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| **Meeting** | Group Board of Directors in Public |
| **Date** | Wednesday 4 November |
| **Time** | 09:00 |
| **Location** | Hybrid |

| Agenda Item | | Lead | Presenter | Action |
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| 1. | Welcome and Apologies for Absence | Steve Igoe, Chair | | Note |
| 2. | Declarations of Interest | Steve Igoe, Chair | | Note |
| 3. | Minutes of the Previous Meeting | Steve Igoe, Chair | | Approve |
| | 3.1 Group Board of Directors in Public Minutes – 2 September | | | |
| **WUTH and WCHC Statutory Board Minutes** | | | | |
| | 3.2 WUTH Board of Directors in Public Minutes – 2 September | | | Approve |
| 4. | Action Log | Steve Igoe, Chair | | Note |
| **Standing Items** | | | | |
| 5. | Patient Story | Gail Meers, Director of Nursing | | Note |
| 6. | Chair Update – **Verbal** | Steve Igoe, Chair | | Note |
| 7. | Chief Executive Officer Report | Janelle Holmes, Chief Executive Officer | | Note |
| 8. | Integrated Performance Report | Executive Directors | | Note |
| 9. | Board Assurance Framework (BAF) | Ali Hughes, Director of Corporate Affairs & Communications | | Approve |
| 10. | Lead Governors Report – **Verbal** | Tony Cragg & Eileen Hume, WUTH & WCHC Lead Governors | | Note |
| **Joint Committee Chairs Reports** | | | | |
| 11. | Joint Quality and Safety Committee | Professor Chris Bentley | | Assure |
| 12. | Joint Digital Committee | Haris Sultan | | Assure |
| 13. | Joint Finance and Performance Committee | Meredydd David | | Assure |

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| 14. | Joint People Committee – **Verbal** | Lesley Davies | | Assure |

## WUTH and WCHC Statutory Board Committee Chairs Reports

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| 15. | WUTH Charitable Funds Committee – **Verbal** | Lesley Davies | | Assure |
| 16. | WUTH Audit and Risk Committee | Lisa Greenhalgh | | Assure |
| 17. | WCHC Audit and Risk Committee | Lisa Greenhalgh | | Assure |

## Regulatory Reports

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| 18. | WUTH Safeguarding and Complex Care Annual Report 2025/26 | Gail Meers, Director of Nursing | | Assure |
| 19. | WCHC Safeguarding Annual Report 2025/26 | Gail Meers, Director of Nursing | | Assure |
| 20. | WUTH Complaints Annual Report 2025/26 | Gail Meers, Director of Nursing | | Assure |
| 21. | WCHC Complaints Annual Report 2025/26 | Gail Meers, Director of Nursing | | Assure |
| 22. | WUTH Emergency Preparedness, Resilience and Response (EPRR) Core Standards | Hayley Kendall, Executive Managing Director | | Assure |
| 23. | WCHC Emergency Preparedness, Resilience and Response (EPRR) Core Standards | Hayley Kendall Executive Managing Director | | Assure |
| 24. | WUTH Guardian of Safe Working Report Q1 2026/27 | Dr Nikki Stevenson, Chief Medical Officer | Dr Hayley Heffernan, Guardian of Safe Working | Note |
| 25. | WUTH Maternity and Neonatal Services Report | Gail Meers, Director of Nursing | Jo Lavery, Divisional Director of Nursing & Midwifery | Discussion |
| 26. | WUTH Antimicrobial Stewardship Annual Report 2025/26 | Dr Nikki Stevenson, Chief Medical Officer | Chris Green, Director of Pharmacy | Assure |

## WUTH and WCHC Statutory Board Regulatory Reports

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| 27. | WCHC Accountable Officer Controlled Drugs Annual Report 2025/26 | Dr Nikki Stevenson, Chief Medical Officer | Chris Green, Director of Pharmacy | Assure |

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| 28. | WUTH Equality Diversity and Inclusion Biannual Report (including WRES/WDES) | Jenny Grant, Chief People Officer | | Note |
| 29. | WCHC Equality Diversity and Inclusion Biannual Report (including WRES/WDES) | Jenny Grant, Chief People Officer | | Note |

## Governance and Assurance

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| 30. | Fit and Proper Persons Annual Update and Policy | Ali Hughes, Director of Corporate Affairs & Communications | Cate Herbert, Board Secretary | Assure |
| 31. | Managing Conflicts of Interest Bi-annual Update | Ali Hughes, Director of Corporate Affairs & Communications | Cate Herbert, Board Secretary | Assure |

## Wallet Items for Information

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| 32. | 2025/26 Annual Submission to NHS England North West: Appraisal and Revalidation | Dr Nikki Stevenson, Chief Medical Officer | | Note |

## Closing Business

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| 33. | Questions from Governors and Public | Steve Igoe, Chair | | |
| 34. | Meeting Review | Steve Igoe, Chair | | |
| 35. | Any other Business | Steve Igoe, Chair | | |

## Date and Time of Next Meeting

Wednesday 3 February, 09:00

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| **Meeting** | Group Board of Directors in Public |
| **Date** | Wednesday 2 September 2026 |
| **Location** | Hybrid |

**Members present:**

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| SI | Steve Igoe | Joint Chair |
| SR | Dr Steve Ryan | Joint Non-Executive Director |
| LD | Lesley Davies | Joint Non-Executive Director |
| MD | Meredydd David | Joint Non-Executive Director |
| CB | Professor Chris Bentley | Joint Non-Executive Director |
| LG | Lisa Greenhalgh | Joint Non-Executive Director |
| JH | Janelle Holmes | Joint Chief Executive |
| CD | Chris Douglas | Joint Chief Nurse |
| HK | Hayley Kendall | Joint Executive Managing Director |
| JG | Jenny Grant | Joint Chief People Officer |
| MS | Matthew Swanborough | Joint Chief Strategy Officer |
| MC | Mark Chidgey | Joint Chief Finance Officer |
| AH | Ali Hughes | Joint Director of Corporate Affairs & Communications |
| GR | Gareth Robinson | Joint Director of Transformation & Turnaround |
| NS | Dr Nikki Stevenson | Joint Chief Medical Officer |

**In attendance:**

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| CH | Cate Herbert | Board Secretary |
| JJE | James Jackson-Ellis | Corporate Governance Officer |
| CM | Chris Mason | Chief Information Officer |
| JL | Jo Lavery | Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 19 |
| MSa | Mustafa Sadiq | Consultant – item 19 |
| TN | Tracey Nolan | Freedom to Speak Up Lead – item 22 |
| CG | Chris Green | Director of Pharmacy – item 28 |
| TC | Tony Cragg | WUTH Lead Public Governor |
| EH | Eileen Hume | WCHC Lead Public Governor |
| FF | Fiona Fleming | Head of Communications and Marketing |
| JT | John Taylor | Observer |

**Apologies:**

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| JC | Dr Joanne Chwalko | Joint Chief Integration and Partnerships Officer |

| Agenda Item | Minutes | Action |
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| 1. | **Welcome and Apologies for Absence**<br><br>SI welcomed members to the meeting. Apologies are noted above. | |
| 2. | **Declarations of Interest** | |

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| | No interests were declared and no interests in relation to the agenda items were declared. | |
| **3.** | **Minutes of Previous Meeting**<br><br>The minutes of the previous meeting held on 3 June were **APPROVED** as an accurate record. | |
| **4.** | **Action Log**<br><br>The Group Board **NOTED** the action log. | |
| **5.** | **Patient Story**<br><br>The Board received a video story from Clare highlighting her experience as a birthing partner and retired midwife. The story described Clare's her positive experience of being a birthing partner during a birth in the maternity and neonatal wards.<br><br>Members agreed this was a positive patient story.<br><br>The Board **NOTED** the video story. | |
| **6.** | **Chair Update**<br><br>SI thanked the Executive Team for robustness and level of detail provided in the reports.<br><br>SI advised that an Extraordinary Board meeting was held to discuss the Winter Plan Board Assurance Statements which had been submitted to NHSE. SI also encouraged staff to take up the offer of vaccination.<br><br>SI advised that the Urgent and Emergency Care Upgrade Programme (UECUP) had finished and the new facility was open.<br><br>SI reported that various meetings had taken place with the NHSE regarding the statutory transaction Statement of Case. SI had also joined a national meeting to discuss issues relating to neonates and maternity.<br><br>SI reported that further Finance Performance Recovery Meetings had taken place, with work progressing at pace to deliver the required outcomes.<br><br>The Board **NOTED** the verbal update. | |
| **7.** | **Chief Executive Officer Report**<br><br>JH highlighted positive performance across both Trusts despite sustained demand, including improvements in elective, urgent and emergency care, cancer and community services. | |

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| | JH noted the opening of the new Urgent and Emergency Care Facility, progress with the Better Together Programme and Strategic Outline Case, and ongoing work relating to national oversight and assurance.<br><br>JH also highlighted the award of the Wirral 0-19 Healthy Child Programme contract, positive patient experience survey results and external recognition across a number of services.<br><br>LD welcomed the Cheshire and Merseyside Annual Work and queried how the approach would move from cure to prevention, while factoring in health inequalities data, and align with the shift towards community-based care.<br><br>JH advised that Cheshire and Merseyside Collaborative was focused on delivering the blueprint and achieving the expected performance. JH added as ICB commissioning arrangements develop there was a need to shape future delivery, including how this can be delivered at Place level and Wirral Provider Alliance could be aligned with the health inequalities agenda.<br><br>SR highlighted the positive outcomes and metrics from the Cancer Patient Experience Survey in urology, which had also been subject to a deep dive at Quality and Safety Committee.<br><br>SR welcomed the good work and queried opportunities for greater integration between 0-19 services and hospital provision.<br><br>JH confirmed that safeguarding would be the first area of integration as part of the 0-19 service and that this was being brought together through the corporate nursing review. JH also referred to integration with Alder Hey and ongoing work relating to SEND services in Wirral, including the development of improvement plans.<br><br>HK noted that the improvements within urology were linked to cancer improvement funding and emphasised the importance of this work and the role of the Cancer Alliance.<br><br>The Board **NOTED** the report. | |
| **8.** | **Integrated Performance Report**<br><br>NS declared one Never Event relating to a surgical case from 2024. The patient had not suffered harm, and the appropriate governance routes were being followed to ensure learning. NS advised that the previous issue relating to NEWS2 had been resolved.<br><br>SR queried LocSSIPs compliance.<br><br>NS advised that compliance was monitored at Divisional and Trust-wide level using the LocSSIPs proforma. An improvement meeting | |

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| | was in place, and a Trust-wide audit was planned to take place quarterly.<br><br>SI queried why the Never Event from 2024 had only now been reported.<br><br>NS advised that the event had been identified through follow-up and retrospective review.<br><br>CD highlighted the reduction in pressure ulcers, noting this remained a quality improvement priority. Significant input from teams had produced good results in pilot areas, with no Category 4 pressure ulcers reported. Staffing fill rates for RNs and CSWs during both day and night shifts were above 90%.<br><br>LD commented about the increase in C Diff cases and queried what could be done differently to change the pattern. LD also queried whether there were any trends within the 297 concerns, particularly given the higher number of Level 1 concerns.<br><br>CD advised that a quality improvement session was scheduled for the following week, focusing on reinforcing basic practices and cleanliness. Work was also taking place with other Trusts, alongside continued reinforcement of bare below the elbow's requirements. A reduction had been seen in August, and it was important that this was maintained.<br><br>NS advised that Level 1 concerns had not resulted in formal complaints. Recurring themes related to access to treatment and communication.<br><br>HS queried the mechanism for translating Friends and Family Test (FFT) feedback into service improvements.<br><br>CD advised that there were defined criteria and opportunities for free-text feedback, from which themes could be identified. Other patient experience data could also be gathered.<br><br>SR noted that patient experience surveys provided greater detail on which to act.<br><br>SR noted the C Diff figures and asked about the work underway with system partners.<br><br>NS commented about the link with antimicrobial stewardship. A Place-level workstream was considering this.<br><br>HK reported improvements in 12-hour DTA performance and ED, with good RTT, cancer and diagnostic performance. Areas of concern remained in relation to the 4-hour standard for Type 1 activity, with continued focus required on capacity, resources, grip and control. Performance for Type 1 remained below the required | |

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| | level, while ambulance handover performance needed to be maintained.<br><br>HK advised that work within UEC included zoned clinic teams, nursing and medical teams and daily huddles. Executive performance reviews were considering ongoing issues, with stronger Executive presence in the department to provide a visible presence. August RTT performance was expected to be achieved, although September remained a risk.<br><br>LD welcomed the positive position regarding patients waiting over 12 hours and queried gaps in the resident doctor rota out of hours.<br><br>HK advised that the August rotation had resulted in some staff being unavailable. The rota was also being considered in the context of financial recovery.<br><br>LD queried preparations for winter and ambulance handovers.<br><br>HK advised that work was ongoing for this winter in line with the winter plan. An Urgent Care Coordination Centre for Wirral was planned from the following year, which was expected to support greater impact.<br><br>SR queried the current position for mental health patients, noting previous issues.<br><br>HK advised that changes in processes and capacity within the mental health provider had resulted in a small proportion of 12-hour breaches.<br><br>SR queried whether harm reviews were undertaken for patients experiencing long waits, including within elective care.<br><br>NS advised that dynamic risk assessments were undertaken based on prolonged waits. Formal risk assessment arrangements were in place for elective pathways but for urgent care. Cases involving moderate harm or above were reported through the governance structure and considered through the Patient Safety Response Panel, linking with PSIRF.<br><br>HK provided an update on WCHC. UEC, walk-in and UTC performance had been maintained, with improvement at VCH. CICC performance compared well with others, alongside progress on waiting lists and RTT.<br><br>HK advised areas of concern included CAS response times, which had increased in July, although progress had subsequently been made with further work required. Community dental services and seven-day ECGs remained areas of focus.<br><br>SR queried prevention work within children's dental services. | |

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| | CD advised that the ICB was leading an improvement programme which included providing toothbrushes and toothpaste to every child.<br><br>MC reported at the end of July 2026 (Month 4), WUTH is reporting a deficit of £10.7m, which is in line with plan. The identified key risks within the plan include full CIP delivery, activity/case mix and maintaining grip and control.<br><br>MC explained WUTH's revised planned deficit of £21.3m has been accepted by NHSE and, as a result, the Trust has now received Deficit Support Funding for Q1 and Q2. The Trust continues to adhere to the agreed cash mitigation plan as until a sustainable financial position is achieved, this will remain a significant issue.<br><br>MC reported at the end of July 2026 (Month 4), WCHC is reporting a £0.9m surplus, a £0.3m positive variance to plan.<br><br>MC stated the reported position reflects favourable performance across pay and non-pay expenditure, partially offset by a shortfall in delivery of the Cost Improvement Programme (CIP).<br><br>MC noted the reported financial position is positive, the workforce and CIP positions indicate that part of this benefit reflects under-delivery of planned savings rather than fully sustainable underlying improvement. Total WTE is 6.69 above plan, driven by unachieved CIP and higher than planned bank spend.<br><br>Members welcomed the position at M4 and access to deficit support funding.<br><br>MD also commented about the quality of reporting through Joint Finance and Performance Committee, including the focus on delivery of the financial plan and the strong line of sight.<br><br>JG reported WUTH workforce performance remains below targets for sickness absence, mandatory training, and appraisals. Improvement plans include a sickness transformation project targeting less than 5% within three years, wellbeing initiatives, dedicated training support, and targeted appraisal interventions.<br><br>JG stated WCHC workforce position is marked by persistent sickness absence above the Trust's 5% target. Improvement work has reduced overall and long-term absence, while further targeted interventions are planned across services.<br><br>LD noted that improvements remained necessary within Estates.<br><br>HK advised that sickness absence within Estates was at its lowest level and expressed confidence that this could be sustained. | |

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| | The Board:<br>• **NOTED** performance to the end of July 2026 (or latest available months data); and<br>• **NOTED** the summary position reflecting the latest publication of the NOF is also included in the IPR.<br>• **NOTED** that the Trust continues to operate within the NHSE NW Finance Performance and Recovery (FPRM) process. | |
| **9.** | **Board Assurance Framework (BAF)**<br><br>AH reported six reviewed risks currently score highly: unscheduled care demand at RR20; planned or scheduled care at RR16; workforce at RR16; delivery of the three-year financial plan at RR15; service transformation and sustainable efficiency at RR15; and critical infrastructure or cyber-attack at RR15.<br><br>AH stated Joint Finance and Performance Committee and Joint Quality and Safety Committee supported raising ID01 because of continuing unscheduled care pressures and their consequential effect on the Trust's legal undertakings with NHSE and its published NOF position.<br><br>AH explained the Joint Quality and Safety Committee recommends adding a risk that quality governance, patient safety arrangements, and assurance mechanisms may not be sufficiently effective, responsive, or consistently supported.<br><br>The Board:<br>• **APPROVED** the recommendation from the Finance & Performance Committee supported by the Quality Committee to increase the risk rating of ID01 to RR20.<br>• **APPROVED** the recommendation from the Quality & Safety Committee that a new strategic risk is included in the BAF related to the patient safety and quality governance framework<br>• **REVIEWED** the risk ratings noting that there are 6 high-level strategic risks<br>• **APPROVED** the updates for each risk as reported<br>• **NOTED** that further work through the Committees of the Board will continue to monitor each of the strategic risks | |
| **10.** | **Lead Governors Report – Verbal**<br><br>EH stated she had been appointed Lead Governor of WCHC in August 2026. She had joined the National Lead Governors Association network and the Cheshire and Merseyside Lead Governors Network.<br><br>EH stated she intended to meet the Lead Governor of WUTH, to establish collaborative working arrangements.<br><br>TC welcomed EH and looked forward to meeting her. | |

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| | The Board **NOTED** the verbal update. | |
| **11.** | **Joint Committee Chairs Reports – Joint Quality and Safety Committee**<br><br>SR alerted members that reduced North West Deanery doctor allocations are particularly affecting the Emergency Department and Neonatal Unit. Mitigations are being developed, with potential budget implications. Work continues to improve Emergency Department safety checklist compliance and the early identification of tissue ulcers.<br><br>SR also alerted members that heatwave-related challenges with MRI scanner cooling have prompted a Trust-wide audit of heat-sensitive equipment resilience.<br><br>SR alerted members that a prior-year never event involving retained nasal packing, with no patient harm, will be investigated under PSIRF. The incident predated subsequent Trust-wide improvement work.<br><br>SR referenced the additional AAA report recognising enhanced requirements for visibility of Board oversight of Maternity and Neonatal services.<br><br>SL alerted members to an increase in neonatal deaths during the first half of 2026 prompted reviews of deaths from 2025 and 2026, although no thematic concerns or escalation issues had been identified. The internal rapid-review process has been strengthened. The Board is also expected to continue monitoring maternity triage, particularly the physical environment, timely access to medical advice, and systems for tracking and reporting.<br><br>SR summarised the various “Advise” and “Assure” matters from the meeting on 13 August.<br><br>The Board **NOTED** the report. | |
| **12.** | **Joint Committee Chairs Reports – Joint Digital Committee**<br><br>HS alerted members that Freedom of Information and Subject Access Request recovery performance improved through temporary staffing and managed clinical coding, but WUTH remains outside statutory response timescales. NHS England also set new board-level cyber assurance expectations, while delays in a small number of the 45 digital portfolio projects are creating pressure on specialist resources and dependent project sequencing. | |

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| | HS summarised the various “Advise” and “Assure” matters from the meeting on 19 June.<br><br>LD asked if digital training was required of staff.<br><br>CM advised that the focus was on embedding digital training within wider workforce and clinical training, rather than treating it separately.<br><br>SI asked whether training would be competency-based and tailored to staff profiles.<br><br>CM confirmed that, from a clinical perspective, EPR competency should be assessed regularly following initial training, with further training targeted at identified areas of weakness rather than generic refresher training. The CNIO was also supporting the development of digital champions.<br><br>SR highlighted the importance of coding quality, particularly in supporting the work of the Mortality Review Group.<br><br>MC advised that the target was 100% coding, with a focus also on the depth and quality of coding. Work was underway with the coding system supplier to identify gaps.<br><br>CB asked how digital developments could deliver pathway benefits for therapies and how this was reflected within existing strategies.<br><br>MS advised that the Digital Strategy was being aligned with clinical service strategies. A review was also underway to consider the most appropriate structure for the digital team, including opportunities relating to automation and AI.<br><br>The Board **NOTED** the report. | |
| **13.** | **Joint Committee Chairs Reports – Joint People Committee**<br><br>LD alerted members that WUTH substantive and bank staffing are below plan, while agency staffing is above plan because of Emergency Department and Theatres demand. Sickness remains above target at 5.25 percent, appraisal compliance is below target at 85.35 percent, and recruitment delays are contributing to agency expenditure. WCHC workforce levels are just above plan, but sickness has risen to 5.69 percent, turnover remains above target, and role-specific mandatory training compliance requires continued attention.<br><br>LD also alerted members that time to hire has increased and recruitment timelines will continue to be challenging. Processes are in place to identify recruitment pinch points and additional HR resource has been deployed to reduce time-to-hire | |

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| | LD summarised the various “Advise” and “Assure” matters from the meeting on 16 July.<br><br>SI requested that the Committee be provided with an update on Right to Work checks, given the ongoing scrutiny in his area, and to ensure processes are place were resilient and robust.<br><br>JG agreed to take this forward.<br><br>The Board **NOTED** the report. | Jenny Grant |
| **14.** | **Joint Committee Chairs Reports – Joint Finance and Performance Committee**<br><br>MD stated the Committee had met during May - July and focused on the July meeting.<br><br>MD alerted members that WUTH submitted a revised planned deficit of £21.3m for 2026/27, which was expected to be accepted by NHSE, although written approval remained outstanding. WUTH was 33 WTE ahead of plan at M3, but staff costs were £1.6m adverse to plan, driven by WLI costs, additional bank holidays, the Hantavirus response and continued premium rate pay. Stronger controls and CIP delivery were required.<br><br>MD also alerted members that the cash balance was £1.1m at period end, with continued cash support required pending deficit support funding. Delivery of CIP and productivity improvements across Medicine, Surgery and DCS remained high risk, particularly given the increased savings required in Q3 and Q4.<br><br>MD alerted members that Q3 and Q4 CIP schemes were well developed; however, delivery of the anticipated savings remained dependent on operational realisation of benefits. The risk profile was shifting from CIP delivery towards grip and control. While several Divisions remained on track, the run rate was not reducing as expected, increasing the overall financial risk.<br><br>MD summarised the various “Advise” and “Assure” matters from the meeting on 23 July.<br><br>The Board **NOTED** the report. | |
| **15.** | **WUTH Charitable Funds Committee**<br><br>LD alerted members that several charity-specific policies are overdue for review, although no immediate compliance or regulatory breach was identified the updated policies will be presented at the next meeting.<br><br>LD summarised the various “Advise” and “Assure” matters from the meeting on 9 July. | |

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| | The Board **NOTED** the report. | |
| **16.** | **WUTH Maternity and Neonatal Services Report**<br><br>JL and MSa provided assurance on the quality, safety, performance, risks, and improvement work across maternity and neonatal services.<br><br>JL and MSa stated no maternity or neonatal Patient Safety Incident Investigations were declared in July 2026, and there were no new Maternity and Newborn Safety Investigation referrals or active investigations. The Perinatal Quality Oversight Model continues to provide structured oversight of incidents, outcomes, workforce, patient experience, risks, and improvement activity.<br><br>JL and MSa explained Maternity Incentive Scheme Year 8 delivery remains on track, with the Training Compliance Touch Point achieved. The Trust has strengthened evidence tracking to support compliance with all six Safety Action Standards.<br><br>JL and MSa updated on workforce and service capacity, noting consultant obstetric attendance standards remain compliant, and planned Caesarean birth capacity is sufficient to meet demand. However, neonatal workforce standards remain non-compliant, requiring Board approval of a three-year improvement plan; additional funding and recruitment opportunities are also supporting maternity workforce sustainability.<br><br>JL and MSa reported the Trust maintains 100% compliance with all six elements of the Saving Babies' Lives Care Bundle Version 3, while the Maternal Care Bundle is 50 percent compliant and targeted for full implementation by March 2027.<br><br>JL and MSa explained the Trust has developed action plans responding to the Nottingham Ockenden Review and AMOS findings, addressing governance, incident learning, staffing, training, fetal surveillance, risk assessment, documentation, and engagement with women and families.<br><br>MD raised whether, given the increasing number of national requirements and guidance, there was a point at which existing requirements could be removed rather than continually adding further expectations.<br><br>JL advised as recommendations were removed or embedded into practice, further requirements were often added. She noted the importance of sustaining improvements once embedded.<br><br>CD emphasised the importance of ensuring the Division had appropriate information and resources to respond to national | |

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| | oversight and scrutiny. CD commended the work of the team and stressed the importance of sustaining improvements.<br><br>MD sought clarification regarding the recommendation for approval within one of the appendices, particularly the implications of non-compliance with the workforce standard.<br><br>JL clarified that this was not a compliance requirement for the current year. Board approval was being sought to support a longer-term approach. A three-year plan would review gaps, ensure mitigations were in place and review roles and responsibilities, with this work informing a business case. The outcome of the review relating to Level 2 and Level 3 neonates was expected by the end of December.<br><br>Members agreed with and supported the proposed approach.<br><br>MD noted that the team was high performing and asked how cultural leadership and other outcomes, could be measured.<br><br>JL advised that cultural leadership had been developed over the previous two years and that a new programme was due to commence. It was agreed that a future update could include relevant metrics and outcomes.<br><br>LD highlighted workforce training as a recurring theme regarding low compliance, asking about the impact and potential consequences of not meeting requirements when reporting to regulators.<br><br>JL advised that the key areas within MIS were met and fully compliant. Some training was not mandatory and Trust-level compliance had not been achieved in those areas. No related incidents or concerns had been identified.<br><br>LD asked what could be done to improve compliance with mandatory training and whether an aspiration could be set to achieve the required level.<br><br>MSa advised that allocating training time was easier for consultants, where this could be incorporated into SPA time, but that equivalent arrangements were more difficult for midwives.<br><br>SR noted MS's attendance and commented that this demonstrated the positive culture within the team.<br><br>The Board:<br>• **NOTED** no maternity or neonatal Patient Safety Incident Investigations (PSIIs) were declared during July 2026.<br>• **NOTED** MIS Year 8 delivery remains on track, with successful achievement of the Training Compliance Touch | |

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| | Point and continued progress towards final submission in March 2027.<br>• **NOTED** compliance has been maintained with Saving Babies' Lives Care Bundle Version 3 and consultant obstetric attendance standards.<br>• **NOTED** the planned Caesarean Birth Capacity Mapping confirms capacity remains sufficient to meet demand, supported by two additional elective Caesarean section sessions introduced during 2025.<br>• **NOTED** the Homebirth Service Safety and Quality Review confirmed that WUTH continues to provide a safe, sustainable, and well-governed homebirth service.<br>• **NOTED** Neonatal workforce standards remain non-compliant; a three-year workforce improvement plan requires Board approval.<br>• **NOTED** Progress continues across the Maternal Care Bundle, Perinatal Equity and Anti-Discrimination Programme (PEADP), maternity triage improvements, organisational development programme, and workforce initiatives.<br>• **NOTED** The Trust has reviewed the findings of the Nottingham Ockenden Review and the AMOS Review and has established action plans to address identified recommendations.<br>• **NOTED** PMRT reviews have identified learning opportunities, with strengthened multidisciplinary review processes now in place for all neonatal deaths. | |
| **17.** | **WUTH Infection Prevention and Control Annual Report 2025/26**<br><br>CD highlighted that the report explains how the Trust demonstrated compliance with Regulation 12 of the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the ten associated criteria, the National IPC Board Assurance Framework, and IPC standards.<br><br>CD explained although the Trust exceeded the NHS threshold for C Diff in 2025/26, it recorded 16 fewer cases than in the previous year. An IPC improvement plan is to support targeted work during 2026/27, with the aim of preventing further cases and avoiding exceedance of the next threshold.<br><br>CD added significant changes occurred in IPC leadership during 2025/26 and anticipates that a more stable structure in 2026/27 will strengthen the integration of IPC into organisational decision-making.<br><br>The Board were **ASSURED** that IPC systems and processes continue to be robustly implemented to effectively evidence compliance with The Code of Practice on the Prevention and | |

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| | Control of Infections, Care Quality Commission Health and Social Care Act 2008, Regulation 12. | |
| **18.** | **WCHC Freedom to Speak Up Annual Report 2025/26**<br><br>CD provided an overview of the report, highlighting the Trust was supported by 115 FTSU Champions who promote a speak-up culture within teams and staff networks.<br><br>CD added Community Nursing accounted for the highest proportion of concerns reported (31%), with 63% of concerns raised either openly or confidentially through the FTSU Guardian, reflecting staff confidence in the process.<br><br>CD highlighted 87% of the Community Nursing concerns relate to the process of re-banding specific job roles.<br><br>CB noted the positive work undertaken and thanked the FTSU Guardian for her work to recruit over 100 Champions.<br><br>MD noted that Community Nursing appeared to have the highest number of concerns. MD suggested in future reports to provide a breakdown of concerns raised by staff group, relative to each group's proportion of the overall workforce.<br><br>The Board were **ASSURED** that FTSU systems and processes continue to be robustly implemented throughout WCHC. | Chris Douglas/Jenny Grant |
| **19.** | **WUTH Freedom to Speak Up Annual Report 2025/26**<br><br>TN reported the 2025 NHS Staff Survey revealed a decline in staff confidence regarding speaking up and belief that concerns would be addressed, falling below national averages.<br><br>TN explained the number of individuals speaking up remained steady at 79 for both 2024/25 and 2025/26, with an increase noted in the last two quarters and early 2026/27. Enhanced visibility, training, and promotion have contributed to this rise, indicating some staff feel psychologically safe to raise concerns.<br><br>TN added attitudes and behaviours accounted for over 44% of concerns, consistent with the previous year. Bullying and harassment concerns decreased from 40 to 28 cases.<br><br>TN noted patient safety-related concerns decreased from eight to two in 2025/26, reflecting a national downward trend and indicating effective use of incident reporting mechanisms.<br><br>MD asked how the number of concerns reported compared with Trusts of a similar size. | |

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| | TN advised that comparative data was available and that Q1 data had been submitted, which would allow analysis to be undertaken but cautioned every Trust was different.<br><br>SI asked about triangulation with other reporting mechanisms.<br><br>TN advised that information was triangulated with HR and there were no concerns regarding staff not reporting issues. It was noted that clinical staff were also likely to raise concerns through incident reporting instead of FTSU.<br><br>The Board **NOTED** the report. | |
| **20.** | **WUTH Learning from Deaths Report Q4 2025/26**<br><br>NS highlighted SHMI was 1.01 and remained within the expected range, while the rolling 12-month HSMR was 111, in the above-expected range. The HSMR position was due to uncoded care episodes and coding backlogs, as previously reported to Committee and Board.<br><br>NS added of the 62 reviews discussed by the Mortality Review Group during Q4, escalated reviews comprised 7 cases with no care issues, 7 where care issues would not have affected the outcome, 11 where care issues may have affected the outcome, and 2 where care issues affected the outcome.<br><br>NS stated mortality reviews identified issues involving feeding and diet, delayed senior review that contributed to poor patient experience in some cases, and medication errors that did not cause harm.<br><br>HS acknowledged the number of learning disability mortality reviews had increased from 2 to 9 compared to quarter 3 and 4 and queried if any themes had been identified.<br><br>NS stated these were referred externally to the the National LeDeR Programme in line with practice.<br><br>The Board **NOTED** the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group. | |
| **21.** | **WCHC Learning from Deaths Report Q4 2025/26**<br><br>NS highlighted four deaths were reviewed, including one neonatal death that had not involved care from WHCT services. No deaths met the criteria for StEIS reporting, and no deaths were reported to the coroner service. | |

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| | NS added all four deaths were analysed to assess whether Trust care caused harm or contributed to the deaths. No gaps or omissions in Trust care were identified.<br><br>The Board:<br>• Were **ASSURED** that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with Trust policy; and<br>• Were **ASSURED** the Trust is actively involved in supporting the system-wide development of processes reporting and learning from deaths. | |
| **22.** | **WUTH Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26**<br><br>HK highlighted this report gives assurance on the Trust's emergency preparedness, resilience and response arrangements, statutory compliance, improvement activity and priorities.<br><br>HK highlighted the Trust achieved substantial compliance in its NHS England EPRR Core Standards self-assessment, improving from partial compliance in 2024/25. An independent MIAA audit gave moderate assurance and generated actions covering business continuity planning, risk management, policy alignment, training and annual work planning.<br><br>CB asked whether business continuity planning templates were being implemented consistently in line with policy and sought assurance regarding oversight arrangements.<br><br>HK advised that the issue related to consistent use of the template rather than adherence to processes to ensure it is in line with the recommended NHS England template.<br><br>HK added a quarterly report was provided to the Executive and Risk Assurance Committee and Joint Finance and Performance Committee were sighted on the Core Standards on an annual basis.<br><br>The Board:<br>• **NOTED** the contents of the EPRR Annual Report 2025/26;<br>• Were **ASSURED** regarding the Trust's emergency preparedness arrangements and compliance activities; and<br>• **NOTED** the priorities and work programme for the forthcoming year. | |
| **23.** | **WCHC Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26**<br><br>HK stated the report was prepared as part of the Trust's duties as a Category 1 Responder under the Civil Contingencies Act 2004, the report outlines arrangements for emergency response, | |

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| | business continuity and continued delivery of commissioned services.<br><br>HK added it includes the reviewed Major Incident Plan, which must be updated annually, and an annual training and exercising programme.<br><br>HK provided an update on EPRR resourcing across both Trusts and advised that the EPRR Lead at WCHC was retiring, whilst the WUTH lead was due to commence a period of long-term sickness absence. It was noted that maintaining EPRR leadership capacity is a statutory requirement.<br><br>HK confirmed discussions were ongoing with the ICB to identify arrangements to address the resource gap and ensure compliance with statutory obligations.<br><br>LG commented about the date recorded on page 337 as February 2025 and asked whether this related to the MIAA review undertaken in 2024.<br><br>HK agreed to clarify the date.<br><br>The Board:<br>• Were **ASSURED** by the Annual EPRR report for the year 2025/26 that the Trust has plans and processes in place in order to react to incidents to ensure services, that the Trust is commissioned to deliver continue; and<br>• **APPROVED** the annually reviewed Major Incident Plan (MIP) | Hayley Kendall |
| **24.** | **WUTH Mortuary Board Assurance Statement**<br><br>CD referenced the letter received from NHS England following findings from the Nottingham maternity review and the Human Tissue Authority report.<br><br>CD added actions in the letter including reviewing progress against the 29 relevant recommendations, maintain a time-limited action plan, identify executive leadership for safeguarding after death, oversee mortuary facilities through effective governance, review Human Tissue Authority reportable incidents from 2015 to 2026, and complete the premises assurance model self-assessment.<br><br>CD highlighted the provisional assurance statements were sent to NHS England by the 31 July 2026 deadline and were considered at the Joint Quality Committee in August.<br><br>Members were assured on the governance, compliance, and improvement actions for mortuary oversight. | |

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| | The Board:<br>• **NOTED** the findings and requirements arising from the Nottingham maternity review, the Human Tissue Authority report and the Fuller Inquiry (appendix 1);<br>• **APPROVED** the Board Assurance Statements at Appendix 2, following recommendation to the Board by the Quality and Safety Committee. | |
| **25.** | **WCHC Policy Update – Managing Conflicts of Interest**<br><br>CH sought approval to extend the Managing Conflicts of Interest Policy until the end of December 2026. The extension would allow recently identified audit recommendations to be incorporated before the policy completes the ratification process.<br><br>The Board **APPROVED** the extension of the policy to the end of December 2026. | |
| **26.** | **WUTH Accountable Officer Controlled Drugs Report 2025/26**<br><br>CG highlighted WUTH reported 381 controlled drugs-related issues between April 2025 and March 2026, compared with 320 in 2024/25. Of these, 74 (19%) were actual incidents and 307 (81%) were near misses; seven caused low harm and the remainder caused no harm.<br><br>CG stated the regional Controlled Drugs Local Intelligence Network considers WUTH a high-number, low-harm reporter, which the report associates with an open reporting culture.<br><br>CG advised prescribing incidents were the largest category, with 104 reports, followed by governance and administration incidents, with 58 each. The Emergency Department recorded the highest number of incidents, with 84.<br><br>SR commented this report had been reviewed at Joint Quality and Safety Committee, noting the increase in incidents but remaining a low-harm reporter.<br><br>The Board:<br>• **NOTED** the report;<br>• **APPROVED** the recommendations | |
| **27.** | **Questions from Governors and Public**<br><br>No questions were raised. | |
| **28.** | **Meeting Review**<br><br>Members agreed it had been a good meeting, and everyone had the opportunity to contribute. | |
| **29.** | **Any other Business** | |

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| | CH stated elections for WUTH Governors would commence shortly in time for the Annual Members' Meeting in November. | |

*(The meeting closed at 12:45)*

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| **Meeting** | WUTH Board of Directors in Public |
| **Date** | Wednesday 2 September 2026 |
| **Location** | Hybrid |

**Members present:**

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| SI | Steve Igoe | Joint Chair |
| SR | Dr Steve Ryan | Joint Non-Executive Director |
| LD | Lesley Davies | Joint Non-Executive Director |
| MD | Meredydd David | Joint Non-Executive Director |
| CB | Professor Chris Bentley | Joint Non-Executive Director |
| LG | Lisa Greenhalgh | Joint Non-Executive Director |
| JH | Janelle Holmes | Joint Chief Executive |
| CD | Chris Douglas | Joint Chief Nurse |
| HK | Hayley Kendall | Joint Executive Managing Director |
| JG | Jenny Grant | Joint Chief People Officer |
| MS | Matthew Swanborough | Joint Chief Strategy Officer |
| MC | Mark Chidgey | Joint Chief Finance Officer |
| AH | Ali Hughes | Joint Director of Corporate Affairs & Communications |
| GR | Gareth Robinson | Joint Director of Transformation & Turnaround |
| NS | Dr Nikki Stevenson | Joint Chief Medical Officer |

**In attendance:**

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| CH | Cate Herbert | Board Secretary |
| JJE | James Jackson-Ellis | Corporate Governance Officer |
| CM | Chris Mason | Chief Information Officer |
| TC | Tony Cragg | WUTH Lead Public Governor |
| EH | Eileen Hume | WCHC Lead Public Governor |
| FF | Fiona Fleming | Head of Communications and Marketing |
| JT | John Taylor | Observer |

**Apologies:**

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| JC | Dr Joanne Chwalko | Joint Chief Integration and Partnerships Officer |

| Agenda Item | Minutes | Action |
|---|---|---|
| 1 | **Welcome and Apologies for Absence**<br><br>SI welcomed members to the meeting. Apologies are noted above. | |
| 2 | **Declarations of Interest**<br><br>No interests were declared and no interests in relation to the agenda items were declared. | |
| 3 | **Minutes of Previous Meeting** | |

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| | The minutes of the previous meeting held on 3 June were **APPROVED** as an accurate record. | |
| **4** | **Action Log**<br><br>The Group Board **NOTED** the action log. | |
| **5** | **WUTH Charitable Funds Committee**<br><br>LD alerted members that several charity-specific policies are overdue for review, although no immediate compliance or regulatory breach was identified the updated policies will be presented at the next meeting.<br><br>LD summarised the various “Advise” and “Assure” matters from the meeting on 9 July.<br><br>The Board **NOTED** the report. | |
| **6** | **WUTH Accountable Officer Controlled Drugs Report 2025/26**<br><br>CG highlighted WUTH reported 381 controlled drugs-related issues between April 2025 and March 2026, compared with 320 in 2024/25. Of these, 74 (19%) were actual incidents and 307 (81%) were near misses; seven caused low harm and the remainder caused no harm.<br><br>CG stated the regional Controlled Drugs Local Intelligence Network considers WUTH a high-number, low-harm reporter, which the report associates with an open reporting culture.<br><br>CG advised prescribing incidents were the largest category, with 104 reports, followed by governance and administration incidents, with 58 each. The Emergency Department recorded the highest number of incidents, with 84.<br><br>SR commented this report had been reviewed at Joint Quality and Safety Committee, noting the increase in incidents but remaining a low-harm reporter.<br><br>The Board:<br>• **NOTED** the report;<br>• **APPROVED** the recommendations | |
| **7** | **Questions from Governors and Public**<br><br>No questions were raised. | |
| **8** | **Meeting Review**<br><br>Members agreed it had been a good meeting, and everyone had the opportunity to contribute. | |

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| **9** | **Any other Business**<br><br>CH stated elections for WUTH Governors would commence shortly in time for the Annual Members' Meeting in November. | |

*(The meeting closed at 12:45)*

**Action Log**
**Group Board of Directors in Public**
**4 November 2026**

| No. | Date of Meeting | Minute Ref | Action | By Whom | Action Status | Due Date |
|---|---|---|---|---|---|---|
| 1 | 2 September 2026 | 13 | To provide an update on the Trusts compliance to Right to Work checks at the next Joint People Committee | Jenny Grant | In progress. Scheduled for November Joint People Committee. | November 2026 |
| 2 | 2 September 2026 | 21/22 | To include in future Freedom to Speak Up reports a breakdown of concerns raised by staff group, relative to each group's proportion of the overall workforce | Chris Douglas/Jenny Grant | Complete. This has been fed back to the authors for incorporating into the next report. | January 2027 |
| 3 | 2 September 2026 | 25 | To clarify the dates on page 337 of the pack (section 1.3) | Hayley Kendall | Complete. Dates clarified and confirmed. | November 2026 |

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

**04 November 2026**

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| **Title** | Chief Executive Officer Report |
| **Area Lead** | Janelle Holmes, Chief Executive |
| **Author** | Janelle Holmes, Chief Executive |

| **Purpose of the Report and Recommendation** | |
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| **Report For** | Information |
| It is recommended that the Board:<br>• 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 provides an update on key developments, achievements, emerging issues and areas of focus across the Trust. The matters reported do not give rise to any new or changed principal risks requiring inclusion within the Board Assurance Framework (BAF). The Board can be assured that risks associated with the activities described are identified, assessed and managed through the Trust's established governance, risk management and assurance processes, with strategic risks reflected within the BAF and subject to routine oversight by the Board and its committees.

| **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:** | |
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| 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 |

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

| 1 | Narrative |
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| 1.1 | **Performance**<br>Both Trusts continue to operate in the context of continued demand on services, urgent care performance across both Trusts remains a concern, however positively 12-hour waits reduced in September and were significantly better than trajectory, although further improvement remains necessary.<br><br>Referral to treatment performance remains strong across both Trusts and positive cancer performance continues across the 31- and 62-day standards.<br><br>Both Trusts are reporting a positive variance to plan for the month 6 financial position.<br><br>Various actions are underway to both Trusts with teams responding proactively to demand and working collaboratively to support the delivery of care for the Wirral population.<br><br>A detailed summary of the position is included in the Integrated Performance Report. |
| 1.2 | **Local News and Developments**<br><br>**NHS Oversight Framework 26-27 - Q1 published**<br><br>The Q1, 26-27 segmentation according to the NHS Oversight Framework has been published.<br><br>• **WUTH has been placed in segment 3 for Quarter 1 of 26/27**. This is an improvement from the Q4 position. The ranking in the acute and specialist league table is 99/134 (Q4 position had been 123/134). The WUTH (average) score has improved by 0.20 from 2.85 to 2.65.<br><br>• **WCHC has been placed in segment 2 for Quarter 1 of 26/27**. This is a deterioration from the Q4 position. The ranking in the community and mental health league table is 16/58 (Q4 position had been 10/61). The WCHC (average) score has deteriorated by 0.07 from 1.98 to 2.05.<br><br>**NHSE NW Performance Accountability Framework published**<br><br>NHS England Northwest has recently published its Performance Accountability Framework (PAF), introducing a consistent regional approach to oversight, support, improvement and accountability across providers and integrated care systems. The |

framework complements the national NHS Oversight Framework (which remains the national framework for organisational assessment and segmentation) and places particular emphasis on earned autonomy, organisational delivery, board capability and effective governance. The Trust continues to strengthen these capabilities through delivery of its improvement priorities, including the actions associated with its legal undertakings programme.

The Trust welcomes the framework's focus on improvement, transparency and proportionate oversight and will continue to engage constructively with regional colleagues as the arrangements are implemented.

The Board can take assurance that the Trust's existing governance, performance and risk management arrangements provide a strong foundation for responding to these requirements, with strategic risks continuing to be monitored through the Board Assurance Framework.

**NHSE legal undertakings (WUTH)**

The Trust continues to work constructively with NHS England in relation to its legal undertakings and remains fully engaged with all associated oversight arrangements.

The Trust is working collaboratively with NHS England to agree exit criteria that will reflect the improvements made.

The Board will continue to receive updates as this work progresses, with a clear focus on maintaining strong governance, sustainable improvement and assurance for patients, partners and regulators.

**Corridor Care Summit**

A second Corridor Care Summit was held on 13 October 2026 where both Trusts reaffirmed their shared commitment to reducing and ultimately eliminating corridor care as a key strategic priority.

The summit brought together colleagues from across acute and community services to reflect on progress made since the inaugural event in April, share learning from national and local initiatives, and identify further actions to improve patient flow, safety and experience. A consistent message throughout the discussions was that corridor care should not be accepted as normal practice and that addressing it requires collective action across the whole health and care system rather than being viewed solely as an emergency care issue.

The summit reinforced that corridor care is fundamentally a quality, safety, dignity and patient experience issue, as well as a significant challenge for staff working under sustained operational pressure.

Both Trusts remain committed to working together to improve flow across hospital and community settings, strengthen operational grip and governance, support staff, and deliver sustainable improvements that reduce reliance on corridor areas. This work will continue to be a major focus as the organisations prepare for winter and seek to improve outcomes and experiences for patients and colleagues alike.

**Better Together - Journey to Integration**

The Better Together Programme continues to make strong progress as both Trusts work towards their shared ambition of delivering more integrated, sustainable and person-centred health and care services for the communities we serve.

Following the launch of the Joint Strategy earlier this year, work has continued at pace to translate our shared vision into tangible improvements for patients, service users and staff. Development of the supporting clinical and enabling strategies is progressing well, helping to shape future models of care that build on the strengths of both organisations whilst improving access, outcomes and experience.

Alongside the strategic planning work, practical integration continues across a range of clinical and corporate services. Collaborative working is becoming increasingly embedded, with progress being made in areas including Therapies, Musculoskeletal Services and Cardiology.

A significant milestone has been achieved with the completion of the Strategic Outline Case (SOC) and continued engagement with both regional and national colleagues within NHS England, alongside the Cheshire and Merseyside Integrated Care Board. This engagement has provided an important opportunity to test and refine the proposed approach, ensuring a shared understanding of the strategic rationale, anticipated benefits and future ambitions of the programme. As the statutory transaction process progresses, both Trusts are now actively focused on developing the Full Business Case and Post-Transaction Implementation Plan.

The Corporate Services organisational change programme also continues to progress, with Phase 3 now underway and all services actively engaged in formal consultation. This represents a significant programme of change and reflects the commitment of colleagues across both organisations to shaping the future operating model and supporting closer integration.

I would like to recognise and thank all colleagues involved for their professionalism, engagement and continued dedication throughout this process. Their willingness to contribute ideas, embrace new ways of working and remain focused on delivering high-quality services is helping to build strong foundations for the future success of the Better Together programme.

**Bereavement Care Charter launch event**

On 2 October WUTH held a special launch event for the new Bereavement Care Charter, bringing together health and care partners from across the borough in a shared commitment to providing compassionate support for people who have lost a loved one.

The Charter out a series of pledges designed to ensure bereaved families are treated with dignity, kindness and understanding at one of the most difficult times in their lives.

Led by the Trust and developed with input from bereaved relatives and people with lived experience, the Charter reflects a collective commitment to placing families at the heart of bereavement care. The launch event brought together healthcare professionals, partners and bereaved family members who have helped shape the initiative through their insight, feedback and experiences.

