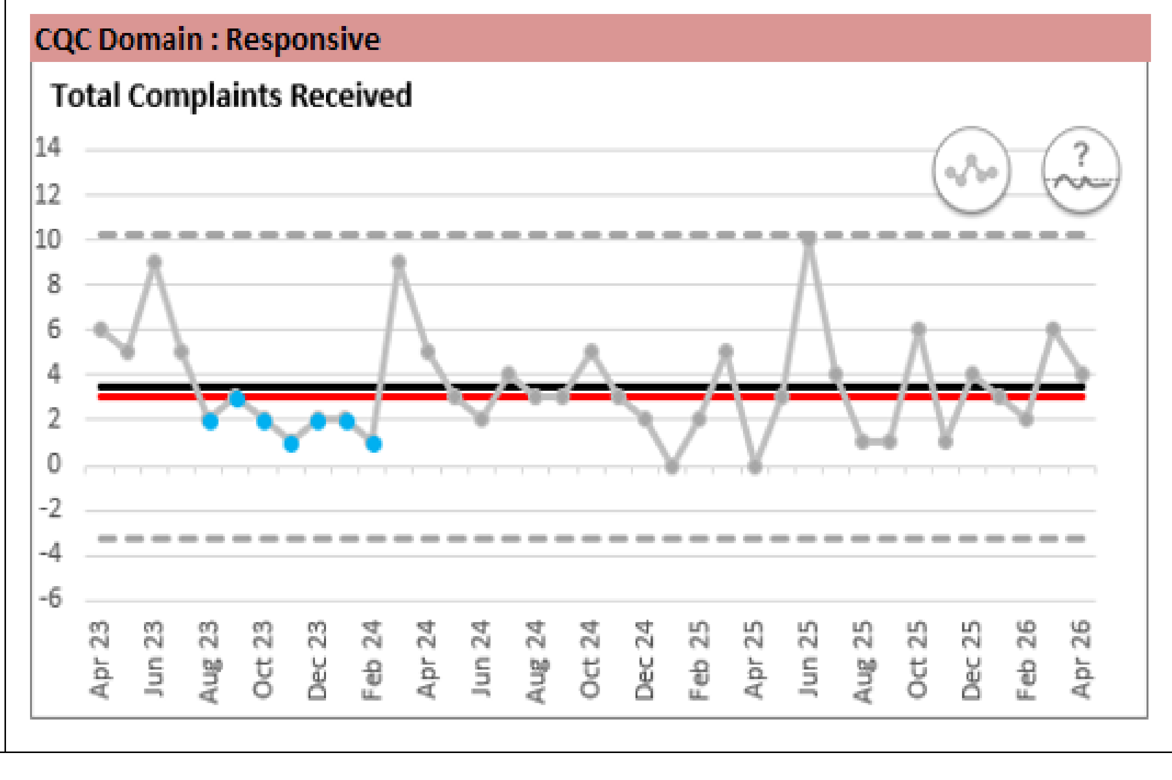
FFT - % of People who would recommend our services

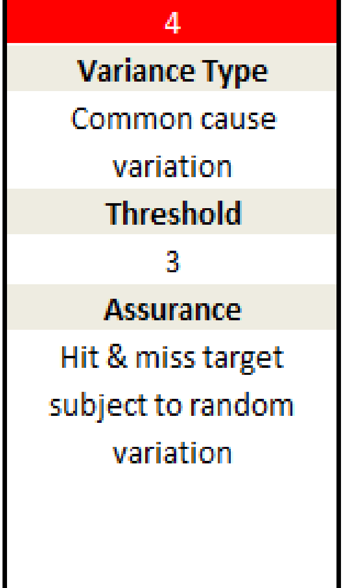




Apr-26
90.1%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

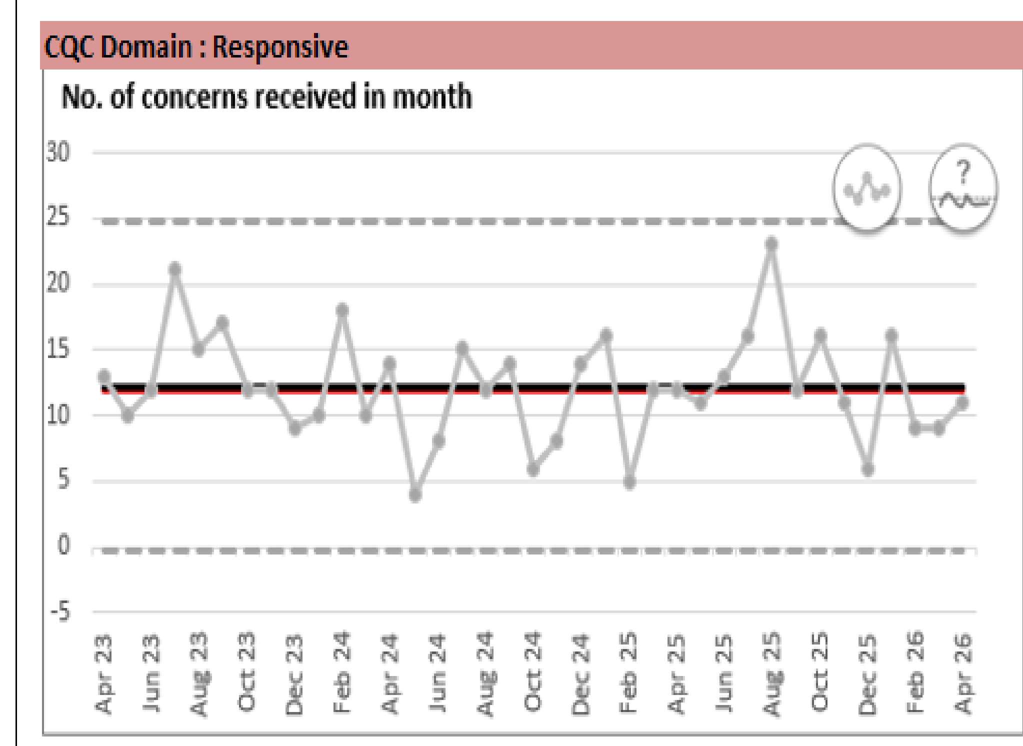
Total Complaints Received





Apr-26
4
Variance Type
Common cause variation
Threshold
3
Assurance
Hit & miss target subject to random variation

No. of concerns received in month



Apr-26
11
Variance Type
Common cause variation
Threshold
12
Assurance
Hit & miss target subject to random variation

EMD Operations Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
4-hour Accident and Emergency Target (including APH UTC)	Apr 26	62.55%	≥57.63%			61.1%
Number of inpatients not meeting the Criteria to Reside	Apr 26	182	-			157
Patients waiting longer than 12 hours in ED from a decision to admit	Apr 26	735	≤0			651
Proportion of patients more than 12 hours in ED from time of arrival	Apr 26	18.07%	≤20.84%			18.3%
Ambulance Handovers: % < 30 mins	Apr 26	65.77%	≥95%			54.7%
Ambulance Handovers: % < 45 mins	Apr 26	85.64%	≥100%			73.4%
18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Apr 26	65.42%	≥63.88%			59.1%
Referral to Treatment - total open pathway waiting list	Apr 26	43867	≤46923			45238
Referral to Treatment - cases exceeding 52 weeks	Apr 26	283	≤429			1421
Referral to Treatment - cases waiting 78+ wks	Apr 26	0	≤0			5
Cancer Waits - reduce number waiting 62 days +	Mar 26	50	≤50			136
Cancer - Faster Diagnosis Standard	Mar 26	84.05%	≥77.73%			73.0%
Cancer waits – % receiving first definitive treatment within 31 days of decision to treat	Mar 26	91.83%	≥91.39%			91.4%
Cancer Waits - 62 days to treatment (monthly)	Mar 26	75.86%	≥75.51%			74.5%
Diagnostic Waiters, 6 weeks and over - DM01	Apr 26	92.04%	≥94.5%			93.0%
Long length of stay - number of patients in hospital for 21 or more days	Apr 26	186	≤79			168

Highlights

4-hours
Overall, 4-hour performance, including APH UTC, improved by 2 percentage points compared with April. Improvement in UTC workforce stability since Quarter 4 of 2025/26 has supported this recovery.

Reduction in 12-hour waits
The proportion of patients waiting more than 12 hours in ED reduced by 2 percentage points compared with the previous month, indicating some improvement in patient flow.

Ambulances handover
Although ambulance handover performance remains non-compliant against the standard, the Trust continues to perform comparatively strongly both nationally and across Cheshire and Merseyside.

Referral to Treatment
The Trust achieved caseload, 18-week referral, 52 and 65-week targets for April 2026.

Cancer 28-day standard
The Trust achieved the 28-day faster diagnosis standard in March 2026.

Areas of Concern

4-hours
Type 1 4-hour performance remains a significant concern and continues to be adversely affected by ED crowding. Attendances in April were 15% higher than in April 2025, increasing operational pressure across the department.

12-hour waits in ED
Despite improvement since April, 12-hour performance remains in the lower national quartile, indicating that sustained improvement is still required.

Cancer 31-day and 62-day standards
The Trust underachieved against the 31 and 62-day standards. 62-day performance is forecast to be achieved in April 2026.

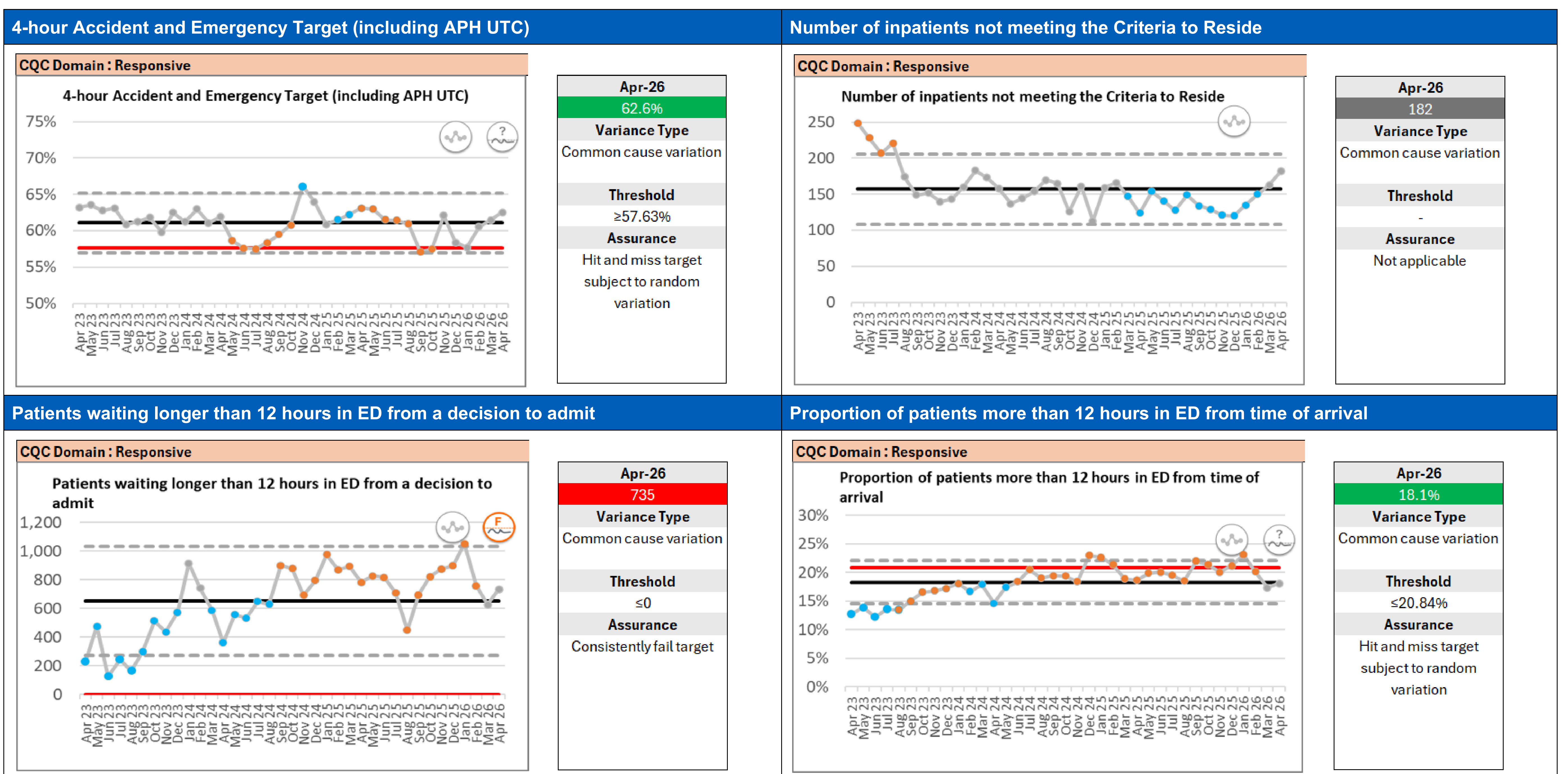
Forward Look (Actions)

ED flow and handovers
Work will continue to focus on improving patient flow through ED, particularly during periods of peak demand in the late afternoon and early evening when ambulance arrivals often occur in surges. A system improvement plan is in place for 2026/27 focus on reducing attendances to ED with utilising out of hospital services that meet the patients needs other than the emergency department.

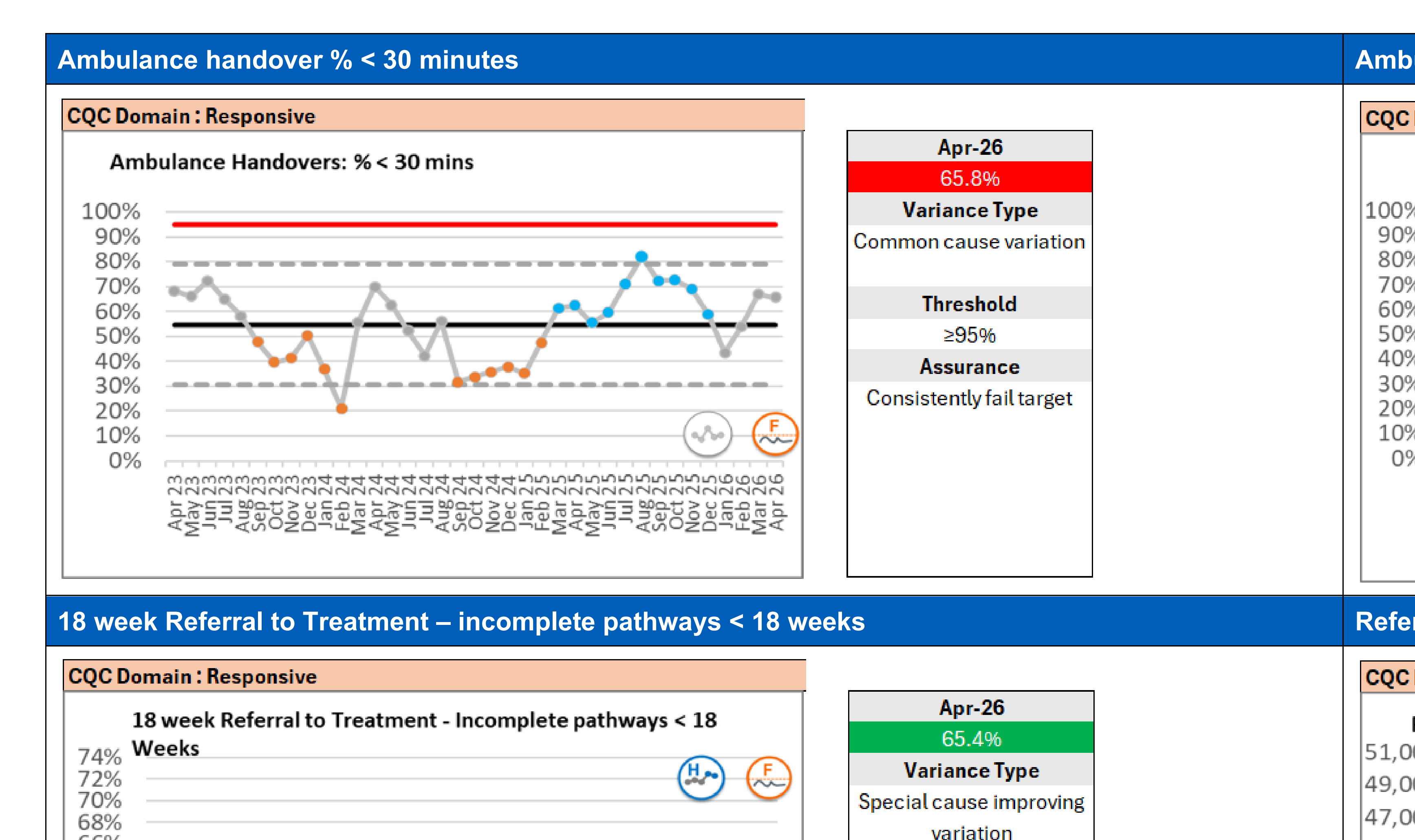
New ED go-live (UECUP completion)
The new ED pathway, scheduled to go live on 27th July, is expected to improve internal flow and reduce ambulance handover delays through a more effective department layout and process.

Operational focus
Continued emphasis will be placed on workforce stability, same-day emergency care pathways, and timely admission/discharge processes to support improvements in 4-hour and 12-hour performance. In line with the need to expand the offer of SDEC in the

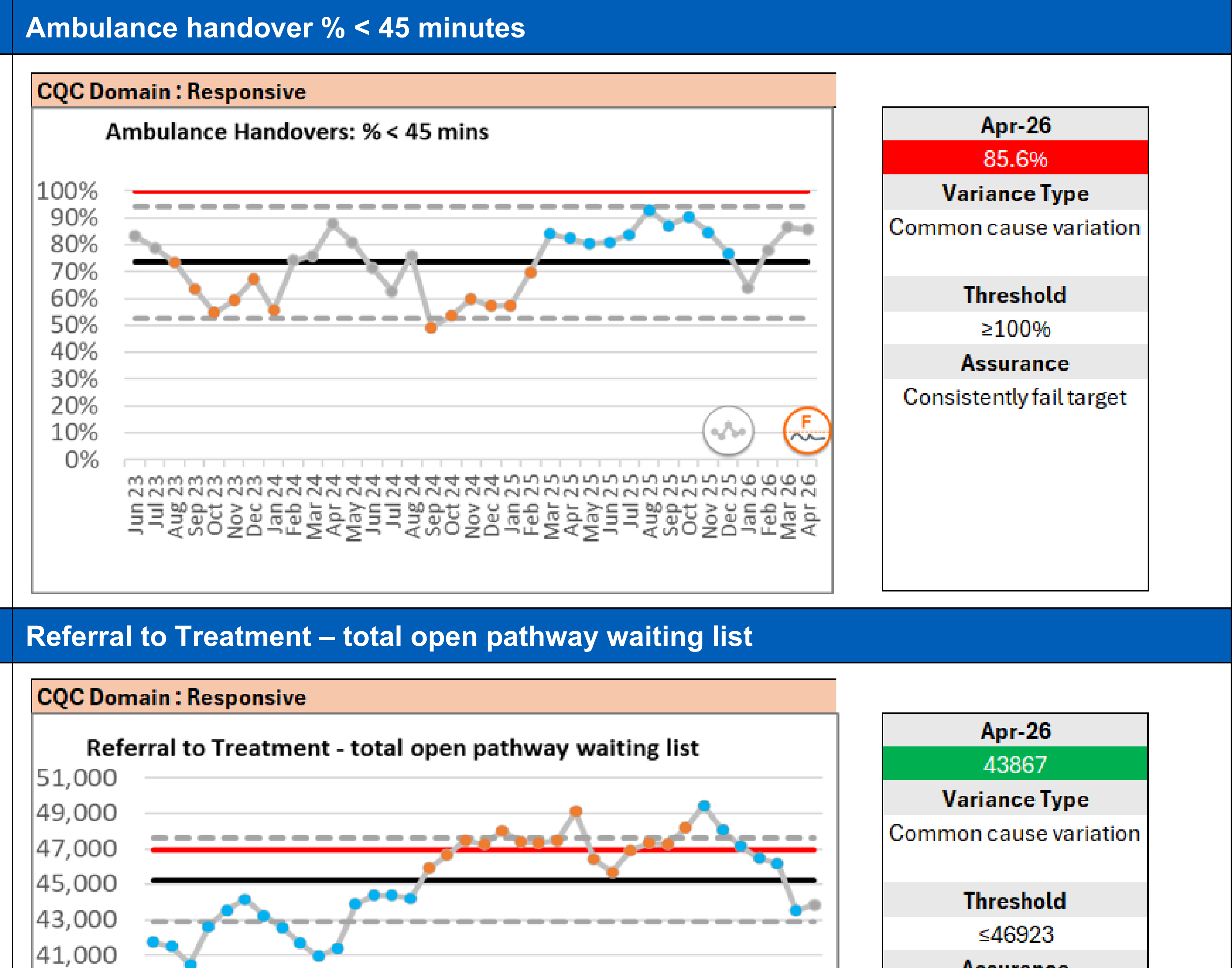
		Trust Recent approval from the system for capital funding that will support the build of a dedicated SDEC unit. The works are planned for quarter 3, 2026/27 with a planned completion date for early 2027/28. **RTT** The positive impact of additional validation on Performance in March and April is recognised. Review of the capacity of the validation team is being undertaken which includes exploration of AI and RPA solutions in order to maintain levels of validation to support performance. Divisions are currently developing bids to access RTT related budget included in annual plans in order to deliver increased activity. **Cancer** Divisions have compiled cancer improvement plans for 2026/27 by tumour site to address pressures on 31-day performance and requirements to increase performance in line with agreed trajectories. **Diagnostic performance** Diagnostic performance in April was impacted by non-obstetric ultrasound. Weekly tracking of performance in May has seen this recover to above target levels. Non-obstetric ultrasound is high volume meaning small disruptions in service have an impact on overall performance. The Division is undertaking review to develop plans that more resilience to referral increases or staffing pressures.


4-hour Accident and Emergency Target (including APH UTC)
CQC Domain : Responsive
4-hour Accident and Emergency Target (including APH UTC)
75%
70%
65%
60%
55%
50%
Apr-26
62.6%
Variance Type
Common cause variation
Threshold
≥57.63%
Assurance
Hit and miss target subject to random variation
Number of inpatients not meeting the Criteria to Reside
CQC Domain : Responsive
Number of inpatients not meeting the Criteria to Reside
250
200
150
100
50
0
Apr-26
182
Variance Type
Common cause variation
Threshold
-
Assurance
Not applicable
Patients waiting longer than 12 hours in ED from a decision to admit
CQC Domain : Responsive
Patients waiting longer than 12 hours in ED from a decision to admit
1,200
1,000
800
600
400
200
0
Apr-26
735
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
Proportion of patients more than 12 hours in ED from time of arrival
30%
25%
20%
15%
10%
5%
0%
Apr-26
18.1%
Variance Type
Common cause variation
Threshold
≤20.84%
Assurance
Hit and miss target subject to random variation

Ambulance handover % < 30 minutes



Ambulance handover % < 45 minutes



18 week Referral to Treatment – incomplete pathways < 18 weeks

CQC Domain : Responsive

18 week Referral to Treatment - Incomplete pathways < 18 Weeks

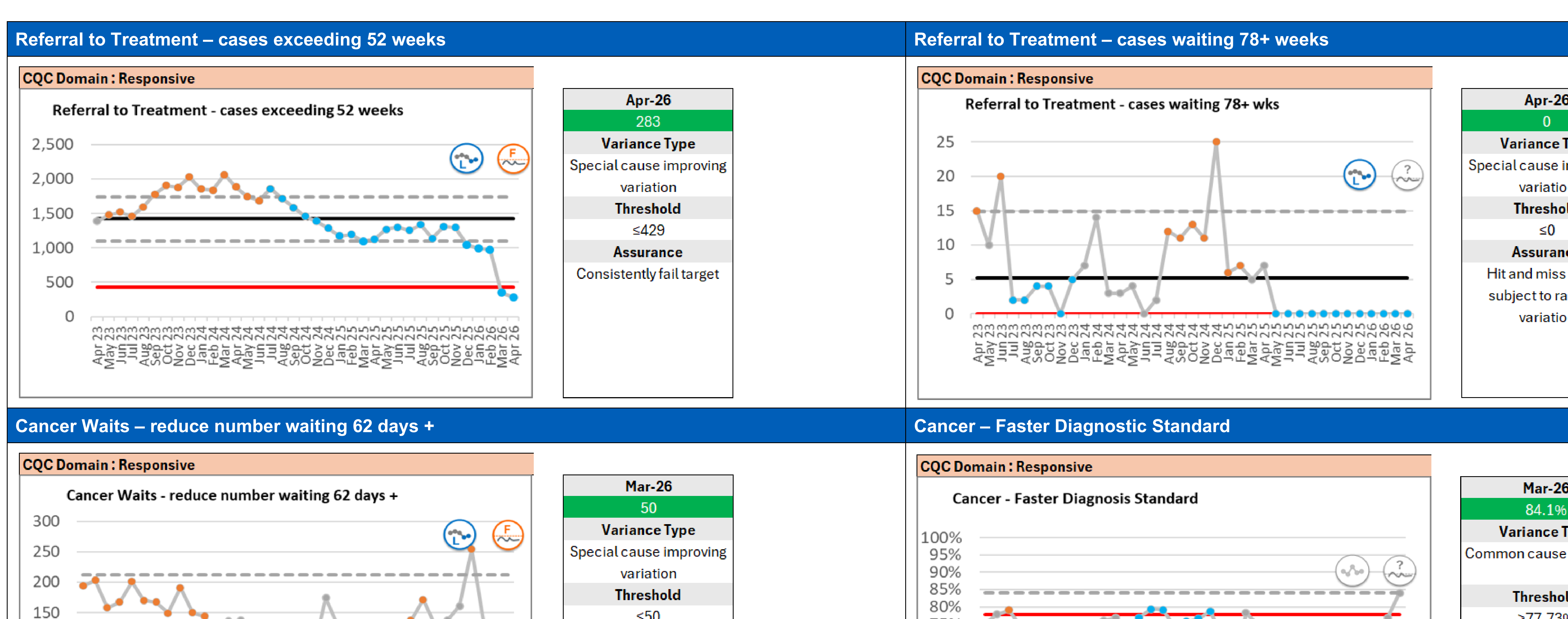
Apr-26
65.4%
Variance Type
Special cause improving variation
Threshold
≥63.88%
Assurance
Consistently fail target

Referral to Treatment – total open pathway waiting list

CQC Domain : Responsive

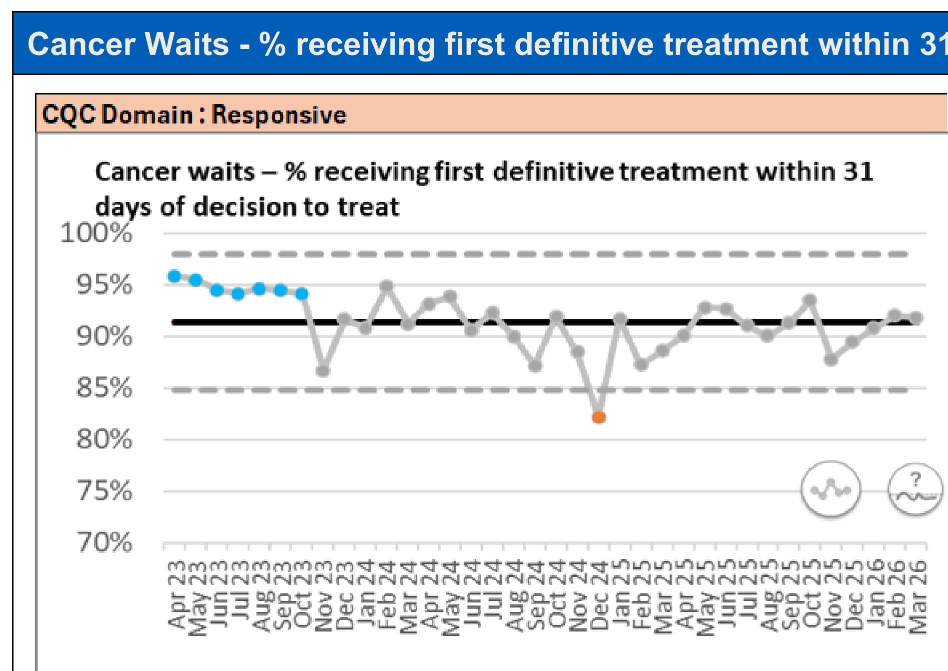
Referral to Treatment - total open pathway waiting list

Apr-26
43867
Variance Type
Common cause variation
Threshold
≤46923
Assurance
Hit and miss target subject to random variation


Referral to Treatment – cases exceeding 52 weeks
CQC Domain : Responsive
Referral to Treatment - cases exceeding 52 weeks
Apr-26
283
Variance Type
Special cause improving variation
Threshold
≤429
Assurance
Consistently fail target
Referral to Treatment – cases waiting 78+ weeks
CQC Domain : Responsive
Referral to Treatment - cases waiting 78+ wks
Apr-26
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
Cancer Waits - reduce number waiting 62 days +
Mar-26
50
Variance Type
Special cause improving variation
Threshold
≤50
Assurance
Consistently fail target
Cancer – Faster Diagnostic Standard
CQC Domain : Responsive
Cancer - Faster Diagnosis Standard
Mar-26
84.1%
Variance Type
Common cause variation
Threshold
≥77.73%
Assurance
Consistently fail target

Cancer Waits - % receiving first definitive treatment within 31 days of decision to treat

CQC Domain : Responsive

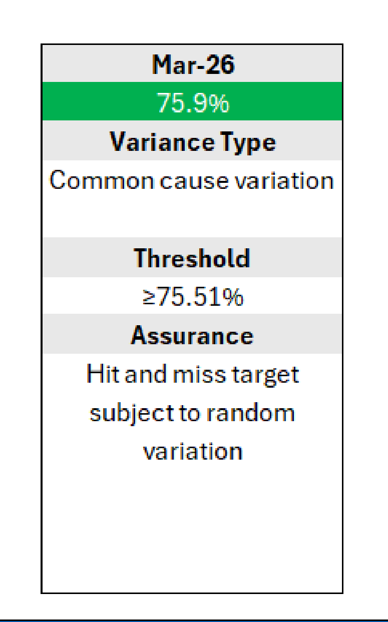


Mar-26
91.8%
Variance Type
Common cause variation
Threshold
≥91.39%
Assurance
Hit and miss target subject to random variation

Cancer waits - 62 days to treatment (monthly)

CQC Domain : Responsive

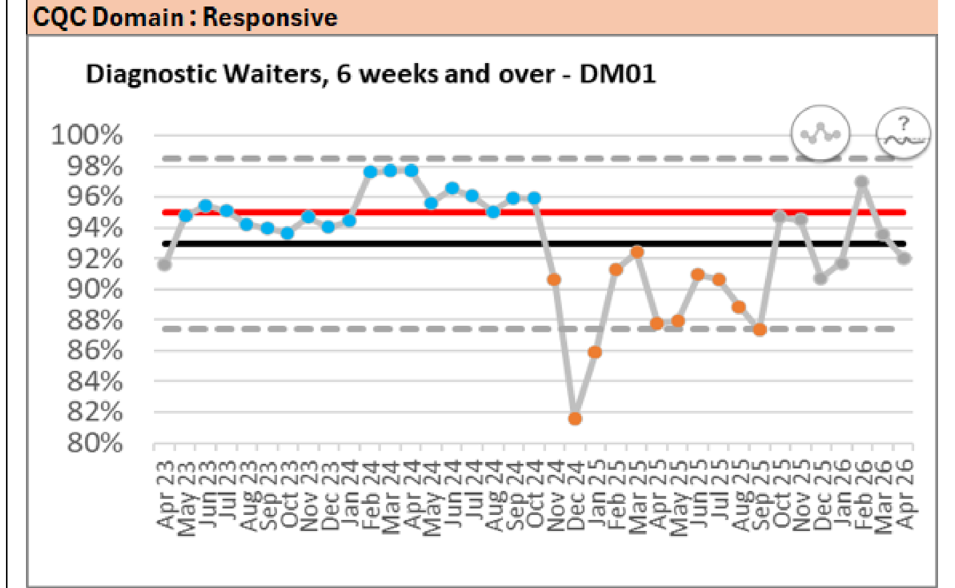
Cancer Waits - 62 days to treatment (monthly)

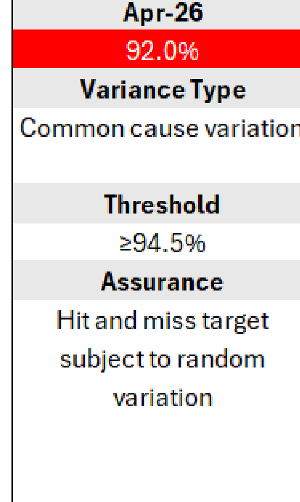


Mar-26
75.9%
Variance Type
Common cause variation
Threshold
≥75.51%
Assurance
Hit and miss target subject to random variation

Diagnostic Waiters – 6 weeks and over – DM01

CQC Domain : Responsive

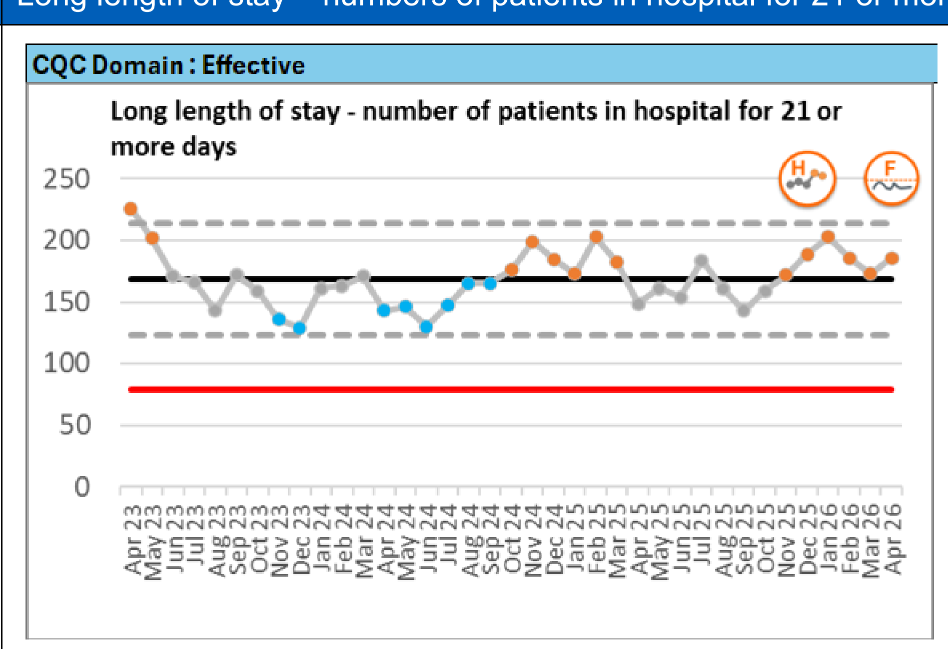




Apr-26
92.0%
Variance Type
Common cause variation
Threshold
≥94.5%
Assurance
Hit and miss target subject to random variation

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

CQC Domain : Effective



Apr-26
186
Variance Type
Special cause concerning variation
Threshold
≤79
Assurance
Consistently fail target

Operational Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
WIC & UTC Attendances seen within 4 hrs	Apr 26	96.8%	95.0%			96.1%
CICC Occupancy Rate (Commissioned Beds)	Apr 26	97.3%	92.0%			92.2%
CICC Median LoS (Active Beds Daily Snapshot)	Apr 26	16.3	21.0			18.7
Urgent Community Response - 2 hours	Apr 26	88.3%	70.0%			87.5%
GPOOH - UCAT Response Times (60 min response)	Apr 26	98.4%	98.0%			98.7%
GPOOH - UCAT Response Times (15 min response)	Apr 26	73.4%	65.0%			68.4%
GPOOH - UCAT Response Times (30 min response)	Apr 26	91.5%	90.0%			92.8%
GPOOH - CAS Response Times (20 min response)	Apr 26	69.4%	75.0%			69.5%
GPOOH - CAS Response Times (2hr response)	Apr 26	68.6%	90.0%			69.8%
GPOOH - NHS111 Response Times	Apr 26	66.4%	75.0%			60.2%
RTT - % of Patients Seen Within 18 Weeks	Apr 26	100.0%	92.0%			99.8%
DM01 - % of Patients Waiting with a Wait Under 6 weeks	Apr 26	99.5%	99.0%			100.0%
UTC Attendances seen within 4 hrs	Apr 26	96.9%	95.0%			97.7%
VCHC Attendances seen within 4 hrs	Apr 26	95.9%	95.0%			94.4%
Eastham Attendances seen within 4 hrs	Apr 26	98.6%	95.0%			93.6%

Highlights

Urgent care access performance remained strong across most sites, with attendances generally seen within the 4-hour standard.

WIC/UTC 4-hour performance continue to show sustained delivery

UCAT response time performance was maintained across key priority standards.

Community and intermediate care beds show a positive position, including occupancy and length of stay

Areas of Concern

CAS Response Times
CAS response times remain below the expected standard and continue to require close operational oversight. Performance is being affected by sustained pressure on out-of-hours capacity and demand, which is limiting the ability to consistently allocate dedicated GP resource to these cases. In practice, clinicians are prioritising the most acute cases first, meaning that some lower-acuity CAS cases may wait longer, although this is managed within a clinically safe process. Shift managers and GP coordinators continue to review caseloads to mitigate risk and support timely clinical response wherever possible.

Response time for NHS 111
NHS 111 response times continue to be impacted by the ongoing focus on emergency department streaming and increasing face-to-face capacity within UTC/GPOOH as part of the wider unplanned care improvement plan. While this work supports system flow and reduces pressure elsewhere, it has created competing demands on clinical resource, with an impact timeliness for other case types. Clinical teams and shift managers are actively managing this through triage, real-time workforce deployment, and risk-based prioritisation to maintain patient safety.

Forward Look (Actions)

Plans to address the ongoing performance challenges include a review of the workforce model to ensure the balance between ED streaming, CAS, and NHS 111 demand is aligned against live activity and risk.

Strengthen ringfenced GP capacity for CAS response periods where feasible, particularly during predictable peaks in out-of-hours demand.

Undertake demand and acuity analysis of CAS and NHS 111 cases to identify opportunities for pathway redesign, skill mix optimisation, or alternative clinical handling.

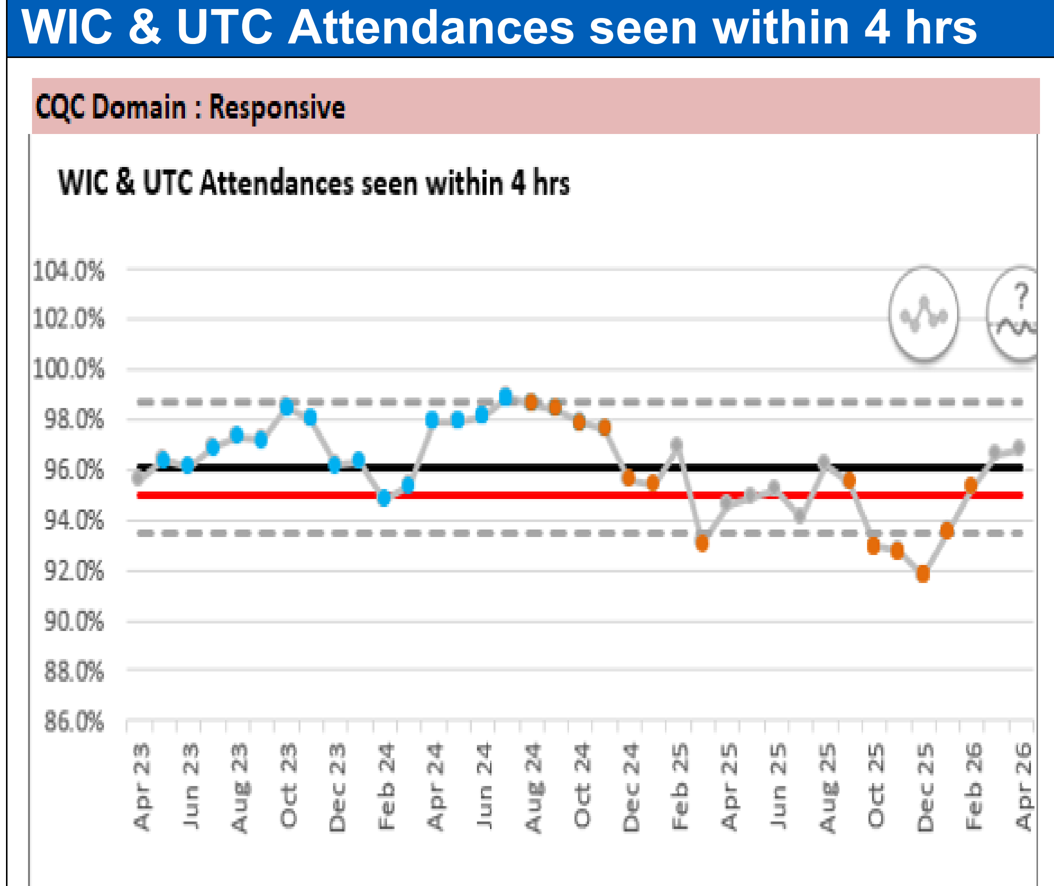
Monitor the impact of ED streaming on wider service responsiveness and report trade-offs transparently through routine performance review.

Develop targeted improvement actions focused on reducing delays in lower-performing response categories while maintaining safe prioritisation of higher-acuity patients.

Several of the actions are part of the wider urgent and Emergency Care Improvement plan and the review of the model for the urgent care services.

WIC & UTC Attendances seen within 4 hrs

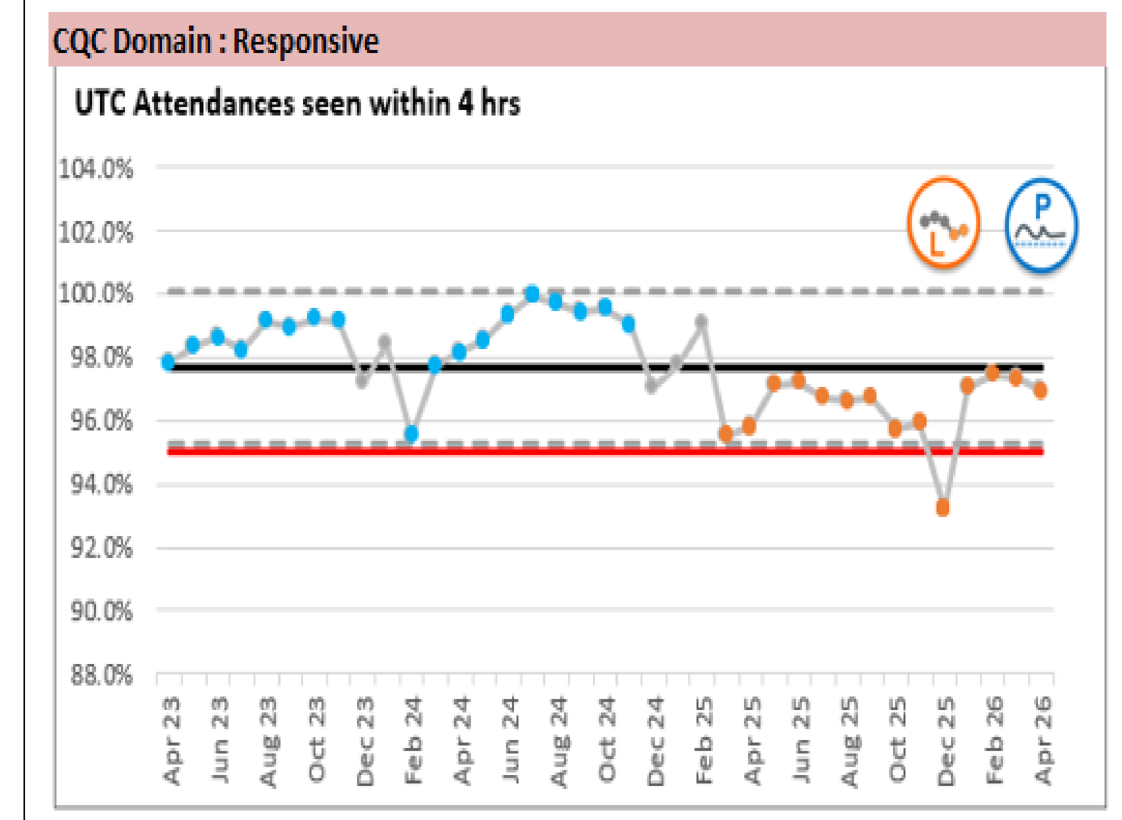
CQC Domain : Responsive



Apr-26
96.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

UTC Attendances seen within 4 hrs

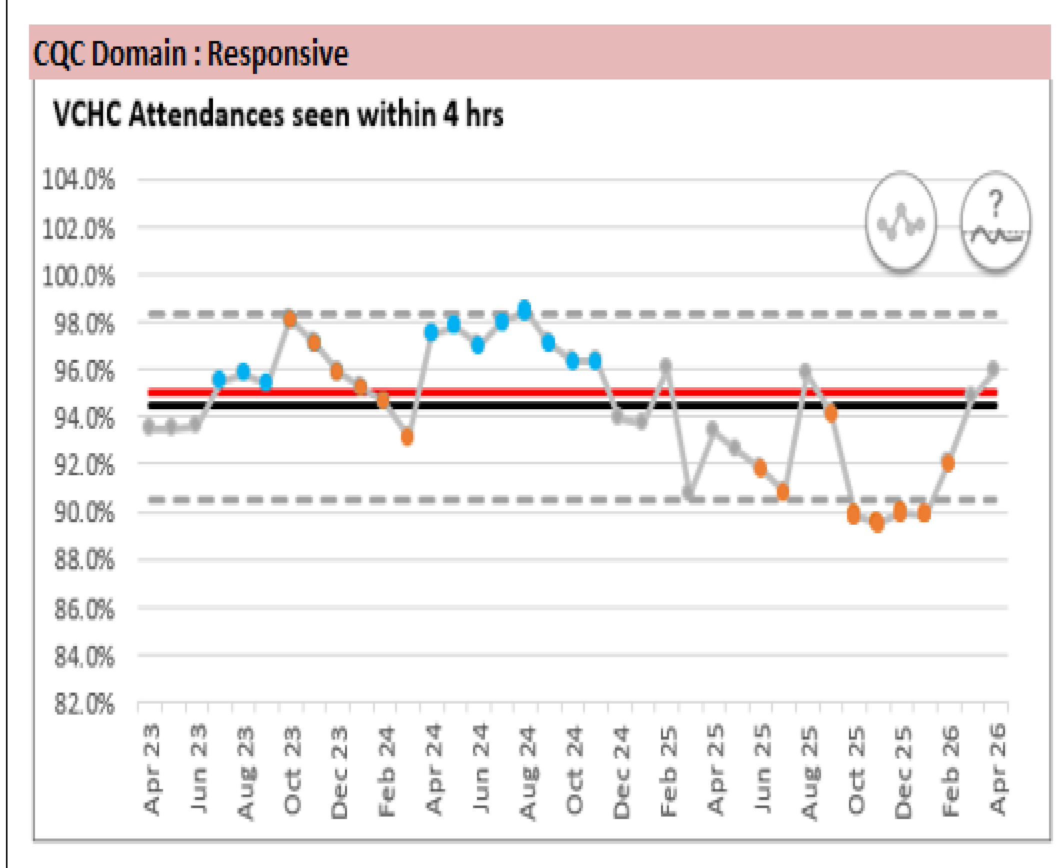
CQC Domain : Responsive



Apr-26
96.9%
Variance Type
Special cause variation - Concerning
Threshold
≥95%
Assurance
Consistanly hit target

VCHC Attendances seen within 4 hrs

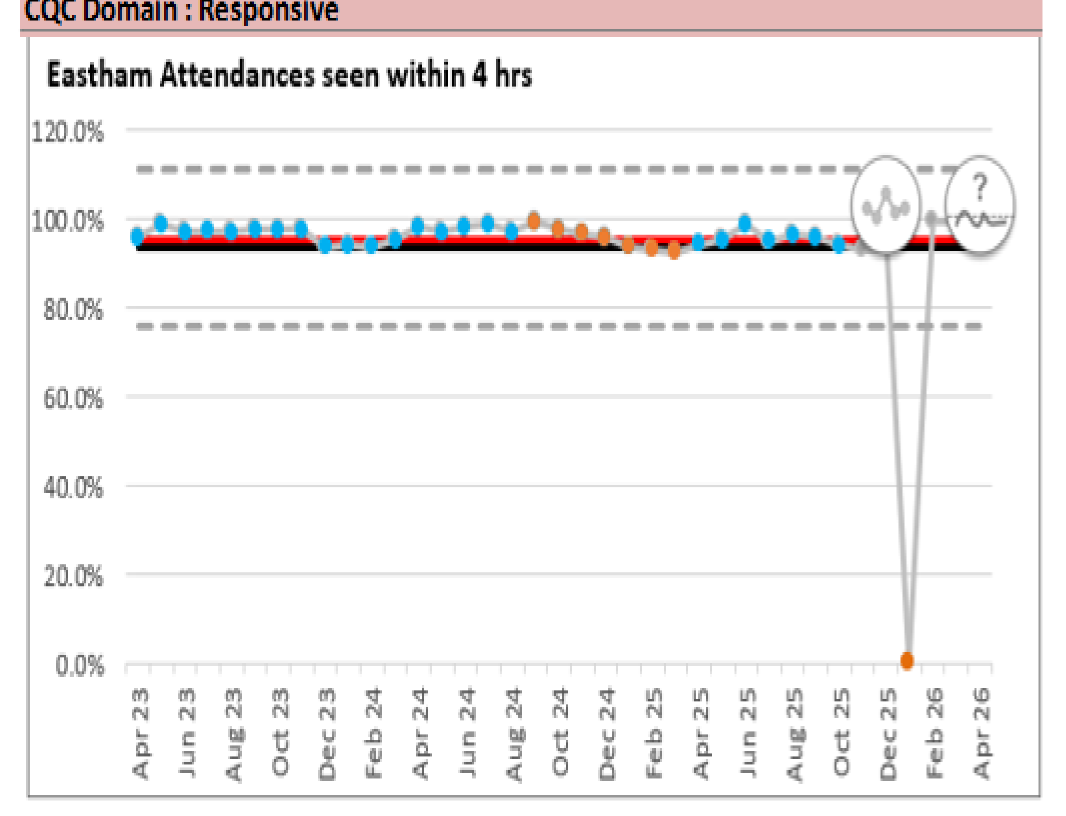
CQC Domain : Responsive



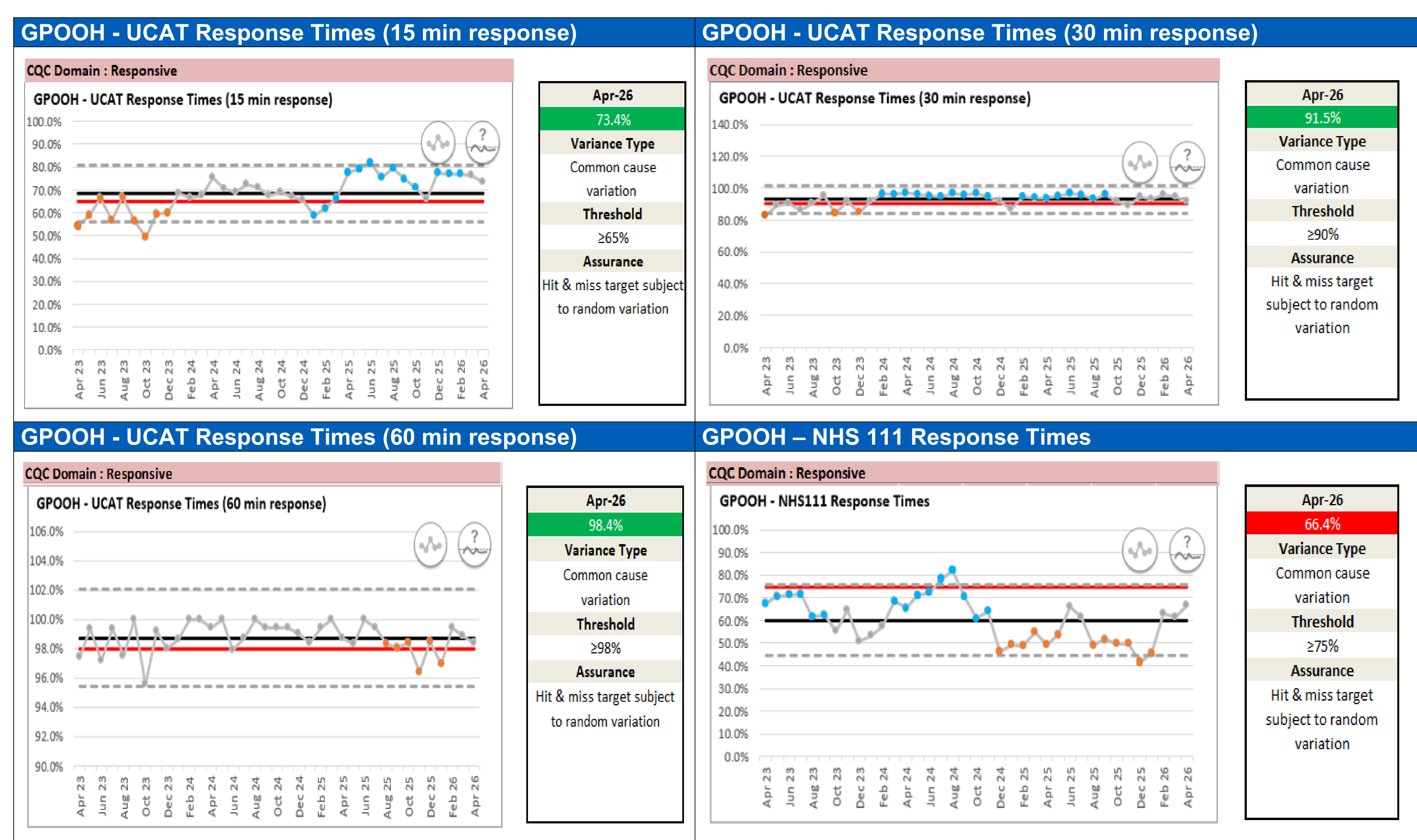
Apr-26
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Eastham Attendances seen within 4 hrs