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| | Organisations attending the event included representatives from community services, nursing homes, hospice care, funeral services, NHS England and the Cheshire and Merseyside Integrated Care Board. The initiative builds on the Trust's commitment to delivering outstanding care for patients and recognises the vital importance of supporting those closest to them.<br><br>There was a fantastic attendance, and I would like to recognise the hard work and dedication of the staff across the Trust who organised the event and to all those who attended.<br><br>**Knowsley 0-25 contract**<br><br>Following a competitive procurement process and the successful conclusion of the standstill period, Wirral Community Health & Care NHS FT is delighted to have been awarded the Knowsley Healthy Child Programme contract for a further 5 years.<br><br>This is a significant contract that supports the health, wellbeing and development of children, young people and families in Knowsley. Building on our strong track record of delivering this service over a number of years, we look forward to continuing to work with partners to provide high-quality, accessible and responsive care that improves outcomes for local communities.<br><br>The Trust has also been awarded a contract extension for the Cheshire East 0-19 service for a further 6 months until September 2027.<br><br>These successes reflect the dedication, professionalism and commitment of our staff, whose hard work and focus on delivering excellent services for children and families have been instrumental in securing these important contracts for the future. |
| **1.3** | **Regional and National News and Developments**<br><br>**Consultant Industrial Action – November**<br><br>NHS consultant doctors in England will stage a 48-hour strike starting on 25 November 2026. Organised by the British Medical Association (BMA), the walkout will run from 06:59 GMT on Monday, 25 November until 06:59 GMT on Wednesday, 27 November. Planning and mitigating actions take place via the Trust's EPRR route and impact across the Trust is carefully monitored.<br><br>**Health Bill**<br><br>The Trust continues to monitor the progress of the Health Bill through Parliament and the potential implications for NHS governance, accountability and patient involvement arrangements. Of relevance is the recent confirmation that local Healthwatch organisations and Healthwatch England will be retained, recognising the importance of maintaining an independent patient and public voice within the health and care system.<br><br>The Trust remains committed to ensuring that the views and experiences of patients, service users, carers, staff and local communities continue to inform decision-making and service improvement. |

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| | In recognition of the potential implications of the legislation for Foundation Trust governance, the Lead Governors from both Trusts are actively engaging in regional and national Governor forums to understand emerging developments, share learning and help inform future local arrangements. The Board will continue to monitor the Bill's progress and keep Governors and stakeholders updated as further detail becomes available.<br><br>**Professor Anne Eden CBE to join UHL Group as interim Chair**<br><br>Professor Anne Eden CBE will join NHS University Hospitals of Liverpool Group as interim Chair, following a meeting of our Council of Governors. Anne's role was agreed upon by the Council of Governors, on an interim basis, with the support of NHS England. She brings extensive NHS leadership experience to UHL Group, having served as Regional Director for NHS England in the Southeast since 2017, and previously spent two years at the NHS Trust Development Authority.<br><br>**NHS Cheshire and Merseyside's Director of Population Health 2025/26 Annual Report**<br><br>NHS Cheshire and Merseyside's Director of Population Health, Professor Ian Ashworth, has published his 2025/26 Annual Report, highlighting the role of the NHS in preventing ill health, reducing health inequalities and improving population health.<br><br>The report, 'Future-focused prevention', showcases examples of work taking place across Cheshire and Merseyside to embed prevention into healthcare services, alongside recommendations for how organisations can build on this progress. The report is also accompanied by a film which brings a range of powerful stories to life. |
| **1.4** | **WUTH Health and Safety**<br>There was four Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported between August and September. 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.<br><br>There was one Patient Safety Incident Investigations (PSII) opened between August and September under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been commenced in line with legislation and national guidance. |
| **1.5** | **Published Reports of Interest**<br>The Board will also be aware of several high-profile national reports and campaigns over recent months (see below), including:<br><br>• **Thirlwell Inquiry - Report into events at the Countess of Chester Hospital, 2015- 2018.** The Thirlwall Inquiry report examining the events at the Countess of Chester Hospital neonatal unit from 2015 to 2018 has said that NHS managers need to be held to greater accountability. The Board has already considered the findings from the Inquiry and is actively considering each the findings and recommendations through existing governance arrangements. |

Following publication of the Thirlwall Inquiry report, I can confirm that the Board has considered the findings and recommendations and is actively reviewing the implications for both Trusts through existing governance, quality and safeguarding arrangements.

In line with national guidance, assurance work is underway to consider each recommendation in detail, including speaking up culture, safeguarding, staff training and escalation processes, governance and oversight, bereavement care, and relevant clinical safety requirements.

The Board can be assured that this work is being given appropriate priority and oversight, with actions being incorporated into established assurance mechanisms and reported through the relevant Board committees. This approach will ensure that learning from the Inquiry is fully considered, any areas for improvement are identified and addressed, and that both Trusts continue to promote a culture of openness, professional curiosity, patient safety and accountability.

- **NHS England (NHSE) - Unauthorised, inappropriate and unjustifiable access to confidential patient information.** Sir Jim Mackey, Chief Executive Officer of NHS, has issued a letter to all NHS bodies setting out immediate steps for investigating, reporting and managing breaches in this area. The Joint Digital Committee will receive assurance on the Trusts response to this letter at its next meeting in November 2026.

I can confirm that the Trust has taken proactive steps to reinforce expectations around confidentiality, information governance and the lawful use of patient information. A communication has been issued to all colleagues by the Trust's Senior Information Risk Owner (SIRO), emphasising that access to patient records must only occur where there is a legitimate and authorised reason, and reminding staff of their professional and organisational responsibilities.

This has been supported by a Trust-wide awareness campaign, reinforcement through management teams and continued audit and monitoring arrangements.

The Board can be assured that the Trust takes any potential breach of patient confidentiality extremely seriously and has robust processes in place to prevent, detect, investigate and respond to concerns, whilst maintaining public confidence in the way patient information is safeguarded.

The following are reports recently published and of interest to members of the Board, staff and public.

- **NHSE - Maternity and Neonatal 10 Point Plan assurance process.** Developed in response to recent independent reviews of maternity and neonatal services, these documents set out the assurance process for the Maternity and Neonatal 10 Point Plan and the expectations for Trusts – https://www.england.nhs.uk/publication/maternity-and-neonatal-10-point-plan-assurance-process/
- **DHSC - Care continuity between midwifery and health visiting services: principles for practice.** This guidance sets out practical, practice-focused principles to strengthen continuity between midwifery and health visiting services

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| | across pregnancy, birth and the postnatal period. It reflects current policy, evidence and learning, with a particular focus on relational continuity, shared professional oversight and co-ordinated working at points of transition. It aligns with national priorities for integrated, community-based postnatal care – https://www.gov.uk/government/publications/care-continuity-between-midwifery-and-health-visiting-services<br>• **Kings Fund - Key facts and figures about the NHS.** This briefing sets out to answer some of the most frequently asked questions which the Kings Fund receives about the NHS, such as: What's the NHS annual budget? How many doctors and nurses are there? What's the cost of an operation? https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs<br>• **Healthcare Quality Improvement Partnership (HQIP) - National Audit of Care at the End of Life (NACEL): State of the Nations report.** The sustainable delivery of high quality end of life care requires ongoing review and continuous improvement to ensure compassionate and appropriate treatment. This report shows encouraging improvements in several aspects of care, with overall access to specialist palliative care remaining stable at 97% of hospital providers. It also highlights areas requiring further attention, such as the recording of spiritual, religious, and cultural needs. As a result, it recommends further national research into inequalities in end of life care and stronger system-level oversight of provider quality improvement plans. https://www.hqip.org.uk/report/nacel-712/<br>• **HQIP - National Maternity and Perinatal Audit NMPA): State of the Nation report.** This report presents findings from almost 600,000 singleton births in NHS maternity services across England, Scotland and Wales during 2024 - highlighting inequalities in timely access to maternity care and changing patterns of birth. It examines key measures of maternity care and outcomes, identifies national trends and variation, and makes recommendations to support quality improvement across maternity services. Local level initiatives and campaigns targeted at improving rates of timely pregnancy booking should be co-designed with groups and communities most likely to receive care after 10 weeks to ensure their needs are met. https://www.hqip.org.uk/report/nmpa-734/<br>• **HFMA Briefing – Sickness to prevention.** Sickness to prevention is one of three transformations that the governments of all four nations of the United Kingdom (UK) conclude is necessary to ensure that the NHS can be sustained. In an ageing population and with limited resource growth the need to prevent people becoming ill is a key to both better patient outcomes and more efficient solutions. This briefing summarises the approach to prevention taken by each of the four nations, the issues that the prevention and early diagnosis agenda raises and the role that finance staff have in securing delivery. https://www.hfma.org.uk/publications/sickness-prevention |
| **1.6** | **Communications and Engagement**<br><br>**Finalists announced for the Better Together Awards 2026**<br><br>A huge congratulations to our finalists for the Better Together Staff Awards 2026. This is the first time we've celebrated staff from both Wirral University Teaching Hospital and Wirral Community Health and Care together. We received 448 nominations, and our judges had a really tough job choosing the finalists from so many amazing entries. |

A big thank you to everyone who took the time to nominate a colleague or team this year.

The awards will take place at Thornton Hall Hotel on the evening of Friday 20 November, where the winners will be announced.

Our finalists are: *(in alphabetical order)*

| Category | Finalists |
|---|---|
| **Learner of the Year** | Olivia Fearon - Unplanned Care Therapy Team<br>Rachel Malam - Liscard Community Nursing<br>Tom Spence - Aseptics, Pharmacy |
| **Innovation & Improvement** | Gynaecology Clinical Pathways Team<br>Urgent & Emergency Care Improvement Team<br>Wirral Heart Failure Team |
| **Inclusion in Practice** | Sophie Steele - UTC<br>St Helens 0-19 Team (North, South, Haydock and Admin)<br>St Helens North 0-19 Team |
| **Excellence in Partnership Working** | Adult Speech and Language Therapy<br>Community Integrated Response Team<br>Dr John Tsang, Dr Tom Kennedy and the Wirral Pop Up Service |
| **Charity Champion 'Molby Award'** | Martin Pritchard-Howarth - DME<br>Sarah Broadbent - Birkenhead 0-19 Service<br>Stephanie Norris - EFC |
| **Support Services Team of the Year – WUTH** | eRoster Team<br>WUTH Improvement Team<br>WUTH IT Team |
| **Support Services Team of the Year – WCHC** | Central Admin and Booking Service<br>Knowsley 0-25 Admin Team |
| **Inspirational Leadership** | Jennifer Hough - Radiology<br>Judith Blease - Safeguarding<br>Rachel Shoukair - Family Nurse Partnership |
| **Clinical Team of the Year - WUTH** | Frailty Team<br>Stoma Nursing Team<br>Transitional Care (Neonates) |
| **Clinical Team of the Year - WCHC** | Children's Speech and Language Therapy<br>Sexual Health Wirral<br>St Helens 0-19 |
| **People's Choice - WUTH** | Fertility Team<br>HDU (Day and Night Team)<br>Sharon Johnstone - Outpatients |

| | |
|---|---|
| **People's Choice - WCHC** | Phil Rhodes - Fit Club<br>Sue Firth - SPA & Intermediate Care Teams<br>Victoria Central Medical Team (formerly Field Road) - Community Nurses, day and night staff |

**Employee Recognition - Award Winners**

At the Monthly All Staff Briefing, we were pleased to recognise and congratulate colleagues as follows:

- Theatres Band 7 Speciality Leads, winners of Employee / Team of the Month for Patient Care for August. The team was recognised for its outstanding leadership and teamwork during Hub Optimisation Week, helping to ensure theatre activity ran smoothly and efficiently
- Clinical Skills, POCT Team, TVN, Divisional Educators, the Transfusion Education Team and Dominique Gill, winners of WUTH's Employee / Team of the Month for Support Service
- Brendan Meehan received the Volunteer Making a Difference Award in recognition of the time, enthusiasm and support he gives to our hospitals
- Employee of the Month - Support Services went to Chloe Buckley, Junior Information Analyst – Trauma and Orthopaedics for her leadership and commitment to service improvement which have delivered significant and measurable benefits to both the Surgery Division and the wider Trust through the successful implementation and optimisation of Outpatient Procedure coding and reporting processes.
- The Community Nursing Admin Team received the WCHC Monthly Standout Award recognising their outstanding support to services across the Trust, ensuring continuity during staffing pressures and helping clinical colleagues remain focused on patient care. Their professionalism, collaborative approach and unwavering commitment to patients and colleagues exemplify the values of both organisations.

**Celebrating our Allied Health Professionals at WUTH**

Colleagues came together to celebrate Allied Health Professionals (AHP) Day on Wednesday 14 October, recognising the important contribution our AHP teams make to patient care across Wirral.

To mark the occasion, AHP colleagues organised an information stand at the main entrance of Arrowe Park Hospital, alongside a marketplace event in the Education Centre featuring interactive displays and activities.

AHPs, support staff and students showcased their professions, shared information about career pathways and highlighted the wide range of services they provide to patients.

As the third largest clinical workforce in health and care, AHPs play a vital role across WUTH, from Physiotherapy and Occupational Therapy to Radiography, Dietetics and many more specialties.

Thank you to everyone who helped organise and support the celebrations!

**New memorial tree unveiled at Arrowe Park Hospital in tribute to organ donors**

A new memorial honouring organ donors and their families has been unveiled at Arrowe Park Hospital to mark the start of Organ Donation Week.

The Organ Donation Memorial Tree, titled The Gift, was officially unveiled on Monday 21 September, providing a permanent place at the hospital to remember those who have given the gift of organ donation.

Created by Wirral artist Emma Rodgers, the striking metal sculpture takes the form of an oak tree.

The tree features individual metal leaves carrying the names of those remembered through the memorial, with further names able to be added in the years ahead, allowing The Gift to continue to grow as a lasting tribute to organ donors and their families.

It was a pleasure to join donor families and colleagues from WUTH, including members of the Organ Donation Committee.

**A huge thank you to our Arrowe Park Abseil fundraisers**

A huge thank you to everyone who took part in the Arrowe Park Abseil on 18 September. It was a brilliant day, and we're incredibly grateful to everyone who stepped over the edge to raise money for WUTH Charity.

Thank you too to friends, family, colleagues and supporters who sponsored our fundraisers and cheered them on throughout the day. Your support makes a real difference.

**Wear red to show racism the red card**

Friday 16 October was Wear Red Day, and we were proud to support it across WUTH and WCHC.

Wear Red Day is a National Day of Action led by the charity Show Racism the Red Card. It was a chance for all of us to show, together, that racism has no place in our hospitals, our community services or our communities.

Staff were encouraged to wear something red to support the cause. Colleagues across our hospital and community teams have already been showing the red card this week. Thank you to everyone who has taken part.

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

**04 November 2026**

| | |
|---|---|
| **Title** | 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 September 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 July 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

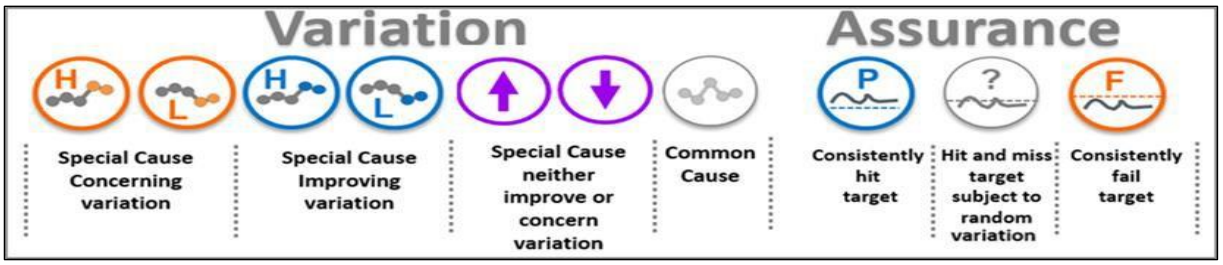
| **Contribution to Integrated Care System objectives (Triple Aim Duty):** | |
|---|---|
| **Better health and wellbeing for everyone** | Yes |
| **Better quality of health services for all individuals** | Yes |
| **Sustainable use of NHS resources** | Yes |

| **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 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. |

| 2 | General guidance and Statistical Process Charts (SPC) |
|---|---|
| 2.1 | <br>**Orange dots signify a statistical cause for concern. A data point will highlight orange if it:**<br>• Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.<br>• 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.<br>• Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.<br>**Blue dots signify a statistical improvement. A data point will highlight blue if it:**<br>• Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.<br>• 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.<br>• 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 | March 2027 Target |
|---|---|---|---|---|---|---|---|
| Sickness absence % - in-month rate | Sep 26 | 5.84% | ≤5% | | | 5.91% | |
| Staff turnover % - in-month rate | Sep 26 | 1.13% | ≤1% | | | 87.31% | |
| Mandatory training % compliance | Sep 26 | 90.34% | ≥90% | | | 91.82% | |
| Appraisal % compliance | Sep 26 | 83.23% | ≥88% | | | 0.84% | |
| 4-hour Accident and Emergency Target (including APH UTC) | Sep 26 | 53.55% | ≥60.38% | | | 60.7% | 64.69% |
| Number of inpatients not meeting the Criteria to Reside | Sep 26 | 150 | ≤114.9041 | | | 158 | 80 |
| Patients waiting longer than 12 hours in ED from a decision to admit | Sep 26 | 498 | ≤1448 | | | 647 | 1235 |
| Proportion of patients more than 12 hours in ED from time of arrival | Sep 26 | 20.58% | ≤18.18% | | | 18.3% | 15.00% |
| Ambulance Handovers: % >15 mins | Sep 26 | 86.50% | ≤74.99% | | | 79.7% | 74.99% |
| Ambulance Handovers: % > 45 mins | Sep 26 | 28.07% | ≤0% | | | 17.3% | 0.00% |
| 18 week Referral to Treatment - Incomplete pathways < 18 Weeks | Sep 26 | 65.89% | ≥66.8% | | | 59.9% | 70.30% |
| Referral to Treatment - total open pathway waiting list | Sep 26 | 43310 | ≤44271 | | | 45115 | 41087 |
| Referral to Treatment - cases waiting 65+ wks | Sep 26 | 0 | ≤0 | | | 8 | 0 |
| Referral to Treatment - % of 52+wk waiters | Sep 26 | 0.56% | ≤0.79% | | | 1.80% | 0.58% |
| Cancer Waits - reduce number waiting 62 days + | Aug 26 | 72 | ≤40 | | | 127 | ?? |
| Cancer - Faster Diagnosis Standard | Aug 26 | 74.39% | ≥79.95% | | | 73.6% | 81.32% |
| Cancer waits – % receiving first definitive treatment within 31 days of decision to treat | Aug 26 | 94.23% | ≥92.64% | | | 91.6% | 94.00% |
| Cancer Waits - 62 days to treatment (monthly) | Aug 26 | 78.18% | ≥77.54% | | | 74.9% | 80.00% |
| Diagnostic Waiters, 6 weeks and over - DM01 | Sep 26 | 92.87% | ≥93.5% | | | 93.1% | 94.50% |
| Long length of stay - number of patients in hospital for 21 or more days | Sep 26 | 189 | ≤79 | | | 170 | 79 |
| Corridor Care - average daily number of patients in month | Sep 26 | 30 | - | | | 38 | - |
| Corridor Care - total number of patients in month | Sep 26 | 923 | - | | | 1158 | - |
| Clostridioides difficile (healthcare associated) | Sep 26 | 7 | ≤8 | | | 11 | |
| Pressure Ulcers - Hospital Acquired Category 3 and above | Sep 26 | 3 | ≤0 | | | 2 | |
| Duty of Candour compliance - breaches of DoC standard for Serious Incidents | Sep 26 | 5 | ≤0 | | | 0 | |
| Patient Safety Incidents | Sep 26 | 1392 | - | | | 1237 | |
| FFT Overall experience of very good & good: ED | Sep 26 | 49.0% | ≥95% | | | 74.7% | |
| FFT Overall experience of very good & good: Inpatients | Sep 26 | 97.5% | ≥95% | | | 95.8% | |
| FFT Overall experience of very good & good: Outpatients | Sep 26 | 98.5% | ≥95% | | | 95.8% | |
| FFT Overall experience of very good & good: Maternity | Sep 26 | 100.0% | ≥95% | | | 96.4% | |
| Patient Experience: concerns received in month - Level 1 (informal) | Sep 26 | 431 | ≤173 | | | 244 | |
| Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal) | Sep 26 | 5 | ≤3 | | | 3 | |
| Falls – Moderate to Severe Harm | Sep 26 | 0.14 | ≤0 | | | 0.15 | |
| WUTH Average RN Day Staffing Fill Rates | Sep 26 | 88.0% | ≥90% | | | 89.1% | |
| WUTH Average RN Night Staffing Fill Rates | Sep 26 | 91.0% | ≥90% | | | 91.0% | |
| WUTH Average CSW Day Staffing Fill Rates | Sep 26 | 88.0% | ≥90% | | | 87.4% | |
| WUTH Average CSW Night Staffing Fill Rates | Sep 26 | 109.0% | ≥90% | | | 100.4% | |
| MRSA Cases | Sep 26 | 1 | ≤0 | | | 0 | |
| MSSA Cases | Sep 26 | 2 | ≤0 | | | 2 | |
| % of adult patients VTE risk-assessed on admission | Sep 26 | 97.9% | ≥95% | | | 97.3% | |
| Never Events | 2026/27 | 1 | ≤0 | | | | |
| NEWS2 Compliance | Sep 26 | 89.9% | ≥90% | | | 89.4% | |
| Mortality (SHMI) | May 26 | 0.957 | <1 | | | 1.020 | |
| Agency spend | Sep 26 | 1.3% | ≤0.8% | | | | |
| I&E Position | Sep 26 | -£15.1m | -£15.4m | | | | |
| Cumulative CIP | Sep 26 | £10.4m | £10.4m | | | | |
| Capital Expenditure | Sep 26 | £6.5m | £7.4m | | | | |
| Cash Position | Sep 26 | £5.1m | £2.7m | | | | |
| Staff Vacancy as % of workforce | Sep 26 | 19.8% | ≤7% | | | 12.2% | |
| Subject Access requests - waiting list | Sep 26 | 2340 | ≤2252 | | | | |
| FOI – Waiting List | Sep 26 | 150 | ≤75 | | | | |
| Clinical coding completeness (Freeze) | Aug 26 | 100.0% | ≥100% | | | 94.2% | |

**WUTH 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**  | - Mortality (SHMI)<br>- WUTH Average CSW Night Staffing Fill Rates | - Clinical coding completeness (Freeze)<br>- NEWS2 Compliance<br>- FFT Overall Experience of very good & good : Inpatients<br>- FFT Overall Experience of very good & good : Outpatients<br>- WUTH Average CSW Day Staffing Fill rates<br>- Cancer waits – 62 days to treatment (monthly)<br>- Cancer – Faster Diagnosis Standard<br>- RTT – total open pathway waiting list<br>- RTT – cases waiting 65+ wks<br>- | - 18 week RTT - Incomplete pathways < 18 wks<br>- Cancer waits – reduce number waiting 62 days +<br>- % of 52+ wk waiters | - Corridor Care – average daily number of patients in month<br>- Corridor Care – total number of patients in month |
| | **Common Cause**  | - % of adult patients VTE risk-assessed on admission<br>- 12 hr waits from decision to admit in ED | - Staff turnover % in month rate<br>- Never Events<br>- Clostridioides difficile (healthcare associated)<br>- Pressure Ulcers – Hospital Acquired Cat 3 and above<br>- FFT Overall experience of very good & good: Maternity<br>- Patient Experience – complaints in month per 1000 staff – Level 2 (formal)<br>- Falls – Moderate to Severe Harm (per 1000 bed days)<br>- WUTH Average RN Day Staffing Fill Rates<br>- WUTH Average RN Night Staffing Fill Rates<br>- MRSA Cases<br>- MSSA Cases<br>- Number of inpatients not meeting the criteria to reside<br>- 12 hr waits from arrival in ED<br>- Cancer waits - % receiving first definitive treatment within 31 days of decision to treat<br>- Diagnostic Waiters, 6 weeks and over – DM01<br>- Ambulance Handovers % > 15mins | - Sickness absence % - in month rate<br>- Ambulance Handovers % > 45 mins | |
| | **Special Cause Concerning**  | - | - Appraisal % Compliance<br>- Mandatory Training % compliance<br>- Duty of Candour compliance – breaches of DoC standard for serious incidents<br>- Patient Experience: Concerns received in month – Level 1 (informal)<br>- 4-hour ED Target (including APH UTC) | - Staff Vacancy as % of workforce<br>- FFT Overall experience of very good & good: ED<br>- Long length of stay – number of patients in hospital for 21 or more days | - Patient Safety Incidents |

## WUTH NHS Oversight Framework (NOF) Dashboard Q1 2026-2027

| | | 2026/27 - Qtr 1 Metric Performance | | | | | Metric Value Quartiles 2026/27 Q1 | | | | | Domain Performance Qtr 1 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Metric** | **Domain Group** | **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** |
| **Access to Services Domain** | | | | | | | | | | | | | |
| % of cases waiting <18wks for elective treatment | Elective Care | 65.39% | 66 | Jun-26 | ↑ | 65.05% | | | **65.39%** | | 65.45 to 62.32 | **2.86** | **3** |
| % of cases waiting >52wks for elective treatment | Elective Care | 0.71% | 46 | Jun-26 | ↑ | | | **0.71%** | | | 0.47 to 1.07 | | |
| % of cases waiting >52wks for community treatment | Elective Care | 50.34% | 74 | Jun-26 | ↓ | | | | | **50.34%** | 7.61 to 100 | | |
| % of cases waiting <18wks for community treatment | Elective Care | 25.86% | 74 | Jun-26 | ☒ | | | | | **25.86%** | 65.07 to 0 | | |
| % of referrals waiting >6wks for test or procedure | Diagnostics | 4.95% | 21 | Jun-26 | ☒ | | **4.95%** | | | | 0 to 9.47 | | |
| % of cases meeting 28day Faster Diagnosis Standard | Cancer Care | 79.27% | 62 | Q1 2026/27 | ↑ | 79.52% | | | **79.27%** | | 79.51 to 75.16 | | |
| % of cases treated within 62 days of referral | Cancer Care | 77.62% | 28 | Q1 2026/27 | ↑ | 76.36% | **77.62%** | | | | 100 to 77.39 | | |
| % of A&E pts admitted, transferred, discharged <4hrs | Urgent Care | 73.20% | 81 | Q1 2026/27 | ↑ | 57.25% | | | **73.20%** | | 75.6 to 70.85 | | |
| % of pts >12hrs in ED without being admitted, transferred, discharged | Urgent Care | 19.85% | 119 | Q1 2026/27 | ↑ | | | | | **19.85%** | 12.68 to 100 | | |
| **Experience of Care Domain** | | | | | | | | | | | | | |
| CQC inpatient survey satisfaction rate | Experience | 2 | - | Q1 2026/27 | ⇔ | | | **2** | | | - | **2.83** | **4** |
| NHS staff survey advocacy sub-score | Experience | 5.94 | 119 | 2025 | ☒ | | | | | **5.94** | 6.19 to 0 | | |
| **Effeciveness of Care and Population Health Domain** | | | | | | | | | | | | | |
| % of inpts refered to and seen by in-house tobacco service who attempt to stop | Preventing Ill Health | 73.33% | 9 | To Mar 2026 | ☒ | | **73.33%** | | | | 100 to 45.8 | **1.91** | **2** |
| Summary Hospital Mortality Indicator | Outcomes | 2 | - | Q1 2026/27 | ⇔ | | | **2** | | | - | | |
| Delayed inductions rate | Outcomes | 31.20 | 59 | Q1 2025/26 | ☒ | | | **31.20** | | | 17.75 to 31.2 | | |
| % of patients readmitted within 30 days of discharge | Effective Discharge | 2 | - | Q1 2026/27 | ☒ | | | **2** | | | - | | |
| **Patient Safety Domain** | | | | | | | | | | | | | |
| Clinical audit outlier score | High Quality Care | 1 | - | Q1 2026/27 | ☒ | | **1** | | | | - | **2.57** | **3** |
| No. of cases of MRSA in last 12 months | Safe Outcomes | 2.00 | - | To Jun 2026 | ⇔ | | | **2.00** | | | 1 to 3 | | |
| Rate of e-coli | Safe Outcomes | 1.25 | - | To Jun 2026 | ↑ | | | | **1.25** | | - | | |
| Rate of c-difficile | Safe Outcomes | 1.31 | - | To Jun 2026 | ↑ | | | | | **1.31** | - | | |
| NHS Staff survey - raising concerns sub-score | Safe Culture | 6.01 | 118 | 2025 | ⇔ | | | | | **6.01** | 6.14 to 0 | | |
| **Finance, Productivity and Innovation Domain** | | | | | | | | | | | | | |
| Combined finance score | Finance | 2 | - | Q1 2026/27 | ↑ | | | **2** | | | - | **2.49** | **3** |
| Planned surplus/deficit | Finance | -4.18% | 113 | Q1 2026/27 | ↑ | | | | | **-4.18%** | -2.92 to -100 | | |
| Variance to plan year-to-date | Finance | 0.02 | 23 | Q1 2026/27 | ↑ | | **0.02** | | | | 100 to 0.01 | | |
| Relative cost difference (National Cost Collection Index) | Productivity | 85.68 | 4 | Dec-25 | ☒ | | **85.68** | | | | 0 to 94.28 | | |
| % of clinical trials setup within 90 days | Innovation | 0.00% | 104 | Q1 2026/27 | ☒ | | | | | **0.00%** | 29.63 to 0 | | |
| Overall Data Quality Maturity Index | Innovation | 91.5 | 87 | Apr-26 | ☒ | | | | **91.5** | | 93 to 90.5 | | |
| **People Domain** | | | | | | | | | | | | | |
| Sickness Absence rate | People and Culture | 5.72% | 94 | To Mar 2026 | ↑ | | | | **5.72%** | | 5.36 to 5.86 | **2.92** | **4** |
| NHS Staff Survey engagement theme sub-score | People and Culture | 6.35 | 126 | 2025 | ⇔ | | | | | **6.35** | 6.55 to 0 | | |
| National Education and Training Survey overall experience sub-score | People and Culture | 80.34% | 21 | 2025 | ☒ | | | **80.34%** | | | 78.8 to 76.34 | | |
| NHS staff standards sub-score | People and Culture | 7.30 | 124 | Q3 2025-26 | ☒ | | | | | **7.3** | 7.42-0 | | |
| % of frontline healthcare workers to receive a flu vaccination | People and Culture | 43.60% | 108 | Feb-26 | ☒ | | | | **43.60%** | | 50.35 to 44.73 | | |
| Temporary staffing bank score | Workforce | 2 | - | Q1 2026/27 | ☒ | | | **2** | | | - | | |
| Temporary staffing agency score | Workforce | 2 | - | Q1 2026/27 | ☒ | | | **2** | | | - | | |

## WCHC Indicators Dashboard

| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Turnover Rolling 12 Months | Sept 26 | 10.5% | 12.0% | | | 12.4% |
| Mandatory Training Compliance | Sept 26 | 94.3% | 90.0% | | | 95.0% |
| Sickness Absence | Sept 26 | 6.9% | 5.0% | | | 6.5% |
| Sickness Absence (Short Term) | Sept 26 | 2.4% | 2.0% | | | 1.6% |
| Sickness Absence (Long Term) | Sept 26 | 4.6% | 3.0% | | | 4.9% |
| Agency usage | Sept 26 | 0.2% | 1.0% | | | 0.9% |
| Variance to Agency Cap (£) | Sept 26 | -206461 | - | | | -177197.8 |
| % of Agency Usage against Funded WTE | Sept 26 | 0.0% | - | | | 0.6% |
| % of Bank Usage against Funded WTE | Sept 26 | 4.3% | - | | | 3.5% |
| % of Contracted FTE Vacancies | Sept 26 | 4.8% | 6.0% | | | 5.0% |
| WIC & UTC Attendances seen within 4 hrs | Sept 26 | 88.3% | 95.0% | | | 96.10% |
| CICC Occupancy Rate (Commissioned Beds) | Sept 26 | 95.7% | 92.0% | | | 95.5% |
| CICC Median LoS (Active Beds Daily Snapshot) | Sept 26 | 16 | 21 | | | 18.6 |
| Urgent Community Response - 2 hours | Sept 26 | 90.4% | 70.0% | | | 87.6% |
| GPOOH - UCAT Response Times (60 min response) | Sept 26 | 98.3% | 98.0% | | | 98.8% |
| GPOOH - UCAT Response Times (15 min response) | Sept 26 | 76.3% | 65.0% | | | 69.2% |
| GPOOH - UCAT Response Times (30 min response) | Sept 26 | 93.6% | 90.0% | | | 93.0% |
| GPOOH - CAS Response Times (20 min response) | Sept 26 | 63.5% | 75.0% | | | 69.7% |
| GPOOH - CAS Response Times (2hr response) | Sept 26 | 83.8% | 90.0% | | | 70.9% |
| GPOOH - NHS111 Response Times | Sept 26 | 79.7% | 75.0% | | | 61.9% |
| RTT - % of Patients Seen Within 18 Weeks | Sept 26 | 100.0% | 92.0% | | | 99.8% |
| DM01 - % of Patients Waiting with a Wait Under 6 weeks | Sept 26 | 100.0% | 99.0% | | | 100.0% |
| UTC Attendances seen within 4 hrs | Sept 26 | 85.5% | 95.0% | | | 97.7% |
| VCHC Attendances seen within 4 hrs | Sept 26 | 86.6% | 95.0% | | | 94.3% |
| Eastham Attendances seen within 4 hrs | Sept 26 | 96.3% | 95.0% | | | 93.9% |
| Serious untoward incidents - reported via StEIS (Exc. IPC Contract) | Sept 26 | 0 | 0 | | | 0 |
| No. of Incidents reported | Sept 26 | 448 | 475 | | | 481 |
| Patient Safety Incidents | Sept 26 | 187 | 200 | | | 203 |
| Never events | Sept 26 | 0 | 0 | | | 0 |
| No. of ICO reportable IG incidents | Sept 26 | 0 | 0 | | | 0 |
| Total Complaints Received | Sept 26 | 8 | 3 | | | 3 |
| Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust | Sept 26 | 0 | 0 | | | 0 |
| Missed medication incidents resulting in moderate or severe harm | Sept 26 | 0 | 0 | | | 0 |
| No. of Incidents reported with a moderate and above harm level | Sept 26 | 0 | 0 | | | 0 |
| Clostridium difficile infections resulting in moderate or severe harm | Sept 26 | 0 | 0 | | | 0 |
| MRSA infections with learning identified for the Trust | Sept 26 | 0 | 0 | | | 0 |
| Falls resulting in moderate or above harm | Sept 26 | 0 | 0 | | | 0 |
| % of all incidents with moderate and above harm level relating to Trust | Sept 26 | 0.5% | 4.6% | | | 1.4% |
| No. of concerns received in month | Sept 26 | 2 | 12 | | | 12 |
| FFT - % of People who would recommend our services | Sept 26 | 95.3% | 90.0% | | | 91.5% |
| Falls resulting in moderate or above harm per 1,000 Occupied Bed Days | Sept 26 | 0.00 | 0.00 | | | 0.13 |
| Serious untoward incidents - reported via StEIS (IPC Contract) | Sept 26 | 0 | 0 | | | 0 |
| No. of reported no and low harm patient safety incidents | Sept 26 | 174 | 200 | | | 190 |

**WCHC Scorecard Matrix – to be populated as per table above with WCHC indicators.**

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

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

## Wirral Community Health and Care NHS Foundation Trust

TABLE 1: SCORED METRICS (Contributing to Segmentation)

| | | 2025/26 - Qtr 4 Metric Performance | | | | | Metric Value Quartiles 2025/26 Q4 | | | | | Domain Performance Qtr 4 | | 2025/26 - Qtr 3 Metric Performance | | | | Domain Performance Qtr 3 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% | 1/42 | Mar-26 | ⇔ | - | 1 | | | | 0 to 0.02 | 1 | 1 | 0.0% | 1/41 | Q3 2025/26 | 1 | 1 | 1 |
| **EFFECTIVENESS & EXPERIENCE DOMAIN** | | | | | | | | | | | | | | | | | | | |
| Urgent Community Response 2-hour performance | Community | 85.98% | 24/38 | Q4 2025/26 | ↑ | 70% | | | 2.08 | | 88.86% to 79.80% | 2.08 | 2 | 85.92% | 21/38 | Q3 2025/26 | 2 | 2.11 | 2 |
| **PATIENT SAFETY DOMAIN** | | | | | | | | | | | | | | | | | | | |
| Staff survey - raising concerns | Acute/Community | 6.9 | 14/61 | 2025 | ↓ | - | | | 1.65 | | 6.95 to 6.81 | 1.65 | 1 | 6.94 | 18/61 | 2024 | 1 | 1.85 | 1 |
| CQC safe inspection score | Acute/Community | 2 | 2 | 2023 | ⇔ | - | | 2 | | | | | | 2 | 2 | 2023 | 2 | | |
| **PEOPLE & WORKFORCE DOMAIN** | | | | | | | | | | | | | | | | | | | |
| Sickness absence rate | Acute/Community | 7.49% | 52/61 | Q3 2025/26 | ↓ | - | | | | 3.75 | 6.52% to 7.95% | 3.48 | 4 | 7.45% | 58/61 | Q2 2025/26 | 4 | 3.37 | 4 |
| Staff survey engagement score | Acute/Community | 6.85 | 45/61 | 2025 | ↓ | - | | | 3.2 | | 7.08 to 6.95 | | | 7.02 | 37/61 | Dec-24 | 3 | | |
| **FINANCE & PRODUCTIVITY DOMAIN** | | | | | | | | | | | | | | | | | | | |
| Planned surplus/deficit | Acute/Community | 0.85% | 6/61 | 2025/26 plan | ⇔ | Breakeven/ Surplus | 1 | | | | 2.39 to 0 | 1.09 | 1 | 0.85% | 6/61 | Q3 2025/26 | 1 | 1.09 | 1 |
| Variance YTD to plan | Acute/Community | 3.70% | 1/61 | Mth12 2025/26 | ↑ | - | 1 | | | | 2.27 to 0.21 | | | 2.27% | 1/61 | Dec-25 | 1 | | |

*** arrow denotes improvement or deterioration from previous score**

## CMO Quality and Safety Summary - WUTH

| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| % of adult patients VTE risk-assessed on admission | Sep 26 | 97.9% | ≥95% | | | 97.3% |
| Never Events | 2026/27 | 1 | ≤0 | | | |
| NEWS2 Compliance | Sep 26 | 89.9% | ≥90% | | | 89.4% |
| Mortality (SHMI) | May 26 | 0.957 | <1 | | | 1.020 |

### Highlights

• VTE risk assessment compliance remains consistently above the 95% threshold, demonstrating sustained reliability in the assessment of adult patients on admission.

• NEWS2 compliance shows special-cause improvement, indicating that recent improvement activity is having a positive effect.

• SHMI remains within the expected range and consistently meets the required threshold.

### Areas of Concern

• NEWS2 compliance is not yet consistently meeting the required threshold. Although the overall direction is improving, variation remains, and further work is required to embed reliable assessment, documentation and escalation across all clinical areas.

• Never Events remain a zero-tolerance measure. The never event was declared in this financial year but the incident itself occurred in the 2024/25 financial year.

### Forward Look (Actions)

• Maintain oversight of VTE risk-assessment compliance, with prompt divisional review of any deterioration or clinical areas falling below threshold.

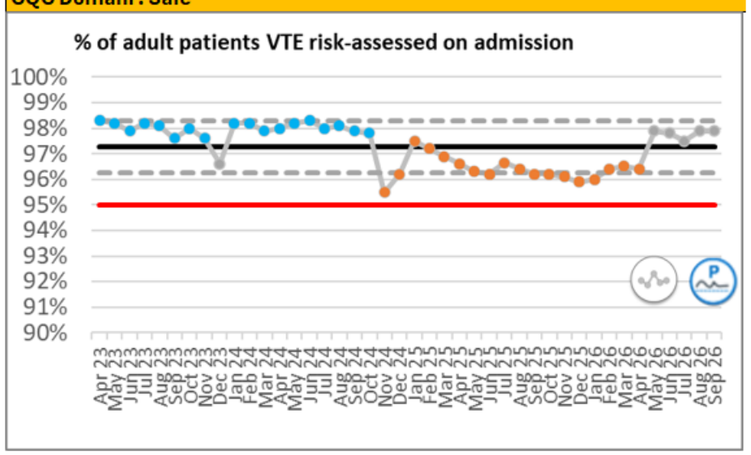
• Continue targeted improvement work to achieve and sustain reliable NEWS2 assessment, documentation and escalation, with focused support for clinical areas demonstrating unwarranted variation. New digital solution planned for Q4 will help with oversight and real time escalation.

• Never event review has been completed, and learning has been shared with teams. Processes in theatre have been strengthened to reflect the learning identified

• Maintain oversight of VTE risk-assessment compliance, with prompt divisional review of any deterioration or clinical areas falling below threshold.

## % of adult patients VTE risk assessed on admission

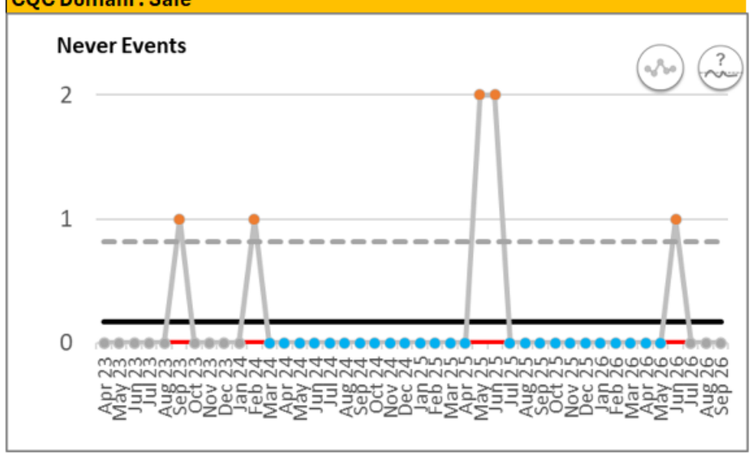
CQC Domain : Safe




| Sep-26 |
|---|
| 97.9% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Consistently hit target |

## Never Events

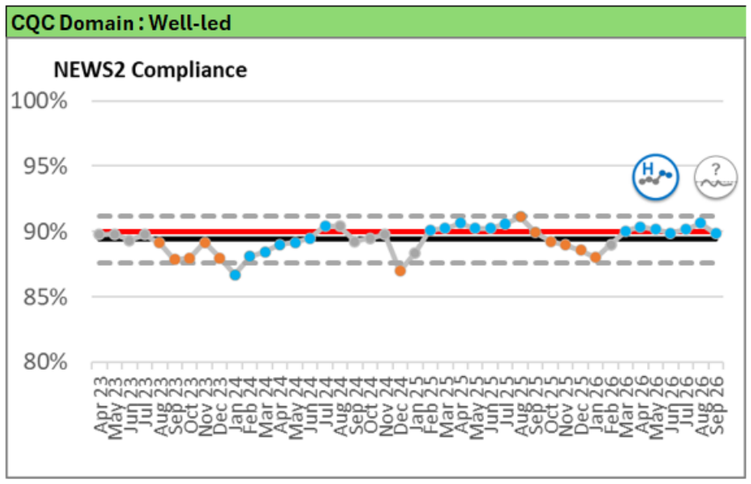
CQC Domain : Safe




| 2026/27 |
|---|
| 1 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## NEWS 2 Compliance

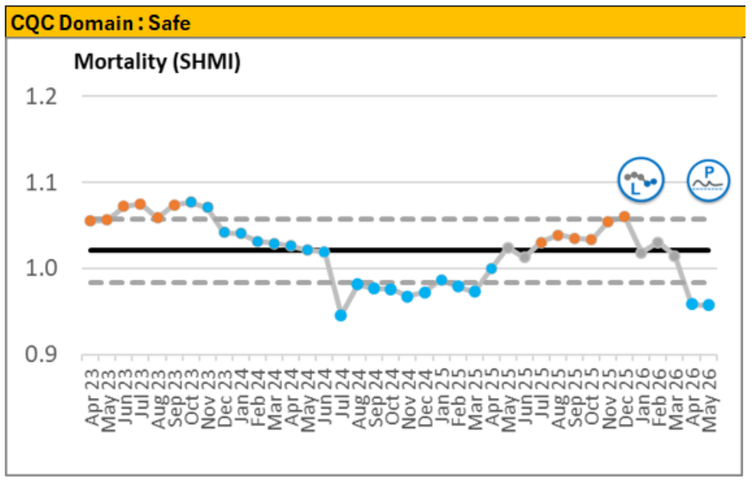
CQC Domain : Well-led




| Sep-26 |
|---|
| 89.9% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Mortality (SHMI)

CQC Domain : Safe




| May-26 |
|---|
| 0.9571 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| <1 |
| **Assurance** |
| Consistently hit target |