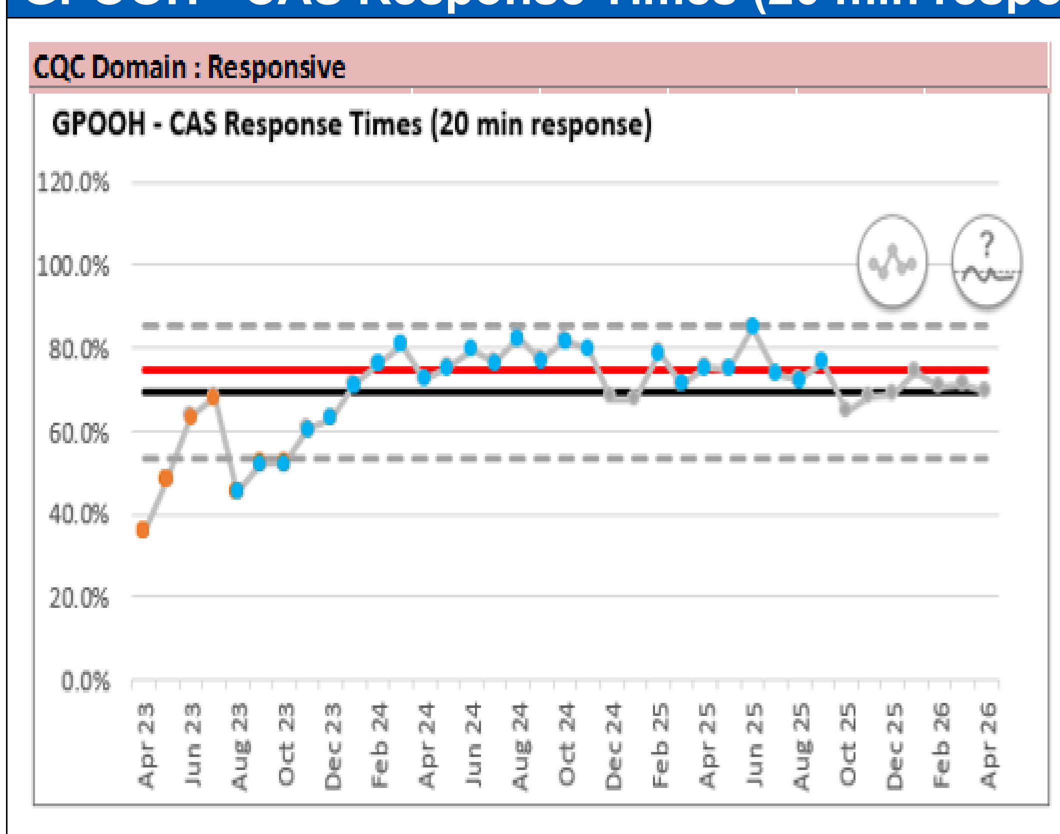
CQC Domain : Responsive



Apr-26
98.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

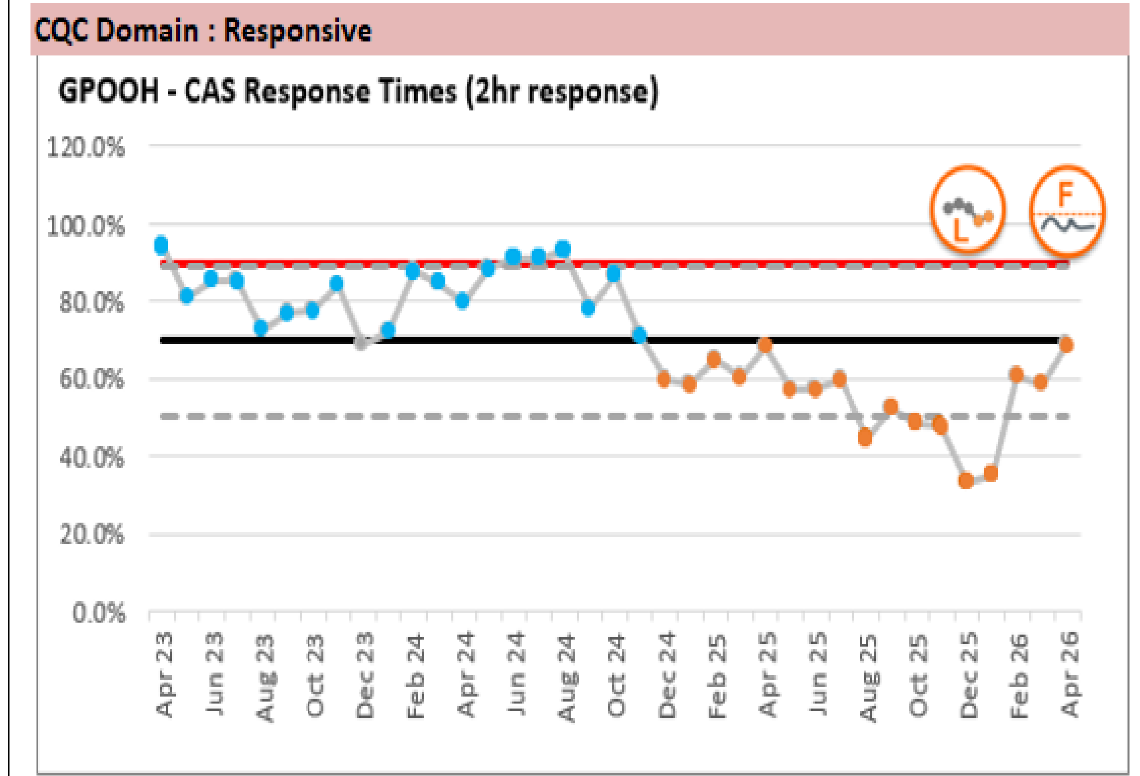

GPOOH - UCAT Response Times (15 min response)
CQC Domain : Responsive
GPOOH - UCAT Response Times (15 min response)
Apr-26
73.4%
Variance Type
Common cause variation
Threshold
≥65%
Assurance
Hit & miss target subject to random variation
GPOOH - UCAT Response Times (30 min response)
CQC Domain : Responsive
GPOOH - UCAT Response Times (30 min response)
Apr-26
91.5%
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
GPOOH - UCAT Response Times (60 min response)
Apr-26
98.4%
Variance Type
Common cause variation
Threshold
≥98%
Assurance
Hit & miss target subject to random variation
GPOOH – NHS 111 Response Times
CQC Domain : Responsive
GPOOH - NHS111 Response Times
Apr-26
66.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

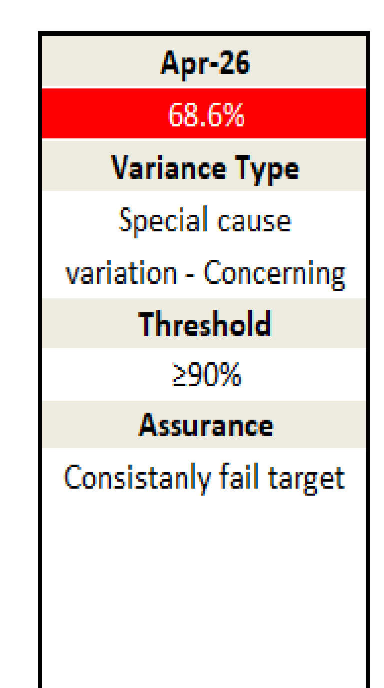
GPOOH - CAS Response Times (20 min response)



Apr-26
69.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

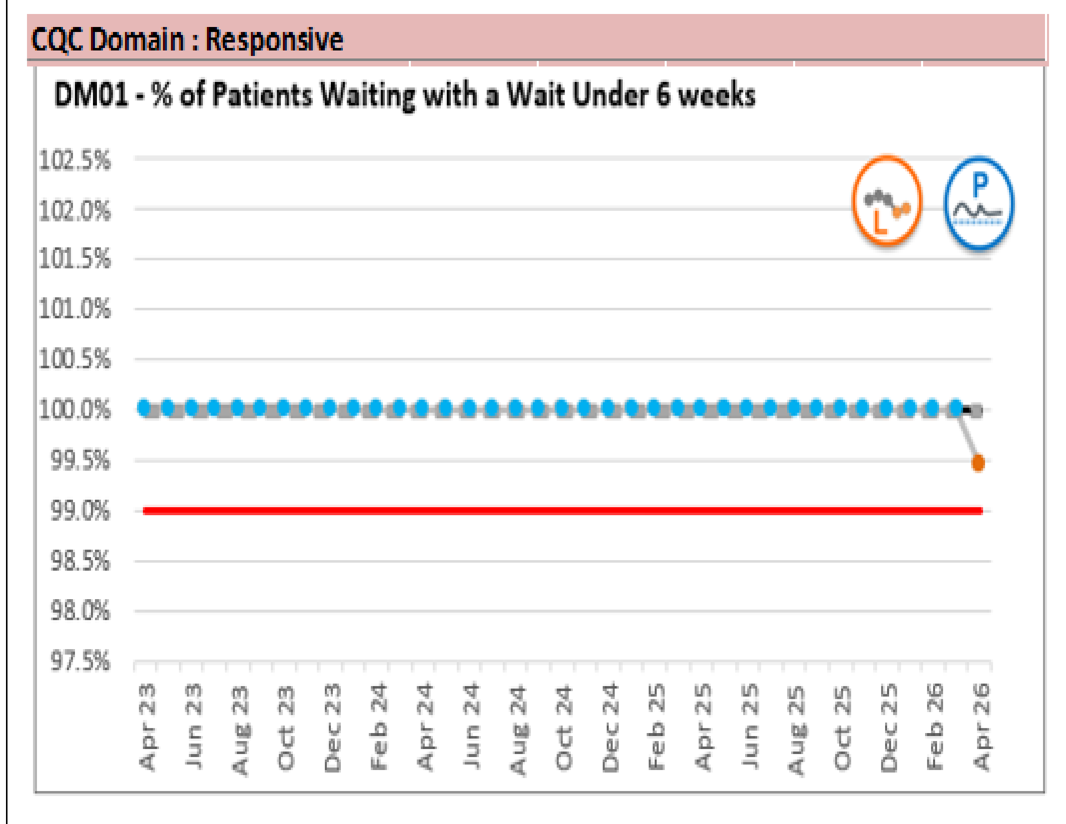
GPOOH - CAS Response Times (2hr response)





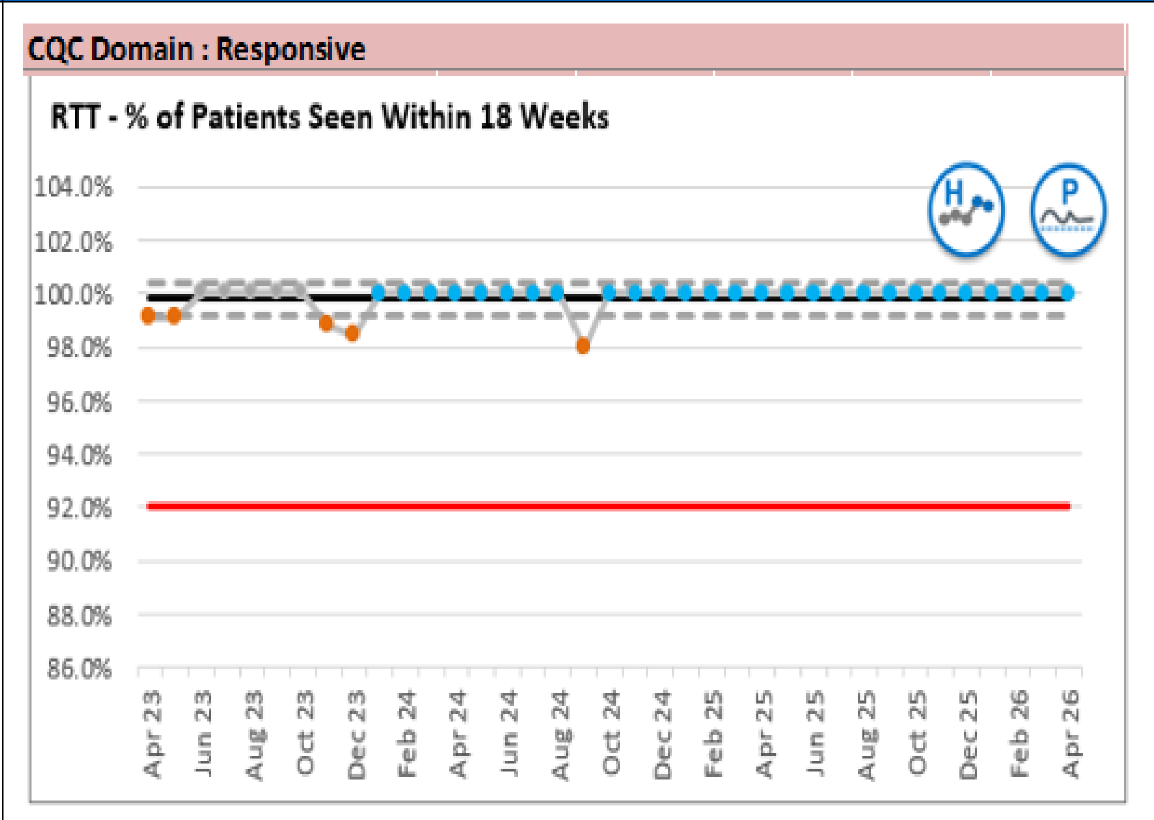
Apr-26
68.6%
Variance Type
Special cause variation - Concerning
Threshold
≥90%
Assurance
Consistanly fail target

DM01 - % of Patients Waiting under 6 weeks

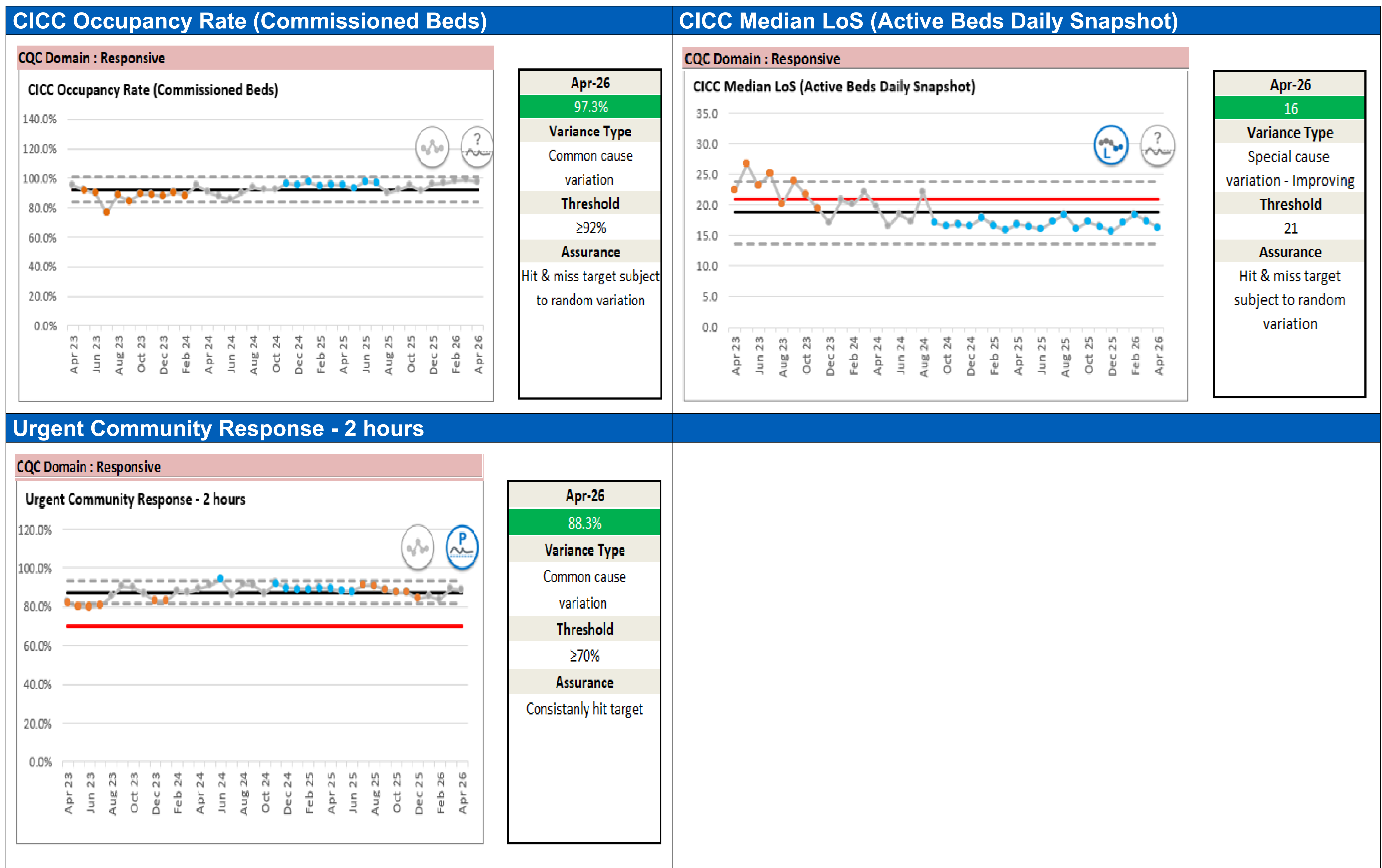


Apr-26
99.5%
Variance Type
Special cause variation - Concerning
Threshold
≥99%
Assurance
Performance consistently achieves the target

RTT- % of Patients seen within 18 Weeks



Apr-26
100%
Variance Type
Special Cause variation - Improving
Threshold
≥92%
Assurance
Performance consistently achieves the target



CICC Occupancy Rate (Commissioned Beds)
CQC Domain : Responsive
CICC Occupancy Rate (Commissioned Beds)
140.0%
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Apr 23
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Dec 24
Feb 25
Apr 25
Jun 25
Aug 25
Oct 25
Dec 25
Feb 26
Apr 26
Apr-26
97.3%
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
CICC Median LoS (Active Beds Daily Snapshot)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Apr-26
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
Urgent Community Response - 2 hours
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Apr-26
88.3%
Variance Type
Common cause variation
Threshold
≥70%
Assurance
Consistanly hit target

Waiting Lists

Waiting list movement in Month - April 2026				
Directorate	Within 6 Weeks	Within 12 Weeks	Within 18 Weeks	Total waiting
Nursing	61% (-13%)	92% (-4%)	99% (-1%)	574 (-2)
Specialist Medical	85% (-5%)	100% (0%)	100% (0%)	3002 (555)
Specialist Medical - Dental	45% (3%)	68% (10%)	84% (12%)	274 (10)
Therapies	52% (-7%)	78% (-1%)	89% (0%)	4691 (132)

0-19/25 Performance

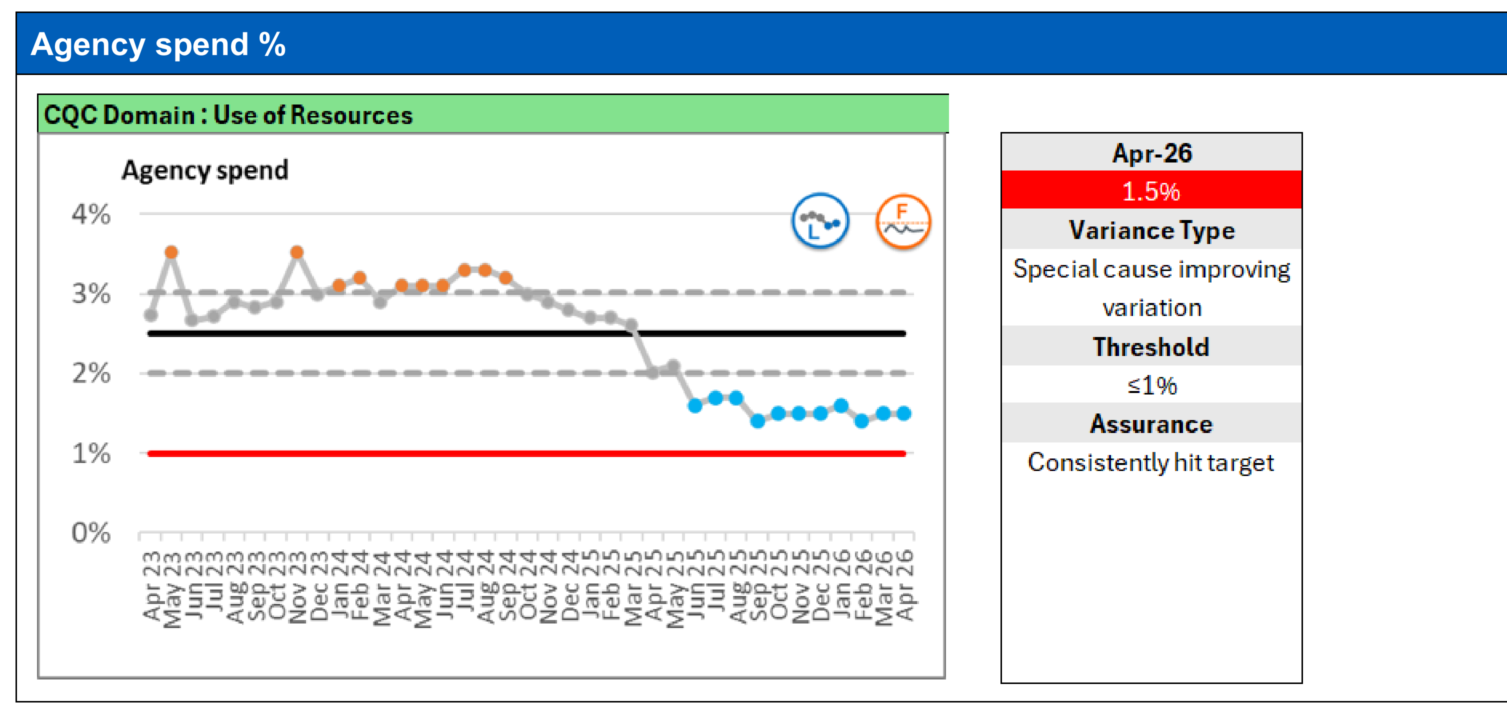
0-19/25 Services - April 26								
KPI	East Cheshire		Knowsley		St Helens		Wirral	
	In Mth	YTD	In Mth	YTD	In Mth	YTD	In Mth	YTD
Birth visits 14 days	89.1%	89.1%	90.9%	90.9%	90.7%	90.7%	92.2%	92.2%
12 month reviews	88.1%	88.1%	93.8%	93.8%	92.9%	92.9%	93.3%	93.3%
2.5 year reviews	88.4%	88.4%	88.5%	88.5%	94.0%	94.0%	95.1%	95.1%
Breastfeeding 6-8 weeks	61.5%	61.5%	35.4%	35.4%	37.4%	37.4%	44.1%	44.1%

CFO Finance Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Apr 26	1.5%	≤1%			2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

Agency spend %

CQC Domain : Use of Resources



Apr-26
1.5%
Variance Type
Special cause improving variation
Threshold
≤1%
Assurance
Consistently hit target

Finance

Executive Summary

At the end of April 2026 (M1), the Trust is reporting a balanced position against plan year to date. The M1 position includes the impact of industrial action, which is assumed to be funded from a combination of local and national mitigations.

The Trust's financial plan is yet to be agreed with NHSE and therefore remains subject to revision.

The Trust identified three key risks in the Trust plan:

- Full CIP Delivery: The primary risk to achieving the 2026/27 financial position is delivery of our CIP target of £30.7m. The current risk adjusted forecast for delivery is £23.1m.
- Activity / Casemix: After accounting for the impact of industrial action, estimated elective income is in line with plan at M1.
- Maintaining Grip and Control: Additional actions to support delivery of the agreed plan have been maintained, with enhanced controls across variable pay, non-core spend, discretionary non-pay, elective income, and a non-clinical vacancy freeze remaining in effect.

The deficit continues to exert 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 M1 was £2.7m, in line with NHSE's stipulated minimum cash balance. The Trust is adhering to the agreed cash mitigation plan, but until a sustainable financial position is achieved, this remains a significant issue. The revenue support applications for April and May were approved, and the application for June has been submitted.

It is important to note that management of risks against this plan alone does not deliver long-term financial sustainability. The significant improvement required for sustainability will be delivered through the medium-term finance plan (MTFP).

The risk ratings for delivery of agreed KPIs in 2026/27 are:

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Agency spend	Apr 26	1.5%	≤1%			2.5%
I&E Position	Apr 26	-£2.9m	-£3.0m			
Cumulative CIP	Apr 26	£1.2m	£1.6m			
Capital Expenditure	Apr 26	£0.1m	£1.2m			
Cash Position	Apr 26	£2.7m	£2.7m			

The Board is asked to:

- Note the report.

- Note that the plan has not been approved by NHSE and that further measures are required to meet the mandated control total.
- Note that the Trust's most immediate finance risk remains the cash position, that the Trust continues to follow the agreed processes for mitigating this issue and therefore to
- Approve that the CFO submits additional applications based on confirmed need.
- Approve the revisions to the capital budget.

I&E Position

Narrative:

The table below summarises the M1 position:

	In Month		
Cost Type	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£39.8m	£39.5m	-£0.2m
Other Operating Income	£3.4m	£3.8m	£0.4m
Total Income	**£43.2m**	**£43.4m**	**£0.2m**
Employee Expenses	-£33.9m	-£34.1m	-£0.2m
Operating Expenses	-£12.6m	-£12.4m	£0.2m
Non Operating Expenses	-£0.5m	-£0.3m	£0.2m
CIP	£0.9m	£0.5m	-£0.4m
Total Expenditure	**-£46.2m**	**-£46.3m**	**-£0.1m**
Reported Position	**-£3.0m**	**-£2.9m**	**£0.0m**

Key variances within the YTD position are:

Clinical Income – after adjusting for IA, clinical income is £0.2m off plan, driven by £0.1m lost elective activity in Surgery and £0.1m in respect of high cost drugs and devices.
Other Operating Income – positive variance of £0.4m driven by increased HEE monies.
Employee Expenses - £0.2m adverse variance principally driven by remaining escalation capacity and additional bank spend due to IA offset by our risk provision.
Operating expenses – £0.2m positive variance mainly driven by reduced spend on supplies within Estates.

The Trust's agency costs remained at 1.5% of total pay bill for the month, which is above the revised target of 1.0% set by NHSE.

Cumulative CIP

Narrative:

The Trust has delivered £1.2m of recurrent CIP at M1 against a profiled target of £1.6m, resulting in an early shortfall against plan. This is offset by underspends elsewhere that the Trust is currently reviewing to confirm whether the improvement in run rate can be transacted as CIP.

For 2026/27 as a whole, the CIP target is 6%, equivalent to £30.7m and 305 WTE. At the start of the year, schemes identified total £30.9m, which is 101% of target, but this reduces to £23.0m on a risk-adjusted basis. This means the overall value identified is encouraging, but the deliverability of the programme remains the more significant issue and will require continued grip through operational and divisional governance routes.

Elective Activity

Narrative:

After accounting for Industrial Action, elective and day case activity is £0.1m below plan at M1 - this is driven by Trauma and Orthopaedics. The level of underperformance remains subject to estimation and coding assumptions.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2026/27 at M1:

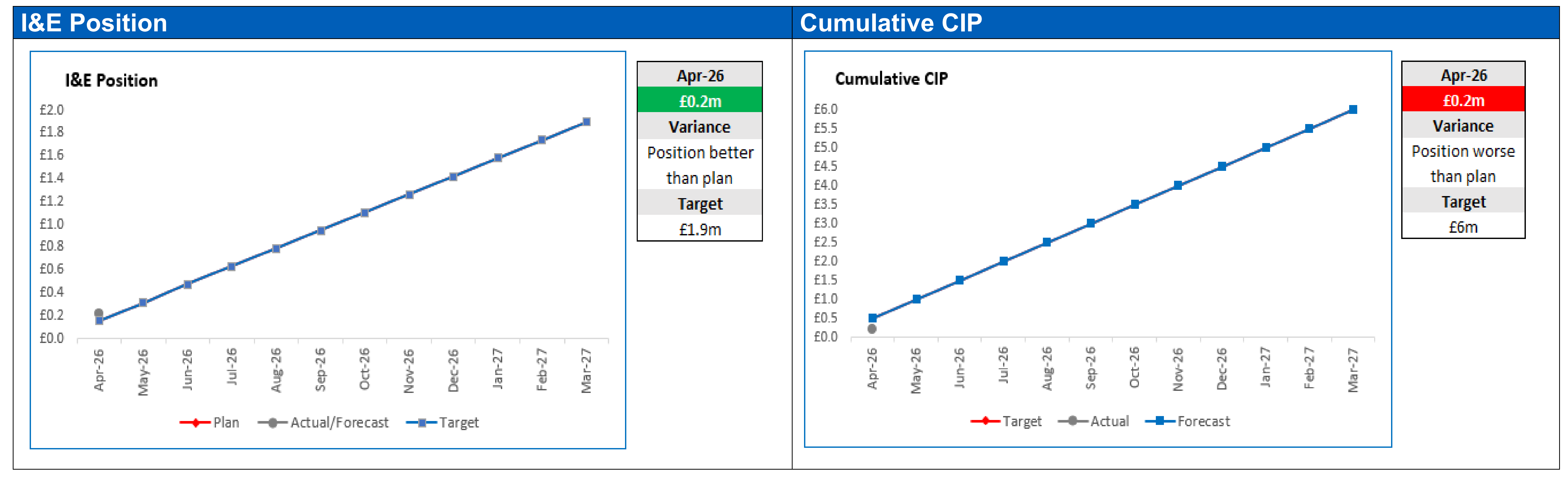
Description	Approved Budget at M1
CDEL	
Internally Generated	£9.765m
Internally Funded	£4.386m
ICB/PDC/WCHC	£5.175m
Estates Safety	£5.288m
Charity	£0.000m
Confirmed CDEL	**£24.614m**
Total Funding for Capital	**£24.614m**
Capital Programme	
Estates, facilities and EBME	£8.013m
Operational delivery	£10.956m
Medical Education	£0.075m
Transformation	£1.000m
Digital	£0.900m
UECUP	£1.708m
PDC commitments	£0.295m
ICB hosted	£1.668m
Charity	£0.000m
Approved Capital Expenditure Budget	**£24.614m**
Total Anticipated Expenditure on Capital	**£24.614m**
Under/(Over) Commitment	**£0.000m**

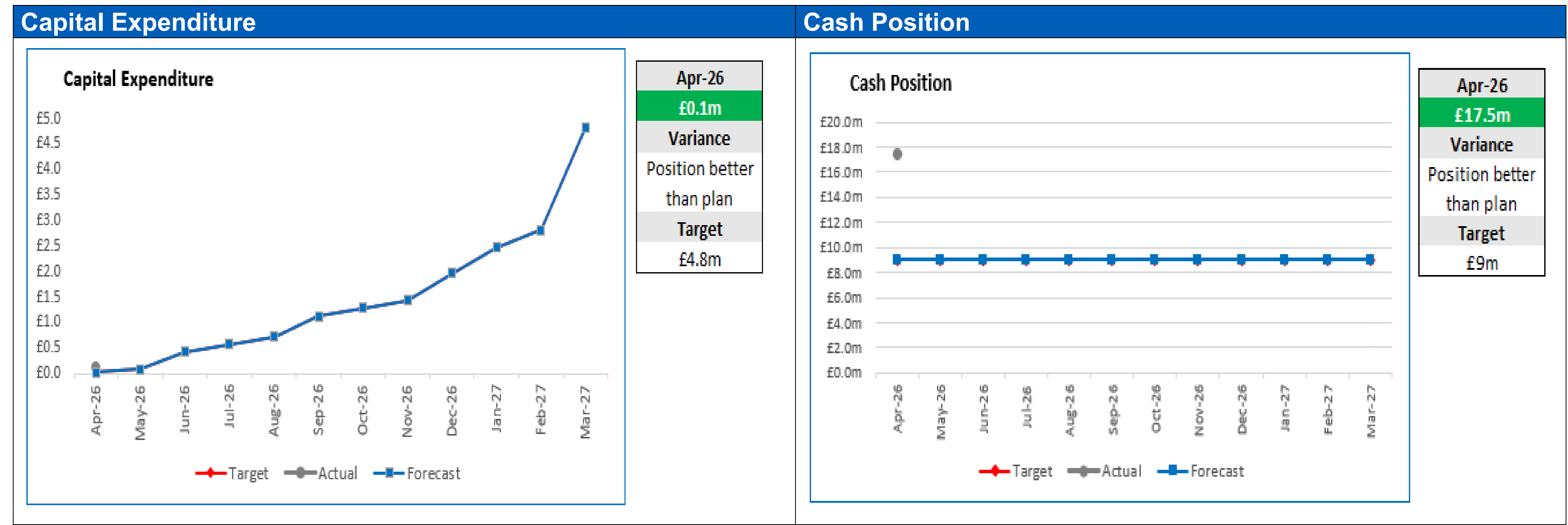
This includes the assumed external funding and cost of Same Day Emergency Care scheme, which has yet to receive full approval from NHSE.

Cash Position
Narrative: The cash balance at the end of M1 was £2.7m. NHSE has continued to approve cash support, the requirements for which are driven by having a non-cash backed deficit. The Trust's cash mitigation actions are consistent with the NHS cash regime. These include: <u>Management of payments</u> - continued daily management of payments to and from other organisations both NHS and non NHS. <u>Analysis/CFO oversight</u> - Continued daily monitoring and forecasting of the Trust cash position and our Public Sector Payment Performance metrics. <u>Debt recovery</u> - Monitoring and escalation of any aged debt delays. <u>Support</u> - the national 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.

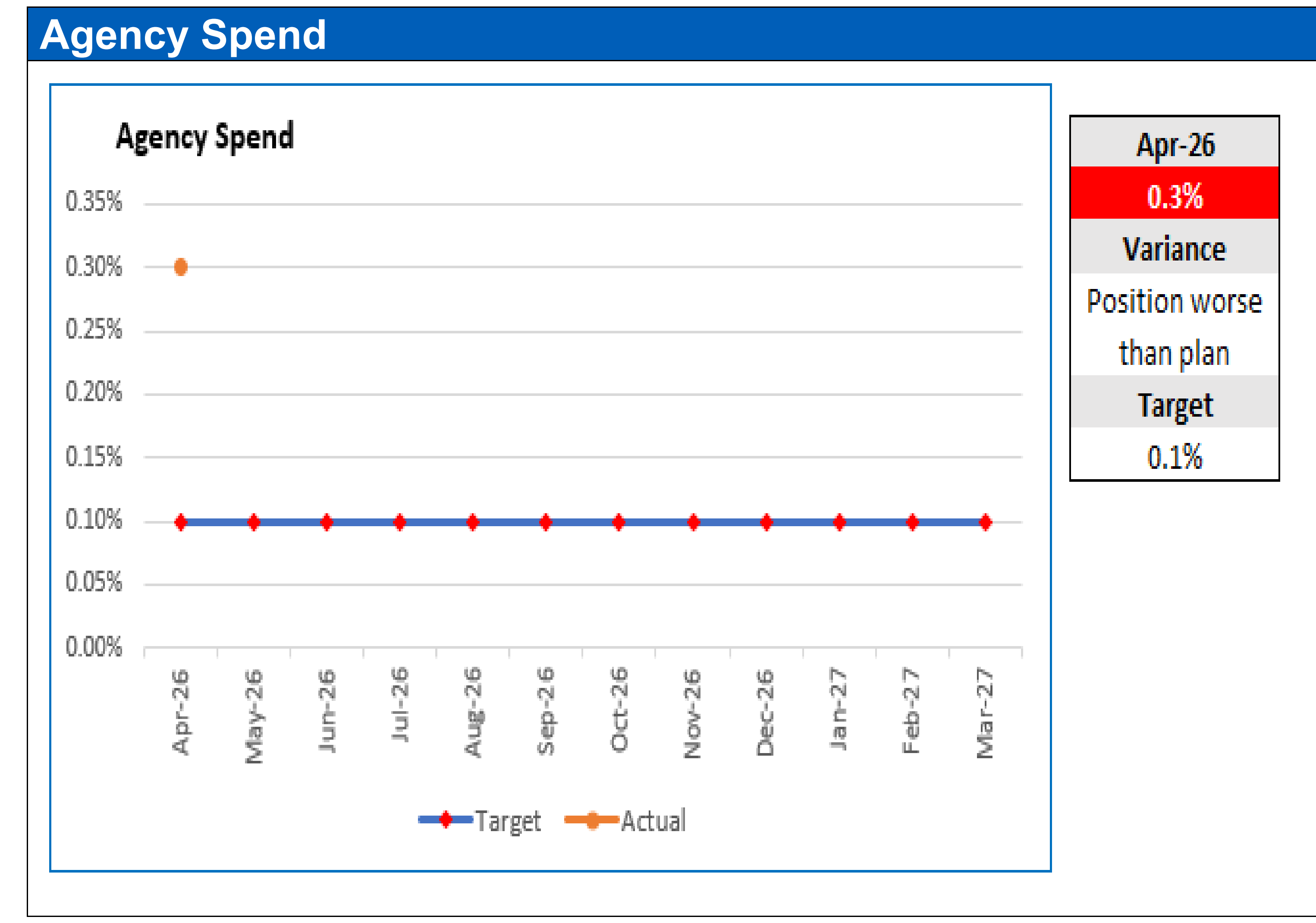
Finance Summary - WCHC

Statutory Financial Targets	RAG (M1)	RAG (Forecast)
Financial stability	Green	Green
Agency spend	Red	Green
Financial sustainability	Green	Green
Financial Efficiency	Red	Green
Capital	Green	Green
Cash	Green	Green




Capital Expenditure
Cash Position
Capital Expenditure
£5.0
£4.5
£4.0
£3.5
£3.0
£2.5
£2.0
£1.5
£1.0
£0.5
£0.0
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Target
Actual
Forecast
Apr-26
£0.1m
Variance
Position better than plan
Target
£4.8m
Cash Position
£20.0m
£18.0m
£16.0m
£14.0m
£12.0m
£10.0m
£8.0m
£6.0m
£4.0m
£2.0m
£0.0m
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Oct-26
Nov-26
Dec-26
Jan-27
Feb-27
Mar-27
Target
Actual
Forecast
Apr-26
£17.5m
Variance
Position better than plan
Target
£9m

Agency Spend



Apr-26
0.3%
Variance
Position worse than plan
Target
0.1%

Finance

Executive Summary

At the end of April 2026 (M1), the Trust is reporting a £0.1m surplus to plan, with the overall year to date position presented with no variance to plan. The reported position reflects favourable performance across pay and non-pay expenditure, partially offset by an early shortfall in delivery of the Cost Improvement Programme (CIP).

While the reported financial position is positive at this early stage, the planned workforce and CIP positions for 26/27 are not yet realised and therefore the Trust has not yet delivered the required fully sustainable underlying improvement. For example workforce total numbers are above plan, equivalent to 2.2%, driven by CIP not yet delivered.

The risk ratings for delivery of agreed KPIs in 2026/27 are:

KPI	Latest data period	Measure	Target	Variance	Assurance	Mean
Agency Spend	Apr-26	0%	<=1%			
I&E Position	Apr-26	£0.2m	£0.2m			
Cumulative CIP	Apr-26	£0.2m	£0.5m			
Capital Expenditure	Apr-26	£0.1m	£0.0m			
Cash Position	Apr-26	£17.5m	£9.0m			

The Board is asked to:
- Note the report.
- Note that full CIP delivery is required to achieve the planned sustainable financial position.

I&E Position

Narrative:

The table below summarises the M1 position:

Cost Type	In Month		
	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£8.8m	£8.8m	-£0.0m
Other Operating Income	£0.2m	£0.2m	£0.0m
Total Income	**£9.0m**	**£9.0m**	**£0.0m**
Employee Expenses	-£7.0m	-£6.8m	£0.3m
Operating Expenses	-£1.6m	-£1.5m	£0.1m
Non Operating Expenses	-£0.6m	-£0.5m	£0.0m
CIP	£0.4m	£0.0m	-£0.4m
Total Expenditure	**-£8.9m**	**-£8.8m**	**£0.0m**
Reported Position	**£0.2m**	**£0.2m**	**£0.1m**

The Trust is reporting a £0.2m surplus at M1. This is attributable to positive variances in pay and non-pay, partly offset by a shortfall in CIP delivery. There is no variance to plan in respect of income, with the majority of income being received via block contract.

Employee expenses have a £0.3m positive variance, with underspends across a number of services and corporate areas. This is supported by a substantive pay underspend of £0.394m, despite unachieved CIP of £0.185m.

Agency costs are £0.017m adverse in month, driven by Specialist Medical Services, while bank costs are £0.254m adverse, driven by Specialist Medical Services (£0.098m), Community Response (£0.089m) and Nursing (£0.045m).

Operating expenditure has a positive variance of £0.1m, with underspends across all categories and divisions.

The month 1 position therefore remains positive overall, but until savings are recurrently delivered within CIP the underlying position will need continued review.

Cumulative CIP

Narrative:

The Trust's CIP target for 2026/27 is 6%, equivalent to £6.0m and 64 WTE, this target is profiled equally across the year. At M1, the target is £0.5m, with £0.2m achieved.

The key focus for month 2 onwards will therefore be on converting the identified opportunities and underspends into transacted, recurrent benefit and ensuring that delivery improves sufficiently to deliver the full year target.

Capital Expenditure

Narrative:

The table below confirms the Trust's capital budget for 2026/27 at M1:

Description	Approved Budget at M1
CDEL	
Internally Generated	**£3.678m**
ICB/PDC	**£1.167m**
Estates Safety	**£0.031m**
Confirmed CDEL	**£4.876m**
Total Funding for Capital	**£4.876m**
Capital Programme	
Estates, facilities and EBME	**£0.371m**
Operational delivery	**£1.276m**
Transformation	**£0.160m**
Digital	**£0.560m**
PDC commitments	**£1.167m**
IFRS16	**£1.342m**
Approved Capital Expenditure Budget	**£4.876m**
Total Anticipated Expenditure on Capita	**£4.876m**
Under/(Over) Commitment	**£0.000m**

Cash Position

Narrative:

The cash balance at the end of M1 was £17.5m.

CPO Workforce Summary - WUTH

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Sickness absence % - in-month rate	Apr 26	5.53%	≤5%			5.94%
Staff turnover % - in-month rate	Apr 26	0.62%	≤1%			87.73%
Mandatory training % compliance	Apr 26	88.82%	≥90%			92.05%
Appraisal % compliance	Apr 26	87.33%	≥88%			0.83%

Highlights

Appraisal % Compliance

Organisational appraisal compliance remains slightly below the 88% KPI (last met December 2025 at 88.32%). However, there are some divisions that regularly meet the KPI each month.

Data from April demonstrates a minimal increase in Trust compliance in comparison to March (87.01% vs 87.33%), with improved compliance in Clinical Support, Estates Facilities & Capital, and Women & Children's divisions.

Division	March 2026 (%)	April 2026 (%)	Variance (%)	KPI	Compliance
Clinical Support	87.77	88.78	+ 1.01	88%	
Corporate Support	82.89	80.40	- 2.49		
ED	65.61	N/A	N/A		
EF&C	80.64	83.22	+ 2.58		
Medicine	90.77	87.01	- 3.76		
Surgery	93.09	91.09	- 2.00		
W&C	87.89	91.40	+ 3.51		
Trust	**87.01**	**87.33**	**+ 0.32**		

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

- Clinical Support – 88.78%
- Surgery – 91.09%
- Women & Children's – 91.40%

Areas of Concern

Appraisal % Compliance

Data shows a reduction in compliance in Corporate Services, Surgery and Medicine. Although Surgery had a reduction in compliance (-2.00%) they are still meeting the Trust KPI. ED has joined with the Medicine Division, meaning the month-on-month comparison between March and April is not available within the workforce reports. This has also contributed to the fall in compliance within Medicine for April 2026.

Forward Look (Actions)

Appraisal % Compliance

Recent actions taken

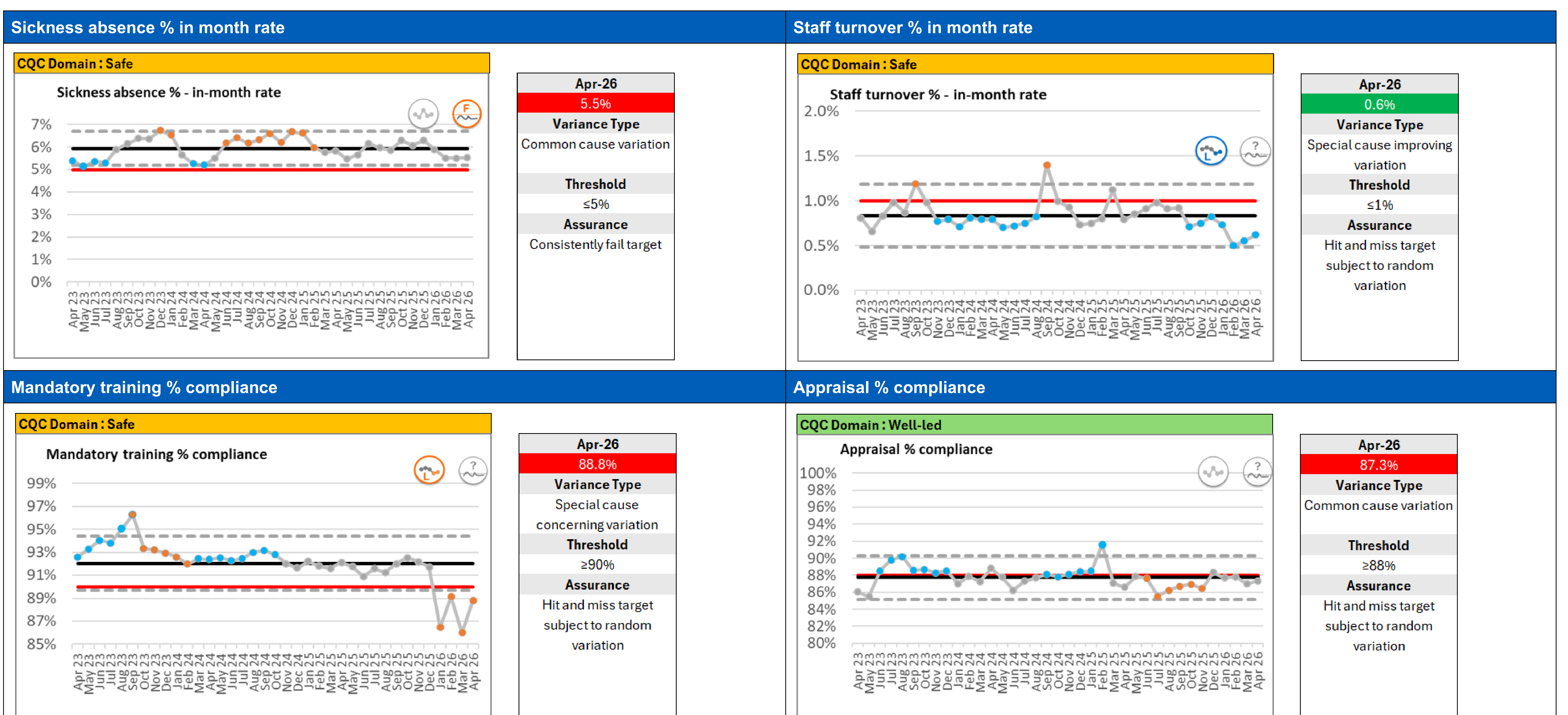
- Appraisal audits are now live. Selection for audit is based on compliance being below target for 3 months or more. The audit is intended to be supportive and aims to identify reasons for non-compliance; barriers preventing compliance and to understand the appraisal experience of staff.
- e-Learning package now live and available for completion via ESR. The content is to support staff in engaging with and gaining more value from their appraisal and check-in discussions.
- An additional reporting field within the workforce reports showing how many check ins (1:1's/ management supervision) has been introduced. This improvement is following feedback from divisions via HRBP's.
- A review of the training materials has concluded and now has stronger messaging regarding compliance reporting and the importance of managers gaining access to the workforce reports so that they can proactively monitor compliance positions.
- Appraisal training for reviewers (managers) continues to be available for access.

Looking forward actions and recommendations:

- Ongoing proactive targeting of appraisal audits based on compliance positions.
- Review of appraisal audit effectiveness to be conducted in Q2/ Q3.
- HRBP's working with their respective divisional leadership teams to drive compliance improvement, with OD support, where required.
- Feedback re the new Appraisal and Check In documentation continues to be positive, indicating that it's more intuitive. Consequently, conducting a fuller review of the appraisal paperwork moved to Q3 2026.

Sickness Absence	Sickness Absence	Sickness Absence
Both Corporate Support (4.29%) and Medicine & Acute Division (4.66%) were below target.	Sickness absence levels continue to be above the Trust's 5% target and following a period of active reduction post winter have stabilised at 5.5% with a narrow variance. Latest performance is 5.53% in-month which is a very slight increase of 0.02% since March (5.51%) but an improved in-month position compared to April 25 (5.84%). The rolling sickness absence has improved each month and is currently at 5.92%. This is also an improved position on the rolling sickness rate compared to April 25 (6.16%). LT sickness increased to 3.65% and ST decreased to 1.90%. The current in-month top 3 reasons are: • Mental health (34.77%) • MSK (8.51%) and • Gastro (7.87%). Surgery has the highest sickness rate at 6.42%, followed by Estates, Facilities & Capital (6.39%), W&C (6.36%) and Clinical Support Division (5.65%). The three main staff groups for sickness are: Additional Clinical Services (7.54%), Estates and Ancillary (6.93%) and Nursing and Midwifery (5.66%). BAF risk 4 currently stands at 16 due to the increased likelihood of sickness absences, significant period of change for corporate services and the impact Trust financial pressures are having on delivery (vacancy freeze etc). Sickness absence has been identified as one of the 'drivers of the deficit' and included within the medium-term financial plan. Through last year's Sickness Absence project extensive work has been undertaken across the Trust consisting of targeted interventions tailored to the requirements of the Trust, all in addition to BAU sickness absence management. This has resulted in the rolling sickness absence reducing from 6.13% to 5.94% achieving cost avoidance of £726K (from staff groups roles backfilled via premium spend). 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 and therefore require targeted Trust level plans to ensure further improvements to reduce sickness back within tolerance ≤5%. The Trust continues to implement a wide range of supportive interventions as well as robust application of the policy. Due to the success of the sickness absence project a new 3-year Sickness Transformation project is underway with the aim of reducing	**Sickness Transformation Project** • Objective to reduce Trust wide sickness to <5% within 3 years, with a longer-term target to meet the NHS 10-year plan target of 4.3%. For 2026 the target ai £1m contributing to the Trust Cost Improvement Programme broken down into divisional plans with specific targets plus "Everyday Counts" communications campaign. • 4 Workstreams: ➢ Workstream 1: Targeted Staff Group / Divisional specific action plans ➢ Workstream 2: Strengthening leadership and management accountability ➢ Workstream 3: Proactive Wellbeing Support ➢ Workstream 4: Strengthening Trust Policy and process to further drive change **Proactively supporting physical health and wellbeing:** • Aligned with the top reason for sickness, Wellbeing Surgeries took place in April & May. • Active promotion of Mental Health during May – which is Mental Health Awareness month, with a range of activities including a dedicated drop-in event. • Smoking cessation clinic for staff • Continuation of the communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness, current focus on debt awareness. • Latest cohort of the Well WUTH & WCHC RTW programme in-progress (7 attendees in total across both Trusts) • New Well WUTH and WCHC intranet site in-development • WUTH Psychotherapist has provided additional psychological support post traumatic event and to support staff to safe from suicide • Cervical Screening Living Well Bus (mobile clinic) attending in August. Early screening is key to prevent cancers and promote health. • New psychological intervention process, support and training being designed for managers to help staff post a significant event. • New 'Well in Work' programme currently in design. **Managing Absence:** • Following the pilot of Well WUTH & WCHC the first cohort in January returned 12 out of the 15 staff, 2 remained absent due to complex health and 1 retired. The March cohort is currently being evaluated and the May programme has commenced. • New Resident Doctors' RTW SOP agreed at JLNC. • Continuation of sickness absence training.

	sickness initially to within the tolerance ≤5% and then further, as detailed in the NHS 10-year plan, and delivering significant savings through reductions in premium backfill outlay.	• High impact action plans for each Division focused on hot spots. • 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.
Mandatory Training Compliance % Trust compliance has increased from March onwards. Across 25/26 Q4 and 26/27 Q1, Trust compliance dropped below the 90% KPI due to an increase in staff required to undertake fire safety e-learning (86.11% compliance in April 26 compared to 47.22% compliance in Jan 26) and changes from the final implementation stages of the core skills training framework v1.1. This drop was anticipated and rapid improvement has been sustained with compliance once again close to target.	**Mandatory Training Compliance %** Whilst overall compliance is increasing, some courses have low compliance figures e.g: • Resuscitation L3 for Adults (60%) and Paediatrics (56.73%) • IPC Level 2, and Resuscitation L2 (paediatric) are also below 80%. Discussions are on-going with the course SME's to discuss what further support is required to increase compliance.	**Mandatory Training Compliance %** The Trust is awaiting the new updated core skills training framework. This was due in May however due to council elections and a change in health secretary, this has been moved back with no confirmed date for publication. The Trust is ready to support both PVP and Moving Handling to become fully aligned along with any additional changes the new framework indicates.


Sickness absence % in month rate
CQC Domain : Safe
Sickness absence % - in-month rate
Apr-26
5.5%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Consistently fail target
Staff turnover % in month rate
CQC Domain : Safe
Staff turnover % - in-month rate
Apr-26
0.6%
Variance Type
Special cause improving variation
Threshold
≤1%
Assurance
Hit and miss target subject to random variation
Mandatory training % compliance
CQC Domain : Safe
Mandatory training % compliance
Apr-26
88.8%
Variance Type
Special cause concerning variation
Threshold
≥90%
Assurance
Hit and miss target subject to random variation
Appraisal % compliance
CQC Domain : Well-led
Appraisal % compliance
Apr-26
87.3%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit and miss target subject to random variation

Workforce Summary - WCHC

KPI	Latest date period	Measure	Target	Variation	Assurance	Mean
Turnover Rolling 12 Months	Apr 26	12.8%	10.4%			12.5%
Mandatory Training Compliance	Apr 26	94.8%	90.0%			95.0%
Sickness Absence	Apr 26	6.4%	5.0%			6.5%
Sickness Absence (Short Term)	Apr 26	1.2%	2.0%			1.6%
Sickness Absence (Long Term)	Apr 26	5.2%	3.0%			4.9%
Agency usage	Apr 26	0.3%	1.0%			0.9%
Variance to Agency Cap (£)	Apr 26	-203784.4	-			-175005.4
% of Agency Usage against Funded WTE	Apr 26	0.00%	-			0.6%
% of Bank Usage against Funded WTE	Apr 26	4.40%	-			3.4%
% of Contracted FTE Vacancies	Apr 26	3.8%	6.0%			5.1%

Highlights

Turnover %

Whilst turnover is above target, target is under review as higher turnover will support required headcount reductions in line with the Trust's workforce plan.

Areas of Concern

Sickness Absence

Sickness absence remains a cause for concern as it is above the Trust ≤5% target at 6.4% with a clear contribution from long-term sickness across the year. The in-month rate shows a slight (0.11%) increase compared to March 2026 and the rolling remains elevated but static at 7.06%.

Long term sickness peaked at 6.25% in August'25 and following extensive sickness absence work this has reduced month by month for 6 out of the 8 months (apart from the expected seasonal increase in Nov and Dec) and is down to 4.62% in April'26.

The top 3 reasons are:

- Mental health (anxiety, stress, depression) (42.89%)
- Gastro (11.34%)
- MSK (10.86%)

Localities with the highest sickness absence are Specialist Medical (8.54%), Community Response (7.19%), Nursing (7.54%), Corporate (12.32%) and Children's (5.77%). Only Therapies are below target (4.63%). All areas have demonstrated an improvement in-month except for Nursing (1.8% increase, rising from 5.74% in March to 7.54% in April).

Recorded RTW discussions improved to 81%.

Forward Look (Actions)

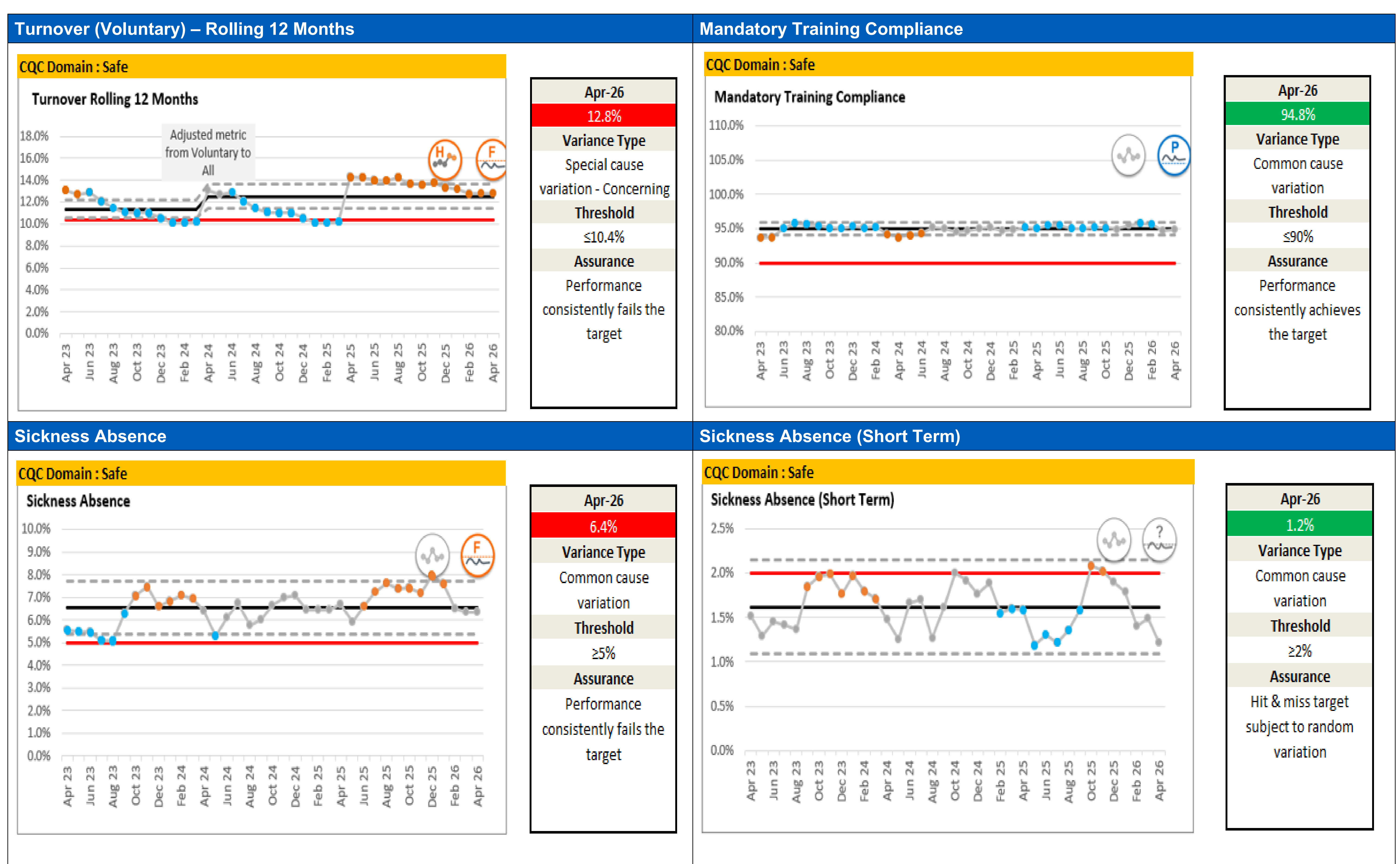
Sickness Sustainability Project

- Objective to reduce Trust wide sickness to <5% within 3 years, with a longer-term target to meet the NHS 10-year plan target of 4.3%. For 2026 the target is a 1.1% reduction to 6%.
- 4 Workstreams:
  - Workstream 1: Strengthening leadership and management accountability
  - Workstream 2: Proactive Wellbeing Support
  - Workstream 3: Service Specific Targeted Action Plans
  - Workstream 4: Strengthening Trust Policy and Process to further drive change

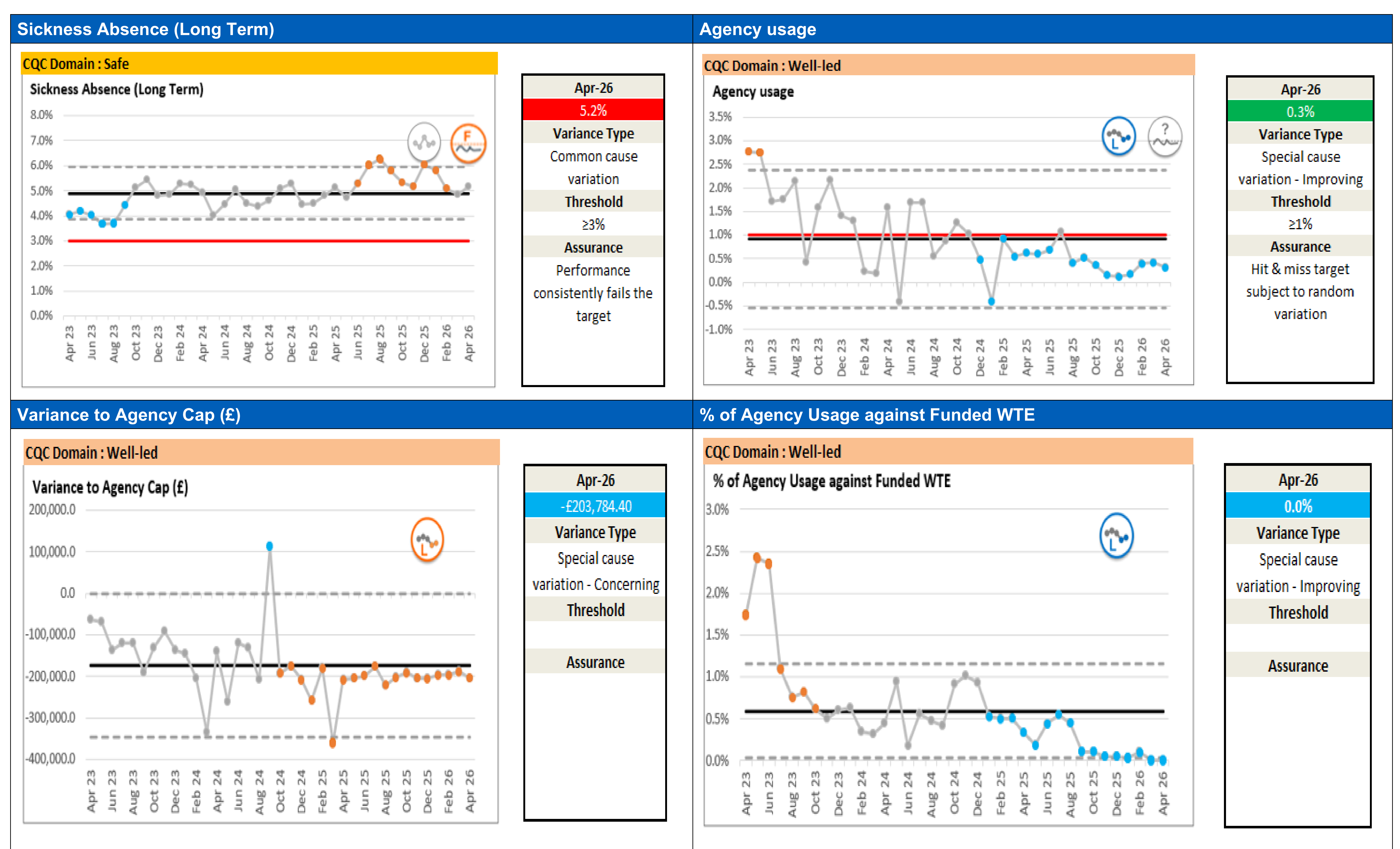
Proactively supporting health & wellbeing:

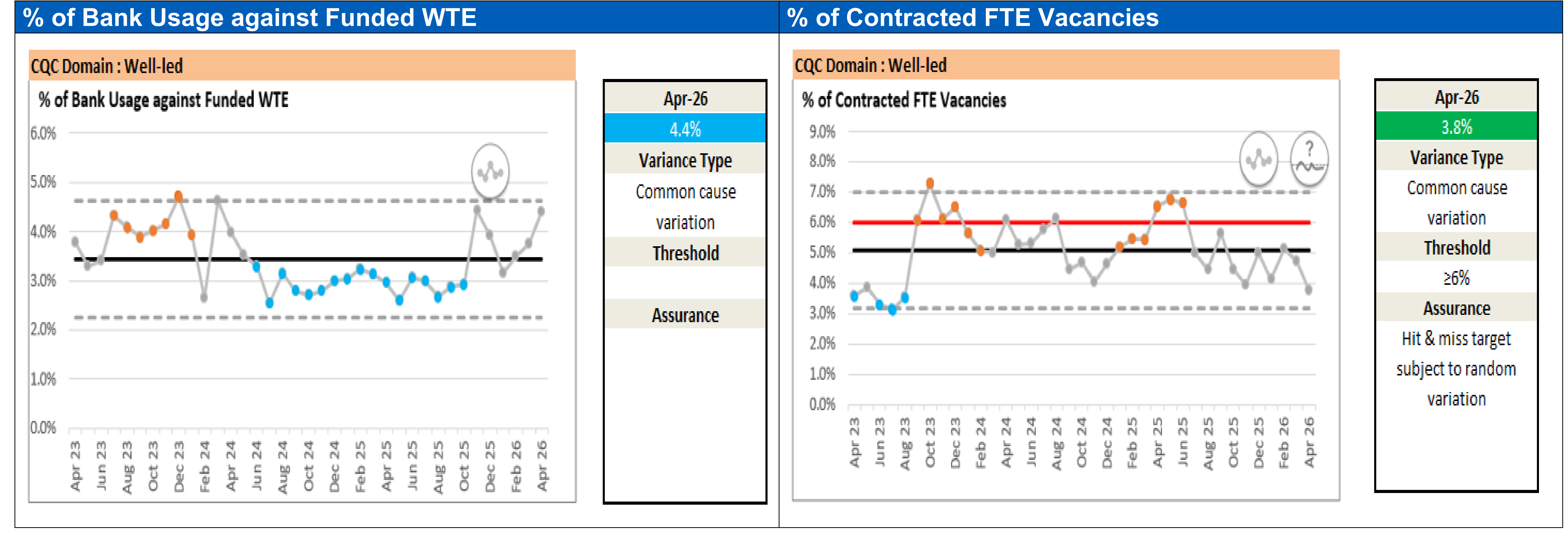
- Aligned with the top reason for sickness, Wellbeing Surgeries took place in April and May.
- Active promotion of Mental Health during May – which is Mental Health Awareness month, with a range of activities including a dedicated drop-in event.
- Mental Health First Aiders their departmental areas and contact details promoted on Staff Zone.

	The risk score on the register has been reviewed and increased to a 15 bringing it in line with WUTH and reflecting the likelihood. Sickness absence has been identified as a 'driver of sustainability' to reduce absence, increase worker availability and increase productivity. Through the new Sickness Transformation project building on the extensive work that was delivered through the sickness absence interventions last year, 4 workstreams of work are being undertaken aiming to reduce both the rolling sickness absence and bank usage.	• Continuation of communication campaign 'Every Day Counts' aimed at raising awareness that the Trust are proactively tackling sickness focus on stress awareness. • Latest cohort of the Well WUTH & WCHC RTW programme in-progress (7 attendees in total across both Trusts) • New Well WUTH and WCHC intranet site in-development. • WUTH Psychotherapist has provided additional psychological support post traumatic event and has supported managers with a new workshop keeping staff safe from suicide and improve mental health. • Further effective wellbeing conversation training being delivered. • EAP uptake has increased this quarter to 26.7%. • New 'Well in Work' programme currently in design. **Managing Absence:** • Following the pilot of Well WUTH & WCHC the first cohort in January returned 12 out of the 15 staff, 2 remained absence due to complex health and 1 retired. The March cohort is currently being evaluated and the May programme has commenced. • Continued focus on LTS cases ensuring plans to return to work and formal progression as per policy. • Exploration of an OD led listening event for Urgent Care Centre staff. • Further review undertaken of PAM OH Reports to assess quality. • Sharing of example high impact action plans down to ward/team level with Service Lead to improve focus and accountability • 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. • 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. • Local Sickness Audits reported through PCOG.



Turnover (Voluntary) – Rolling 12 Months
CQC Domain : Safe
Turnover Rolling 12 Months
Adjusted metric from Voluntary to All
Apr-26
12.8%
Variance Type
Special cause variation - Concerning
Threshold
≤10.4%
Assurance
Performance consistently fails the target
Mandatory Training Compliance
CQC Domain : Safe
Mandatory Training Compliance
Apr-26
94.8%
Variance Type
Common cause variation
Threshold
≤90%
Assurance
Performance consistently achieves the target
Sickness Absence
CQC Domain : Safe
Sickness Absence
Apr-26
6.4%
Variance Type
Common cause variation
Threshold
≥5%
Assurance
Performance consistently fails the target
Sickness Absence (Short Term)
CQC Domain : Safe
Sickness Absence (Short Term)
Apr-26
1.2%
Variance Type
Common cause variation
Threshold
≥2%
Assurance
Hit & miss target subject to random variation


Sickness Absence (Long Term)
CQC Domain : Safe
Sickness Absence (Long Term)
Apr-26
5.2%
Variance Type
Common cause variation
Threshold
≥3%
Assurance
Performance consistently fails the target
Agency usage
CQC Domain : Well-led
Agency usage
Apr-26
0.3%
Variance Type
Special cause variation - Improving
Threshold
≥1%
Assurance
Hit & miss target subject to random variation
Variance to Agency Cap (£)
CQC Domain : Well-led
Variance to Agency Cap (£)
Apr-26
-£203,784.40
Variance Type
Special cause variation - Concerning
Threshold
Assurance
% of Agency Usage against Funded WTE
CQC Domain : Well-led
% of Agency Usage against Funded WTE
Apr-26
0.0%
Variance Type
Special cause variation - Improving
Threshold
Assurance



% of Bank Usage against Funded WTE
CQC Domain : Well-led
% of Bank Usage against Funded WTE
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr 23
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Dec 24
Feb 25
Apr 25
Jun 25
Aug 25
Oct 25
Dec 25
Feb 26
Apr 26
Apr-26
4.4%
Variance Type
Common cause variation
Threshold
Assurance
% of Contracted FTE Vacancies
CQC Domain : Well-led
% of Contracted FTE Vacancies
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr 23
Jun 23
Aug 23
Oct 23
Dec 23
Feb 24
Apr 24
Jun 24
Aug 24
Oct 24
Dec 24
Feb 25
Apr 25
Jun 25
Aug 25
Oct 25
Dec 25
Feb 26
Apr 26
Apr-26
3.8%
Variance Type
Common cause variation
Threshold
≥6%
Assurance
Hit & miss target subject to random variation

Group Board of Directors in Public **Item 8**

03 June 2026

Title	Joint Board Assurance Framework 26-27
Area Lead	All Exec Leads
Author	Ali Hughes, Joint Director of Corporate Affairs & Communications

Purpose of the Report and Recommendation	
Report For	Approval

This report provides the Board of Directors with the new strategic risks in the Board Assurance Framework for review and approval, following work completed by Committees of the Board during April & May 2026.

It is recommended that the Board:

- Reviews the detail shared in relation to each of the risks and the new format of the BAF agreed in April 2026
- Reviews the risk ratings noting that there are currently 5 high-level strategic risks.
- Approves the position reported
- Notes that further work through the Committees of the Board will continue to monitor each of the risks

Key Points to Note

The new Joint BAF has been developed to align with the strategic objectives as set out in the new Joint Strategy. The Group Board approved the strategic objectives on 1 April 2026. A new structure for the BAF has also been agreed which will be implemented during Q1 26-27 with input from each of the Joint Committees.

Key Risks

This report relates to these key risks:

- The BAF records the principal risks that could impact on the Trusts' ability in achieving their strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trusts being unable to achieve their strategic objectives or statutory obligations. There are opportunities through the effective development and use of the BAF, to enhance the delivery of the 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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	No
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
1 April 2026	Group Board	Board Assurance Framework 26-27	The Group Board reviewed and approved the new strategic risk for monitoring through the BAF during 2026-27.
16 April 2026	Digital Committee	Board Assurance Framework 26-27	The Committee reviewed strategic risk ID12 and agreed that ID11 should have oversight by the Committee for a cyber focus. The risk appetites and risk ratings were agreed and ID11 was amended to reflect a 'Seek' appetite
22 April 2026	Finance & Performance Committee	Board Assurance Framework 26-27	The Committee reviewed five strategic risks ID01, ID02, ID05, ID06 and ID11. The risk appetites and risk ratings were agreed and ID06 was amended to reflect a 'Seek' appetite.
27 May 2026	People Committee	Board Assurance Framework 26-27	The Committee reviewed the two strategic risks, ID03 and ID04, and agreed to a further review of ID04 with a particular focus on the controls related to Staff Experience and Engagement and the current risk rating. The Committee also supported an amendment to the risk appetite of both risks to 'Seek' recognising the transformational change required across the Trust during 26-27.
29 May 2026	Quality Committee	Board Assurance Framework 26-27	The Committee reviewed the three strategic risks (ID01, ID02 and ID08) and supported the risk appetite statements and the current risk ratings and target risk ratings, recognising the on-going role of the Committee to continually review and monitor the risks.

1	Narrative
1.1	The Group Board has in place a full Board Assurance Framework which has been developed to reflect the new Joint Strategy approved in April 2026. Each of the Joint Committees of the Group Board maintains oversight of strategic risks relevant to the duties and responsibilities of the committee. These are detailed in **appendix 1** with alignment to strategic objectives, Executive Lead and committee oversight included. A new structure for the BAF 26-27 has also been developed and the Committees of the Board have reviewed the development of the detail for each strategic risk in the new format.
1.2	Of the 12 strategic risks, 9 have been reviewed by the relevant Committees as described above in the governance journey. The detail for strategic risk ID07 - *Failure to comply with relevant codes of governance, regulation and legislative requirements* is included in the attached appendix for Board review. This will have continued oversight through the Audit & Risk Committees for each statutory Board but given the committee schedule this will not meet again until September 2026. The detail for strategic risks ID09 and ID10 is not included as they will both be reviewed by the Integration Management Board in June 2026.
1.3	Of the 10 strategic risks that have been reviewed, six are currently scoring high-level. These are: ID01 - Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience (RR16). ID02 - Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience (RR16). ID03 - Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care (RR16). ID05 - Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability (RR15). ID06 - Failure to embed service transformation and deliver sustainable efficiency gains (RR15). ID11 - Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care (RR15).

2	Implications

2.1	**Patients** • Any gaps related to these strategic risks could have an impact on the provision of high-quality services, impacting on patient safety and patient experience. • The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**People** • Any gaps related to these strategic risks could have an impact on other people strategic risks including the retention of a skilled workforce. • The quality impact assessments and equality impact assessments 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.

Risk Description	Risk Theme	Strategic Objective	Committee oversight	Exec Lead
1. Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Operational effectiveness	**Delivering Excellence** We will create the conditions for outstanding care and performance	Quality Finance & Performance	Chief Medical Officer Executive Managing Director
2. Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.	Operational effectiveness	**Delivering Excellence** We will create the conditions for outstanding care and performance	Quality Finance & Performance	Chief Medical Officer Executive Managing Director
3. Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care.	Workforce	**Our People** We will nurture an inclusive, compassionate culture where people thrive	People	Chief People Officer
4. Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported	Workforce	**Our People** We will nurture an inclusive, compassionate culture where people thrive	People	Chief People Officer
5. Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability.	Finance & Capital	**Improve and Innovate** We will make improvement and innovation part of how we work	Finance & Performance	Chief Finance Officer
6. Failure to embed service transformation and deliver sustainable efficiency gains.	Operational effectiveness	**Improve and Innovate** We will make improvement and innovation part of how we work	Finance & Performance	Director of Turnaround & Transformation
7. Failure to comply with relevant codes of governance, regulation and legislative requirements	Operational effectiveness	**Delivering Excellence** We will create the conditions for outstanding care and performance	Audit & Risk	Director of Corporate Affairs & Communications
8. Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities.	Quality & Patient Experience	**Healthier Communities** We will drive health equity and support healthier lives	Quality	Chief Nurse
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 and financial) not being realised.	System working & Collaboration	**Collaboration & Partnerships** We will work as one system and one organisation	IMB	Chief Strategy Officer
10. Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services	System working & Collaboration	**Collaboration & Partnerships** We will work as one system and one organisation	IMB	Chief Integration Officer
11. Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care.	Digital & Data Operational Effectiveness	**Advance Digitally** We will develop a secure, connected digital ecosystem fit for the future **Delivering Excellence** We will create the conditions for outstanding care and performance	Finance & Performance Digital (for cyber focus)	Executive Managing Director
12. Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively.	Digital & Data	**Advance Digitally** We will develop a secure, connected digital ecosystem fit for the future	Digital	Chief Finance Officer / SIRO

Committee	Risks	
Quality	3	1, 2 & 8
People	2	3 & 4
Finance & Performance	5	1, 2, 5 & 6, 11
Digital	1	12
Audit	1	7
IMB	2	9 & 10

Risk Description	Committee oversight	Exec Lead	Risk appetite	Initial risk rating (April 2026) I x L	Current risk rating (June 2026) I x L
1. Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Quality Finance & Performance	Chief Medical Officer Executive Managing Director	Minimal	4 x 5 (20)	4 x 4 (16)
2. Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.	Quality Finance & Performance	Chief Medical Officer Executive Managing Director	Minimal	4 x 5 (20)	4 x 4 (16)
3. Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care.	People	Chief People Officer	Seek	4 x 4 (16)	4 x 4 (16)
4. Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported	People	Chief People Officer	Seek	3 x 4 (12)	3 x 4 (12)
5. Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability.	Finance & Performance	Chief Finance Officer	Minimal	5 x 4 (20)	5 x 3 (15)
6. Failure to embed service transformation and deliver sustainable efficiency gains.	Finance & Performance	Director of Turnaround & Transformation	Seek	5 x 4 (20)	5 x 3 (15)
7. Failure to comply with relevant codes of governance, regulation and legislative requirements	Audit & Risk	Director of Corporate Affairs & Communications	Minimal	4 x 3 (12)	4 x 3 (812
8. Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities.	Quality	Chief Nurse	Open	4 x 3 (12)	4 x 3 (12)
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 and financial) not being realised.	IMB	Chief Strategy Officer	TBC		
10. Failure to work effectively with system partners to deliver seamless care, maximise collective resources, and provide effective and inclusive services	IMB	Chief Integration Officer	TBC		
11. Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care.	Finance & Performance Digital (for cyber focus)	Executive Managing Director	Seek	5 x 4 (20)	5 x 3 (15)
12. Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively.	Digital	Chief Finance Officer / SIRO	Seek	4 x 4 (16)	4 x 3 (12)

Risk ID	01
Risk theme	Operational Effectiveness
Risk appetite	**Minimal**
Link to strategic objectives	Delivering Excellence - We will create the conditions for outstanding care and performance
Executive lead	Chief Medical Officer & Executive Managing Director
Committee oversight	Quality and Safety Committee Finance and Performance Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	- Reduced ability to provide care in the most appropriate setting, leading to poorer outcomes - Increased ambulance handover delays and emergency department breaches - Reduced system flow, impacting elective capacity and planned care recovery - Reduced patient confidence, satisfaction and overall experience - Poor experience for patients and carers, particularly for frail, elderly and high-risk groups - Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times - Increased complaints, PALS concerns and potential litigation - Reduced confidence from staff, patients and stakeholders - Reduced system flow and inefficiencies across pathways - Reduced staff morale, engagement and retention - Greater reliance on temporary staffing, impacting continuity and cost	4 x 5 (20)	1) Board and Executive oversight of UEC performance	- Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews - Integrated Performance Report - NOF segmentation tracking - CQC action plans - tracking through Board and Committees	- NHSE oversight (ECIST) - Full engagement in Tier 1 meetings - CQC inspection report(s) and on-going CQC engagement - NOF segmentation publication	4 x 4 (16)	- NOF segment 4 (WUTH) - Exit criteria from financial undertakings re: UEC performance	- New engagement arrangements with NHSE – **Director of Corporate Affairs**	- Regional oversight from June 2026	4 x 2 (8)	
			2) Clinical triage and front-door streaming	- Clinical audit of triage/streaming outcomes - Incident reporting - Incident and complaints analysis - Patient experience feedback - Divisional Performance Reviews - EARC oversight & risk reports - Integrated Performance Report - Implementation of continuous flow model to improve egress from ED - GP streaming at front door with triage to UTC	- External clinical audits - NHSE oversight (ECIST)		- Dependency on short-term escalation measures during sustained pressure	- Development of longer-term system capacity and pathway transformation plans - **Executive Managing Director**			
			3) Enhanced community and intermediate care pathways	- UEC improvement programme - Integration of WUTH and and WCHC clinical services - Integration Management Board / Drivers of the deficit (integration programme)	- System flow reviews - C&M UEC improvement programme - Wirral Unscheduled Care Board						
			4) Early discharge planning and discharge to assess models	- Corridor care action plan (submitted to regional team) - Long Length of Stay (LLoS) meeting chaired by CEO - LLoS metrics and delays in discharge - Internal audit reviews - NOF segmentation tracking - Local Corridor care summit held with action plans from all areas submitted to Improvement Team	- System flow metrics		- Discharge planning effectiveness varies by pathway - Mechanism for monitoring and tracking of corridor care summit action plans	- Strengthen early discharge planning, including greater use of trusted assessor and discharge to assess models - **Chief Medical Officer & Chief Nurse Officer**	- Corridor care action plan includes key actions to address discharge planning ~~- Wirral Corridor care summit taking place on 29.4.26~~		

- Financial penalties or loss of income linked to performance breaches - Increased scrutiny and intervention from regulators and system partners - Failure to meet national urgent and emergency care standards (and impact on NOF rating)		5) Daily SITREPs and senior clinical oversight 6) Patient experience monitoring and complaints management 7) Staff wellbeing and support	- Daily executive / senoir leader visibility in ED - Daily safety huddles - Daily escalation routes - Friends and Family Test results - Patient Experience Strategy - Experience of Care framework - Sickness absence reviews - EAP - Clinical and professional supervision - Rota management	- NHSE daily and weekly SITREP submissions - Full engagement in Tier 1 meetings - HealthWatch reviews - National patient surveys - NSS findings and action plans		

Risk ID	02
Risk theme	Operational Effectiveness
Risk appetite	**Minimal**
Link to strategic objectives	Delivering Excellence - We will create the conditions for outstanding care and performance
Executive lead	Chief Medical Officer & Executive Managing Director
Committee oversight	Quality and Safety Committee Finance and Performance Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to effectively manage planned/scheduled care, adversely impacting on quality of care and patient experience	- Deterioration in patient outcomes due to delays in diagnosis and treatment - Increased clinical risk, including avoidable harm - Reduced patient confidence, satisfaction and overall experience - Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times - Increased complaints, PALS concerns and potential litigation - Reduced confidence from staff, patients and stakeholders - Failure to meet national standards and targets (e.g. RTT, cancer pathways, constitutional standards) (and impact on NOF rating) - Reduced system flow and inefficiencies across pathways - Increased pressure on unscheduled, urgent and emergency care - Reduced staff morale, engagement and retention - Greater reliance on temporary staffing, impacting continuity and cost - Financial penalties or loss of income linked to performance breaches - Increased scrutiny and intervention from regulators and system partners	4 x 5 (20)	1) Clear executive and Board oversight of planned care performance	- Board Assurance Framework reviews - Quality Committee and Finance Committee AAA reports to Board - Divisional Performance Reviews - Integrated Performance Report - NOF segmentation tracking - CQC action plans - tracking through Board and Committees	- CQC inspection report(s) and on-going CQC engagement	4 x 4 (16)	- Exit criteria from financial undertakings re: UEC performance	- New engagement arrangements with NHSE - **Director of Corporate Affairs**	- Regional oversight from June 2026	4 x 3 (12)	
			2) Demand and capacity modelling to inform activity planning	- BI reports - Divisional Access & Performance meetings - Integrated Performance Report - Divisional Performance Reviews (WUTH) - Integrated Performance Board (WCHC) - Utilisation of insourcing and LLP to provide capacity to achieve new national targets - EARC oversight & risk reports (WUTH) - NOF segmentation tracking	- NOF segmentation publication		- NOF segment 4 (WUTH)				
			3) Robust waiting list management and validation processes	- RTT and waiting list reports	- NOF segmentation publication		- NOF segment 4 (WUTH) - Learning from complaints, incidents and	- Strengthen triangulation of quality			

		- Waiting list validation audits - Waiting List Health Inequalities Tool (WCHC)			patient feedback not consistently embedded	intelligence - **Chief Nursing Officer**		
	4) End-to-end pathway management	- Divisional Performance Reviews			- Inconsistent clinical prioritisation across pathways	- Standardisation and audit of, clinical prioritisation criteria across all planned care pathways - **Chief Medical Offier & Chief Nursing Offier**		
	5) Workforce planning and job planning aligned to planned care demand	- Workforce and job planning reports - Productivity and compliance data - Theatre and clinic utilisation reports - Utilisation of insourcing and LLP to provide capacity to achieve new national targets			- Limited workforce flexibility to meet demand	- Job plan reviews - **Executive Managing Director & Chief Medical Officer**		
	6) Clinical quality monitoring across planned care pathways	- Clinical harm reviews for long wait patients - Incidents, complaints and patient experience reports - Clinical audit reviews	- National clinical audits - CQC inspection reports					
	4) Early discharge planning and discharge to assess models	- Corridor care action plan (submitted to regional team) - Long Length of Stay (LloS) meeting chaired by CEO - LLoS metrics and delays in discharge - Internal audit reviews - NOF segmentation tracking - Local Corridor care summit held with action plans from all areas submitted to Improvement Team	- System flow metrics		- Discharge planning effectiveness varies by pathway - Mechanism for monitoring and tracking corridor care summit action plan	- Strengthen early discharge planning, including greater use of trusted assessor and discharge to assess models – **Chief Medical Officer and Chief Nurse Officer**	- Corridor care action plan includes key actions to address discharge planning	

Risk ID	03
Risk theme	Workforce
Risk appetite	**Seek**
Link to strategic objectives	Our People – We will nurture an inclusive, compassionate culture where people thrive
Executive lead	Chief People Officer
Committee oversight	People Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to attract, retain and develop a diverse, skilled and engaged workforce to meet activity and operational demand and provide high quality care.	- Poor quality of care and compromised patient safety - Reduced staff morale, engagement and productivity - Increased staff turnover - Over-reliance on temporary staffing - Loss of income - Loss of confidence from patients, staff, partners and commissioners - Reduced system and stakeholder trust in the Trust's leadership and governance	4 x 4 (16)	1) Clear board accountability and reporting	- Named Executive Leads accountable for Workforce Performance - Clear reporting and escalation routes through Board and relevant committees (WSB, People) - Workforce metrics reported through Integrated Performance Report - Drivers of the Deficit Governance Structure	- Regional oversight arrangements - Board Assurance Statements	4 x 4 (16)	- NOF segment 4 – WUTH - NOF segment 1 – WCHC - Single reporting arrangements across both Trusts	- Single IPR in development - Governance arrangements sub-committee under review in WUTH and WCHC		3 x 2 (6)	
			2) Workforce Planning Processes in place	- Triangulation of workforce plan to financial and activity plans - Divisional Performance Reviews - Establishment & Pay Control Panel (EPCP) in place with Executive / CEO chair - CPO is SRO for the Sickness Absence Programme (Drivers of the Deficit)	- Board Assurance Statements - Internal audit reports on workforce processes (ESR, data quality) - NHSE workforce and planning submissions - Model hospital - peer benchmarking		- National shortages in certain roles - Staff turnover rates remain above Trust target - NHSE considered Trust medium-term financial plan to be non-compliant				
			3) Staff Experience & Staff Engagement	- People Experience Team - NSS action plans - Pulse surveys - Health & Wellbeing Support (inc. psychological support, absence management)	- National staff survey results - CQC inspection findings (WCHC – WIC/UTC; WUTH – Medicine & ED)		- Sickness absence remains above Trust target (links to drivers of the deficit) - Drivers of the Deficit Programme planned actions with identified risks				

		- FTSU arrangements & network (reporting to People Committee & Board) - Appraisal completion rates - ‘Well, WUTH/WCHC’ programme to support return to work - HR policies and procedures including flexible working - Employee recognition scheme - New Partnership Agreement launched with Staff Side (WUTH)			- Impact of corporate services organisational change - NSS action plans on staff engagement	- Phase 2 of corporate service organisational change in progress	
	4) Strategic Organisational Development programmes in place	- Leadership development programme (for all levels) aligned to LQF - Mandatory training compliance monitoring - Continuous professional development frameworks - Talent management and succession planning	- National staff survey results - Professional regulatory requirements and accreditation standards				
	5) Equality, Diversity & Inclusion (EDI) Strategy in place	- WRES and WDES action plans - Inclusive recruitment practices - Engaged staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter					

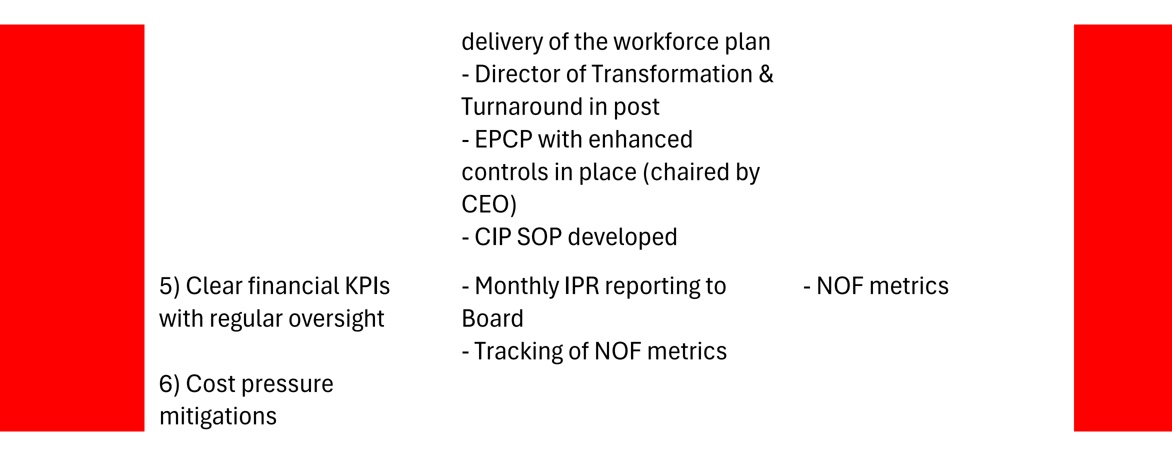
Risk ID	04
Risk theme	Workforce
Risk Appetite	**Seek**
Link to strategic objectives	Our People – We will nurture an inclusive, compassionate culture where people thrive
Executive Lead	Chief People Officer
Committee oversight	People Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported	- Poor quality of care and compromised patient safety - Reduced staff morale, engagement and productivity - Increased staff sickness - Increased staff turnover - Widening inequalities in staff experience and progression - Poor learning culture - Loss of income - Loss of confidence from patients, staff, partners and commissioners - Reduced system and stakeholder trust in the Trust's leadership and governance - Failure to embed NHS People Plan priorities	3 x 4 (12)	1) Clear board accountability and reporting	- Named Executive Leads accountable for Workforce Performance - Clear reporting and escalation routes through Board and relevant committees (WSB, People) - Use of culture metrics and KPIs (e.g., engagement scores, FTSU data, turnover, absence) via IPR	- Regional oversight arrangements - Board Assurance Statements	3 x 4 (12)	- NOF segment 4 – WUTH - NOF segment 1 – WCHC			3 x 2 (6)	
			2) Staff Experience & Staff Engagement	- Strong FTSU arrangements (inc. policy) and Guardian - Structured staff networks influencing policy - New Partnership Agreement launched with Staff Side (WUTH) - Clear and consistent communication on values and behaviours - Employee recognition scheme - Internal communications plan to support Better Together – integration programme - NHSE Staff Experience Assessment Framework implemented	- National staff survey results		- Consistent approach to co-production and staff involvement in decision-making - Full understanding of the experience of multi-cultural staff across the Trust - NSS action plans on staff engagement - Impact of corporate services organisational change	- Phase 2 of corporate services organisational change in progress			
			3) Clear commitment to Equality, Diversity & Inclusion	- EDI strategy aligned to WRES, WDES and NHS People Plan - EDI dashboard reviewed at EDI Steering Group (via PCOG) - Coaching Hub established	- EDS completed (jointly) with overall attainment level – Achieving		- Further development of staff networks - Deliver all actions from WRES action plan - Deliver all actions from WDES action plan				

		- Monitoring of workforce inequalities - EDI mandatory training - Engaged staff networks - Actions to deliver against NHSE Sexual Safety Charter - Bronze status in Anti-Racism Charter				
	4) Staff wellbeing and support offer	- Comprehensive offer to all staff including mental health support, occupational health, flexible working - Proactive management of safe staffing levels - FFT scores (demonstrating patient satisfaction)			- Impact of organisational change (integration programme aligned to statutory transaction)	
	5) Fair People Management Practices	- Transparent and fair HR policies and processes - Appraisal rate and supervision compliance monitoring - New Partnership Agreement launched with Staff Side (WUTH) - Restorative and just culture principles embedded as BAU - PSIRF policy in place				

Risk ID 05
Risk theme Finance & Capital
Risk appetite **Minimal**
Link to strategic objectives Improve & Innovate - We will make improvement and innovation part of how we work
Executive lead Director of Turnaround & Transformation
Committee oversight Finance and Performance Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to deliver the three-year financial plan (26/27 - 28/29) against the agreed MTFP including the in-year CIP delivery plans, impacting on long-term sustainability	- Financial sustainability and damage to the Trusts reputations - Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions - Reduced flexibility to respond to operational pressures and demands - Declining staff morale and engagement - Reduced capacity to invest in workforce productivity and wellbeing initiatives - Reduced confidence from staff, patients and stakeholders	5 x 4 (20)	1) Financial planning and financial governance arrangements	- New Joint Finance Committee ToRs - Standing agenda item (private board) on delivery to plan - Director of Transformation & Turnaround in post - Clear executive accountability	- MIAA grip and control review (moderate assurance)	5 x 3 (15)	- WUTH in financial undertakings - CIP and financial performance accountability not consistently embedded at divisional and budget-holder level	- Engagement with NHSE to define the metrics to remove all undertakings - **DCA / CFO** - Regional oversight arrangements to be confirmed - **DCA / CFO** - Implementation of recommendations from MIAA grip and control review - **CFO**	- Meeting with NHSE on 22 April 2026	5 x 2 (10)	March 2027
			2) Board approved three-year MTFP aligned to system and ICB assumptions / priorities	- Resubmitted plans agreed with NHSE - Board Assurance statements confirming triangulation between workforce, finance and operational delivery - Board papers and minutes - Triangulation with workforce, finance and operations - Voluntary redundancy scheme approved by Board *(for specific, targeted areas)*	- Alignment of plans with ICB / monitored via FPRM process - Full engagement in monthly FPRM process - NHSE support for redundancy funding - Voluntary redundancy scheme approved by NHSE		- Limited ability to influence system decisions that affect long-term affordability - ICB support for decommissioning plans - NHSE support accelerate statutory transaction - Resubmitted plans have a combined gap to national control totals of £14.9m	- Regional oversight arrangements to be confirmed - **DCA / CFO**			
			3) Annual budget setting process aligned to MTFP trajectory					- MiAA costing review agreed through internal audit plan – CFO			
			4) Annual CIP plan with defined CIP governance	- Productivity Improvement Board monitoring CIP delivery including risks to service (chaired by CEO) - Drivers of the Deficit Programme Board reset with agreed business rhythm - Weekly CIP Assurance Group - Clinical guardrails agreed with Board - Triangulation between finance, quality and operational performance when approving or revising CIPs - People Committee tracking			-CIP schemes not sufficiently developed early in the financial year, reducing deliverability - Over-reliance on non-recurrent savings or high-risk schemes - Organisational capacity to deliver the scale of the programme - CIP implementation in divisions and against drivers of the deficit (moving from identification)	- (DoD) Programme Board sign off of current project plans – **May/June 2026**			



		delivery of the workforce plan - Director of Transformation & Turnaround in post - EPCP with enhanced controls in place (chaired by CEO) - CIP SOP developed			
	5) Clear financial KPIs with regular oversight 6) Cost pressure mitigations	- Monthly IPR reporting to Board - Tracking of NOF metrics	- NOF metrics		

Risk ID 06

Risk theme Operational Effectiveness

Risk appetite **Seek**

Link to strategic objectives Improve & Innovate - We will make improvement and innovation part of how we work

Executive lead Director of Transformation & Turnaround

Committee oversight Finance and Performance Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to embed service transformation and deliver sustainable efficiency gains	- Financial sustainability and damage to the Trusts reputations - Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions - Reduced flexibility to respond to operational pressures and demands - Inability to deliver the Trust's strategic objectives and transformation ambitions - Declining staff morale and engagement - Reduced capacity to invest in workforce productivity and wellbeing initiatives - Reduced confidence from staff, patients and stakeholders	5 x 4 (20)	1) Strategic leadership and governance	- Director of Transformation & Turnaround in post - New Joint Finance Committee ToRs - Clear executive accountability - Board and committee papers and minutes evidencing regular review of the programme - Productivity Improvement Board monitoring CIP delivery including risks to service	- Alignment of transformation plans with ICB/system priorities and programmes - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)	5 x 3 (15)	- Regular programme of board visibility	- Standing agenda item on private to provide Board with monthly updates on delivery of transformation / CIP programmes - **DTT & DCA**	- In progress from May 2026	5 x 2 (10)	
			2) Programme and portfolio management	- PMO assurance reports and use of programme dashboards (PIDs) - Clinical guardrails agreed with Board - Escalation reports to Productivity Improvement Board - Productivity improvements tracked as transformation benefits	- Full engagement in monthly FPRM process - Internal audit plan						
			3) Financial and benefits realisation controls	- Executive oversight and SRO for all CIP schemes / drivers of the deficit	- MIAA grip and control review (moderate assurance)			- Implementation of recommendations from MIAA grip and control review - **CFO**			
			4) Integrated quality and safety controls	- New Joint Quality Committee ToRs - Quality & Equality Impact Assessments approved and monitored through Quality Committee - Clinical guardrails agreed with Board - Share oversight of strategic risks (ID01 and ID02) between Quality and Finance Committee related to service delivery - Monthly IPR reporting to Board - Tracking of NOF metrics	- NOF metrics - On-going and proactive engagement with CQC - On-going and proactive engagemne with ECIST - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)		- Limited real-time quality monitoring linked to transformation activity.	- Quality Committee oversight of transformation-related change and outcomes to be strengthened - **DTT & CNO/CMO**			

	5) Workforce and operational controls	- New Joint People Committee ToRs - Workforce report tracking People metrics - EPCP with enhanced controls in place (chaired by CEO)	- Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements - Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC)		
	6) Performance management and reporting	- New Joint Finance Committee ToRs - Integrated Performance Report to Board tracking progress against efficiency metrics	- Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements - Internal Audit reviews focused on delivery effectiveness and benefits sustainability.		