## CNO Quality and Safety Summary - WUTH

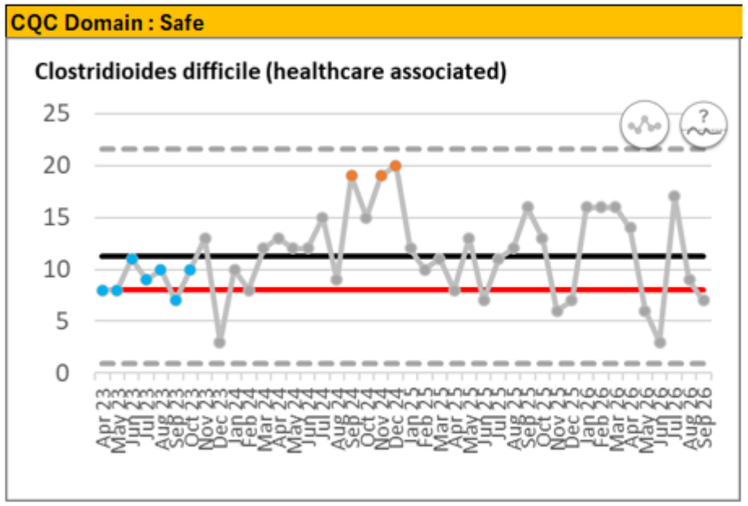
| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Clostridioides difficile (healthcare associated) | Sep 26 | 7 | ≤8 | | | 11 |
| Pressure Ulcers - Hospital Acquired Category 3 and above | Sep 26 | 3 | ≤0 | | | 2 |
| Duty of Candour compliance - breaches of DoC standard for Serious Incidents | Sep 26 | 5 | ≤0 | | | 0 |
| Patient Safety Incidents | Sep 26 | 1392 | - | | | 1237 |
| FFT Overall experience of very good & good: ED | Sep 26 | 49.0% | ≥95% | | | 74.7% |
| FFT Overall experience of very good & good: Inpatients | Sep 26 | 97.5% | ≥95% | | | 95.8% |
| FFT Overall experience of very good & good: Outpatients | Sep 26 | 98.5% | ≥95% | | | 95.8% |
| FFT Overall experience of very good & good: Maternity | Sep 26 | 100.0% | ≥95% | | | 96.4% |
| Patient Experience: concerns received in month - Level 1 (informal) | Sep 26 | 431 | ≤173 | | | 244 |
| Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal) | Sep 26 | 5 | ≤3 | | | 3 |
| Falls – Moderate to Severe Harm | Sep 26 | 0.14 | ≤0 | | | 0.15 |
| WUTH Average RN Day Staffing Fill Rates | Sep 26 | 88.0% | ≥90% | | | 89.1% |
| WUTH Average RN Night Staffing Fill Rates | Sep 26 | 91.0% | ≥90% | | | 91.0% |
| WUTH Average CSW Day Staffing Fill Rates | Sep 26 | 88.0% | ≥90% | | | 87.4% |
| WUTH Average CSW Night Staffing Fill Rates | Sep 26 | 109.0% | ≥90% | | | 100.4% |
| MRSA Cases | Sep 26 | 1 | ≤0 | | | 0 |
| MSSA Cases | Sep 26 | 2 | ≤0 | | | 2 |

| **Clostridioides difficile (healthcare associated)** | | |
|---|---|---|
| **Highlights**<br><br>CDT cases reduced in September, with 3 HOHA and 4 COHA cases.<br>Despite this improvement, there remains a risk that the Trust will exceed the NHSE threshold. | **Areas of Concern**<br><br>• Prompt isolation can be impacted by the location and availability of appropriate side rooms<br>• Environmental condition in some ward areas affects effective cleaning<br>• A more consistent approach to patient hand hygiene is required, including appropriate wipes for patients unable to mobilise independently. | **Forward Look (Actions)**<br><br>• CDT QI workshop held on 19 October 2026, with immediate improvement actions to be identified and implemented<br>• Review the PSIRF approach for IPC hospital-associated infections to ensure appropriate learning and oversight. |
| **Pressure Ulcers Hospital acquired Category 3 and above** | | |
| **Highlights**<br><br>Two Category 3 pressure ulcers worsened in care and one new Category 3 pressure ulcer was reported during September. | **Areas of Concern**<br><br>• Inconsistent completion of PURPOSE-T<br>• Inconsistent skin assessment within six hours of admission<br>• Incorrect pathway and mattress selection<br>• Gaps in wound assessment documentation. | **Forward Look (Actions)**<br><br>• Continue delivery of education and competency assessment through the Pressure Ulcer QI improvement plan<br>• Extend Pressure Ulcer Quality Improvement practices across the organisation<br>• Work with the Cerner team to strengthen tissue viability documentation. |
| **FFT Overall experience of very good & good: ED** | | |
| **Highlights** | **Areas of Concern** | **Forward Look (Actions)** |

| | | |
|---|---|---|
| ED FFT recommend rate reduced to 49%. Transition to the new digital provider resulted in significant disruption to response collection, reducing responses from approximately 650 per month to 96, meaning the current result should be considered alongside the substantially smaller response base. | • Patient feedback continues to identify<br>  ○ Waiting times<br>  ○ Communication<br>  ○ Information about the triage process<br>  ○ Difficulty hearing names being called<br>with some patients reporting that they have missed their place. | • Increase staff engagement and active promotion of FFT<br>• Explore digital calling boards to address patient feedback<br>• SMS feedback collection planned to go live 26 October 2026 to increase response volume and strengthen representativeness. |
| **Complaints** | | |
| **Highlights**<br><br>430 Level 1 concerns and 29 Level 2 formal complaints were received in September. Level 1 concerns increased by 59% from August and were 50% above the preceding 12-month average. Formal complaints reduced from 43 to 29 and remain broadly consistent with the longer-term trend. | **Areas of Concern**<br><br>Timeliness remains the principal concern<br>• Level 1 resolution within three working days improved slightly from 58% to 60%<br>• Formal complaint acknowledgement improved from 35% to<br>• 59%<br>• 17% of formal complaints were responded to within 40 working days, compared with 31% in August.<br><br>• The principle themes remain:<br>  ○ Communication<br>  ○ Access & Admission<br>  ○ Treatment & Procedure. | **Forward Look (Actions)**<br><br>• Maintain focused oversight of complaint acknowledgement and response timeliness<br>  ○ particularly outstanding divisional investigations<br>• Review capacity and processes across the complaints pathway and continue thematic review of the significant increase in Level 1 concerns to determine whether this becomes a sustained trend or identifies service-specific improvement requirements. |
| **Falls – Moderate to Severe Harm** | | |
| **Highlights**<br><br>Moderate to severe harm falls reduced in September to 0.14 per 1,000 bed days, following the increase seen in August. The September position has returned closer to the Trust's established level, although the ambition remains zero avoidable moderate / severe harm. | **Areas of Concern**<br><br>• Moderate to severe harm from falls continues to occur<br>• Engagement with the Falls Champion Network needs strengthening, with low attendance at the first meeting<br>• Continued assurance is also required that the new policy and<br>• supporting resources are being consistently adopted in practice. | **Forward Look (Actions)**<br><br>• Embed the new Falls Policy and strengthen the Falls Champion Network, with ongoing review of moderate / severe harm falls to identify themes and learning<br>• Monitor implementation of the falls boxes and policy to demonstrate whether these interventions are improving falls prevention practice. |
| **Staffing** | | |
| **Highlights**<br><br>RN and CSW staffing fill rates continue to be monitored across day and night shifts, alongside patient acuity and clinical demand.<br>Recruitment activity undertaken previously is supporting the ongoing focus on workforce stability, particularly within CSW staffing. | **Areas of Concern**<br><br>• Variation in fill rates and skill mix continues to require oversight, particularly where staffing pressures coincide with high acuity and operational demand<br>• CSW staffing remains an area requiring continued focus. | **Forward Look (Actions)**<br><br>• Continue focused CSW recruitment and retention, including training and progression opportunities<br>• Maintain senior nursing oversight of staffing, skill mix and patient acuity, with escalation and deployment used to mitigate areas of identified risk. |
| **MRSA/MSSA Cases** | | |
| **Highlights**<br><br>One MRSA and two MSSA bacteraemias were reported in September. The MRSA review identified delayed decolonisation and gaps in assurance around invasive device care. One MSSA case was associated with an infected peripheral cannula; the source of the second remains unknown, with gaps identified in cannula documentation and management. | **Areas of Concern**<br><br>• Peripheral cannula management is emerging as a recurrent area requiring improvement, including insertion, ongoing care and timely removal of invasive devices. | **Forward Look (Actions)**<br><br>• Learning relating to peripheral cannula care has been shared with the Vascular Access Steering Group, with improvement work to focus on strengthening insertion, ongoing management and removal practices. |

## Clostridioides difficile (healthcare associated)

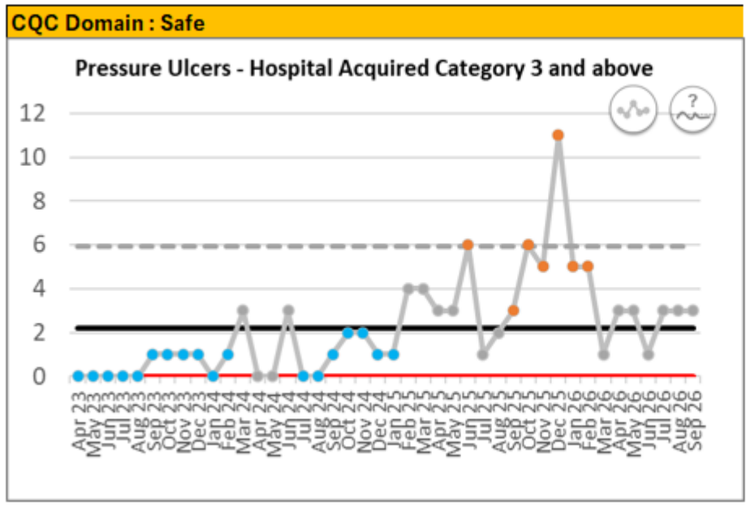
**CQC Domain : Safe**




| Sep-26 |
|---|
| 7 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤8 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Pressure Ulcers – Hospital Acquired Category 3 and above

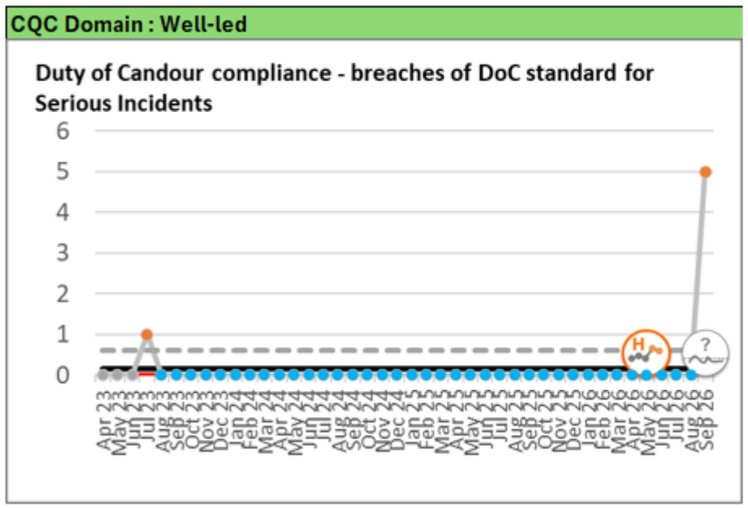
**CQC Domain : Safe**




| Sep-26 |
|---|
| 3 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Duty of Candour Compliance

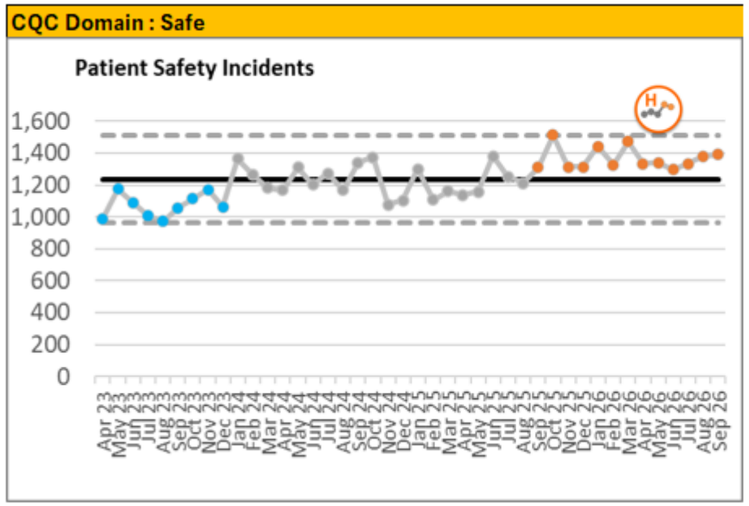
**CQC Domain : Well-led**




| Sep-26 |
|---|
| 5 |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Patient Safety Incidents

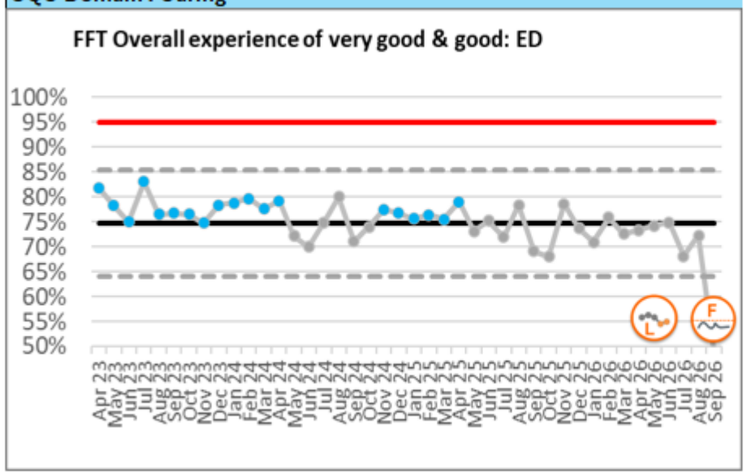
**CQC Domain : Safe**




| Sep-26 |
|---|
| 1392 |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| - |
| **Assurance** |
| Not applicable |

## FFT Overall experience of very good & good – ED

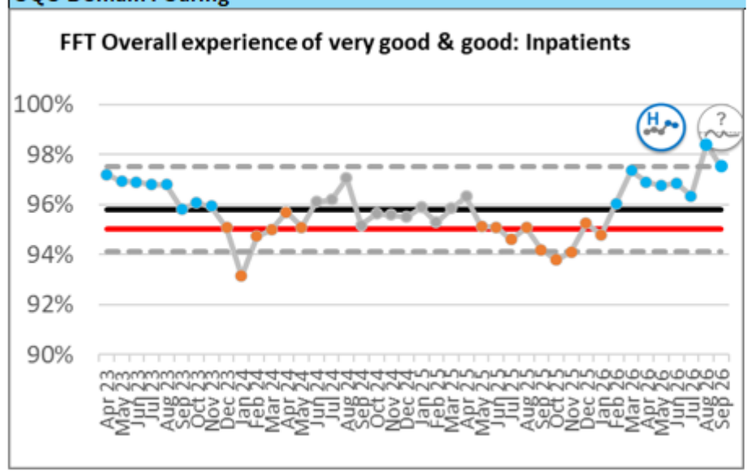
**CQC Domain : Caring**




| Sep-26 |
|---|
| 49.0% |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Consistently fail target |

## FFT Overall experience of very good & good – Inpatients

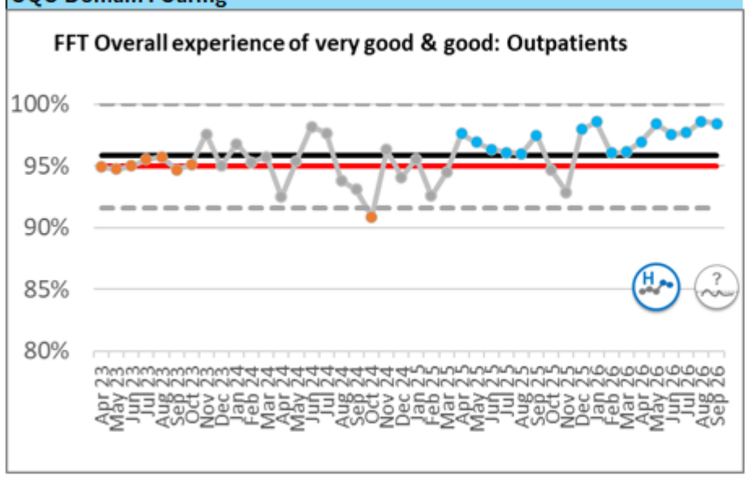
**CQC Domain : Caring**




| Sep-26 |
|---|
| 97.5% |
| **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

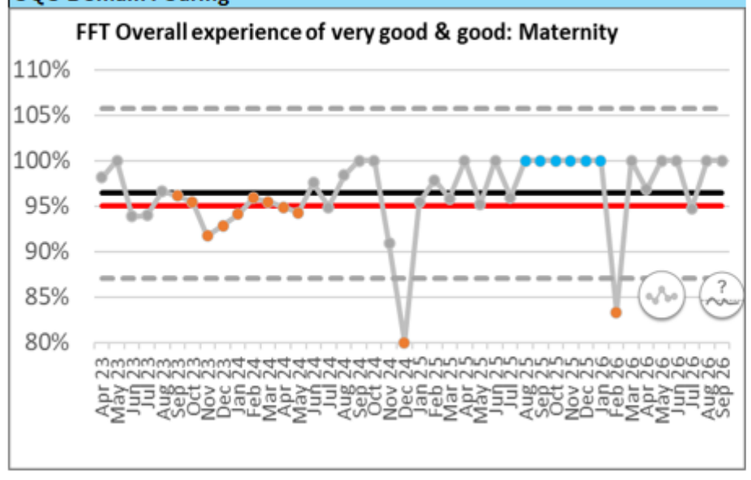
**CQC Domain : Caring**




| Sep-26 |
|---|
| 98.5% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit and miss target subject to random variation |

## FFT Overall experience of very good & good – Maternity

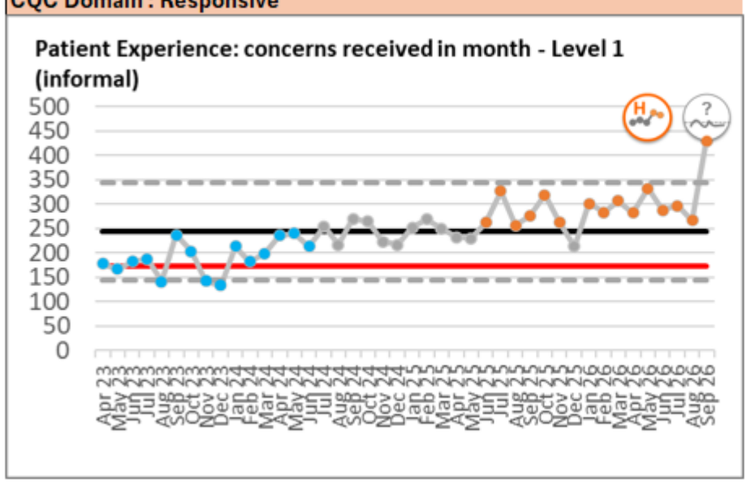
**CQC Domain : Caring**




| Sep-26 |
|---|
| 100.0% |
| **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)

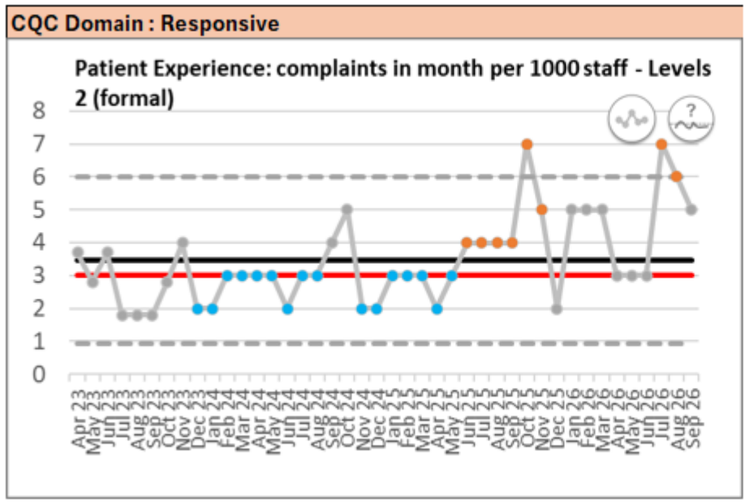
CQC Domain : Responsive




| Sep-26 |
|---|
| 431 |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≤173 |
| **Assurance** |
| Hit and miss target subject to random variation |

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

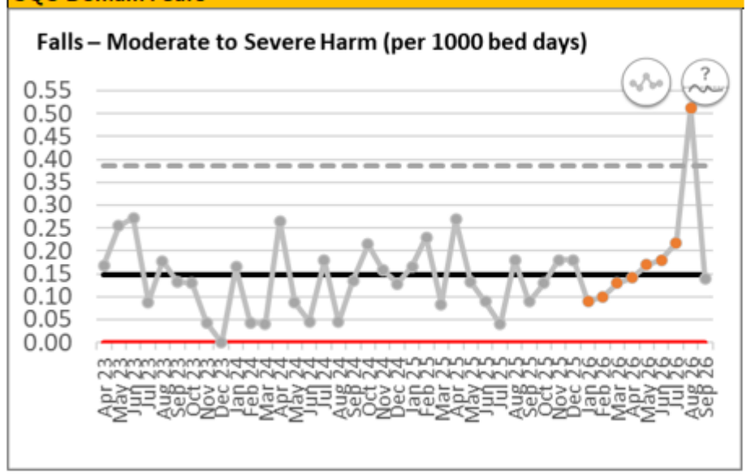
CQC Domain : Responsive




| Sep-26 |
|---|
| 5 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤3 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Falls – Moderate to Severe Harm

CQC Domain : Safe



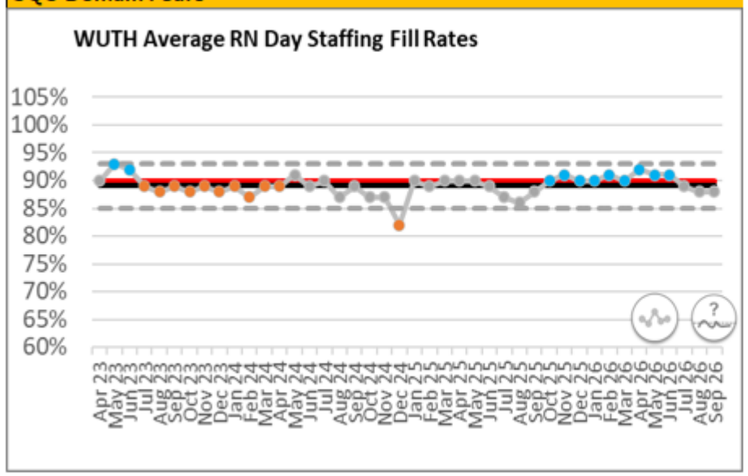

| Sep-26 |
|---|
| 0.14 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Sepsis Screening – Antibiotics within 1 hour

Status: KPI TBC

## Average Registered Nurse Day Staffing Fill Rates

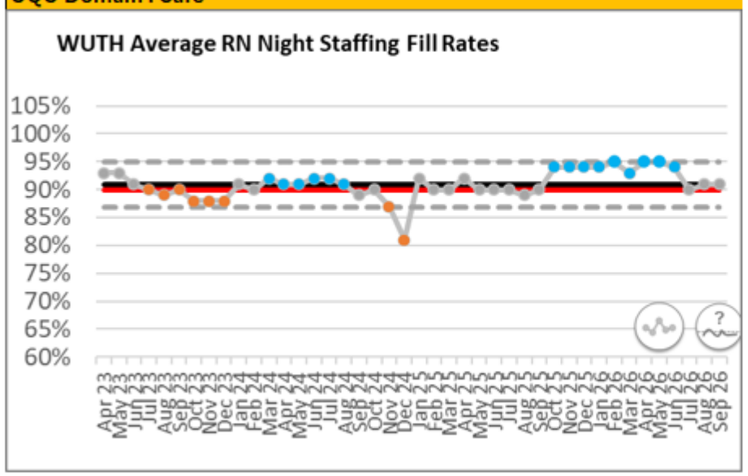
**CQC Domain : Safe**




| Sep-26 |
|---|
| 88.0% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Average Registered Nurse Night Staffing Fill Nurse

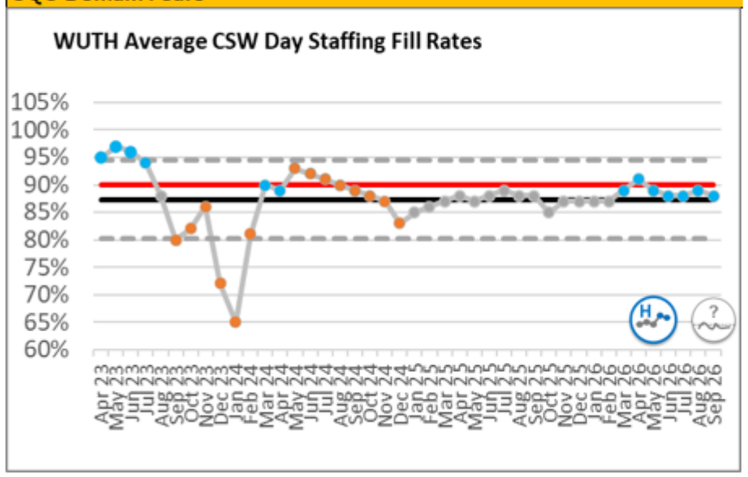
**CQC Domain : Safe**




| Sep-26 |
|---|
| 91.0% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Average Clinical Support Worker Day Staffing Fill Rates

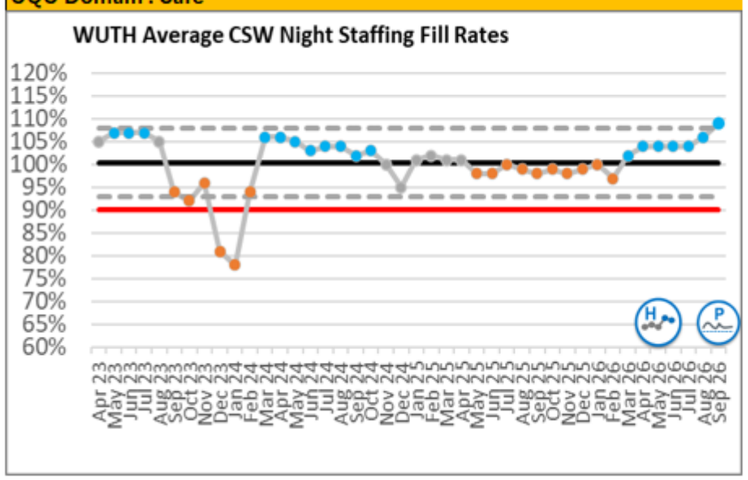
**CQC Domain : Safe**




| Sep-26 |
|---|
| 88.0% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Average Clinical Support Worker Night Staffing Fill Rates

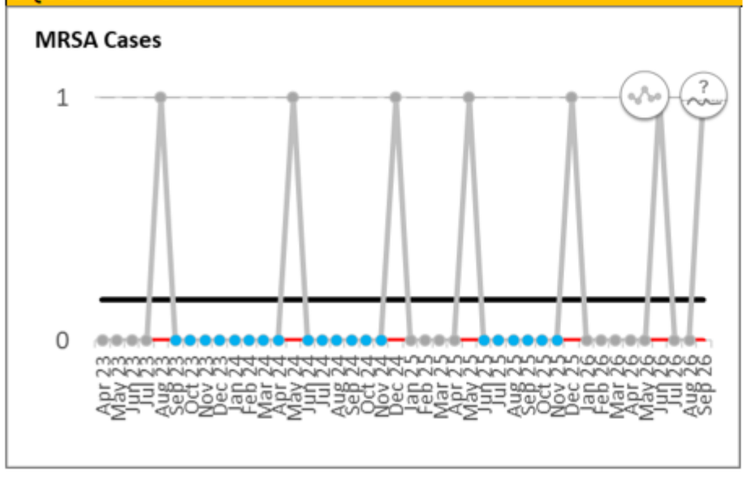
**CQC Domain : Safe**




| Sep-26 |
|---|
| 109.0% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Consistently hit target |

## MRSA Cases

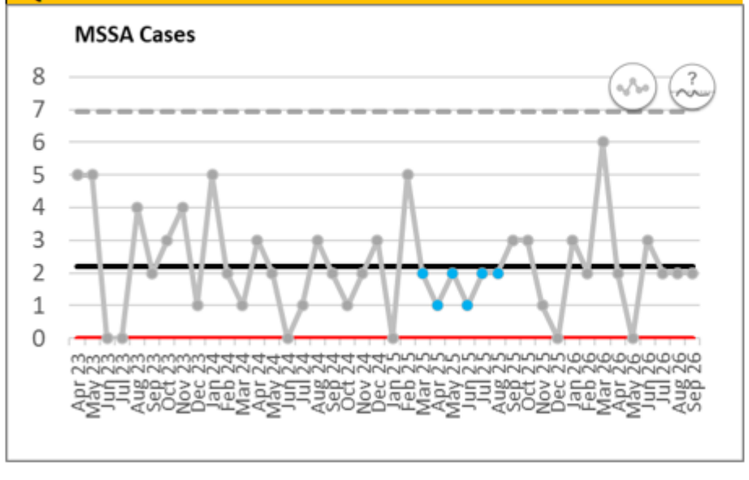
**CQC Domain : Safe**




| Sep-26 |
|---|
| 1 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## MSSA Cases

**CQC Domain : Safe**




| Sep-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) | Sept 26 | 0 | 0 | | | 0 |
| No. of Incidents reported | Sept 26 | 448 | 475 | | | 481 |
| Patient Safety Incidents | Sept 26 | 187 | 200 | | | 203 |
| Never events | Sept 26 | 0 | 0 | | | 0 |
| No. of ICO reportable IG incidents | Sept 26 | 0 | 0 | | | 0 |
| Total Complaints Received | Sept 26 | 8 | 3 | | | 3 |
| Cat 3 & 4 pressure ulcers with safety systems learning identified for the Trust | Sept 26 | 0 | 0 | | | 0 |
| Missed medication incidents resulting in moderate or severe harm | Sept 26 | 0 | 0 | | | 0 |
| No. of Incidents reported with a moderate and above harm level | Sept 26 | 0 | 0 | | | 0 |
| Clostridium difficile infections resulting in moderate or severe harm | Sept 26 | 0 | 0 | | | 0 |
| MRSA infections with learning identified for the Trust | Sept 26 | 0 | 0 | | | 0 |
| Falls resulting in moderate or above harm | Sept 26 | 0 | 0 | | | 0 |
| % of all incidents with moderate and above harm level relating to Trust | Sept 26 | 0.5% | 4.6% | | | 1.4% |
| No. of concerns received in month | Sept 26 | 2 | 12 | | | 12 |
| FFT - % of People who would recommend our services | Sept 26 | 95.3% | 90.0% | | | 91.5% |
| Falls resulting in moderate or above harm per 1,000 Occupied Bed Days | Sept 26 | 0.00 | 0.00 | | | 0.13 |
| Serious untoward incidents - reported via StEIS (IPC Contract) | Sept 26 | 0 | 0 | | | 0 |
| No. of reported no and low harm patient safety incidents | Sept 26 | 174 | 200 | | | 190 |

**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 September 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

Whilst the FFT score for September is 95.3% it must be noted that due to a delay in transitioning to a new digital provider, this response rate was based on a significantly reduced volume of FFT feedback – 64 responses compared with an average response rate of 2084 per month. This is expected to be resolved from October 2026 onwards.

**Areas of Concern**

During the previous reporting month three falls resulting in moderate or above harm were reported at the Community Intermediate Care Centre. After-action reviews have been completed to identify safety systems learning for improvement.

There are four quality metrics reporting a red RAG rated position in September, these relate to incident reporting and complaints.

Incident reporting and complaints are closely monitored throughout the Trust's governance framework, tracked at service level, reporting to SOG and by exception to the Integrated Performance Board. Incident reporting metrics during September are reporting a position of common cause variation with no new themes identified. Incidents will continue to be triangulated with other data sources to effectively identify any emerging themes and trends.

Of the eight complaints received during September five relate to the Trust's urgent care services, highlighting learning in relation to clinical pathways, privacy and communication. Learning from complaints is incorporated into service quality improvement plans, tracked via the Trust's Clinical Risk Management Group. Responsiveness to complaints continues to be a Trust priority for improvement.

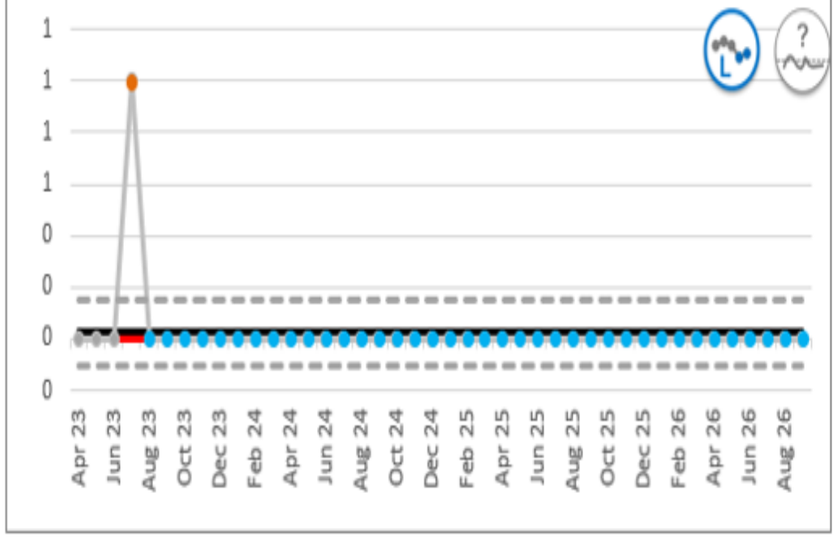
**Forward Look (Actions)**

Clinical Risk Management Group continue to track improvement plans, with new quality improvement driver diagrams for 2026/27 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)

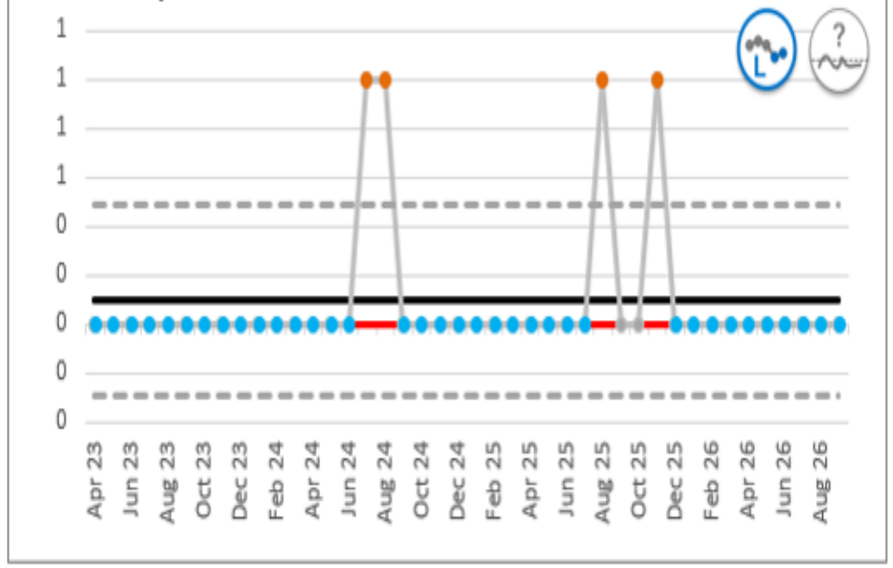
CQC Domain : Safe




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

## No. of ICO reportable IG incidents

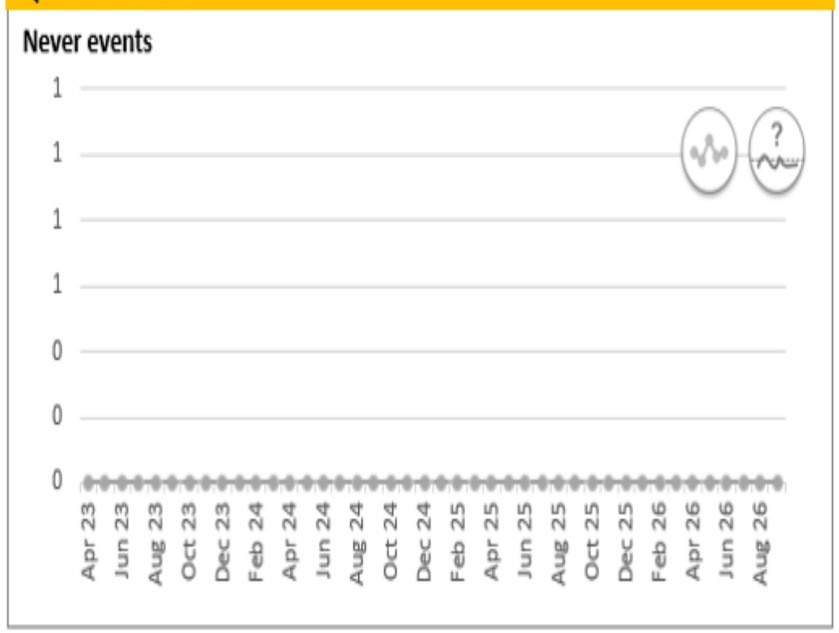
CQC Domain : Safe




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

## Never events

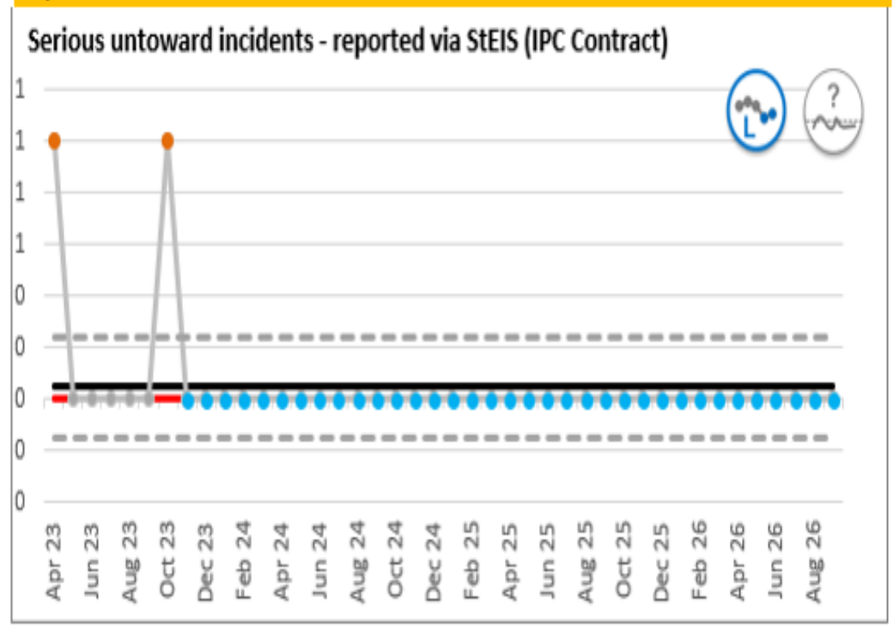
CQC Domain : Safe




| Sep-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)

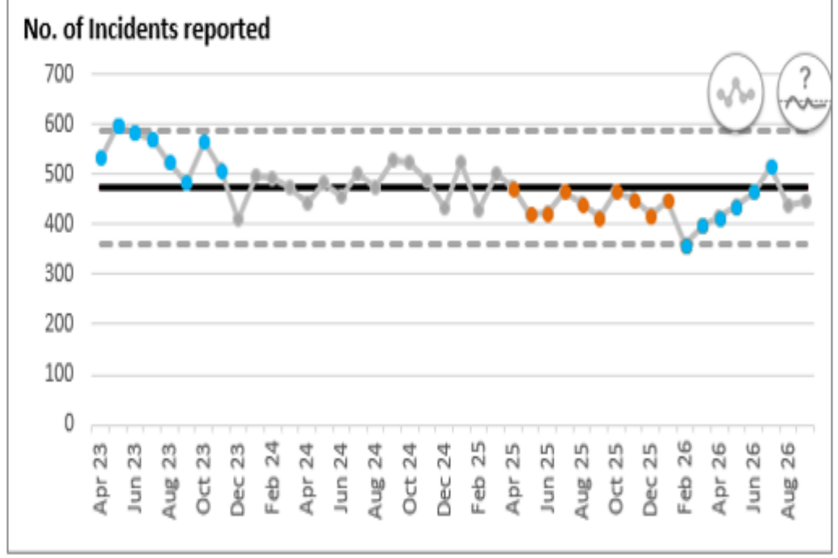
CQC Domain : Safe




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

## Number of Incidents reported

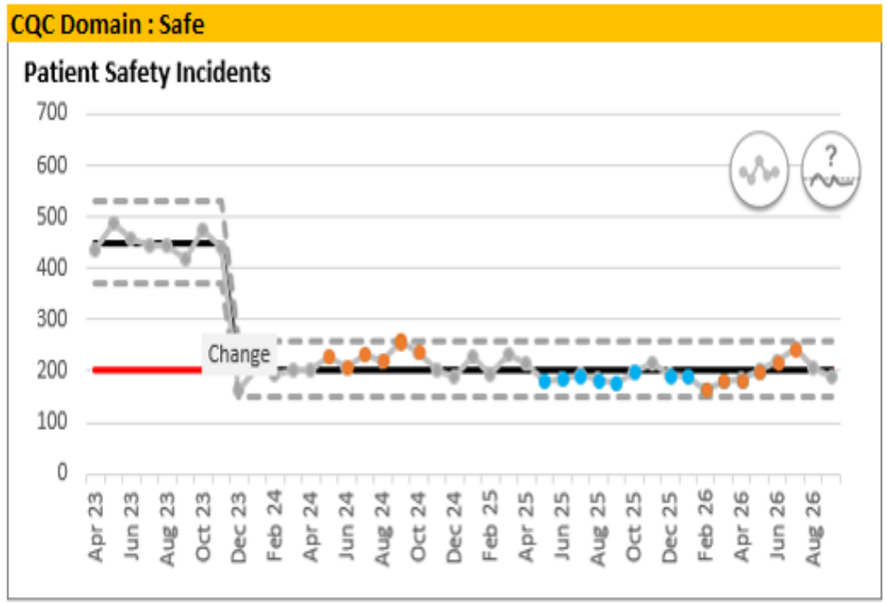
CQC Domain : Safe




| Sep-26 |
|---|
| 448 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 475 |
| **Assurance** |
| Hit & miss target subject to random variation |

## Patient Safety Incidents

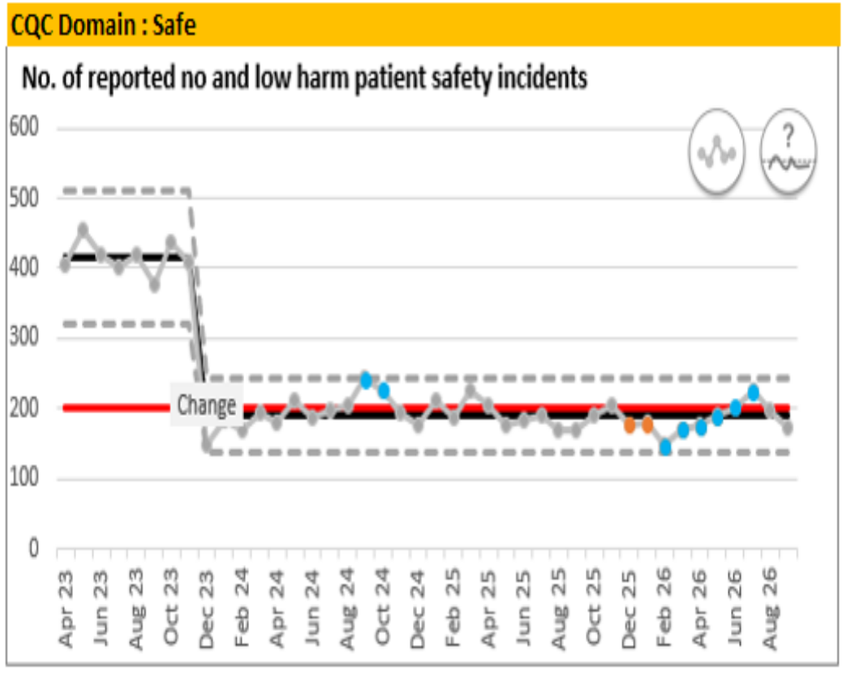
CQC Domain : Safe




| Sep-26 |
|---|
| 187 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 200 |
| **Assurance** |
| Hit & miss target subject to random variation |

## No. of reported no and low harm patient safety incidents

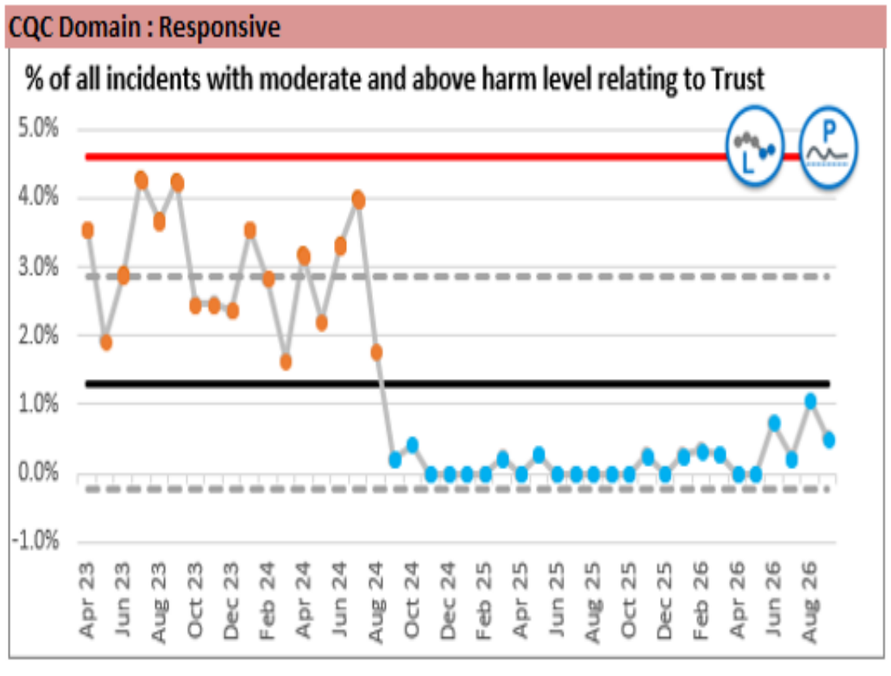
CQC Domain : Safe




| Sep-26 |
|---|
| 174 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 200 |
| **Assurance** |
| Hit & miss target subject to random variation |

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

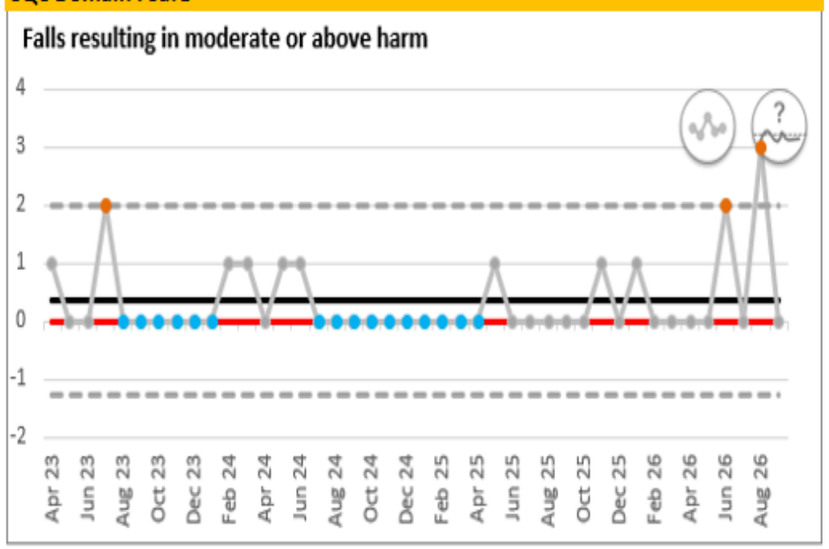
CQC Domain : Responsive




| Sep-26 |
|---|
| 0.5% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| 2.2% |
| **Assurance** |
| Consistanly hit target |