Risk ID	07
Risk theme	Operational Effectiveness
Risk appetite	**Minimal**
Link to strategic objectives	Delivering Excellence – We will create the conditions for outstanding care and performance
Executive lead	Director of Corporate Affairs and Communications
Committee oversight	Audit and Risk Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to comply with relevant codes of governance, regulation and legislative requirements	- Regulatory enforcement action (e.g. CQC enforcement, NHS England intervention) - Legal penalties, fines, or litigation - Loss of provider licence or restrictions on services - Financial loss and increased operational costs - Reputational damage and loss of public confidence - Harm to patients/service users due to non-compliance - Increased scrutiny and oversight from regulators - Internal governance failure impacting strategic delivery	4 x 3 12	1) Board and Executive oversight with designated Executive leads for key compliance areas	- Single Executive Team appointed - Named leads for statutory functions - SIRO appointed (across both Trusts) - Caldicott Guardian appointed (for each Trust) - RO appointed for WUTH - Board composition includes voting and non-voting Directors - FTSU arrangements and Policy	- NHSE oversight arrangements	4 x 3 12				4 x 2 8	
			2) Governance framework in place (inc. policies and procedures and risk management)	- Board and committee governance structures established – Joint Committees/Committees in Common - Audit Committee scrutiny of systems and processes - Scheme of Delegation & Matters Reserved to the Board - Joint SFIs - Risk Policies - Risk Registers – EARC, Audit & Risk Committee, IPB - Joint BAF established with alignment of key strategic risks to Committees - Policy reviews and approval framework	- HOIA opinion annually - External Audit - Internal Audit programme		- Embedding of Joint committees and Committees in Common approach - Establishment of future governance arrangements to statutory transaction - Joint Risk Management process and policy	- Finalise new governance arrangements (post-transaction) - Review of Risk Management Policies			April 2027

	#	Objective	Controls	Assurance		Gaps	Actions	Progress		Date
	3)	Compliance with relevant codes of governance, regulation and legislative requirements	- Annual report - Code of Governance compliance (via Audit Committee) - Provider licence compliance (via Audit Committee) - Tracking of progress against NHSE enforcement undertakings	- External Audit - NHSE oversight arrangements		- NHSE enforcement undertakings remain in place - Full implementation of revised regional oversight arrangements with NHSE - Board review of Board Assurance Statements - Compliance with FOIs and SARs reported to Board of Directors - Refresh of CQC preparedness programme	- Engagement with NHSE is on-going via FPRM meetings and new arrangements are being confirmed - FOI and SAR plans in place - CQC well-led reviews -	- New oversight arrangements expected to take effect from July 2026 inc. tracking of progress against undertakings -		July 2026
	4)	Partnership Governance (Wirral & CMPC)	- CEO Lead in CMPC - Wirral Provider Alliance established - Joint Chief Integration & Partnerships Officer leading WPA -	- CMPC Leadership Board updates to Board of Directors		- Place governance arrangements to reflect changing ICB designation and evolving role of HWB	- Revised Place governance to be discussed with local partners including LA - Revised Wirral Provider Alliance governance arrangements to be developed and agreed	- Both actions are in progress with local partners		September 2026

Risk ID	08
Risk theme	Quality & Patient Experience
Risk appetite	**Open**
Link to strategic objectives	Delivering Excellence - We will create the conditions for outstanding care and performance
Executive lead	Chief Nursing Officer and Chief Strategy Officer
Committee oversight	Quality and Safety Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to plan and deliver services inclusively with people and communities guiding care, and which meet population health needs, and reduce health inequalities.	- Poor patient outcomes, particularly for vulnerable or underserved populations - Widening health inequalities across the population - Reduced patient experience, trust, and engagement - Failure to meet statutory duties (e.g. Equality Act, Health Inequalities duties) - Reputational damage locally and nationally - Increased demand on urgent/emergency care due to unmet need - Inefficient use of resources due to poorly targeted services - Adverse regulatory scrutiny (e.g. CQC findings)	4 x 3 (12)	1) Clear board accountability and reporting	- Named Executive Lead accountable for Health Inequalities - Quality governance structures - Clear reporting and escalation routes through Board and relevant committees (Quality & Safety) - Reporting on inequalities metrics (access, outcomes, experience via PSQB/SOG) - Inclusion Annual Report (WCHC) - Joint Quality priorities	- Regional oversight arrangements - Board Assurance Statements - Audit programmes (clinical audit, equality audits, service reviews)	4 x 3 (12)	- NOF segment 4 (WUTH) including access to services metrics - Inconsistencies in data access, reporting and insight limiting proactive population health management and improvement - Performance dashboards with segmentation by protected characteristics and deprivation	- Improve data quality and insight		4 x 2 (8)	
			2) Clear commitment to Equality, Diversity & Inclusion	- EDI strategy - EDI dashboard reviewed at EDI Steering Group (via PCOG)	- EDS completed (jointly) with overall attainment level – Achieving - National benchmarking data (e.g. Core20PLUS5, NHS England metrics)		- Embed health inequalities impact assessment into all strategic and operational decisions - Inconsistencies in data access, reporting and insight limit proactive population health management and improvement.				
			3) Patient and public involvement frameworks	- Patient experience data (FFT, complaints, engagement feedback)	- CQC inspection reports (WCHC and WUTH 2025) - Compliance with AIS		- Completion of all associated actions in CQC action plans (WCHC and WUTH 2025)	- Develop and implement a clear Health Inequalities Improvement Plan aligned to			

		- Health Inequalities Waiting List Tool in place (WCHC) - Your Voice Group (WCHC) - Councils of Governors				national priorities (e.g. Core20PLUS5) - Further embed waiting list tool		
	4) Impact assessments	- Equality Impact Assessments / Health Inequalities Impact Assessments - EIA/QEIA Standard Operating Procedures	- Audit programmes (clinical audit, equality audits, service reviews)					
	5) Workforce training	- Training in cultural competence and inclusive practice			- Lack of staff confidence in accessing and interpreting health inequalities data -	- Enhance workforce training and leadership capability in population health and inclusion		
	6) System collaboration	- Evolving trusted relationships with system partners (primary care, VCSFE, local authority) to support population health approaches - Chief Integration Officer member of JTEG with local authority - New joint strategy aligns with Cheshire and Merseyside's *All Together Fairer: Our Health & Care Partnership Plan 2024-29*	- Wirral Provider Alliance (WPA) with a shared purpose - *Working in partnership for better health and care in Wirral* - CMPC blueprint / provider strategy - National benchmarking data (e.g. Core20PLUS5, NHS England metrics)		- Fragmentation across system partners - Agreement of future governance arrangements for the WPA to support neighbourhood approaches and strategic commissioning	- Wirral-wide approach to neighbourhood development plans including multiple partners	- WPA governance review in progress	

Risk ID 11

Risk Theme Digital & Data

Risk Appetite **Seek**

Link to strategic objectives Advance Digitally - We will develop a secure, connected digital ecosystem fit for the future
Delivering Excellence - We will create the conditions for outstanding care and performance

Executive Lead Chief Finance Officer / SIRO

Committee oversight Finance and Performance Committee & Digital Committee (cyber focus)

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care	- Poor quality of care and compromised patient safety - Disruption to clinical systems - Reduced access to patient information - Inability to sustain critical services (due to loss of IT, estates or digital infrastructure) - Breach of data protection legislation and IG requirements leading to potential financial penalites and reputational damage - Enforcement action - Reduced staff productivity - Reduced staff morale - Loss of income - Loss of confidence from patients, staff, partners and commissioners - Reduced system and stakeholder trust in the Trust's leadership and governance	5 x 4 (20)	1) Clear board accountability and reporting	- Named Executive Leads accountable for digital, cyber security, estates and business continuity - i.e., SIRO, CIO, EPRR -Clear reporting and escalation routes through Board and relevant committees (Audit, Quality and Finance)		5 x 3 (15)	- Board approved Digital Strategy	- Finalise Digital Strategy	- Enabling strategy to be completed in H2, 26-27	5 x 2 (10)	
			2) Cyber Security Controls - implementation of nationally mandated cyber security standards and controls	- Compliance with NHS Data Security and Protection Toolkit (DSPT) requirements via self-assessment	- Internal audit plan covering cyber security controls, access management and patching compliance - NHS England / national cyber assurance feedback - External penetration testing or cyber maturity assessments						
			3) Business continuity and disaster recovery	- Capital programme reporting evidencing investment in resilience and critical infrastructure - Business Continuity and Disaster Recovery plans - Records of regular testing and exercising (table-top and live tests) - Post-incident and post-exercise reviews	- Internal audit review of BCP and disaster recovery arrangements - *moderate assurance*						

		evidencing learning and improvement			
	4) Data Protection and Information Governance	- SIRO / Information Governance Annual Report to the Board - Mandatory IG training compliance reports for staff	- Internal Audit Reviews of Digital Governance - Digital Maturity Assessment and benchmarking outcomes - Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements) - Internal audit plan testing of controls and processes in place		
	5) Third party and supplier controls	- Contract management processes confirming inclusion of cyber and BCP requirements - Supplier assurance documentation (SOC reports, compliance statements) - Regular review of critical supplier risk registers	- System / national assurance of shared or hosted platforms		
	6) System and external alignment / collaboration	- Reports evidencing participation in system-wide cyber and resilience groups (CMPC)	- Inclusion in national or regional resilience programmes		

Risk	12
Risk theme	Data & Digital
Risk appetite	**Seek**
Link to strategic objectives	Advance Digitally - We will develop a secure, connected digital ecosystem fit for the future
Executive lead	Chief Finance Officer / SIRO
Committee oversight	Digital Committee

Risk Description	Consequences	Inherent risk score (I x L)	Controls	Board Assurance		Current risk score (I x L)	Gaps in control / assurance	Actions		Target risk score (I x L)	Estimated date of achievement of risk score
				Internal	External			Planned	Progress update		
Failure to implement a secure digital infrastructure within the Trusts, and to equip staff with the skills and tools to utilise the infrastructure effectively	- Reliance on systems that are not fit for purpose impacting on service quality and patient - Reduced level of skills in the workforce - Insecurities within systems present vulnerabily to cyber-attacks - Poor staff experience	4 x 4 (16)	1) Exeutive and Board Oversight of Digital and Information Risk	- Defined accountability through the SIRO, CIO/ CNIO - SIRO responsbility included JD - SIRO reports to Board and CIO attends Board - New Joint Digital Committee established ot oversee digital delivery and risk - BAF oversight (ID12) by Joint Digital Committee - Digital Governance arrangements established with minutes and action log tracking - Annual Information Governance Annual Report / Statement	- SIRO network and annual training	4 x 3 (12)	- Board approved Digital Strategy to align with new Joint Strategy - Digital Strategy delivery roadmap - Alignment to MTFP - Capital constraints impacting pace of delivery	- New strategy to be developed as part of the programme of work to develop enablng strategies - **CFO**	- Project scope for Q1, 26-27	4 x 2 (8)	
			2) Existing digital infrastructure is NHS compliant	- Business continuity and disaster recovery plans - DSPT / CAF self-assessment and improvement plan - Penetration testing and vulnerability assessment reports - DPIAs - IG audit findings	- Internal Audit Reviews of Digital Governance - Digital Maturity Assessment and benchmarking outcomes - Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements) - Internal audit plan testing of controls and processes in place		- Legacy infrastructure increasing security and resilience risk				

	3) Digital Programme and Change Management processes	- Digital programmes governed through project and clinical safety frameworks - Gateway reviews and post-implementation reviews - Programme and project dashboards with RAG status	- Supplier performance reports and SLA monitoring		- Programme capacity - End user engagement		
	4) Workforce capability and digital skills	- Training completion data (e.g. IG)			- Trust-wide digital skills framework (variable digital conficence) - Staff survey results relating to digital confidence and usability - Feedback from digital champions		

Group Board of Directors in Public **Item 11**
3 June 2026

Report Title	Committee Chairs Report – Joint Digital Committee
Date of Meeting	16 April 2026
Author	Haris Sultan, Chair, Joint Digital Committee

Alert	• The Joint Digital Committee wishes to alert the Group Board that: ○ **FOI and Subject Access Requests – WUTH Non-Compliance:** The Committee has received and supported an improvement plan, including additional resources, digital workflow improvements and performance dashboards, and noted the SIRO is providing a further update to the Group Board in May. ○ **Clinical Coding Capacity – Workforce Pressures:** Clinical coding capacity remains a significant risk nationally, and WUTH has been more acutely impacted than many other trusts. The Committee was assured there is no current financial impact and received a mitigation plan comprising: internal recruitment, and an external contract to address the backlog, AI-supported capacity is being assessed. The Committee is assured that a structured three-stage plan is in place and being actively managed with appropriate oversight. ○ **Cyber Resilience and Business Continuity:** Cyber remains a material risk to every organisation. The Committee noted that a cyber incident recovery could take months rather than weeks and emphasised the need to strengthen business continuity arrangements accordingly. The Committee sought and received assurance that lessons learned from the previous cyber incident have been reviewed and embedded.
Advise	• The Joint Digital Committee wishes to advise the Group Board that: ○ **Digital Strategy Development:** The 2021–26 digital strategy period has concluded. A new joint digital strategy will be developed and is expected to come to the Digital Committee in the second half of the year. The strategy will be shaped by clinical and operational priorities and aligned to the Cheshire and Merseyside digital strategy. The Wirral Digital Services Review will report to the Committee at the next meeting in June and will inform the practical roadmap toward a single organisation by 2027. ○ **BAF Risk Changes:** The Committee has taken shared ownership of BAF Risk ID11 (business continuity and cyber/infrastructure failure) jointly with FBPAC. In addition, the risk appetite for BAF Risk ID12 has been changed from “open” to “seek”, reflecting the transformational role digital should play and the organisation’s appetite for innovation. ○ **Digital Workforce Competence:** The Committee identified a gap in digital competence and expertise across the workforce.

<table>
<tr><td></td><td>Basic EPR training (e.g. use of Serna) needs to be in place to enable staff to utilise systems to their full capability. This will be an area of ongoing focus for the Committee.</td></tr>
<tr><td>Assure</td><td>The Joint Digital Committee wishes to assure the Group Board that:
Digital Maturity: The Digital Maturity Self-Assessment (DMSA) confirms that WUTH is one of the most digitally mature trusts in the Cheshire and Merseyside system. The Committee had a comprehensive discussion on the overall digital landscape and is satisfied that a clear baseline of performance, risk and delivery confidence has been established for the new Committee.
2026/27 Digital Plan Prioritisation: A structured and transparent prioritisation process has been completed with the Executive Team for the 2026/27 Digital Plan. The plan has been reviewed through a cross-functional panel and includes clear change control arrangements. Future reports will track performance and progress against the agreed plan.
Internal Audit Recommendations: Both WUTH and WCHC audit trackers have been reviewed. WUTH has 10 recommendations in progress (2 overdue, 2 complete, 6 not yet due); overdue items will be reviewed at the Audit and Risk Committee with an extension to May 2026. MIAA reviews of User and Privileged User Management (WUTH – Substantial) and IT Service Continuity and Disaster Recovery (WCHC – Substantial) received positive overall assurance opinions, with targeted medium and low-rated recommendations being actively managed.</td></tr>
<tr><td>Review of Risks</td><td>The Committee has taken shared ownership of BAF Risk ID11 (risk of business continuity failure due to cyber/infrastructure incident) jointly with FBPAC.
The risk appetite for BAF Risk ID12 has been changed from “open” to “seek”.
The Committee questioned whether the risk score for FOI/SAR requires escalation or change and will keep this under review.
No other risks require escalation to the Board at this time; all risks are being appropriately managed through the Digital Committee governance framework.</td></tr>
<tr><td>Other comments from the Chair</td><td>This was the inaugural meeting of the Joint Digital Committee. The Committee had a comprehensive discussion to establish its understanding of the current digital landscape across both organisations.
The Committee acknowledges that its visibility of the WCHC digital position will develop over time and this picture will mature as the Committee establishes its workplan. The next meeting is scheduled for Friday 19 June 2026.</td></tr>
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Group Board of Directors in Public **Item 12**
3 June 2026

Report Title	Committee Chairs Reports – Joint Finance and Business Performance Committee
Date of Meeting	22 April 2026
Author	Meredydd David, Chair of Finance Business Performance Committee

Alert	• The Committee wish to advise members of the Group Board of Directors that: ○ At the end of March 2026 (M12), WUTH is reporting a deficit of £49.5m. This is in line with the forecast that the Trust submitted to NHS England in February but, excluding DSF, is a £27.3m adverse variance to plan. This places significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). ○ At the end of March 2026 (M12), WCHC is reporting a surplus of £5.1m, which was a £4.2m positive variance to plan and this has been reported to NHSE. ○ The significant improvement required for financial sustainability will be delivered through the medium-term finance plan (MTFP). The MTFP for both Trusts for 2026/27 to 2028/29 have been submitted to NHS England and the WUTH plan has yet to be approved. ○ For WUTH, risk ratings for delivery of statutory targets for noting are that the RAG rating for financial stability, financial sustainability and financial efficiency were red, cash was amber and agency spend and capital were green.
Advise	• The Committee wish to advise members of the Group Board of Directors that: ○ The Board reviewed and agreed a revision to the original plan and budget for 2026/27 which included increasing CIP to 6%, reducing cost pressures by £2m and reducing risk/headroom by £1m, delivering an £8m improvement. This moved the combined Trusts deficit position to £24m. This has been submitted to NHSE, ○ At WUTH, there are challenges in meeting the 31- and 62-day cancer standards, though the Trust is forecasting to start 2026/27 achieving all cancer standards. Good progress was highlighted across breast services, and in gynaecology where significant backlogs from the previous year are being addressed through pathway standardisation. Improvements within urology services were also noted. ○ The Trust had participated in the national UEC sprint in March, and a number of sustainable actions had been implemented with improvements to many of the key performance indicators.

	○ WUTH has entered into a new contract with Mersey Healthcare starting on 1st April to provide additional planned care capacity. ○ An options review and opportunities for use of the Frontis site was discussed however it was agreed to pause the decision for the time being until other options were explored in more detail. ○ WCHC has substantial positive performance in most areas including urgent care at 95.3% for the 4 hour target and 83% for UCR performance. Areas for improvement include indicators at the Minor Injuries Unit and GPOOG performance. There is a significant backlog for ECGs and there is a recovery plan in place for Dental waiting times.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Good progress has already been made on identification and risk categorisation of the CIPs for both Trusts though there are gaps in evidencing detail within some plans and these need to be completed by mid-May and are expected to be completed and available. ○ Progress is being made with the estate integration programme and this needs to be aligned with clinical services integration plan. The principles for future estate and space utilisation efficiency will be benchmarked against Model Hospital data and would be reported to a future meeting. ○ For WUTH there were 10 internal audit recommendations currently being tracked, 4 of which are complete, 1 which was not accepted, and 5 which are not yet due. ○ At WCHC the one outstanding Audit recommendation related to the Contract Management Assignment Report and the delay in signing the Knowsley 0-19 contract. It was confirmed this would be resolved in the next two months
Review of Risks	• The joint BAF contains 12 strategic risks and the joint FPC has oversight of 5 of these risks with all 5 scoring high. Risk ID11 is reviewed and tracked by the Joint Digital Committee, as well as FPC solely in respect of controls and mitigations related to cyber. • There were two WCHC high level risks with ID3247 also reported on the WUTH risk register: • ID3256 (RR16) - related to equipment (4 x inhalation sedation machines) in the community dental service coming to the end of their working life and requiring replacement. Work was on-going to facilitate the capital business case. • ID3247 (RR15) - related to reduced staffing for the clinical assessment of complex dysphagia referrals. Alder Hey were unable to support Wirral referrals in the interim. Work was ongoing with Service Directors to manage communication to

	GPs and parents. This risk was also noted as a high-level risk on the WUTH risk register and had been reported to the Executive Assurance & Risk Committee (EARC).
Other comments from the Chair	• Good progress has been made against a challenging environment in delivering the final financial outturn positions in line with revised plans and expectations. The budgets and financial plans for 2026/27 are very challenging and critical to deliver. The FPC will monitor closely the delivery of the CIP, the plan for reduction in WTE and the Drivers of Deficit. FPC meetings are all now in person monthly with an agreed schedule of deep dives into areas where performance is challenging or where there is learning to share.

Group Board of Directors in Public **Item No 15**
3 June 2026

Report Title	Committee Chairs Report – WUTH Audit and Risk Committee
Date of Meeting	23 April 2026
Author	Lisa Greenhalgh, Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ Nothing to alert members to at present
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Year-end BAF position was noted ○ 2025 Anti-Fraud Annual Assessment was submitted and received a green rating overall. 1 component scored amber which was related to the recently implemented Failure to Prevent Fraud Offence, which is the same for all Trusts. ○ BAF Assurance Framework was assessed and confirmed that it is structured to meet the NHS requirements of best practice models. ○ Risk Management Core Controls were reviewed and resulted in a green RAG rating. ○ 2026/27 Anti-Fraud Plan was approved
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Grip and Control report was received with a Moderate Assurance received. PWC had reviewed the report which demonstrated a strengthened grip and control, with some further tweaks identified to strengthen the approach ○ Consultant Job Planning report was received with Moderate Assurance received. ○ Conflict of Interest report was received with Substantial Assurance received. ○ Key Financial Transactional Processing Controls report was received with a High Assurance opinion. ○ Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions. ○ Internal Audit Annual Report & Head of Internal Audit Opinion 2025/26 was a Substantial Assurance indication there is a good system of internal control and controls are being applied consistently.

Review of Risks	• The new BAF is agreed noting the new strategic risks aligned to the new strategic objectives in the Joint Strategy. This will continue to be developed.
Other comments from the Chair	• External Audit is progressing and all parties confirmed no issues in achieving the deadline. • The Draft Annual Governance statement was received with the final statement being presented at the next meeting.

Group Board of Directors in Public
3 June 2026

Item No 16

Report Title	Committee Chairs Report – WCHC Audit and Risk Committee
Date of Meeting	23 April 2026
Author	Lisa Greenhalgh, Chair of Audit and Risk Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ Nothing to alert members to at present
Advise	• The Committee wish to advise members of the Board of Directors that: ○ Year-end BAF position was noted ○ 2025 Anti-Fraud Annual Assessment was submitted and received a green rating overall. 2 components scored amber overall, one on the recently implemented Failure to Prevent Fraud Offence, which is the same for all Trusts, and one for the conflict of interest declaration falling below 80%. ○ 2026/27 Anti Fraud Plan was approved ○ BAF Assurance Framework was assessed and confirmed that it is structured to meet the NHS requirements of best practice models. ○ Risk Management Core Controls were reviewed and were positive
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Key Financial Systems report was received with Substantial Assurance ○ IT Services Disaster Recovery report was received with Substantial Assurance ○ Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions. ○ Internal Audit Annual Report & Head of Internal Audit Opinion 2025/26 was a Substantial Assurance indication there is a good system of internal control and controls are being applied consistently.
Review of Risks	• WCHC High Level Risk Report was received which provided assurance al risks were being managed in line with policy. • The new BAF is agreed noting the new strategic risks align to the new strategic objectives in the Joint Strategy. This will continue to be developed.
Other comments from the Chair	• External Audit is progressing and all parties confirmed no issues in achieving the deadline.

	• The Draft Annual Governance statement was received with the final statement being presented at the next meeting.

WUTH Board of Directors **Item 18**

03 June 2026

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

Purpose of the Report and Recommendation	
Report For	Assurance

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in April 2026. The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (April 2026) key quality and safety metrics and the position of patient safety incidents.

Key Points to Note

It is recommended to: -

- Note the report and associated appendices.
- Note the Quality Oversight Model (PQOM) report.
- Note the position of the Maternity and Newborn Safety Investigations (MNSI) and any declared PSII's.
- Note the position of MIS Year 8 and the board oversight requirements supported by the Quality Committee and Maternity and Neonatal Assurance Meeting.
- Note compliance of 100% with Saving Babies Lives v3.
- Note continued compliance with Ockenden, the Three-Year Delivery Plan and the Maternity Programme on-line Portal (MPOP).
- Note the position with the maternity self-assessment requiring annual Board oversight.
- Note the maternity staffing paper and compliance with Birthrate plus recommendations.
- Note the neonatal staffing paper required to the BoD 6 monthly and the improvements required to be BAPM compliant.
- Note the PMRT reports for Q3 and Q4 25/26.
- Note the MBRRACE-UK Perinatal Mortality Report for 2024.
- Note the official feedback from the NHSE visit held in March 2026.

Key Risks

This report relates to these key Risks:

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

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
June 2026	Patient Safety and Quality Board	Monthly Maternity and Neonatal Services Report	For approval/ discussion
June 2026	Maternity and Neonatal Assurance Meeting	Monthly Maternity and Neonatal Services Report	For approval/ discussion
June 2026	Divisional Quality Board	Monthly Maternity and Neonatal Services Report	For approval/ discussion

1	Perinatal Quality Oversight Model (PQOM) Report
1.1	The Perinatal Quality Oversight Model (PQOM) is reported and included at **Appendix 1,** which provides the latest April 2026 quality and safety metrics for maternity and neonatal services. The model forms a core component of the Trust's governance and assurance framework, supporting the Board in maintaining effective oversight of performance, risk, and improvement activity across the perinatal pathway. For this reporting cycle, the information is presented in a revised slide-pack format. This updated approach has been developed to enhance clarity, improve visual interpretation of key data, and support more focused Board discussion. The Board is asked to review, discuss, and approve the adoption of this revised format for future reporting. The purpose of this monthly report is to provide the Trust Board of Directors with an overview of the key indicators submitted to the Local Maternity and Neonatal System (LMNS) and to NHSE/I via the Northwest Regional Maternity Dashboard. These

	indicators are directly aligned to the quality and safety metrics that underpin the delivery of safe, effective, and person-centred maternity and neonatal care. The slide-pack summarises: • Performance against national and regional expectations • Areas of sustained improvement • Emerging concerns requiring escalation • Key risks and mitigations • Trends and themes across incidents, outcomes, and patient experience This revised format strengthens the transparency and accessibility of information presented to the Board, enabling more effective scrutiny and assurance. Key areas of focus within the oversight model include: • Perinatal safety metrics — monitoring outcomes, variation, and trends across maternity and neonatal pathways • LMNS reporting requirements — ensuring alignment with system wide priorities and collaborative oversight • NHSE/I dashboard submissions — providing standardised reporting against national indicators • Quality and safety performance — including incidents, outcomes, staffing, and patient experience • Risk and escalation processes — ensuring timely identification, management, and escalation of risks Collectively, the Perinatal Quality Oversight Model and the revised reporting format provide the Board with a comprehensive and reliable view of service performance. This supports informed decision-making and reinforces the Trust's commitment to delivering high-quality, safe maternity and neonatal care.

2	**Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)**
2.1	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSII's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region. There were no Patient Safety Incident Investigations (PSIIs) declared within maternity services during April 2026. All relevant cases arising in the period have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) in line with national requirements and the Trust's internal governance processes. One draft MNSI report has been received and is currently undergoing internal review prior to formal sign-off and submission of the Trust's response. In addition, MNSI has received a patient-initiated request relating to a case from 2022, seeking a retrospective review. This request has been acknowledged and is being managed through the established governance and escalation pathways. These activities continue to demonstrate the division's commitment to transparent reporting, robust oversight, and adherence to national patient safety investigation standards.

	There were no Patient Safety Investigation Incidents (PSII's) declared in April 2026 for neonatal services.

3	Maternity Incentive Scheme (MIS) Year 8
3.1	**Maternity (Perinatal) Incentive Scheme (MIS)** The Trust is progressing towards compliance with all six revised MIS Safety Action Standards for 2026, supported by strengthened governance, enhanced clinical oversight, and monthly assurance reporting. Board oversight remains essential to secure the CNST contribution refund and any associated incentive payment. **1. Overview of the Scheme** The Maternity Incentive Scheme (MIS) is a national NHS Resolution programme designed to improve maternity and neonatal safety by linking financial incentives to the delivery of defined safety actions. Now in its eighth year, the scheme: • Rewards Trusts that meet six updated safety standards. • Provides a refund of the additional maternity contribution to CNST. • Offers an incentive payment where applicable. • Reinforces national expectations for robust governance, high-quality clinical practice, and effective learning systems. Updated national guidance (April 2026) is provided in **Appendix 2 and 3**. **2. Current Trust Position** Monthly monitoring via the Maternity and Neonatal Quality Assurance Meeting continues to track progress against each Safety Action Standard. Key points: • A refreshed gap analysis (Appendix 4) reflects the 2026 scheme updates. • Evidence collection and validation processes have been strengthened. • Early indicators show steady progress, with targeted actions underway in areas requiring improvement. • Cross-Divisional collaboration between Maternity, Neonatal, Governance, and Quality teams is supporting delivery. **3. Assurance and Governance** The Trust has implemented: • Enhanced evidence-tracking mechanisms to ensure audit-ready documentation. • Strengthened clinical governance oversight, including escalation routes for emerging risks. • Regular reporting to the Quality and Safety Committee and Board of Directors. • Clear accountability for each safety action, with named leads and defined timelines. These measures ensure the Board receives timely, accurate assurance to support the annual self-declaration. **4. Board Responsibilities** Board oversight is a mandatory requirement of the MIS. The Board must: • Review progress against all six Safety Action Standards. • Confirm that evidence is complete, accurate, and triangulated. • Approve the Trust's self-declaration to NHS Resolution.

	• Ensure that any identified risks are mitigated through appropriate governance and resourcing. Successful compliance will secure the financial refund and maintain the Trust's position as a provider of safe, high-quality maternity and neonatal care. **5. Forward Look** Over the coming months, the Trust will focus on: • Closing remaining gaps identified in **Appendix 4**. • Strengthening data quality and audit trails. • Ensuring staff training, incident learning, and clinical documentation meet national standards. • Preparing for internal and external scrutiny of evidence.

4	**Saving Babies Lives and Maternity Care Bundle (Safety Action**
4.1	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 31st March 2016 the Trust achieved 100% compliance against the 6 elements included at **Appendix 5**. This was an increase from the previous quarter, and the maternity service has met all action plans to achieve full implementation. Compliance will continue to be monitored internally with a further update in the next Board of Directors quarterly paper and via the MIS Year 8 tool.

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

6	**Three Year Delivery Plan – Maternity and Neonatal**
6.1	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 7** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion

	• Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

7	**Maternity Programme Online Portal**
7.1	There is a requirement by the LMNS to report the progress of the Maternity Portal Online Programme (MPOP) to the Board of Directors, and it is included at **Appendix 8.**

8	**Maternity Self-Assessment**
8.1	There is a requirement by NHSE and the Care Quality Commission (CQC) to report the Maternity Self-Assessment tool 6 monthly to the Board of Directors included at **Appendix 9.**

9	**Maternity Workforce**
9.1	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has six maternity continuity of carer teams and has met all upskilling programs and safe staffing levels. There are no further teams planned to be launched and a continued focused approach to deliver the current models of care in line with national directive to enhance women/birthing people. As previously presented to Board of Directors a full workforce review is required to be undertaken every 3 years in line with Ockenden utilising the Birth Rate + workforce tool. The report was received in March 2025 and the maternity workforce with the Board approved action plan and additional posts fully meets birth rate plus compliance. The Board has been requested to continue to support the maternity establishment with no reduction to headcount. The maternity staffing update paper is included in **Appendix 10,** and the Board is requested to note the maternity establishment is now fully compliant with the Birth Rate Plus recommendations. The associated action plan, previously approved by the Board of Directors, has been completed in full, and all posts have been advertised and successfully recruited to.

10	Neonatal Workforce
10.1	An annual joint visit was hosted by WUTH on 5 March 2026, attended by NHSE and the LMNS. The initial feedback was presented at the last quarterly Board of Directors meeting; however, the written feedback is now included at **Appendix 11** for reference.

11	NHSE Visit
11.1	An annual joint visit was hosted by WUTH on 5 March 2026, attended by NHSE and the LMNS. The initial feedback was presented at the last quarterly Board of Directors meeting; however, the written feedback is now included at **Appendix 12** for reference.

12	PMRT Reports
12.1	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 13 and 13**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 3 and Quarter 4 25/26 period.

13	MBBRACE
13.1	Included at **Appendix 14** is the report providing an overview of the 11 neonatal deaths captured in the MBRRACE-UK Perinatal Mortality Report for 2024 births at Arrowe Park Hospital.

14	Conclusion
14.1	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The Trust continues to demonstrate a strong and structured approach to perinatal quality, safety, and governance. The Perinatal Quality Oversight Model (PQOM), supported by the revised reporting format, provides clear, transparent, and comprehensive assurance to the Board. Maternity services remain fully compliant with key national frameworks, including Birthrate Plus®, MIS Year 8 requirements, Ockenden recommendations, and the Saving Babies' Lives Care Bundle, with workforce establishment secured and sustained. There were no new Patient Safety Incident Investigations declared during the reporting period, and robust governance arrangements remain in place to ensure appropriate escalation, investigation, and organisational learning. Whilst neonatal services continue to demonstrate stable performance and effective oversight, further improvement is required to achieve full compliance with British Association of Perinatal Medicine (BAPM) standards. Targeted actions and continued system-wide support are in place to address identified gaps, strengthen service delivery, and ensure alignment with national expectations.

	Overall, the Trust remains well positioned to sustain delivery against national safety ambitions while maintaining a clear focus on continuous improvement, equity, and the delivery of safe, high-quality, and person-centred care. The next paper will continue to update on the delivery of safe maternity and neonatal services.

15	Implications
15.1	**Patients** • The appendices outline the standards we adhere to deliver a safe service, with excellent patient care. • Continued delivery of safe, high-quality, and person-centred care across maternity and neonatal service • Assurance that national safety recommendations (Ockenden, SBLv3, MIS) are fully embedded • Strengthened focus on safety outcomes, learning, and patient experience • Ongoing implementation of equity and equality priorities, improving access and outcomes for all women and families • The recent NHSE visit gave assurance of a high quality and safe maternity service.
15.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH with the anticipation to meet all 10 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports women/birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Strengthened Board assurance through enhanced PQOM reporting format . • Continued compliance with Ockenden Immediate and Essential Actions. • Robust systems in place for incident reporting, investigation, and learning. • Improved transparency supporting effective scrutiny and informed decision-making.
15.3	**Finance** • To continue to operate safely and effectively, there is a requirement for sustained financial commitment to support current service delivery and risk mitigation arrangements. • Achievement of the maternity incentive scheme Year 7 means a refund of the additional contribution and potentially a share of any unallocated funds. • Reinforces value through safe staffing and risk reduction, minimising financial exposure linked to avoidable harm. • No additional financial risks identified within this reporting period.

15.4	**Compliance**
	• This supports several reporting requirements, each highlighted within the report.
	• Full alignment with national regulatory and assurance frameworks, including:
	  o NHS Resolution MIS
	  o CQC maternity safety expectations

	◦ NHSE/I reporting requirements ◦ LMNS oversight • Strengthened Board assurance through enhanced PQOM reporting format. • Continued compliance with Ockenden Immediate and Essential Actions. • Robust systems in place for incident reporting, investigation, and learning. • Improved transparency supporting effective scrutiny and informed decision-making.

Group Board of Directors in Public **Item 19**

03 June 2026

Title	WUTH Biannual Establishment Review
Area Lead	Chris Douglas, Chief Nurse
Author	Julie Roy, Director of Nursing Johanna Ashworth-Jones, Programme Developer

Purpose of the Report and Recommendation	
Report For	Information

The purpose of this report is to provide the Trust Board with assurance that WUTH has met its regulatory requirements in accordance with national guidance 'Developing Workforce Safeguards' (NHSI 2018). National guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time National Quality Board (NQB 2016 & 2018).

In addition, the report demonstrates that the Trust has met effective governance requirements aligned to workforce decisions which promote patient safety and comply with the Care Quality Commission (CQC) fundamental standards.

This report comprises of an Executive summary report to support presentation at Trust Board and a comprehensive full report detailing process, assurance evidence, outcomes and next steps which will be published on the Trust website.

It is recommended that the Board/Committee (delete as appropriate):

- Note the report

Key Points to Note

The Trust has met the standards and expectations within Developing Workforce safeguards requirements for adult inpatient wards. In addition, there are evolving processes in place to support professional judgement establishment setting within specialist areas.

This report highlights a series of new and proposed workstreams that will ensure standardised approaches to safe staffing. These new initiatives and increased scrutiny and controls will provide a positive impact on patient safety and quality of care whilst also supporting efficiency reviews and increased transparency of staffing metrics.

There is confidence that daily staffing monitoring processes are in place with a good system of internal control being applied to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy.

Key Risks

This report relates to the following key risks:

Emergency Department:

1091-Staffing Levels & Temporary escalation areas

270 – staffing challenges associated with surge in activity and overcrowding

2354 – increased falls and challenges to provide staffing to support close observations

Surgical Division:

2352 - Pressures to move staff to cover other departments including ED.

Women's & Children's

2120- PAU/CED: Lack of sufficient trained staff to transfer to children's ward

1782- GOPD: Increased activity and consultant clinic without increase in nursing establishment to support

2267 – Neonatal – unable to meet BAPM level 3 guidance in relation to senior supportive nurse roles.

2298 – Hospital at home – low staffing levels due to sickness and maternity

1981 – Children's ward – reduced staffing at weekends

2255- Ward 54 – reduced CSW support

2355 – BAPM outreach staffing challenges

Medical Division:

2308- Pressures to move staff to cover other departments including ED.

2387 – M1 nurse staffing- LLOS – Escalation beds

607- staffing challenges to cover ETOC

DCS:

435 – Critical Care – potential risks related to fulfillment of optimal staffing levels

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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
n/a			

1	Narrative
1.1	**Background** The purpose of a safe staffing nursing establishment review is to ensure that sufficient nursing capacity and capability is available to provide individualised, person-centered care in a safe and effective way. This is achieved through consideration of a range of decision-making factors which are detailed in a framework of expectations set out by the National Quality Board (NQB 2016 & 2018) enabling a triangulated approach to staffing decisions. These are; **Expectation 1** — **Right Staff**: 1.1 evidence-based workforce planning; 1.2 professional judgement; 1.3 compare staffing with peers **Expectation 2** — **Right Skills**: 2.1 mandatory training development and education; 2.2 working as a multi-professional team; 2.3 recruitment and retention **Expectation 3** — **Right Place and Time**: 3.1 productive working and eliminating waste; 3.2 efficient deployment and flexibility; 3.3 efficient employment and minimising agency Hospital Trusts are required to comply with the NQB 2016 & 2018 guidance which states that providers: • Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. • Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to always keep them safe. • Must use an approach that reflects current legislation and guidance where it is available. These expectations also form part of 'Developing Workforce Safeguards' (NHSI 2018), along with other recommendations for consideration to provide a triangulated approach for the review of staffing requirements. Trusts must demonstrate that they have used the following three components as part of their safe staffing reviews: • Evidence-based tools (where they exist). • Professional judgement. • Outcomes
1.2	**Governance** Alongside the regulatory requirement to undertake a formal 6 monthly review of nurse staffing establishments, a bi-monthly safe staffing report is presented to People Committee.

The embedded expectations table:

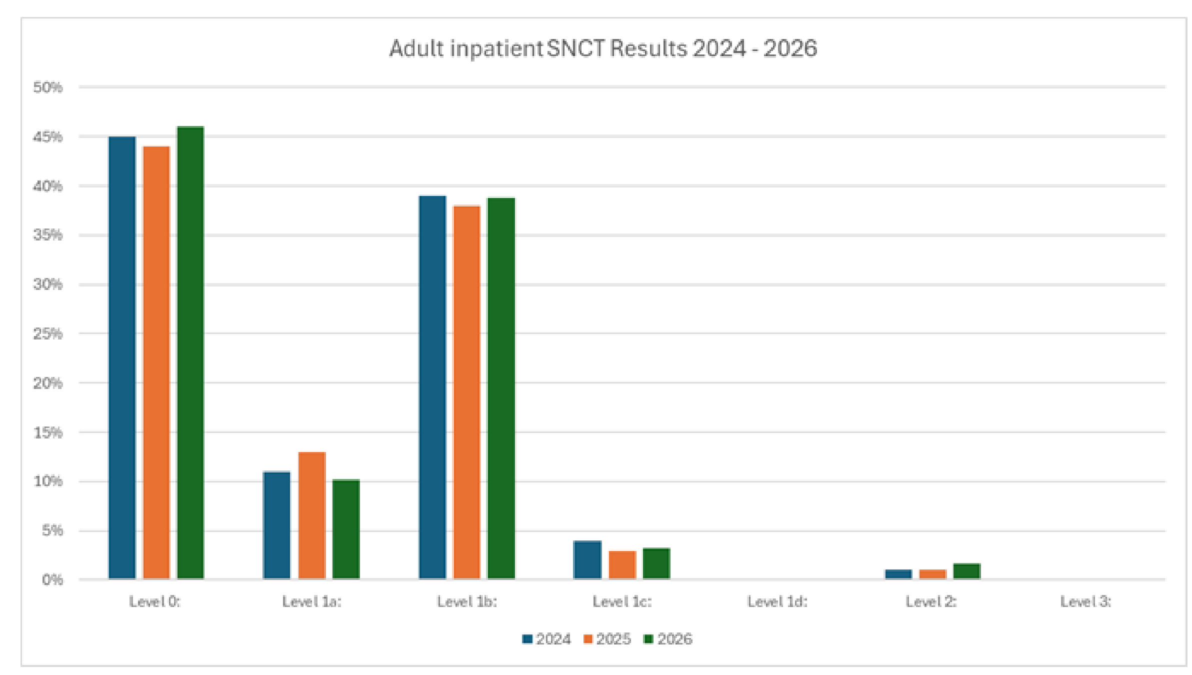
Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

	The bi-monthly report provides an oversight of safe staffing assurances including any known impact on patient care, safety, or experience. Included is a comprehensive dashboard providing a month-by-month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD) data, shifts that have experienced any 'red flags', and patient experience metrics. Any known risk is highlighted along with mitigations and plans to enhance staffing assurances moving forward. The bi-monthly report provides narrative and statistical process control (SPC) charts based on the data within a staffing assurance dashboard. In addition, WUTH complies with NHSE Digital requirements to submit monthly staffing data in relation to fill rates and calculation of CHPPD. These monthly returns are available for review on the Trust public website as per national guidance recommendations.

2	**Establishment Review**
2.1	**Process** The Trust has a standardised approach to establishment setting within the adult inpatient wards (SOP, Appendix 1). This consists of reviewing an establishment template includes nurse sensitive indicators, acuity and dependency results, workforce metrics, quality impact measures and finance, incorporating over 80 indicators (Appendix 2). New for this year's template was the inclusion of a professional judgement self-assessment, this RAG rated assessments prompts evaluation of key factors in line with the establishment indicators ensuring there is a more transparent analysis. These templates are used to consult with each localised leadership model i.e., Ward Manager, Matron, and Associate Director of Nursing. Proposals are then presented by the Divisional Nurse Director at a 'confirm and challenge' meeting with the Chief Nurse and supporting specialist leads. Children's services used the Children's and Young Persons (C&YP) SNCT tool. Specialist areas such as Critical Care, Maternity Services, Neonatal Unit and the Emergency Department have specialist specific establishment reviews aligned to the appropriate national guidance which are detailed later in this report.
2.2	**Expectation 1: Right Staff** **Adult Safer Nursing Care Tool** The Safer Nursing Care Tool SNCT is a NICE-endorsed evidence-based tool, NHS organisations are required to have a licence to utilise it and staff must undertake training and pass an assessment in order to use it.

As part of the establishment review template the results of the previous SNCT audits are considered, including discussion in relation to any significant variances in data to ensure that there is confidence in the application of the tool. ‘Red rules’ within the tool indicate that where that has been a change of location, configuration or patient case mix since the previous audit then this should be considered as a new data set and comparison, or judgment cannot be used based on SNCT results until there are two data collection points.

The chart below shows the Adult SNCT levels of care across each of the three audits since using the revised October 2023 tool. The chart shows little variance across the overall Trust results. This would suggest a degree of confidence in a consistent delivery and approach to how the SNCT has been implemented.



There were some level 1d & level 3 patients during the audit however not enough to create a percentage figure.

Patient care levels: Adult inpatient SNCT

- Level 0 – Needs met by provision of normal wards.
- Level 1a – Unstable with a greater potential to deteriorate.
- Level 1b – Stable condition but are dependent on nursing care to meet most of their needs.
- Level 1c – Stable condition but requiring additional intervention to mitigate risk.
- Level 1d – Stable condition but requiring intervention by 2 or more people to mitigate risk.
- Level 2 – Requires management in designated beds / required staffing expertise or transfer to designated level 2 facility.
- Level 3 – Advanced respiratory support / multiple organ failure

2.3 **Expectation 1 – Right Staff**

The Chief Nurse leads the development of a nursing workforce plan for WUTH, this must take into consideration current financial challenges and controls and ensure that the nursing and midwifery workforce is resilient and able to sustain high quality care and patient safety.

2.4 Expectation 2 – Right Skills

Mandatory training

Ensuring staff have the right skills to undertake their role safely and confidently is a national NHS requirement. WUTH has robust Ward to Board processes in place to monitor the compliance of staff against mandatory and role essential training including a specific Education Governance Group.

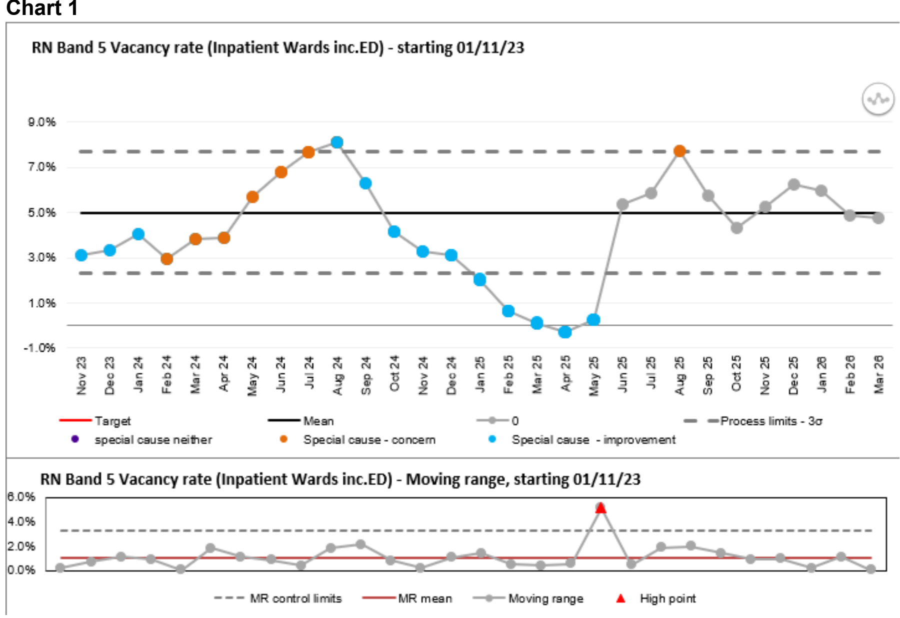
2.5 Expectations 2 – Right Skills

Recruitment & Retention

Data from NHS England reports the national registered nurse (RN) vacancy rate as 6% (Sept 25). WUTH reports nurses' & CSW vacancy data as part of the bi – monthly safe staffing report to People Committee, for ward-based nurses (including Emergency department) WUTH has held a vacancy rate in line with the national or below with the latest vacancy rate at the time of this report 4.77% Mar 26.

The Nursing Workforce Lead within Corporate Nursing, works closely with Divisional Directors of Nursing to support timely recruitment of Registered Nurses with a particular focus on supporting newly qualified RNs into band 5 positions.

Chart 1



CSW recruitment

Following the conclusion of a Trust wide organisational change process affecting CSWs, CSW vacancy data continues to be reported as special cause concern. Recruitment and retention work is ongoing with several actions:

- Local recruitment led by each Division
- Planned quarterly recruitment events supported by Trust's workforce team
- A CSW Development programme led by NHS Professionals
- A successful ED specific recruitment event targeting band 3 recruitment

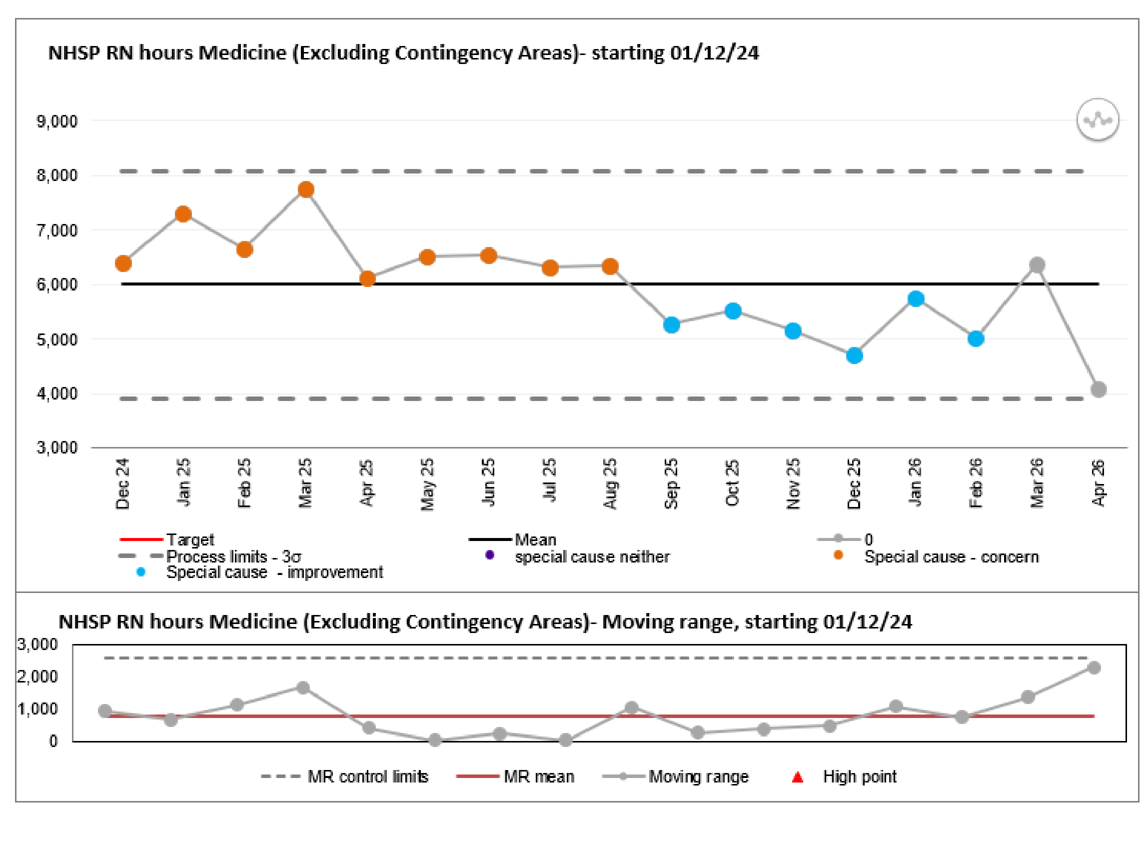
	Expectation 2: Right skill **Enhanced Therapeutic Observation of Care (ETOC)** Patients who are at risk of falls, cognitive impairment which manifests in behavioural challenges, cared for under a deprivation of liberty (DOL's) patients may require varied levels of ETOC to help maintain patient and staff safety. WUTH has a robust system in place to ensure individual patient risk assessments are completed appropriately and to ensure that the level of observation provided is proportionate. Patients requiring 'within arm's reach' supervision has to be undertaken by CSW band 3 or above. WUTH is part of the regional community of practice (COP), through which organisations are sharing learning outcomes and good practice to ensure quality of care and potential financial efficiencies, some examples include designated ETOC teams and diversional activities co-coordinators. The increased resource demands associated with ETOC patients is a national agenda topic and is reflected in the inclusion of aligned levels within the Adult SNCT and the new C&YP SNCT. Trusts whose demographic population profiles include significant proportions of older people, are therefore more likely to have a greater ETOC requirement. It is imperative that staff are equipped with the relevant skills to support ETOC patients and maintain patient and staff safety. It is anticipated that WUTH will be implementing a set of training competencies through the regional COP work and will continue to enhance its assistive tech approach to aid during Qtr. 2.
2.5	**Clinical Support Workers** Clinical Support Workers (CSWs) are an integral component of the nursing and midwifery workforce supporting registered nurses and midwives to deliver safe and effective care across the Trust. Following a period of industrial action in 2023, a retrospective pay process was undertaken to recompense CSWs for work undertaken at a band 3 level whilst they were in a band 2 role. Subsequently a Trust-wide organisational change process has been implemented to significantly increase the number of band 3 CSW roles and create a new Band 2 Health Care Assistant (HCA) role. During this period, the Trust has experienced an increasing CSW vacancy rate with challenges in reviewing accurate data during the implementation of Trust-wide changes. Staff development and upskilling is now underway aiming to improve retention and support staff experience and safe patient care. Trust wide CSW recruitment has been piloted successfully and local recruitment is ongoing. Several approaches for CSW and HCA recruitment are required whilst supporting development and training of current staff to improve staff experience and retention. A deep dive paper was presented to People Committee 30th March 2026 outlining next steps. The increase in band 3 roles across the organisation has been a key consideration within this round of establishment reviews, their impact aligned to key nursing sensitive indicators will be evaluated through the next set of establishment reviews and on-going safe staffing monitoring to ensure that the Band 2 / 3 models in each area are optimal.

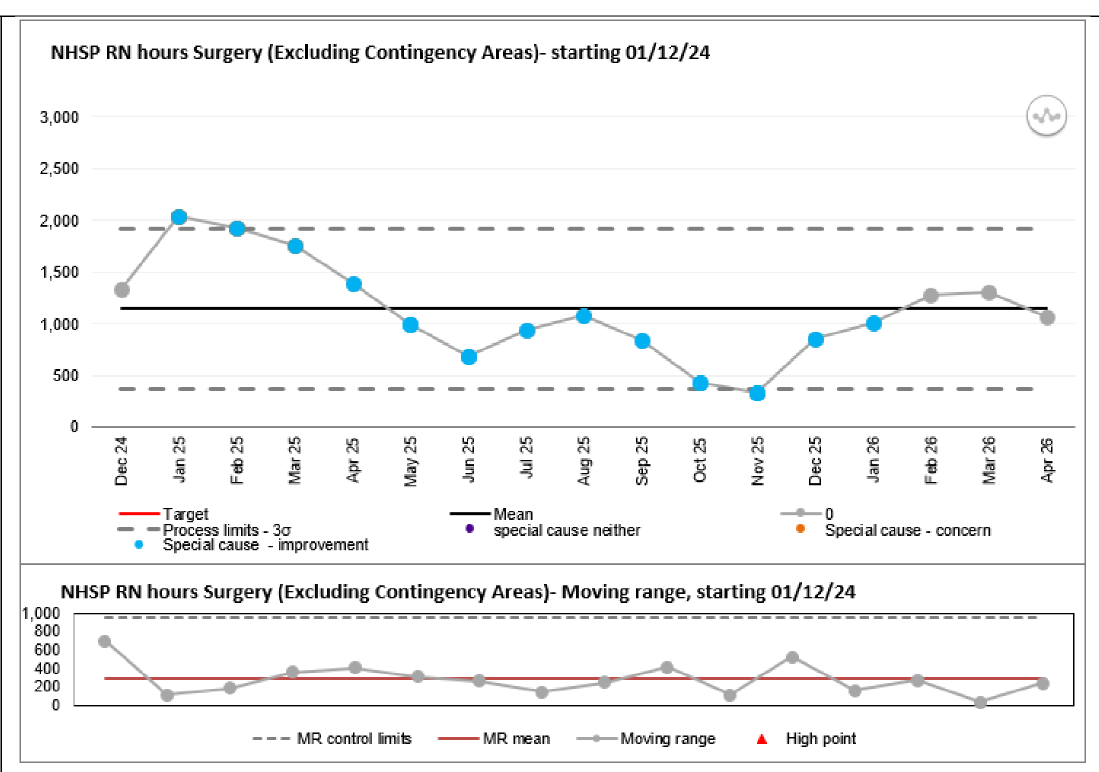
2.6	**Expectation 3 – Right place and time**

E – Roster & temporary staffing

It is well recognised following Lord Carter's review of productivity and efficiency of NHS Acute hospitals 2016 that good roster control and management will provide efficiencies such as reducing the requirement on bank and agency staff and ensuring that there are the right staff, in the right place, at the right time by planning staffing against activity and demand aligned to experience and skills.

WUTH has a roster control meeting in place, chaired by the Director of Nursing with attendance by senior nurse leaders for each division. These review meetings comprise of monitoring key performance indicators aligned to good roster management and data led discussions in relation to additional control measures, such as mis-match shift reports, retrospective shift allocation and NHSP request rationale and usage. High level outputs are reported within the bimonthly safe staffing report to People Committee. The two SPC charts below demonstrate the improvements achieved in relation to the reduction in RN NHSP shifts excluding escalation areas across the medical and surgical divisions.