## Falls resulting in moderate or above harm

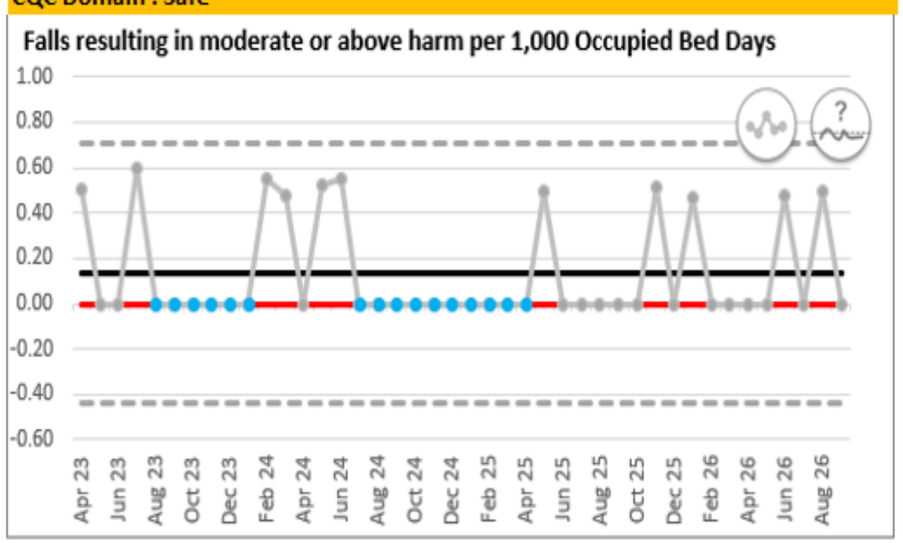
CQC Domain : Safe




| Sep-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

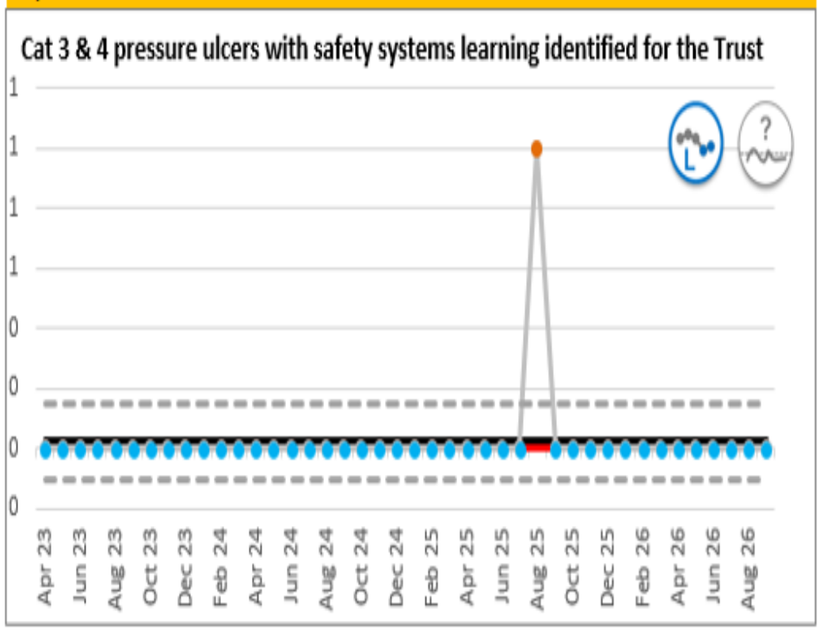
CQC Domain : Safe




| Sep-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

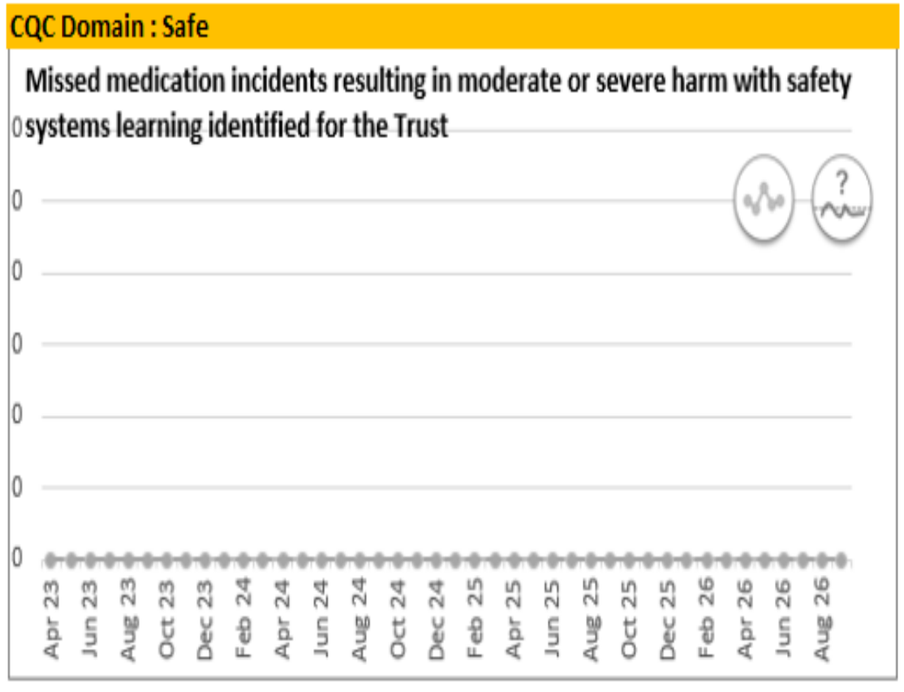
CQC Domain : Safe




| Sep-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

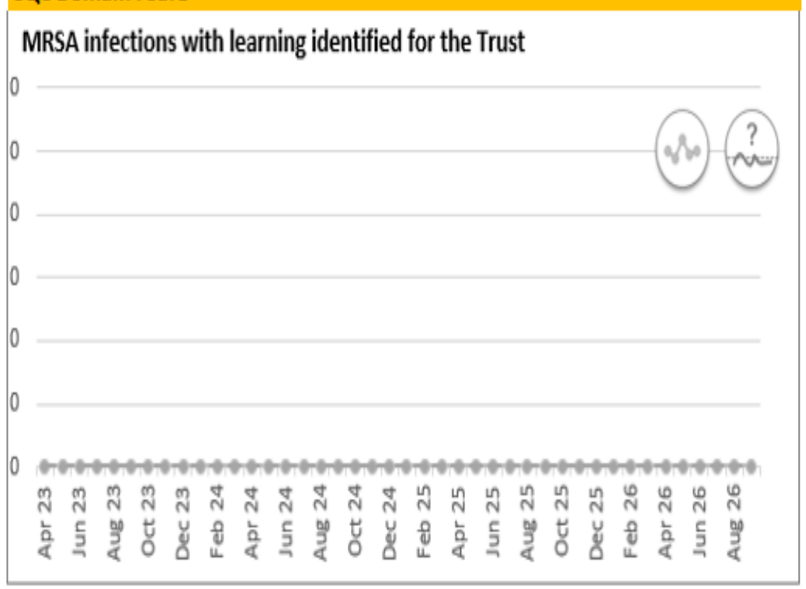
CQC Domain : Safe




| Sep-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

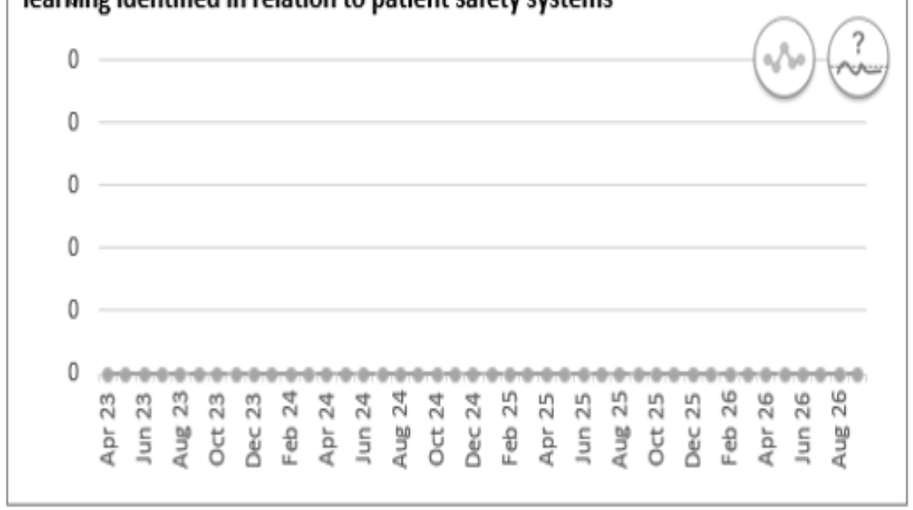
CQC Domain : Safe




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

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

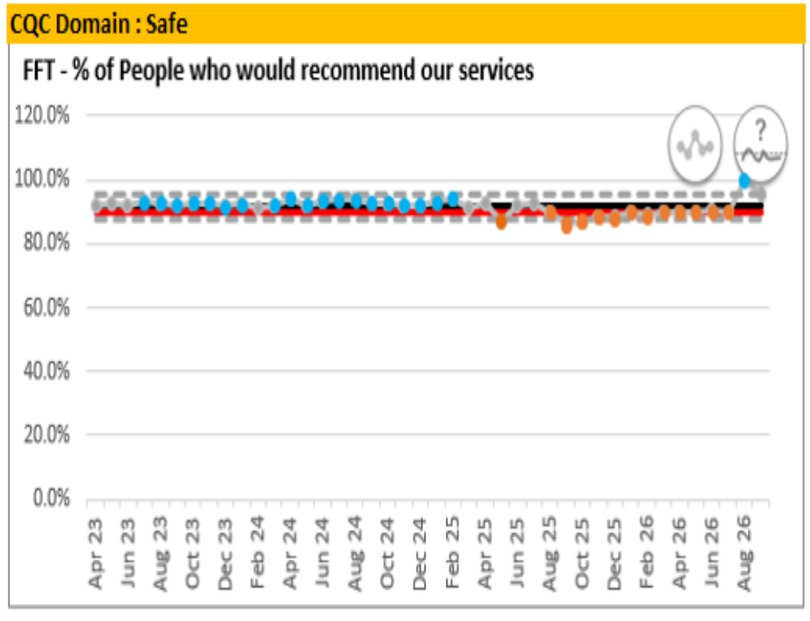
CQC Domain : Safe




| Sep-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

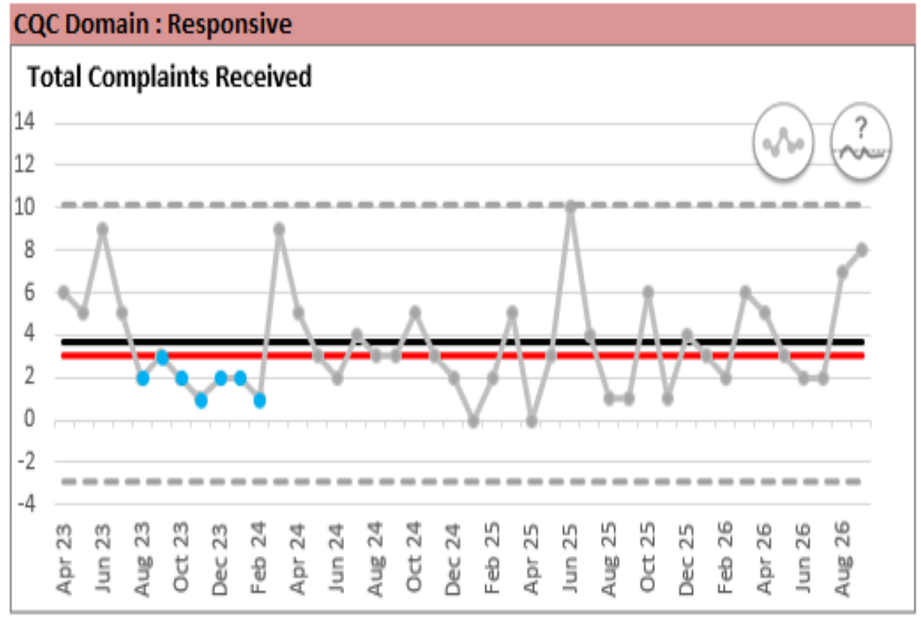
CQC Domain : Safe




| Sep-26 |
|---|
| 95.3% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit & miss target subject to random variation |

## Total Complaints Received

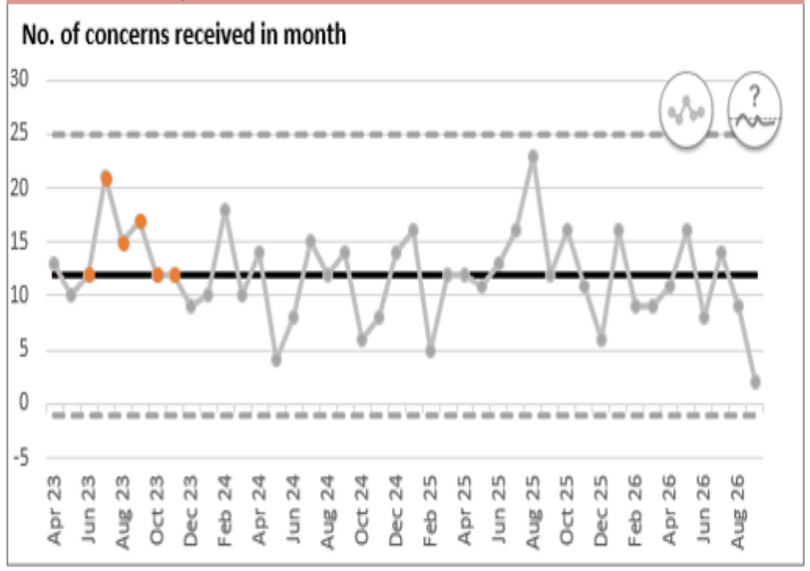
CQC Domain : Responsive




| Sep-26 |
|---|
| 8 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| 3 |
| **Assurance** |
| Hit & miss target subject to random variation |

## No. of concerns received in month

CQC Domain : Responsive




| Sep-26 |
| --- |
| 2 |
| **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 | March 2027 Target |
|---|---|---|---|---|---|---|---|
| 4-hour Accident and Emergency Target (including APH UTC) | Sep 26 | 53.55% | ≥60.38% | | | 60.7% | 64.69% |
| Number of inpatients not meeting the Criteria to Reside | Sep 26 | 150 | ≤114.9041 | | | 158 | 80 |
| Patients waiting longer than 12 hours in ED from a decision to admit | Sep 26 | 498 | ≤1448 | | | 647 | 1235 |
| Proportion of patients more than 12 hours in ED from time of arrival | Sep 26 | 20.58% | ≤18.18% | | | 18.3% | 15.00% |
| Ambulance Handovers: % >15 mins | Sep 26 | 86.50% | ≤74.99% | | | 79.7% | 74.99% |
| Ambulance Handovers: % > 45 mins | Sep 26 | 28.07% | ≤0% | | | 17.3% | 0.00% |
| 18 week Referral to Treatment - Incomplete pathways < 18 Weeks | Sep 26 | 65.89% | ≥66.8% | | | 59.9% | 70.30% |
| Referral to Treatment - total open pathway waiting list | Sep 26 | 43310 | ≤44271 | | | 45115 | 41087 |
| Referral to Treatment - cases waiting 65+ wks | Sep 26 | 0 | ≤0 | | | 8 | 0 |
| Referral to Treatment - % of 52+wk waiters | Sep 26 | 0.56% | ≤0.79% | | | 1.80% | 0.58% |
| Cancer Waits - reduce number waiting 62 days + | Aug 26 | 72 | ≤40 | | | 127 | ?? |
| Cancer - Faster Diagnosis Standard | Aug 26 | 74.39% | ≥79.95% | | | 73.6% | 81.32% |
| Cancer waits – % receiving first definitive treatment within 31 days of decision to treat | Aug 26 | 94.23% | ≥92.64% | | | 91.6% | 94.00% |
| Cancer Waits - 62 days to treatment (monthly) | Aug 26 | 78.18% | ≥77.54% | | | 74.9% | 80.00% |
| Diagnostic Waiters, 6 weeks and over - DM01 | Sep 26 | 92.87% | ≥93.5% | | | 93.1% | 94.50% |
| Long length of stay - number of patients in hospital for 21 or more days | Sep 26 | 189 | ≤79 | | | 170 | 79 |
| Corridor Care - average daily number of patients in month | Sep 26 | 30 | - | | | 38 | - |
| Corridor Care - total number of patients in month | Sep 26 | 923 | - | | | 1158 | - |

**Highlights**

- 12-hour waits reduced in September and were significantly better than
- trajectory, although further improvement remains necessary.
- RTT caseload and 65- and 52-week wait trajectories were delivered.
- Positive cancer performance continues across the 31- and 62-day standards.

**Areas of Concern**

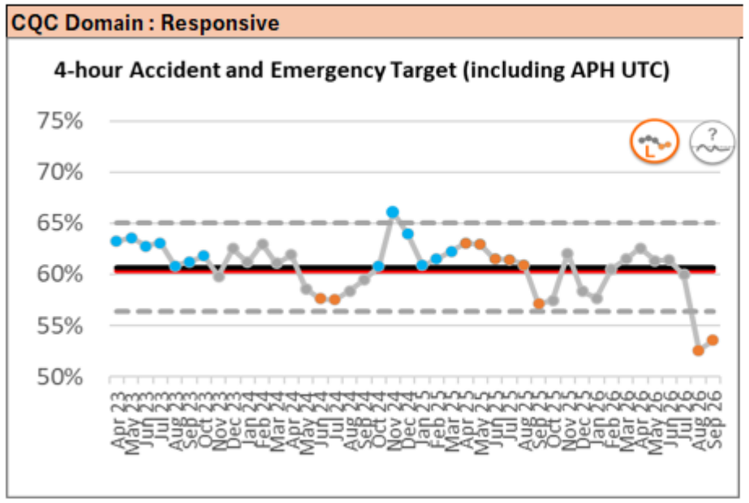
- 4-hour performance remains a significant concern, with deterioration following implementation of the Single Front Door.
- 12-hour performance improved marginally but remains above trajectory.
- DM01 was below plan due to the anticipated in-month endoscopy capacity gap.
- Ambulance handover performance is deteriorating, with increasing handover times and 45-minute breaches requiring urgent operational focus.
- The number of patients with NCTR remains above trajectory.

**Forward Look (Actions)**

- RTT funding confirmed but will not deliver the clock stop improvements until the end of November for <18 week %.
- DM01 will be compliant at the end of October
- FDS improvements delivered and will be compliant by the end of November.
- UEC / flow reset commencing 26th October will support getting back to a positive ambulance handover time.
- Winter workshop with partners held on 22nd October to test winter plans to deliver against the NCTR trajectory as the winter period approaches.

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

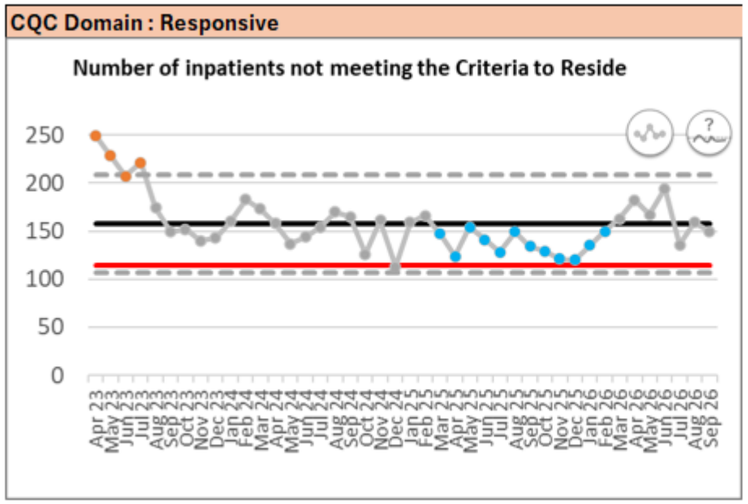
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 53.6% |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≥60.38% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Number of inpatients not meeting the Criteria to Reside

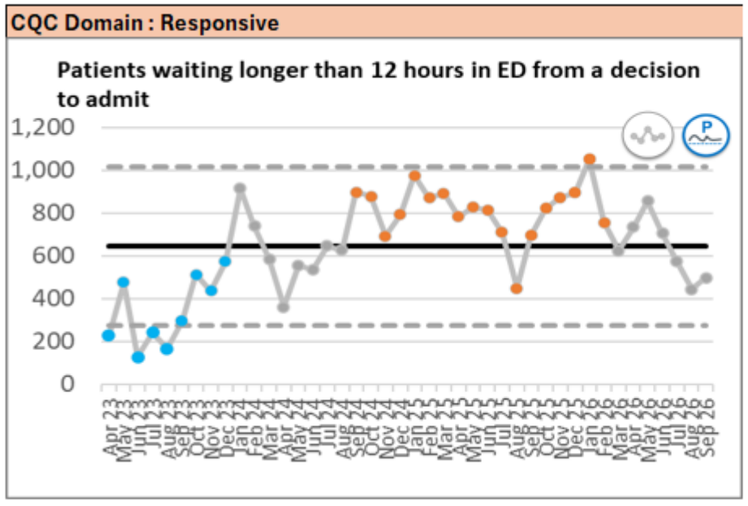
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 150 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤114.9041 |
| **Assurance** |
| Hit and miss target subject to random variation |

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

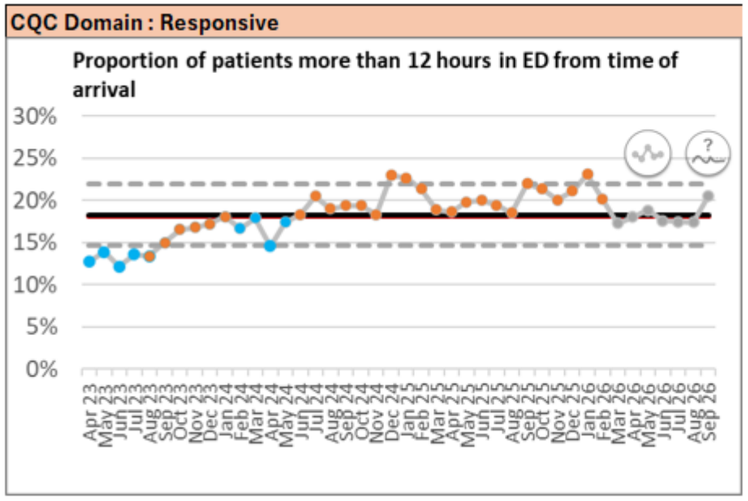
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 498 |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤1448 |
| **Assurance** |
| Consistently hit target |

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

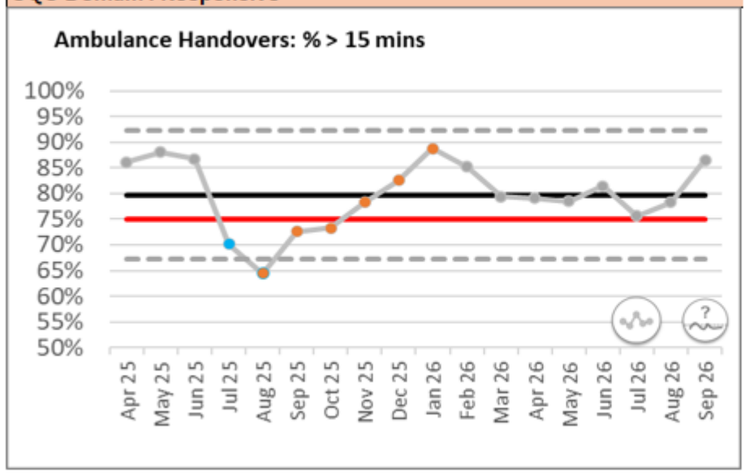
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 20.6% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤18.18% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Ambulance handover % < 30 minutes

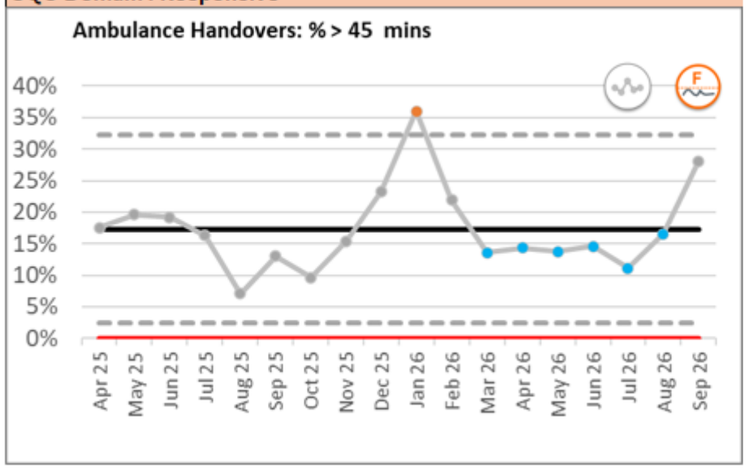
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 86.5% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤74.99% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Ambulance handover % < 45 minutes

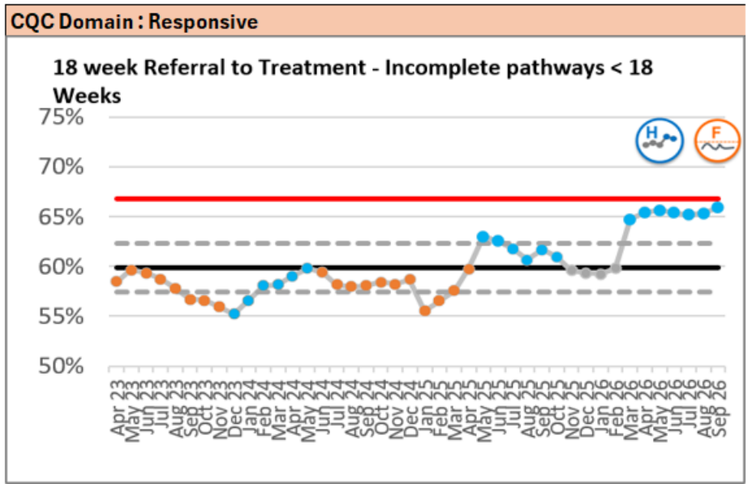
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 28.1% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤0% |
| **Assurance** |
| Consistently fail target |

## 18 week Referral to Treatment – incomplete pathways < 18 weeks

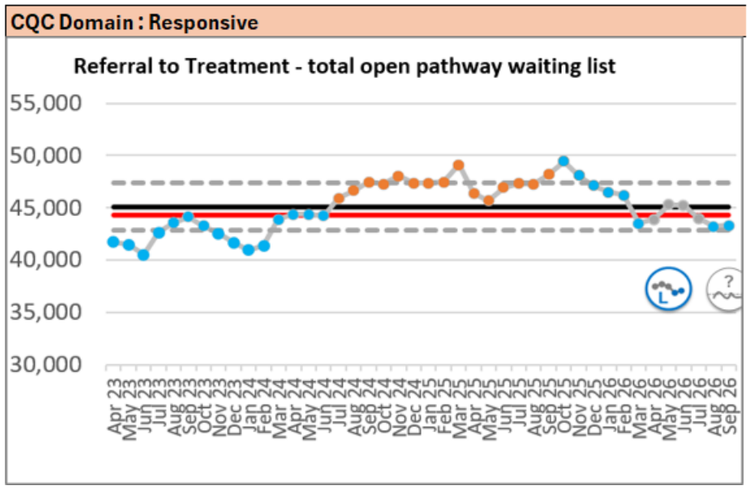
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 65.9% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥66.8% |
| **Assurance** |
| Consistently fail target |

## Referral to Treatment – total open pathway waiting list

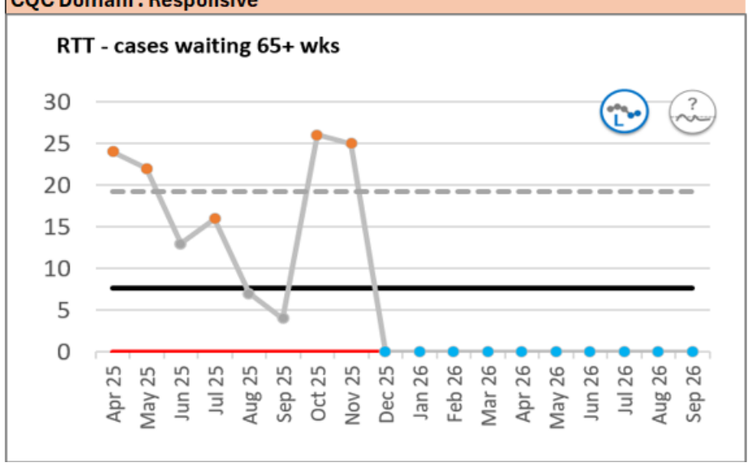
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 43310 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≤44271 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Referral to Treatment – cases exceeding 52 weeks

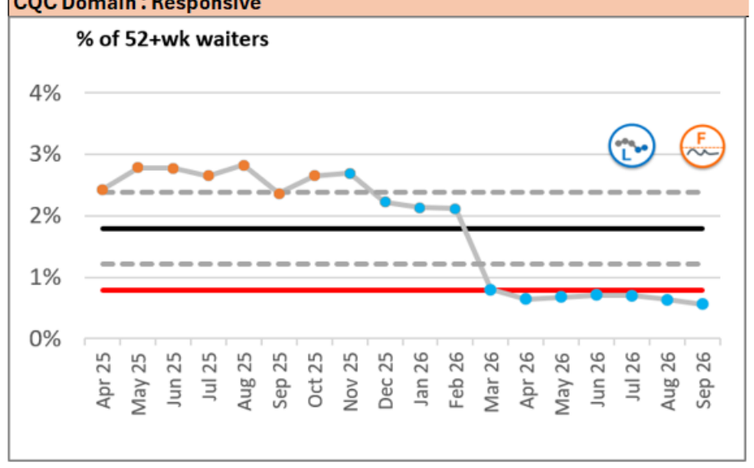
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 0 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≤0 |
| **Assurance** |
| Hit and miss target subject to random variation |

## Referral to Treatment – cases waiting 78+ weeks

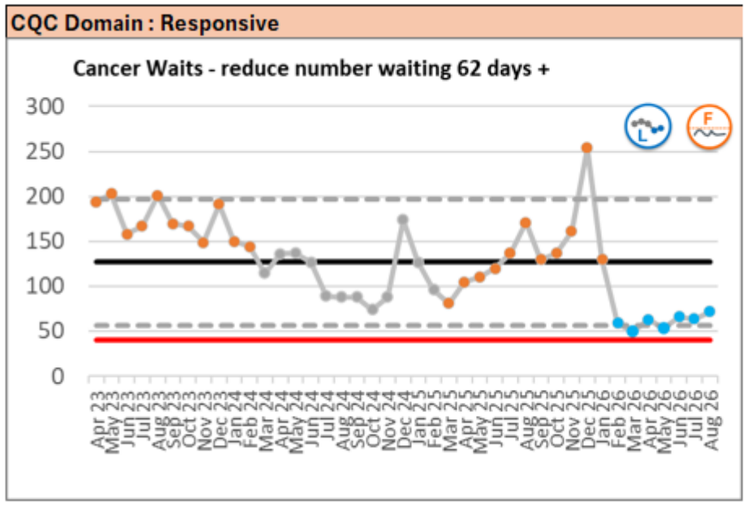
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 0.56% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≤0.79% |
| **Assurance** |
| Consistently fail target |

## Cancer Waits – reduce number waiting 62 days +

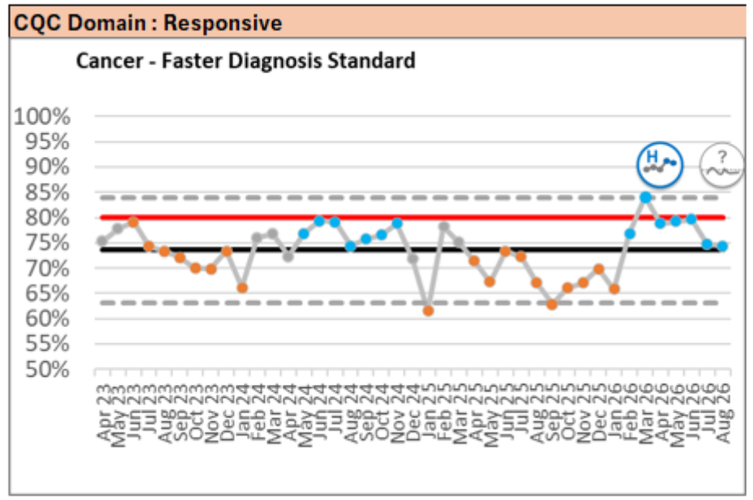
**CQC Domain : Responsive**




| Aug-26 |
|---|
| 72 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≤40 |
| **Assurance** |
| Consistently fail target |

## Cancer – Faster Diagnostic Standard

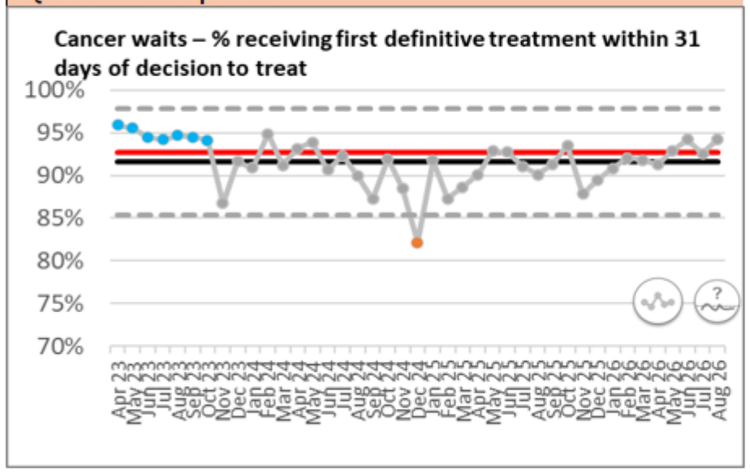
**CQC Domain : Responsive**




| Aug-26 |
|---|
| 74.4% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥79.95% |
| **Assurance** |
| Consistently fail target |

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

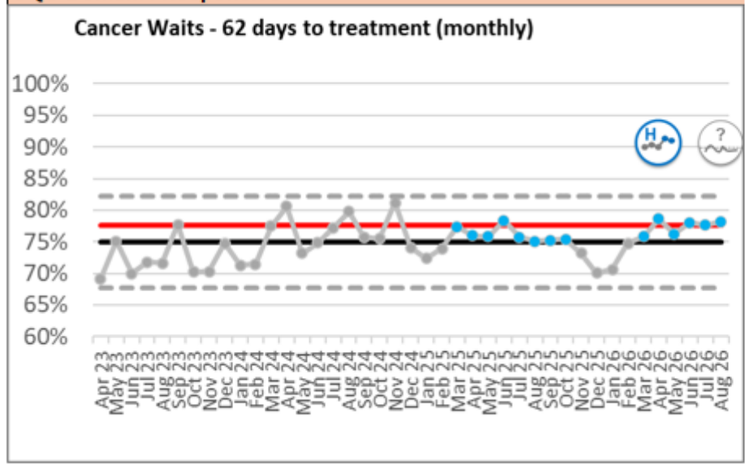
**CQC Domain : Responsive**




| Aug-26 |
|---|
| 94.2% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥92.64% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Cancer waits - 62 days to treatment (monthly)

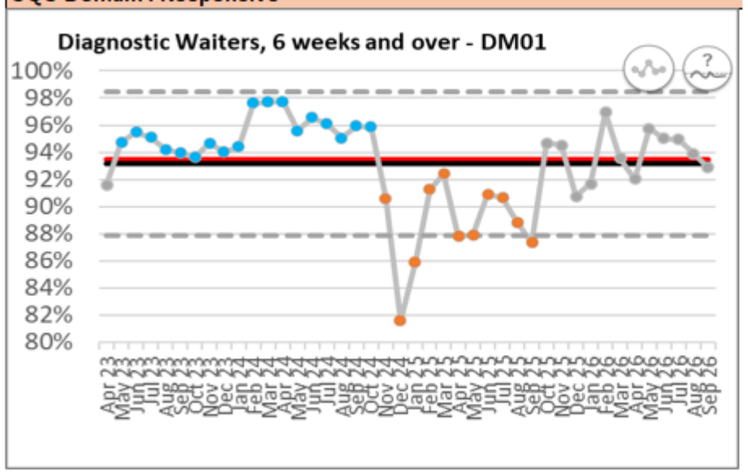
**CQC Domain : Responsive**




| Aug-26 |
|---|
| 78.2% |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| ≥77.54% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Diagnostic Waiters – 6 weeks and over – DM01

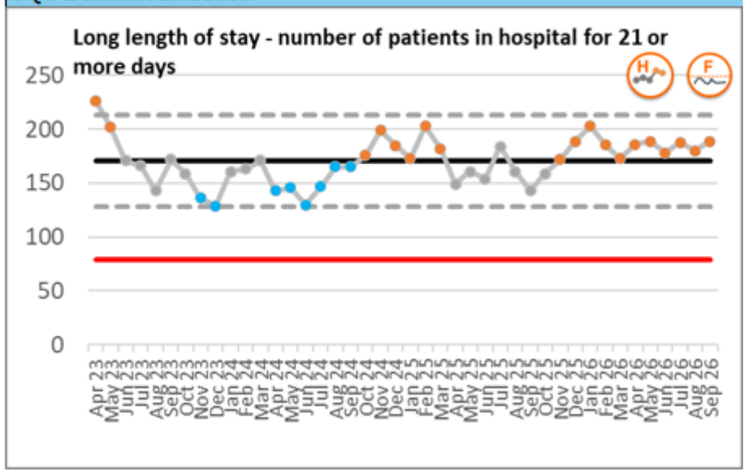
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 92.9% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥93.5% |
| **Assurance** |
| Hit and miss target subject to random variation |

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

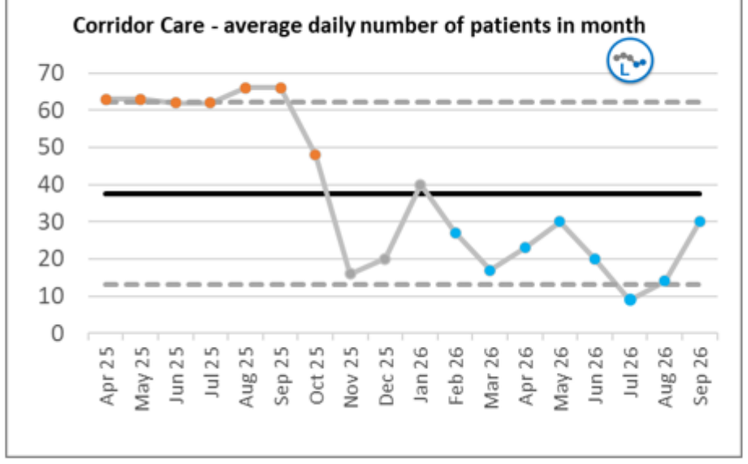
**CQC Domain : Effective**




| Sep-26 |
|---|
| 189 |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≤79 |
| **Assurance** |
| Consistently fail target |

## Corridor Care – average daily number of patients in month

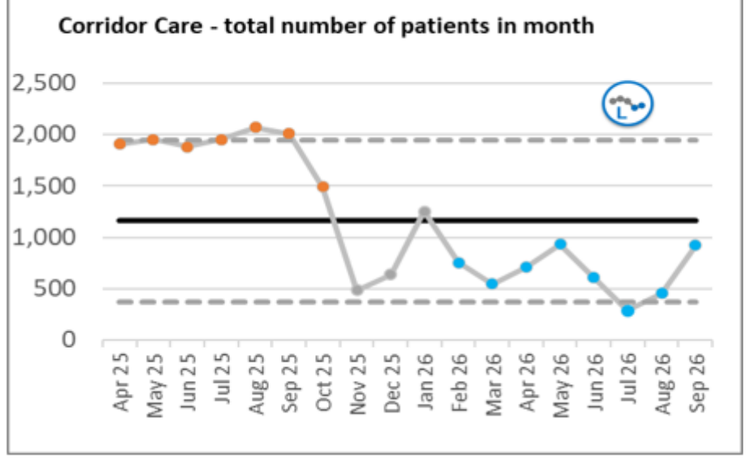
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 30 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| - |
| **Assurance** |
| Not applicable |

## Corridor Care – total number of patients in month

**CQC Domain : Responsive**




| Sep-26 |
|---|
| 923 |
| **Variance Type** |
| Special cause improving variation |
| **Threshold** |
| - |
| **Assurance** |
| Not applicable |

## Operational Summary - WCHC

| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| WIC & UTC Attendances seen within 4 hrs | Sept 26 | 88.3% | 95.0% | | | 96.10% |
| CICC Occupancy Rate (Commissioned Beds) | Sept 26 | 95.7% | 92.0% | | | 95.5% |
| CICC Median LoS (Active Beds Daily Snapshot) | Sept 26 | 16 | 21 | | | 18.6 |
| Urgent Community Response - 2 hours | Sept 26 | 90.4% | 70.0% | | | 87.6% |
| GPOOH - UCAT Response Times (60 min response) | Sept 26 | 98.3% | 98.0% | | | 98.8% |
| GPOOH - UCAT Response Times (15 min response) | Sept 26 | 76.3% | 65.0% | | | 69.2% |
| GPOOH - UCAT Response Times (30 min response) | Sept 26 | 93.6% | 90.0% | | | 93.0% |
| GPOOH - CAS Response Times (20 min response) | Sept 26 | 63.5% | 75.0% | | | 69.7% |
| GPOOH - CAS Response Times (2hr response) | Sept 26 | 83.8% | 90.0% | | | 70.9% |
| GPOOH - NHS111 Response Times | Sept 26 | 79.7% | 75.0% | | | 61.9% |
| RTT - % of Patients Seen Within 18 Weeks | Sept 26 | 100.0% | 92.0% | | | 99.8% |
| DM01 - % of Patients Waiting with a Wait Under 6 weeks | Sept 26 | 100.0% | 99.0% | | | 100.0% |
| UTC Attendances seen within 4 hrs | Sept 26 | 85.5% | 95.0% | | | 97.7% |
| VCHC Attendances seen within 4 hrs | Sept 26 | 86.6% | 95.0% | | | 94.3% |
| Eastham Attendances seen within 4 hrs | Sept 26 | 96.3% | 95.0% | | | 93.9% |

### Highlights

Operational performance remains strong. The KPI position for M6 26-27 is:

- 79 Green KPIs
- 5 Amber KPIs
- 7 Red KPIs

Highlights by exception:

- Patient waiting over 4-hours remains a challenge due to staffing pressures within the service
- CICC LoS remains in a strong position, with good flow on the ward
- 0-19/25 services – all key metrics across the four regional teams performing above target

Waiting lists – RTT and DM01 100% and majority of non RTT-reportable waiting lists continue to improve in terms of volume of patients waiting and access times.

### Areas of Concern

- **UTC/MIU:** Staff sickness and bank pick up rate: increase with sickness in month and reduction in pick up of bank shifts has resulted on a few occasions in month limiting the service offer from Eastham. The pressure has also been seen at MIU with the service having to reduce the opening times on days of staff shortage.
- **Waiting lists**: remedial action plans remain in place for Community Dental, Cardiology and MSK services. Dental waits are related to volume of patients awaiting paediatric exodontia. Cardiology challenges related to the volume of outstanding resting and 7 day ECGs after significant increases in referral rates. MSK relates to increasing demands on the service and an aim to reduce the volume patients awaiting first appointments ahead of therapies integration programme of work. All three services making progress with reducing volumes and access times.

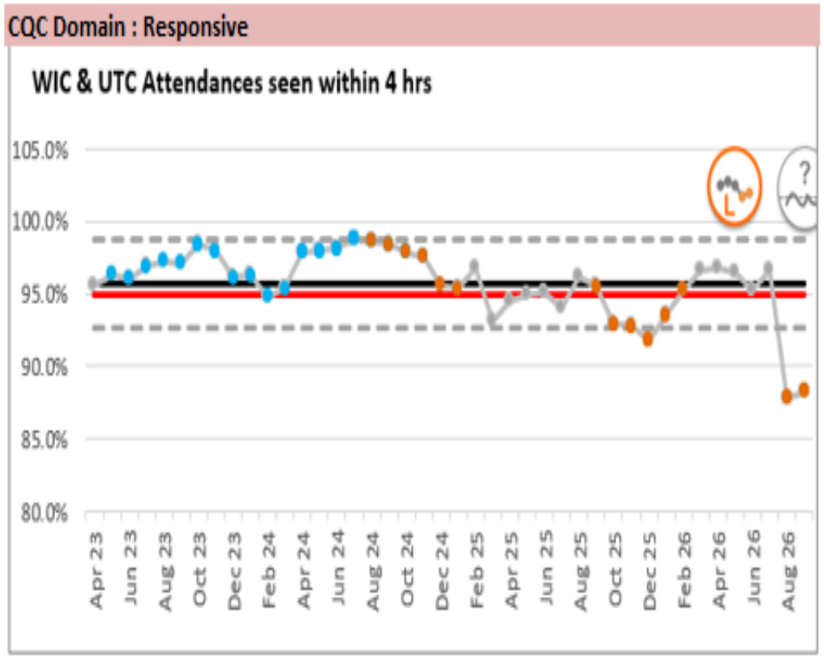
### Forward Look (Actions)

- **UTC/MIU –** progress at pace with recruitment of both nursing and GP posts to reduce the reliance on bank pick up. Recruitment of nurses to increase the workforce to mitigate the shortfall for times of increase in sickness and demand.
- **Waiting lists**: **Dental** – secured additional funding to support additional theatre lists to reduce backlogs. Ongoing collaborative working with WUTH to maximise theatre throughput and additional capacity. Remedial actions, monitoring and validation have resulted in improvements in waiting times and waiting list size. **Cardiology** - joint action plan remains in place with community, acute trust and ICB colleagues to maximise available capacity across WCHC and WUTH. **MSK** – recovery trajectory in place, actions include validation, improvements in productivity and service successful in bid for additional resource from GIRFT. Funding will be used to provide additional physio capacity and trial Community Assessment Days in collaboration with One Wirral and tertiary sector partners.

| | | |
|---|---|---|
| | | |

## WIC & UTC Attendances seen within 4 hrs

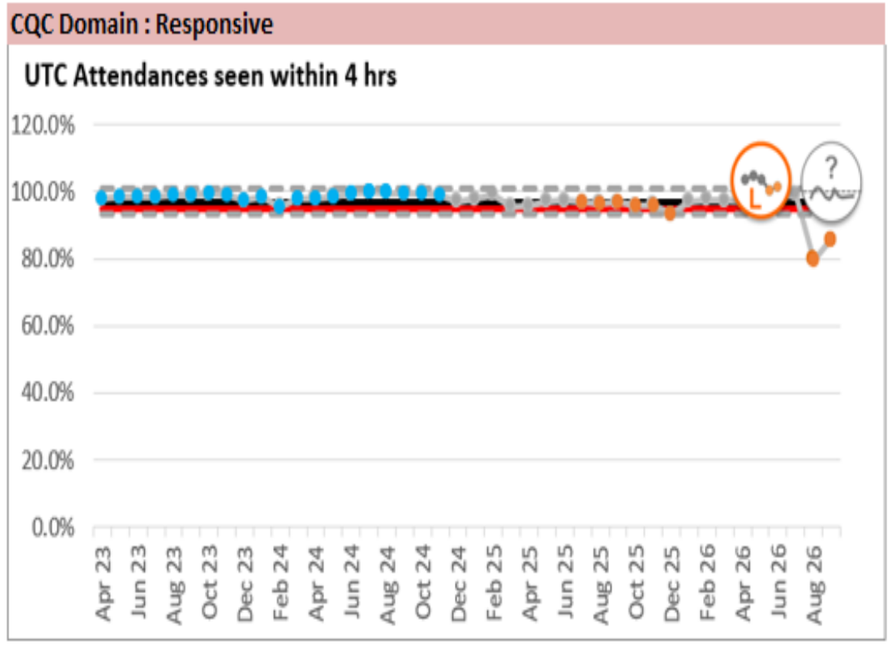
CQC Domain : Responsive




| Sep-26 |
|---|
| 88.3% |
| **Variance Type** |
| Special Cause variation - Concerning |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit & miss target subject to random variation |

## UTC Attendances seen within 4 hrs

CQC Domain : Responsive

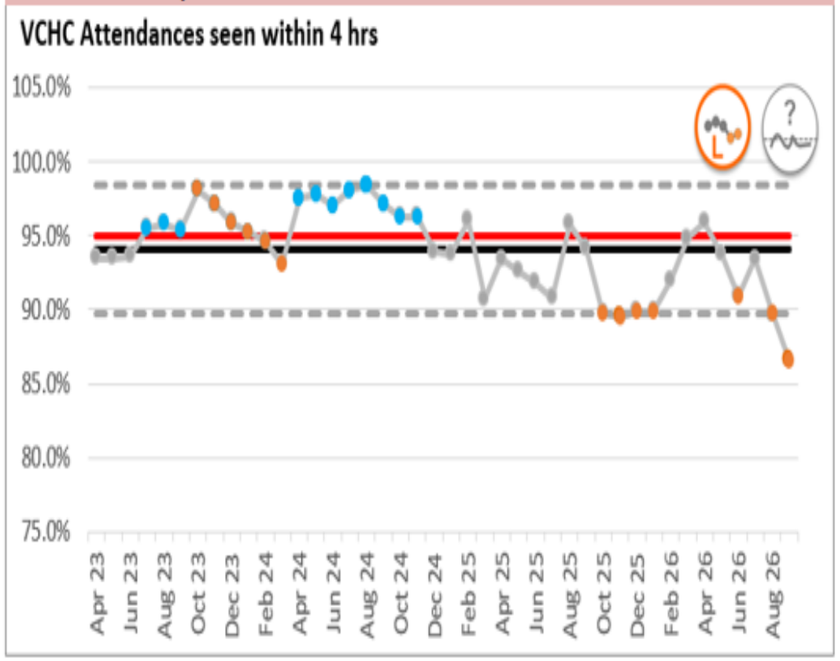



| Sep-26 |
|---|
| 85.5% |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit & miss target subject to random variation |

## VCHC Attendances seen within 4 hrs

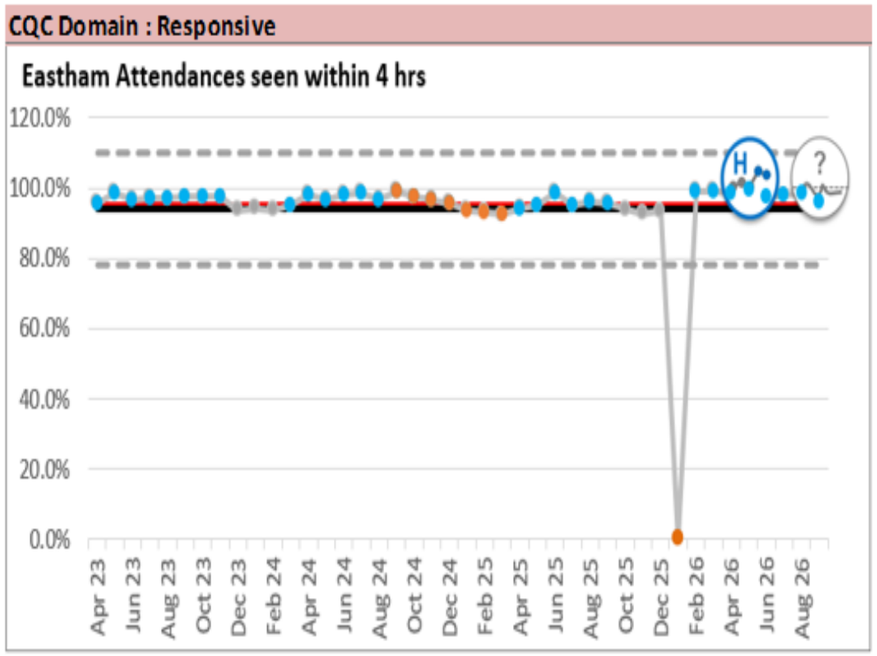
## Eastham Attendances seen within 4 hrs

CQC Domain : Responsive




| Sep-26 |
|---|
| 86.6% |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit & miss target subject to random variation |

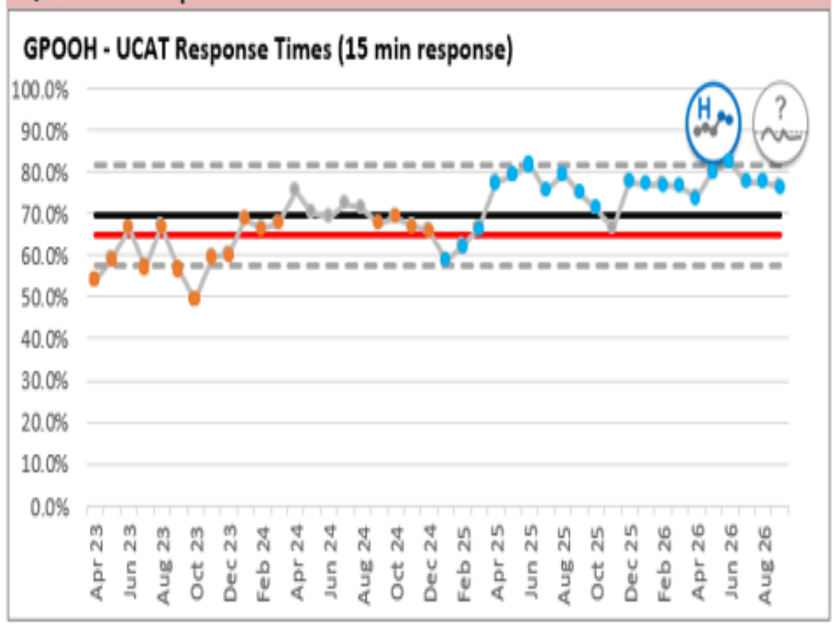
CQC Domain : Responsive




| Sep-26 |
|---|
| 96.3% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| ≥95% |
| **Assurance** |
| Hit & miss target subject to random variation |

## GPOOH - UCAT Response Times (15 min response)

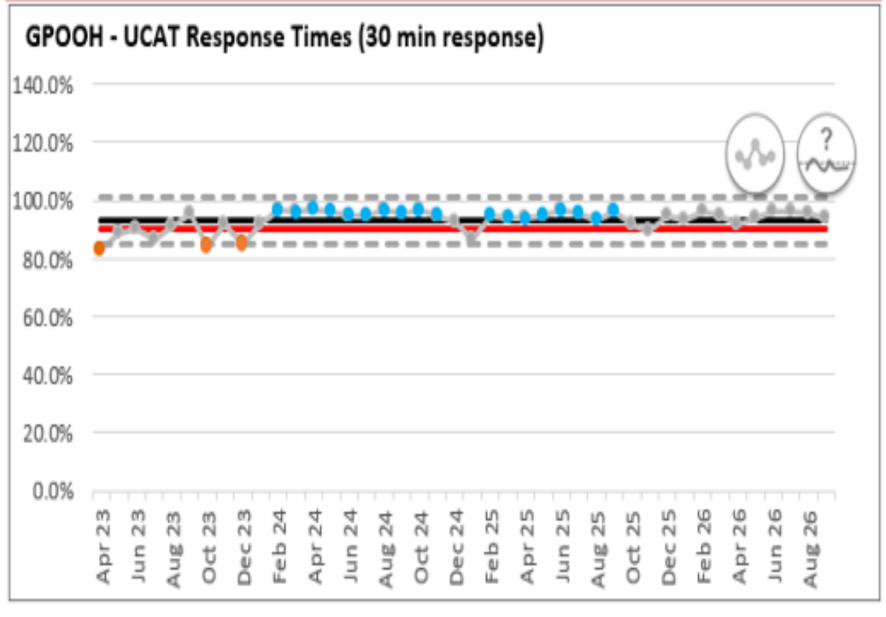
CQC Domain : Responsive




| Sep-26 |
|---|
| 76.3% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| ≥65% |
| **Assurance** |
| Hit & miss target subject to random variation |

## GPOOH - UCAT Response Times (30 min response)

CQC Domain : Responsive

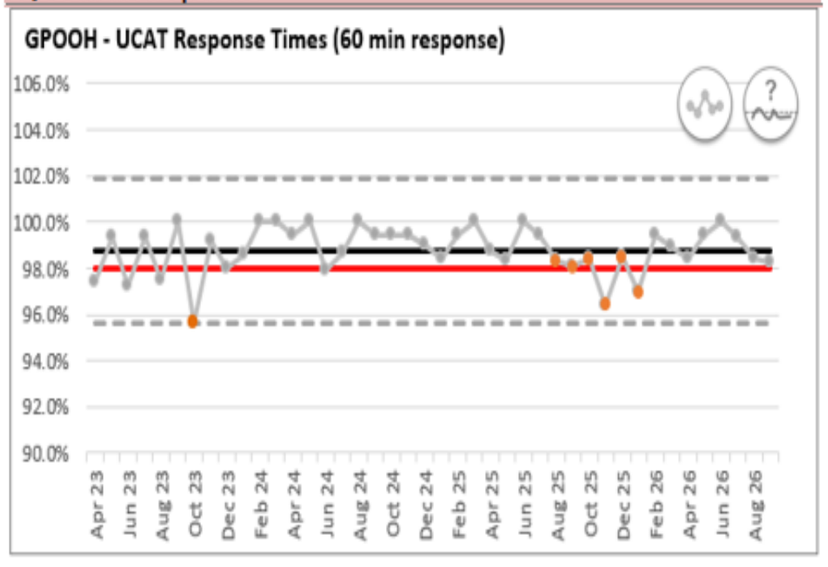



| Sep-26 |
|---|
| 93.6% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit & miss target subject to random variation |

## GPOOH - UCAT Response Times (60 min response)

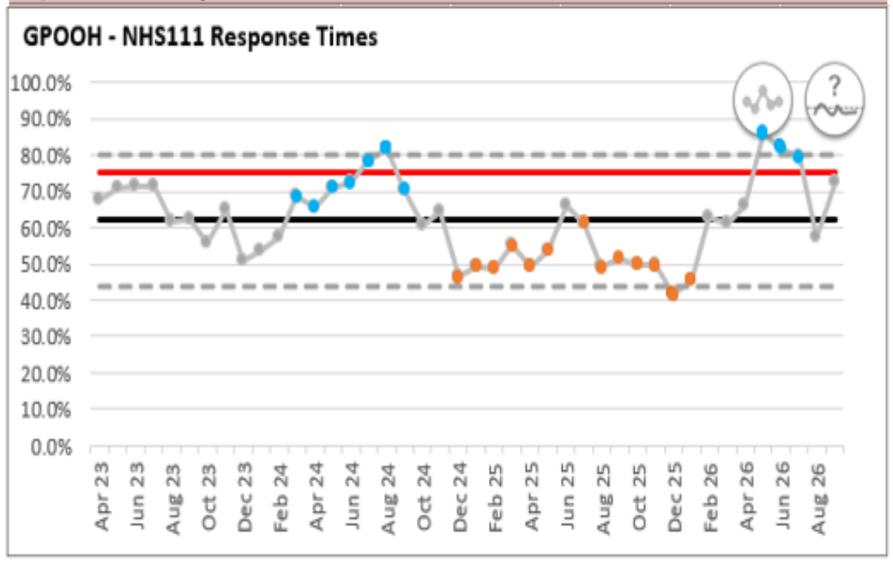
## GPOOH – NHS 111 Response Times

**CQC Domain : Responsive**




| Sep-26 |
|---|
| 98.3% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥98% |
| **Assurance** |
| Hit & miss target subject to random variation |

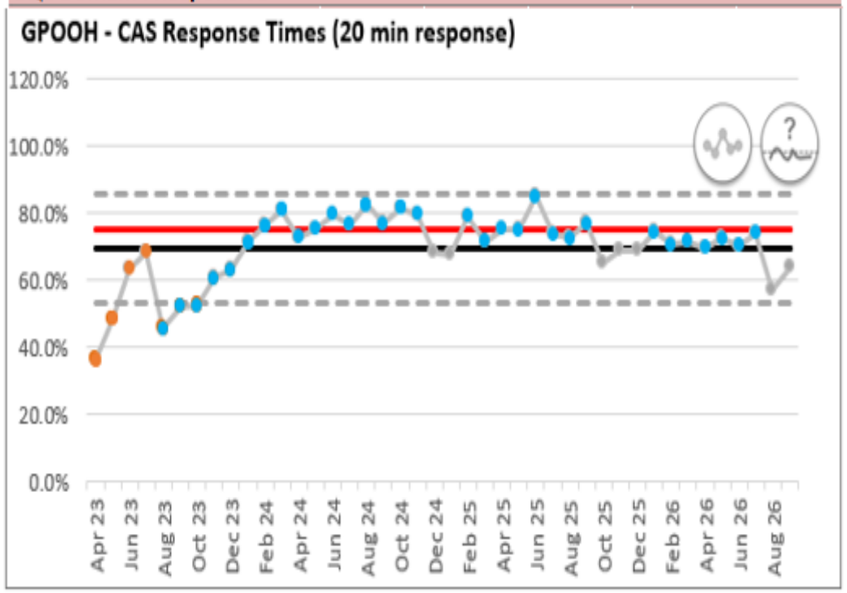
**CQC Domain : Responsive**




| Sep-26 |
|---|
| 79.7% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥75% |
| **Assurance** |
| Hit & miss target subject to random variation |

## GPOOH - CAS Response Times (20 min response)

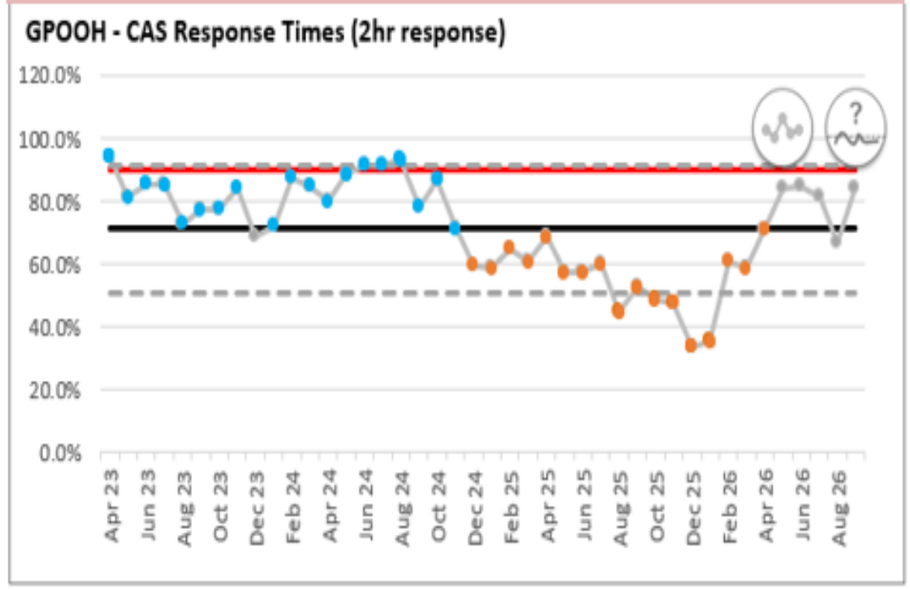
CQC Domain : Responsive




| Sep-26 |
|---|
| 63.5% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥75% |
| **Assurance** |
| Hit & miss target subject to random variation |

## GPOOH - CAS Response Times (2hr response)

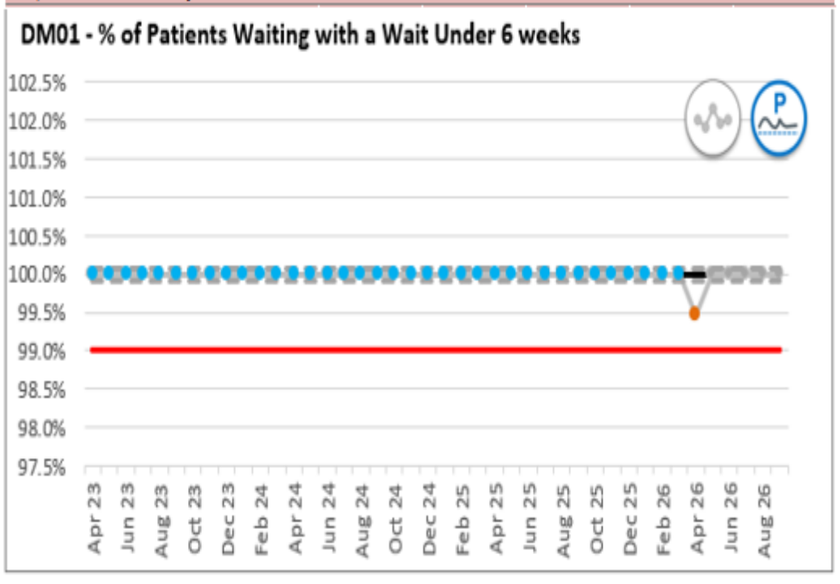
CQC Domain : Responsive




| Sep-26 |
|---|
| 83.8% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit & miss target subject to random variation |

## DM01 - % of Patients Waiting under 6 weeks

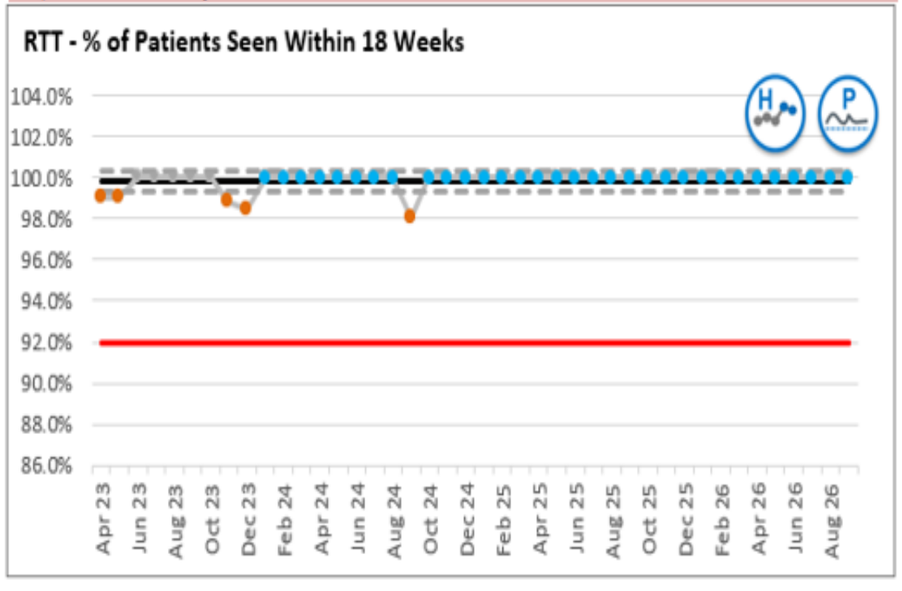
CQC Domain : Responsive




| Sep-26 |
|---|
| 100% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥99% |
| **Assurance** |
| Performance consistently achieves the target |

## RTT- % of Patients seen within 18 Weeks

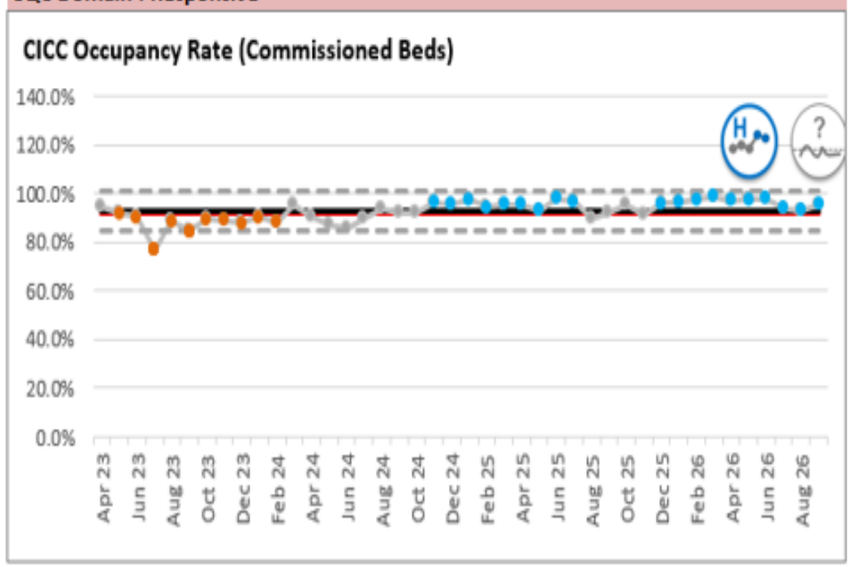
CQC Domain : Responsive




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

## CICC Occupancy Rate (Commissioned Beds)

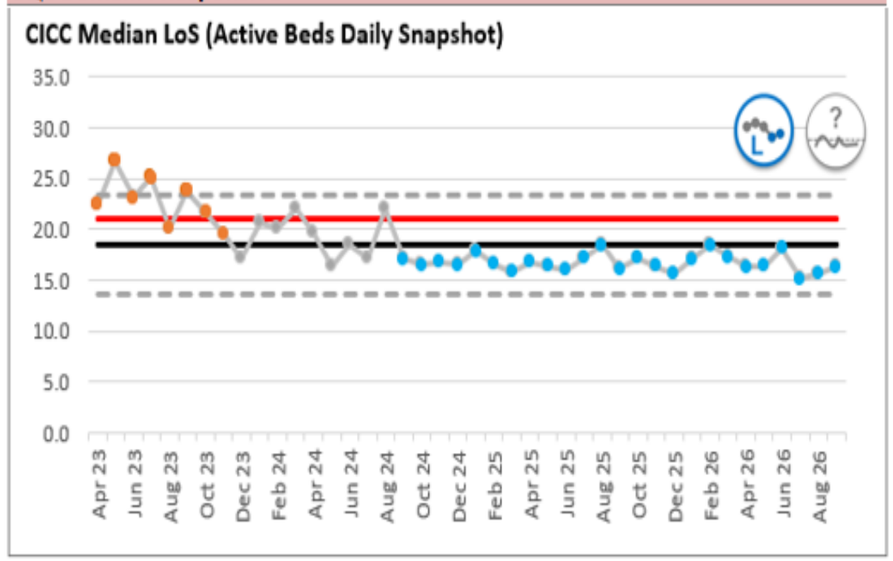
CQC Domain : Responsive




| Sep-26 |
|---|
| 95.7% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| ≥92% |
| **Assurance** |
| Hit & miss target subject to random variation |

## CICC Median LoS (Active Beds Daily Snapshot)

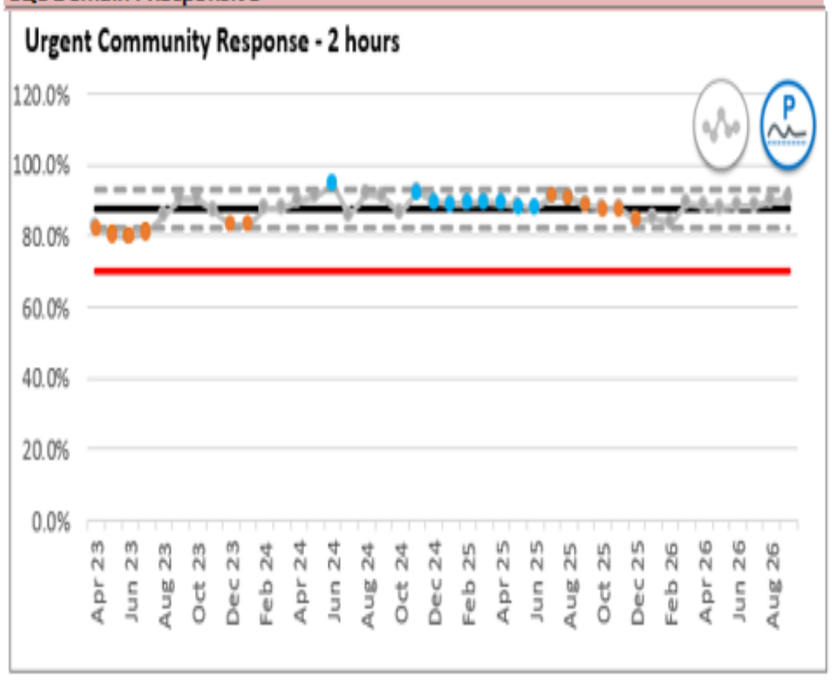
CQC Domain : Responsive




| Sep-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




| Sep-26 |
|---|
| 90.4% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥70% |
| **Assurance** |
| Consistanly hit target |

## Waiting Lists

| Waiting list movement (since Mth04) - September 2026 | | | | |
|---|---|---|---|---|
| Directorate | Within 6 Weeks | Within 12 Weeks | Within 18 Weeks | Total waiting |
| Nursing | 66% (5%) | 90% (-4%) | 97% (-3%) | 704 (62) |
| Specialist Medical | 82% (1%) | 99% (1%) | 100% (1%) | 2439 (-277) |
| Specialist Medical - Dental | 27% (-9%) | 45% (-14%) | 71% (-7%) | 328 (20) |
| Therapies | 44% (-4%) | 62% (-10%) | 83% (-2%) | 5675 (372) |

## 0-19/25 Performance

| 0-19/25 Services - September 26 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| KPI | East Cheshire | | Knowsley | | St Helens | | Wirral | |
| | In Mth | YTD | In Mth | YTD | In Mth | YTD | In Mth | YTD |
| Birth visits 14 days | 83.0% | 87.5% | 92.8% | 93.5% | 95.7% | 94.3% | 94.7% | 94.8% |
| 12 month reviews | 89.1% | 88.8% | 93.1% | 92.7% | 96.9% | 94.5% | 93.1% | 93.2% |
| 2.5 year reviews | 85.8% | 87.9% | 89.3% | 88.4% | 95.3% | 94.9% | 89.3% | 88.6% |
| Breastfeeding 6-8 weeks | 59.3% | 60.1% | 49.0% | 39.7% | 45.6% | 42.9% | 46.5% | 46.5% |

## Finance Summary - WUTH

At the end of September 2026 (M6), WUTH is reporting a deficit of £4.6m or £15.1m excluding deficit support funding, a year-to-date position that is a £0.1m positive variance to plan.

The Trust identified three key risks in the Trust plan:

- Full CIP delivery:
- Activity and case mix:
- Maintaining grip and control:

The Trust continues to forecast full achievement of the agreed finance plan.

It is important to note that management of risks alone does not deliver long-term financial sustainability. Sustainability will be delivered through the medium-term finance plan (MTFP).

| KPI | Latest data period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Agency spend | Sep 26 | 1.30% | <=0.8% | | | |
| I&E Position | Sep 26 | -£15.1m | -£15.2m | | | |
| Cumulative CIP | Sep 26 | £10.4m | £10.4m | | | |
| Capital Expenditure | Sep 26 | £6.5m | £7.4m | | | |
| Cash Position | Sep 26 | £5.1m | £2.7m | | | |

**Highlights**

The Trust is £0.1m ahead of plan at M6 with an improved cash position

**Areas of Concern**

Continued mitigation of the 3 risks highlighted in the report above.

**Forward Look (Actions)**

The Trust's actions focus on the 3 key risks:

- Full delivery of CIP
- Full delivery of contracted activity levels
- Maintaining agreed financial controls.

### I&E Position

**Narrative:**

The table below summarises the M6 position including deficit support funding (DSF):

| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Cost Type | Plan | Actual | Variance | Plan | Actual | Variance |
| Clinical Income from Patient Care Activities | £41.7m | £43.8m | £2.1m | £249.8m | £255.5m | £5.7m |
| Other Operating Income | £4.2m | £4.1m | -£0.1m | £24.5m | £24.0m | -£0.5m |
| **Total Income** | **£45.9m** | **£47.9m** | **£1.9m** | **£274.4m** | **£279.6m** | **£5.2m** |
| Employee Expenses | -£32.5m | -£34.2m | -£1.7m | -£200.2m | -£204.8m | -£4.6m |
| Operating Expenses | -£13.5m | -£13.8m | -£0.3m | -£75.9m | -£76.9m | -£1.0m |
| Non Operating Expenses | -£0.5m | -£0.4m | £0.1m | -£3.0m | -£2.5m | £0.5m |
| **Total Expenditure** | **-£46.5m** | **-£48.4m** | **-£1.9m** | **-£279.1m** | **-£284.2m** | **-£5.1m** |
| **Reported Position** | **-£0.5m** | **-£0.5m** | **£0.0m** | **-£4.7m** | **-£4.6m** | **£0.1m** |

Key variances within the YTD position are:

- **Income:** The positive variance is driven by non-recurrent / one-off transactions.
- **Pay:** Pay expenditure is above plan year to date with both bank and agency expenditure as significant drivers of this variance.
- **Other expenditure:** The position includes expenditure relating to Hantavirus, which is offset by income.

.

The Trust's agency costs remained at 1.3% of total pay bill for the month, which is above the national target of 0.8%.

## Cumulative CIP

**Narrative:**
The Trust delivered £1.8m of CIP at M6 which is in line with the monthly target. Cumulative delivery at M6 is £10.3m, also in line with the year-to-date target.

The full-year CIP requirement is £30.7m, equivalent to 6%. The Trust has identified £31.1m of schemes, representing 102% of the target, this reduces to £26.1m, or 85% when risk-adjusted.

Continued focus is required to convert the full programme into fully developed, transacted and recurrent savings as the profiled requirement increases over the remainder of the year.

## Elective Activity

**Narrative:**
Elective and day-case activity are below plan within Surgery and Medicine. Each division has a plan to deliver the full contracted activity levels.

## Capital Expenditure

**Narrative:**
At M6, the Trust has incurred capital expenditure of £6.456m against forecast expenditure of £7.430m, representing expenditure £0.974m lower than plan.

| Scheme | Capital Budget 2026/27 | Forecast spend M6 | Actual spend M6 | Variance |
|---|---|---|---|---|
| Estates and backlog maintenance | £7.209m | £1.800m | £1.826m | £0.026m |
| Operational delivery | £9.276m | £2.300m | £2.181m | -£0.119m |
| IT equipment | £0.900m | £0.650m | £0.619m | -£0.031m |
| Medical education | £0.075m | £0.000m | £0.000m | £0.000m |
| Transformation | £1.000m | £0.250m | £0.000m | -£0.250m |
| PDC Commitments | £5.581m | £2.430m | £1.830m | -£0.600m |
| **TOTAL CAPITAL PLAN 26/27** | **£24.041m** | **£7.430m** | **£6.456m** | **-£0.974m** |

The principal variances are:

- PDC commitments: £0.60m behind forecast.
- Transformation: £0.25m behind forecast.
- Operational delivery: £0.12m behind forecast.
- IT equipment: £0.03m behind forecast.
- Estates and backlog maintenance: £0.03m ahead of forecast.

The full capital expenditure plan is forecast to be delivered in 26/27.

## Cash Position

**Narrative:**
The cash balance at the end of M6 was £5.1m.

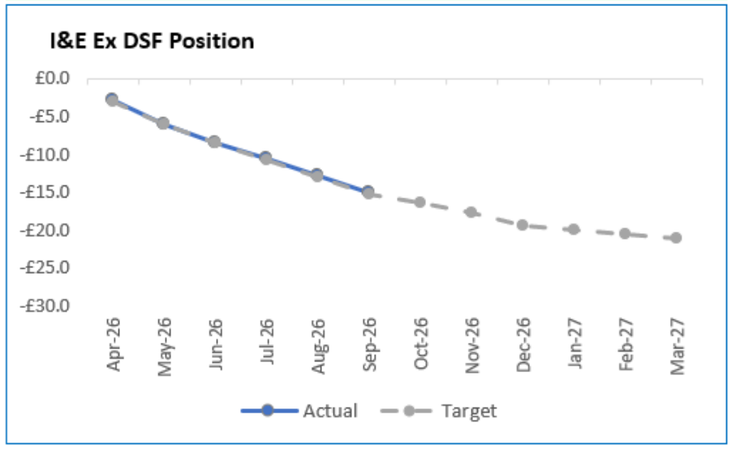
In M6 NHSE confirmed that the Trust would receive Deficit Support Funding for Q3. The Trust continues to maintain strict controls in respect of cash.

The Trust's cash mitigation actions are consistent with the NHS cash regime. These include:

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

## I&E Position

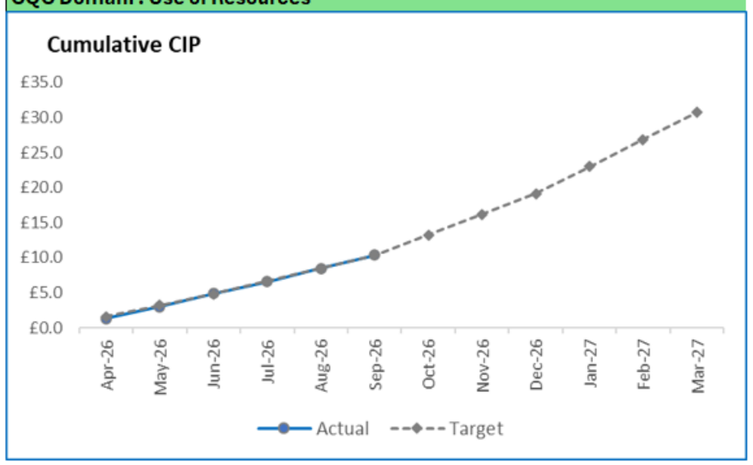
**CQC Domain: Use of Resources**




| Sep-26 |
|---|
| £-15.1m |
| **Variance Type** |
| Position meets the plan |
| **Target** |
| -£15.2m |

## Cumulative CIP

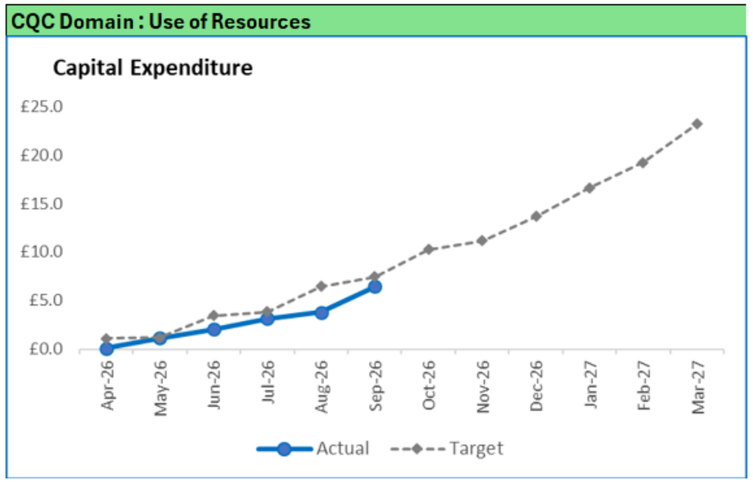
**CQC Domain : Use of Resources**




| Sep-26 |
|---|
| £10.4m |
| **Variance Type** |
| Position meets the plan |
| **Target** |
| £10.4m |

## Capital Position

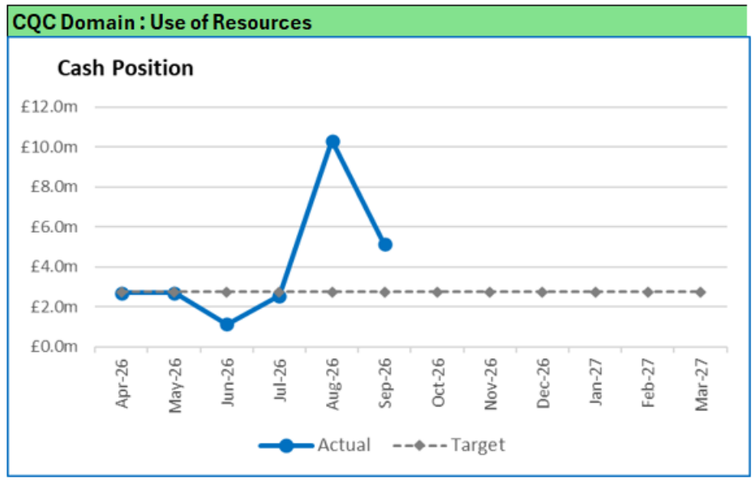
**CQC Domain : Use of Resources**




| Sep-26 |
|---|
| £6.5m |
| **Variance Type** |
| Position does not meet the plan |
| **Target** |
| £7.4m |

## Cash position

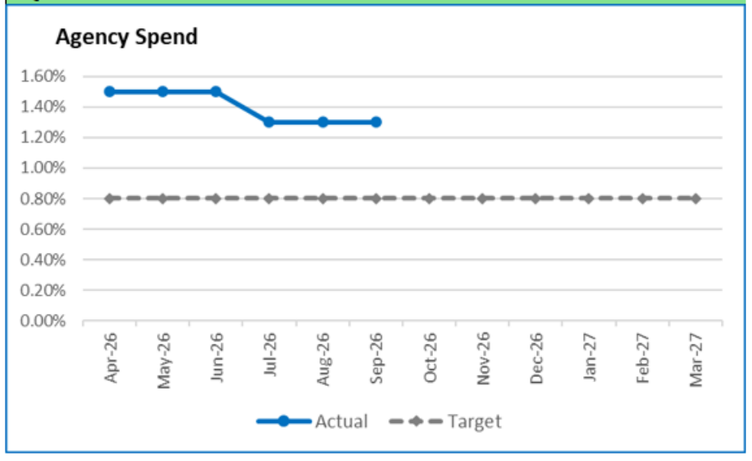
**CQC Domain : Use of Resources**




| Sep-26 |
|---|
| £5.1m |
| **Variance** |
| Position meets the plan |
| **Target** |
| £2.7m |

## Agency spend %

**CQC Domain : Use of Resources**




| Sep-26 |
| --- |
| 1.3% |
| **Variance Type** |
| Position does not meet the plan |
| **Threshold** |
| ≤0.8% |

## Finance Summary - WCHC

At the end of September 2026 (M6), WCHC is reporting a surplus of £2.1m, a year-to-date position that is a £1.2m positive variance to plan.

The Trust continues to forecast full achievement of the agreed finance plan.

The risk ratings for delivery of statutory targets in 2026/27 are:

| KPI | Latest data period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Agency spend | Sep 26 | 0.30% | <=0.1% | | | |
| I&E Position | Sep 26 | £2.1m | £0.9m | | | |
| Cumulative CIP | Sep 26 | £2.3m | £3.0m | | | |
| Capital Expenditure | Sep 26 | £2.3m | £1.1m | | | |
| Cash Position | Sep 26 | £13.5m | £9.0m | | | |

**Highlights**

The Trust is £1.2m ahead of plan at M6.

The main driver of this position is underspends in respect of pay, which is £1.6m underspent.

**Areas of Concern**

The main area of concern for the Trust is full delivery of the Cost Improvement Programme, which is £0.7m behind plan at M6.

**Forward Look (Actions)**

Convert the CIP programme into formally transacted and sustainable savings.

Maintain the favourable pay position while addressing the level of bank expenditure and bank WTE above plan.

## Commentary

At M6, WCHC is reporting a year-to-date favourable variance of £1.2m against plan.

The principal factors within the position are:

- Employee expenses: Expenditure is £1.6m below plan across all divisions.
- Operating expenditure: Expenditure is £0.6m below plan, driven principally by premises costs.
- CIP: Cost reductions are being maintained through the favourable variance against plan but have not yet been formally transacted as CIP.

The favourable overall position should therefore be viewed alongside the outstanding requirement to convert CIP into formally transacted savings and the impact of non-recurrent benefits within the position.
The full-year CIP target is £6.0m with the target profiled equally across the financial year. At M6, cumulative CIP achievement is £2.3m against a year-to-date target of £3.0m.
Full-year schemes of £7.5m have been identified, representing 124% of the target. This reduces to £6.7m, or 113% of the target, when risk-adjusted.

| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Cost Type | Plan | Actual | Variance | Plan | Actual | Variance |
| Clinical Income from Patient Care Activ | £9.2m | £9.3m | £0.0m | £53.3m | £53.3m | £0.0m |
| Other Operating Income | £0.2m | £0.2m | £0.0m | £1.3m | £1.5m | £0.2m |
| **Total Income** | **£9.4m** | **£9.5m** | **£0.1m** | **£54.6m** | **£54.8m** | **£0.3m** |
| Employee Expenses | -£7.2m | -£6.7m | £0.5m | -£42.2m | -£40.6m | £1.6m |
| Operating Expenses | -£1.5m | -£1.5m | -£0.0m | -£9.5m | -£8.9m | £0.6m |
| Non Operating Expenses | -£0.6m | -£0.5m | £0.0m | -£3.4m | -£3.2m | £0.1m |
| CIP | £0.0m | £0.0m | -£0.0m | £1.4m | £0.0m | -£1.4m |
| **Total Expenditure** | **-£9.3m** | **-£8.8m** | **£0.4m** | **-£53.6m** | **-£52.7m** | **£0.9m** |
| **Reported Position** | **£0.2m** | **£0.7m** | **£0.5m** | **£1.0m** | **£2.1m** | **£1.2m** |

## Capital

At M6, WCHC has incurred capital expenditure of £2.254m against forecast expenditure of £1.130m, representing expenditure £1.124m ahead of forecast.

| Scheme | Capital Budget 2026/27 | Forecast spend M6 | Actual spend M6 | Variance |
|---|---|---|---|---|
| Estates and backlog maintenance | £0.684m | £0.210m | £0.062m | -£0.148m |
| Operational delivery | £1.179m | £0.510m | £0.400m | -£0.110m |
| IT equipment | £0.560m | £0.210m | £0.419m | £0.209m |
| Transformation | £0.160m | £0.200m | £0.000m | -£0.200m |
| IFRS16 | £1.342m | £0.000m | £1.228m | £1.228m |
| PDC Commitments | £1.167m | £0.000m | £0.145m | £0.145m |
| **TOTAL CAPITAL PLAN 26/27** | **£5.092m** | **£1.130m** | **£2.254m** | **£1.124m** |

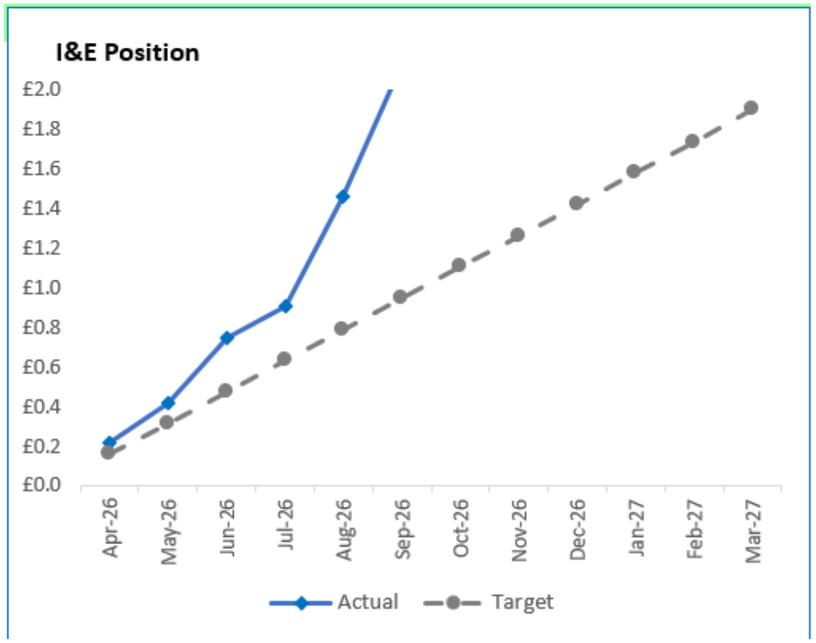
The principal variances are:

- **Estates and backlog maintenance:** £0.062m spent against a forecast of £0.210m, £0.148m behind forecast.
- **Operational delivery:** £0.400m spent against a forecast of £0.510m, £0.110m behind forecast.
- **IT equipment:** £0.419m spent against a forecast of £0.210m, £0.209m ahead of forecast.
- **Transformation:** No expenditure against a forecast of £0.200m, £0.200m behind forecast.
- **IFRS 16:** Expenditure of £1.228m with no corresponding M6 forecast.
- **PDC commitments:** Expenditure of £0.145m with no corresponding M6 forecast.

The full-year capital budget is £5.092m, comprising £0.684m for estates and backlog maintenance, £1.179m for operational delivery, £0.560m for IT equipment, £0.160m for transformation, £1.342m for IFRS 16 and £1.167m for PDC commitments.

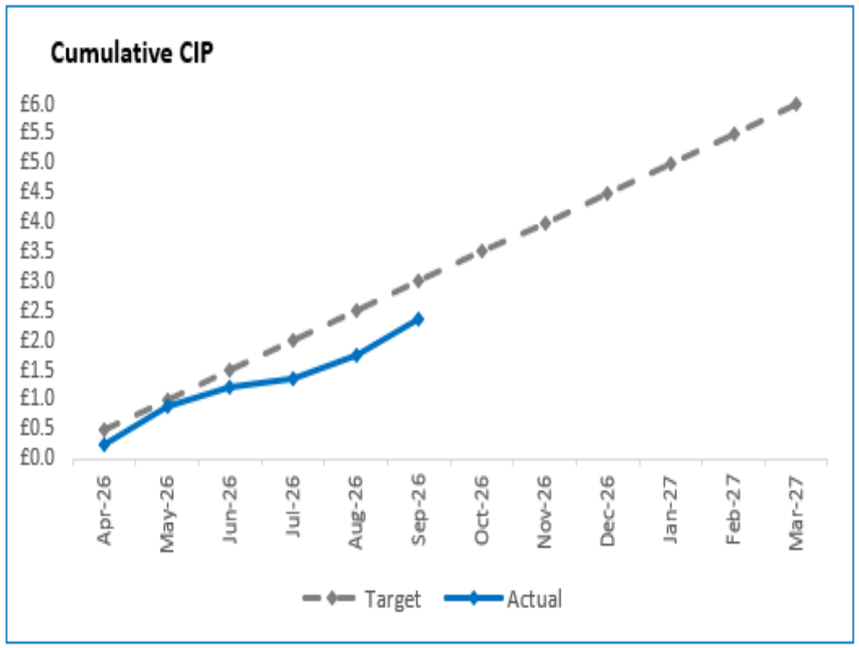
The reported year-to-date variance is principally a phasing issue associated with IFRS 16 and PDC commitments. Delivery of transformation, estates and operational schemes will require continued monitoring over the remainder of the year.

## I&E Position



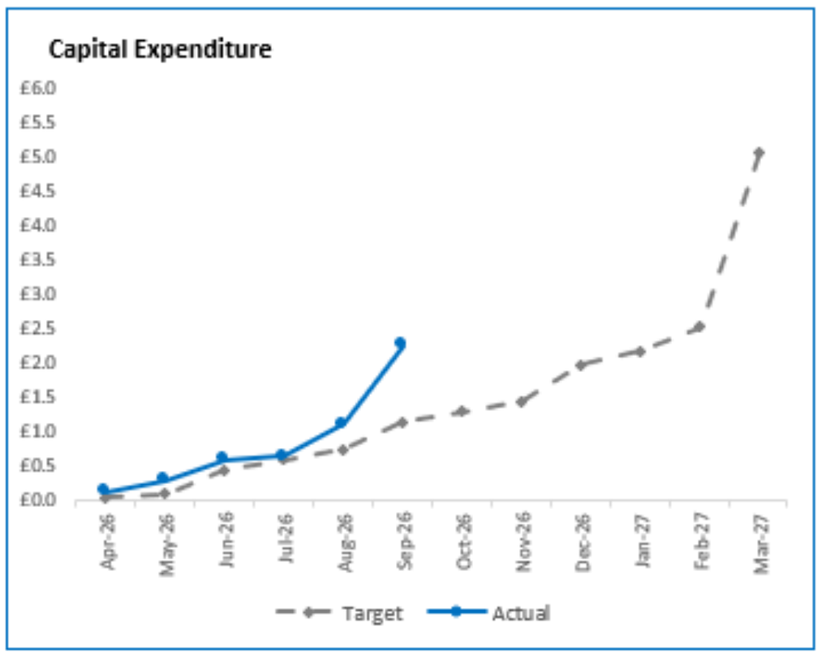

| Sep-26 |
|---|
| £2.1m |
| **Variance Type** |
| Position better than plan |
| **Target** |
| £0.9m |

## Cumulative CIP



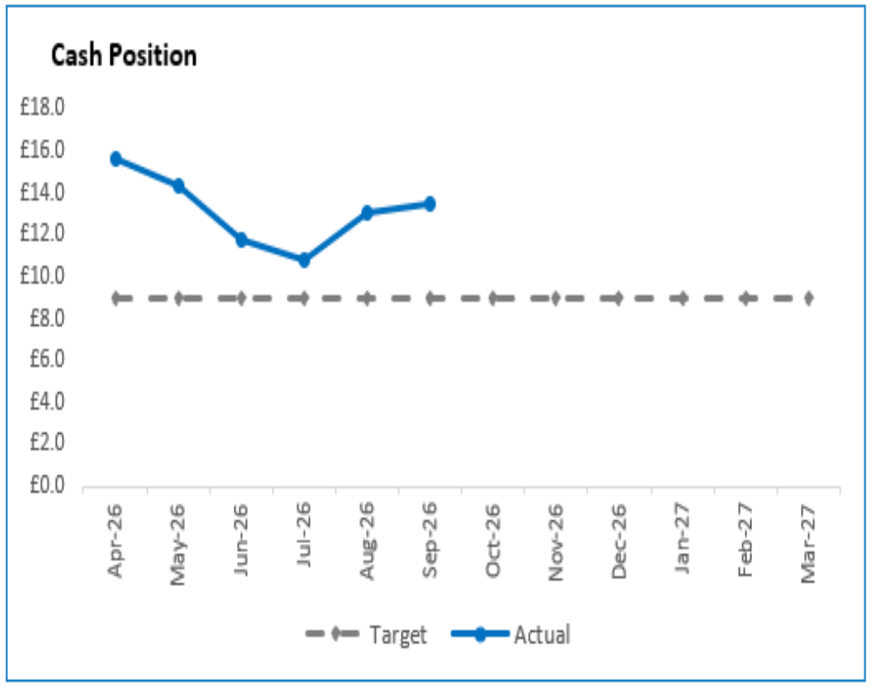

| Sep-26 |
|---|
| £2.4m |
| **Variance** |
| Position worse than plan |
| **Target** |
| £2m |

## Capital Expenditure



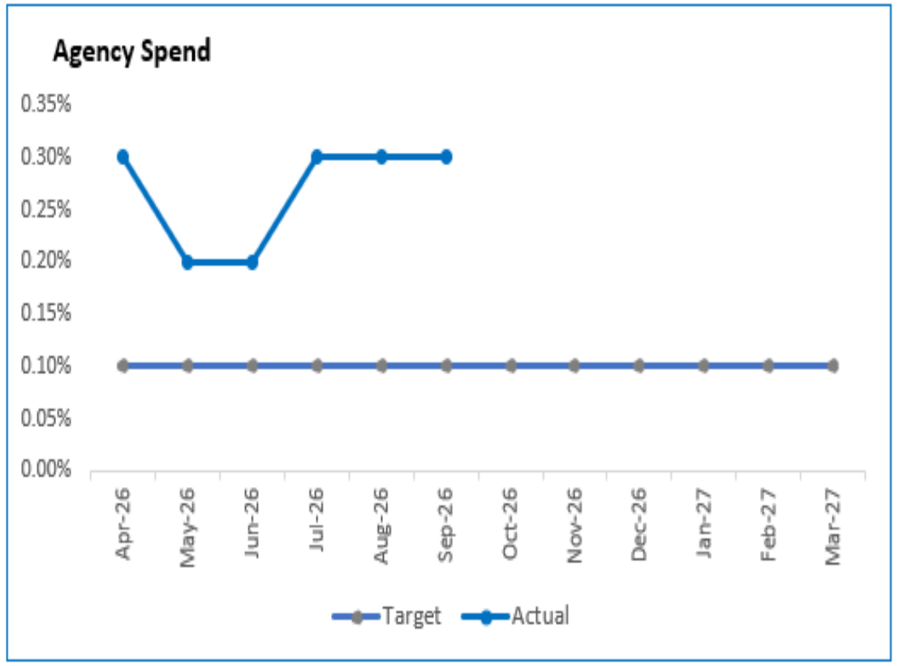

| Sep-26 |
|---|
| £2.3m |
| **Variance Type** |
| Position higher than plan |
| **Target** |
| £1.1m |

## Cash Position




| Sep-26 |
|---|
| £13.5m |
| **Variance** |
| Position better than plan |
| **Target** |
| £9m |

## Agency Spend




| Sep-26 |
| --- |
| 0.3% |
| **Variance** |
| Position worse than plan |
| **Target** |
| ≤0.1% |

## CPO Workforce Summary - WUTH

| KPI | Latest date period | Measure | Target | Variation | Assurance | Mean |
|---|---|---|---|---|---|---|
| Sickness absence % - in-month rate | Sep 26 | 5.84% | ≤5% | | | 5.91% |
| Staff turnover % - in-month rate | Sep 26 | 1.13% | ≤1% | | | 87.31% |
| Mandatory training % compliance | Sep 26 | 90.34% | ≥90% | | | 91.82% |
| Appraisal % compliance | Sep 26 | 83.23% | ≥88% | | | 0.84% |

### Highlights

**Appraisal Compliance:**

WUTH has seen a marginal increase in compliance from 83.00% in August 26 to 83.23% in September 26. Women and Children's remain the only Division above the Trust KPI at 88.56%, however this has reduced from 90.12% in August 26. Increases can however also be seen in:

- Clinical Support and Diagnostics; from 86.58% to 87.68% and nearing Trust target
- Estates, Facilities and Capital Planning; from 74.64% to 75.03%
- Surgery from 85.56% to 87.32% and nearing Trust target.