SafeCare E-roster Module

WUTH is set to launch SafeCare within the surgical division 1st July 2026. SafeCare within the Allocate E-roster system, provides visibility of staffing levels based on patient numbers and acuity and dependency, enabling day-to-day operational changes to the roster, in real time, which will support any required redeployment of substantive staff across wards and allocation of any temporary staffing. This SafeCare module however is reliant on correct e-rosters being in place and staff inputting patient acuity and dependency 3 times a day. Ward 54 within the women's and children's division will be launched 1st August. Preparation for launch within the medical division is underway which includes the cleansing of roster templates and increasing staff trained in the use of SNCT.
Outputs from SafeCare will provide a greater understanding of staffing demands and safe staffing oversight. WUTH will utliise the SNCT model which will capture the requirements of ETOC patients. These data reports will also be utilised as part of the establishment review process and reviewed at regular intervals through the roster review meetings.

Expectation 3 – Right place and time

Escalation beds
WUTH has experienced prolonged periods of high levels of activity which has continued outside of the predicted winter months pressures. The table below shows the current number of escalation beds open. WUTH has had to utilise additional staffing resources from NHSP to maintain safe staffing.

In addition to the escalation beds WUTH also operates a continuous flow policy with several wards taking additional patients based upon their predicted discharges. During the time of the SNCT audit 12 wards recorded additional information indicating that

they had continuous flow patients, with several wards recording continuous flow patients every day.

Division	Ward (Green = Returned)	Funded Beds (Finance data)	Escalation Beds (SNCT forms)
Medicine & Acute	21	30	1
Medicine & Acute	26	29	4
Medicine & Acute	31	28	2
Medicine & Acute	36	34	1
Medicine & Acute	37	8	1
Medicine & Acute	38	37	1
Medicine & Acute	CCU	6	1
Medicine & Acute	CRC	30	2
Medicine & Acute	M1	30	10
Surgical	10	22	4
Surgical	14	37	1
W&Cs	54 Gynae	8	4

Integration – services redesign – SDEC models

Proposals to significantly increase the offer of Same Day Emergency Care (SDEC) at WUTH are under review. It is anticipated that this enhanced provision of same-day assessment, diagnostics and treatment will transform care and significantly reduce the requirement for escalation areas and beds and the associated temporary staffing pressures.

3.0 Establishment review outcomes

Outcome details of the establishment reviews for each Adult inpatient ward are provided in the tables below. The outcomes have been reviewed by the Chief Nurse and Chief Finance officer for overall approval. There were a total of 5 wards with proposed changes as detailed below. Ward 17/SEU, Ward 21, 22, 27and ward 33.

As highlighted earlier in the report, utilising Adult SNCT results as a basis for recommendations to changes in establishments should only be done after a minimum of two audits. In addition, national guidance is clear that the decision making for establishment change must be focussed on professional judgement using the triangulation of data intelligence.

Table 1 displays adult inpatient wards with ward 26 and M1 displaying the impact of the escalation beds described further within this report.

Table 1

WUTH 2026 SNCT Results Comparison table

Division	Ward	WTE Funded Establishment *(Excluding house keepers & ward Clerks)*	SNCT 2026 Results *Excluding level 1c & 1d ETOC**	SNCT 2026 Results Including *level 1c & 1d ETOC**	Outcome
Surgical	10	31.21	30.53	30.53	No Change
	11	40.62	38.86	39.07	No Change
	14	53.68	51.5	51.5	No Change
	18	45.23	36.61	36.94	No Change
Medical	21	41.44	45.96	56.01	Skill mix change
	22	41.26	35.29	45.25	Skill mix change
	23	43.07	43.34	44.72	No Change
	24	31.43	27.95	30.82	No Change
	25	37.53	38.8	41.73	No Change
	26	41.20	39.82 (29beds) 42.7 (33beds)	49.85 (29beds) 57.28 (33beds)	No Change
	27	41.32	38.01	40.16	Skill mix change
	31	40.37	42.31	54.16	No Change
	33	38.83	38.86	39.08	Reduction
	36	47.91	47.77	54.26	No Change
	38 & 37	70.07	72.5	73.56	No Change
	CRC	39.72	36.55	42.97	No Change
	M1	40.42	47.61 (30beds) 63.84 (40beds)	49.04(30beds) 64.91 (40 beds)	No Change
	AFU	40.01	50.12	51.41	No Change

The surgical division has two wards where the bed base has "ring fenced" elective activity beds shown in table 2 below.

Table 2

Ring Fenced Elective Orthopaedic Beds					
Division	**Ward**	**WTE Funded Establishment** *(Excluding house keepers & ward Clerks)*	**SNCT 2026 Results** *Excluding level 1c & 1d ETOC**	**SNCT 2026 Results** Including *level 1c & 1d ETOC**	**Outcome**
Surgic al	12 & WAFFU	38.56	35.82	38.28	No Change
	M2 Ortho	18.63	11.85	11.85	No Change

4 wards across the medical, surgical and womens & childrens division who undertook the adult SNCT audit have a combined funded establishments with staff who work across the combined areas of responsbiiliy and whom are managed by the same budget leadership. These combined establishments provide a challenge when reviewing SNCT reulsts as the Adult SNCT is only applicable for bedded overnight stay

areas. Table 3 presents the SNCT data for these wards indicating which part of the combined establishment has not been included to provide some additional context. .

Areas with combined establishments where part of the funded establishment is not included in the SNCT calculation due to the nature of the activity.					
Division	**Ward**	**WTE Funded Establishment** *(Excluding house keepers & ward Clerks)*	**SNCT 2026 Results** *Excluding level 1c & 1d ETOC**	**SNCT 2026 Results** Including *level 1c & 1d ETOC**	**Outcome**
Surgical	SEU -17 Excluding SEU	51.15	25.06	25.51	Increase
Medical	32 & CCU Excluding Cath lab, Cardiac day ward	64.36	50.31	50.31	No Change
	30 Excluding Haematology Day Ward	37.8	44.63	44.63	No Change
W&Cs	Gynae Excluding Gynae Day Case	25.02	14.03	14.03	No Change

Surgical Division

As highlighted in table 1 there was just 1 surgical ward where a change was proposed. This change was a slight increase in the 2nd ward manager's hours from 0.82WTE to a full time post for SEU / ward 17.

At a divisional level, staff are redeployed appropriately as identified through daily staffing meetings and staffing allocation is planned in line with patient theatre allocation lists. The deployment of Safecare detailed further in this report will support a greater understanding of this redeployment activity.

Medical Division

AMU, MSSW and UMAC are currently undergoing an organisational change process, with the planned closure of MSSW.
4 wards within the medical division proposed changes during the establishment review process with all changes linked to ETOC considerations. Wards 21, 22 and 27 have similar staffing models and patient case mixes as elderly medicine wards. All three wards have a significant number of patients who require some level of ETOC, the proposed changes for these areas are to reduce the 5th registered nurse on the early shift and increase a band 3 CSW on the late shift. This provides a surplus amount

within the budget that will be used to support a business case for an additional CSW band 3 on the early shift, with an expectation that this will reduce NHSP spend.

Ward 33 has proposed a reduction of a CSW late shift, however the budget from this would be used to cover the extra costs of additional ETOC across the Division. ETOC provision is one of the biggest reasons for additional NHSP spends within the division however there is no budget for this.

In addition to the provision of ETOC shifts the medical division also have staffing challenges in the provision of safe staffing for additional escalation beds, detailed further in the report.

Emergency Department

WUTH is currently upgrading its Emergency Department (ED) as part of a multimillion-pound capital investment. As ED transitions between the old environment and the new build the department is accommodated across several different areas which has resulted in some unforeseen staffing resource challenges. In addition, the Trust has experienced ongoing operational activity pressures which has resulted in ED having to utilise several temporary escalation areas which require additional staff to maintain patient safety.

Staff from across the Trust have supported the Emergency Department during significant times of escalation adding additional staffing pressures across other clinical areas. WUTH held a Corridor Care Summit May 2026 with an overarching improvement plan and actions supported by the Trust's service improvement team. In recognition of the changing patient case mix and an increased length of stay, the Imperial College who are responsible for the development and implementation of SNCT have adapted their ED SNCT tool. This revised tool now includes the collection of the number of patients who have been in the ED for >12hours and aligned a specialist staffing multiplier. Whilst details of this multiplier is protected by a licencing agreement, for the purpose of this report it is acknowledged that the staffing requirement for this type of patient i.e. >12 LOS is higher than 4 other levels of patient acuity and dependency highlighting the challenging nature of caring for and ensuring clinical treatment in these temporary environments. The EDSNCT recommends a headroom for EDs at 27%, national recommendations sit at 25% and WUTH's ED headroom is 23%.

The new ED is planned to be completed in summer 2026 and the planned staffing model for the new department layout is being reviewed by the senior Divisional team, with the Director of Nursing.

Daily dynamic risk assessments are in place to support safe staffing within the ED with clear routes of escalation and communication within the organisation which are overseen at executive level.

Maternity Services

Maternity services use a nationally recognised safe staffing tool Birthrate Plus® which is completed daily and shared across the regional network. Monthly outcome results including the number of red flags, compliance with the tool and any escalation implementations or diverts are reported in the bimonthly Workforce Assurance

Committee report for monitoring and escalation. In addition, staffing for maternity services is also reported to the Executive team in relation to Ockendon report updates, progression against continuity of care model implementation and PSQB reports. Following the annual Birthrate Plus® staffing recommendation report March 2025, a business case was presented with an uplifted staffing model to meet recommendations. All of these posts have now been recruited providing a full establishment.

There were no proposed immediate changes to the maternity services establishment, however at the confirm and challenge meeting it was acknowledged that during the recent NHS visit they identified a gap in the provision of dedicated safeguarding maternity posts. It was also agreed that a potential business case would be put forward to increase the current band 6 telephone triage cover to a band 7 post.

Children's Services

The Children's ward was reviewed within the Women's & Children's establishment confirm and challenge meeting chaired by the Chief Nurse. It was acknowledged that the Children's ward is a combined funded establishment with Children's Day case (not captured within SNCT) and whilst there were no proposals to change the current establishment it was acknowledged that there are two risks on the risk register related to the provision of safe staffing. The first 2120 in relation to the proximity of PAU / CED to the ward and the requirement for both areas to support with transfers of patients and cover for breaks etc. This can provide additional pressure at weekends as the Children's ward has a reduced staffing model (risk 1981).

Children's services have specific RCN guidance in relation to staffing levels with suggested patient to registered nurse ratios, also incorporating guidance on acuity levels and alignment to children's age. Whilst this guidance is incorporated as part of the professional judgement in determining staffing levels day to day for the Children's ward, there is currently no mechanism to digitally capture and monitor compliance against this guidance.

There is a specific Children's SNCT with similar implementation requirements to meet the licence agreement criteria. At the time of the audit WUTH utilised the "old" CY&P SNCT. This tool does not always accurately reflect current staffing demands as it does not incorporate ETOC requirements. WUTH regularly supports paediatrics patients with complex care needs including CAMHS patients who require additional therapeutic observation support. The new tool, released by NHS England 13th May 2026 has yet to confirm training dates for its use.

Additional assurances that influence professional judgement include WUTH's attendance at the daily Cheshire and Merseyside network meeting where activity details are recorded and information on acuity shared. WUTH are also a member of four children's services networks, Paediatric, Neonatal, Critical Care and Surgical, these networks provide regional support, scrutiny and gather staffing and patient data in relation to activity and workforce indictors.

Neonatal Unit

There were no proposed changes to the current staffing establishment within the neonatal unit. During the confirm and challenge meeting it was acknowledged that

	there were some gaps in recommended staffing numbers for supportive roles. The division have covered some of these gaps by flexing some of the roles in Maternity services such as bereavement and IT nurse to support the neonatal unit. In addition is was recognised that there are also gaps in the recommended numbers of Allied Health Professional AHP roles which is on the risk register. Due to the acute nature of neonatal medicine, it can be difficult to accurately predict required staffing levels and therefore the application of professional judgement using average activity & acuity, aligned to staffing guidance recommendations form the basis of staffing deployment within WUTH's neonatal unit. This approach is in line with the British Association of Perinatal Medicine BAPM guidance. WUTH's neonatal unit is part of a regional neonatal network and is represented at daily meetings to identify any required mutual aid, diverts or escalations. **Critical Care** The current staffing establishment for critical care has been mapped according to the Guidelines for the Provision of Intensive Care Services (2022) (GPICS) developed by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). This provides a baseline of how the unit is staffed according to the standards. The staffing establishment is sufficient to ensure that the standards are achieved.

STANDARD OPERATING PROCEDURE TEMPLATE

Document title:	*Wirral University Teaching Hospital (WUTH) SOP for Nurse Staffing Establishment Review Process V6.*
Document ref:	
Document author:	Johanna Ashworth-Jones Vic Peach Tracy Fennell
Job Title:	Programme Developer / Deputy Chief Nurse / Chief Nurse
Date:	Updated September 2023
Approved by:	Tracy Fennell Chief Nurse
Review by (date):	September 2024
Reviewed by	Sam Westwell Chief Nurse & Julie Roy July 2024
Review Date	July 2026

1. Purpose of SOP

The purpose of this Standard Operating Procedure (SOP) is to provide structured guidance for the completion of the 6 monthly Nursing establishment reviews.

2. Abbreviations and Definitions

RN: Registered Nurse

CSW: Care Support Worker

DTI's: Deep Tissue Injury

WTE: Whole Time Equivalent

HROD: Human Recourses & Organisational Development

CHPPD: Care Hours per patient Day

SSOT: Safe Staffing Oversight Tool

ADoN: Associate Directors of Nursing

WUTH: Wirral University Teaching Hospital

3. Who does this apply to?

This SOP applies to:

The Corporate Nursing Team,

Divisional Directors of Nursing,
Finance Department
Deputy Chief Nurse /Chief Nurse.
AHP Lead
Workforce Lead
Ward Managers
Matrons
Divisional Directorate Managers

4. When it should be used

This procedure should be followed every 6 months and or in line with any service development changes.

5. Procedure

As per the guidance from the National Quality Board, Developing Workforce Safeguards, multi factorial indicators should be considered as part of the nurse staffing establishment process to provide an informed presentation of data to support professional judgement when setting Establishments. WUTH undertakes this presentation in the completion of Establishment review templates which consists of 92 indicators for consideration. Appendix 2.

It is the responsibility of the Corporate Nursing Team to populate 64% of the establishment templates, Divisions are asked to populate the remaining 36% of indicators and are also asked to confirm the details provided prior to the Confirm and Challenge meeting with the Chief Nurse and provide any amendments in advance of the meeting.

Using the guidance set out in the National Quality Board, Safe, sustainable and productive staffing guidance resource 2018. Summary table below as table 1. The Establishment templates are split into the following sections:

- Current Ward Model
- Staffing Data
- Acuity & Dependency Results
- Operational
- Patient Harms
- Workforce sensitive indicators
- Finance
- Additional support
- Patient experience
- Narrative
- Audit
- Staff Experience

Table 1:

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Current Ward Model

The current ward model sections compromises of 19 indicators, and identifies current Leadership, Speciality information, Skill Mix and skill ratios indicators including CSW band 2 / 3 models current and proposed.

Staffing Data

This section compares staffing data with RCN guidance on nurse-to-patient ratios, CHPPD, Staffing incident data, SSOT intel data such as the number of professional judgement red shifts, Eroster completion and comparative benchmarking where available.

Acuity and Dependency Audit results:

WUTH uses the Shelford Acuity (SNCT) Tool to measure Acuity and Dependency every six months. This is one of the recommended tools set out in the Quality board guidance.

The audit consists of a minimum 21day day capture of each patient's acuity and dependency level at the same time per day and is completed by the Ward Manager or the Ward Deputy these are then signed off by the divisional matrons and Associate Directors of Nursing. Corporate Nursing team also review and advise on any validation queries or any significant variances. Training where required is provided by the corporate nursing team. All documentation is provided by the Corporate Nursing Team

and distributed in advance of the audit. Audit forms are collected at regular intervals by the Corporate Nursing Team.

Results are broken down into different levels of required care which provides additional intel to inform professional judgment on required workforce skill mix and CSW / RN ratios.

Operational

This section provides an opportunity for the division to highlight any environmental factors for consideration or additional services provided by the area of review.

Patient Harms (Nurse sensitive indicators)

Nurse sensitive indicators is a generic term for several quality indicators, for the purpose of the establishment reviews this consist of a selection of patient harms and serious incidents as other nurse sensitive indicators are captured under further quality headings such as patient experience as detailed further in this SOP.

Patient Harms – for the purpose of the establishment review the data presented is based on prevalence per PTBD within the last 3 months and reviews of moderate and above hospital acquired harms.

Workforce sensitive indicators

Workforce indicators are presented as a range of the last 6 months and the current / latest month data. Data is produced by HROD/ Workforce department and is collated by the Corporate Nursing Team.

Indicators for inclusions within the review template consist of:

- Mandatory Training Compliance – current month
- Appraisal Compliance – current month
- Sickness – 6 month range and current month
- Vacancy rate – 6 month range and current month for both RNs and CSWs
- Maternity – current
- Performance and Suspensions – current

Finance

Data is requested from Finance and cross referenced with the divisional senior teams for inclusion in the establishment review templates and then populated by the corporate

nursing team. This section considers and prompts discussion in relation to NHSP spend and budget performance positions.

Additional Support

This section allows an opportunity to look at the MDT approach to patient care allocated to the ward, this includes the provision and input from AHPs and reviews the support for student nurses as part of future workforce planning.

Patient Experience

Patient experience is recognised as a fundamental quality measure and output indicator therefore several patient experience feedback indicators are included within this section including localised and national measures.

Narrative

This section is for completion by the division and provides an initial opportunity to document current ward pressures and potential opportunity ward models for consideration as part of the establishment review.

Audit

Quality Audit results are included from the last 3 months or in line with the auditing schedule. The audits included as part of the establishment review are as follows:

- Ward accreditation
- IPC annual audit
- Perfect Ward: Ward Sister
- Perfect Ward Matrons
- Safeguarding audit
- Controlled Drugs audit

Staff Experience

This section is for completion by the division and collates key elements of staff experience these include exit interview themes and trends, national staff survey results including where available localised pulse data and freedom to speak up concerns.

Confirm and Challenge

The template provides a section for narrative capture within the Confirm and Challenge process meeting, this includes summary notes from localised review between the Ward Manager, Matron and ADN, as outlined in the flow chart Appendix 1 Each template

should be signed by the Divisional Director of Nursing, Matron or Associate Director of Nursing, Ward Manager, Finance lead and Divisional Director.

Divisional Directors from other divisions not presenting are also asked to attend the confirm and challenge meetings to provide a level of interdependent challenge and professional judgment.

Specialist areas

WUTH has a number of specialist areas where safer staffing is aligned to nationally agreed parameters or where a specialist acuity tool is in place to support establishment setting. These are:

Emergency Department:

The Shelford company introduced a specialist EDSNCT in 2022. The licence requirements for the use of the EDSNCT requires staff to undergo an evaluated training session by NHSE/I & Shelford group. Staff have to pass a test in order to be authorised to use the tool and provide cascade training within the organisation.

The EDSNCT is completed over a 12-day period at two points twelve hours a part until each of the 24hour periods is completed.

Critical Care

There is currently no validated acuity tool in place for the review of critical care staffing however patient acuity is defined into 4 levels, these levels have also been aligned to recommended nurse to patient ratios but are open to flexibility based on other factors such as presence of supervisory shift leaders, contribution of health care support workers, staff skill mix and environmental factors. These recommendations advise critical care units should have minimum nursing establishments that allow one registered nurse per patient staffing levels for level-3 (intensive care) patients; and one nurse for every two patients for level-2 (high dependency) patients. Skill mix and experience is a significant factor in deploying these recommended ratios as critical care nurses are expected to have specialist skills including, having knowledge of advanced assessments of patients' breathing and the advantages and disadvantages of non-invasive and invasive therapies to support breathing, such as mechanical ventilation.

Maternity Services

Maternity services use the Birth rate+ acuity and dependency tool, this tool is completed daily and is inputted into a centralised data capture system that supports regional collaborative support. In addition to the acuity tool NHS Maternity services are transitioning to a care delivery model "continuity of care" . Outputs from the birth rate+ tool and progression to the continuity of care model is reviewed as part of the establishment review process.

Children’s services

Childrens services adhere to the Royal College of nursing mandatory staffing levels guidance see table 2. This is primarily based on patients ages although additional acuity factors are considered for the high dependency unit using the critical care acuity level principle and staffing ratio recommendations.

Child age	Number of nursing staff	Number of children
Under 2 years	1	3
Above 2 Day shifts	1	4
Above 2 night shifts	1	5

Appendix 1: **Wirral University Teaching Hospital Establishment Review Process: Adult inpatients**

Completion of Acuity and Dependency Audit *(Minimum 21day, completed Trust wide, divisional sign off in place)*

↓

Corporate Nursing process results and circulate to Divisions.

↓

Establishment review templates populated by Corporate Nursing and sent out to Divisions for review of completed indicators and population of divisional specific information.

(Minimum of two weeks prior to Confirm and Challenge meeting with Deputy Chief Nurse)

↓

Divisional Directors of Nursing / Associate Directors of Nursing to meet with ward specific leadership teams (Matron and Ward Manager) to review each establishment template. Each establishment template must be signed off by the Ward Manager to demonstrate establishment proposals have been agreed / discussed.

↓

Proposed establishment changes to be agreed and signed by Divisional Senior Triumvirate before presentation at confirm and challenge meeting.

↓

Divisional Directors of Nursing / ADoN to attend Confirm and Challenge (C&C) Meeting with Chief Nurse / Deputy Chief Nurse, Corporate Nursing team/ Lead AHP, Workforce, Education, HR and Finance leads.

↓

Any proposed changes supported in principle at the C& C meeting, modelled and costed in line with current budget and or further financial pressures for presentation to Chief Nurse and Director of Finance

↓

Circulated for discussion to the Executive Team via EMT

↓

Chief Nurse and Director of Finance to meet to formally sign off approved proposal following modelling proposal presentations.

↓

Deputy Chief Nurse / DNDs and Chief Nurse to provide formal sign off of final Establishment review outcomes for inclusion in Board report

Wirral Community Health and Care
NHS Foundation Trust

Wirral University Teaching Hospital
NHS Foundation Trust

Group Board of Directors in Public **Item 20**

03 June 2026

Title	Joint Patient Safety Incident Response Policy and Framework Plans
Area Lead	Chris Douglas, Joint Chief Nurse
Author	Lorraine Adams, Head of Patient Safety and Governance Claire Wedge, Deputy Chief Nurse

Purpose of the Report and Recommendation

Report For	Approval

It is recommended that the Board:

- Approve the Joint Patient Safety Incident Response Policy;
- Note the WUTH Patient Safety Incident Response Plan; and
- Note the WCHC Patient Safety Incident Response Plan

Key Points to Note

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF).

It sets out how Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC) will approach the development and monitoring of effective safety systems and processes, to improve our patient safety culture.

A unified policy will support identification of patient safety learning across shared pathways, supporting future integration of services.

The Patient Safety Incident Response Framework (PSIRF) Plans outlines the Trust's approach to responding to incidents for the purpose of learning and improving patient safety.

Key Risks

This report relates to the following BAF risks:

- Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.
- Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.
- Failure to comply with relevant codes of governance, regulation and legislative requirements
- Failure to deliver an inclusive, compassionate and person-focused culture where staff can thrive, and where their health, wellbeing, and morale are supported

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
February 2026	Patient Safety Quality Board	Joint Patient Safety Incident Response Framework Policy	Approved
16 April 2026	PSQB (WUTH)	PSIRF Plan	Approved
27 April 2026	SOG (WCHC)	PSIRF Plan	Approved
01 May 2026	Joint Quality and Safety Committee Chairs approval	PSIRF Plan: WCHC and WUTH	Approved
29 May 2026	Joint Quality and Safety Committee	As above	Approved

1	Narrative
1.1	**Joint Patient Safety Incident Response Policy (appendix 1)** The Joint Patient Safety Incident Response policy outlines the governance framework to embed effective safety systems and processes to learn from patient safety events proportionately and triangulate our safety systems learning. The framework represents a shift in the way the NHS responds to patient safety incidents and is a significant step forwards in embedding systems thinking to support a culture of continuous quality improvement as part of the NHS patient safety strategy.

	The policy supports the development and maintenance of an effective patient safety incident response system that integrates four key aims: • Compassionate engagement and involvement of those affected by patient safety incidents • Application of a range of system-based approaches to learning from patient safety incidents • Considered and proportionate response to patient safety incidents • Supportive oversight focused on strengthening response system functioning and improvement
1.2	**Patient Safety Incident Response Framework (PSIRF) Plans (appendix 2 and 3)** The Patient Safety Incident Response Framework (PSIRF) Plans outlines the Trust's approach to responding to incidents for the purpose of learning and improving patient safety. As part of the integration journey between WCHC and WUTH, the plans have been aligned to reflect jointly agreed priorities. This will maximise collective impact, supported by robust monitoring mechanisms across both organisations to assure patient safety. The PSIRF Plans are aligned to national standards, including the following areas: • Trust Safety Culture • How we learn from incidents • Learning mechanisms • PSIRF Training • Defining the Trust's patient safety incident profile • PSIRF Plan: National event response • PSIRF Plan: Local focus

2	**Implications**
2.1	**Patients** • Effective implementation of the PSIRF Policy across both organisations will support delivery of safe, quality care, maximising patient experience through a culture of continuous learning and improvement • The Trust is committed to ensuring compliance with equality and diversity standards for staff and people who use the Trust services • The PSIRF Plans provide assurance that the Trust has developed robust mechanisms, supporting proportionate investigation of incidents to assure patient safety
2.2	**People** • Implementation of the PSIRF Policy supports regulatory compliance and effective use of resources • This will positively impact on employee health, wellbeing and inclusivity • The policy will positively impact on internal and external stakeholders across the local system

	• The PSIRF Plans provide a consistent, transparent framework to engage staff across the organisation in the incident investigation and learning response process. The plans recognise the impact on staff involved in the investigation process and provide a supportive framework to identify learning via a psychologically safe culture
2.3	**Finance** • There are no financial implications associated with the PSIRF Policy • Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action • Robust Patient Safety processes can reduce the potential for litigation involving the Trust
2.4	**Compliance** • Implementation of the PSIRF Policy will support regulatory compliance and the delivery of safe care • Effective PSIRF Plans evidence regulatory compliance in relation to the Care Quality Commission regulatory framework

Policy Reference: xxx

Patient Safety Incident Response Policy

Version: 4

Author(s) Name:	Lorraine Adams	**Author(s) Designation:**	Head of Patient Safety and Governance
Author(s) Dept	Governance Support Unit – GSU (WUTH) Quality and Governance (WCHC)		
Co-Author(s) Name:	Cindy Freeman Quality and Governance (WCHC)	**Co-Author(s) Designation:**	Clinical Safety Manager
Co-Author(s) Dept			
Approval Date:		**Approval Group:**	
Ratification Date:		**Ratification Group:**	
Published Date:		**Review Date:**	
Target Audience:	Staff working for Wirral University Teaching Hospital and Wirral Community Health and Care Foundation Trust		
Links to other Policies, Strategies, Procedures etc.			

Key Points to support Staff

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF). It sets out how Wirral University Teaching Hospital and Wirral Community Health and Care NHS Foundation Trust will approach the development and monitoring of effective safety systems and processes, to improve our patient safety culture.

Both Trusts have worked over the last 18 months to embed elements of Safety I and II. A Safety System II approach is aligned to a proactive, restorative and learning culture. Safety System I recognises a complex adaptive system in which humans make things work by problem solving and adapting to the pressures in their environment. The Safety System II approach has a key focus on understanding what works well, as learning requires curiosity and systems thinking. We want to create space for honest accounts of fallibility, as this builds trust and openness, and we no longer tolerate blame or superficial learning. The right culture is essential to create safe systems.

The Trusts are committed to supporting psychological safety working in collaboration with those affected by a patient safety incident such as, staff, patients, families, and carers. This facilitates opportunities for everyone to have a voice and contribute to change ideas.

Both Trusts have already implemented the initial NHS England Health Education England Patient Safety Training Syllabus. We will enhance these core principles by continuing to develop patient safety competencies and by creating stronger links across patient safety events, learning and continuous improvement. Safety learning will drive effective quality improvements and clinical audit in areas identified as key priorities and known safety system risks. NHS England are currently updating training requirements for PSIRF this is due to be published April 2026. We will review training to support compliance with national guidance.

The Trusts will work in partnership with our patient safety partners to learn from recurring incidents, complaints and feedback from patients and families. This approach fosters increased transparency and openness to support incident reporting in a safe and learning environment. Using an appreciative inquiry model to include insight from things that have gone well and where things have not gone as planned.

The Trusts will continue to learn and be responsive to feedback from the annual NHS staff survey metrics based on specific patient (and staff) safety questions. As this reflects how well the patient safety culture is making positive changes on a day-to-day basis.

The Trusts recognise that NHS services have a core role to play in reducing inequalities in health. This can be achieved by improving access to services and tailoring those services around the needs of the local population, in an inclusive way. The Trusts are committed to delivering on their statutory obligations under the Equality Act (2010). Data will be used to assess any disproportionate patient safety risks, from across the nine protected characteristics. Both Trusts have strategies which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.

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1 Introduction & Purpose

This policy sets out our governance framework to embed effective safety systems and processes to learn from patient safety events proportionately and triangulate our safety systems learning. This approach helps to balance resources between conducting learning responses when new learning is highlighted and releasing time for making the safety improvements to strengthen patient safety. These requirements are fundamental to demonstrating we are delivering on the aims of the Patient Safety Incident Response Framework (PSIRF).

The framework embeds patient safety incident responses within a wider system of safety improvement and prompts a significant cultural shift towards systematic strengthening of patient safety management. This policy integrates the four key aims of PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement

This Policy needs to be read in conjunction with WUTH/WCHC individual Patient Safety Incident Response Plans, which are separate documents and held within each organisation setting out how this policy will be implemented and explaining the processes involved. The aim is to have a joint plan when next reviewed.

2 Definitions

This section should describe the meaning of any key points used within the policy, to highlight its meaning to the reader.

AAR	After Action Review
CAG (WCHC)	Clinical Assurance Group
CRMG (WCHC)	Clinical Risk Management Group
DOC	Duty of Candour
GMC	General Medical Council
HSSIB	Health Services Safety Investigation Body
ICS	Integrated Care System
ICB	Integrated Care Board
JUSS	Joint Union Staff Side
MDT review	Multi-disciplinary Team - Group of members review incident
NMC	Nursing and Midwifery Council
OPG	Operational Performance Group
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partners
PSII	Patient Safety Incident Investigation

PSRPM (WUTH)	Patient Safety Response Planning Meeting
PSQB (WUTH)	Patient Safety Quality Board
Safety (SEIPS Model)	Systems Engineering Initiative for Patient safety
SAFE	Standards Assurance Framework for Excellence
SWARM huddles	A review by the team involved / on duty at the time of the incident including the SEIPs model for accurate learning
Thematic review	Number of similar incidents are reviewed for themes and trends
Work as done	How you work in practice
Work as prescribed	Work as directed by policies and procedures within the system
Work as imagined	The potential discrepancy between work as done and work as prescribed
Work as disclosed	Is the way people work and feel safe to disclose this aligns to psychological safety
Psychological Safety	Psychological safety is the shared belief that team members can speak up with ideas, questions, concerns, or mistakes without fear of punishment, humiliation, or retribution. It means feeling safe to take risks, be vulnerable, and challenge the status quo, which is vital for patient safety and improving team culture and a wider safety culture
Appreciative Inquiry	Appreciative Inquiry (AI) is a positive, strengths-based approach that focuses on building more of what works well, rather than focusing only on fixing problems. Instead of asking "what is wrong?", AI asks "what is right, and how can we do more of it?
Just and Learning Culture	A Just and Learning Culture in the NHS is an environment that balances fairness and accountability, focusing on what went wrong rather than who is to blame. It encourages staff to report errors, share learning, and speak up without fear of punishment, aiming for improved safety rather than finding blame

3 Duties & Responsibilities

This section describes the duties and responsibilities of anyone involved in the process being described in the policy.

WUTH employees	All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system Ulysses and will record the level of harm they know has been experienced by the person affected. They are responsible for keeping up to date with patient safety training role specific and upholding the PSIRF culture
WCHC employees	All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system Datix and will record the level of harm they know has been experienced by the person affected. They are responsible for keeping up to date with patient safety training role specific and upholding the PSIRF culture

4 Policy Aims

This policy sets out how Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care Trust (WCHC) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across both Trusts. Responses under this policy follow a systems-based approach which recognises that patient safety often is a result of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach and the actions or inactions of people, or ‘human error’, will not be stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, financial investigations and audits, coronial inquests, and criminal investigations) exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of investigation responses, but other processes do not influence the remit of a patient safety response.

Patient Safety Culture

Both Trusts aim to focus on a ‘Just and Learning culture’ that facilitates continuous learning, creates psychological safety which supports staff to raise and address concerns, and focuses upon good practice that is shared. We are both committed to promoting and improving the quality and safety of care and treatment that all patients receive in the hospital and community, as well as preserving the safety of staff, visitors, and others.

To achieve this, it is important to support and embed a positive reporting culture throughout both organisations to enable learning when things do not go as expected. Safety conscious organisations are ones that are receptive to adverse incidents so they can learn, develop, and change practice. We have embedded these principles into our procedures for the review of incidents.

In accordance with the Equality Act, 2010 this policy will support both Trusts to show that learning responses and investigations are reviewed with fairness and transparency. This is to reassure all staff, patients and families regardless of their protected characteristics that they are supported and listened to, when raising a concern or reporting an incident relating to the quality of care and patient safety.

We recognise the significant impact that being involved in a PSII or a learning response, such as an After-Action Review, can have on staff and patients/families. We will actively

engage with staff and patients/families receive the support they need to positively contribute to the review of the incident.

There is a range of support and information available across both trusts for staff:

- Line management
- Occupational Health
- Freedom to Speak up guardian
- Information leaflet regarding the process of an investigation
- Contributing to the investigation

There is a range of support for patients/families and carers across both trusts for

- A named lead to support you through the process
- Information Leaflets
- Signposting to Wired
- Contributing to the investigation

The Patient Safety Partner (PSP)

The trusts have embedded the new role of patient safety partners over the last 3 years and uses both level 3 and level 4 Patient Safety Partners. Currently across both trusts there are five patient safety partners who are used for a range of activities level dependant, they support patient safety and strengthening systems and processes. Drawn from amongst our patients, family members or carers, partners will offer their own experiences and skills to add perspective to our quality and safety improvement work.

They will become members of committees, work with project teams, consult on policy and support learning to contribute a different and independent perspective, enriching and ensuring the best patient experience is achieved.

They will be involved in a wide range of activities and programmes of work and will contribute to improving governance and leadership within the Trust. The patient safety partners will be supported by the Head of Patient Safety and Governance; this is a dual role across both Trusts.

The partners will be provided with guidance and expectations on their role, and they will have regular scheduled reviews and any training they require will be based on their individual experience and knowledge.

Addressing Health Inequalities

Both Trusts recognise that the NHS has a primary role to play in reducing inequalities in health under the Equality Act (2010). The merging of both trusts will support with strengthening our systems and help with reducing health inequalities and enable effective working with our external partners, work has already started with working with the PCNs in reducing health inequalities.

Both Trusts are committed to delivering their statutory obligations by using data intelligently to improve access to services and tailoring services around the needs of the local population in an inclusive way. Focusing across a range of protected characteristics

and apparent inequalities. To strengthen our work in addressing health inequalities, we will commit to:

- Reviewing our individual safety data, to help identify any disproportionate risk to patients with specific characteristics. This data will be used to make recommendations to our Trusts Board and partner agencies on how to work together in partnership to tackle these risks and issues.

- Respond to issues related to health inequalities as part of our patient safety incident response policy and plans.

- Engaging with patients, families and staff following a patient safety incident, with consideration of their individual needs.

- Uphold a system-based approach, ensuring that staff have received relevant training and development to support this approach. This will support the development of a Being Fair culture and help reduce areas of disparity.

Engagement and involvement following a patient safety incident Patients, families, carers and Staff.

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system, that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Patients and families will be supported throughout the PSII process by a named Engagement Lead. Staff involved in a PSII will receive support from their Line manager or another named lead. The Engagement Lead will facilitate how patients/families are able to contribute their experience and perspective to the investigation process to best meet their personalised needs. Engagement Leads will have undertaken specific training to perform this role; this can be accessed via the HSSIB or procured training from an agreed provider.

The Duty of Candour has been included as a professional and legal responsibility Regulation 20 under the Health and Social Care Act 2008 (Regulated Activities) 2014. Staff Involvement (including partner agencies) is of paramount importance when responding to a patient safety incident to provide a holistic and inclusive approach from the outset. This policy should also be read in conjunction with each trust's incident management policy.

Patient Safety Incident Response Planning (PSIRF) supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. Both Trusts utilised data sets for patient safety responses and our existing safety improvement workstreams to enable an effective strategic and proportional patient safety response.

The plan has considered other sources of feedback and intelligence both qualitative and

quantitative, such as complaints, risks, legal claims, safeguarding cases, mortality reviews and other forms of direct feedback from staff and patients. The plans are under continual review and will be updated as required and in accordance with emerging intelligence and improvement efforts. In line with the requirements of the Patient Safety Incident Response Framework the plan is published on our external facing website.

To support patient safety incident responses, PSIRF recognises that resources and capacity to investigate and learn effectively from PSII is paramount (see appendix 1 for investigation by type). It is therefore essential that both Trusts evaluates its capacity, resources and competency requirements to deliver each trusts plan. The decision to undertake an unplanned patient safety incident investigation will be made at: -

- Patient Safety Response Planning meeting (PSRP) for WUTH or by a senior manager so learning is not delayed and to promote safety
- At WCHC it will be agreed at the Clinical Risk Management Group or by the Safety Incident Review Group so learning is not delayed and to promote safety

The allocation of an Investigation Lead and an Engagement Lead will be made by

- The Division at WUTH
- Quality and Governance for WCHC

Training

Patient Safety Syllabus

When patients are harmed, it has an impact on them, their loved ones, our staff, and others who work in WUTH and WCHC. It is crucial that all staff, whatever their roles, see safety not just as our collective responsibility, but as a key priority. We all need to think differently about what patient safety means and how we can make improvements.

Overall, we can make both Trusts even safer by:

- Dealing with risks before they can cause harm
- Working to create a positive patient safety culture
- Building safer systems
- Recognising everyone's role in patient safety

Safety Syllabus	WUTH	WCHC
Level One – Essentials for Patient Safety (estimated completion time 30mins) Is the starting point for all NHS staff, and includes sections on: • Listening to patients and raising concerns • The systems approach to safety, where instead of focusing on the performance of individual	In Place and monitored	In place and monitored

members of staff, we try to improve the way we work • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety		
Level two – Access to Practice (estimated completion time 45mins) Access to practice is intended for all clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are two sessions: The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe). The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame). Level two Access to Practice includes an assessment, which on completion staff will receive a certificate and will have access to the sector specific sessions covering Mental Health, Primary Care, Maternity Care, Acute Care, and Management and Administration.	In place and monitored	In place for all front-line staff
Level One – Essentials for Patient Safety for Boards and senior leadership teams (estimated completion time 30mins) Additional session for senior leaders and executive teams, covering: • The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety incidents on staff at all levels	Under review	In place and monitoring
Level two – Sector Specific sessions (Accessible following completion of Level two Access to Practice)	Under review	Under review

On completion of Level 2 Access to Practice all staff will have access to five patient safety sector specific sessions covering good practice, human factors, risk management, systems thinking, and safety culture. Each of these sessions can be completed by individuals or used as part of a group discussion. These sessions aim to highlight the learning from Level 2 – Access to Practice. The sessions cover: • Mental Health • Primary Care • Acute Care • Maternity Care • Management and Administration		
Levels 3 and 4 Levels 3 and 4 are delivered through a blended-learning approach, with several modules delivered through online learning and followed up with an in-person event. Levels 3 and 4 explore topics such as: • Unpacking system issues • Managing patient safety risks • Understanding cultural, legal, and regulatory factors • Designing solutions	Total of 2 staff Trained working across both organisations	Total of 2 staff Trained working across both organisations Other member of staff undergoing

The Patient Safety Incident Response Framework describes three roles necessary for a patient safety incident investigation to meet the required standard.

- Learning response lead
- Oversight role
- Engagement lead

Training is provided for all three roles, as follows

Training for investigations and working with Patients and Families	WUTH	WCHC
HSSIB- A systems approach to investigating and learning from patient safety incidents	In Place, and data set available on ESR	In place
Procured training as agreed by NHSE		Medled over 3 years now concluded data set available on ESR of staff trained – WCHC will utilise HSSIB training

Engagement Lead Training	HSSIB	Incorporated in Medled Training
Oversight Roles level 3 and 4 /Level 1 senior boards and leaders	Level 1 senior leadership under review	In Place

Reviewing our PSIRF Policy and PSIRP

The PSIRP is a 'living document', that will be appropriately reviewed every 18 months as we make our way along our PSIRF journey and as both trusts become one. We will monitor the effectiveness of our plans, via the joint Patient Safety Risk and learning Review Panel and review outcomes on a quarterly basis, for both trusts. The report will flow through PSQB for WUTH and CRMG at WCHC.

The Patient Safety Risk and Learning Review Panel Meets monthly and reviews the risks identified for both organisations as per PSIRF plan. This meeting is data driven with dashboards and the triangulated of Complaints, concerns, claims, key areas of the risk register and Section 42 incidents (where there is learning). The key areas provide analysis of themes and trends and decisions are made of the next steps. The group looks at all levels of harms to support Quality Improvement, these are monitored with an Statistical Process Chart (SPC) to review the effectiveness and outcomes.

The decision-making process for the learning response.

The PSIRP provides details of the governance and oversight process, to highlight how learning and improvement is taking place across both organisations including the decision-making process, at WUTH this is the Patient Safety Response planning meeting.

At WCHC, this involves the Safety Incident Review Group who conduct an initial review of the incident, usually a case review, MDT review or a Swarm Huddle which is discussed and moderate harms and above are shared with the Clinical Risk Management Group. The group review recommendations and a peer agreement made if further learning is required, proportionally, to highlight safety systems learning. Then a learning response is conducted. This can be an After-Action Review, a Thematic Review or Case Study Review. If the incident requires a wider or joint systematic review a PSII may be agreed. At these meetings it will also be agreed if the incident meets the Duty of Candour requirements, which are outlined below: -

Regulation 20 (Duty of Candour) definitions of harm	**NRLS definitions of harm**	**LFPSE definitions of harm**	**LFPSE level of Harm**
Source:	Regulation 20 (Duty of Candour) Health and Social Care Act 2008 (Regulated	NRLS Degree of Harm FAQs	Policy Guidance on Recording Patient Safety Events and Levels of Harm

	Activities) Regulations 2014.		
Severe (physical)	"...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in severe harm 'severe harm' means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition."	"Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons."	Severe harm is when at least one of the following apply: • permanent harm or permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more
Moderate (physical)	"...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in moderate harm moderate harm is defined as:	"Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm to one or more persons receiving NHS funded care."	Moderate harm is when at least one of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not

	a. harm that requires a moderate increase in treatment, and b. significant, but not permanent, harm. 'Moderate increase in treatment' means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);"		need immediate life-saving intervention • has limited or is likely to limit the patient's independence, but for less than 6 months • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm
Prolonged psychological	"...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in prolonged psychological harm" "'prolonged psychological harm' means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days"	The FAQs state that psychological harm is not excluded and could fall under either "severe" or "moderate". It does not specify a period.	**Moderate psychological harm** Moderate psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that extends for less than 6 months • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than 6 months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within 6 months

			Severe psychological harm Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than 6 months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than 6 months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within 6 months

The aim is not to investigate the same incidents in a reiterative manner, when there is no new learning, as no added value. PSIRF recognises the need to put more resources into making effective systematic safety quality improvements, enhancing data maturity, and sharing learning. This can be via through case studies, bulletins and shared learning events, for key areas or organisationally depending on the learning. Evidence of these approaches are key to enable an audit trail for monitoring how well this process is embedded across services.

Learning responses following a patient safety incident should commence as soon as possible after the patient safety incident has been identified.

The time frame for completion of an initial investigation such as an AAR is usually around 2 – 4 weeks for learning to be identified and actioned. Timing depends on the complexity of the patient safety event as a panel approach may be required, including subject experts eg to be shared with coroner or shared with families are part of Duty of Candour

In general, a PSII will be expected to be completed within a 3-month timeframe and will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. In exceptional circumstances, a longer timeframe may be required for completion eg joint PSIi's. In this case, any extended timeframe should be agreed between the Trusts and those affected. A balance must be drawn between conducting a thorough investigation with the impact of extending the timescale can have on those involved, and the risk that delayed findings may adversely have in affecting safety in the clinical environment. No local patient safety incident investigation should take longer than six months.

Actions and Plans

It is the responsibility of the service to develop SMART actions, focusing on value added areas for making the most improvements to patient safety, this may require a range of systematic safety actions. Weak actions are:

- reminding staff to follow policy
- supervising one member of the team
- Getting staff to write reflections

Ways to strengthen systematic safety systems:

- Changes in a team's workflow that they have been actively involved in developing
- Building 'forcing functions' into electronic health care systems
- Truly understanding work as done, prior to making changes
- The intervention is likely to eliminate the risk / or minimise the risk
- The intervention is readily available
- Inequalities are reduced by the intervention
- Follow up safety improvements with audits – to clarify if they are becoming embedded or require further review

Time needs to be spent considering how to improve the identified area, this can include multiple safety actions as a result. It is important to consider and clearly define the area for improvement, to check that safety actions are specific and effective. Safety actions need to be responsive to the improvement area, with clear action planning and clinical analysis to make the most effective safety improvements.

The acronym **SMART** stands for:

- **Specific**: Clearly define the goal, using action verbs
- **Measurable**: clarify that the goal can be measured to track progress
- **Achievable**: Set a realistic goal that can be accomplished
- **Relevant**: The goal should matter to you and align with other objectives
- **Time-bound**: Set a deadline for achieving the goal

  This framework is commonly used in goal setting to create clear and attai nable objectives.

All overarching action plans should be monitored monthly via PSQB for WUTH and CRMG for WCHC, this supports both organisations with known key areas of risk and supports timely completions or escalations.

Individual Actions from a PSII will be monitored via the Patient Safety Response Planning meeting for WUTH and for WCHC, CRMG. This supports the imperative nature of Quality Improvements, and that evidence of completion is held at both trusts

Both Trusts, Patient Safety Incident Response Plans, have outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Divisions and services will work collaboratively with the Patient Safety Team, the Improvement team and others for a co-ordinated and aligned approach to development of action plans and resultant improvement efforts. Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through the Safety Risk and Learning Review Panel who will work collaboratively with the Patient Safety Team, the Improvement team and others to provide a seamless approach to development of the safety improvement plans and resultant improvement efforts

How the organisation meets the national patient safety standards

The Executive Chief Nurse will oversee the development, review and approval of Trust's joint policy and individual PSIRF plans, ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that both Trusts has implemented over a few years.

To achieve the development of the plan and policy both Trusts will be supported by internal resources within the Governance Service Unit for WUTH and for WCHC the Quality and Governance Team. This will initially be reviewed at PSQB for WUTH and the Clinical Assurance Group which is led at Director level/Deputy Chief Nurse, prior to sign off at committee, once approved this will be reviewed by Cheshire and Mersey Regional ICB.

Promoting PSIRF as central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Committee/Board meetings on a quarterly basis. This will enable the Board/committee to ask further questions for assurance and support a continuous understanding of organisational safety.

The Trusts will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its clinicians in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plans should be undertaken at least every 18 months to comply with both PSIRF guidance on policy development alongside a review of all safety actions.

Complaints and appeals

At WUTH and WCHC we recognise that there will be occasions when patients, or carers are dissatisfied with aspects of the care and services provided by either Trust.

Both Trusts are committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the National Health Service Complaints (England) Regulations 2009. As per individual policies for managing complaints and concerns.

5 References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities
core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Appendix 1

Investigation by Type	When to use
AAR After action Review	After Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement. Ideally an AAR needs to be finally approved within 4 weeks of the incident being recognised. Can be used across organisations or teams AARs are structured around four questions: 1. What was expected? 2. What actually happened? 3. Why was there a difference? 4. What has been learnt
MDT Multidisciplinary Team Meeting	Is a fact finding when patients have had multiple touch points with different professions needs to be completed within 2 weeks and all professionals need to be available to discuss care and understand learning
SWARM huddle	A swarm huddle approach aims to explore in a post-incident huddle what happened and how it happened in the context of how care was being delivered in the real world (i.e. work as done). It needs to be started ideally as soon as possible once the incident has occurred but within 24 hours. Can be used cross organisations or teams
PSII Patient Safety Incident Investigation	Normally after an initial AAR, MDT or swarm huddle when further learning is required or national policy is required. This needs to be completed with 3 months unless patients and families need more time for involvement.

Equality Analysis

The Equality Analysis (EA) form should be completed in the following circumstances:

- All new policies
- All policies subject to renewal
- Business cases submitted for approval to hospital management impacting on service users or staff
- Papers submitted to hospital management detailing service redesign/reviews impacting on service users or staff
- Papers submitted to Board of Directors for approval that have any impact on service users or staff

<table>
<tr><td>Title</td><td colspan="4">Patient safety incident response policy</td></tr>
<tr><td>Policy Reference</td><td colspan="4">387</td></tr>
<tr><td>Lead Assessor</td><td colspan="4">Lorraine Adams</td></tr>
<tr><td>Date Completed</td><td colspan="4">01/05/2026</td></tr>
<tr><td rowspan="4">What groups have you consulted with? Include details of involvement in the EA process</td><td>Staff in area concerned</td><td>R</td><td>Staff side colleagues</td><td>☐</td></tr>
<tr><td>Service users</td><td>☐</td><td>HR</td><td>☐</td></tr>
<tr><td>Other</td><td>☐</td><td>Other</td><td>☐</td></tr>
<tr><td colspan="4">Please Give Details</td></tr>
<tr><td colspan="5">What is being assessed? Please provide a brief description and overview of the aims and objectives</td></tr>
<tr><td colspan="5">The purpose of this policy is to outline the principles that should be followed in line with the national Patient Safety Incident Response Framework, established in September 2023.</td></tr>
<tr><td colspan="5">Who will be affected (Staff, patients, wider community?)</td></tr>
<tr><td colspan="5">Staff, patients and wider community as PSIRF will involve patients, families and patient safety partners.</td></tr>
</table>

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your proposal/document has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed overleaf.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis. For further support with this, please refer to the Library and Knowledge Service accessible via the Trust's intranet site or switchboard.

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Positive: • Advance equality of opportunity • Foster good relations between different groups • Address explicit needs of equality target groups	**Negative:** • Unlawful discrimination, harassment and victimisation • Failure to address explicit needs of equality target groups	**Neutral:** • It is quite acceptable for the assessment to come out as Neutral impact • Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Group	**Any potential impact?** **Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (inc physical and mental impairments)	Positive	If the policy is implemented effectively, the approach should lead to a reduction in inequality and inequity in patient safety outcomes for people with protected characteristics. PSIRF promotes open compassionate engagement and involvement of those affected by patient safety incidents. It provides the opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents. Data and insights gathered through the PSIRF approach will be used to assess any disproportionate patient safety risks, from across the nine protected characteristics. Both Trusts have strategies which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.
Age	Positive	As above
Race (all ethnic groups)	Positive	As above
Religion or belief	Positive	As above

Sexual Orientation	Positive	As above
Pregnancy & Maternity	Positive	As above
Gender	Positive	As above
Gender Re-assignment	Positive	As above
Human Rights	Positive	As above
Other e.g. Carers	Positive	As above

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

In all cases - you should submit this document with your paper and / or policy in accordance with the governance structure with copies to wih-tr.EqualityWUTH@nhs.net for monitoring purposes.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

<table>
<tr><th colspan="2">Who and how have you engaged to gather evidence to complete your full analysis? (List)</th></tr>
<tr><th>Name & Job Title</th><th>Name & Job Title</th></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="2">What are the main outcomes of your engagement activity?</th></tr>
<tr><td colspan="2"></td></tr>
<tr><th colspan="2">What is your overall analysis based on your engagement activity?</th></tr>
<tr><td colspan="2"></td></tr>
</table>

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the risk register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Following completion of the full analysis you should submit this document with your paper and or policy in accordance with the governance structure.

You should also send a copy of this document to wih.tr.equalityWUTH@nhs.net for monitoring purposes.