**Sickness Absence:**

WUTH in month sickness absence has improved from 6.03% in August 26 to 5.84% in September 26, a reduction of 0.19 percentage points. The rolling sickness absence rate is 5.85%.

Clinical Support and Corporate Support are below the Trust sickness target of 5% in September at 4.80% and 4.27% respectively.

Improvements can also be seen across the key staff groups previously identified as sickness hotspots:

- Additional Clinical Services reduced from 8.91% to 8.32%
- Estates and Ancillary reduced from 7.10% to 7.04%
- Nursing and Midwifery reduced from 6.29% to 6.16%.

### Areas of Concern

**Appraisal Compliance:**

Corporate Services compliance is 71.78% in the Sept 26 compliance report within which the staff TUPE'd on 1st Dec 25 are highlighted as requiring the most focus with a compliance figure of 46.72%.

Estates, Facilities and Capital compliance is 75.03% in the Sept 26 compliance Report within which Estates Directorate highlighted as requiring the most focus with a compliance figure of 57%.

Although not the lowest area of non-compliance, the Pathology Directorate appear to have been non-compliant for 20+ months and are currently 71.82%, the lowest area of non-compliance within Clinical Support and Diagnostics.

**Sickness Absence:**

Despite the improvement in September, sickness absence remains above the Trust 5% target.

The highest divisional sickness rates are:

- Surgery 7.13%
- Estates, Facilities and Capital 6.48%
- Medicine and Urgent Care 6.01%
- Women and Children's 5.78%.

The main staff group hotspots remain Additional Clinical Services at 8.32%, Estates and Ancillary at 7.04% and Nursing and Midwifery at 6.16%.

### Forward Look (Actions)

**Appraisal Compliance:**

Quality audit review has been paused to focus on deep dive into appraisal data to support enhanced understanding of areas with continued non/low compliance. Further engagement and support underway with area leads with a clear focus on increasing uptake.

Assurance has been sought from Corporate Leaders that appraisal will be a priority focus post Phase Three. An action is held within WSB to monitor appraisal compliance with Corporate Leads presenting their plans for compliance,

Deep dive report to be shared with WSB for further review and action along with reviewed reporting of audit findings.

**Sickness Absence:**

The Sickness Transformation Project continues with the objective of reducing Trust-wide sickness to below 5% within three years, with a 2026 financial target of £1.1m savings contributing to the Trust Cost Improvement Programme.

Delivery continues through four key workstreams:

- Targeted Trust-wide, staff group and divisional action plans
- Strengthening leadership and management accountability
- Proactive wellbeing support
- Strengthening policy and processes to drive sustained improvement

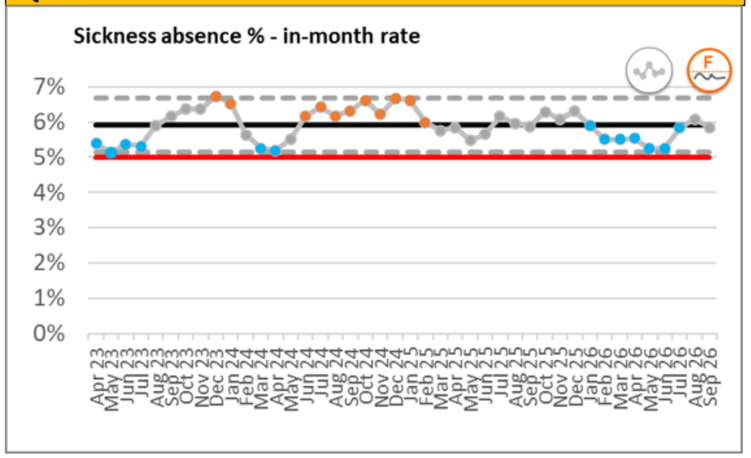
Targeted support continues for areas with the highest levels of sickness, alongside proactive health and wellbeing interventions including the Well in Work Programme, Well Wirral Return to Work Programme, improved mental health referral triage and targeted psychological support.

Divisional performance and delivery against sickness improvement plans will continue to be monitored, with targeted

| | | |
|---|---|---|
| | | HR support and escalation where improvement is not being achieved.<br><br>Priority focus remains on targeting hotspot services in divisions, breaking down the challenge to 'bitesize' targeted plans that feel manageable for leaders – i.e. how many staff need to be in work to achieve the 5%? Focus upon long term cases that don't have a return to work date. Targeted training and audits in hotspot areas. |
| **Turnover:**<br><br>Permanent workforce turnover for September 26 is 0.91%.<br><br>Women and Children's has the lowest divisional turnover at 0.31%, followed by Clinical Support at 0.44% and Surgery at 0.60% | **Turnover:**<br><br>September traditionally sees increased workforce movement linked to the start of the academic year, career development opportunities and the annual Medical and Dental rotation. Some increase in turnover is therefore anticipated during this period.<br><br>In addition, increased turnover within Corporate Services is expected following the completion of Phase 2 of the organisational change programme, with further workforce movement anticipated as Phase 3 progresses.<br><br>Corporate Support has the highest permanent workforce turnover at 2.26%, which should be considered in the context of the ongoing organisational change programme, followed by Estates, Facilities and Capital at 1.47% and Medicine and Urgent Care at 1.02%.<br><br>The highest permanent workforce turnover by staff group is Administrative and Clerical at 1.81%, followed by Additional Clinical Services at 1.45% and Estates and Ancillary at 1.12%. | **Turnover:**<br><br>Turnover will continue to be monitored as the organisational change programme progresses through Phase 3, alongside expected seasonal workforce movement and Medical and Dental rotations.<br><br>Leaver reasons and turnover hotspots will continue to be reviewed to distinguish expected organisational change and seasonal movement from emerging underlying retention issues. |

## Sickness absence % in month rate

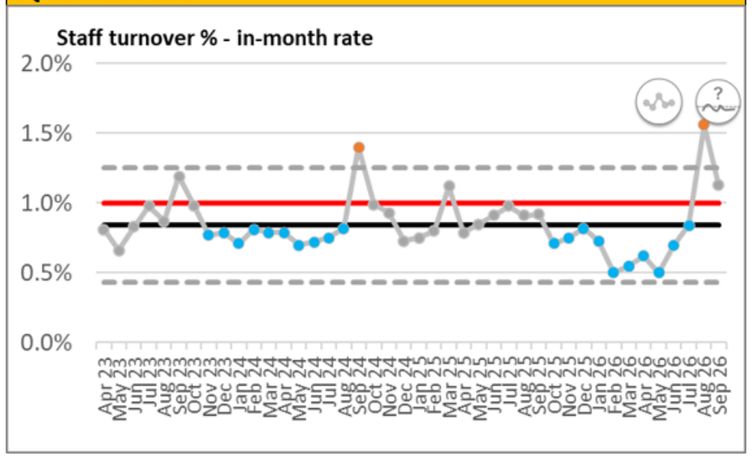
**CQC Domain : Safe**




| Sep-26 |
|---|
| 5.8% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤5% |
| **Assurance** |
| Consistently fail target |

## Staff turnover % in month rate

**CQC Domain : Safe**




| Sep-26 |
|---|
| 1.1% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≤1% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Mandatory training % compliance

**CQC Domain : Safe**




| Sep-26 |
|---|
| 90.3% |
| **Variance Type** |
| Special cause concerning variation |
| **Threshold** |
| ≥90% |
| **Assurance** |
| Hit and miss target subject to random variation |

## Appraisal % compliance

**CQC Domain : Well-led**




| Sep-26 |
|---|
| 83.2% |
| **Variance Type** |
| Special cause concerning 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 | Sept 26 | 10.5% | 12.0% | | | 12.4% |
| Mandatory Training Compliance | Sept 26 | 94.3% | 90.0% | | | 95.0% |
| Sickness Absence | Sept 26 | 6.9% | 5.0% | | | 6.5% |
| Sickness Absence (Short Term) | Sept 26 | 2.4% | 2.0% | | | 1.6% |
| Sickness Absence (Long Term) | Sept 26 | 4.6% | 3.0% | | | 4.9% |
| Agency usage | Sept 26 | 0.2% | 1.0% | | | 0.9% |
| Variance to Agency Cap (£) | Sept 26 | -206461 | - | | | -177197.8 |
| % of Agency Usage against Funded WTE | Sept 26 | 0.0% | - | | | 0.6% |
| % of Bank Usage against Funded WTE | Sept 26 | 4.3% | - | | | 3.5% |
| % of Contracted FTE Vacancies | Sept 26 | 4.8% | 6.0% | | | 5.0% |

## Highlights

Sickness remains above the 5% target in four of five directorates, with Therapies the only directorate within target at 4.96%. The principal assurance concern is concentrated long-term/high-impact absence accounting for 4.6% of absences across a number of services, particularly Specialist Medical, Nursing and Community Response, while several individual teams continue to demonstrate strong attendance below 5%. Short term sickness attributed for 2.4% of all absences.

Children's Services: Absence improved to 5.87%, but remains above the 5% target; the reduction in FTE lost alongside an increase in episodes indicates improvement in long-term absence but increased short-term sickness.

Community Response: Absence deteriorated to 8.13%, with both episodes and FTE lost increasing, indicating pressure from sickness frequency alongside higher-impact absence. Right Care Hub (3.94%) and Centralised Booking Service (3.00%) are below target,

Nursing: Absence increased significantly from 5.97% to 7.58%, with the increase in FTE lost substantially exceeding the increase in episodes, indicating longer-duration sickness as the key pressure. Good performance includes St Catherine's (0.32%), Directorate Management (2.04%), Claughton (3.09%), New Brighton (3.26%) and The Warrens (4.32%);

Specialist Medical: Community Dental (0%) and Sexual Health (3.45%) are below the 5% Target.

Therapies: Overall absence improved to 4.96% and is therefore within the 5% target, although the number of sickness episodes increased, signalling continued short-term absence activity Podiatry has improved to 0.4% and Rehabilitation at Home to 4.7%;

## Areas of Concern

Anxiety/stress/depression and other psychiatric illness is the prominent reason for long-term absence category, alongside musculoskeletal-related absence; short-term absence is spread across episodic causes including gastrointestinal illness, headache/migraine, cold/cough/flu and other minor illnesses.

Children's Services: the most significant hotspots are Knowsley Enhancing Families (22.22%) and Knowsley South (20.96%), alongside Vaccinations/Immunisations/Screeners (13.13%).

Community Response: CIRT remains the principal concern at 10.38%, including Home First at 10.46%; the annual trend identifies recurrence of longer-term absence cases as an important driver.

Nursing: the most significant hotspot is Ageing Well & Frailty at 21.18%, followed by Nights (14.24%), Palliative Care (13.71%) and West Kirby (12.59%).

Specialist Medical: This is the highest directorate-level absence position at 9.50%, increasing from 7.56%; FTE lost increased despite fewer episodes, indicating greater impact from existing/longer-duration cases. The most significant pressures are Urgent & Primary Care Admin (51.67%) and VHCH Minor Injuries Unit (31.17%), with UTC and DVT both around 17%.

Therapies: The principal outliers are Weight Management (25.8%) and Pelvic Health (13.8%).

## Forward Look (Actions)

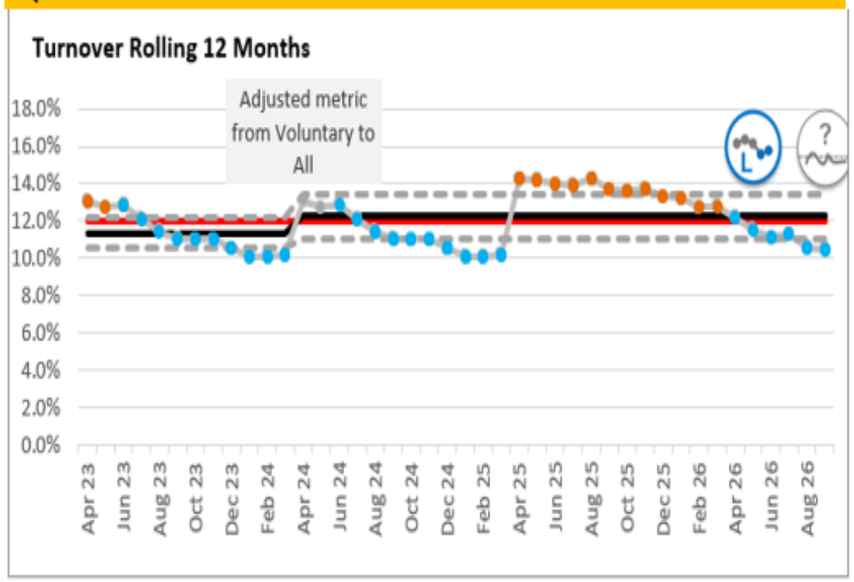
**Strengthened performance reporting and accountability**
Enhanced sickness absence reporting to the WCHC SLT, providing clearer visibility of performance against the 5% target, including long and short term absence trends and service hotspots. This enables earlier identification of deterioration and clearer accountability for improvement actions.

**Enhanced governance and targeted intervention**
Introducing a strengthened sickness absence governance structure, with routine scrutiny of directorate, service and team level hotspots, particularly areas with sustained or deteriorating absence. This provides greater grip on outliers and ensures targeted recovery actions are identified, monitored and escalated where improvement is not being achieved.

**Strengthened assurance on policy application**
Trialling a sickness absence audit to triangulate reported performance with evidence that the sickness absence policy is being applied consistently in practice. The audit will provide additional assurance on management controls, identify gaps in application and inform targeted support or corrective action.

## Turnover – Rolling 12 Months

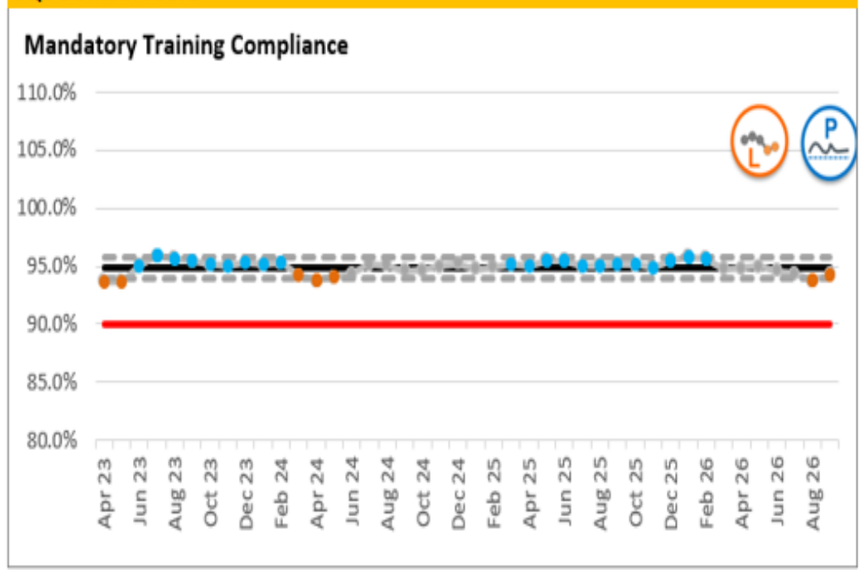
CQC Domain : Safe




| Sep-26 |
|---|
| 10.5% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| ≤12.01% |
| **Assurance** |
| Hit & miss target subject to random variation |

## Mandatory Training Compliance

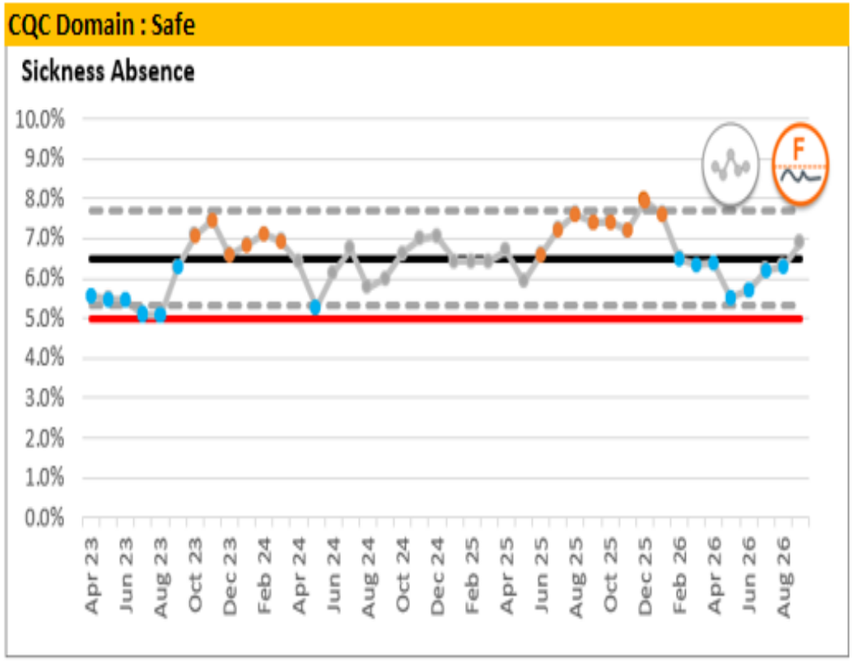
CQC Domain : Safe




| Sep-26 |
|---|
| 94.3% |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| ≤90% |
| **Assurance** |
| Performance consistently achieves the target |

## Sickness Absence

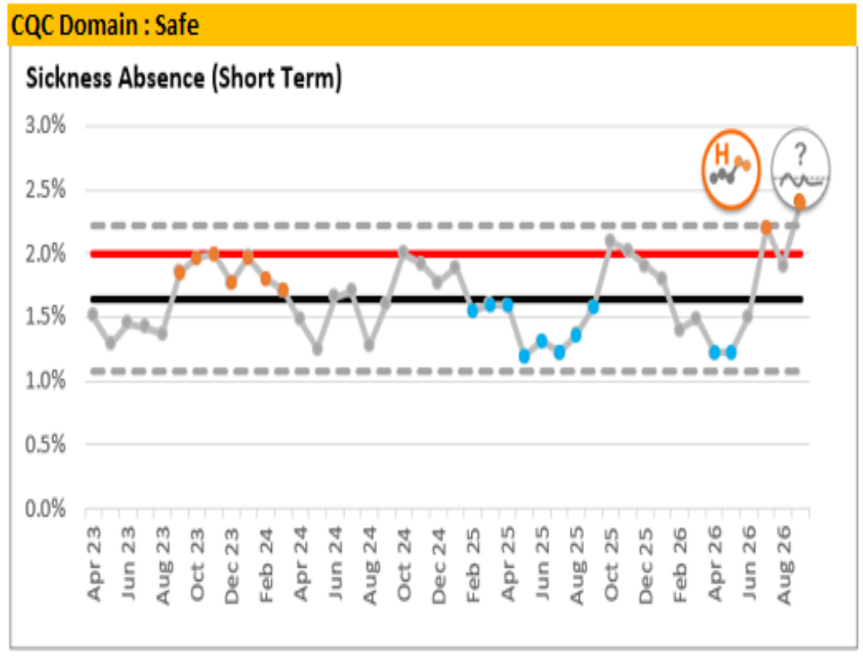
CQC Domain : Safe




| Sep-26 |
|---|
| 6.9% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥5% |
| **Assurance** |
| Performance consistently fails the target |

## Sickness Absence (Short Term)

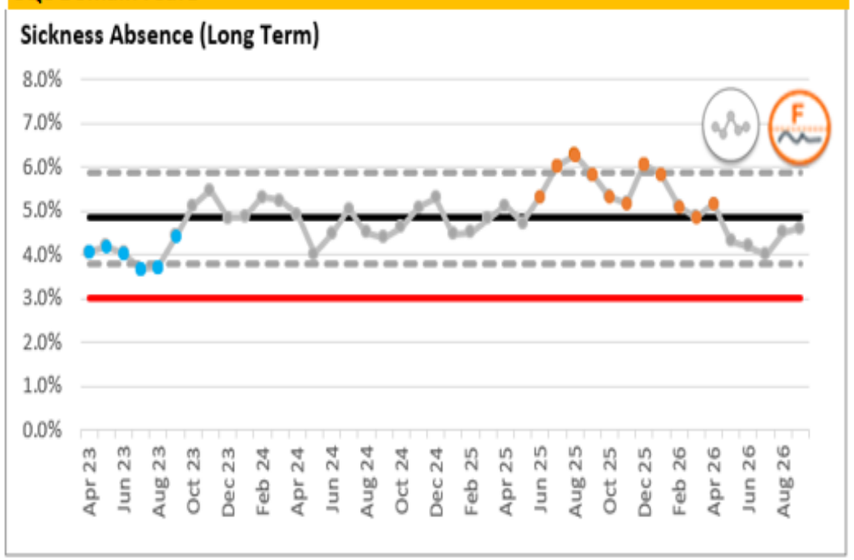
CQC Domain : Safe




| Sep-26 |
|---|
| 2.4% |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| ≥2% |
| **Assurance** |
| Hit & miss target subject to random variation |

## Sickness Absence (Long Term)

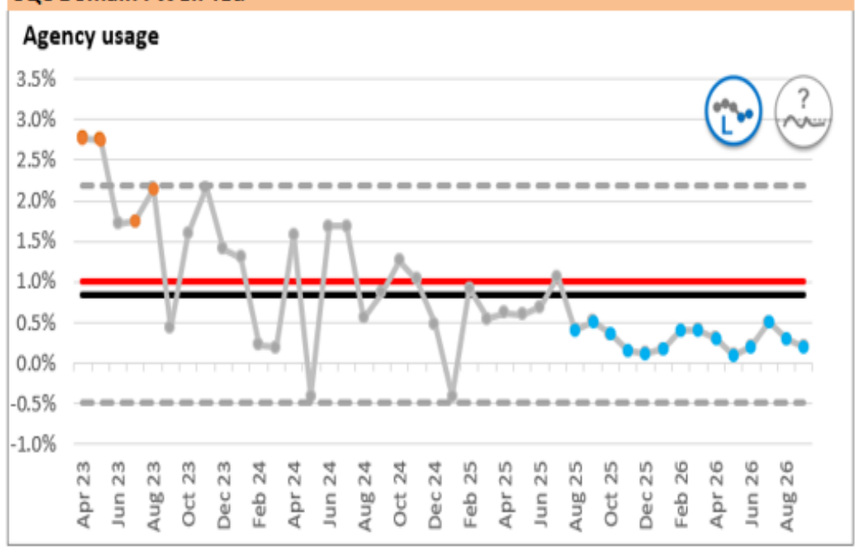
CQC Domain : Safe




| Sep-26 |
|---|
| 4.6% |
| **Variance Type** |
| Common cause variation |
| **Threshold** |
| ≥3% |
| **Assurance** |
| Performance consistently fails the target |

## Agency usage

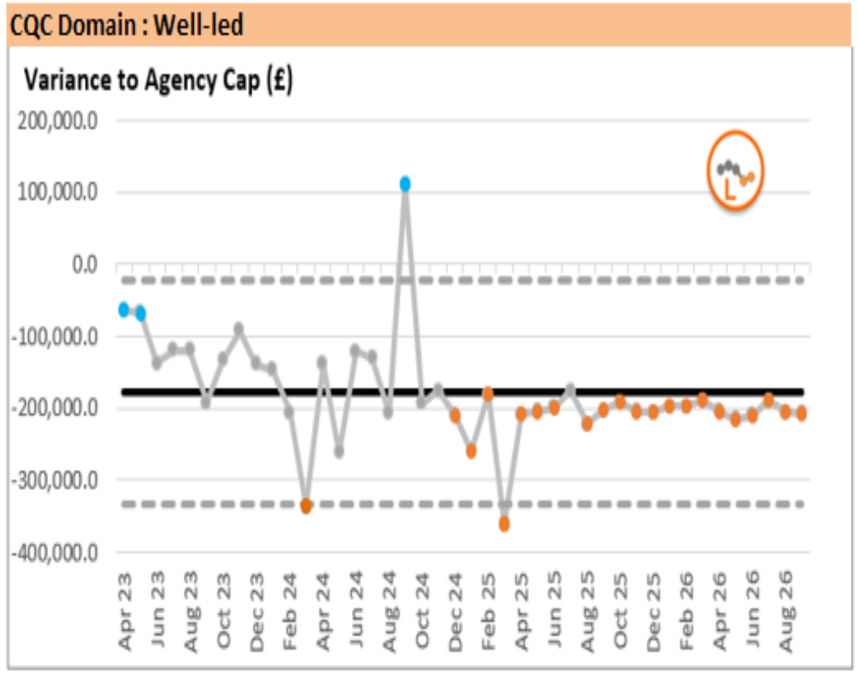
CQC Domain : Well-led




| Sep-26 |
|---|
| 0.2% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| ≥1% |
| **Assurance** |
| Hit & miss target subject to random variation |

## Variance to Agency Cap (£)

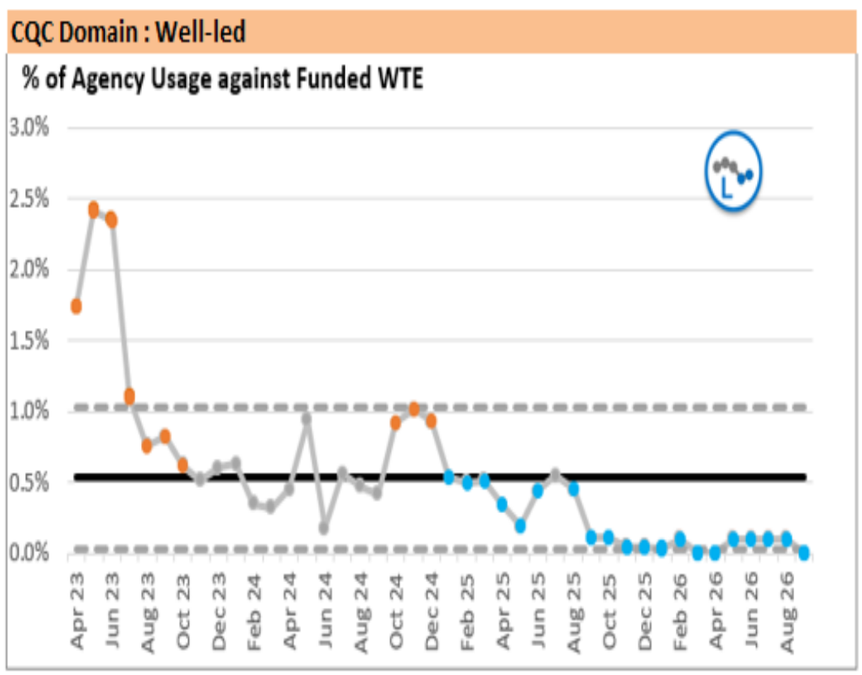
CQC Domain : Well-led




| Sep-26 |
|---|
| -£206,461.00 |
| **Variance Type** |
| Special cause variation - Concerning |
| **Threshold** |
| |
| **Assurance** |
| |

## % of Agency Usage against Funded WTE

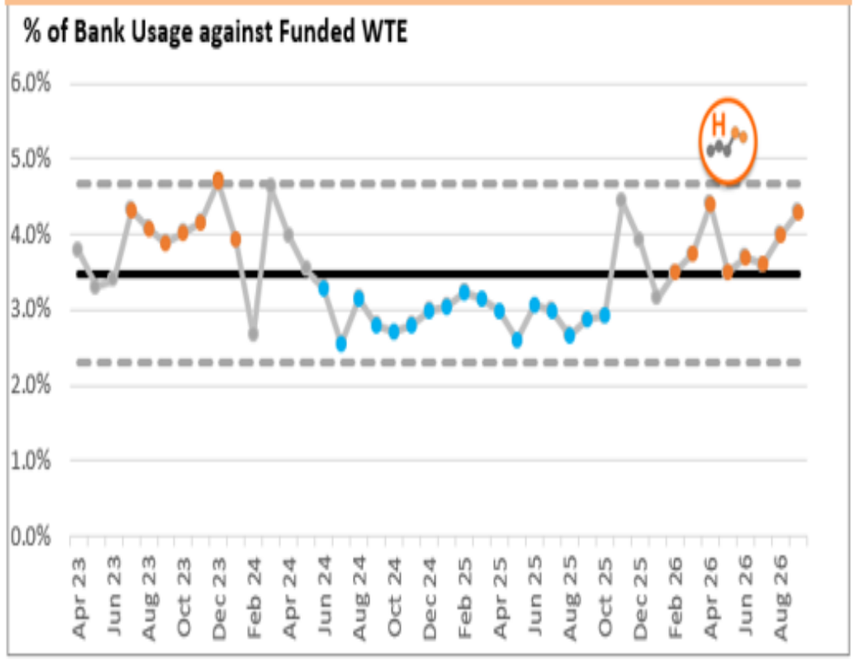
CQC Domain : Well-led




| Sep-26 |
|---|
| 0.0% |
| **Variance Type** |
| Special cause variation - Improving |
| **Threshold** |
| |
| **Assurance** |
| |

## % of Bank Usage against Funded WTE

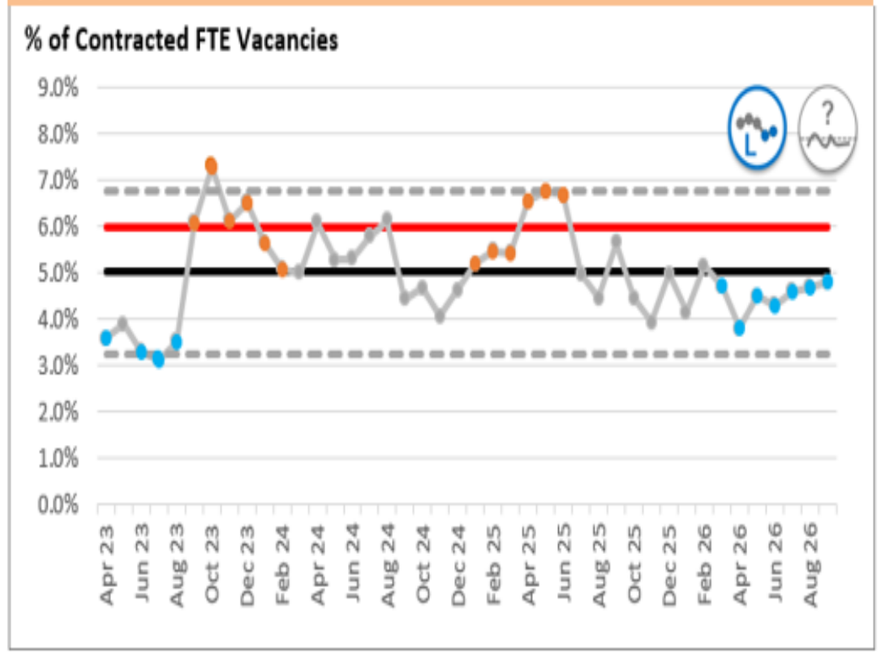
CQC Domain : Well-led




| Sep-26 |
|---|
| 4.3% |
| Variance Type |
| Special cause variation - Concerning |
| Threshold |
| |
| Assurance |

## % of Contracted FTE Vacancies

CQC Domain : Well-led




| Sep-26 |
|---|
| 4.8% |
| Variance Type |
| Special cause variation - Improving |
| Threshold |
| ≥6% |
| Assurance |
| Hit & miss target subject to random variation |

**Group Board of Directors in Public** **Item 9**

**04 November 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 September and October 2026.

It is recommended that the Group Board:

- Reviews the risk ratings noting that there are 6 high-level strategic risks
- Approves the updates for each risk as reported
- Notes that further work through the Committees of the Board will continue to monitor each of the strategic risks with a particular focus during November and December on actions

## Key Points to Note

The Joint BAF has been developed to align with the strategic objectives 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 implemented and each of the Committees of the Board has maintained oversight of each of the relevant strategic risks.

## 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 | 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** |
| 1 April 2026 | Group Board | Board Assurance Framework 26-27 | The Group Board reviewed and approved the new strategic risks 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 dual oversight by the Committee (with the Finance 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 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 strategic risks ID01, ID02 and ID08 and supported the risk appetite statements and the current risk ratings and target risk ratings. |
| 19 June 2026 | Digital Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID11 and ID12. The correspondence from NHSE Head of Cyber Security, NHSE/ DHSC on board and executive assurance processes |

| | | | |
|---|---|---|---|
| | | | in relation to cyber security risk was noted for risk ID12. There were no proposed changes to risk ratings. |
| 24 June 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID01, ID02, ID05, ID06 and ID11 and a proposal in relation to increasing the risk rating of ID01 was considered. |
| 16 July 2026 | People Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID03 and ID04 noting that ID03 is a high-scoring risk at RR16. The Committee also noted the interdependency between culture and patient safety and the importance of monitoring quality metrics as an indicator of culture; this was agreed to be referenced in ID03.<br>The Committee received a summary of the People Strategy and Operational Priorities for 2026-27 mapped to ID03 and ID04. There were no proposed changes to risk ratings. |
| 23 July 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID01, ID02, ID05, ID06 and ID11 and a proposed increase in the risk rating for ID01 was supported recognising the continued demands on unscheduled care and the consequential impact on the Trust's legal undertakings with NHSE and the Trust's published NOF position. |
| 13 August 2026 | Quality Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID01, ID02 and ID08. The proposed increase in risk rating of ID01 was considered and supported by the Committee (as above).<br>The Committee considered the inclusion of a new risk related to patient safety and quality governance frameworks - *see below.* |
| 19 August 2026 | Integration Management Board | Board Assurance Framework 26-27 | The Committee reviewed risks ID09 and ID10 and there were no proposed changes to risk ratings. |
| 27 August 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed risks ID01, ID02, ID05, ID06 and ID11 and following the meeting of the Quality Committee in August 2026, noted that reference to the clinical guardrails had been included to support the controls of ID01, and the outpatient transformation programme had been referenced as part of the risk mitigation for ID02. |
| 2 September 2026 | Group Board of Directors | Board Assurance Framework 26-27 | The Group Board approved the recommendation to increase the risk rating of ID01 to RR20, and the recommendation to include a new strategic risk related to |

| | | | |
|---|---|---|---|
| | | | patient safety and quality governance. The Group Board noted the oversight by the Committees and the position in relation to all risks, with 6 scoring at a high level. |
| 10 September 2026 | WUTH Audit & Risk Committee<br><br>WCHC Audit & Risk Committee | Board Assurance Framework 26-27 | The Committees noted the recent approvals made by the Group Board and the updates for each risk as reported.<br>The Committees also received an update in relation to ID07 and agreed the current risk rating, controls and assurances.<br>It was agree that that the Audit & Risk Committees would receive the full BAF at future meetings to review the position in relation to all the strategic risks. |
| 16 September 2026 | Digital Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to risk ID11 (from a cyber perspective) and ID12 noting the current risk rating in the context of current controls. |
| 24 September 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to risk ID01, ID02, ID05, ID06 and ID11 noting the joint review and oversight of risks with both the Quality & Safety and Digital Committees.<br>The updates to the controls and assurance and particularly the strengthening of controls to reflect the recently updated EPRR core standards were noted.<br>There were no proposed changes to risk ratings. |
| 28 September 2026 | Quality & Safety Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to ID01, ID02 and ID08 noting the joint review and oversight of ID01 and ID02 (also as high scoring risks) with the Finance & Performance Committee.<br>The Committee also proposed an addition to ID03 (referred to the People Committee) to demonstrate the interdependency between culture and patient safety and quality and the importance of monitoring quality metrics as an indicator of culture.<br>There were no proposed changes to risk ratings. |
| 30 September 2026 | People Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to ID03 and ID04, noting that ID04 is one of the high scoring risks on the BAF.<br>There were no proposed changes to risk ratings with the Committee reflecting the continuing importance and significance of |

| | | | |
|---|---|---|---|
| | | | workforce culture across both organisations. |
| 15 October 2026 | Integration Management Board | Board Assurance Framework 26-27 | The IMB reviewed the updates shared in relation to ID09 and ID10 and agreed an increase to the risk rating of ID09 to RR12 to reflect the statutory transaction process and timeline. It was noted that ID09 will continue to track through IMB for oversight. |
| 22 October 2026 | Finance & Performance Committee | Board Assurance Framework 26-27 | The Committee reviewed the updates shared in relation to risk ID01, ID02, ID05, ID06 and ID11 noting the joint review and oversight of risks with both the Quality & Safety and Digital Committees. There were no proposed changes to risk ratings. |

| 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.<br><br>Each of the Joint Committees of the Group Board maintains oversight of strategic risks relevant to the duties and responsibilities of the committee.<br><br>The Audit & Risk Committee of each Trust also receives a regular update on the monitoring of the strategic risks. |
| **1.2** | All of the strategic risks included in the BAF are detailed in **appendix 1** with alignment to strategic objectives, Executive Lead and committee oversight included. |
| **1.3** | Since the last meeting of the Group Board all 12 strategic risks have been reviewed by the relevant Committees.<br><br>The new strategic risk (ID13) recommended by the Quality & Safety Committee and approved by the Board in September 2026, is currently being developed and will be reviewed by the Committee at its next meeting in November 2026. |
| **1.4** | Of the 12 strategic risks, **six** remain **HIGH** scoring risks.<br><br>These are:<br><br>ID01 - Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience (RR20).<br><br>ID02 - Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience (RR16).<br><br>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).<br><br>ID06 - Failure to embed service transformation and deliver sustainable efficiency gains (RR15).<br><br>ID11 - Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care (RR15). |
| **1.5** | There are no recommendations to the Board to increase or amend any risk ratings. |
| **1.6** | The Joint Committees of the Board will continue to oversee the relevant strategic risks and assurance on process and tracking will be provided to each of the Audit & Risk Committees in September 2026. |

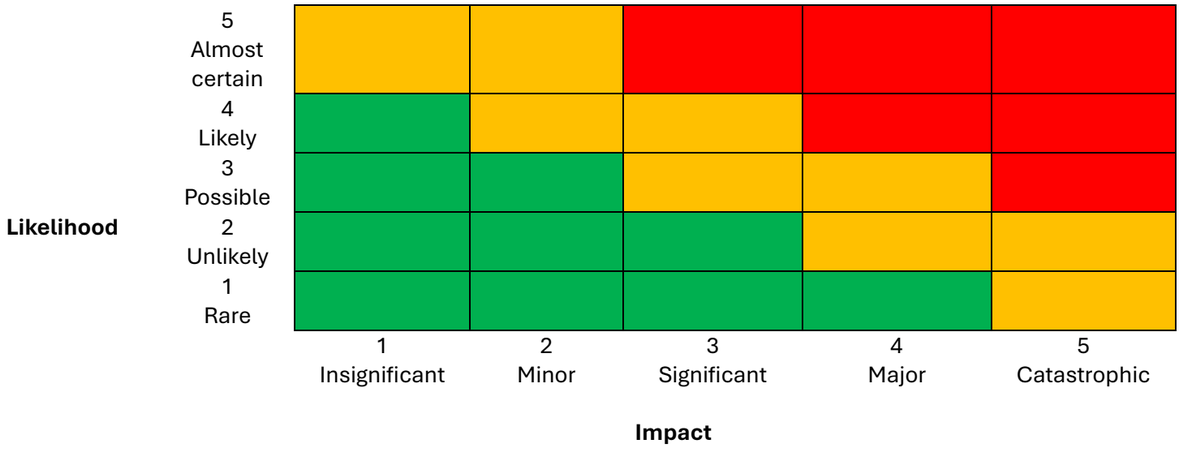
| **2** | **Implications** |
|---|---|
| **2.1** | **Patients**<br>• Any gaps related to these strategic risks could have an impact on the provision of high-quality services, impacting on patient safety and patient experience.<br>• The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF. |
| **2.2** | **People**<br>• Any gaps related to these strategic risks could have an impact on other people strategic risks including the retention of a skilled workforce.<br>• The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF. |
| **2.3** | **Finance**<br>• Any financial or resource implications are detailed in the BAF for each strategic risk. |
| **2.4** | **Compliance**<br>• 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**<br>We will create the conditions for outstanding care and performance | Quality<br>Finance & Performance | Chief Medical Officer<br>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**<br>We will create the conditions for outstanding care and performance | Quality<br>Finance & Performance | Chief Medical Officer<br>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**<br>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**<br>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**<br>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**<br>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**<br>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**<br>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**<br>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**<br>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<br><br>Operational Effectiveness | **Advance Digitally**<br>We will develop a secure, connected digital ecosystem fit for the future<br><br>**Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Finance & Performance<br><br>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**<br>We will develop a secure, connected digital ecosystem fit for the future | Digital | Chief Finance Officer / SIRO |

| | | | | |
|---|---|---|---|---|
| 13. The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks. | Quality & Patient Experience | **Delivering Excellence**<br>We will create the conditions for outstanding care and performance | Quality | Chief Nurse<br>Chief Medical Officer |

| **Committee** | **Risks** | |
|---|---|---|
| Quality | 4 | 1, 2, 8 & 13 |
| 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 (August 2026) I x L |
|---|---|---|---|---|---|
| 1. Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. | Quality<br>Finance & Performance | Chief Medical Officer<br>Executive Managing Director | Minimal | 4 x 5 (20) | 4 x 5 (20) |
| 2. Failure to effectively manage planned/scheduled care, adversely impacting on activity, statutory targets, quality of care and patient experience. | Quality<br>Finance & Performance | Chief Medical Officer<br>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 | Open | 3 x 5 (15) | 3 x 3 (9) |
| 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 | Seek | 3 x4 (12) | 3 x 4 (12) |
| 11. Failure of critical infrastructure or cyber-attack, leading to business continuity issues and compromised patient care. | Finance & Performance<br><br>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) |
| 13. The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks. | Quality | Chief Nurse<br>Chief Medical Officer | | | |


Likelihood
5
Almost certain
4
Likely
3
Possible
2
Unlikely
1
Rare
1
Insignificant
2
Minor
3
Significant
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Major
5
Catastrophic
Impact

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| **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<br>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<br>- Increased ambulance handover delays and emergency department breaches<br>- Reduced system flow, impacting elective capacity and planned care recovery<br>- Reduced patient confidence, satisfaction and overall experience<br>- Poor experience for patients and carers, particularly for frail, elderly and high-risk groups<br>- Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times<br>- Increased complaints, PALS concerns and potential litigation<br>- Reduced confidence from staff, patients and stakeholders<br>- Reduced system flow and inefficiencies across pathways<br>- Reduced staff morale, engagement and retention<br>- Greater reliance on temporary staffing, impacting continuity and cost<br>- Financial penalties or loss of income linked to performance breaches<br>- Increased scrutiny and | 4 x 5 (20) | 1) Board and Executive oversight of UEC performance | - Weekly UEC report to Execs from UEC oversight group<br>Board Assurance Framework reviews<br>- Quality Committee and Finance Committee AAA reports to Board<br>- Divisional Performance Reviews (WUTH)<br>- Integrated Performance Board (WCHC)<br>- Integrated Performance Report<br>- NOF segmentation tracking<br>- CQC action plans - tracking through Board and Committees<br>- Standing paper to private Board presenting progress to Financial Plan including CIP and legal undertakings<br>- Quality Committee scrutiny of quality and patient safety impacts arising from demand pressures.<br>- Finance & Performance Committee review of operational performance and recovery trajectories<br>- Ongoing monitoring of the CQC UEC and Medicine Action Plan with evidence of sustainable action completion<br>- Patient Safety Response Panel assurance regarding PSIRF implementation, Duty of Candour compliance and safety learning<br>- Quarterly patient safety reporting supports triangulation of quality impacts arising from operational pressures<br>- Weekly Executive-led recovery meetings focused on Medicine & Urgent Care | - NHSE oversight (ECIST)<br>- Full engagement in Tier 1 meetings<br>- CQC inspection report(s) and on-going CQC engagement<br>- NOF segmentation publication<br>- WUTH improvement from NOF Segment 4 to Segment 3 in Q1 2026/27<br>- Improvement in national acute and specialist ranking from 123/134 to 99/134<br>- Improvement in overall NOF score from 2.85 to 2.65<br>- Quality Committee and Finance & Performance Committee joint oversight of quality, performance and recovery trajectories. | ~~4 x 4 (16)~~<br><br>4 x 5 (20) | ~~- NOF segment 4 (WUTH)~~<br>- Agreement of exit criteria from legal undertakings re: UEC performance<br>- Pending Q1 review of undertakings from NHS<br>- Implementation of the NHSE NW Performance Accountability Framework<br>~~- Sufficient assurance that current improvements in UEC performance are sustainable and capable of delivering exit from legal undertakings and further improvement in NOF segmentation~~ | ~~- New engagement arrangements with NHSE – **Director of Corporate Affairs**~~<br>- Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – **Director of Corporate Affairs**<br>~~- WUTH invited to next national corridor care summit in September 2026 - **CMO, Exec MD**~~ | - Regional performance oversight meetings from June / July 2026<br>- NHSE performance oversight arrangements emerging – June/July 2026 – **in progress with NHSE** including new Performance Accountability Framework (PAF) | 4 x 2 (8) | |

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| intervention from regulators and system partners<br>- Failure to meet national urgent and emergency care standards (and impact on NOF rating) | | - Divisional recovery plans aligned to UEC improvement and patient flow priorities<br>- Financial Recovery Programme includes dedicated Drivers of the Deficit workstream focused on urgent and emergency care demand, flow and discharge<br>- Regular monitoring of corridor care action plans and associated performance measures | | | | |
| | 2) Clinical triage and front-door streaming | - Clinical audit of triage/streaming outcomes<br>- Incident reporting<br>- Incident and complaints analysis<br>- Patient experience feedback<br>- Divisional Performance Reviews (WUTH)<br>- Integrated Performance Board (WCHC)<br>- EARC oversight (WUTH) & high-level risk reports (WCHC)<br>- Integrated Performance Report<br>- Implementation of continuous flow model to improve egress from ED<br>- GP streaming at front door with triage to UTC<br>- Clinical guardrails agreed as part of transformation and CIP programme<br>- New Emergency Department and UTC co-location implemented<br>- Resolution of patient experience concerns regarding shared paediatric/adult waiting areas through implementation of the new ED/UTC facilities as part of the UECUP programme | - External clinical audits<br>- NHSE oversight (ECIST)<br>- Cheshire and Mersey UEC standardisation programme | | - Dependency on short-term escalation measures during sustained pressure<br>- Delays in implementing case for change to align to C&M UEC standardisation programme (WUTH & WCHC)<br>- Continued reliance on temporary escalation spaces and episodic corridor care during periods of peak demand indicates that sustainable capacity and flow solutions are not yet fully established | - Development of longer-term system capacity and pathway transformation plans - **Executive Managing Director** |
| | 3) Enhanced community and intermediate care pathways | - UEC improvement programme<br>- Integration of WUTH and WCHC clinical services<br>- Integration Management Board / Drivers of the deficit (integration programme)<br>- Integration programme now includes UEC-related clinical pathways across WUTH and WCHC service<br>- Drivers of the Deficit UEC programme operating across both organisations | - System flow reviews<br>- C&M UEC improvement programme<br>- Wirral Unscheduled Care Board<br>- Cheshire and Mersey UEC standardisation programme<br>- Active participation in Cheshire & Mersey UEC standardisation programme<br>- System flow reviews through Place and Provider Collaborative governance | | - Delays in implementing case for change to align to C&M UEC standardisation programme (WUTH & WCHC) | |

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| | | | - Weekly Executive-led recovery meetings focused on Medicine & Urgent Care<br>- Divisional recovery plans aligned to UEC improvement and patient flow priorities<br>- Financial Recovery Programme includes dedicated Drivers of the Deficit workstream focused on urgent and emergency care demand, flow and discharge<br>- Regular monitoring of corridor care action plans and associated performance measures | | | | | |
| | 4) Early discharge planning and discharge to assess models | - Quality metrics relating to harm, incidents, complaints and patient experience associated with unscheduled care pressures<br>- Corridor care action plan (submitted to regional team)<br>- Long Length of Stay (LloS) meeting chaired by CEO<br>- LLoS metrics and delays in discharge<br>- Internal audit reviews<br>- NOF segmentation tracking<br>- Local Corridor care summit held with action plans from all areas submitted to Improvement Team<br>- Sustained reduction in corridor care compared with January 2026 baseline<br>- Improved ambulance handover performance providing evidence of improved patient flow<br>- Continued monitoring of corridor care through action plans and governance processes<br>- Routine monitoring of discharge delays and corridor care metrics | - System flow metrics<br>- Corridor care metrics<br>- Internal audit reviews of urgent and emergency care pathways, patient flow and discharge processes | | - Discharge planning effectiveness varies by pathway<br><br>- 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 summit in planning for October 2026 - **CMO/CNO/DCA**~~<br>CEO-led task& finish group on patient flow - **CEO** | - Corridor care action plan includes key actions to address discharge planning<br>~~- Wirral Corridor care summit taking place on 29.4.26~~ | |
| | 5) Daily SITREPs and senior clinical oversight<br><br>6) Patient experience monitoring and complaints management | - Daily executive / senoir leader visibility in ED<br>- Daily safety huddles<br>- Daily escalation routes<br>- Friends and Family Test results<br>- Patient Experience Strategy<br>- Experience of Care framework | - NHSE daily and weekly SITREP submissions<br>- Full engagement in Tier 1 meetings<br>- HealthWatch reviews<br>- National patient surveys | | | | | |