Consultation, Communication, and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis			This document is embedded within the Policy template
Policy Author Checklist			Checked for workforce / development, medicines, finance, or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Current Version Development	Patient Safety Quality Board (WUTH) SOG (WCHC) Integrated Care Board		
Trust Staff Consultation via Intranet			

Date notice posted in the News Bulletin.		**Date notice posted on the intranet**	

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
Trust wide communications to raise awareness of PSIRF and this policy.	GSU (WUTH) and Quality and Governance Service (WCHC) via Trust Communications
Presentation at Chief Nurse Check in / All Staff Briefing	Safety Management Lead
Dissemination to Consultant body	Deputy Medical Director

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Aug 2023	1	Leigh McNeill	
May 2024	2	Leigh McNeill	Amendment to REC Process to include Multi- REC cases
DEC 2024	3	Catherine Cumberlidge	Amendment to REC Process to more proportionate response to falls, pressure ulcers and IPC incidents.
January 26	4	Lorraine Adams	Amended as now a joint policy with WCHC

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Timeliness of Patient Safety Responses: • Managerial Review - 5 working days • Rapid Evaluation of Care (REC) - 5 working days. • Facilitated Reflective Session (FRS) Reports – 40 working days • PSIIs – (individual timescales) maximum 6 months	95% completed in timescale	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance
Training of Response Leads • PSII Leads having undergone 2 day HSIB training • FRS Leads having undergone in house training • REC Leads having undergone in house training	100% compliance	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance
Engagement Lead allocation for all PS Responses	100% compliance	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Governance Meeting Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Governance Support Unit / Quality and Governance Service	PSQB / SOG	Quarterly

Safety of Patients and Public

Confirm the content of this policy does **not** risk the safety of patients or the public if it is uploaded to the public facing website	X
If the content ***does*** *affect the safety of patients or the public* if it is uploaded to the public facing website *please contact the Policy Coordinator or Risk Management Team for advice*	

Patient Safety Incident Response Plan

2026-27

Patient safety incident response plan

Version 3.3

Effective date:

Review date: Annual.

	NAME	TITLE	DATE
Author	Lorraine Adams	Head of Patient Safety and Governance	30 April 2026
Authoriser	Chris Douglas	Chief Nurse	30 April 2026

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Introduction: Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) is a revised approach to how the NHS responds and learns from Patient Safety Incidents. Central to the National Patient Safety Strategy, PSIRF represents a significant cultural shift in how organisations and systems collectively respond to patient safety incidents. The approach maximises learning opportunities supporting the delivery of strengthening safety systems as part of a culture of continuous improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF plan supports a dynamic response to incidents, ensuring it remains reflective of current priorities within the local context of care delivery. This approach focuses on the system and culture in which care is delivered, utilising the most appropriate investigation technique to maximise organisational learning. One of the underpinning principles of PSIRF is to implement a proportionate response to investigations, with an emphasis on conducting systems-based investigations.

A summary of patient safety definitions is included in **Appendix A.**

Purpose

The purpose of this Patient Safety Incident Response Plan is to outline how Wirral University Teaching Hospital NHS Foundation Trust (referred to as the Trust) will respond to patient safety incidents reported by staff, patients, families and carers to support a transparent culture of continuous learning and improvement.

This will be achieved by:

- Focussing on system level analysis, supporting the identification of complex, interconnected causal factors and system issues
- Implementing improvement science to prevent or reduce the likelihood of incident recurrence, supported by effective risk mitigation strategies
- Focussed delivery on the quality of investigations rather than quantity, ensuring full stakeholder engagement including patients, families, carers and staff
- Utilise quality improvement methodologies to implement, sustain and embed system wide improvements and quality outcomes to people in receipt of our care

The Trust is currently working towards integrating with Wirral Community Health and Care NHS Foundation Trust. This provides an opportunity to strengthen joint clinical pathways, improving quality and patient safety.

To ensure the plan is based on a robust evidence base, data from a wide range of sources has been analysed to determine priority areas. These priorities have been subject to divisional engagement across the Trust and with our partners at Wirral Community Health and Care NHS Foundation Trust. The priorities have also been presented to Healthwatch Wirral, ensuring the views of local people are fully considered.

This has resulted in the identification of five joint priorities for implementation during 2026/27, prior to the development of a formal joint plan.

Our services

The Trust provides a wide range of inpatient and outpatient services. Clinical Services are aligned into five clinical divisions: Emergency Department, Medicine Division, Surgery Division, Diagnostics & Clinical Support Division and Women & Children's Division.

The Trust's 5-year delivery plan, which includes the integration with Wirral Community Health and Care NHS Foundation Trust, will provide an opportunity to strengthen patient safety across shared care pathways. This will support the delivery of safe, effective person-centred care across a wide range of acute and community settings.

In line with the ambitions of the NHS 10 Year Health Plan, we will lead on the delivery of pro-active neighbourhood health across Wirral. This will be supported by the development of a joint PSIRF plan, aligned to the priority areas of transformational change, including:

- Neighbourhood health – frailty, dementia and end of life care
- Urgent and Emergency Care
- Elective Care
- Diagnostics and cancer care
- Children and Young People
- Maternity Care

Maternity Services

As the primary provider of maternity services across Wirral, the Trust is progressing with the development of a dedicated Maternity PSIRF Plan for implementation during 2026/27**.** This plan will encompass all maternity and neonatal care delivered by the Wirral Women's and Children's Hospital, ensuring a consistent and system-wide approach to learning, safety, and quality improvement.

The Maternity PSIRF Plan will support enhanced learning from events occurring throughout the maternity pathway, including pregnancy, intrapartum care, and up to 28 days post-birth. Its purpose is to strengthen our safety culture, improve the quality of investigations, and ensure that insights are translated into meaningful improvements for women, babies, and families.

Our safety culture

The Trust recognise that a positive safety culture requires effective collaboration and engagement with a wide range of people, including staff, teams, patients, service users, families, carers and our local system partners. The aim of this is to deliver high-quality, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

The core principles of PSIRF promote a positive safety culture, through the application of system-thinking, supportive oversight, and the compassionate engagement of those affected by patient safety incidents.

The Trust recognises that patient safety incidents are often signs of underlying systemic issues that require wider, system-level action. By fostering a culture of openness, equity and learning, where staff feel confident to speak up when things go wrong, we are able to develop a positive safety culture of learning and continuous improvement.

The Trust has two patient safety specialists who have supported the transition from safety I to safety II.

Person Centered Approach **Safety System-I** **(x)**	**Systems Centered Approach** **Safety System-II** **(✓)**
Individuals who make errors are seen as careless, at fault and not working within policies	Poor organisational patient safety design may set people up to fail - need to **understand work as done**
Blame and punish individuals, e.g. *write reflections, asked to repeat training, not supported*	Focus on the **safety system** rather than the individual, within a **restorative culture** and with collaboration
Remove individual and improve quality/safety	Changing and **improving the system** improves patient safety – changing the lens supports **appreciative inquiry**

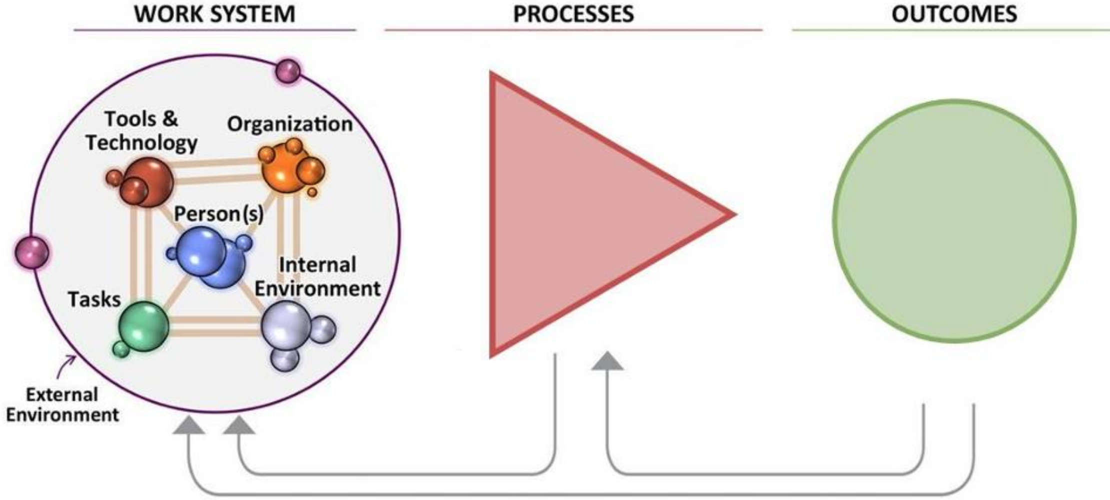
To support the identification of systems learning the Trust uses established investigation methods, including:

- Swarm Huddles
- After-Action Reviews (AARs)
- Patient Safety Incident Investigations (PSIIs)
- Multi-disciplinary Team (MDT) Reviews
- Thematic Reviews

How we learn from incidents

The Trusts' approach to learning from incidents is based on the System Engineering Initiative for Patient Safety – SEIPS framework.

SEIPS Framework



We recognise that work systems should support our staff to deliver safe care. Patient safety incidents occur from multiple interactions within complex work systems. By thoroughly examining each aspect of the work system, we are able to identify wider system processes that will deliver better outcomes for our patients.

Approaches to learning from incidents

A Trust-wide Safety Huddle is held at 08:45hrs Monday – Friday, this includes a summary of incidents reported on the Trust's incident reporting system in the last 24 hours, with a weekend summary being reported each Monday morning. Severe harm incidents or incidents where the requirement for rapid learning is required are progressed to a swarm huddle.

The Trust's Incident Decision Making Tree is included in **Appendix B**.

Incident Reporting

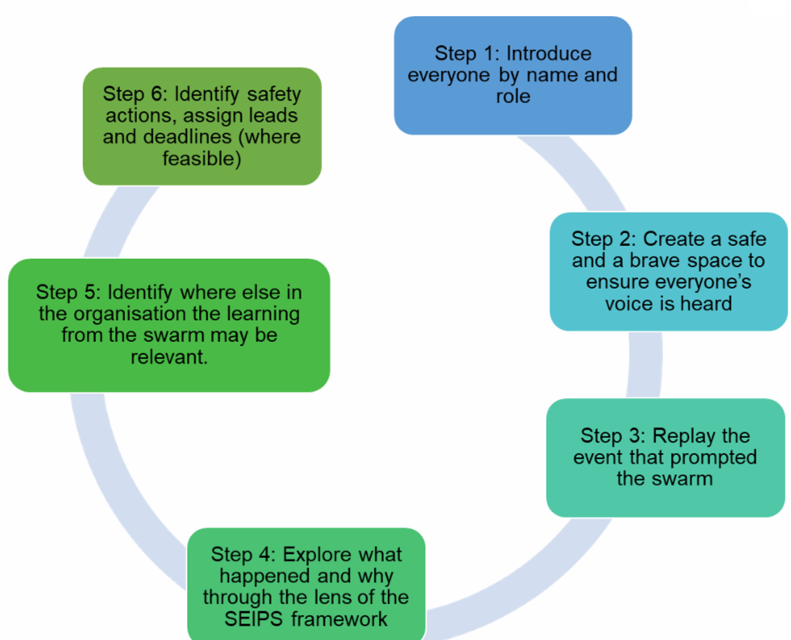
When an incident is reported, an initial risk score is calculated using severity and likelihood. High scoring incidents classified as 16 and above are escalated to the appropriate Associate Medical Director and Divisional Director of Nursing. This will support identification of any immediate action required. All incidents are reviewed by the Divisional Governance team, supporting early identification of themes and trends.

Swarm Huddle

Swarm huddles are our immediate response to learning from severe incidents that require a rapid review. They are commenced as soon as possible after a patient safety incident occurs and should be completed within 24 hours. The huddle should be led by a senior clinician and involve the staff involved in the incident.

The swarm huddle will result in the identification of immediate learning to be rapidly implemented to mitigate any future risk to patient safety.

Six steps – Swarm Huddle



The swarm huddle is reviewed by the Divisional Triumvirate and members of the Executive team, who will agree the most appropriate approach to further investigation to maximise learning. The swarm huddle and recommendation for further investigation are presented at the Trust's weekly Patient Safety Response Planning Meeting for approval.

After-Action Reviews (AARs)

After-Action Reviews are routinely completed for incidents resulting in moderate and above harm and can be used for lower harm incidents for the purpose of learning and improvement. They are structured around the following four questions:

1. **What was expected?** Participants describe what they would expect to happen in situations such as this
2. **What actually happened?** Participants describe what they did, saw or experienced during the event
3. **Why was there a difference?** Participants explore what got in the way of expectations being met and what enabled expectations to be achieved or exceeded. This includes consideration of the work environment, technology and tools, tasks, people, organisation and external influences
4. **What has been learnt?** Participants describe what they have learnt – may be about themselves, about the team/s and/or about the wider organisational context that influenced the event

The essentials of AARs are included in **Appendix C.**

We aim to complete AARs within two weeks. On completion, AARs are presented at the Trust's weekly Patient Safety Response Planning Meeting for approval. Completed action plans are monitored through monthly divisional quality board meetings (DQBs) reporting by exception to the Patient Safety Response Planning Meeting and Patient Safety Quality Board (PSQB).

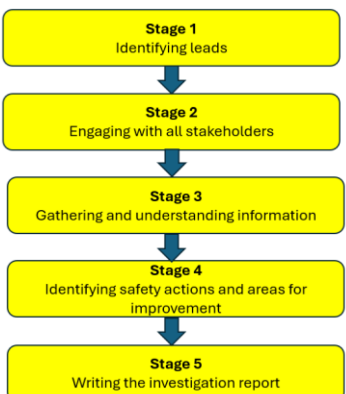
Patient Safety Incident Investigations (PSIIs)

A patient safety incident investigation (PSII) is completed when an incident or near-miss indicates significant patient safety risks and the potential for new learning. The aim of the PSII is to understand:

- What happened
- When did it happen
- Why did it happen
- What contributed to it happening
- What can be learned
- How the Trust can share the learning
- How the Trust can prevent something similar happening again

It's important that patients, families and carers are invited to be part of the PSII process; their decision to participate or not, will be fully respected. An engagement lead will be allocated for each PSII, so there is a single point of contact for patient and family engagement. We aim to complete PSIIs within a period of three to six months; however, timescales can be adjusted depending on the complexity of the incident. Extension requests will be discussed with all participants and approved by the Executive team.

Each PSII follows five key stages:



On completion, PSIIs are progressed to a panel for review prior to executive approval. Learning is presented at the weekly Patient Safety Response Planning Meeting. Completed actions plans are monitored through monthly DQB meetings, reporting by exception to the Patient Safety Response Planning Meeting and PSQB.

Multidisciplinary Team (MDT) review

An MDT review is used within the Trust to support us to:

1. Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents)
2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability
3. To explore a safety theme, pathway, or process
4. To gain insight into ‘work as done’ in a health and social care system

‘work’ as done’ means how care is delivered in everyday practice, not how it is envisaged in policies and procedures (known as work as prescribed) or recounted in a walk through (work as described).

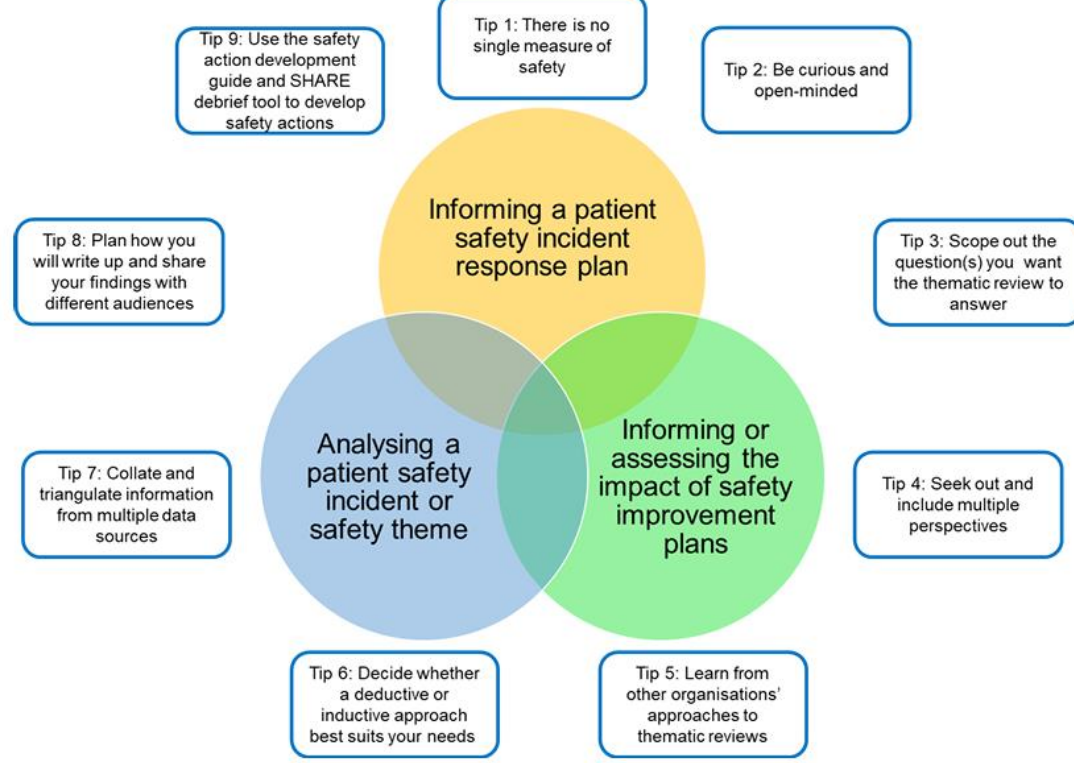
The decision to commence an MDT review is made at the weekly Patient Safety Response Planning meeting. We aim to complete the reviews within two months.

On completion, the learning is presented at the Trust’s weekly Patient Safety Response Planning Meeting for final approval. Completed actions plans are monitored through monthly DQB meetings reporting by exception to the Patient Safety Response Planning Meeting and PSQB.

Thematic Reviews

The Trust uses thematic reviews to help identifying patterns, themes and links within data to support learning. This approach is used to inform our PSIRF plan and identification of safety priorities. The approach is guided using the following national framework:

Three thematic review approaches to support learning and improvement:



How learning is shared

Learning from incident reviews and investigations are disseminated across the Trust through several mechanisms including:

- Daily Patient Safety Huddles – within services and at Trust level
- Trust governance meetings from Ward to Board
- Dedicated PSIRF newsletter
- The All staff briefing – a monthly meeting led by the Executive team

Impact and outcomes of identified improvement actions are tracked via our audit programme and close monitoring of incidents, complaints and patient feedback.

PSIRF training

The Trust recognises the importance of training to support the successful implementation of PSIRF across the organisation. To support our staff to understand and effectively contribute to our patient safety culture, the following training is provided and monitored across each division:

Safety Syllabus
Level One – Essentials for Patient Safety This is the starting point for all NHS staff, and includes sections on: • Listening to patients and raising concerns • The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety
Level two – Access to Practice Access to practice is intended for all clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are two sessions: The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe). The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame). Level two Access to Practice includes an assessment, which on completion staff will receive a certificate and will have access to the sector specific sessions covering Mental Health, Primary Care, Maternity Care, Acute Care, and Management and Administration.
Level One – Essentials for Patient Safety for Boards and senior leadership teams Additional session for senior leaders and executive teams, covering: • The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety

<table>
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- The harmful effects of safety incidents on staff at all levels

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Level two – Sector Specific sessions (Accessible following completion of Level two Access to Practice)

On completion of Level 2 Access to Practice all staff will have access to five patient safety sector specific sessions covering good practice, human factors, risk management, systems thinking, and safety culture. Each of these sessions can be completed by individuals or used as part of a group discussion. These sessions aim to highlight the learning from Level 2 – Access to Practice. The sessions cover:

- Mental Health
- Primary Care
- Acute Care
- Maternity Care
- Management and Administration

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Levels 3 and 4 – Patient Safety Specialist Training

Levels 3 and 4 are delivered through a blended-learning approach, with several modules delivered through online learning and followed up with an in-person event. Levels 3 and 4 explore topics such as:

- Unpacking system issues
- Managing patient safety risks
- Understanding cultural, legal, and regulatory factors
- Designing solutions

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Patient Safety Training is supported by a number of dedicated and specialist roles across the Trust, including:

Patient Safety Specialists

The Trust have two trained Patient Safety Specialists in partnership with Wirral Community Health and Care NHS Foundation Trust.

They provide a key role in the local implementation of the NHS Patient Safety Strategy, supporting the development of our patient safety culture, safety systems and improvement activity.

Patient Safety Partners

Patient Safety Partners (PSPs) are dedicated roles, supporting the Trust to ensure patient safety is always at the forefront of everything that we do. The roles can be undertaken by patients, carers, family or other members of our local community.

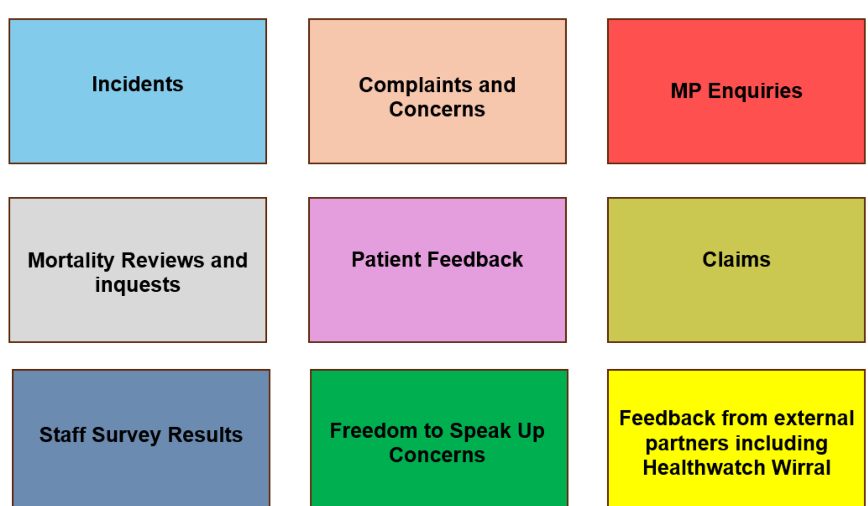
The Trust has seen a fantastic response to the recruitment of volunteer patient safety partners. We currently have three patient safety partners who support the patient safety portfolio. Their input, expertise and time are unbelievably valuable and appreciated by the trust. They have attended Key meetings across the trust such as Patient Safety Quality Board, Patient Safety Steering Group, Patient Safety Response Planning Meeting, and the Fundamentals of Care meeting.

Engagement Leads

The Trust has twenty nominated engagement leads; during 2026/2027 we aim to increase the numbers of engagement leads within the trust who have completed additional, dedicated PSIRF training. This will ensure that all patient safety responses will have a trained engagement lead. Our engagement leads will ensure that patients and family members have the opportunity to be actively engaged in the learning response process.

Defining our patient safety incident and improvement profile

To ensure our PSIRF plan reflects the current priorities within the Trust, data received from 01 April 2024 – 31 December 2025 was analysed. This included, but was not limited to the following areas:



In total, this resulted in the analysis of over 30,220 incidents, with reported harm levels as follows:

Reported level of harm	Total number of incidents	% of total incidents
No Harm (inc near miss)	22002	72.8%
Low Harm	7833	25.9%
Moderate Harm	334	1.1%
Severe Harm	31	0.1%
Catastrophic (fatal)	20	0.1%

Stakeholder Engagement

During February 2026, the identified priority areas were considered in partnership with Wirral Community Health and Care NHS Foundation Trust at a joint quality priorities workshop. This engagement event was vital to enable us to work closely together and share learning to strengthen patient safety. In addition, the priorities have also been presented to Healthwatch Wirral, ensuring the views of local people have been fully considered.

Five local joint priorities have been identified for 2026/27:

- Pressure Ulcers
- Medications
- Falls
- Discharge
- Infection prevention and control

The developed priorities will be progressed through an integrated governance system across both Trust's to promote patient safety and strengthen our systems and processes – this is a key priority for 2026/27.

Services covered by this PSIRF Plan

Recognising the potential for transferability of learning, this plan and data analysis has been inclusive of all services across the Trust. As previously identified, the Trust is in the process of developing a dedicated maternity PSIRF Plan for implementation during 2026/27. The plan will be inclusive of all maternity and neonatal healthcare delivered by the Wirral Women's and

Children's Hospital, maximising learning and quality improvement during pregnancy and up to 28 days following birth.

Approach to Quality Improvement (QI)

The Trust is committed to continuous improvement using recognised improvement methodology to deliver safe, quality care. Our approach empowers staff at all levels to identify, test and sustain changes that improve patient access, experience and outcomes. Aligning closely to the principles of NHS Impact, the Trust continues to provide training to develop confidence and capability in QI approaches to support delivery of the patient safety plan.

Our patient safety incident response plan: national event response requirements

National priorities have been developed to support a consistent approach to responding to patient safety incidents. The table below outlines how we will respond to the nationally identified priorities to achieve improvements in patient safety.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Swarm Huddle conducted to establish facts and agree immediate actions. This will inform the decision regarding further investigation required, including an After-Action Review (AAR) or consideration of a Patient Safety Incident Investigation (PSII)	Create local organisational actions reporting into the overarching improvement actions plan and share learning via the PSIRF focus on bulletin for organisational learning
Death thought more likely than not due to issues in care.	AAR and or PSII/swarm Perinatal Mortality Review Tool. All perinatal deaths, including stillbirths and neonatal deaths, are reviewed through the PMRT process to ensure robust learning, timely family engagement, and system learning thematic learning response	Investigation will be agreed depending on the type and circumstances. Create local organisational actions reporting into the PSIRF bulletin or case study to be shared across agreed areas within the trust.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies	PSII	Create local organisational actions to progress throughout the Trust's governance framework, considering alignment to an existing Safety Improvement Plan.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led AAR/ PSII may be required	

Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review	Create local organisational actions, reporting through Trust governance considering alignment to an existing Safety Improvement Plan.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR	Create local organisational actions, reporting these into the Trust's PSIRF learning bulletin and case studies, considering alignment to an existing Safety Improvement Plan.
Incidents that are considered to have potential learning of a significant level and complexity, to require an extensive investigation to allow the required quality improvement activities	Decision around the most appropriate investigation will be done on a case-by-case basis, AAR/ SWARM/MDT/ PSII	Divisions will create local organisational actions with learning disseminated via established dissemination mechanisms including the Trust's PSIRF learning bulletin and case studies, demonstrating clear alignment to existing Safety Improvement Plans. These will be supported by the Governance Support Unit patient safety team.
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to conduct the relevant investigations. When required, the Trust will fully support these investigations.	
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	The trust will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews, and any other safeguarding reviews	
Incidents in NHS screening programmes	The Trust will consult with the screening quality assurance service for	Create local organisational actions reporting throughout the Trust's governance framework,

	locally led learning response	considering alignment to an existing Safety Improvement Plan.
Incident meeting MNSI criteria	Referred to Maternity and Newborn Safety Investigations (MNSI) for independent patient safety incident investigation	Respond to recommendations as required, progressing actions throughout the Trust's governance framework, consider alignment to an existing Safety Improvement Plan.

Our patient safety incident response plan: Local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Falls	Individual Patient Safety Response for falls with harm. All falls reviews will be proportionate and consideration of AAR/PSII/Thematic learning Review/MDT, SWARM reporting into an organisational Quality Improvement Plan tracked at the Trust's Patient Safety Quality Board (PSQB).	Review of reoccurring areas for improvement against current patient safety. This will include a Quality Improvement driver diagram jointly working with WCHC
Pressure Ulcers	Individual Patient Safety Response for pressure ulcers of category 3 or category 4, or when the manager's assessment highlights that there has been at least moderate harm impact to the patient from other pressure damage. All reviews will enable thematic analysis of findings and learning. These will report into an organisational Quality Improvement Plan	Review of reoccurring areas for improvement against current patient safety improvement plan This will include a driver diagram for joint Quality Improvements working with WCHC. The Trust's Patient Safety Risk and Learning review panel will provide a mechanism for dynamic triangulation of data against the developed outcome measures.
Medication Incidents moderate and above or themes relating to the 7 rights of medication administration	Individual Patient Safety Response or Thematic Review as discussed and agreed at Patient Safety Response Planning Meeting or Patient Safety Risk and Learning review panel these will report into an organisational Quality Improvement plan	Review of reoccurring areas for improvement against current patient safety improvement plan This will include a driver diagram for Quality Improvement jointly working with WCHC

Discharge Incidents that have led to a readmission/ or harm to a patient	PSII/AAR/Thematic Review	Areas for improvement and individual patient safety actions discussed at Safety Risk and Learning Review panel to support oversight and consider patient safety improvement plans
Incidents leading to Healthcare Associated Infections	PSII/AAR Thematic review to feed into an organisation Quality Improvement Plan	Review of reoccurring areas for improvement against current patient safety improvement plan. This will include a driver diagram for Quality Improvement.

References

Policy 387 Patient Safety Incident Response Policy

Policy 007 Duty of Candour and Engagement Policy

Policy 041a Incident Reporting and Management Policy

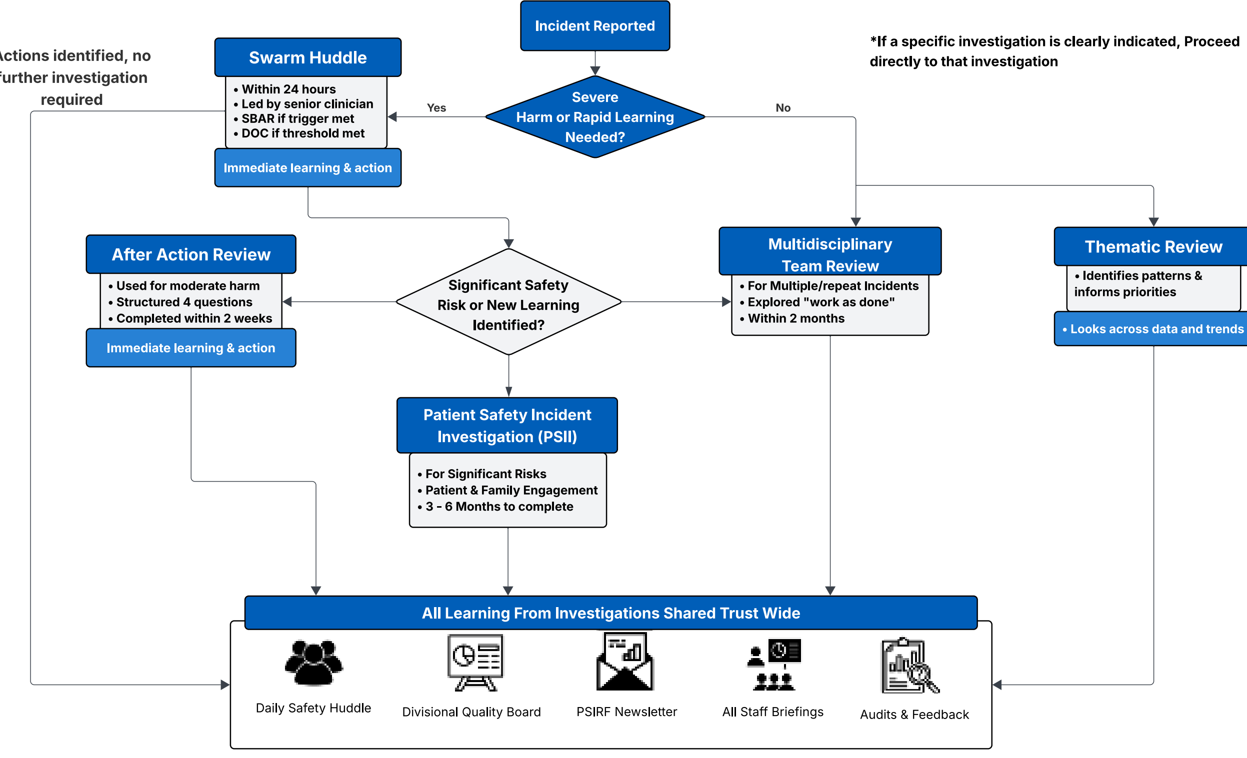
NHS England (2023) Patient safety learning response toolkit [online] https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Appendix A: Summary of Patient Safety Definitions

Term	Definition
Patient safety incident	An unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.
Learn From Patient Safety Events (LFPSE) service	The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. On submission, the incidents can be viewed by the Care Quality Commission (CQC) and Integrated Care Board (ICB), supporting sharing and trend analysis at a regional and national level.
Patient Safety Incident Response Framework (PSIRF)	NHS framework that guides how organisations respond to patient safety incidents, focusing on compassionate engagement, proportionate system-based learning, and using insight from incidents to improve safety and reduce future harm.
PSIRF Plan	A local document that sets out how an organisation will carry out its incident response activity. It specifies which types of incidents will be prioritised for deep investigation.
PSIRF Policy	An organisation's overarching strategy for responding to patient safety incidents, ensuring the process is consistent and supportive.
Safety Huddle	Safety huddles (or safety briefs) are short meetings used for sharing information about potential or existing safety problems. They increase safety awareness among front-line staff, allow for teams to address identified safety issues, fostering a culture of safety

Swarm Huddle	A rapid gathering of staff immediately after an incident to collect information and manage immediate risks.
After-Action Review (AAR)	A structured, facilitated discussion among team members immediately after an event to understand what happened and why.
Patient Safety Incident Investigation (PSII)	A comprehensive, "deep dive" investigation into a specific incident to identify interconnected systemic causes.
Multi-Disciplinary Thematic (MDT) Review	A collaborative review process involving various specialists to gain different perspectives on an incident.
Safety Culture	The beliefs, perceptions and values shared in relation to risks within the organisation. This includes: ▪ Continuous learning and improvement of safety risks ▪ Supportive and psychologically safe teamwork ▪ Enabling and empowering speaking up by all

Appendix B: Incident Decision-Making Tree



Appendix C: Essentials of AAR

AAR is	AAR is not
A method for enabling an open and honest conversation about an event that can be used on its own or as part of a wider suite of methods	The same as an investigation
A debrief for those involved, led by a skilled facilitator	A meeting undertaken by an untrained person
Primarily for those directly involved in an event although others may attend if helpful to aid learning	A managerial meeting about an event without those directly involved present
A conversation structured around four AAR questions that is allowed to evolve for the purpose of learning	A bureaucratic documentation exercise to collect information about an event to be reported through governance structures
An opportunity to involve patients, families and carers in the learning conversation providing doing so maintains a psychologically safe space for all those affected	A space where patients, families and carers are expected to attend without considering the psychological safety and welfare of all those affected
A psychologically safe space where people can speak openly without fear of blame or judgement	A debrief that drifts into a scrutiny of people's actions and decisions
A space where all those present are heard and all contributions are valued equally, irrespective of rank or status	An opportunity for a few individuals to 'have their say' and dominate the conversation
Focused on exploring 'work as done' by asking 'What would you **expect** to happen?	Focused on what **should have** happened (for example, as described in policy and protocols)
A debrief that **may** result in a written document that summarises collective learning and is written in the third person (we learnt that….)	A minuted meeting where information shared by participants in the AAR is detailed in a written report
An opportunity to talk about everyday work and the lived reality and experiences of participants	A place where people are judged or blamed for the expectations and experiences that they describe

A space to understand the perspectives and experiences of those in the room	A space for rigid exploration and theming of different elements of a 'work system' (that is, organisation, work environment, task, technology and tools, external influences, person)
An opportunity to develop and agree actions that can be agreed and enacted by people participating in the review	An opportunity to dictate actions for others to complete
A space to highlight concerns about the wider system that may need to be shared with and taken forward by relevant safety/governance groups	A place to decide actions outside the sphere of control of those present

Patient Safety Incident Response Plan

2026-27

Patient Safety Incident Response Plan

Effective date:

Estimated refresh date: September 2027

	NAME	TITLE	DATE
Author (s)	L Adams C Freeman	Head of Patient Safety and Governance Clinical Safety Manager	30 April 2026
Authoriser	Chris Dougals	Chief Nurse	30 April 2026

Version Control	Date	Comments	Approved By	
V1	September 2023	New NHSE guidance	Quality and Governance Committee	
V2	Revised	No material changes	Not applicable	
V3	Current version	Updated priority safety themes and joint priorities with Wirral University Teaching Hospital	Clinical Assurance Group and Quality and Governance Committee	

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Introduction: Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) is a revised approach to how the NHS responds and learns from Patient Safety Incidents. Central to the National Patient Safety Strategy, PSIRF represents a significant cultural shift in how organisations and systems collectively respond to patient safety incidents. The approach maximises learning opportunities supporting the delivery of strengthening safety systems as part of a culture of continuous improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF plan supports a dynamic response to incidents, ensuring it remains reflective of current priorities within the local context of care delivery. This approach focusses on the system and culture in which care is delivered, utilising the most appropriate investigation technique to maximise organisational learning. One of the underpinning principles of PSIRF is to implement a proportionate response to investigations, with an emphasis on conducting systems-based investigations.

A summary of patient safety definitions is included in **Appendix A.**

Purpose

The purpose of this Patient Safety Incident Response Plan is to outline how Wirral Community Health and Care NHS Foundation Trust (referred to as the Trust) will respond to patient safety incidents reported by staff, patients, families and carers to support a transparent culture of continuous learning and improvement.

This will be achieved by:

- Focussing on system level analysis, supporting the identification of complex, interconnected causal factors and system issues
- Implementing improvement science to prevent or reduce the likelihood of incident recurrence, supported by effective risk mitigation strategies
- Focussed delivery on the quality of investigations rather than quantity, ensuring full stakeholder engagement including patients, families, carers and staff
- Utilise quality improvement methodologies to implement, sustain and embed system wide improvements and quality outcomes to people in receipt of our care

The Trust is currently working towards integrating with Wirral University Teaching Hospital NHS Foundation Trust. This provides an opportunity to strengthen joint clinical pathways, improving quality and patient safety.

To ensure the plan is based on a robust evidence base, data from a wide range of sources has been analysed to determine priority areas. These priorities have been subject to divisional engagement across the Trust and with our partners at Wirral University Teaching Hospital NHS Foundation Trust. The priorities have also been presented to Healthwatch Wirral, ensuring the views of local people are fully considered.

This has resulted in the identification of five joint priorities for implementation during 2026/27, prior to the development of a formal joint plan.

Our services

The Trust provides a wide range of community services and has an inpatient service. Clinical Services are aligned into seven localities:

We have seven operational localities:

- South Wirral Locality
- Birkenhead Locality
- West Wirral Locality
- Wallasey Locality
- Wirral System 1
- Wirral System 2
- Wirral and Regional System

The Trust's 5-year delivery plan, which includes the integration with Wirral University Teaching Hospital NHS Foundation Trust, will provide an opportunity to strengthen patient safety across shared care pathways. This will support the delivery of safe, effective person-centred care across a wide range of acute and community settings.

In line with the ambitions of the NHS 10 Year Health Plan, we will lead on the delivery of pro-active neighbourhood health across Wirral. This will be supported by the development of a joint PSIRF plan, aligned to the priority areas of transformational change, including:

- Neighbourhood health – frailty, dementia and end of life care
- Urgent and Emergency Care
- Better care for long term conditions
- Children and Young People
- Tackling health inequalities

Our safety culture

The Trusts recognise that a positive safety culture requires effective collaboration and engagement with a wide range of people, including staff, teams, patients, service users, families, carers and our local system partners. This aim of which, is to deliver high-quality, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

The core principles of PSIRF promote a positive safety culture, through the application of system-thinking, supportive oversight, and the compassionate engagement of those affected by patient safety incidents.

The Trust recognises that patient safety incidents are often signs of underlying systemic issues that require wider, system-level action. By fostering a culture of openness, equity and learning, where staff feel confident to speak up when things go wrong, we are able to develop a positive safety culture of learning and continuous improvement.

The Trust has two patient safety specialists who have supported the transition from safety I to safety II

Person Centered Approach **Safety System-I** **(x)**	**Systems Centered Approach** **Safety System-II** **(✓)**
Individuals who make errors are seen as careless, at fault and not working within policies	Poor organisational patient safety design may set people up to fail - need to **understand work as done**
Blame and punish individuals, e.g. *write reflections, asked to repeat training, not supported*	Focus on the **safety system** rather than the individual, within a **restorative culture** and with collaboration
Remove individual and improve quality/safety	Changing and **improving the system** improves patient safety – changing the lens supports **appreciative inquiry**

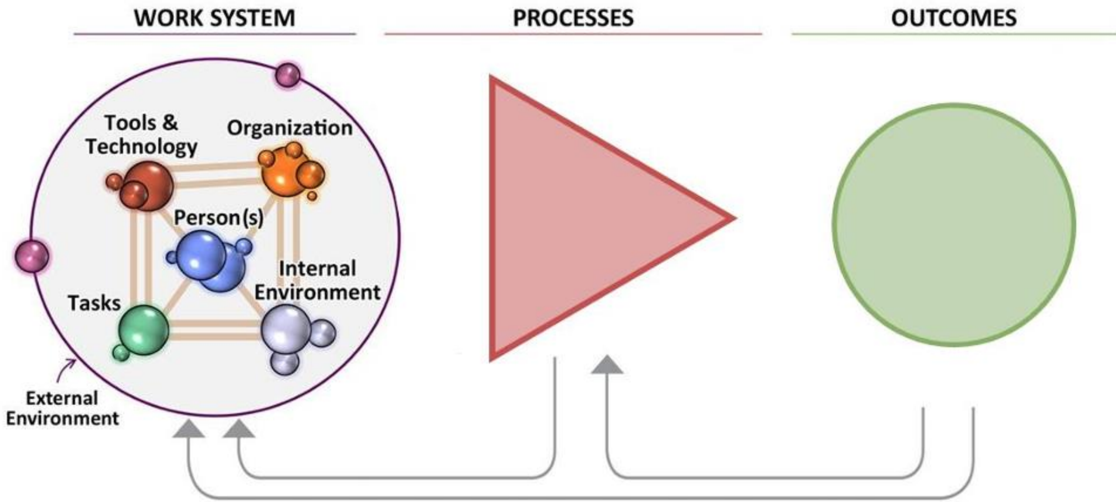
To support the identification of systems learning the Trust uses established investigation methods, including:

- Swarm Huddles
- After-Action Reviews (AARs)
- Patient Safety Incident Investigations (PSIIs)
- Thematic Reviews

How we learn from incidents

The Trusts' approach to learning from incidents is based on the System Engineering Initiative for Patient Safety – SEIPS framework.

SEIPS Framework



We recognise that work systems should support our staff to deliver safe care. Patient safety incidents occur from multiple interactions within complex work systems. By thoroughly examining each aspect of the work system, we are able to identify wider system processes that will deliver better outcomes for our patients.

Approaches to learning from incidents

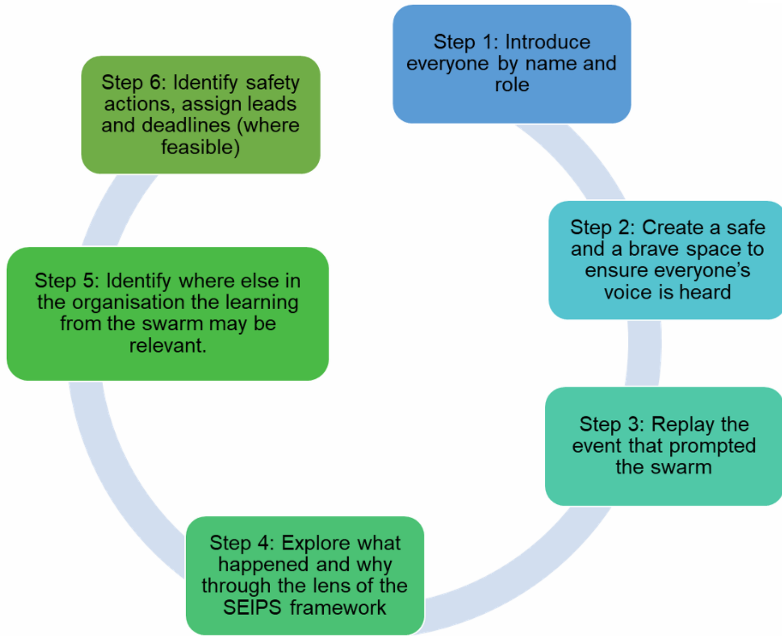
The Trust's Incident Decision Making Tree is included in **Appendix B**.

Swarm Huddle

Swarm huddles are our immediate response to learning from severe incidents that require a rapid review. They are commenced as soon as possible after a patient safety incident occurs and should be completed within 24 hours. The huddle should be led by a senior clinician and involve the staff involved in the incident.

The swarm huddle will result in the identification of immediate learning to be rapidly implemented to mitigate any future risk to patient safety.

Six steps – Swarm Huddle



The swarm huddle is reviewed by the Quality and Governance Patient Safety leads, who present at the Clinical Risk Management Group. Decisions are then made for the most appropriate approach and if further investigation is required to maximise learning.

After-Action Reviews (AARs)

After-Action Reviews are routinely completed for incidents resulting in moderate and above harm and can be used for lower harm incidents for the purpose of learning and improvement. They are structured around the following four questions:

1. **What was expected?** Participants describe what they would expect to happen in situations such as this
2. **What actually happened?** Participants describe what they did, saw or experienced during the event
3. **Why was there a difference?** Participants explore what got in the way of expectations being met and what enabled expectations to be achieved or exceeded. This includes consideration of the work environment, technology and tools, tasks, people, organisation and external influences

4. **What has been learnt?** Participants describe what they have learnt – may be about themselves, about the team/s and/or about the wider organisational context that influenced the event

The essentials of AARs are included in **Appendix C.**

We aim to have the first draft AARs within two weeks. On completion, AARs are presented at the Trust's fortnightly Clinical Risk Management Group (CRMG) for approval. Completed actions plans are monitored through CRMG and Divisional SMT SAFE

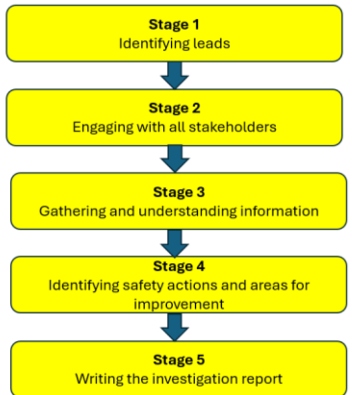
Patient Safety Incident Investigations (PSIIs)

A patient safety incident investigation (PSII) is completed when an incident or near-miss indicates significant patient safety risks and the potential for new learning. The aim of the PSII is to understand:

- What happened
- When did it happen
- Why did it happen
- What contributed to it happening
- What can be learned
- How the Trust can share the learning
- How the Trust can prevent something similar happening again

It's important that patients, families and carers are invited to be part of the PSII process; their decision to participate or not, will be fully respected. An engagement lead will be allocated for each PSII, so there is a single point of contact for patient and family engagement. We aim to complete PSIIs within a period of three to six months; however, timescales can be adjusted depending on the complexity of the incident. Extension requests will be discussed with all participants and approved by the Executive team.

Each PSII follows five key stages:

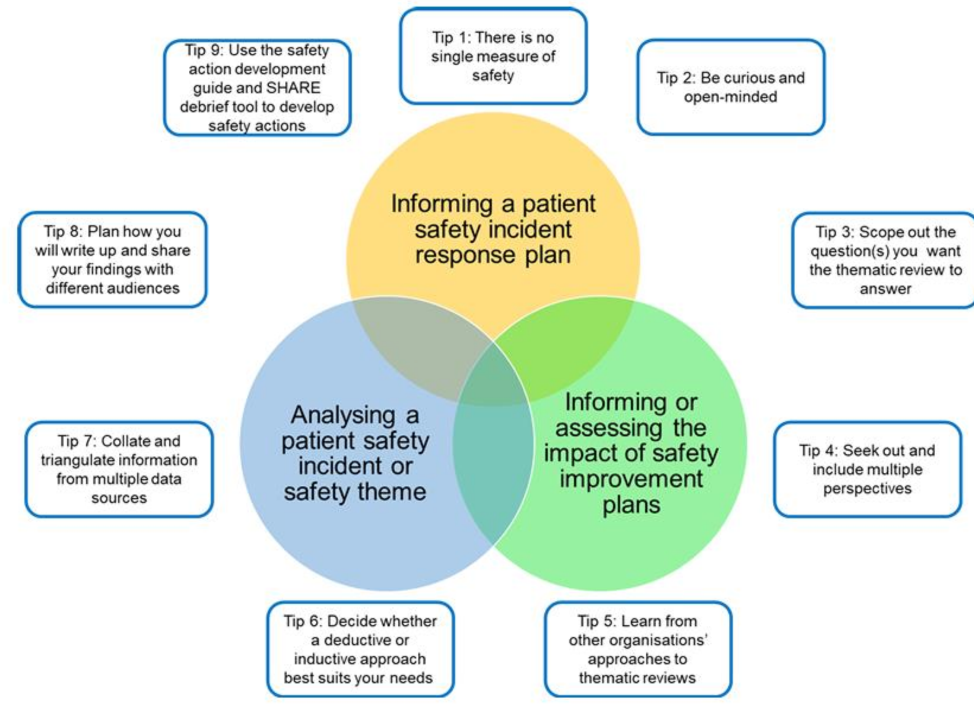


On completion, PSIIs are progressed to CRMG for approval where learning is shared, with Teams, localities, patients and families and via the trust PSIRF Focus bulletin

Thematic Reviews

The Trust uses thematic reviews to help identifying patterns, themes and links within data to support learning. This approach is used to inform our PSIRF plan and identification of safety priorities. The approach is guided using the following national framework:

Three thematic review approaches to support learning and improvement:



How learning is shared

Learning from incident reviews and investigations are disseminated across the Trust through several mechanisms including:

- Daily Patient Safety Huddles – within services
- Trust governance meetings
- Dedicated PSIRF newsletter
- The All staff briefing – a monthly meeting led by the Executive team

Impact and outcomes of identified improvement actions are tracked via our audit programme and close monitoring of incidents, complaints and patient feedback.

PSIRF training

The Trust recognises the importance of training to support the successful implementation of PSIRF across the organisation. To support our staff to understand and effectively contribute to our patient safety culture, the following training is provided and monitored across each locality:

<table>
<tr><th>Safety Syllabus</th></tr>
<tr><td>Level One – Essentials for Patient Safety

This is the starting point for all NHS staff, and includes sections on:

• Listening to patients and raising concerns
• The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work
• Avoiding inappropriate blame when things don’t go well
• Creating a just culture that prioritises safety and is open to learning about risk and safety</td></tr>
<tr><td>Level two – Access to Practice

Access to practice is intended for all clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are two sessions:

The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe).</td></tr>
</table>

The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame). Level two Access to Practice includes an assessment, which on completion staff will receive a certificate and will have access to the sector specific sessions covering Mental Health, Primary Care, Maternity Care, Acute Care, and Management and Administration.
Level One – Essentials for Patient Safety for Boards and senior leadership teams Additional session for senior leaders and executive teams, covering: • The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety incidents on staff at all levels
Level two – Sector Specific sessions (Accessible following completion of Level two Access to Practice) On completion of Level 2 Access to Practice all staff will have access to five patient safety sector specific sessions covering good practice, human factors, risk management, systems thinking, and safety culture. Each of these sessions can be completed by individuals or used as part of a group discussion. These sessions aim to highlight the learning from Level 2 – Access to Practice. The sessions cover: • Mental Health • Primary Care • Acute Care • Maternity Care • Management and Administration
Levels 3 and 4 – Patient Safety Specialist Training Levels 3 and 4 are delivered through a blended-learning approach, with several modules delivered through online learning and followed up with an in-person event. Levels 3 and 4 explore topics such as: • Unpacking system issues • Managing patient safety risks • Understanding cultural, legal, and regulatory factors • Designing solutions

Patient Safety Training is supported by a number of dedicated and specialist roles across the Trust, including:

Patient Safety Specialists

The Trust have two trained Patient Safety Specialists in partnership with Wirral University Teaching Hospital

They provide a key role in the local implementation of the NHS Patient Safety Strategy, supporting the development of our patient safety culture, safety systems and improvement activity.

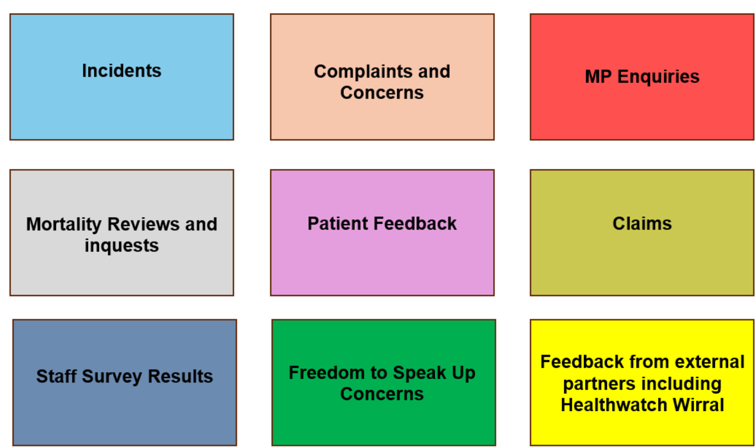
Patient Safety Partners

Patient Safety Partners (PSPs) are dedicated roles, supporting the Trust to ensure patient safety is always at the forefront of everything that we do. The roles can be undertaken by patients, carers, family or other members of our local community.

The Trust has seen a fantastic response to the recruitment of volunteer patient safety partners. We currently have two patient safety partners who support the patient safety portfolio. Their input, expertise and time are unbelievably valuable and appreciated by the trust. They have attended Key meetings across the trust such as Clinical Risk Management Group and Safety Risk and Learning Review Panel Patient Safety.

Defining our patient safety incident and improvement profile

To ensure our PSIRF plan reflects the current priorities within the Trust, data received from 01 January 2024 – 31 December 2025 was analysed. This included, but was not limited to the following areas:



In total, this resulted in the analysis of over 11,228 incidents, with reported harm levels as follows:

Reported level of harm	Total number of incidents	% of total incidents
No Harm (inc near miss)	7750	69.0
Low Harm	3059	27.2
Moderate Harm	417	3.7
Severe Harm	2	0.0
Catastrophic (fatal)	0	0.0

Stakeholder Engagement

During February 2026, the identified priority areas were considered in partnership with Wirral University Teaching Hospital NHS Foundation Trust at a joint quality priorities workshop. This engagement event was vital to enable us to work closely together and share learning to strengthen patient safety. In addition, the priorities have also been presented to Healthwatch Wirral, ensuring the views of local people have been fully considered.

Five local joint priorities have been identified for 2026/27:

- Pressure Ulcers
- Medications
- Falls
- Discharge
- Infection prevention and control

The developed priorities will be progressed through an integrated governance system across both Trust's to promote patient safety and strengthen our systems and processes – this is a key priority for 2026/27.

Services covered by this PSIRF Plan

Recognising the potential for transferability of learning, this plan and data analysis has been inclusive of all services across the Trust.

Approach to Quality Improvement (QI)

The Trust is committed to continuous improvement using recognised improvement methodology to deliver safe, quality care. Our approach empowers staff at all levels to identify, test and sustain changes that improve patient access, experience and outcomes. Aligning closely to the principles of NHS Impact, the Trust continues to provide training to develop confidence and capability in QI approaches to support delivery of the patient safety plan.

Our patient safety incident response plan: national event response requirements

National priorities have been developed to support a consistent approach to responding to patient safety incidents. The table below outlines how we will respond to the nationally identified priorities to achieve improvements in patient safety.

National Priority	Trust Response
Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII at WCHC, create local actions which will report into the overarching improvement. If applicable work in collaboration with other trusts involved in care
Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII at WCHC, create local organisational actions reporting into the PSIRF bulletin or case study to be shared across agreed areas within the trust. if applicable work in collaboration with other trusts involved in care
Maternity and neonatal incidents meeting HSSIB criteria	Not applicable to WCHC as relates to maternity services
Child deaths	Locally led PSII, as appropriate and SUIDIC process reporting through Trust governance considering alignment to any existing Safety Improvement Plan
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Mortality Review Group, create local organisational actions, reporting these into the Trust's PSIRF learning bulletin and case studies,

	considering alignment to any existing Safety Improvement Plan.
Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority. The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk) Create local organisational actions reporting throughout the Trust's governance framework, considering alignment to any existing Safety Improvement Plan.

Our patient safety incident response plan: Local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Falls	Individual Patient Safety Response for falls with harm. All falls reviews will be proportionate and consideration of AAR/PSII/Thematic learning Review/MDT, SWARM reporting into an organisational Quality Improvement Plan tracked at the Trust's Integrated Performance Board.	Review of reoccurring areas for improvement against current patient safety. This will include a Quality Improvement driver diagram jointly working with WUTH.
Pressure Ulcers	Individual Patient Safety Response for pressure ulcers of category 3 or category 4, or when the manager's	Review of reoccurring areas for improvement against current patient safety

	assessment highlights that there has been at least moderate harm impact to the patient from other pressure damage. All reviews will enable thematic analysis of findings and learning. These will report into an organisational Quality Improvement Plan.	improvement plan. This will include a driver diagram for joint Quality Improvements working with WUTH. The Trust's Patient Safety Risk and Learning review panel will provide a mechanism for dynamic triangulation of data against the developed outcome measures.
Medication Incidents moderate and above or themes relating to the 7 rights of medication administration	Individual Patient Safety Response or Thematic Review as discussed and agreed at Clinical Risk Management Group or Patient Safety Risk and Learning review panel these will report into an organisational Quality Improvement plan.	Review of reoccurring areas for improvement against current patient safety improvement plan. This will include a driver diagram for Quality Improvement jointly working with WUTH.
Discharge Incidents that have led to a readmission/ or harm to a patient	PSII/AAR/Thematic Review	Areas for improvement and individual patient safety actions discussed at Safety Risk and Learning Review panel to support oversight and consider patient safety improvement plans.
Incidents leading to Healthcare Associated Infections	PSII/AAR Thematic reviews report into an organisation Quality Improvement Plan	Review of reoccurring areas for improvement against current patient safety improvement plan. This will include a driver diagram for Quality Improvement.

References

Policy GP60 Patient Safety Incident Response Policy

Policy GP43 Duty of Candour and Engagement Policy

Policy GP08 Incident Reporting and Management Policy

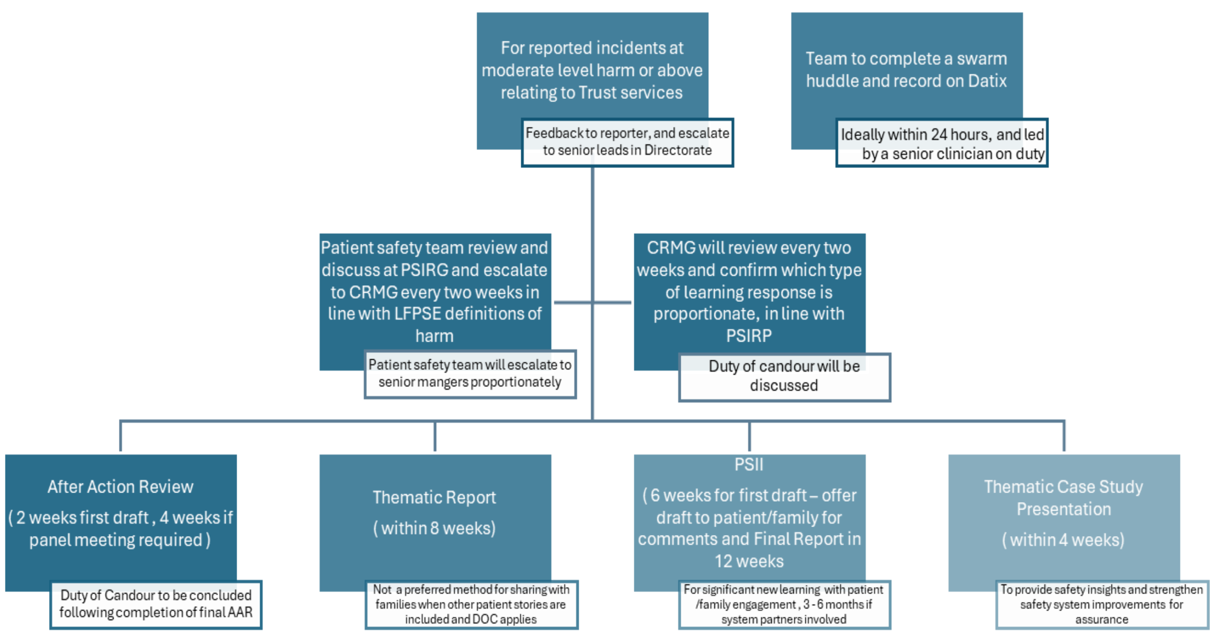
NHS England (2023) Patient safety learning response toolkit [online] https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Appendix A: Summary of Patient Safety Definitions

Term	Definition
Patient safety incident	An unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.
Learn From Patient Safety Events (LFPSE) service	The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. On submission, the incidents can be viewed by the Care Quality Commission (CQC) and Integrated Care Board (ICB), supporting sharing and trend analysis at a regional and national level.
Patient Safety Incident Response Framework (PSIRF)	NHS framework that guides how organisations respond to patient safety incidents, focusing on compassionate engagement, proportionate system-based learning, and using insight from incidents to improve safety and reduce future harm.
PSIRF Plan	A local document that sets out how an organisation will carry out its incident response activity. It specifies which types of incidents will be prioritised for deep investigation.
PSIRF Policy	An organisation's overarching strategy for responding to patient safety incidents, ensuring the process is consistent and supportive.
Safety Huddle	Safety huddles (or safety briefs) are short meetings used for sharing information about potential or existing safety problems. They increase safety awareness among front-line staff, allow for teams to address identified safety

	issues, fostering a culture of safety
Swarm Huddle	A rapid gathering of staff immediately after an incident to collect information and manage immediate risks.
After-Action Review (AAR)	A structured, facilitated discussion among team members immediately after an event to understand what happened and why.
Patient Safety Incident Investigation (PSII)	A comprehensive, "deep dive" investigation into a specific incident to identify interconnected systemic causes.
Multi-Disciplinary Thematic (MDT) Review	A collaborative review process involving various specialists to gain different perspectives on an incident.
Safety Culture	The beliefs, perceptions and values shared in relation to risks within the organisation. This includes: ▪ Continuous learning and improvement of safety risks ▪ Supportive and psychologically safe teamwork ▪ Enabling and empowering speaking up by all

Appendix B: Incident Decision-Making Tree



All learning shared, as required, across Directorates to promote patient safety culture
Daily Safety Huddles
PSIRF Bulletin
Staff Briefings/Team meeting

CRMG – Clinical Risk Management Group – verifies duty of candour (DoC), level of harm and relevant external governance requirements. CRMG approves final learning responses and track action plan progress
PSIRG – reviews moderate harms and above reported on Datix, level of harm may be revised in line with LFPSE definitions when appropriate, all information and rationale recorded don Datix, and an incident review paper prepared for CRMG every two weeks
PSII- Patient Safety Incident Investigation – based on safety systems analysis (SEIPs - Systems Engineering Initiative for Patient Safety)

Appendix C: Essentials of AAR

AAR is	AAR is not
A method for enabling an open and honest conversation about an event that can be used on its own or as part of a wider suite of methods	The same as an investigation
A debrief for those involved, led by a skilled facilitator	A meeting undertaken by an untrained person
Primarily for those directly involved in an event although others may attend if helpful to aid learning	A managerial meeting about an event without those directly involved present
A conversation structured around four AAR questions that is allowed to evolve for the purpose of learning	A bureaucratic documentation exercise to collect information about an event to be reported through governance structures
An opportunity to involve patients, families and carers in the learning conversation providing doing so maintains a psychologically safe space for all those affected	A space where patients, families and carers are expected to attend without considering the psychological safety and welfare of all those affected
A psychologically safe space where people can speak openly without fear of blame or judgement	A debrief that drifts into a scrutiny of people's actions and decisions
A space where all those present are heard and all contributions are valued equally, irrespective of rank or status	An opportunity for a few individuals to 'have their say' and dominate the conversation
Focused on exploring 'work as done' by asking 'What would you **expect** to happen?	Focused on what **should have** happened (for example, as described in policy and protocols)
A debrief that **may** result in a written document that summarises collective learning and is written in the third person (we learnt that….)	A minuted meeting where information shared by participants in the AAR is detailed in a written report
An opportunity to talk about everyday work and the lived reality and experiences of participants	A place where people are judged or blamed for the expectations and experiences that they describe

A space to understand the perspectives and experiences of those in the room	A space for rigid exploration and theming of different elements of a ‘work system’ (that is, organisation, work environment, task, technology and tools, external influences, person)
An opportunity to develop and agree actions that can be agreed and enacted by people participating in the review	An opportunity to dictate actions for others to complete
A space to highlight concerns about the wider system that may need to be shared with and taken forward by relevant safety/governance groups	A place to decide actions outside the sphere of control of those present

Wirral Community Health and Care
NHS Foundation Trust

Wirral University Teaching Hospital
NHS Foundation Trust

Group Board of Directors in Public **Item 21**

03 June 2026

Title	Director of Infection Prevention & Control Annual Report 1 April 2025 – 31 March 2026
Area Lead	Chris Douglas, Joint Chief Nursing Officer / Director of Infection Prevention & Control
Author	Helen Wilcox, Head of Infection Prevention & Control

Purpose of the Report and Recommendation	
Report For	Approval

The purpose of this report is to share the contents of the Director of Infection Prevention and Control Annual Report: 01 April 2025 – 31 March 2026.

It is recommended that the Board:

- Is assured that IPC systems and processes continue to be robustly implemented to effectively evidence compliance with The Code of Practice on the Prevention and Control of Infections, Care Quality Commission Health and Social Care Act 2008, Regulation 12
- Approve the report

Key Points to Note

The purpose of this report is to provide assurance to the Quality and Safety Committee to demonstrate compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and demonstrate compliance with the ten criterion outlined in the Act and to provide assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards.

The Head of IPC is proud of the achievements made during the annual reporting period, and the IPC Team have worked flexibly and responsively to ensure staff have been supported throughout the reporting period.

Key Risks

This report relates to the following BAF risks:

- Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.
- Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience.
- Failure to comply with relevant codes of governance, regulation and legislative requirements

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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	No
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
29 May 2026	Quality and Safety Committee	Director of Infection Prevention and Control Report: 01 April 2025 – 31 March 2026	For assurance.

1	Narrative
1.1	The annual report provides an overview of the significant achievements made to assure trust standards in relation to IPC practice and associated regulatory compliance. These are clearly evidenced throughout the report and include: • Six criterion of the IPC BAF are fully compliant, with four partially compliant • Trust wide achievement of 98.4% compliance with Level 1 IPC training • Trust wide achievement of 90.3% compliance with Level 2 IPC training • 88.9% completion of the Trust's hand hygiene audit programme • Zero Community Trust attributed cases of Clostridioides difficile infection • Zero Community Trust attributed MRSA bacteraemia cases • A robust programme of IPC audit to monitor environmental standards within Wirral premises • Responsive, flexible service provision to Trust staff and to the wider community of Wirral Place

2	Implications

2.1	**Patients** • Infection prevention and control (IPC) is essential in practice to safeguard patient health and reduce healthcare-associated infections • Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services
2.2	**People** • Individualised care delivery is provided by the Trust, ensuring compliance with equality and diversity standards for staff and people who use Trust services
2.3	**Finance** • Delivery of high-quality services will support the Trust's financial position, reducing the potential for litigation and regulatory action
2.4	**Compliance** • This report demonstrates compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 and demonstrate compliance with the ten-criterion outlined in the Act and to provide assurance regarding implementation of the National Infection Prevention and Control Board Assurance Framework (IPC BAF) and to ensure compliance with infection prevention and control (IPC) standards.

Director of Infection Prevention and Control Annual Report

2025/26

Director of Infection Prevention and Control Annual Report 01 April 2025 – 31 March 2026

Executive Summary

1. The Director of Infection Prevention and Control annual report provides a summary of the infection prevention and control activity undertaken in 2025/26. As a trust and as an IPC team, we have built our activity around collaboration, integration and our shared ambition to improve outcomes for people in our services. There has been a particular focus on our integration opportunities with our infection prevention & control (IPC) colleagues working in Wirral University Teaching Hospitals NHS Foundation Trust (WUTH).

2. The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Code of Practice) outlines the regulations relating to the prevention and control of infection. Within this, the Code of Practice sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention.

3. The national IPC Board Assurance Framework (IPC BAF) published by NHS England continues to be used to provide an evidence-based approach to maintain the safety of patients, staff and others and provides assurance to the Board of Directors via the Quality and Safety Committee.

4. This annual report is set out against each criterion of the Code of Practice and the IPC BAF to support assurance to the Board of Directors of the IPC activity carried out across the Trust throughout 2025/26.

5. As demonstrated in the IPC BAF, there are 12 areas of partial compliance across 4 criterion, with the other 6 criterion being fully compliant. Where there are areas of partial compliance, they have been included in the IPC annual work programmes with the recognition that some objectives will progressed as part of future integration opportunities.

6. The report highlights the work undertaken by the IPC Team during 2025/26, with the team continuing to respond flexibly to ensure staff working in community services have been supported to deliver care in a safe way.

7. Throughout 2025/2026, WCHC continued to provide an Infection Prevention and Control Service (IPCS) to the wider community of Wirral through its commissioned service with Wirral Borough Council.

8. Key priorities for 2026/27 will include:

   - integrated infection prevention teams
   - maintaining service delivery as part of organisational change
   - quality improvement with a real focus on prevention
   - education, training and empowerment

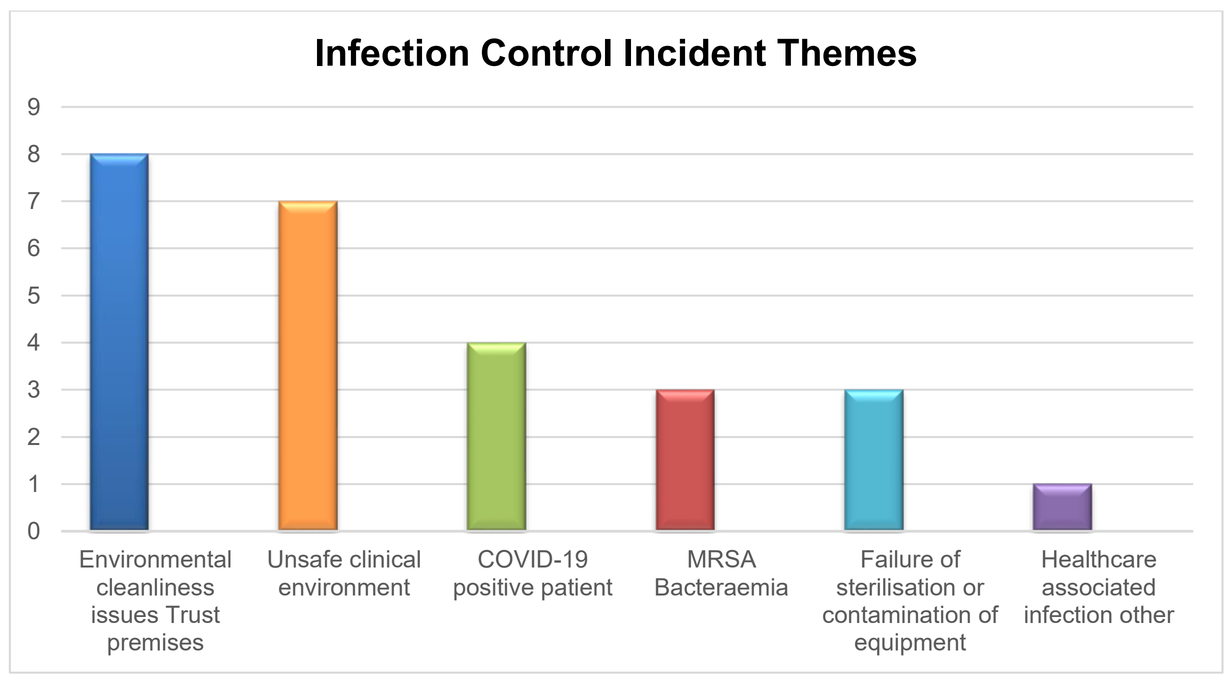
CRITERION 1:
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

9. The IPC Team have provided advice, support and leadership to all trust services to support compliance with IPC practices and to actively contribute to quality improvement and patient safety.

10. In accordance with the Trust's IPC governance assurance framework, all identified risks have been effectively managed via the trusts operational risk register during 2025/26, with monitoring via the Trust's IPC group, reporting to the Quality and Safety Committee.

11. During the reporting period there were 26 infection control related incidents reported on the trusts incident reporting system Datix, the breakdown of the incidents is outlined in figure 1.

Figure 1: Infection Prevention and Control Incidents and Themes Reported 1 April 2025 to 31 March 2026



12. Following review at service level, all IPC themed incidents are reviewed at the IPC Group in accordance with the trust's governance framework. Themes included environmental cleaning standards in Wirral managed premises. These incidents were managed by the Head of Capital Projects and Estates in accordance with the trust's internal governance processes.

13. During the reporting period, a total of 29 IPC environmental audits of Wirral premises were completed by the IPC Team.

Figure 2: IPC Environmental Audit Themes and Trends

Audit Issues

Audit Issue	Count
Audit Issue: Environment	12
Audit Issue: Cleaning	8
Audit Issue: Domestic Room	6
Audit Issue: Treatment Room - Clinical	4
Audit Issue: Personal Protective Equipment	3
Audit Issue: Dirty Utility/Sluice	3
Audit Issue: Sharps Handling & Disposal	3
Audit Issue: Equipment	3
No issues identified	2
Audit Issue: Bedrooms	1
Audit Issue: Kitchen/Chilled Water	1
Audit Issue: Waste Management	1
Audit Issue: Bathrooms/Showers/Toilets	1
Audit Issue: Other	1
Audit Issue: Patient Toilets	1
Audit Issue: Minimising risk of infection	1
Audit Issue: Baby Changing Facilities	1

14. In response to the audits undertaken, action plans were developed by service leads which are tracked via Directorate Safe Operations Performance Group (Safe/OPG), with high level assurance provided to the IPC group via Directorate reports.

15. In addition to the annual IPC environmental audit programme, the IPC team have:

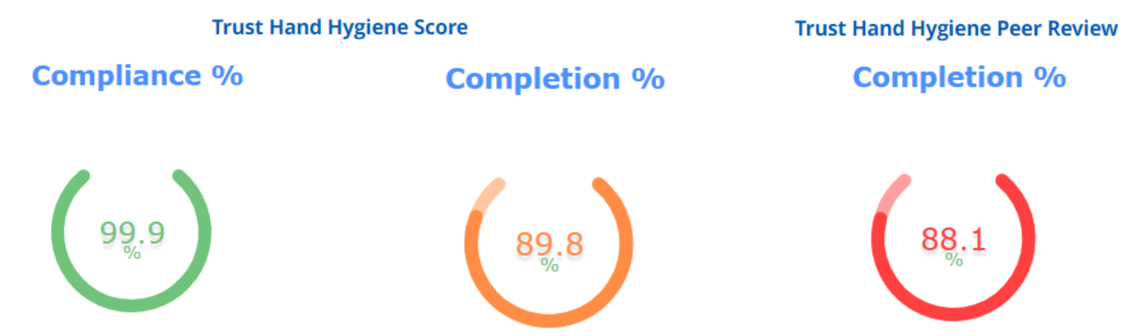
    - undertaken regular supportive visits to trust services to support the implementation of appropriate IPC standards, including enhanced support to the Community Intermediate Care Centre (CICC)
    - attended Senior Management Team meetings to promote 'The gloves are off' quality improvement project
    - responsive visits to the Urgent Treatment Centre, Eastham and VCH Walk in Centres as part of measles preparedness plans to develop robust processes to safely manage people with suspected or confirmed measles when attending trust premises
    - assisted the Bladder and Bowel service in delivering training to care homes across the Wirral, focusing on use of continence products, catheter management, and UTI prevention
    - joint assessment with the trust's provider of hand hygiene consumables to review dispenser placement within clinical areas to ensure we are maximising opportunities for hand hygiene at the point of care
    - supported the National Standards of Healthcare Cleanliness (NHSC) efficacy audit programme
    - supported the system wide Catheter Associated Urinary Tract Infection (CAUTI) audit

16. To support IPC governance and assurance processes, 3 IPC assurance audits are held on the trusts Standards Assurance for Excellence (SAFE) system for monthly completion by all patient facing services. Compliance is reviewed at Directorate Safe / OPG meetings and assurance provided to Safe Operations Group (SOG) and IPCG.

17. The Trust has continued to monitor hand hygiene compliance across all frontline clinical services on a quarterly basis, compliance is tracked via SAFE and reported by exception to the IPCG and SOG.

18. During 2025/26, 89.8% of eligible staff completed the required hand hygiene audits with 99.9% compliance with the required standards. To provide a greater level of assurance, audits are also peer reviewed, to observe standards in clinical practice; 88.1% of completed audits have been peer reviewed.

Figure 3: Hand Hygiene Essential Steps Compliance and Completion Rates



CRITERION 2:
The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

19. The IPC Team work closely with the Estates team to ensure that IPC standards are considered as part of any refurbishments. The team have continued to provide support to the Head of Capital Projects & Estates and operational services to ensure IPC is considered as part of any service re-design, which included:

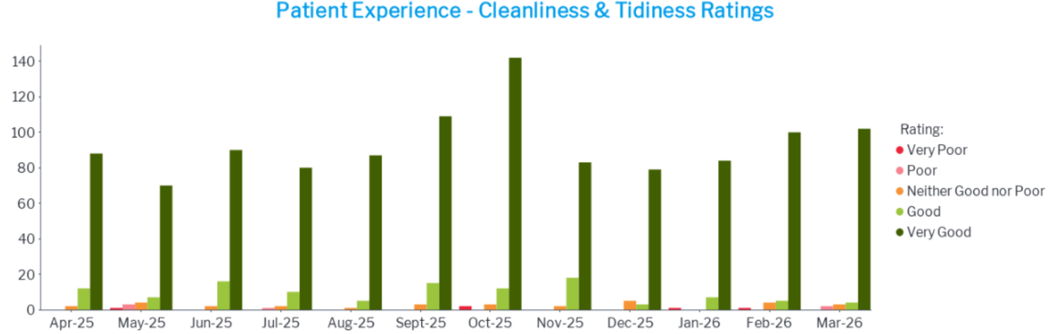
    - relocation of the MSK service from the Arrowe Park Hospital (APH) site to St Catherines Health Centre (SCHC)
    - air quality testing in conjunction with Rediair was completed within CICC
    - supporting with the completion of a planned programme of refurbishment to Eastham Clinic to improve environmental standards within the setting following a successful capital bid application
    - the Interim Lead Nurse became a key member of the Urgent and Emergency Care Upgrade Programme (UECUP) group supporting collaborative working with WUTH IPC Matron
    - continuing to support with attendance at the efficacy audit programme

20. Patient Led Assessments of the Care Environment (PLACE) were successfully completed in 2025 with a positive outcome and significant improvement in the environment evident. The cleanliness assessment score was 99.78% which is higher than the national average.

21. The Head of Capital Projects and Estates is working with the trusts waste contactor to ensure consistency with NHS England's clinical waste strategy specifically segregation of waste into appropriate waste streams.

22. As part of the Trusts commitment to collecting service user feedback, data is also collected in response to people's experience of the cleanliness of the care environment. This is reviewed at the quarterly IPC Group.

Figure 4: Patient Experience - Cleanliness and Tidiness Ratings



23. The IPCT continue to work closely with the Medical Devices Safety Officer to ensure correct processes are in place for the decontamination of medical devices and have worked closely with CICC Service Lead to support improvements in equipment decontamination processes across the three wards within CICC.

CRITERION 3:
Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

24. In November 2025, NHS England wrote to all NHS trusts and Integrated Care Boards in England with a call to action to ensure we are working with prescribers and clinical leads to make the changes required to meet the targets in the national action plan (NAP) for AMR.

25. The 2024-29 NAP included a national ambition to increase the percentage of access antibiotics prescribed to 70% or over as a percentage of all antibiotics prescribed. Using the 2024 UK AWaRe classification, antibiotics are classified into access, watch and reserve. By prescribing a higher percentage of access antibiotics, watch and reserve antibiotics will be less impacted by the development of resistant bacteria.

26. Between April 2025 and December 2025, 60.3% of antibiotics prescribed or supplied via Patient Group Directions (PGDs) within WCHC were in the access category. This compares to a national percentage of 65.6 % of antibiotics within primary care and 53.8% of antibiotics within secondary care in the access category during 2024. The trust will adopt the national ambition of 70% or above whilst promoting adherence to Cheshire and Merseyside antimicrobial guidelines.

27. All PGDs that authorise the supply of antibiotics were based on Cheshire and Merseyside and national (NICE) evidence-based antimicrobial guidelines.

28. During 2025/26 the Medicines Management Team conducted 6 audits of antibiotics associated with a high risk of *Clostridioides difficile* prescribed within the Urgent Treatment Centre. In each of the audits, 20 patient records were examined by extracting information from the electronic patient record. The exception to this were the quinolone audits due to the low number of prescriptions for these antibiotics, all the quinolones prescribed were audited.

29. Audit findings were monitored at service level and at the Medicines Governance Group. The results were also discussed at the quarterly V300 Non-Medical Prescribing Forums. Results of the audits were reported back to individual prescribers via their line manager and when a training need was identified, extra training was provided.

30. The percentage compliance with Cheshire and Merseyside and NICE guidelines were as follows:

Date Prescribed	Antibiotic	Choice of antibiotic in line with guidelines	Choice and duration of antibiotic in line with guidelines	Sample size audited	Total number prescribed	Comment
April 2025	Cephalosporins (all prescriptions audited were cephalexin)	90% 18/20	85% 17/20	20	47	
June 2025	Co-amoxiclav	95% 19/20	85% 17/20	20	105	

August 2025	Quinolones	75% 3/4	75% 3/4	4	4	Low sample size expected as not first line treatment
October 2025	Quinolones	93% 13/14	79% 11/14	14	14	Low sample size expected as not first line treatment
December 2025	Cephalosporins (all prescriptions audited were cephalexin)	95% 19/20	95% 19/20	20	59	
February 2026	Co-amoxiclav	90% 18/20	85% 17/20	20	107	

31. During 2025/26, the trust participated in a bench marking audit of CICC. A template tool was used to audit the antibiotics initiated within CICC during one week in October. The results of this audit were disappointing with only 44% of antibiotics prescribed in line with guidelines. The low % adherence could be attributed to the low audit sample with only 9 antibiotics initiated and a locum prescriber in attendance.

32. This audit was repeated in January 2026, where 8 antibiotics were prescribed. During this period substantive prescribers were covering the unit and the % of antibiotics in line with guidelines was 88%, with 75% with the correct antibiotic and the correct duration. This improvement followed feedback to staff and reflected a more stable workforce.

33. In addition to the audits, the trust requires all practitioners who prescribe, administer or advise on antibiotics to complete antimicrobial resistance awareness training. At the end of 2025/26, 95.5 % of eligible staff had completed the training.

34. Training compliance rates are tracked monthly at service level throughout the organisation, with trajectories for improvement developed where required, reporting by exception to SOG.

CRITERION 4:
The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

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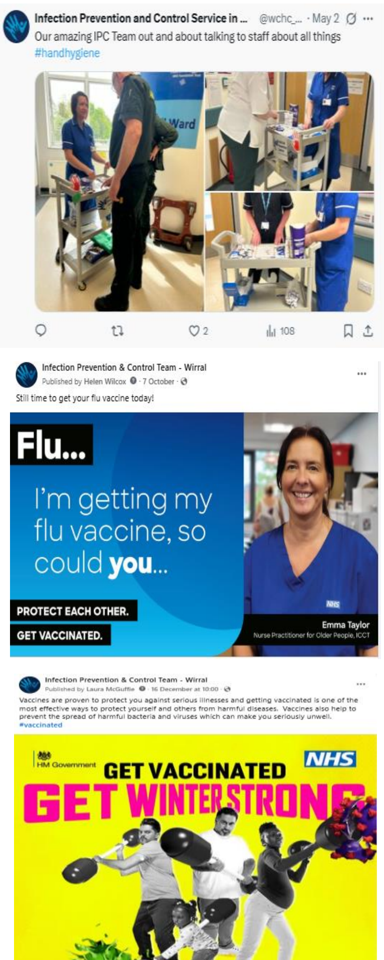
35. Communication is key in promoting effective IPC and the IPC Team have taken a proactive approach in promoting IPC at every opportunity, this has included:

- contacting patients in the community who have *Clostridioides* difficile to provide education, advice and support
- delivering a programme of activity aimed at healthcare professionals, service users and members of the public to recognise the World Health Organization's Global Hand Hygiene Day which is celebrated each year in May
- delivering a robust communications plan, produced in collaboration with the Trusts Communications and Marketing team, to recognise International Infection Prevention Week in October
- attending a variety of carers events to share key IPC messages to unpaid and informal carers
- sharing wellbeing and improving hydration messages in response to the warmer weather

- engaging with the trusts Your Voice Group to seek patient and carer feedback on an information leaflet produced for patients receiving longer term antibiotic therapy for *C.diff*
- working jointly with WUTH IPC colleagues to update the hospital patient information leaflet on *C.diff,* to include advice for people to follow once discharged from the hospital setting and to promote self-care
- developing an IPC leaflet for the public promoting key messages to prevent and control infection
- sharing key messages to support people to keep well this winter via comms and social media
- supporting the Public Health Delivery Services Project Management team to develop a public communications campaign for *C.diff*
- working in conjunction with WCHCs Bladder and Bowel service to produce a UTI and urinary catheter poster which was shared with community trust staff and ASC
- continuing to utilise the trusts social media platforms to share relevant IPC content

36. Resources and information continue to be made available on the IPC digital hub for all IPC related information for all providers of community care, including WCHC staff.

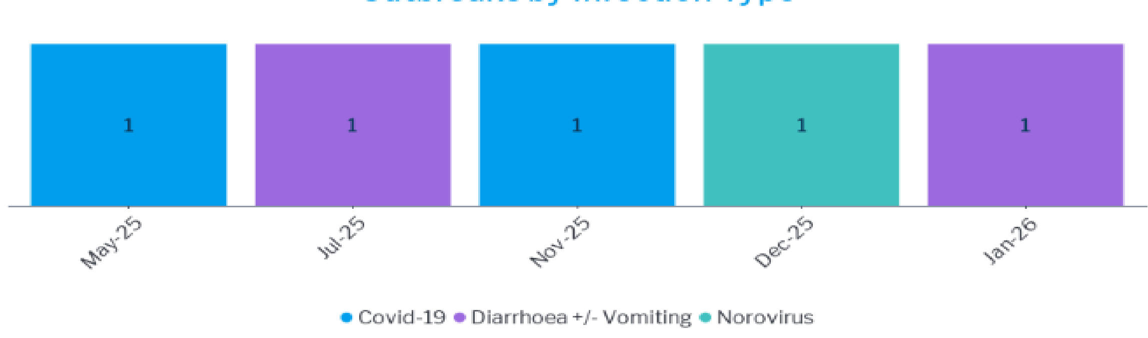
Figure 5: Communication and Engagement Examples 2025/26



CRITERION 5:
That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

37. During the reporting period, 5 outbreaks of infection were identified within the Community Intermediate Care Centre (CICC), all were managed well and in accordance with IPC guidance.

Figure 6: Outbreaks within CICC



38. To support a cycle of continuous learning and improvement a review of each outbreak is undertaken through Outbreak Control Groups. Any subsequent actions are monitored via the trusts existing governance routes.

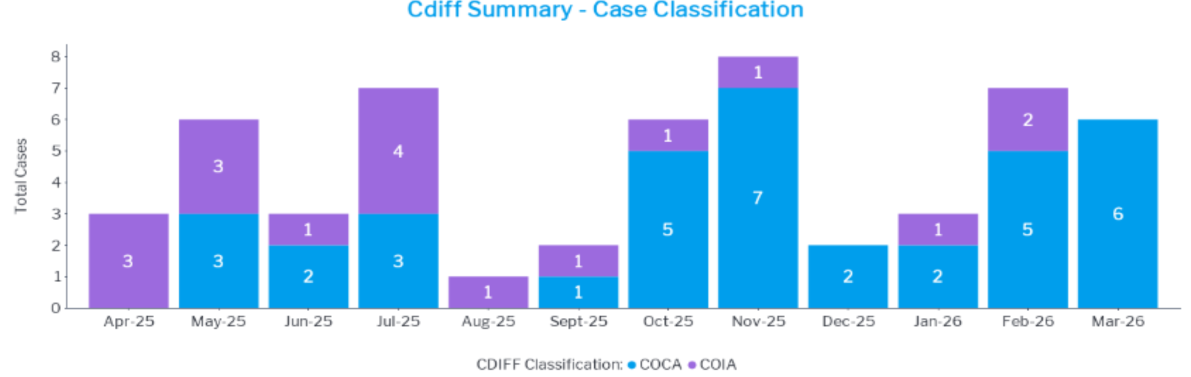
39. There was a *C.diff* Period of Increased Incidence (PII) on one ward at CICC, additional IPC measures were initiated, and the ward was monitored for a period of 28 days, no further cases were identified.

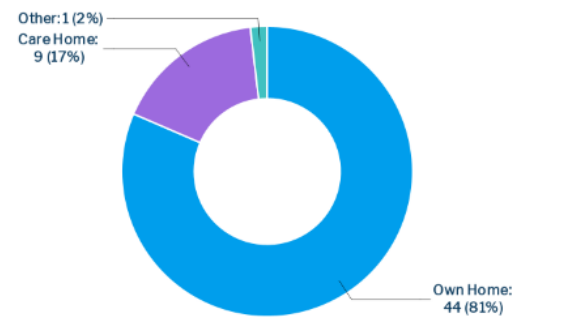
40. During 2025/26, 3 people were identified to have a community associated MRSA bacteraemia which was reported to the IPCT as part of the Local Authority contract. Learning was external to the trust and was shared with relevant system partners.

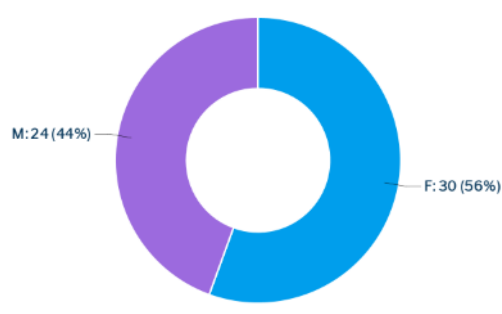
41. The IPCS completed Rapid Infection Control Reviews (RICs) for 54 people who had a community associated *Clostridioides difficile* infection (CDI) as part of the Local Authority contract for the wider Wirral system. Of the 54 RICs undertaken by the IPCS:

- 36 people were classified as community onset community associated (COCA)
- 18 people were classified as community onset indeterminate association (COIA)

Figure 7: Community Associated *Clostridioides* difficile Toxin Positive Cases 1st April 2025 – 31st March 2026







42. The IPC team have worked collaboratively at a system level to support a reduction in cases of *C.diff* across the local health economy. The team continue to work closely with WUTH colleagues and system partners to progress priority areas for improvement as part of Wirral's C.*diff* strategy. This has included but not limited to:

    - developing and implementing an admission flowchart for unexplained diarrhoea for the Community Intermediate Care Centre (CICC)
    - delivering *C.diff* management and UTI prevention training to teams in the Urgent Community Response directorate
    - working closely with WCHCs Bladder and Bowel service to improve the management of urinary catheters and Urinary Tract Infections (UTIs)

43. Following the launch of the Patient Safety Incident Response Framework (PSIRF) the IPC team have worked to align Healthcare Associated Infection (HCAI) reviews with the framework and are continuing to review how the principles of PSIRF can be applied in IPC, working with system colleagues to ensure a cohesive approach to patient safety IPC incidents.

44. A side room (isolation) priority guide for CICC was developed to support ward staff to thoroughly risk assess the use of side rooms for those people with a known or suspected infection risk.

45. The IPCS have developed a new SystmOne Transfer of Care template which includes an IPC risk assessment for patients returning to CICC following ED admission.

46. In response to the evolving Measles situation in July 2025, UKHSA reported a national standard measles incident response to the rising cases of measles in England. Wirral system preparedness meetings were established. The community IPCS supported Wirral Place with measles outbreak preparedness and response plans, which included updating and reviewing guidance, measles risk assessment, reinforcing infection prevention and control practices and working with communications colleagues to share measles messages. The IPCS responded to several measles situations and learning was shared at the Wirral system preparedness meeting.

47. The system wide Catheter Associated Urinary Tract Infection (CAUTI) audit took place in March 2026 with the formal audit report expected earlier in 2026/27.

48. The IPC team continues to work hard to support the local population and to improve health outcomes associated with UTIs. The IPCS continue to be pivotal member of the system UTI improvement group and work closely with WCHC's Bladder and Bowel service.

CRITERION 6:
Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

49. During the reporting period, compliance with mandatory and role essential IPC training was:

- Level 1 98.4%
- Level 2 90.3%
- Aseptic Technique 88.9%

50. The IPC Team have provided informal training to higher risk areas of the trust including:

- delivery of *C.diff* management, hydration and UTI prevention training to the Community Frailty team, Home First Team and CICC
- facilitation of an interactive hand hygiene session to the Home First team
- in conjunction with SC Johnson, delivered an interactive hand hygiene session to the staff at CICC

51. The IPCS have provided regular themed updates through internal communications to staff to ensure they are aware of their responsibilities to prevent and control infection.

52. A gap analysis was completed and approved by members of the IPCG in relation to the Trusts assurance of staff Fit testing for use of FFP3 masks.

CRITERION 7:
The provision or ability to secure adequate isolation facilities.

53. All inpatient wards at the Community Intermediate Care Centre provide single room ensuite accommodation that can be used for patients requiring isolation where appropriate.

54. Isolation facilities are available at Trust Walk in Centres and Urgent Treatment Centre where required.

55. The IPC Team have worked with operational services to ensure adequate isolation facilities in the event a person presents with suspected measles or other communicable disease.

56. An infection risk and isolation stratification tool to support effective use of side rooms has been developed and implemented to support effective use of side rooms at CICC.

CRITERION 8:
The ability to secure adequate access to laboratory support as appropriate.

57. Laboratory services for the trust are provided by Chester and Wirral Microbiology Service. The laboratories operate according to the requirements of national accreditation bodies for the investigation and management of disease/infections. There is nothing to report by exception for 2025/26.

CRITERION 9:
That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

58. All IPC policies are tracked through the IPC Group to ensure that review dates are not exceeded, where extensions have been required this has been granted by the Quality and Safety Committee.

59. IPC01 Operational Policy has expired with an extension agreed until June 2026.The policy will be considered as part of the Trusts integration

60. The following policies have been approved by the Quality and Safety Committee during 2025/26:

    - IPC04 Management of Inoculation Incidents (including management of safe sharps)

    The following policies have been reviewed and will be submitted to the Quality and Safety Committee during quarter 1 2026/2027:

    - IPC13 Management of *C.diff*
    - IPC24 Management of Meticillin Resistant *Staphylococcus Aureus* (MRSA)

CRITERION 10:
That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

61. Occupational Health Services are provided via People Asset Management (PAM) who are the contracted occupational health service for Trust staff and are managed by the Chief People Officer function. To ensure staff are appropriately supported, the IPC Team signpost Trust staff to PAM where occupational health specialist advice is required.

62. Appointment of the Joint Head of Occupational Health & Wellbeing WUTH / WCHC in response to integration of the Trusts.

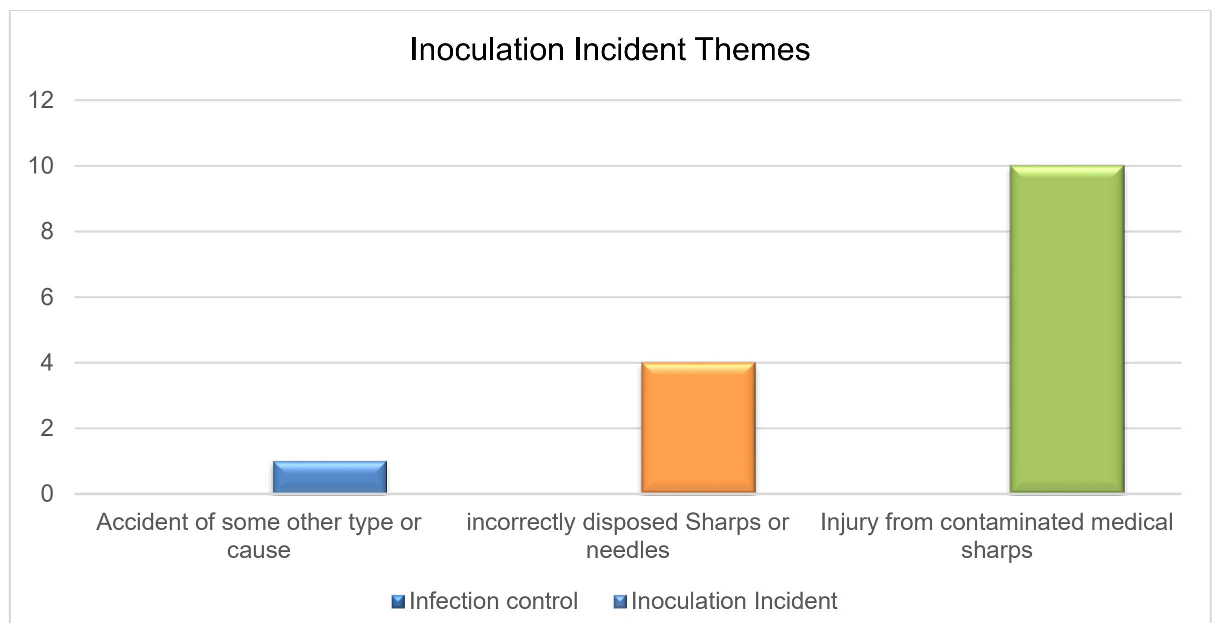
63. The Joint Head of Occupational Health & Wellbeing WUTH / WCHC is working with PAM OH to ensure staff have required health checks, immunisations and clearance.

64. The Trust ended its staff seasonal influenza vaccination programme on 31st March 2026. Vaccination levels at the end 2025/26 were 47.3% of healthcare workers had received their seasonal flu vaccination. An evaluation of the influenza vaccination programme has been completed by the lead for the staff flu programme and can be found in Appendix 1.

65. Learning from the programme will inform planning for 2026/27.

66. During the reporting period there have been 15 inoculation incidents which have all been appropriately managed in accordance with Trust policy. Themes and trends are continually monitored, and all inoculation injuries are reviewed by the Head of IPC.

Figure 8: Inoculation Incidents and Themes April 2025 to March 2026



Summary

67. The IPC team have delivered a robust IPC activity programme within 2025/2026.

68. The annual work programme for 2026/27 will continue to deliver against key national standards including The Health and Social Care Act 2008: code of practice on the prevention and control of infections, NHS England IPC Board Assurance Framework and the National IPC Manual.

69. The IPC team have continued to collaborate with regional and local system partners on preparedness projects, response to national and local outbreaks of infection and quality improvement initiatives.

70. The IPCS have continued to widen the reach of the service through digital communication, collaboration and education and training within community services, voluntary organisations and to the public.

71. Effective IPC practices require commitment from all staff, including both clinical and non-clinical staff groups and WCHC remains committed to continuous quality improvement to ensure sustainable improvement in infection prevention and control practice whilst supporting a zero tolerance of avoidable infection and harm to our patients and staff.

72. Contributing and leading on aspects of the C.diff strategy and implementing a PSIRF approach for infection control reviews of Healthcare Associated Infections (HCAIs) has supported system learning.

Author:
Helen Wilcox, Head of Infection Prevention and Control

Contributors:
Sarah Deveney, Interim Lead Nurse Infection Prevention and Control
Laura McGuffie, Senior Administrator

Appendix 1 Seasonal Staff Flu Programme Evaluation

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Seasonal Staff Flu Programme Evaluation

October 2025 to March 2026

Staff Flu programme 25/26

- The steering group established in July 2025
- Steering group membership consisted of representatives from
  - HR
  - Business Intelligence
  - Service Director
  - Procurement
  - Medicines Management
  - Clinicians representing peer vaccinators for Wirral, Cheshire East
  - Communications
  - Estates

Peer Vaccinators

- Comms sent to Service Directors in June 2025 asking for staff to be nominated from each of their services who would administer the flu vaccination to their colleagues.
- Peer vaccinators not required in 2025/2026 season to provide clinic sessions; only required to vaccinate the colleagues within their team or service.
- Flu vaccines storage was improved to allow vaccines to be available much closer to the peer vaccinators to reduce travel time collecting and maintain the cold chain.

Vaccine Fridges

Vaccine fridges were utilised and redistributed from 0 – 19 service which were no longer required. This allowed influenza vaccines to be stored in the following areas

- Cheshire East
- St Helens
- Pasture Rd Community Nursing
- VCH Community Nursing
- South Wirral Community Nursing
- The Warrens Community Nursing
- St Catherine's Health Centre
- CICC
- Palliative Care Team
- MIU VCH
- Bladder and Bowel Service, Fender Clinic

Communication Campaign

- Comms bulletin had dedicated section for flu campaign from September 2025
- Screen savers to remind staff of the importance of having their vaccine
- All user email sent to staff on the day when a clinic session was planned, allowing for staff to take the opportunity to have their vaccine
- Dedicated section on staff zone providing information for staff to understand the importance of having their flu vaccine
- Information provide by Cheshire and Merseyside ICB on qualitative research undertaken into why staff have or do not have their flu vaccine was utilised to enhance the information provided to staff, to allow them to make an informed decision regarding having their influenza vaccine.
- Dedicated flu inbox wcnt.flu@nhs.net allowed staff to contact the team to arrange to have their influenza vaccine at a suitable time and place.

Staff Flu programme 25/26

- 100% of staff eligible for the vaccination, including, contracted staff working for the Trust under a service level agreement, security staff working on WCHC sites, cleaners, volunteers and students with direct patient contact
- Vaccines offered

Seqirus Cell-based trivalent	Egg Free	ALL Staff

- Staff encouraged to contact the peer vaccinator within their team for the vaccine.
- Staff could also contact the flu inbox to arrange vaccination
- Set clinic sessions provided and the details shared on staffzone and Staff Bulletin

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Data April 2026

	NORTH WEST	157,777	72,127	45.7%
1	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	5,027	2,914	58.0%
2	THE CHRISTIE NHS FOUNDATION TRUST	3,026	1,625	53.7%
3	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	993	529	53.3%
4	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2,915	1,541	52.9%
5	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	4,433	2,337	52.7%
6	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1,112	568	51.1%
7	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3,794	1,918	50.6%
8	BOLTON NHS FOUNDATION TRUST	4,850	2,421	49.9%
9	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	3,320	1,657	49.9%
10	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	8,342	4,140	49.6%
11	EAST CHESHIRE NHS TRUST	1,777	873	49.1%
12	THE WALTON CENTRE NHS FOUNDATION TRUST	1,010	489	48.4%
13	STOCKPORT NHS FOUNDATION TRUST	4,379	2,119	48.4%
14	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	7,200	3,414	47.4%
15	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	19,637	9,308	47.4%
16	WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	1,086	514	47.3%
17	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	14,661	6,619	45.1%
18	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1,202	540	44.9%
19	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	3,271	1,450	44.3%
20	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	9,790	4,334	44.3%
21	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	6,224	2,741	44.0%
22	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4,915	2,118	43.1%
23	PENNINE CARE NHS FOUNDATION TRUST	3,749	1,612	43.0%
24	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3,587	1,519	42.3%
25	MERSEY CARE NHS FOUNDATION TRUST	8,943	3,680	41.1%
26	WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST	5,220	2,117	40.6%
27	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1,409	567	40.2%
28	NORTH WEST AMBULANCE SERVICE NHS TRUST	4,855	1,950	40.2%
29	LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	6,478	2,563	39.6%
30	GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	4,138	1,636	39.5%
31	EAST LANCASHIRE HOSPITALS NHS TRUST	8,378	3,205	38.3%

Statistics » Vaccinations: Flu

What went well

- **Peer vaccinators in teams**
- **Easy access to vaccines due to distribution of strategically placed vaccine fridges**

- Responsiveness of staff working on the project
- Staff training via NHS E-learning
- Dedicated Teams Channel for all peer vaccinators to access
- Support of Medicines Management Team
- Robust Communication Plan
- Using RAVS to record vaccinations given
- Funding provide by NHSE for the flu campaign utilised to provide Bank Nurse support increased opportunity for staff to have vaccine

Group Board of Directors in Public **Item 22**

03 June 2026

Title	WUTH Guardian of Safe Working Annual Report (including Q4 2025/26)
Area Lead	Dr Nikki Stevenson, Chief Medical Officer/Deputy CEO
Author	Dr Alice Arch, Guardian of Safe Working

Purpose of the Report and Recommendation	
Report For	Information

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).

It is recommended that the Board/Committee:

- Note the report

Key Points to Note

This report covers the period 1st January to 31st March 2026 (Q4 2025/2026) 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.