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| | 7) Staff wellbeing and support | - Sickness absence reviews<br>- EAP<br>- Clinical and professional supervision<br>- Rota management<br>- *See also strategic risk ID03 and ID04* | - NSS findings and action plans | | | | |
| | 8) System partnership working | - UEC Programme Board<br>- Daily, weekly and monthly reporting on demand, capacity, patient flow, length of stay, delayed discharges and escalation levels<br>- Quality metrics relating to harm, incidents, complaints and patient experience associated with unscheduled care pressures<br>- Drivers of the Deficit UEC programme with actions across WUTH and WCHC<br>- Participation in system operational resilience groups.<br>- Review of system escalation plans and winter planning arrangements.<br>- Monitoring of discharge pathways and community capacity through Place and Provider Collaborative meetings<br>- HWB workshop completed to establish future system priorities and working arrangements<br>- UEC Programme Board monitoring demand, flow, discharge and escalation metrics<br>- Joint quality improvement programmes across WUTH and WCHC focused on falls prevention, pressure ulcers and shared clinical pathways to support safer system flow | - Full engagement in system tiering meetings<br>- Wirral Provider Alliance<br>- HWB workshop to define future priorities and working arrangements - August 2026<br>- Full engagement with ECIST improvement support<br>- Model Hospital and GIRFT reviews<br>- Healthwatch engagement for patient voice<br>- GIRFT and Model Hospital benchmarking | | - Limited influence over capacity and performance within partner organisations.<br>- Limited assurance regarding impact of community and social care capacity constraints on performance. | | |

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| **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<br>Finance and Performance Committee |
| **Consequences** | - Deterioration in patient outcomes due to delays in diagnosis and treatment<br>- Increased clinical risk, including avoidable harm<br>- Reduced patient confidence, satisfaction and overall experience<br>- Widening health inequalities, with vulnerable groups disproportionately affected by long(er) waiting times<br>- Increased complaints, PALS concerns and potential litigation<br>- Reduced confidence from staff, patients and stakeholders<br>- Failure to meet national standards and targets (e.g. RTT, cancer pathways, constitutional standards) (and impact on NOF rating)<br>- Reduced system flow and inefficiencies across pathways<br>- Increased pressure on unscheduled, urgent and emergency care<br>- Reduced staff morale, engagement and retention<br>- Greater reliance on temporary staffing, impacting continuity and cost<br>- Financial penalties or loss of income linked to performance breaches<br>- Increased scrutiny and intervention from regulators and system partners |

| Risk Description | 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 |
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| | | | Internal | External | | | Planned | Progress update | | |
| **Failure to effectively manage planned/scheduled care, adversely impacting on quality of care and patient experience** | 4 x 5 (20) | 1) Clear executive and Board oversight of planned care performance | - Weekly planned activity report to Execs<br>- Board Assurance Framework reviews<br>- Quality Committee and Finance Committee AAA reports to Board<br>- Divisional Performance Reviews (WUTH)<br>- Integrated Performance Board (WCHC)<br>- Integrated Performance Report<br>- NOF segmentation tracking<br>- CQC action plans (WUTH & WCHC) - tracking through Board and Committees<br>- WUTH improved from NOF Segment 4 to Segment 3 in Q1 2026/27<br>- Improvement in national acute provider ranking from 123/134 to 99/134<br>- WCHC deterioration (0.02) to NOF segment 2 in Q1 2026/27 | - CQC inspection report(s) and on-going CQC engagement (WUTH & WCHC)<br>- Contract monitoring arrangements with ICB/NHSE | 4 x 4 (16) | - Agreement of exit criteria from legal undertakings re: UEC performance<br>- Pending Q1 review of undertakings from NHSE<br>- Implementation of the NHSE NW Performance Accountability Framework | - New engagement arrangements with NHSE - **Director of Corporate Affairs**<br>- Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – **Director of Corporate Affairs** | - NHSE performance oversight arrangements emerging in progress with NHSE including new Performance Accountability Framework (PAF) | 4 x 3 (12) | |
| | | 2) Demand and capacity modelling to inform activity planning | - BI reports<br>- Divisional Access & Performance meetings<br>- Integrated Performance Report | - NOF segmentation publication | | - ~~NOF segment 3 (WUTH)~~ | | | | |

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| | | - Divisional Performance Reviews (WUTH)<br>- Integrated Performance Board (WCHC)<br>- Utilisation of insourcing and LLP to provide capacity to achieve new national targets<br>- EARC oversight (WUTH) & high-level risk reports (WCHC)<br>- WUTH improved from NOF Segment 4 to Segment 3 in Q1 2026/27<br>- Improvement in national acute provider ranking from 123/134 to 99/134<br>- Divisional reforecasting process identifying elective productivity opportunities.<br>- Continued use of insourcing, waiting list initiatives and LLP capacity to support elective recovery. | | | | | |
| | 3) Robust waiting list management and validation processes | - RTT and waiting list reports<br>- Waiting list validation audits<br>- Waiting List Health Inequalities Tool (WCHC)<br>- NOF segment 2 (WCHC)<br>- Elective recovery trajectories monitored through Divisional Access Meetings and Performance Reviews<br>- Use of additional capacity through LLP and insourcing to support delivery of national targets<br>- Clinical harm reviews for long waiters<br>- WCHC Friends and Family Test scores remain above 90%, providing positive assurance regarding patient experience whilst awaiting treatment<br>- Complaints quality improvement plan established following audit review, with actions monitored through governance structures | - NOF segmentation publication | | ~~- NOF segment 4 (WUTH)~~<br>- Learning from complaints, incidents and patient feedback not consistently embedded | - Strengthen triangulation of quality intelligence - **Chief Nursing Officer**<br>- Full RTT review - pending - **Executive Managing Director** | | |
| | 4) End-to-end pathway management | - Divisional Performance Reviews<br>- Divisional pathway reviews aligned to elective recovery objectives<br>- Clinical prioritisation oversight through specialty governance arrangements | | | - Inconsistent clinical prioritisation across pathways | - Standardisation and audit of, clinical prioritisation criteria across all planned care pathways - **Chief Medical Officer & Chief Nursing Officer** | | |
| | 5) Workforce planning and job planning aligned to planned care demand | - Workforce and job planning reports<br>- Productivity and compliance data<br>- Theatre and clinic utilisation reports<br>- Utilisation of insourcing and LLP to provide capacity to achieve new national targets | - NOF segmentation publication | | - Limited workforce flexibility to meet demand<br>- Workforce capacity challenges remain within some specialist services, creating a potential risk to elective access and recovery trajectories | - Job plan reviews - **Executive Managing Director & Chief Medical Officer** | | |

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| | 6) Clinical quality monitoring across planned care pathways | - Clinical harm reviews for long wait patients<br>- Incidents, complaints and patient experience reports<br>- Clinical audit reviews<br>- Patient Safety Response Panel reporting demonstrates low levels of serious patient safety investigations and effective oversight of learning through PSIRF<br>- Service Line Reporting implementation to support pathway optimisation and productivity improvement.<br>- Use of specialty-level productivity data to identify elective improvement opportunities. | - National clinical audits<br>- CQC inspection reports | | | | | | |
| | 7) Early discharge planning and discharge to assess models | - Corridor care action plan (submitted to regional team)<br>- Long Length of Stay (LLoS) meeting chaired by CEO<br>- LLoS metrics and delays in discharge<br>- Internal audit reviews<br>- NOF segmentation tracking<br>- Local Corridor care summit held with action plans from all areas submitted to Improvement Team | - System flow metrics | | - Discharge planning effectiveness varies by pathway<br>- 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**<br>~~- Corridor care summit in planning for September 2026~~ **~~- CMO/CNO/DCA~~** | -Corridor care action plan includes key actions to address discharge planning | |
| | 8) Outpatient transformation programme | - Rollout of Ambient Voice Technology commenced | | | | | | | |

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| **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 |
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| | | | | 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<br>- Reduced staff morale, engagement and productivity<br>- Increased staff turnover<br>- Over-reliance on temporary staffing<br>- Loss of income<br>- Loss of confidence from patients, staff, partners and commissioners<br>- Reduced system and stakeholder trust in the Trust's leadership and governance<br>- Reduced staff wellbeing and increased risk of burnout<br>- Increased employee relations cases, grievances and conflict<br>- Negative impact on recruitment reputation and employer brand<br>- Reduced patient experience through | 4 x 4 (16) | 1) Clear board accountability and reporting | - Named Executive Leads accountable for Workforce Performance<br>- Clear reporting and escalation routes through Board and relevant committees (WSB, People)<br>- Workforce metrics reported through Integrated Performance Report<br>- Drivers of the Deficit Governance Structure<br>- Strategic and operational priorities for 26/27 (aligned to relevant BAF risk)<br>- Quality Committee reporting on key quality and patient safety metrics | - Regional oversight arrangements<br>- Board Assurance Statements | 4 x 4 (16) | - NOF segment 4 – WUTH<br>- NOF segment 1 – WCHC<br>- Single reporting arrangements across both Trusts<br>- Analysis of Trusts position against new NOF metrics | - Single IPR in development - **DCA**<br>- Governance arrangements below committee under review in WUTH and WCHC - **DCA**<br>- Review of performance against new Workforce NOF metrics - **CPO**<br>- Deliver against each of the strategic and operational priorities for 26/27 - provide assurance to the Committee via regular reports - **CPO** | - Single IPR produced in June 2026, with further updates planned for September 2026 to reflect new NOF metrics<br>- BI completing a review of current and anticipated performance against new Workforce NOF metrics | 3 x 2 (6) | **Q3 26-27** |
| | | | 2) Workforce Planning Processes in place | - Triangulation of workforce plan to financial and activity plans<br>- Divisional Performance Reviews<br>- Establishment & Pay Control Panel (EPCP) in place with Executive / CEO chair<br>- CPO is SRO for the Sickness Absence | - Board Assurance Statements<br>- Internal audit reports on workforce processes (ESR, data quality)<br>- NHSE workforce and planning submissions<br>- Model hospital - peer benchmarking | | - National shortages in certain roles<br>- Staff turnover rates remain above Trust target<br>- NHSE considered Trust medium-term financial plan to be non-compliant<br>- Ongoing challenges recruiting to specific professional groups and | - Delivery of the workforce plan through service improvement and workforce transformation – **CPO**<br>- Corporate Services integration<br>- Clinical Services integration | - Phase 2 complete. Phase 3 commenced. | | |

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| | disengaged workforce | | | Programme (Drivers of the Deficit)<br>- Enhanced recruitment pipeline monitoring including vacancy, offer and time-to-hire metrics.<br>- Analysis of workforce deployment against operational workforce plans using worked WTE methodology | - Recruitment pipeline reporting including time-to-hire, vacancy and offer data.<br>- Workforce establishment performance against plan through worked WTE reporting | | registered workforce roles<br>- Further assurance required regarding delivery of workforce transformation plans necessary to support recurrent financial improvement | | | | | |
| | | | 3) | Staff Experience & Staff Engagement | - People Experience Team working across both WUTH & WCHC<br>- NSS staff engagement score (WUTH & WCHC) tracking<br>- NSS action plans in Divisions (WUTH & WCHC)<br>- Tracking of key workforce metrics including turnover, absence, ER cases (via WSB, PCOG, Committee and IPR)<br>- Quarterly Pulse surveys<br>- Health & Wellbeing Support (inc. psychological support, absence management)<br>- FTSU arrangements & network (reporting to People Committee & Board)<br>- Annual appraisal process (WUTH & WCHC)<br>- Appraisal completion rates<br>- 'Well, WUTH/WCHC' programme to support return to work<br>- HR policies and procedures including flexible working<br>- Employee recognition scheme | - National staff survey results and benchmarking data (WUTH & WCHC)<br>- CQC inspection findings (WCHC – WIC/UTC; WUTH – Medicine & ED)<br>- Monthly workforce performance report including sickness, turnover, retention and recruitment metrics.<br>- Sickness audit reports demonstrating compliance with attendance management processes.<br>- Employee Assistance Programme utilisation and outcomes reporting.<br>- Early attrition reporting and analysis of reasons for leaving | | - Sickness absence remains above Trusts target (links to drivers of the deficit) (WUTH & WCHC) with long-term absence continuing to increase<br>- Sickness drivers of the Deficit Programme planned actions with identified risks<br>- Impact of corporate services organisational change on employee experience and engagement<br>- Impact of clinical services integration on employee experience and engagement<br>- NSS action plans on staff engagement<br>- Real-time employee experience metrics<br>- Variable staff survey response rates across divisions<br>- Inconsistent appraisal compliance across both Trusts (WCHC = 57.6%)<br>- Further assurance on the effectiveness, equity and sustainability of recruitment, career progression and promotion pathways to support workforce retention, inclusion and | ~~- Phase 2 of corporate service organisational change completed~~<br>- Corporate Services integration<br>- NSS action plan tracking<br>- Deliver sickness absence transformation programme (WUTH & WCHC) with specific focus on long-term absence<br>- Implementation of medical E-roster (WUTH)<br>- Implement targeted retention and early-career interventions in areas with highest levels of turnover – **Ass. CPO**<br>- Deliver focused appraisal recovery plan - **Ass. CPO**<br>- Review recruitment pathways and onboarding processes - **Ass. CPO** | - Phase 3 of corporate service organisational change due to commence | | **Q3, 2026-27** |

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| | | - New Partnership Agreement launched with Staff Side (WUTH)<br>- Employee Assistance Programme (EAP) utilisation and wellbeing support monitoring across both Trusts<br>- Monthly sickness absence audits assessing compliance with Attendance Management Policy<br>- Monitoring of early attrition (leavers within first 12 months) and turnover drivers' analysis<br>- Return-to-work compliance monitoring and targeted management intervention in high absence areas | | | future leadership capacity<br>- Understanding of underlying drivers of turnover<br>- Recruitment performance remains above target timescales | | |
| | 4) Strategic Organisational Development programmes in place - *see control 7 below*. | - Leadership development programme (for all levels) aligned to LQF<br>- Mandatory training compliance monitoring<br>- Continuous professional development frameworks<br>- Talent management and succession planning | - National staff survey results<br>- Professional regulatory requirements and accreditation standards | | - Development of a people & culture dashboard<br>- Management capability programme with a focus on inclusive and compassionate leadership | | |
| | 5) Equality, Diversity & Inclusion (EDI) Strategy in place | - Board and senior leader anti-racism training completion<br>- WRES and WDES reports, tracking of key indicators and action plans<br>- Inclusive recruitment practices<br>- Joint staff networks with Executive sponsor arrangements | - Annual WRES and WDES reporting | | - Implementation of recommendations from the Lord Mann Review<br>- Further assurance required on workforce experience and retention of protected groups | - Deliver action plans from WRES, WDES and EDI dashboard findings<br>- Establish Race Equity Co-Creation Group and implement actions from the Lord Mann Review<br>- Strengthen monitoring and triangulation of staff survey, | |

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| | | | - Actions to deliver against NHSE Sexual Safety Charter<br>- Bronze status in Anti-Racism Charter<br>- Anti-racism accreditation and assurance reporting<br>- EDI dashboard monitoring employee lifecycle and workforce experience indicators by protected characteristic<br>- Inclusive recruitment and leadership development programmes | | | employee relations, FTSU and EDI data to identify emerging workforce culture risks | |
| | 6) Multi-year Cultural Development Programme | - People Committee approval of Cultural Development approach and methodology<br>- Trend analysis of NSS themes, pulse surveys and engagement metrics<br>- FTSU thematic reports (via Quality Committee) | | - Development of a people & culture dashboard<br>- Management capability programme with a focus on inclusive and compassionate leadership | - Establish culture metrics within Integrated Performance Report - **Ass. CPO**<br>- Consolidate WUTH & WCHC employee experience reporting - **Head of People Experience**<br>- Undertake annual culture assessment and benchmarking - **Ass. CPO** | - To be developed as the multi-year cultural development programme is established (Q3, 26-27) | |
| | ~~7) Leadership visibility programme~~<br>Implementation of NHS Staff Standards and NHS Leadership & Management Framework across both Trusts | - Executive breakfast sessions with Divisions (WUTH & WCHC)<br>- Monthly All Staff Briefings (WUTH & WCHC)<br>- Exec & NED Walkabouts<br>- Joint baseline assessment against the six NHS Staff Standards<br>- Workforce Steering Board and People & Culture Oversight Group monitoring arrangements | | - ~~Implementation of NHS Leadership & Management Framework (and consider how it aligns with Leadership Quality Framework)~~<br>- ~~Implementation of new NHS Staff Standards~~<br>- Baseline compliance with the six NHS Staff Standards has not yet been fully assessed across WUTH and WCHC<br>- Further assurance required regarding | - Complete a joint baseline assessment and develop a prioritised improvement plan - **CPO**<br>- Align organisational development, culture programme, leadership development and workforce assurance arrangements to | | |

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| | | - | Workforce measures mapped against the six Staff Standards | | management capability, leadership behaviours and staff experience as measured through the framework | the new framework<br>- **CPO** | |

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| **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 |
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| | | | | 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<br>- Reduced staff morale, engagement and productivity<br>- Increased staff sickness<br>- Increased staff turnover<br>- Widening inequalities in staff experience and progression<br>- Poor learning culture<br>- Loss of income<br>- Loss of confidence from patients, staff, partners and commissioners<br>- Reduced system and stakeholder trust in the Trust's leadership and governance<br>- Failure to embed NHS People Plan priorities | 3 x 4 (12) | 1) Clear board accountability and reporting | - Named Executive Leads accountable for Workforce Performance<br>- Clear reporting and escalation routes through Board and relevant committees (WSB, People)<br>- Use of culture metrics and KPIs (e.g., engagement scores, FTSU data, turnover, absence) via IPR<br>- Strategic and operational priorities for 26/27 (aligned to relevant BAF risk) | - Regional oversight arrangements<br>- Board Assurance Statements | 3 x 4 (12) | - NOF segment 4 – WUTH<br>- NOF segment 1 – WCHC<br>- Single reporting arrangements across both Trusts<br>- Analysis of Trusts position against new NOF metrics | - Single IPR in development<br>- Governance arrangements below committee under review in WUTH and WCHC<br>- Review of performance against new Workforce NOF metrics<br>- Deliver against each of the strategic and operational priorities for 26/27 - provide assurance to the Committee via regular reports | - Single IPR produced in June 2026, with further updates planned for September 2026 to reflect new NOF metrics<br>- BI completing a review of current and anticipated performance against new Workforce NOF metrics | 3 x 2 (6) | **Q3 26-27** |
| | | | 2) Staff Experience & Staff Engagement | - People Experience Team working across both WUTH & WCHC<br>- NSS staff engagement score (WUTH & WCHC) tracking<br>- Strong FTSU arrangements (inc. policy) and Guardian | - National staff survey results and benchmarking data (WUTH & WCHC)<br>- CQC inspection findings (WCHC - WIC/UTC; WUTH - Medicine & ED)<br>- Monthly workforce performance report including sickness, | | - Sickness absence remains above Trusts target (links to drivers of the deficit) (WUTH & WCHC)<br>- Consistent approach to co-production and staff involvement in decision-making<br>- Full understanding of the experience of multi- | - ~~Phase 2 of corporate services organisational change in progress~~<br>- Delivery of the workforce plan through service improvement | - Phase 3 of corporate service organisational change due to commence | | **Q3, 26-27** |

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| | | - Structured staff networks influencing policy<br>- New Partnership Agreement launched with Staff Side (WUTH)<br>- Clear and consistent communication on values and behaviours<br>- Employee recognition scheme<br>- Internal communications plan to support Better Together – integration programme<br>- NHSE Staff Experience Assessment Framework implemented<br>- NSS action plans in Divisions (WUTH & WCHC)<br>- Tracking of key workforce metrics including turnover, absence, ER cases (via WSB, PCOG, Committee and IPR)<br>- Quarterly Pulse surveys<br>- Monthly workforce performance reporting including sickness, turnover, recruitment and appraisal compliance<br>- EAP utilisation<br>- NHS Staff Standards baseline assessment findings<br>- Employee Assistance Programme (EAP) utilisation and wellbeing support monitoring across both Trusts | - Sickness audit reports demonstrating compliance with attendance management processes.<br>- Employee Assistance Programme utilisation and outcomes reporting.<br>- Early attrition reporting and analysis of reasons for leaving | | cultural staff across the Trust<br>- NSS action plans on staff engagement<br>- Impact of corporate services organisational change on employee experience and engagement<br>- Impact of clinical services integration on employee experience and engagement<br>- NSS action plans on staff engagement<br>- Real-time employee experience metrics<br>- Variable staff survey response rates across divisions<br>- Further assurance on the effectiveness, equity and sustainability of recruitment, career progression and promotion pathways to support workforce retention, inclusion and future leadership capacity<br>- Implementation of recommendations from the Lord Mann Review<br>- Further assurance required regarding retention of staff during the first year of employment and the effectiveness of onboarding and early career support arrangements | and workforce transformation<br>- Corporate Services integration<br>- Clinical Services integration<br>- Review of appraisal process in WUTH to reflect WCHC approach - Q2 26-27<br>- NSS action plan tracking<br>- Deliver sickness absence transformation programme (WUTH & WCHC)<br>- Deliver focused appraisal recovery plan - **Ass. CPO** | |
| 3) | Clear commitment to Equality, Diversity & Inclusion | - Board and senior leader anti-racism training completion<br>- EDI strategy aligned to WRES, WDES and NHS People Plan | - EDS completed (jointly) with overall attainment level – Achieving<br>- Annual WRES and WDES reporting | | - ~~Further development of staff networks~~<br>- Deliver all actions from WRES action plan<br>- Deliver all actions from WDES action plan | - Deliver action plans from WRES, WDES and EDI dashboard findings | |

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| | | - EDI dashboard reviewed at EDI Steering Group (via PCOG)<br>- Coaching Hub established<br>- Monitoring of workforce inequalities<br>- EDI mandatory training<br>- Engaged staff networks<br>- Actions to deliver against NHSE Sexual Safety Charter<br>- Bronze status in Anti-Racism Charter<br>- Joint staff networks with Executive sponsor arrangements<br>- Equality Rights briefing to Board seminar | - Further assurance required on workforce experience and retention of protected groups | - Establish Race Equity Co-Creation Group and implement actions from the Lord Mann Review<br>- Strengthen monitoring and triangulation of staff survey, employee relations, FTSU and EDI data to identify emerging workforce culture risks |
| 4) | Staff wellbeing and support offer | - Comprehensive offer to all staff including mental health support, occupational health, flexible working<br>- Proactive management of safe staffing levels<br>- FFT scores (demonstrating patient satisfaction)<br>- Employee Assistance Programme utilisation<br>- Monthly sickness absence audits assessing policy compliance<br>- Population health analysis linking sickness absence trends to workforce health needs | - Impact of organisational change (corporate & clinical) (integration programme aligned to statutory transaction)<br>- Sickness absence remains above target driven by anxiety, stress and depression, indicating continuing workforce wellbeing risks<br>- Further assurance that population health and inequality data links to targeted wellbeing interventions | - Develop and implement a 3-year Wellbeing Strategic Plan and associated delivery plans - **Asso. CPO**<br>- Establish reporting against agreed wellbeing success measures (sickness absence, staff survey outcomes, retention and staff engagement) - **Asso. CPO** |
| 5) | Fair People Management Practices | - Transparent and fair HR policies and processes<br>- Appraisal rate and supervision compliance monitoring<br>- New Partnership Agreement launched with Staff Side (WUTH)<br>- Restorative and just culture principles embedded as BAU | - Further assurance required regarding leadership capability and behavioural consistency across managers as implementation of the NHS Leadership & Management Framework progresses | |

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| | | - PSIRF policy in place<br>- NHS Leadership & Management Code and Standards – self-assessment and development activity | - Appraisal compliance remains below target level | | | |
| 6) | Multi-year Cultural Development Programme | - People Committee approval of Cultural Development approach and methodology<br>- Trend analysis of NSS themes, pulse surveys and engagement metrics<br>- FTSU thematic reports (via Quality Committee) | - Development of a people & culture dashboard | - Establish culture metrics within Integrated Performance Report<br>- Consolidate WUTH & WCHC employee experience reporting<br>- Undertake annual culture assessment and benchmarking | - To be developed as the multi-year cultural development programme is established (Q3, 26-27) | |
| 7) | Implementation of NHS Staff Standards and NHS Leadership & Management Framework across both Trusts | - Executive breakfast sessions with Divisions (WUTH & WCHC)<br>- Monthly All Staff Briefings (WUTH & WCHC)<br>- Exec & NED Walkabouts<br>- Joint baseline assessment against the six NHS Staff Standards<br>- Workforce Steering Board and People & Culture Oversight Group monitoring arrangements<br>- Workforce measures mapped against the six Staff Standards | - Baseline compliance with the six NHS Staff Standards has not yet been fully assessed across WUTH and WCHC<br>- Further assurance required regarding management capability, leadership behaviours and staff experience as measured through the framework | - Complete a joint baseline assessment and develop a prioritised improvement plan - **CPO**<br>- Align organisational development, culture programme, leadership development and workforce assurance arrangements to the new framework - **CPO** | - | |

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| **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 |
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| | | | | 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<br>- Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions<br>- Reduced flexibility to respond to operational pressures and demands<br>- Declining staff morale and engagement<br>- Reduced capacity to invest in workforce productivity and wellbeing initiatives<br>- Reduced confidence from staff, patients and stakeholders | 5 x 4 (20) | 1) Financial planning and financial governance arrangements | - New Joint Finance Committee<br>- Standing agenda item (private board) on delivery to plan<br>- Director of Transformation & Turnaround in post<br>- Clear executive accountability<br>- Exec-level SROs for Drivers of the Deficit programmes agreed | - MIAA grip and control review (moderate assurance)<br>- Engagement in FPRM processes (inc. with PWC)<br>- Letter received from NHSE (26.08) confirming MTFP accepted with conditions | 5 x 3 (15) | - WUTH in financial undertakings<br>- Agreement of exit criteria with NHSE<br>- CIP and financial performance accountability not consistently embedded at divisional and budget-holder level<br>- NHSE approval of revised plan and confirmation re: DSF<br>- Implementation of the NHSE NW Performance Accountability Framework | - Engagement with NHSE to define the metrics to remove all undertakings - **DCA / CFO**<br>- Exit criteria from legal undertakings (metrics and assurance levels) to be agreed with NHSE – **Director of Corporate Affairs**<br>~~- Regional oversight arrangements to be confirmed - **DCA / CFO**~~<br>- Implementation of recommendations from MIAA grip and control review - **CFO**<br>- ~~Further communication expected from NHSE re: DSF - **CFO**~~ | ~~- Meeting with NHSE on 22 April 2026 – complete~~<br>~~- NHSE performance oversight arrangements emerging – June/July 2026~~<br>~~- NHSE Director of Intensive Support & System Co-ordination to meet with DCA – August 2026 - **COMPLETE**~~ | 5 x 2 (10) | March 2027 |
| | | | 2) Board approved three-year MTFP aligned to system and ICB assumptions / priorities | - M1 & M2 & M3 financial plan delivered (WUTH & WCHC)<br>- Resubmitted plans approved by Board (WUTH)<br>- Response to national escalation letter (18.05.26)<br>- Compliant plan agreed (WCHC)<br>- Board Assurance statements confirming triangulation between workforce, finance and operational delivery<br>- Board papers and minutes – standing item with finance, CIP and regulatory oversight updates<br>- Triangulation with workforce, finance and operations<br>- Exec-level SROs for Drivers of the Deficit programmes agreed | - Ongoing monthly scrutiny through NHSE Financial Performance and Recovery Meetings (FPRM)<br>- Acceptance of MTFP by NHSE subject to conditions<br>- Alignment of plans with ICB / monitored via FPRM process<br>- Full engagement in monthly FPRM process<br>- NHSE support for redundancy funding<br>- Voluntary redundancy scheme approved by NHSE<br>- Letter received from NHSE (26.08) confirming MTFP accepted with conditions | | - Limited ability to influence system decisions that affect long-term affordability<br>- ICB support for decommissioning plans<br>- NHSE support to accelerate statutory transaction<br>~~- Resubmitted plans have a combined gap to national control totals of £14.9m~~<br>- Delivery of elective income - financial plan assumes sustained recovery and throughput<br>- Pressures in urgent care impacting on delivery of the financial plan<br>- Sufficient assurance that workforce productivity improvements, activity assumptions and other | ~~- Regional oversight arrangements to be confirmed - **DCA / CFO**~~<br>- *Elective recovery actions – see ID02*<br>- *Unplanned care recovery actions – see ID01*<br>- FRPM process supporting national conversations re: statutory transaction timeline – **CEO**<br>- Implement and monitor delivery of the workforce productivity programme aligned to MTFP assumptions - **CPO / CFO** | - NHSE performance oversight arrangements emerging – June/July 2026 – **in progress with NHSE** including new Performance Assessment Framework (PAF) | | |

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| | | | - M5 position showing WUTH reporting within £0.1m of plan YTD.<br>- WCHC reporting a £0.7m favourable variance to plan at M5.<br>- Monthly Board reporting evidencing triangulation between finance, workforce and activity performance.<br>- Improving underlying deficit trajectory compared to prior year run rate | | | key planning assumptions underpinning the MTFP remain achievable and will support delivery of the agreed financial trajectory | - Monitor elective recovery and income delivery through existing operational recovery programmes - **Exec MD** | |
| | | 3) Annual budget setting process aligned to MTFP trajectory | - Consistent budget setting processes across both Trusts | | | | - MiAA costing review (WUTH & WCHC) agreed through internal audit plan – **CFO** | |
| | | 4) Annual CIP plan with defined governance, quality oversight and benefits realisation | - CEO-chaired Productivity Improvement Board providing oversight of delivery and quality impacts.<br>- Weekly CIP Assurance Group (chaired by Director of Turnaround & Transformation)<br>- Drivers of the Deficit Programme Board reset with agreed business rhythm<br>- Clinical guardrails agreed with Board<br>- Triangulation between finance, quality and operational performance when approving or revising CIPs<br>- People Committee tracking delivery of the workforce plan<br>- Director of Transformation & Turnaround in post<br>- ECPC with enhanced controls in place (chaired by CEO)<br>- CIP SOP developed<br>- Further refinement of the risk-adjusted CIP position<br>- WUTH achieved YTD CIP, WCHC is behind target at M6<br>- Clinical guardrails agreed by Board and embedded within CIP governance<br>- Weekly Executive-led recovery meetings for Medicine & Urgent Care and Surgery Divisions | - Monthly CIP delivery reviewed through FPRM process | | - Sufficient assurance that identified CIP schemes and recovery initiatives will deliver the recurrent savings and benefits assumed within the MTFP<br>- Insufficient assurance that divisional recovery plans will deliver recurrent improvements and reduce the Trust's underlying run rate to the level required | ~~- (DoD) Programme Board sign off of current project plans with SROs – **May/June 2026**~~<br>- Financial Recovery Plan in development for Board approval in December 2026 - **DTT**<br>- Implement the Financial Recovery Programme and monitor delivery through Drivers of the Deficit governance arrangements - **CFO / DTT**<br>- Finalise, approve and monitor quantified divisional recovery plans for Medicine & Urgent Care and Surgery, including recurrent financial benefit trajectories and cash-releasing impact – **CFO/Exec MD** | - Weekly executive recovery meetings established, mitigation schedules due October 2026 and on-going monitoring through FPG - **ON TRACK** | |

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| | 5) Clear financial KPIs with regular oversight | - Financial governance arrangements in place (see above)<br>- Monthly IPR reporting to Board (WUTH & WCHC)<br>- Tracking of NOF metrics via Finance Committee and IPR<br>- FPG papers shared with FPC for information / wallet items (AAA report)<br>- Tracking of workforce, productivity and finance metrics through integrated performance reporting<br>- Regular review of divisional grip-and-control performance, including agency, bank, overtime and WLI expenditure<br>- Executive-led review of run-rate performance and forecast trajectory<br>- Monthly divisional reforecasting process established through FPG | - NOF metrics<br>- Monthly review of key finance metrics through FPRM process | - Sufficient assurance that financial accountability, grip-and-control arrangements and recovery programme ownership are consistently embedded at divisional and budget-holder level across both organisations | - Embed financial accountability framework across divisions and budget holders - **CFO / Exec MD**<br><br>~~Revised scope, chair and membership of Finance Performance Group - **CFO**~~ | - On-going through strengthened financial governance arrangements including FPG – **ON TRACK**<br><br>~~New FPG arrangements from June 2026~~ |
| | ~~6) Cost pressure mitigations~~ | | | | | |
| | 7) Integrated Financial Recovery Programme and Drivers of the Deficit Programme | -Drivers of the Deficit Programme Board reset with executive SRO ownership<br>- Monthly monitoring of recovery trajectories.<br>- Financial Recovery Programme being developed and tracked through governance structure. | - Recovery programme progress reviewed through NHSE oversight arrangements and FPRM process<br>- Review of recovery programme milestones through WUTH legal undertakings oversight arrangements | - Sufficient assurance that the Financial Recovery Programme and Drivers of the Deficit programmes will deliver the planned recurrent financial improvements required by the MTFP | | |

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| **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 |
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| | | | | Internal | External | | | Planned | Progress update | | |
| **Failure to embed service transformation and deliver sustainable efficiency gains** | - Financial sustainability and damage to the Trusts reputations<br>- Regulatory and system impact - increased scrutiny and intervention, loss of autonomy, further sanctions<br>- Reduced flexibility to respond to operational pressures and demands<br>- Inability to deliver the Trust's strategic objectives and transformation ambitions<br>- Declining staff morale and engagement<br>- Reduced capacity to invest in workforce productivity and wellbeing initiatives<br>- Reduced confidence from staff, patients and stakeholders | 5 x 4 (20) | 1) Strategic leadership and governance | - Director of Transformation & Turnaround in post<br>- New Joint Finance Committee ToRs<br>- Clear executive accountability<br>- Board and committee papers and minutes evidencing regular review of the programme<br>- Productivity Improvement Board monitoring CIP delivery including risks to service across both Trusts<br>- Standing paper to private Board presenting progress to Financial Plan including CIP and legal undertakings<br>- Drivers of the Deficit Programme Board established with Executive SRO ownership of all workstreams<br>- Integration programme progressing across corporate services, estates and clinical services with Phase 3 implementation commenced<br>- Financial Recovery Programme established to support delivery of productivity and UEC transformation opportunities. | - Alignment of transformation plans with ICB/system priorities and programmes<br>- Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC) | 5 x 3 (15) | ~~- Regular programme of board visibility~~<br>- Insufficient assurance that transformation programmes are delivering sustainable operational and financial benefits at the pace required by the MTFP | ~~- Standing agenda item on private to provide Board with monthly updates on delivery of transformation / CIP programmes - **DTT & DCA**~~<br>- Develop a consolidated transformation benefits realisation framework with reporting through Finance & Performance Committee - **DTT** | ~~- In progress from May 2026~~<br>- At M6, SLR implementation and PMO oversight provide increasing assurance regarding identification, monitoring and quantification of transformation benefits | 5 x 2 (10) | |

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| | 2) Programme and portfolio management | - PMO assurance reports and use of programme dashboards (PIDs)<br>- Clinical guardrails agreed with Board<br>- Escalation reports to Productivity Improvement Board (monthly)<br>- Productivity improvements tracked as transformation benefits<br>- All Drivers of the Deficit programmes have defined SRO ownership and delivery milestones<br>- Programme confidence ratings and risk-adjusted delivery assessments reviewed through PMO arrangements<br>-Financial recovery meetings established for Medicine and Surgery to strengthen programme delivery and grip-and-control<br>- Formal PMO tracking of divisional recovery actions and Drivers of the Deficit Programmes<br>- All divisions have completed reforecast assessments with driver analysis and mitigation plans<br>- Weekly Executive-led recovery meetings established for red-rated divisions | - Full engagement in monthly FPRM process<br>- Internal audit plan<br>- FPRM review includes assessment of transformation delivery and CIP trajectories | | - Insufficient assurance that programme milestones, dependencies and benefits are being delivered consistently across all transformation workstreams | | |
| | 3) Financial and benefits realisation controls | - Executive oversight and SRO for all CIP schemes / drivers of the deficit<br>- Weekly CIP Assurance Group (WUTH & WCHC)<br>- Risk adjusted CIP programme reduced to £32.8m against £36.7m requirement, providing clearer visibility of delivery risk<br>~~- Improvement in risk-adjusted position during August~~ | - MIAA grip and control review (moderate assurance) | | - Insufficient assurance that transformation benefits are translating into recurrent financial improvement and reduced run-rate expenditure | - Implementation of recommendations from MIAA grip and control review - **CFO** | |

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| | | | - Weekly CIP Assurance Group monitoring delivery across both organisations<br>- CIP programme supported by quantified workforce reduction assumptions and month by month delivery tracking<br>- Financial Recovery Programme being aligned to CIP and Transformation programmes through FPG governance | | | | | |
| | 4) Integrated quality and safety controls | | - New Joint Quality Committee ToRs<br>- Quality & Equality Impact Assessments approved and monitored through Quality Committee<br>- Clinical guardrails agreed with Board<br>- Share oversight of strategic risks (ID01 and ID02) between Quality and Finance Committee related to service delivery<br>- Monthly IPR reporting to Board (WUTH & WCHC)<br>- Tracking of NOF metrics<br>- Clinical guardrails in place | - NOF metrics<br>- On-going and proactive engagement with CQC<br>- On-going and proactive engagement with ECIST<br>- 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<br>- Workforce report tracking People metrics<br>- EPCP with enhanced controls in place (chaired by CEO)<br>- Sickness absence programme forecast to deliver £875k of benefits through reduction in temporary staffing usage. - Further work underway to strengthen rostering grip-and-control arrangements | - Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements<br>- Active engagement in system-wide transformation and collaboration via Cheshire & Merseyside Provider Collaborative (CMPC) | | - Insufficient assurance that workforce reductions will be delivered at the scale and pace required | - Develop a workforce transformation recovery plan - **CPO/DTT** | |

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| | | - Workforce reduction programme monitored through CIP governance arrangements | | | | |
| | 6) Performance management and reporting | - New Joint Finance Committee ToRs<br>- Integrated Performance Report to Board tracking progress against efficiency metrics (WUTH & WCHC)<br>- Integrated performance reporting includes workforce, activity, finance and transformation metrics<br>- Risk-adjusted CIP forecast and benefits trajectories reviewed routinely through governance arrangements<br>- Service Line Reporting strategy approved with programme to embed costing intelligence into operational and transformation decision making<br>- SLR outputs being used to identify productivity, stabilisation and future CIP opportunities for 27/28 and 28/29 | - Benchmarking (e.g. Model Hospital, peer comparison) evidencing efficiency improvements<br>- Internal Audit reviews focused on delivery effectiveness and benefits sustainability. | | - Use Service Line Reporting outputs to identify and quantify future transformation and productivity opportunities for inclusion in the 27/28 and 28/29 financial recovery plans - **CFO/DTT** | - At M6, Service Line Reporting implementation and PMO oversight provide increasing assurance regarding identification, monitoring and quantification of transformation benefits. | |

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| **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 |
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| | | | | 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)<br>- Legal penalties, fines, or litigation<br>- Loss of provider licence or restrictions on services<br>- Financial loss and increased operational costs<br>- Reputational damage and loss of public confidence<br>- Harm to patients/service users due to non-compliance<br>- Increased scrutiny and oversight from regulators<br>- Internal governance failure impacting strategic delivery | 4 x 3<br>12 | 1) Board and Executive oversight with designated Executive leads for key compliance areas<br>2) Governance framework in place (inc. policies and procedures and risk management) | - Single Executive Team appointed<br>- Named leads for statutory functions<br>- SIRO appointed (across both Trusts)<br>- Caldicott Guardian appointed (for each Trust)<br>- RO appointed for WUTH<br>- Board composition includes voting and non-voting Directors<br>- FTSU arrangements and Policy<br>- Board and committee governance structures established – Joint Committees/Committees in Common<br>- Audit Committee scrutiny of systems and processes<br>- Scheme of Delegation & Matters Reserved to the Board<br>- Joint SFIs<br>- Risk Policies<br>- Risk Registers – EARC, Audit & Risk Committee, IPB<br>- Joint BAF established with alignment of key strategic risks to Committees<br>- Policy reviews and approval framework | - NHSE oversight arrangements<br>- HOIA opinion annually<br>- External Audit<br>- Internal Audit programme | 4 x 3<br>12 | - Establishment of future governance arrangements to statutory transaction<br>- Joint Risk Management process and policy | - Design, approve and implement new governance arrangements (post-transaction)<br>- Review of quality governance and patient safety governance frameworks<br>- Complete committee review of effectiveness (both joint and CiC)<br>- Review of Risk Management Policies<br>- Under review following MIAA review | - Sub-committee arrangements priority next review including EARC and IPB, and DPRs | 4 x 2<br>8 | April 2027 |

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| | | - Joint Committee and Committees in Common approach established | | | - Review of Partnership Agreement in light of potential revised transaction timetable | - Testing of continued scope of the PA to be completed with Hill Dickinson (October/November 2026) | - In progress. | | |
| 3) | Compliance with relevant codes of governance, regulation and legislative requirements | - Annual report - Code of Governance compliance (via Audit Committee)<br>- Provider licence compliance (via Audit Committee)<br>- Tracking of progress against NHSE enforcement undertakings - regular private board paper shared with NHSE<br>- Board Assurance tracking document developed for multiple areas from national reviews | - External Audit<br>- NHSE oversight arrangements<br>- On-going CQC engagement meetings | | - NHSE enforcement undertakings remain in place - *Q1 review outcome expected*<br>- ~~Full implementation of revised regional oversight arrangements with NHSE~~<br>- Agreement of undertakings exit criteria with NHSE<br>- Board review of Board Assurance Statements<br>- Compliance with FOIs and SARs reported to Board of Directors<br>- Refresh of CQC preparedness programme | - Engagement with NHSE is on-going via FPRM meetings and new arrangements are being confirmed<br>- Q1 undertakings review to determine exit criteria for agreement<br>- Board to Board meeting with NHSE in September 2026<br>- FOI and SAR plans in place<br>- CQC well-led reviews | - New oversight arrangements expected to take effect from July 2026 inc. tracking of progress against undertakings | | ~~July 2026~~ October 2026 |
| 4) | Partnership Governance (Wirral & CMPC) | - CEO Lead in CMPC<br>- Wirral Provider Alliance established<br>- Joint Chief Integration & Partnerships Officer leading WPA<br>- | - 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<br>- Revised Wirral Provider Alliance governance arrangements to be developed and agreed | - Both actions are in progress with local partners | | September 2026 |

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| **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 |
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| | | | | 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<br>- Widening health inequalities across the population<br>- Reduced patient experience, trust, and engagement<br>- Failure to meet statutory duties (e.g. Equality Act, Health Inequalities duties)<br>- Reputational damage locally and nationally<br>- Increased demand on urgent/emergency care due to unmet need<br>- Inefficient use of resources due to poorly targeted services<br>- Adverse regulatory scrutiny (e.g. CQC findings) | 4 x 3 (12) | 1) Clear board accountability and reporting | - Named Executive Lead accountable for Health Inequalities<br>- Quality governance structures<br>- Clear reporting and escalation routes through Board and relevant committees (Quality & Safety)<br>- Reporting on inequalities metrics (access, outcomes, experience via PSQB/SOG)<br>- Inclusion Annual Report (WCHC)<br>- Joint Quality priorities<br>- NOF Q1 26/27 position understood for both Trusts – paper shared with FPC and Board | - Regional oversight arrangements<br>- Board Assurance Statements<br>- Audit programmes (clinical audit, equality audits, service reviews) | 4 x 3 (12) | - ~~NOF segment 4 (WUTH) including access to services metrics~~<br>- Inconsistencies in data access, reporting and insight limiting proactive population health management and improvement<br>- Performance dashboards with segmentation by protected characteristics and deprivation | - Improve data quality and insight | - See control 7 | 4 x 2 (8) | |
| | | | 2) Clear commitment to Equality, Diversity & Inclusion | - EDI strategy<br>- EDI dashboard reviewed at EDI Steering Group (via PCOG) | - EDS completed (jointly) with overall attainment level – Achieving<br>- National benchmarking data (e.g. Core20PLUS5, NHS England metrics) | | - Embed health inequalities impact assessment into all strategic and operational decisions<br>- Inconsistencies in data access, reporting and insight limit proactive population health management and improvement. | | | | |

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| | 3) | Patient and public involvement frameworks | - Patient experience data (FFT, complaints, engagement feedback)<br>- Health Inequalities Waiting List Tool in place (WCHC)<br>- Your Voice Group (WCHC)<br>- Councils of Governors | - CQC inspection reports (WCHC and WUTH 2025)<br>- Compliance with AIS | | - Completion of all associated actions in CQC action plans (WCHC and WUTH 2025)<br>- Inconsistent community representation from some underserved or seldom-heard groups | - Develop and implement a clear Health Inequalities Improvement Plan aligned to national priorities (e.g. Core20PLUS5)<br>- Further embed waiting list tool | |
| | 4) | Impact assessments | - Equality Impact Assessments / Health Inequalities Impact Assessments<br>- EIA/QEIA Standard Operating Procedures | - Audit programmes (clinical audit, equality audits, service reviews) | | | | |
| | 5) | Workforce training | - Training in cultural competence and inclusive practice<br>- Leadership development and staff awareness sessions delivered to increase confidence in interpreting population health and inequalities data | | | - Lack of staff confidence in accessing and interpreting health inequalities data<br>- Health inequalities and inclusion considerations to be incorporated into service planning and quality improvement methodologies | - 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<br>- Chief Integration Officer member of JTEG with local authority<br>- New joint strategy aligns with Cheshire and Merseyside's *All Together Fairer: Our Health & Care* | - Wirral Provider Alliance (WPA) with a shared purpose - *Working in partnership for better health and care in Wirral*<br>- CMPC blueprint / provider strategy<br>- National benchmarking data (e.g. Core20PLUS5, NHS England metrics) | | - Fragmentation across system partners<br>- 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<br>- Joint programmes with local authority and primary care partners to address identified inequalities in priority communities | - WPA governance review in progress - **Chief Integration & Partnerships Officer / DCA** |

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| | | *Partnership Plan 2024-29*<br>- Joint analysis of NOF performance indicates opportunities for an integrated provider model to strengthen outcomes, access and population health performance across Wirral | | | | |
| 7) | Data Quality & Insight | - Routine review of NOF metrics across both Trusts to identify variation in access, quality and outcomes and support targeted improvement activity<br>- Quarterly benchmarking against national and Cheshire & Merseyside peers through NOF reporting arrangements | - Internal audit reviews of data quality arrangements and reporting processes | - Data quality improvement work across both organisations to increase completeness of demographic data and improve identification of underserved groups.<br>- Health inequalities metrics routinely reviewed through Quality and Safety Committee and relevant operational groups, with escalation arrangements established | - Further development of population health dashboards to provide segmentation by deprivation, ethnicity, age, disability and other protected characteristics | |

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| **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<br>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 |
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| | | | | 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<br>- Disruption to clinical systems<br>- Reduced access to patient information<br>- Inability to sustain critical services (due to loss of IT, estates or digital infrastructure)<br>- Breach of data protection legislation and IG requirements leading to potential financial penalties and reputational damage<br>- Enforcement action<br>- Reduced staff productivity<br>- Reduced staff morale<br>- Loss of income<br>- Loss of confidence from patients, staff, partners and commissioners<br>- 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 in each Trust<br>-Clear reporting and escalation routes through Board and relevant committees (Audit, Quality and Finance) and relevant sub-groups in each Trust (IGDS and IAG)<br>- Annual EPRR Core Standards self-assessment completed and approved through Trust governance arrangements. WUTH declared compliance with 59 of 62 applicable standards (95% compliance; substantially compliant<br>- Annual EPRR Core Standards self-assessment completed and approved through Trust governance arrangements. WCHC declared compliance with 54 of 58 | - NHSE cyber security guide for executive and non-executive directors<br>- Compliance assessed against the NHS England EPRR Framework and Civil Contingencies Act requirements | 5 x 3 (15) | - Board approved Digital Strategy<br><br>- Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested. | - Finalise Digital Strategy - **CFO/CIO**<br><br>- Develop report structure based on NHSE guidance (issued June 2026) - **CIO** | - Enabling strategy to be completed in H2, 26-27 | 5 x 2 (10) | - Q4, 26-27 |