Key Risks

This report relates to these key risks:

- BAF Risk 3

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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	No
Healthier Communities – We will drive health equity and support healthier lives	No
Collaboration and Partnerships – We will work as one system and one organisation	No
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
May 2026	Joint People Committee	As above	As above

1	Narrative
1.1	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	13	13	0
Acute Internal Medicine	0	2	2	0
Emergency Surgery	0	5	5	0
Endocrinology and Diabetes	0	4	4	0
Gastroenterology	0	1	1	0
General Medicine	0	162	162	0
General Paediatrics	0	2	2	0
General Practice	0	7	7	0
General Surgery	0	20	20	0
Geriatric Medicine	0	7	7	0

Neonates	0	2	2	0
Obstetrics and Gynaecology	0	6	6	0
Ophthalmology	0	1	1	0
Otolaryngology (ENT)	0	12	12	0
Oral & Maxillofacial Surgery	0	2	2	0
Psychaitry	0	6	6	0
Renal Medicine	0	1	1	0
Respiratory Medicine	0	1	1	0
Stroke	0	2	2	0
Trauma and Orthopaedics	0	13	13	0
Urology	0	12	12	0
Total	**0**	**281**	**281**	**0**

Exception reports by Grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	71	71	0
F2	0	17	17	0
CT1-2 / ST1-2	0	86	86	0
ST3-8	0	22	22	0
Total	**0**	**196**	**196**	**0**

Exception reports (response time)						
Grade	Within 48 hours	Within 7 days	8-14 days	15-30 days	31-50 days	Still open
F1	21	15	12	2	1	0
F2	6	3	1	0	0	0
CT1-2 / ST1-2	3	8	1	1	0	0
ST3-8	4	2	1	0	0	0
Total	34	28	15	3	1	0

Exception reports (regarding training/academic issues)

Exception reports for Education				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	2	13	15	0
F2	3	0	3	0
CT1-2 / ST1-2	0	1	1	0
ST3-8	0	2	2	0
Total	5	16	21	0

Annual data for 2025-2026

Exception reports by Department - April 2025 until March 2026				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Accident and Emergency	0	12	12	0
Acute Internal Medicine	0	2	2	0
Emergency Surgery	0	5	5	0
Endocrinology and Diabetes	0	4	4	0
Gastroenterology	0	1	1	0
General Medicine	0	160	160	0
General Paediatrics	0	2	2	0
General Practice	0	7	7	0
General Surgery	0	20	20	0
Geriatric Medicine	0	7	7	0
Neonates	0	2	2	0
Obstetrics and Gynaecology	0	6	6	0
Ophthalmology	0	1	1	0
Otolaryngology (ENT)	0	12	12	0
Oral & Maxillofacial Surgery	0	2	2	0
Psychiatry	0	6	6	0
Renal Medicine	0	1	1	0
Respiratory Medicine	0	1	1	0
Stroke	0	2	2	0
Trauma and Orthopaedics	0	13	13	0
	0	12	12	0
Total	0	278	278	0

Exception reports by Grade - April 2025 until March 2026				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	153	153	0
F2	0	17	17	0
CT1-2 / ST1-2	0	86	86	0
ST3-8	0	22	22	0
Total	0	278	278	0

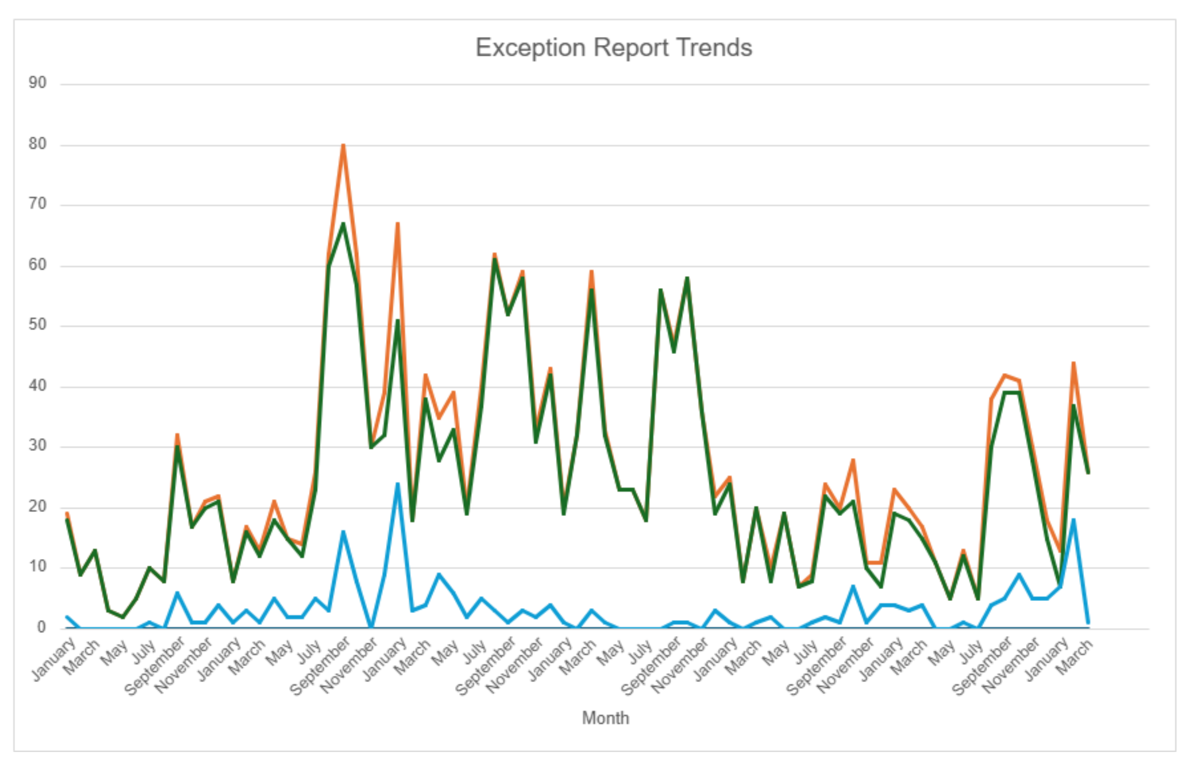
Exception reports by Rota - April 2025 until March 2026				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E 20 per cent Fellow	0	6	6	0
A and E SHO	0	2	2	0
A and E SpR/ST3	0	4	4	0
CGH Fellow	0	4	4	0
ENT	0	11	11	0
GP 2025	0	19	19	0
GP F2 LIFT	0	2	2	0
Medicine F1	0	104	104	0
Medicine IMY2/3/SHO	0	40	40	0
Medicine SpR	0	7	7	0
Ger Med GPST	0	3	3	0
General Paediatrics T1	0	2	2	0
Neonates SpR	0	2	2	0
O&G F1	0	1	1	0
O&G T1	0	4	4	0
Ophthalmology	0	1	1	0
DCT	0	2	2	0
Psych F1 2024 LIFT MT	0	6	6	0
Renal T1	0	3	3	0
Stroke T1	0	2	2	0
Surgical F1	0	37	37	0
Surgery SHO	0	2	2	0
Surgical SpR	0	1	1	0
T&O extra F1	0	2	2	0
T&O SHO	0	8	8	0
Urology Junior rota	0	2	2	0
Total:	0	278	278	0

Exception reports (response time) - April 2025 until March 2026						
Grade	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	72	38	35	13	6	0
F2	7	3	3	0	1	0
CT1-2 / ST1-2	19	21	20	11	0	0
ST3-8	17	5	2	5	0	0
Total	115	67	60	29	7	0

Exception reports (regarding training/academic issues)

Exception reports for Education - April 2025 until March 2026				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	38	38	0
F2	0	3	3	0
CT1-2 / ST1-2	0	15	15	0
ST3-8	0	12	12	0
Total	0	68	68	0

Exception report trends over time



Exception report trends per month since 2016 contract in. Orange represents total number of exception reports, green hours and blue education. Note reports for both

categories can be entered on a single report and so total does not equal a cumulative sum of hours or education reports.

Exception Reports

There has been an increase in exception reports over the year, particularly since August. The majority of these have been from Foundation year 1 doctors and in the medical specialties. The pattern of exception reports continues to have more than one peak a year. These largely reflect the rotations of the resident doctors to new work areas, which may reflect an adjustment to new work areas and workload within the different specialties.

During the last year, in Quarter 4, the new framework for Exception Reporting has been implemented. This was originally planned for September 2025 but instead was implemented on the 4th February 2026 changeover. As had been predicted with a change in framework the number of reports submitted from August onwards has risen when compared with last year's data. These reports do not include correctly submitted exception test reports which are accounted for separately under the system and show on the system as fulfilled on acknowledgment.

There were however some exception reports which were submitted as tests but not using the test function. These forms were acknowledged as tests but claiming for additional hours or TOIL as a test were agreed, as this would have resulted in incorrect actions being completed from test reports. The move from DRS4 to DRS5 resulted in a few forms being submitted under the incorrect system for the timescale. For a short crossover period exception reports were managed in either account, in DRS5 only by the end of the period. As part of this framework implementation all of the necessary processes were passed through the JLNC for approval as required.

The increase in exception reports may reflect an increased awareness of exception reporting through national campaigns, as the increased reflects the proposed implementation rather than the actual implementation date of the new process which was widely publicised to resident doctors and final year medical students. It may also have increased due to changes within the process, with more anonymity for the residents. This may have an impact on the interventions which are possible as supervisors are no longer included in the pathway. There has been a noticeable increase in the number of exception reports which are not agreed under the new process. These are primarily where information is not provided by the residents which allows the report to be agreed, even after communication from the Central Resourcing Team (CRT) and the Guardian Of Safe Working (GOSW). This has resulted in more reports being submitted, increased workload for the GOSW and CRT. Since the framework change there have been 5 exception reports withdrawn after submission by the residents and 35 not agreed by the CRT/GOSW, including those discussed above as part of the test process incorrectly submitted as standard reports (11 of 35), from a total of 79 reports.

Work schedule reviews

	There have been 2 work schedule reviews in the last year. One of these has resulted in an alteration to the work schedule for a group of doctors. The other resulted in recompense of shifts for individual doctors on one rota whose personalised work schedule shifts did not reflect the generic work schedule for their area of work. These have now been resolved. There have been several requests for work schedule reviews through the exception reporting process. These have been addressed against criteria for requiring a work schedule review and largely found not to meet the criteria. This has been communicated with the residents as required. **Vacancies** The trust continues to have a significant number of vacancies at resident level. This continues to have an effect on the staffing levels on the wards and access of the resident doctors to leave. There has been a significant increased in the number of reports where short staffing on the wards is being named as a reason for overruns and inability to access teaching due to unfilled shifts, minimum staffing levels on the wards and residents being moved at short notice to cover different clinical areas. There have also been exception reports for having to cover more than one bleep or work areas when oncall. There is a plan to assess and manage staffing levels which hopes to improve this situation. Communication with the medical staffing teams has aimed to help in the shorter term. **Fines** There have been no access or completion fines and no information breech fines issued during the year (implementation of these fines was a part of the new framework as of 4/2/26). There have been penalty rates applied to 2 exception reports in Q4. The total number of exception reports raised at a penalty rate to 4 within the year. **Detriment Survey** An anonymous detriment survey was sent out to the residents in April 2026. There was very limited response but no report of actual or perceived detriment to exception reporting was made. We continue to encourage exception reporting as required by attending induction for all onboarding of resident doctors, Resident Doctors Forum and the response to exception reports, even where the reports are not agreed.

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.

Group Board of Directors in Public **Item 23**

03 June 2026

Title	WUTH Mortuary Services Annual Report 2025/26
Area Lead	Alistair Armstrong, HTA Designated Individual
Author	Alistair Armstrong, HTA Designated Individual

Purpose of the Report and Recommendation	
Report For	Assurance

The purpose of this report is the annual report from the Mortuary for the financial year 2025/26 as required as part of the Fuller inquiry recommendations and compliance with HTA licensing standard

It is recommended that the Board:

- Gain continued assurance that the processes and governance in place in the mortuary are robust and compliant with the HTA and license conditions.
- Gain assurance around the response to the recommendations in the Fuller inquiry phase 2 report that directly affect the mortuary and the role of designated individual
- Take note of the specific recommendations from the Fuller inquiry phase 2 report that require action/assurance from the executive board.
- Take assurance from the actions implemented in the mortuary to improve security following a serious security breach incident.

Key Points to Note

There is continued assurance around the compliance of the mortuary with the Human Tissue Authority (HTA) standards for the maintenance of the trust HTA license. There is also continued assurance relating to the compliance of the mortuary with the international standard 15189:2022 as demonstrated by the maintenance of accreditation by the United Kingdom Accreditation service (UKAS) during an inspection in December 2025 where the mortuary had limited findings raised. This report also highlights assurance relating to staffing in the mortuary including awareness of the designated individual, their background, reporting arrangements and the legal responsibilities of this role.

As part of this annual review there is also a review of security access audits and any serious incidents. The trust had a serious incident in December 2025 where there was a single episode of a security breach in the mortuary which was reported to the HTA. The trust has immediately responded to the incident and a series of actions have been implemented to tighten security arrangements and the designated individual is assured by these actions that the incident should not re-occur.

Contained in the annual report is a review of the recommendations from the Fuller Inquiry phase 2 and assurance around these recommendations that directly affect the trust, mortuary and the role of the designated individual. There are no concerns relating to the implementation of these findings in full and the trust is already compliant with the vast majority of the recommendations.

Key Risks
This report relates to these key Risks: • The maintenance of the trust Human Tissue Authority License for the making of a PM examination, removal of relevant material from the deceased and storage of bodies of the deceased and relevant material for use for scheduled purposes. License Number 12027. • Implementation of the recommendations from the Fuller inquiry phase 2 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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	No
Collaboration and Partnerships – We will work as one system and one organisation	No
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
16th April 2026	Patient Quality Safety Board (PQSB)	Mortuary Annual Report 2025/26	The report to go the Quality Committee
23rd April 2026	Divisional Quality Board	Mortuary Annual Report 2025/26	For noting
29th May 2026	Joint Quality and Safety Committee	Mortuary Annual Report 2025/26	The report to go to Group board for Directors Public

1	Narrative
1.1	**Introduction / Background** To be compliant with the Human Tissue Act 2004 certain activities in the mortuary require a license from the Human tissue authority (HTA). The trust was granted a license in April 2008 under the license number 12027. This license is for the following regulated activities: • Making of a post-mortem examination

	• Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation. • Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose. The Human Tissue Authority regulate licensed mortuaries against a rigorous set of standards as outlined in the Post-mortem Examination Licensing Standards and Guidance Version 3 September 2022. These standards cover all activities in the mortuary from procedures and processes, governance and quality systems, facilities, traceability, consent, and equipment. Inspections by the HTA are now carried out un-announced and through a variety of methods including site visits and evidential compliance assessments (ECA). ECA assessments are done remotely through a review of evidence submitted by the DI regarding compliance with specific areas of the standard. The mortuary is also assessed by the United Kingdom Accreditation Service as part of the accreditation of cellular pathology. This is to the international ISO standard 15189:2022 and is assessed against robust accreditation standards. As part of this the department of Cellular pathology which includes the mortuary is assessed on an annual basis to ensure continued compliance with the ISO15189:2022 standard. The latest inspection was conducted on the 3rd and 4th December 2025 which included the mortuary. The next surveillance UKAS inspection is scheduled in the first week of November 2026. Due to a significant incident in an NHS mortuary unrelated to the Trust, the Fuller inquiry was commissioned. After conducting a review of the relevant Trust in phase 1 of the inquiry and making recommendations relating solely to this organisation, the Fuller inquiry was expanded in phase 2 to cover the wider organisations relating to the care of deceased. The phase 2 report was published on the 15th of July 2025 and as part of this several recommendations were made relating specifically to NHS trusts. These were relating to the role of the designated individual, responsibilities at board level and security in the mortuary. As part of this an annual report into the mortuary was required at board level. ○
1.2	**Staffing and the Role of the Designated Individual** As part of the HTA license the trust has a nominated Designated Individual who has statutory duties in Section 18 of the Human Tissue Act 2004. They are to secure that: • the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity. • suitable practices are used in the course of carrying on that activity; and • the conditions of the licence are complied with. The designated Individual for the trust is Alistair Armstrong. Under the Human Tissue Act of 2004, the designated individual has **sole legal responsibility** for compliance with the HTA license number 12027. Whilst the Human Tissue Act currently places

	statutory responsibility with the Designated Individual, the Trust recognises the Fuller Inquiry's emphasis on strengthened board-level oversight and governance The designated individual in post is a HCPC registered Biomedical Scientist with over 25 years' experience as a registered professional in the field of Cellular Pathology, which includes Histopathology and mortuary activities. The DI's main role within the trust is the post of Cellular Pathology Service Manager which includes the mortuary and is direct line manager of the mortuary manager. As Cellular Pathology Service manager the DI is a senior manager in the division of Diagnostics and Clinical Support and attends divisional governance and management meetings. The DI reports to the trust quality committee on a twice-yearly basis and has a direct line of reporting to the Chief Medical Officer (HTA license holder) regarding any escalations. The mortuary is now fully established, and the establishment through a successful business case in 2025 has increased to 3 WTE mortuary technicians and 1 WTE mortuary manager. This ensures the mortuary has the resources to deal with the increasing demand for the service whilst meeting HTA and UKAS compliance standards. The mortuary technicians within the trust are highly trained and experienced and led by a mortuary manager who is full-time and is a fully qualified mortuary technician with a professional background in the field of mortuaries with over 30 years of experience. The mortuary manager is supported by the HTA DI who is also the direct line manager of the mortuary manager.
1.3	**Assurance around activities to ensure compliance in the mortuary with HTA standards.** The department has not had any inspection or evidential compliance assessments in 2025-26. The department as part of HTA compliance has significant governance in place. This includes ensuring that there are procedures covering all activities under the license, all procedures and HTA reportable categories in the mortuary are risk assessed, and improvement actions are implemented. All staff under the license are fully trained appropriately and undergo annual competency assessments which are not limited to just mortuary technicians but porters, funeral directors and any other staff who work under the license. There is a comprehensive audit strategy that covers all activities in the mortuary including security. In assurance of these activities: • The mortuary has procedures in place for all activities; these have all be reviewed as appropriate and are all within review date and implemented by mortuary staff. • All mortuary staff, porters and funeral directors have been trained as appropriate and have been competently assessed in the activities they conduct. • Security arrangements are in place and are monitored and audited monthly and this schedule is up to date. • Daily security checks are in place from January 2026 • All activities regarding the mortuary processes and any areas of risk have been risk assessed and are in date including HTA reportable incident categories. All identified improvement actions have been undertaken.

- The comprehensive audit schedule for the mortuary covers all activities and is within the planned schedule including the implementation of any identified actions.
- Equipment and facilities are up to date and in good condition.
- Mortuary has a large storage capacity of 148 spaces and has arrangements with other regional mortuaries for mutual aid in the event of any fridge/freezer issues or in the unlikely event demand outstrips capacity.

The mortuary unfortunately had to report an HTA reportable incident (HTARI) in December 2025 due to a serious security breach and this is discussed in section 1.5 regarding serious incidents and security report.

The coroner is very satisfied with the service the mortuary is providing and has raised no current concerns with the service.

1.4 Assurance relating to Accreditation to the international standard ISO15189:2022 by UKAS

The mortuary was assessed by UKAS in December 2025 against the very robust international standards ISO15189:2022. The inspection went very well due to the dedication of the mortuary team, and four findings were raised against the mortuary. These are detailed below with the corrective action implemented.

- There is no CCTV and/or agreed date of implementation of CCTV in the foyer room at the porter entrance to the mortuary/body store. – **This has now been installed as part of security improvements**
- Witnessed lone working risk assessment RA183 which includes installation of 'panic' alarm. Staff are not aware and do not use the panic alarm for the lone worker- **The risk assessment has been reviewed, and a panic alarm has been installed regarding viewings when a mortuary technician may be alone with relatives in a possible distressing situation.**
- There is no evidence of metrological calibration to ISO 17025 of temperature monitoring system (Comark) of fridges and freezers in body store – **This is now in place and all future preventative maintenance visits will include calibration to ISO 17025.**
- There is no evidence of reflective/objective evidence (questions and answers) of learning undertaken in competency assessments in the lab and mortuary – **Competency assessment process has been reviewed and improved to include reflective/objective evidence.**

All evidence regarding these four findings relating to the mortuary have been implemented and submitted to UKAS and all the findings have been closed.

1.5 Review of Serious incidents and Security report

The trust had one serious incident in 2025/26. This was related to a serious security breach on the 21st of December 2025. The incident was escalated by the HTA DI to the divisional management team upon discovery on the 22nd of December 2025 and further escalated in meetings with the board members on the 23rd of December 2025. There was no harm or interference with the deceased, but unauthorised access was identified. The incident was reported by the Designated Individual to the HTA as a HTA reportable incident (HTARI) under the category of serious security breach on the 23rd of

December 2025. This was the first time the mortuary has had to report a security breach since the implementation of the revised HTA standards in 2022 relating to security and before this there were no reported security incidents.

A review was conducted into the incident and submitted to the HTA including recommended improvement actions to reduce the risk of a reoccurrence of this type of incident.

Although there is a local mortuary policy and security risk assessments, there is no specific formal Trust policy in place regarding the requirements for authorised access and the specified approved reasons for accessing the mortuary including out of hours access. To strengthen this the managers on-call handbook has also been updated with information relating to mortuary security and access out of hours, along with further communication to staff.

The review also identified that security could be improved within the mortuary despite regular security access CCTV audits.

Immediate action was taken, and signage is now displayed on the mortuary porters entrance highlighting the area is restricted access and only authorised staff can enter. A further daily security check has been implemented, and the mortuary staff review the out of hours swipe card access on a daily basis.

With implementation of these additional security measures the mortuary security procedure [**MSOP33 Mortuary security procedure**] and risk assessment **RA184** was reviewed to document these changes.

Following this incident there are monthly reviews as to who has access to the mortuary, as a preventative measure.

All the actions identified in the incident review have been completed apart from the implementation of the trust policy regarding mortuary security which is currently out to consultation as part of the governance process for the implementation of new trust policies and procedures.

Since the incident there have been no further detected security issues relating to the mortuary both via detailed monthly security audits and through the daily checks of overnight out of hours access.

The incident review report has been submitted to the HTA as per the HTARI protocol.

Review of security audits
The mortuary undertakes monthly security audits. This monthly audit comprised of a review of the swipe card access data during a defined period in the month and a review of the activity associated with each access and the type of staff accessing the mortuary. This also included a review of the CCTV from the entrances to the mortuary and body storage areas for each activity of swipe card access to ensure all access was appropriate. There was a 100% compliance with conducting these audits each month. In the 12 monthly audits there was no unauthorised access or access for an unscheduled purpose and all access in the audit periods was linked to the delivery of a deceased. In the audits there was a trend of a few occasions when one of the two porters had not swiped out of the mortuary as per protocol. This was identified and action taken with the portering managers to remind staff to always swipe in and swipe

	out for both porters when access the mortuary. There are also visible signs at exit points to remind staff to swipe out. In the new daily checks of swipe card access data out of hours in place since the security breach in December 2025 no inappropriate access has been identified and there was no access other than access to deliver a deceased to the mortuary. **Further improvements in security** New upgraded security cameras have been installed in the mortuary in 2026 to cover all areas and make the mortuary fully compliant with the Fuller recommendations. The CCTV system has been connected to the main hospital CCTV system to ensure appropriate control and ensure security footage is secure. CCTV has also been upgraded at the body store at Clatterbridge hospital.
1.6	**Review of Fuller inquiry Recommendations – Phase 2** Phase 2 of the Fuller Inquiry included NHS hospitals, independent hospitals, medical education settings, hospices, ambulances, local authority mortuaries and body stores, care homes, and the funeral sector. The Inquiry also considered how different faith organisations safeguard the security and dignity of the deceased when facilitating burials or funerary ceremonies. The phase 2 report was published on the 15th of July 2025 and as part of this several recommendations were made relating specifically to NHS trusts. These were relating to the role of the designated individual, responsibilities at board level and security in the mortuary. The recommendations specific to the trust which relate directly to the mortuary and the current position reading the recommendations are detailed below. Section 1.5 highlights those recommendations that are specific to the board. **Recommendation 1**: All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify any unauthorised access to the facility. • the strength and effectiveness of barriers to prevent unauthorised access to the facilities. • the systems in place to identify any access to deceased people for unauthorised purposes; and • how CCTV is used, including its monitoring and any audits undertaken. **Response**: The mortuary already has risk assessments relating to security in the mortuary as required by HTA standards. There are processes in place to restrict access to the mortuary via the Paxton swipe card system and the list of those granted access is reviewed regularly. All access must be authorised by either the Mortuary manager or the HTA designated Individual. The mortuary manager audits access to the mortuary and links this to reviewing the CCTV footage to ensure the access is for an authorised scheduled purpose. Any detected unauthorised access would be reported to the HTA as a HTA reportable incident (HTARI) under the category of security breach

	and be fully investigated. The trust has only had one incident of this nature in December 2025. **Recommendation 2:** All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area, and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges. **Response**: The mortuary has CCTV covering all entrances into the mortuary and covering all the doors of body fridges. The mortuary does not have double-ended fridges that open into the post-mortem room so there is no requirement to install CCTV in the post-mortem room. CCTV has been installed in the reception area and so it is covering the entrances from the inside specifically the funeral director entrance as the hospital entrance where the deceased are delivered to the mortuary are already covered. New upgraded security cameras have been installed, and the CCTV system is connected to the main hospital CCTV system to ensure appropriate control and ensure security footage is secure. CCTV is also installed at the body store at Clatterbridge hospital. **Recommendation 3:** All NHS trusts should routinely audit the access data of all facilities used to store deceased people. **Response**: The trust is already compliant with this recommendation and is auditing access data of facilities used to store deceased and has been passed compliant in this area by the HTA during an evidential assessment relating to the security standards. **Recommendation 4:** The practice of using shared electronic swipe cards for specific staff groups should cease immediately. **Response**: The trust does not use shared electronic swipe card access; access is via staff badges only which has the swipe card access installed. **Recommendation 5:** All NHS trusts should consider putting systemic operational barriers in place that prevent the security and dignity of deceased people from being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons. **Response**: The mortuary has an area to place phones and cameras to prevent the security and dignity of the deceased being compromised. The trust has a policy in place for no filming are taking pictures in a clinical area and any abuse of this detected through security audits would be escalated for appropriate management. **Recommendation 6:** All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.

Response: The mortuary and designated individual take every breach of security seriously and any breach of security is mandated to be reported the HTA as a HTA reportable incident of which the designated individual has a legal responsibility to undertake this. As part of this a full investigation would be required with the assistance from the trust security manager and would be reported through the trust serious incident process. This has been evidenced by the recent security breach.

Recommendation 8: All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.

Response: The trust is compliant with this recommendation, and all exits have swipe out points to leave the mortuary at both Arrowe park hospital and at Clatterbridge body store.

Recommendation 9: All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.

Response: The mortuary manager and HTA designated individual review monthly as part of auditing, the lists of those with access to the mortuary and ensure staff with access is appropriate.

Recommendation 10: NHS trusts should ensure that Designated Individuals have enough time and resources to fulfil their responsibilities, including time for learning and development.

Response: The designated Individual is the Cellular Pathology Service Manager who has over 10 years of experience in working in the sector specifically around HTA compliance. The designated individual has three years' experience in the role of HTA DI. The DI has support from the trust, but it is important to ensure that the DI has protected time to undertake this role given the multiple pressures upon their time.

Recommendation 11: NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.

Response: The role of the DI is documented in this paper including legal responsibility and is documented in all committee reports produced by the designated individual.

Recommendation 12: NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.

Response: The designated individual attends divisional quality board, the trust Patient Safety and Quality Board and Quality committee. The Di also reports directly to the license holder who is the Chief Medical Officer for the organisation.

Recommendation 13: A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager.

	Recommendation 14: NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements. **Response for both recommendations**: The mortuary manager is full time and is a fully qualified mortuary technician with a professional background in the mortuary with over 30 years of experience. The mortuary manager is supported by the HTA DI who is also the direct line manager of the mortuary manager. Establishment has been increased in the mortuary in the last 12 months to ensure adequate resources are available.
1.7	**Fuller phase 2 recommendations relating to the board.** Recommendations 15-20 are specific to executive board level and require consideration by the board for implementation. Recommendation seventeen is not applicable to the Wirral University Teaching Hospital as the trust does not currently have any temporary facilities for the storage and care of the deceased people. **Recommendation 15**: All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: • staffing matters. • security incidents. • all serious incidents. • Human Tissue Authority reports (where applicable); and • all security audits, including audits of access and any access breaches. **Recommendation 16**: Trust boards should assure themselves that the recommendations in this Report have been implemented **Recommendation 17**: Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people. **Recommendation 18**: Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements. **Recommendation 19**: NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance. **Recommendation 20**: The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores.

2	**Implications**

2.1	**Patients** • No implications for patients except for the implementation of the Fuller Inquiry Phase 2 recommendations to ensure the dignity of deceased in protected
2.2	**People** • No implications to people
2.3	**Finance** • No implications to finance
2.4	**Compliance** • The assessment of the mortuary for compliance with the international standard ISO15189:2022 demonstrated the mortuaries continued compliance with robust regulatory and accreditation standards therefore there are no implications identified in this report in relation to regulatory standards. • There are implications in this report regarding the implementation of the Fuller Inquiry Phase 2 recommendations. These implications relate to recommendations 15-20 which are board level recommendations that require consideration.

Group Board of Directors in Public **Item 24**

03 June 2026

Title	WUTH Registers of Interest and Hospitality Annual Update
Area Lead	Ali Hughes, Joint Director of Corporate Affairs and Communications
Author	Cate Herbert, Board Secretary

Purpose of the Report and Recommendation	
Report For	Information

The purpose of this report is to provide the Committee with year-end updates on the register of interests, the register of gifts and hospitality.

It is recommended that the Board

- Notes the Register of Interests at Appendix 1, and the Register of Gifts and Hospitality at Appendix 2.

Key Points to Note

As of 31 March, there were 1672 staff who fell within the categories outlined in the Trust policy and 1444 of those have completed their annual declaration/review. This is 86% of those required which remains better than the sector best practice figure of 85%.

Key Risks

This report relates to these key risks:

- Upholding standards of transparency and adhering to the standards set by NHS England to safeguard taxpayer monies.

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	No
Our People – We will nurture an inclusive, compassionate culture where people thrive	No
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	No

Collaboration and Partnerships – We will work as one system and one organisation	No
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
April 2026	Audit and Risk Committee	WUTH Registers of Interest and Hospitality Annual Update	Note
October 2025	Audit and Risk Committee	Managing Conflicts of Interest Policy	Approval

1	Narrative
1.1	**Registers of Interests End of Year Update** The Trust's Managing Conflicts of Interest Policy was reviewed and approved in October 2025 by the WUTH Audit and Risk Committee. As set out in that policy, that Committee has a responsibility of oversight for the register of interests and the register of gifts and hospitality. As of 31 March, there were 1672 staff who fell within the categories outlined in the Trust policy and 1444 of those completed their annual declaration/review. This is 86% of those required which remains better than the sector best practice figure of 85%. The current list of Board and Senior Directors' Register of Interest is attached at Appendix 1. This will be provided to the Group Board in June and uploaded to the WUTH website following then.
1.2	**Registers of Gifts and Hospitality End of Year Update** The Managing Conflicts of Interest Policy lays out the requirements for declaring gifts and hospitality, and these are set in line with the model policy requirements. Gifts should be declared if valued over £50, and hospitality over £25 should be declared, with any hospitality over £75 requiring manager approval. The Trust generally advises that gifts should be refused or donated to charity. Whilst the nature of gifts and hospitality is less straightforward than the register of interests, the team ensure regular communications are included in the bulletins and briefings sent out to staff to remind them to declare gifts and hospitality. This is escalated around key points of the year, such as Christmas and year end. There were no gifts declared in year above the £50 mark. The Register is attached at Appendix 2.

2	Implications
2.1	**Patients** • No direct implications on patients

2.2	**People** • This report applies to all staff (gifts and hospitality), and those individuals identified in the Managing Conflicts of Interest policy.
2.3	**Finance** • No direct financial implications.
2.4	**Compliance** • The Trust has an obligation to manage conflicts of interest and gifts/hospitality in a transparent way, with safeguards in place around the use of taxpayer funds. This is set out both in guidance from NHS England, and in the Trust's policies.

Interest Type	Employee	Date Arose	Date Ended	Role	Interest Description (Abbreviated)	Provider	Approval	Approver
Loyalty Interests	Alison Hughes	17/11/2025		Joint Director of Corporate Affairs & Communications	I am Joint Director of Corporate Affairs and Communications for WUTH and WCHC	Wirral Community Health and Care	YES	Janelle Holmes
Outside Employment	Chris Bentley	13/08/2025		Non-Executive Director	Consulting work. Established 01/12/2019.	Professor Chris Bentley Consulting Ltd	YES	Stephen Igoe
Loyalty Interests	Chris Bentley	13/08/2025		Non-Executive Director	the programme involves sight-saving pogrammes in several low income countries and reviews and approves promising clinical treatment and public health programmes. Co	Orbis Programme and Medical Advisory Committee	YES	Stephen Igoe
Outside Employment	Chris Bentley	13/08/2025		Non-Executive Director	Visiting lecturer teaching on public health modules – Liverpool University. commenced 2013.	Liverpool University	YES	Stephen Igoe
Outside Employment	Chris Bentley	13/08/2025		Non-Executive Director	Visiting lecturer teaching on public health modules – Sheffield University. Commenced 2009	Sheffield University	YES	Stephen Igoe
Loyalty Interests	Chris Bentley	13/08/2025		Non-Executive Director	Chairman of Trustees – Sheffield Health International Partnerships – small charity providing links between Sheffield NHS/social care and the developing world, particularly I	Sheffield Health International Partnerships	YES	Stephen Igoe
Loyalty Interests	Chris Bentley	13/08/2025		Non-Executive Director	Member of the National Advisory Committee on Resource Allocation, and Chair of the Technical Advisory Group DHSC/NHS England. Commenced 2008	DHSC/NHS England	YES	Stephen Igoe
Loyalty Interests	Chris Bentley	13/08/2025		Non-Executive Director	Joint NED for WUTH and WCHC.	WUTH/WCHC	YES	Stephen Igoe
Loyalty Interests	Deborah Smith	21/10/2024		Joint Chief People Officer	Debs is Joint Chief People Officer for Wirral Community Health and Care and Wirral University Teaching hospital	Wirral Community Health and Care	YES	Janelle Holmes
Outside Employment	Deborah Smith	01/04/2026		Joint Chief People Officer	Joint Admin Director role. This is an unpaid voluntary position, which is undertaken in my own time. RCRD is a limited company.	Rainy City Roller Derby	YES	Janelle Holmes
Loyalty Interests	Haris Sultan	01/04/2025		Non-Executive Director	Treasurer and Trustee of Liverpool Medical Student Society	Liverpool Medical Student Society	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	16/07/2025		Non-Executive Director	Advisory Board Member at the REAL Supply Research Unit (Centre of Health Economics University of York). Commenced Feb 2024.	REAL Supply Research Unit (Centre of Health Economics University of Yo	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	16/07/2025		Non-Executive Director	Fellow of the Royal Society of Arts, Manufactures and Commerce. Commenced October 2023.	Royal Society of Arts, Manufactures and Commerce	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	01/01/2025		Non-Executive Director	Strategy Consultant working with Modality Partnership	Modality Partnership	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	01/04/2025		Non-Executive Director	BME Leadership Network Steering Group Member – NHS Confederation	NHS Confederation	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	01/09/2025		Non-Executive Director	Medical Student at the University of Liverpool. Commenced September 2021	University of Liverpool	YES	Stephen Igoe
Loyalty Interests	Haris Sultan	16/01/2026		Non-Executive Director	University of Oxford PPI co-applicant - Programme Development Grant Data-driven equity monitoring for equitable access, outcomes, and experience in NHS hospitals	University of Oxford	YES	Stephen Igoe
Loyalty Interests	Hayley Kendall	17/11/2025		Joint Exec Managing Director	I am Joint Executive Managing Director for both WUTH and WCHC.	Wirral Community Health and Care	YES	Janelle Holmes
Loyalty Interests	Janelle Holmes	11/11/2024		Joint Chief Executive Officer	I am the joint CEO of WUTH & WCHC	Wirral Community Health & Care Trust (WCHC)	YES	David Henshaw
Loyalty Interests	Joanne Chwalko	17/11/2025		Joint Chief Integration & Partnerships Officer	I am Joint Chief Integration and Partnerships Officer for both WUTH and WCHC	Wirral Community Health and Care	YES	Janelle Holmes
Outside Employment	Lesley Davies	01/06/2022		Non-Executive Director	Education consultancy	Seymour Place Associates Limited	YES	Catherine Herbert
Outside Employment	Lesley Davies	01/03/2023		Non-Executive Director	National Leader for Governance	Department for Education	YES	David Henshaw
Loyalty Interests	Lesley Davies	09/01/2025		Non-Executive Director	Chair	Cheshire College South and West	YES	David Henshaw
Loyalty Interests	Lesley Davies	11/08/2025		Non-Executive Director	I am a Joint NED for WUTH and WCHC	Wirral Community Health and Care	YES	Stephen Igoe
Outside Employment	Mark Chidgey	07/04/2025		Joint Chief Finance Officer	Ad-hoc / occasional paid lecturing and education duties in support of healthcare courses for example the Elizabeth Garrett Anderson course. My input is minimal and proba	Alliance MBS Business School - The University of Manchester	YES	Janelle Holmes
Loyalty Interests	Mark Chidgey	17/11/2025		Joint Chief Finance Officer	I am Joint Chief Finance Officer for both WUTH and WCHC since 17/11/2025	Wirral Community Health and Care	YES	Janelle Holmes
Loyalty Interests	Matthew Swanborough	01/09/2021		Joint Chief Strategy Officer	Partner employed in management position at Manchester University NHS Foundation Trust	NHS	N/A	
Loyalty Interests	Matthew Swanborough	17/11/2025		Joint Chief Strategy Officer	I am Joint Chief Strategy Officer for WCHC and WUTH	Wirral Community Health and Care	YES	Janelle Holmes
Loyalty Interests	Meredydd David	20/06/2025		Non-Executive Director	Deputy lieutenant, Cheshire Lieutenancy (Date commenced: 12 December 2017)	Cheshire Lieutenancy	YES	Stephen Igoe
Loyalty Interests	Meredydd David	01/06/2025		Non-Executive Director	Chair of Governors Furness College Cumbria	Furness College Cumbria	YES	Stephen Igoe
Loyalty Interests	Meredydd David	20/06/2025		Non-Executive Director	Joint NED for WUTH and WCHC	WUTH/WCHC	YES	Stephen Igoe
Loyalty Interests	Nicola Stevenson	22/03/2020		Joint Chief Medical Director	Spouse is Consultant Intensivist at LUFT	Liverpool University Hospitals NHS Foundation Trust	YES	David McGovern
Loyalty Interests	Nicola Stevenson	20/10/2025		Joint Chief Medical Director	Spouse is a member of the Green Party	Green Party	YES	Janelle Holmes
Loyalty Interests	Nicola Stevenson	17/11/2025		Joint Chief Medical Director	I am Joint Chief Medical Officer for WUTH and WCHC.	Wirral Community Health and Care	YES	Janelle Holmes
Outside Employment	Stephen Igoe	01/04/2025		Chairman	NED and Finance Committee chair	Lancashire ICB	YES	David Henshaw
Outside Employment	Stephen Igoe	01/04/2025		Chairman	NED from April 2025, Joint Chair from 3rd November 2025	Wirral Community Trust	YES	Janelle Holmes
Loyalty Interests	Steven Ryan	17/10/2025		Non-Executive Director	I am a joint NED for WCHC and WUTH	Wirral Community Health and Care	YES	Stephen Igoe
Outside Employment	Lisa Greenhalgh	22/09/2022		Non-Executive Director	I am the Chair of the Remunerations Committee and member of the Audit and Risk Committee	Torus Group	Yes	Stephen Igoe
Outside Employment	Lisa Greenhalgh	01/09/2021		Credit Committee Member	Part of the Committee that approves loans of between £250k and £1.6m that support the UK's best innovative SME businesses.	Innovate UK	YES	Stephen Igoe
Outside Employment	Lisa Greenhalgh	01/03/2026		Non-Executive Director	NED at Enveco Waste Management Ltd	Enveco Waste Management Ltd	YES	Stephen Igoe
Outside Employment	Lisa Greenhalgh	01/08/2019		Director	Consulting work	LSG Advisory Ltd	YES	Stephen Igoe
Outside Employment	Chris Douglas	12/01/2026		Former CNO	Employed by C&M ICB until 12th July 2026	C&M ICB	Yes	Janelle Holmes

Date Declared	Interest Type	Employee	Role	Date hospitality provid	Hospitality provider name	Provider Type	Interest Description (Abbreviated)	Value £'s	Declined	Senior Approval obtained	Authorised by
13/04/2026	Hospitality	Elizabeth Jones	Consultant Haematologist	13/04/2026	Attendance at BSH Conference	Commercial Company	Roche - paid for my attendance at the BSH conferencecost for member approx £200Conference is sponsored bu multiple pharmacy companies	200	No	No	
12/04/2026	Hospitality	Heidar Zafarani Zadeh	Consultant	01/04/2026	Bayer	Commercial Company	Cardiovascular Summit 2025 Bayer's Cardiovascular Summit took place in London on the 3rd and 4th of October 2025. Designed to offer education including expert perspectives	250	No	No	Approved Study leave
11/04/2026	Hospitality	Lucy Williams	Clinical Lead - Renal	01/04/2026	Stanningley Pharma Limited	Commercial Company	Sponsorship for UK Kidney Week Conference in Harrogate 10/3/26 -12/3/26	554.8	No	Yes	AHP Education Committee
09/04/2026	Hospitality	Denise Langhor	Consultant	09/04/2026	BMA	Other	Work for BMA at times involves travel to London. the BMA will pay for train travel and accommodation if required to stay overnight. Amount variable depending on whether in a	2000	No	No	
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	25/11/2025	The Kings Fund	Charity	Panel Chair at the Creating The Healthiest Generation Of Children Conferences - Expenses were for the train to London	100	No	Yes	
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	12/02/2026	Healthcare Excellence Through Technology (HETT) Leaders Summit	Commercial Company	Panel speaker at the HETT Leaders Summit in Leeds - expenses were reimbursement for the train to/from the conference	40	No	No	
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	12/11/2025	Northern, Yorkshire and Humberside Digital and Informatics Forum	NHS Organisation	Keynote speaker at the NYHDIF Conference - accommodation and travel costs to the conference in york	130	No	Yes	
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	11/11/2025	NHS Providers	Charity	2 day NHS Providers conference Tickets - I was a speaker at the conference therefore my tickets were free	595	No	Yes	Sir David Henshaw
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	11/11/2025	NHS Providers	Charity	Hotel and Trains to Manchester for NHS Providers Conference as I was speaking on the main stage - £100 Hotel and £10 Train	110	No	Yes	Alison Hughes
25/02/2026	Hospitality	Haris Sultan	Non-Executive Director	16/10/2025	Asian Professionals' National Alliance	Other	APNA NHS Conference - Attended the Chairs and CEO Dinner the night before the conference	40	No	Yes	Alison Hughes
19/02/2026	Hospitality	Mohammed Alam	Consultant	12/02/2026	Gedeon Richter	Commercial Company	Catering & accomodation for NW cons meeting planning meeting	150	No	No	
11/11/2025	Hospitality	Matthew Swanborough	Chief Strategy Officer	11/11/2025	Virginia Mason Institute	Commercial Company	Ticket/entry to NHS Providers Conference in Manchester UK, on Wednesday 12th November 2025, provided by Virginia Mason Institute as an event sponsor	410	No	Yes	Chief Executive
22/07/2025	Hospitality	Steven Keogh	Maintenance Manager	15/07/2025	IMMED	Supplier	The trust have purchased new washer/disinfectors for the sterile services project at Arrowe Park Hospital. the machines had been built in the steelco factory and before the trus	500	No	Yes	Peter Comyns Head of Estates
09/07/2025	Hospitality	Sarah Fagan	Trust Decontamination Lead	26/06/2025	IMMED Decontamination Specialists	Supplier	To formally verify that the newly purchased Steelco washer/disinfectors meet the agreed specifications and performance requirements prior to delivery and installation at the St	500	No	Yes	Project team
28/04/2025	Hospitality	Pranshu Agrawal	Consultant	12/06/2024	Enovis - Lima	Supplier	This was an educational event - a cadaveric course organised by the above mentioned company which we use for a certain type of procedure in the trust for a long time. The air	150	No	No	
22/04/2025	Hospitality	Claire Greene	Healthcare Scientist - Professional Manager	11/03/2025	Biomeriuex	Supplier	BIOMÉRIEUX Scientific and medical Meeting (BSAM) 2025 Lisbon, Portugal (2 nights), A relevant clinical and scientific meeting with multinational guest speakers discussing topics	619.54	No	Yes	Nadia duggan
22/04/2025	Hospitality	Nadia Duggan	Healthcare Scientist - Professional Manager	11/03/2025	Biomerieux	Supplier	BIOMÉRIEUX Scientific And Medical (BSAM) Meeting 2025	619.54	No	Yes	Alex Warrington
15/04/2025	Hospitality	Benjamin Twist	Consultant	10/02/2025	Intuitive	Supplier	Travel, accommodation and 1 x evening meal provided to allow direct theatre observation of a well established robotic theatre	500	No	Yes	
15/04/2025	Hospitality	Patrick Rosser	Consultant	09/02/2025	Intuitive	Commercial Company	Travel and accommodation to observe robotic surgery in London	400	No	No	
15/04/2025	Hospitality	Denise Langhor	Consultant	15/04/2025	BMA	Other	Role at BMA involves travel to London and sometimes overnight accommodation. This would typically be approximately £2000 a year but may be more or less depending on cor	2000	No	No	
08/04/2025	Hospitality	Ranjit Dasgupta	Consultant Haematologist	08/04/2025	Jazz pharma	Commercial Company	hospitality for attending British society of haematology annual conference on 27/4 to 29/4 2025	900	No	No	

Group Board of Directors in Public **Item 25**

03 June 2026

Title	Modern Slavery Statements
Area Lead	Ali Hughes, Joint Director of Corporate Affairs & Communications
Author	Cate Herbert, Board Secretary

Purpose of the Report and Recommendation	
Report For	Approval

It is recommended that the Board:

- Approves the WUTH Modern Slavery Statement; and
- Approves the WCHC Modern Slavery Statement

Key Points to Note

The WUTH and WCHC Modern Slavery Statements are appended to this report. This year's statements have been updated in discussion with the Joint Director of Corporate Affairs & Communications and the Assistant Director of Finance – Head of Procurement.

Following Board approval, both statements will be signed by the Chair and the CEO and published on the Trust websites.

Key Risks

This report relates to these key risks:

- BAF Risk 7 – Failure to comply with relevant codes of governance, regulation and legislative requirements

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 strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes

Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	Yes

Governance journey
This is an annual report to the Board.

1	Narrative
1.1	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The requirement for an annual statement is set out in Section 54 of the Act, specifically addressing the requirement for transparency in the supply chain. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The Act requires that the statement is approved annually by the Board of Directors. The WUTH Modern Slavery Statement is appendix 1 and the WCHC Modern Slavery Statement is appendix 2.

2	Implications
2.1	**Patients** • No direct impact on patients
2.2	**People** • No direct impact on staff, though ensuring that modern slavery does not exist throughout the supply chain supports an ethical approach and the fair treatment of everyone impacted by the Trust.
2.3	**Finance** • No financial implications
2.4	**Compliance** • Compliance with the requirements of the Modern Slavery Act 2015 and the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025.

Appendix 1

Modern Slavery Statement

In accordance with the Modern Slavery Act 2015, Wirral University Teaching Hospital NHS Foundation Trust makes the following statement:

Section 54 of the Modern Slavery Act 2015 requires organisations to set out the steps they have taken during the financial year to ensure that slavery and human trafficking are not taking place in any part of their business or supply chains.
The aim of this statement is to demonstrate that the Trust has appropriate arrangements in place and is taking all reasonable steps to prevent modern slavery and human trafficking across its operations and supply chains.

Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high-quality acute care services. Its workforce of more than 6,200 staff serves a population of over 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West. The Trust operates from two main hospital sites, Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebington, and also provides outpatient services from community locations including St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

The Trust has well-established and robust recruitment and vetting procedures and seeks to ensure that its suppliers operate in accordance with the requirements of the Modern Slavery Act 2015.

The Trust has a total non-pay spend of c.£160m on goods, equipment and services. The Trust aims to achieve value for money and promote social value through its contracting and purchasing activity, and the effective use of this spend contributes significantly to the quality of the patient environment and patient care.

The Trust supports the eradication of modern slavery through its procurement procedures and processes and is clear that it expects all potential suppliers to comply with the Modern Slavery Act 2015. In addition, the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 require public bodies procuring goods and services for the purposes of the health service in England to assess the risk of modern slavery in their supply chains and to take reasonable and proportionate steps to mitigate that risk throughout the commercial lifecycle, including when designing procurements, awarding contracts and managing contracts.

The Trust recognises that, whilst legislation provides a framework for addressing incidents of modern slavery, there is also an opportunity to use its purchasing power to help prevent, identify and manage these risks within its supply chain by embedding appropriate controls within procurement activity and supplier management.

The Trust has already adopted a number of measures, including:

- the use of public sector frameworks where there is clear oversight of, and monitoring for, modern slavery risk within the supply chain;
- the mandatory exclusion of any bidder convicted of a human trafficking offence, where applicable under procurement legislation; and

- the inclusion of contractual terms and conditions requiring contractors to support the eradication of slavery and human trafficking within their business and supply chains.

The Trust recognises that these measures will continue to be strengthened in line with the regulations and relevant national guidance, including Procurement Policy Note PPN02/23 and Procurement Policy Note PPN009, and to reflect the requirements of the Procurement Act 2023 and the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025. This includes ensuring that:

- modern slavery risk is considered early in the procurement process, including through preliminary market engagement where appropriate;
- suppliers and, where relevant, their supply chains are subject to proportionate risk assessment and due diligence;
- the Trust maintains awareness of sector-specific and global modern slavery risks in higher-risk categories of spend;
- enhanced due diligence is undertaken for procurements assessed as higher risk;
- modern slavery risks are actively managed within existing contracts and supplier relationships; and
- procurement staff receive appropriate training so that they can recognise, assess and manage modern slavery risk consistently and effectively.

The Trust’s approach will be monitored and reviewed in line with the provisions of its Procurement Strategy.

Appendix 2

Modern Slavery Act Statement

In accordance with the Modern Slavery Act 2015, Wirral Community Health and Care NHS Foundation Trust makes the following statement:

We are committed to having effective practices to prevent slavery and human trafficking in all parts of our organisation and supply chains. Our policies, procedures and procurement practices are designed to reduce the risk of modern slavery and to support early identification, escalation and appropriate action where concerns arise. We provide healthcare services to residents across Wirral. Our services are predominantly local and community based, delivered from around 60 sites across Wirral, including our main clinical bases at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey. We are also commissioned to deliver some community services in West Cheshire and provide children's and young people's services in Cheshire East, Knowsley and St Helens, including health visiting, school nursing, family nurse partnership and breastfeeding support services.

We have inpatient beds within our Community Integrated Care Centre, providing a rehabilitation pathway for patients discharged from hospital. We also provide in-reach support to the local acute trust and to residential and nursing homes across Wirral.

In support of this commitment, the Trust will:

- Comply with the Modern Slavery Act 2015, the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 and associated NHS guidance;
- Take a risk-based and proportionate approach to identifying, assessing and managing modern slavery risks in the procurement of goods and services for the purposes of the health service in England;
- Consider modern slavery risks when designing procurements, evaluating suppliers, setting contractual requirements and managing contracts throughout their lifecycle;
- Make suppliers and service providers aware of our expectations and require them to act lawfully, transparently and responsibly within their operations and supply chains;
- Promote workforce awareness through safeguarding and procurement processes, training and reporting routes; and
- Escalate and respond appropriately to any actual or suspected incidents or indicators of slavery or human trafficking.

The Trust has robust recruitment policies and procedures which are aligned with NHS Employment Check Standards and Care Quality Commission requirements. Controls are in place to support compliance with employment legislation, with regular audit, oversight and review through relevant Trust governance arrangements.

Modern slavery is reflected within the Trust’s safeguarding policies and mandatory training arrangements. Relevant staff receive training through safeguarding programmes, including e-learning, and additional training is provided where roles involve work with children, young people or vulnerable adults. Compliance is monitored through local governance processes and overseen by the Trust Board.

The Trust incorporates modern slavery considerations into its procurement and contract management activity. In line with the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, the Trust will assess modern slavery risk in procurements for goods and services used for the purposes of the health service in England and will take reasonable and proportionate steps to mitigate identified risks throughout the commercial lifecycle.

Where appropriate, this includes setting clear supplier expectations, using contractual provisions and due diligence processes, and keeping risks under review during contract delivery. Suppliers are expected to comply with all applicable law and guidance, to act promptly where risks are identified within their supply chains, and to notify the Trust without delay of any actual or suspected incidents of slavery or human trafficking relevant to the goods or services supplied.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and reflects the Trust’s approach to meeting the requirements of the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025.

It constitutes the Trust’s slavery and human trafficking statement for the financial year ending 31 March 2027.