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| | | | applicable standards (95% compliance; substantially compliant)<br>- Quarterly EPRR reporting through Trust governance structures and Executive Assurance and Risk Committee<br>- Monthly EPRR assurance reporting provided to NHS Cheshire and Merseyside<br>- Service Line Reporting implementation providing improved clinical, operational and financial information to support decision-making | | | | | | |
| | | 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 in each Trust - both Trusts met applicable minimum standard for 25/26 for 6 of 7 foundational cyber security outcomes<br>- Identity, authentication and access controls in place<br>- Role based access controls implemented<br>- Documented vulnerability management process<br>- Regular vulnerability scanning reporting through IT/security governance groups<br>- Organisational risk registers (WUTH & | - Internal audit plan covering cyber security controls, access management and patching compliance for both Trusts<br>- NHS England / national cyber assurance feedback<br>- External penetration testing or cyber maturity assessments | | ~~- Assessment against NHSE 7 foundational outcomes that have the greatest impact on organisational cyber resilience~~<br><br>-Lack of single overarching cyber plan for each Trust (WUTH & WCHC)<br>- 25/26 DSPT/CAF supply chain assurance assessed as below the required standard for both Trusts | -Complete assessment following NHSE letter (June 2026) on board assurance on cyber security risks - **CFO**<br><br>- Adopt new and updated NHSE directive cyber policies to be included in the 2027 next DSPT - **CIO**<br>- Develop single cyber plan for each Trust (from separate plans and records) to include DSPT improvement plans - **CIO**<br>-Review link between strategic risk and operational risks on cyber security | - Paper to Digital Committee in September 2026 setting out evidence for both Trusts - **complete** | | September 2026 |

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| | | 3) Business continuity and disaster recovery | WCHC) include overarching risk of a cyber-attack and potential service disruption<br>- Capital programme reporting evidencing investment in resilience and critical infrastructure<br>- Business Continuity and Disaster Recovery plans including backup solutions for key systems<br>- Incident response plan established with defined escalation processes<br>- Records of regular testing and exercising (table-top and live tests)<br>- Post-incident and post-exercise reviews evidencing learning and improvement<br>- Information Asset register (IAR)<br>- Evidence supporting EPRR compliance included more than 200 supporting documents within the annual self-assessment process<br>- Major incident response structures, action cards and defined leadership responsibilities in place<br>- Business continuity, emergency response and recovery arrangements subject to annual self-assessment against national core standards | - Internal audit review of BCP and disaster recovery arrangements - *moderate assurance*<br>- DSPT review (MiAA)<br>- Annual EPRR submission reviewed through ICB assurance arrangements. | | -Evidence of regular IAR review<br>- Sufficient assurance that business continuity and major incident arrangements have been fully tested across all critical infrastructure failure scenarios, including loss of utilities, estates infrastructure, digital systems and supply chain disruption | -Deliver improvement plan for supply chain - **CIO/Associate Director of Finance - Procurement**<br>- Implement and monitor delivery of EPRR Core Standards improvement plans arising from partially compliant standards and provide quarterly assurance reporting to relevant committees - **Executive Managing Director / Head of EPRR** | |

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| | | - Records of exercises, incident response learning and assurance maintained through EPRR governance arrangements.<br>- Enhanced use of integrated performance, workforce and financial reporting to support operational and transformation decision-making.<br>- Development of analytical capabilities through SLR reporting and associated governance. | | | | | | |
| | 4) Data Protection and Information Governance | - SIRO / Information Governance Annual Report to the Board<br>- Mandatory IG training compliance reports for staff | - Internal Audit Reviews of Digital Governance<br>- Digital Maturity Assessment and benchmarking outcomes<br>- Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements)<br>- Internal audit plan testing of controls and processes in place | | | | | |
| | 5) Third party and supplier controls | - Contract management processes confirming inclusion of cyber security and BCP requirements with regular reviews<br>- Suppliers register in place<br>- Supplier assurance | - System / national assurance of shared or hosted platforms | | - Cyber risk assessments to be consistently repeated during contract life cycle<br>- Supply chain assurance assessed as below the required standard 25/26 | | - Deliver improvement plan for supply chain – **CIO/Associate Director of Finance – Procurement** | |

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| | | | documentation (SOC reports, compliance statements)<br>- Regular review of critical supplier risk registers<br>- Procurement oversight processes | | | DSPT/CAF for both Trusts | |
| | 6) System and external alignment / collaboration | - Reports evidencing participation in system-wide cyber and resilience groups (CMPC) | - Inclusion in national or regional resilience programmes | | | | |
| | 7) Emergency Preparedness, Resilience and Response (EPRR) | - Annual EPRR Core Standards self-assessment completed.<br>- 95% compliance achieved by both Trusts.<br>- Quarterly EPRR reports and action plan monitoring.<br>- - Emergency response exercises and learning reviews | - ICB review of EPRR standards<br>- Compliance with NHS EPRR Framework and Civil Contingencies Act requirements | | - Sufficient assurance that emergency preparedness and business continuity arrangements will remain effective during prolonged or concurrent infrastructure failures | - Deliver improvement actions arising from EPRR Core Standards self-assessment and maintain substantial compliance across both organisations | |
| | 8) Digital Integration, Information Sharing and System Alignment | - Digital systems alignment reported through transaction governance arrangements<br>- Assessment of Day One operating model requirements includes system access, reporting and digital integration requirements<br>- PTIP development includes alignment of reporting, performance management and operational processes | - NHSE transaction assurance process includes review of digital readiness and implementation planning<br>- Independent review and challenge through Deloitte as part of FBC and PTIP development | | - Full alignment of digital systems, reporting infrastructure, information sharing arrangements and user access management across both organisations remains dependent on completion of the transaction and implementation of the future operating model | - Develop and approve a Digital Convergence and Systems Alignment Roadmap, including milestones for system interoperability, access management, reporting alignment and Day One transaction readiness | |

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| **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 |
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| | | | | 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<br>- Reduced level of skills in the workforce<br>- Insecurities within systems present vulnerability to cyber-attacks<br>- Poor staff experience<br>- Impact on the pace of clinical transformation and clinical improvement outcomes | 4 x 4 (16) | 1) Executive and Board Oversight of Digital and Information Risk | - Defined accountability through the SIRO, CIO/ CNIO in each Trust<br>- SIRO responsibility included JD<br>- SIRO reports to Board and CIO attends Board<br>- New Joint Digital Committee established to oversee digital delivery and risk<br>-CIO report to Digital Committee<br>- BAF oversight (ID12) by Joint Digital Committee<br>- Digital Governance arrangements established with minutes and action log tracking in each Trust (IGDS and IAG)<br>- Annual Information Governance Annual Report / Statement<br>- Channel 3 Digital Systems and Functions Review (on track) | - SIRO network and annual training<br>- NHSE cyber security guide for executive and non-executive directors | 4 x 3 (12) | - Board approved Digital Strategy to align with new Joint Strategy<br>- Digital Strategy delivery roadmap<br>- Alignment to MTFP<br>- Capital constraints impacting pace of delivery<br>- Annual report to Board outlining recovery plans for critical systems, including evidence that these plans have been tested.<br>- Dual running of teams across WUTH & WCHC<br>- Co-dependencies related to two corporate teams | - New strategy to be developed as part of the programme of work to develop enabling strategies (*linked to Channel 3 review)* - **CFO**<br>- Develop report structure based on NHSE guidance (issued June 2026) - **CIO**<br>- Establishment of single Digital Team across WUTH & WCHC | - Project scope for Q1, 26-27<br>- Channel 3 Digital Systems and Functions Review (on track) | 4 x 2 (8) | - Q4, 26-27 |

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| | 2) Existing digital infrastructure is NHS compliant | - Business continuity and disaster recovery plans<br>- DSPT / CAF self-assessment and improvement plan - both Trusts met applicable minimum standard for 25/26 for 6 of 7 foundational cyber security outcomes<br>- Penetration testing and vulnerability assessment reports<br>- DPIAs<br>- IG audit findings | - Internal Audit Reviews of Digital Governance<br>- Digital Maturity Assessment and benchmarking outcomes<br>- Audit of DSPT / CAF self-assessment and improvement plan (as per NHSE requirements)<br>- Internal audit plan testing of controls and processes in place | | -Legacy infrastructure increasing security and resilience risk ~~-Assessment against NHSE 7 foundational outcomes that have the greatest impact on organisational cyber resilience~~<br>- 25/26 DSPT/CAF supply chain assurance assessed as below the required standard for both Trusts. | - Complete assessment following NHSE letter (June 2026) on board assurance on cyber security risks - **CFO**<br>- Implementation of new guidance for staff about unlawfully accessing patient medical history of a campaign in response - **CFO/ CIO**<br>- Deliver improvement plan for supply chain - **CIO/Associate Director of Finance - Procurement** | ~~- Paper to Digital Committee in September 2026 setting out evidence for both Trusts – **complete**~~<br>~~- Paper to Digital Committee in September 2026~~ | |
| | 3) Digital Programme and Change Management processes | - Digital programmes governed through project and clinical safety frameworks<br>- Gateway reviews and post-implementation reviews<br>- Programme and project dashboards with RAG status<br>- Training completion data (e.g. IG) | - Supplier performance reports and SLA monitoring | | - Programme capacity<br>- End user engagement | | | |
| | 4) Workforce capability and digital skills | | | | - Trust-wide digital skills framework (variable digital confidence)<br>- Staff survey results relating to digital confidence and usability<br>- Feedback from digital champions | | |

**Group Board of Directors in Public** **Item No 11**
**4 November 2026**

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| **Report Title** | Committee Chairs Reports – Quality and Safety Committee |
| **Date of Meeting** | 28 September 2026 |
| **Author** | Professor Chris Bentley, Chairing Quality and Safety Committee |

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| **Alert** | The Committee wish to alert members of the Group Board of the following:<br>• Performance in managing Complaints is an issue being addressed in both Trusts. This is apparent in their Annual Reports for 2025/26 included in this Board agenda. At WUTH, the rise in numbers outpaced the growth in completed responses, with a substantially larger open and overdue caseload at year end. Assurance was given that quality of responses is good, and process enables safety issues to be picked up and acted on early. A prioritised action plan is addressing clearance of backlogs and reducing clearance times. At WCHC there are smaller numbers, and assurance on handling and learning from complaints has been good. However, a recent MIAA review identified concerns about consistent process, and an action plan is being tracked. The issues were addressed as part of the WCHC Quality and Patient Experience Report to QSC this month.<br>• Other issues raised through the WUTH PSQB as receiving priority attention for Committee included: challenges in the temporary escalation spaces supporting ED; delays in radiology reporting; shortfalls in phlebotomy workforce, and ongoing challenges of the number of children on the waiting list for neurodiversity assessments.<br>• Discussion of WCHC High Level Risks, and the BAF, with a number of staffing pressures in a range of community services, raised a question as to whether the Guardrails for protecting key elements of service were balanced in relation to community services. This, to maintain current activity, and to have the foundation to absorb the strategic plans for hospital to community shifts. CMO and CNO agreed to review. |
| **Advise** | The Committee wish to advise members of the Group Board of the following:<br>• The review of BAF risks ID01, ID02 and ID08 proposed no further controls, assurances or gaps. Committee supported that continuing development of the governance process should establish a set of criteria used to systematically judge change of risk scores towards target.<br>• The ongoing concern at WCHC about inconsistent clinical supervision and its recording was raised. This is being tracked by the Committee via the MIAA internal audit recommendations. |

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| **Assure** | The Committee wish to assure members of the Group Board of the following:<br>• WCHC Quality and Patient Experience Report for August evidenced a positive position across Trust quality and safety metrics. The exception was 2 severe harms falls at CICC, investigation of which is proceeding through PSIRF. There had been a dip in numbers of Friends and Family Test responses in month, but this accompanied a system wide change in supplier, with similar experiences elsewhere.<br>• The WUTH Safeguarding and Complex Care Annual Report 2025/26 provided a comprehensive overview of the Trust's performance. It aligns with national standards and local priorities. It highlights key achievements and priorities for 2026/27. The WCHC Safeguarding Annual Report 2025/26 provides confirmation of continued robust governance arrangements, strong training and supervision performance and high level of achievements in key areas despite a continuing range of pressing staffing pressures. Reports approved for submission to Board.<br>• The WUTH Palliative and End of Life Annual Report was reported to evidence strong performance against national benchmarks, including positive feedback on bereaved family support and Care in the Last Days of Life processes.<br>• Maternity and Neonatal Services Report was considered (between Board Reports). Committee was assured by the extensive report, noting position and progress of:<br>o Quality and safety metrics for August in the Perinatal Quality Oversight Model<br>o The 10-Point Plan and implementation of Martha's Rule<br>o Maternity triage benchmarking<br>o Systems for listening to women and their families, transparently reported outcomes and experience, and corresponding clinical audit<br>• In relation to Medicines Management there were 3 Annual Reports for 2025/26:<br>o WUTH Antimicrobial Stewardship. Particularly important for managing down C.Diff. incidence. Good report shows action taken with improvements; positive outcomes, and priorities for current year.<br>o WCHC Medicines Management. Assurance that medicines are handled safely throughout community services.<br>o WCHC Accountable Officer Controlled Drugs. Committee assured that controlled drugs are handled safely, and approved the Report for Board review.<br>• WCHC Audit and Quality Improvement Programme 2026/27 is progressing well as planned, with additions in year including point of care testing and escalation pathways. Outcomes are tracked on the Trust Information Gateway, and impact overseen by the clinical governance team. |

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| | • At WUTH, several divisions had reported impact of active quality improvement programmes with particular progress noted in pressure ulcer reduction in critical care, and fall reduction initiatives, both Joint PSIRF priorities.<br>• Noted the position for both Trusts in the Internal Audit Tracker and noted the revised position for monitoring internal audits.<br>• WCHC Policy Schedule updates were received with 2 extensions to approval dates |
| **Review of Risks** | • The relevant strategic risks tracked through the BAF were reviewed as described above.<br>• 5 of the 61 WCHC organisational risks are scored as high level. Discussing the mitigations necessary it was agreed that in three of these, staffing concerns were a significant part of the situation, and these were referred across to the People Committee for attention.<br>• Moderate risk was raised in both organisations concerning assuring leadership around Equality, Diversity and Inclusion through transaction period, and identification of a Patient Experience lead. |
| **Other comments from the Chair** | This was a very full agenda, taken forward with substantial interactive discussion, both challenging and supportive. Thanks to contributors for adjusting to substantial and necessary reordering of agenda items, |

**Group Board of Directors in Public** **Item No 12**
**4 November 2026**

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| **Report Title** | Joint Committee Chairs Report – Digital Committee |
| **Date of Meeting** | 16th September 2026 |
| **Author** | Haris Sultan – Chair of the Joint Digital Committee |

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| **Alert** | • The Joint Digital Committee wish to alert members of the Group Board of Directors that:<br>○ **Subject Access Requests (WUTH) -** Committee received a further update on the improvement plan. Performance against the agreed trajectory has been positive, helped by additional temporary capacity. As WUTH is below the statutory response timescales this issue remains a risk. The SIRO will update the Board directly on the resourced improvement plan and the agreed timescales.<br>○ **Supply Chain Assurance -** Both Trusts assessed Supply Chain Assurance (CAF outcome A4.a) as below the required standard in their 2025/26 DSPT submissions. Improvement plans are in place with a target of March 2027. Cheshire and Merseyside wide programme is expected to support this issue. The CIO will report back to the Committee.<br>○ **Digital Capacity and Delivery -** The digital portfolio remains partially assured, in part due to capacity. Integration capacity has been a particular pinch point,. The digital review is due to report before the next meeting. |
| **Advise** | • The Joint Digital Committee wish to advise members of the Group Board of Directors that:<br>○ **Federated Data Platform (FDP) -** WUTH uses the FDP for the Referral to Treatment validation product only. WCHC has no FDP instance. The Committee endorsed the principle that any further deployment must be controlled and benefits-led, with an executive sponsor, a service owner, approved assurance documentation, resourcing and measurable outcomes. Any new requirements or national obligations will come to this Committee before the Board.<br>○ **DSPT 2025/26 submissions** - Both Trusts submitted on time. MIAA independently reviewed 12 CAF outcomes for each Trust. WCHC was rated Low Risk / High Confidence and WUTH Moderate Risk / High |

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| | Confidence. Most outcomes met the NHS England standard. The exceptions were Supply Chain at both Trusts (see Alert) and Managing Data Subject Rights at WUTH, because of the SAR backlog.<br>○ **Ambient Voice Technology (AVT) -** Clinical feedback has been positive, and clinicians themselves are driving adoption. Benefits are tracked through the Productivity and Improvement Board, including measures on the timeliness of patient letters. Funding is secured until May 2027. The future approach depends on the Cheshire and Merseyside funding arrangements and a longer-term strategic solution. The Committee will receive a briefing on benefits realisation at its next meeting.<br>○ **Cyber Security -** From the next meeting, the cyber plan, the cyber risks and the cyber risk register will be a standing item.<br>○ **Internal audit tracker** – Proposed extensions to due dates were reviewed and where appropriate agreed. |
| **Assure** | • The Joint Digital Committee wish to assure members of the Group Board of Directors that:<br>○ **Review of Digital Systems and Functions** - The discovery and design phase is complete across both digital teams. A draft report is due at the end of September and will go to Executives and this Committee in October. The Committee has asked for a high-level roadmap of recommendations and timescales,.<br>○ **Preventing unlawful access to patient records -** This responds to the NHS England national letter. Audit trails record both when information is entered and when a record is opened. Proactive and reactive access audits are run from the EPR, with more proactive auditing around high-profile cases.<br>○ **WCHC Information Governance Annual Report 2025/26 -** IG performance was strong overall. The Committee endorsed the 2026/27 IG priorities. Supplier assurance, records storage, FOI timeliness and integration-related change will stay under oversight. |
| **Review of Risks** | • **BAF ID11 -** The Committee oversees this risk from a cyber perspective. The appropriate risk appetite was reviewed.<br>• **BAF ID12 -** The score is unchanged pending the completion of the digital review. |
| **Other comments from the Chair** | • Future agendas will be split into two sections, so each area gets proper focus. Digital: Transformation and Impact will come first, covering digital strategy, portfolio delivery, benefits realisation and AI, which is now a standing item. IT, IG and Cyber Assurance will follow, covering information governance, |

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| | data protection, compliance and cyber security. The new structure will be used from the next meeting.<br>• The digital review report at the November meeting will be the main input for setting the future shape of digital services across both Trusts.<br>• The Committee noted the MHRA report from the National Commission into the Regulation of AI in Healthcare and its recommendations for a future regulatory framework which has been endorsed in full by the Government |

**Group Board of Directors in Public** **Item No 13**
**4 November 2026**

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|---|---|
| **Report Title** | Joint Committee Chairs Reports – Finance and Performance Committee |
| **Date of Meeting** | August 2026 |
| **Author** | Meredydd David, Chair of Finance and Performance Committee |

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| **Alert** | • The Committee wish to alert members of the Group Board that:<br>• following Month 4 reporting, the Executive Team has escalated the financial risks within Medicine and Urgent Care and Surgery. Both divisions are currently rated Red through the Finance Performance Group assurance process. A series of weekly Executive-led recovery meetings was now in place for both divisions.<br>• at the end of July 2026 (M4), WUTH is reporting a deficit of £10.7m, which is in line with the financial plan. The Trust has submitted to NHSE a revised planned deficit of £21.3m for 26/27, which has been approved. WUTH is 15 WTE behind plan at M4 with a £1.8m adverse variance in staff costs. This is primarily driven by increases in medical staff.<br>• WUTH CIP identified risk-adjusted scheme value is £33.3m, or 91%, creating a £3.4m shortfall against the requirement. Additional financial recovery actions are planned to address under-delivery and support the overall run rate. |
| **Advise** | • The Committee wish to advise members of the Group Board that:<br>○ For WUTH, there is strengthened Executive oversight through the FPG, weekly divisional review meetings, enhanced grip and control measures, and divisional recovery plans focused on returning to plan. Whilst he run rate was improving, reductions were not yet being achieved at the required pace. Non-recurrent measures would support delivery of the plan in-year, but failure to reduce the run rate sufficiently could leave a substantial gap against plan.<br>○ that the year-end position is still expected to be delivered and that the CIP programme remained in a positive position, partly reflecting benefits from actions implemented previously. However, from Month 7 onwards it would be essential to both deliver CIP schemes and achieve a corresponding reduction in the run rate.<br>○ at the end of July 2026 (M4), the WCHC is reporting a surplus of £0.9m, which is a £0.3m positive variance to plan. The Trust is currently 7.00 WTEs behind the workforce plan and CIP month 4 target was £2m and £1.27m had been achieved.<br>○ there is confidence in the delivery of CIP schemes at WCHC but full delivery within the current financial year remained challenging. Greater benefits were more likely to be realised in the following year. |

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| | ○ deficit support funding of £10.6m had been received on 14 August. The current year assumptions included the repayment of revenue support funding.<br>○ 28-day cancer performance was forecast below trajectory due to pressures in Dermatology, Gynaecology and Lower GI.<br>○ urgent and Emergency Care remained challenged, with four-hour performance in the high-40% range against a 65% trajectory. Recovery measures remained underway, including additional elective capacity, cancer insourcing, endoscopy recovery plans and implementation of the One Wirral UEC Improvement Plan ahead of winter.<br>○ for WCHC, overall operational performance remained strong, with a continued focus on maintaining and further improving standards across services.<br>○ Quarterly estates and safety updates for WUTH and WCHC were received and the self-assessments for both would be completed for submission at the end of September and would be reviewed by the net FPC.<br>○ The formation of a South Pathology Hub in partnership with COCH to be hosted by WUTH was considered and recommended to Board for approval. |
| **Assure** | • The Committee wish to assure members of the Group Board that:<br>○ the 8 clinical safety thresholds (guardrails) within which the Trust's turnaround and cost improvement programme will operate, as well as the process to ensure the Trust assesses relevant CIP schemes to ensure they do not breech the agreed thresholds were shared and the committee and given examples of how these are applied in practice.<br>○ June trajectories were achieved for RTT, diagnostics and all three principal cancer standards. July forecasts remained positive for DM01, 31-day and 62-day cancer performance, 12-hour waits, ambulance handovers and corridor care continued to improve despite sustained demand.<br>○ the EPRR Annual Report for 2025/26 achieved substantial compliance in its NHS England EPRR Coe Standards self-assessment and moderate assurance from an MIAA independent audit. The Annual EPRR report for the year 2025/26 for WCHC provided assurance the Trust has plans and processes in place in order to react to incidents to ensure services, that the Trust is commissioned to deliver. |
| **Review of Risks** | • The Committee wish to assure members of the Group Board that:<br>• the BAF risks allocated to the committee were thoroughly reviewed and the details shared in relation to risk ID01, ID02, ID05, ID06 and ID11 and it was agreed there were no further controls, assurances needed or gaps. Current risk ratings were considered in the context of the current controls and assurances and the risk appetite were agreed as appropriate. |

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| | • there were three high level risks for escalation for WCHC, involving four community dental inhalation sedation machines nearing the end of their working life, portable bladder scanners for the bladder and bowel service, and MSK clinical capacity not meeting current demand. The capital equipment request for dental inhalation sedation machines had been approved and that a further request for portable bladder scanners would be considered through the Capital Management Group was expected to receive approval. The committee was advised that the dental risk score was expected to reduce following implementation of capital-related mitigations |
| **Other comments from the Chair** | • Good progress in delivering the financial plan and CIP and clinical targets and trajectories is being made. However, the risk and challenge to delivery increases significantly in Q3 and Q4. The cash position still requires very careful management. |

**Group Board of Directors in Public** **Item No 13**
**4 November 2026**

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|---|---|
| **Report Title** | Joint Committee Chairs Reports – Finance and Performance Committee |
| **Date of Meeting** | September 2026 |
| **Author** | Meredydd David, Chair of Finance and Performance Committee |

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| **Alert** | • The Committee wish to alert members of the Group Board that:<br>• at the end of August 2026 (M5), the WUTH is reporting a deficit of £4.1m, which is £0.1m better than plan however if the Trust does not continue to improve its run rate position through Q3 and Q4, there is a risk with agreed plans to mitigate.<br>• WUTH is 8 WTE behind plan at M5 with a £2.9m adverse variance in staff costs. This is primarily driven by higher than planned bank and agency. In a number of areas there are improvements such as reduced use of agency but this is not fully translating to the overall run rate yet.<br>• challenges in the Medicine & Urgent Care and Surgery divisions remain, and the continued escalation meetings with both divisions, and the support has been put in place to ensure that both divisions achieve their approved budgets<br>• the NHS Oversight Framework(NOF) has now moved from a quartile based approach to the use of a fixed score, reducing the extent to which an organisation's segmentation is influenced by the relative performance of other providers. As a result of this change and the change in measures used WCHC has moved from NOF 1 to NOF 2 and WUTH from NOF 4 to NOF 3 |
| **Advise** | • The Committee wish to advise members of the Group Board that at WUTH:<br>• since March of last year, WUTH has reduced WTE by 154 WTE. This must continue at least at this same rate this year, and is linked to the CIP delivery challenges<br>• challenges around grip and control remain and the financial plan has been achieved through use of some non-recurrent measures, but the underlying position remains challenged.<br>• there is piece of work ongoing to look at general clinical documentation and whether there are elements that should be enhanced to ensure coding is completely accurate.<br>• delivery of the CIP is challenging particularly around completion of the organisational change in corporate services, particularly around the scale of job panels required to enable this change. This is delaying implementation in some areas.<br>• the Same Day Emergency Care business case was considered and recommended to the Board for approval.<br>• WCHC at (M5) is reporting a surplus of £1.5m, which is a £0.7m positive variance to plan. The Trust is currently 5.6 behind plan on WTEs. |

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| | • The Emergency Preparedness, Resilience and Response Standards assessments showed WUTH and WCHC as compliant with areas of compliance requirements being addressed.<br>• WCHC premises Assurance Model self-assessment was considered and approved for submission. It was noted that a review will take place on the arrangements with landlords who own the buildings that WCHC lease and how assurance is provided from those landlords that appropriate maintenance is being carried out. |
| **Assure** | • The Committee wish to assure members of the Group Board that:<br>• 5 high scoring risks are monitored and the assurance position had been strengthened since the MTFP had been accepted by NHSE and that both Trusts were reporting a favourable variance to plan at M5. |
| **Review of Risks** | • Significant risks still remain in the delivery of the Financial Plan over Q3 and Q4.<br>• the Trust's cash position has improved, principally as a result of the receipt of Deficit Support Funding, however it remains a significant financial risk and challenge |
| **Other comments from the Chair** | • Q3 and Q4 financial plan is extremely challenging to deliver especially the timing of the WTE reductions brought forward from 2027/28. These challenges and risks are clearly understood and the Executive and wider leadership team are fully focused on the delivery of the Financial Plan as well as other key clinical performance metrics. |

**Group Board of Directors in Public** **Item 16**
**4 November 2026**

| | |
|---|---|
| **Report Title** | Committee Chairs Report – WUTH Audit and Risk Committee |
| **Date of Meeting** | 10 September 2026 |
| **Author** | Lisa Greenhalgh, Chair of Audit and Risk Committee |

| | |
|---|---|
| **Alert** | • The Committee wish to alert members of the Board of Directors that:<br>○ It was agreed at both the Finance and Performance Committee and Quality and Safety Committee that ID01 risk rating was increased to RR20, reflecting continuing unscheduled care demand and its consequences for quality, patient experience, legal undertakings with NHSE, and the published NOF position.<br>○ Six risks currently have high-level scores, ID01 at RR20, ID02 and ID03 at RR16, and ID05, ID06, and ID11 at RR15. They cover unscheduled care, planned care, workforce, financial planning, service transformation, and critical infrastructure or cyber-attack. |
| **Advise** | • The Committee wish to advise members of the Board of Directors that:<br>○ As recommended from the Quality & Safety Committee a new strategic risk ID13 is included in the BAF related to the patient safety and quality governance framework. |
| **Assure** | • The Committee wish to assure members of the Board of Directors that:<br>○ MIAA reported the 2025/26 Counter Fraud Functional Standard Return achieved an overall Green rating, with 11 of 12 components rated Green and one Amber because the Fraud Risk Assessment was still being completed.<br>○ MIAA presented progress reports for:<br>○ Theatres Utilisation – substantial assurance<br>○ Costings Review – substantial assurance<br>○ Data Security & Protection Toolkit – moderate risk due to 1 high level risk which is known to the Board and an action plan is in place with review by the Digital Committee<br>○ Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions.<br>○ Auditors Annual Report was received which gave an unqualified audit opinion<br>○ The committee noted the actions in progress in order to be compliant with Martyns Law which is expected to be brought in Spring 2027. |

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| **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** | The Committee emphasised the importance of a streamlined and proportionate framework that supports effective oversight and reduces the potential for gaps in reporting.<br><br>The Committee agreed that the full internal audit tracker should be presented, with greater challenge regarding the setting of recommendation completion dates and ongoing monitoring by the Committee. Consideration was also given to establishing a tracker for external audit actions. |

**Group Board of Directors in Public** **Item 17**
**4 November 2026**

| | |
|---|---|
| **Report Title** | Committee Chairs Report – WCHC Audit and Risk Committee |
| **Date of Meeting** | 10 September 2026 |
| **Author** | Lisa Greenhalgh, Chair of Audit and Risk Committee |

| | |
|---|---|
| **Alert** | • The Committee wish to alert members of the Board of Directors that:<br>○ It was agreed at both the Finance and Performance Committee and Quality and Safety Committee that ID01 risk rating was increased to RR20, reflecting continuing unscheduled care demand and its consequences for quality, patient experience, legal undertakings with NHSE, and the published NOF position.<br>○ Six risks currently have high-level scores, ID01 at RR20, ID02 and ID03 at RR16, and ID05, ID06, and ID11 at RR15. They cover unscheduled care, planned care, workforce, financial planning, service transformation, and critical infrastructure or cyber-attack. |
| **Advise** | • The Committee wish to advise members of the Board of Directors that:<br>○ As recommended from the Quality & Safety Committee a new strategic risk ID13 is included in the BAF related to the patient safety and quality governance framework |
| **Assure** | • The Committee wish to assure members of the Board of Directors that:<br>○ The committee were assured of the processes in place to monitor high-level organisational risks as per the Trust's Risk Policy, including oversight by the sub-committees of the Board<br>○ MIAA reported the 2025/26 Counter Fraud Functional Standard Return achieved an overall Green rating, with 11 of 12 components rated Green and one Amber because the Fraud Risk Assessment was still being completed.<br>○ MIAA presented progress reports for:<br>○ Complaints Management Lessons Learned – moderate assurance. Findings would be discussed at the Quality & Safety Committee<br>○ Conflicts of Interest - substantial assurance<br>○ Data Security & Protection Toolkit – low risk<br>○ Internal Audit Follow up and Audit Tracker showed that good progress had been made against implementing all agreed actions.<br>○ Auditors Annual Report was received which gave an unqualified audit opinion |
| **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. |

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|---|---|
| **Other comments from the Chair** | The Committee emphasised the importance of a streamlined and proportionate framework that supports effective oversight and reduces the potential for gaps in reporting.<br><br>The Committee agreed that the full internal audit tracker should be presented, with greater challenge regarding the setting of recommendation completion dates and ongoing monitoring by the Committee. Consideration was also given to establishing a tracker for external audit actions. |

**Group Board of Directors in Public** **Item 18**

**04 November 2026**

| | |
|---|---|
| **Title** | WUTH Safeguarding and Complex Care Annual Report 2025/26 |
| **Area Lead** | Chris Douglas, Joint Chief Nursing Officer |
| **Author** | Karolyn Shaw, Associate Director of Nursing for Safeguarding and Complex Care |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Assurance |

The Safeguarding Annual Report provides an overview of the national and local context of safeguarding, current position and provides assurance that the Trust is meeting its statutory obligations and national safeguarding standards.

Analysis of the annual safeguarding activity including progress made against the objectives set out in the Safeguarding Annual Report 2024/2025 and an overview of the Trust safeguarding priorities moving into 2026/2027.

It is recommended that the Board:

- Note the report, recognising the progress, celebrations and identified areas of improvement moving into 2026/2027.

## Key Points to Note

- The Trust is actively monitoring the Attorney General for Northern Ireland (AGNI) Supreme Court case, which was heard in October 2025 to challenge the Cheshire West "acid test" as being overly broad and lacking clarity. The legal challenge specifically reviews whether a vulnerable individual who lacks capacity can still give valid consent to their care through their expressed wishes or conduct. While the final ruling remained officially pending as of 31 March 2026, monitoring the parameters of this judgment has been designated as a top strategic priority for 2026/27 to immediately update internal legal policies and training workflows.

- The Trust secured a Level 3 'Good' CQC rating for Safeguarding in Urgent and Emergency Services, matching external success with internal data innovation through the launch of an automated tracking BI Portal in Q2. This new digital portal automatically monitors time-critical patient entries and successfully reduced missed Child Protection Information Sharing (CP-IS) alerts. Additionally, by utilising a new joint Health and Social Care tracker paired with an extra-clinic escalation protocol, the Trust effectively overcame severe operational resource shortages to recover statutory Initial Health Assessment (IHA) compliance from a critical low of 20% in Q2 up to a robust 89.5% by Q4.

| Key Risks |
|---|
| This report relates to these key risks:<br>• Divisional Risks - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate<br>• Trust Risk 1366 – Oliver McGowan Mandatory Training (OMMT)<br>• Trust Risk 1872 - The Reasonable Adjustment Digital Flag (RADF) Information Standard.<br>• Trust Risk 1824 – Combined Named Nurse Children and Named Nurse Children Looked After should be separate roles.<br>• Divisional Risk 2228 – IHA statutory compliance. |

| 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** |
| September 2026 | Joint Quality and Safety Committee | Safeguarding Annual Report 2025/2026 | Assurance |
| 20/08/2026 | Patient Safety and Quality Board (PSQB) | Safeguarding Annual Report 2025/2026 | Assurance |
| 04/09/2026 | Safeguarding Assurance Group (SAG) | Safeguarding Annual Report 2025/2026 | For Information |

| 1 | Narrative |
|---|---|
| **1.1** | The Safeguarding and Complex Care Annual Report provides a comprehensive overview of the Trust's safeguarding performance, ensuring alignment with national standards and local priorities. |

**This report:**

- Highlights key achievements and areas for improvement.
- Demonstrates the Trust's commitment to safeguarding excellence.
- Outlines priorities for 2026/27 to drive continuous improvement.

**Key Areas of Focus**

- Protecting Vulnerable People (PVP) Training
  Ensuring all staff receive role-specific safeguarding training aligned with national frameworks.
- Safeguarding Assurance and Accountability Framework (SAAF)
  Monitoring compliance with regional and national safeguarding standards.
- Care Quality Commission (CQC) Updates
  Demonstrating alignment with CQC safeguarding requirements.
- Trust Safeguarding Activity
  Tracking referrals, investigations, and multi-agency collaboration.
- Learning Disabilities/Autism and LeDeR
  Improving outcomes for individuals with learning disabilities and autism.
- Oliver McGowan Mandatory Training (OMMT)
  Ensuring compliance with specialist training requirements.

**Key successes summary during 2025/26:**

There have been several key successes to celebrate during 2025/26 which include:

**Statutory Safeguarding & Data Innovations**

- **Automated CP-IS Tracking**: Transitioned from legacy manual auditing to standardised, automated compliance tracking via a dedicated BI Portal launched in Q2.
- **Reduction in Missed CP-IS Alerts**: The number of safeguarding alerts identified by staff as **not recorded on CP-IS** dropped from **24 in 2024/25 to 17 in the current period**, showing a **clear improvement** in compliance with safeguarding requirements. Fewer missed alerts mean better protection for children at risk.
- **Joint Initial Health Assessments (IHA)**: Successfully launched a joint Health and Social Care IHA tracker to strengthen compliance, oversight, and multi-agency reporting precision.
- Following the **CQC inspection** of our Urgent and Emergency Services, we are proud to celebrate a Level 3 'Good' rating for Safeguarding. This achievement reflects our staff's dedication to protecting vulnerable individuals

**Mental Capacity Act (MCA) & Clinical Interventions**

- **Restrictive Practices Oversight**: Embedded a dedicated recording tool within Cerner to monitor levels of patient observations, objections, and active legal frameworks, including the Mental Capacity Act, Deprivation of Liberty, and Mental Health Act.
- **Critical Medication Framework**: Formulated a draft Standard Operating Procedure in a joint workflow championed by the Deputy Medical Director and Pharmacy to govern the refusal of critical medications under the MCA 2005.
- **DNACPR Compliance Integration**: Partnered with the Resuscitation Services Lead to enhance DNACPR compliance with the MCA 2005 via mandatory training updates and targeted medical staff sessions.
- **Expanded Clinical Auditing**: Strengthened MCA 2005 auditing outside the

| | |
|---|---|
| | Safeguarding WISE framework by integrating compliance questions directly into local falls prevention, nutrition and hydration, catheter insertion, and pressure area care audits.<br>• **Digital Legal Alignment**: Updated electronic Mental Capacity Act and Best Interests templates to formally embed the Supreme Court's "Causative Nexus" decision.<br>• **LPA Protocol Enhancements**: Increased Lasting Power of Attorney (LPA) documentation compliance to 47.2% through mandatory training and electronic form integration.<br>• **Alignment to PSIRF** for Section 42 Statutory investigations embedding learning for pressure sores and discharge issues.<br><br>**Accessible Care & Vulnerable Cohort Support**<br>• **Innovative Maternity Pathways**: Adopted and adapted the Sussex University Maternity Passport into a comprehensive multi-agency pathway to support parents with learning needs.<br>• **High-Risk Domestic Abuse Interventions**: Increased Multi-Agency Risk Assessment Committee (MARAC) referrals to 35 high-risk cases and launched a pilot initiative reviewing domestic abuse links in suicide cases.<br>• **FGM Screening Expansion**: Successfully rolled out Female Genital Mutilation (FGM) routine enquiry questions within Urology services to bolster preventative screening.<br><br>**Training, Quality Assurance & Workforce Compliance**<br>• **Accessible Digital Learning**: Published all 5 MCA educational vodcasts to the Trust intranet to provide flexible, on-demand legal and procedural guidance for frontline staff.<br>• **Prevent Training Excellence**: Maintained 100% full training compliance across all levels of Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP).<br>• **National Training Mandates**: Achieved 83.1% compliance with the Oliver McGowan Mandatory Training (OMMT) (eLearning part A), training 5,306 staff members to improve care quality for autistic individuals and people with learning disabilities.<br>• **Protecting Vulnerable People (PVP)**: Met the 90% contract target for core Level 2 and Level 3 PVP training tiers across key divisions.<br>• **LeDeR Quality Benchmarking**: Completed 24 mortality reviews under the Learning from Lives and Deaths framework, validating that 83% of evaluated cases met high-quality, appropriate care criteria. |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• The commitment by the organsation to safeguarding supports patients during those times of need and when unable to raise concerns advocate on their behalf. There is a recognition of equality, diversity and inclusivity and this is recognised as part of making safeguarding personal, inclusion of reasonable adjustments, translation services and capturing the voice and lived experience of patients.<br>• The Annual report provides assurance of steps taken for complex care mainly Learning Disabilities and Autism which also supports trust wide workstreams |

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| | which support mandatory training (Oliver McGowan) and addressing equality, diversity and inclusivity inclusive of reasonable adjustments (Equality Act 2010). |
| **2.2** | **People**<br>• The Safeguarding Annual Report demonstrates the commitment from the organisation to the Safeguarding Adults Partnership Board and Wirral Safeguarding Childrens Partnership agendas. These partnerships/boards place statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of vulnerable adults and children. Multiagency partnership working is a driver for all safeguarding work streams and the subgroups of the boards are represented by the statutory named roles within the organisation where there is focus on system wide collaboration which as shared vision to protect and safeguard and support all patients, visitors and staff from harm and abuse. |
| **2.3** | **Finance**<br>• Whilst the Safeguarding agenda has no specific financial direct costs outside of cost of staff employment the potential indirect costs that a of breach of contract, failure to comply with statutory requirements or litigation if the organisation fails to discharge its responsibilities could prove significant. |
| **2.4** | **Compliance**<br>• The Safeguarding Assurance and Accountability Framework (SAAF) sets out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB on a quarterly basis. This includes compliance of Initial Health Assessments for Children Looked After, Safeguarding Mandatory Training, Mental Capacity Act and Prevent (The Counter Terrorism and Security Act (2015) and various other legislative KPIs included within the Care Act 2014 and The Children Act (1989). |

Wirral University Teaching Hospital NHS Foundation Trust

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|---|---|
| **Title** | Safeguarding and Complex Care Annual Report 2025/2026 |
| **Area Lead** | Chris Douglas – Joint Chief Nursing Officer |
| **Author** | Karolyn Shaw - Associate Director of Nursing for Safeguarding and Complex Care |
| **Report for** | Information |

## Safeguarding and Complex Care: A year of Progress and Commitment

The Safeguarding and Complex Care Annual Report provides a comprehensive overview of the Trust's safeguarding performance, ensuring alignment with national standards and local priorities. This report:

- Highlights key achievements and areas for improvement.
- Demonstrates the Trust's commitment to safeguarding excellence.
- Outlines priorities for 2026/27 to drive continuous improvement.

**Key Areas of Focus**

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- Safeguarding Assurance and Accountability Framework (SAAF)
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- Care Quality Commission (CQC) Updates
  Demonstrating alignment with CQC safeguarding requirements.
- Trust Safeguarding Activity
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- **Digital Legal Alignment**: Updated electronic Mental Capacity Act and Best Interests templates to formally embed the Supreme Court's "Causative Nexus" decision.
- **LPA Protocol Enhancements**: Increased Lasting Power of Attorney (LPA) documentation compliance to 47.2% through mandatory training and electronic form integration.
- **Alignment to PSIRF** for Section 42 Statutory investigations embedding learning for pressure sores and discharge issues.

**Accessible Care & Vulnerable Cohort Support**

- **Innovative Maternity Pathways**: Adopted and adapted the Sussex University Maternity Passport into a comprehensive multi-agency pathway to support parents with learning needs.
- **High-Risk Domestic Abuse Interventions**: Increased Multi-Agency Risk Assessment Committee (MARAC) referrals to 35 high-risk cases and launched a pilot initiative reviewing domestic abuse links in suicide cases.
- **FGM Screening Expansion**: Successfully rolled out Female Genital Mutilation (FGM) routine enquiry questions within Urology services to bolster preventative screening.

**Training, Quality Assurance & Workforce Compliance**

- **Accessible Digital Learning**: Published all 5 MCA educational vodcasts to the Trust intranet to provide flexible, on-demand legal and procedural guidance for frontline staff.
- **Prevent Training Excellence**: Maintained 100% full training compliance across all levels of Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP).
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- **LeDeR Quality Benchmarking**: Completed 24 mortality reviews under the Learning from Lives and Deaths framework, validating that 83% of evaluated cases met high-quality, appropriate care criteria.

## Key Risks

This report relates to these key risks:

- Divisional Risks - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate
- Trust Risk 1366 – Oliver McGowan Mandatory Training (OMMT)
- Trust Risk 1872 - The Reasonable Adjustment Digital Flag (RADF) Information

Standard.
- Trust Risk 1824 – Combined Named Nurse Children and Named Nurse Children Looked After should be separate roles.
- Divisional Risk 2228 – IHA statutory compliance.

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

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 04/09/2026 | Safeguarding Assurance Group (SAG) | Safeguarding and Complex Care Annual Report 2024/2025 | Information |
| 20/08/2026 | Patient Safety and Quality Board | Safeguarding and Complex Care Annual Report 2024/2025 | Information |

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## Glossary

| | |
|---|---|
| AIS | Accessible Information Standards |
| ASC | Adult Social Care |
| ASD | Autistic Spectrum Disorder |
| BAAF | British Association for Adoption and Fostering |
| BI | Best Interests |
| CDOP | Child Death Overview Panels |
| CiN | Child in Need |
| CSTF | Core Skills Training Framework |
| CLA | Children Looked After |
| CMICB | Cheshire and Merseyside Integrated Care Board |
| CP-IS | Child Protection information sharing |
| CQC | Care Quality Commission |
| CSC | Children Social Care |
| DARDR | Domestic Abuse Related Death Review |
| DoLS | Deprivation of Liberty Safeguards |
| ETOC | Enhanced Therapeutic Observationad and Care |
| FGM | Female Genital Mutilation |
| HOPE | Hold on Pain Eases (HOPE Boxes) |
| IHA | Initial Health Assessments |
| IMCA | Independent Mental Capacity Advocate |
| LA | Local Authority |
| LADO | Local Authority Designated Officer |
| LD | Learning Disability |
| LeDeR | Learning from lives and deaths – People with a learning disability and autistic people |
| LPA | Lasting Power of Attorney |
| LPS | Liberty Protection Safeguards |
| MAPPA | Multi-Agency Public Protection Arrangements |
| MAR | Multi Agency Referral |
| MARAC | Multi Agency Risk Assessment Conference |
| MCA | Mental Capacity Act |
| MND | Motor Neurone Disease |
| MRG | Mortality Review Group |
| MSP | Making Safeguarding Personal |
| NRLS | National Reporting and Learning System |
| OMMT | Oliver McGowan Mandatory Training |
| PBLM | Pre-Birth Liaison Meeting |
| PBTM | Pre-Birth Tracker Meeting |
| PiPoT | People in Positions of Trust |
| PVP | Protecting Vulnerable People Training |
| PSIRF | Patient Safety Incident Review Framework |
| PSQB | Patient Safety Quality Board |
| REC | Rapid Evaluation of Care |
| RPR | Relevant Persons Representative |
| SAG | Safeguarding Assurance Group |
| SAAF | Safeguarding Assurance and Accountability Framework |
| SARs | Safeguarding Adults Reviews |
| S42 | Section 42 (Statutory Investigation) |
| SCAT | Safeguarding Commissioning Assurance Toolkit |
| SUDIC | Sudden Unexpected Deaths of Child |
| WSAPB | Wirral Safeguarding Adults Partnership Board |
| WISE | Wirral Individual Safe Care Every Time Accreditation Programme |

WRAP Workshops to Raise Awareness of Prevent
WSCP The Wirral Safeguarding Children Partnership

## 1 Introduction and Statutory Legislation

**Introduction: Safeguarding and Complex Care Annual Report 2025/26**

Wirral University Teaching Hospital NHS Foundation Trust (the Trust) is dedicated to ensuring the safety, dignity, and wellbeing of our patients, families, staff, and the wider community. Safeguarding is at the heart of our 'Together we will' values, guiding our commitment to delivering high-quality, compassionate care while protecting those most at risk.

This annual report provides a comprehensive overview of our safeguarding and complex care activities, demonstrating how we:

- Meet our statutory responsibilities to safeguard children, adults, and families.
- Promote equality, diversity, and inclusion for patients with complex care needs.
- Drive continuous improvement in our safeguarding practices and processes.

**Our Safeguarding Commitment**

Safeguarding is everyone's responsibility. We are committed to:

- Preventing harm, abuse, and exploitation through proactive care and support.
- Responding effectively to concerns in line with multi-agency procedures.
- Learning from experiences to enhance services for patients, families, and carers.

For individuals with complex care needs, including those with learning disabilities (LD), autistic spectrum disorder (ASD), or motor neurone disease (MND), we strive to eliminate inequalities and ensure equitable access to high-quality care.

**Our Approach**

The Safeguarding and Complex Care Team leads our efforts to:

- Strengthen safeguarding practices across the Trust.
- Collaborate with partners to improve multi-agency responses.
- Adapt to emerging themes and evolving national priorities.

(For further details on our team structure and key definitions, see Appendices 1 and 2.)

Assurance and Accountability

This report provides assurance that the Trust is fulfilling its duties and responsibilities in safeguarding, including:

- Protecting children, adults, and families who use our services.
- Embedding equality, diversity, and inclusion in complex care.
- Achieving compliance with safeguarding standards.

It reflects our ongoing commitment to improving safeguarding practices and ensuring the highest standards of care for all.

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| 1.1 | **Statutory Framework and National Policy Drivers (Safeguarding and Complex Care)**<br><br>Safeguarding and complex care at Wirral University Teaching Hospital NHS Foundation Trust are shaped by national legislation, statutory guidance, and policy drivers. These frameworks ensure the Trust meets its legal obligations while delivering safe, person-centred care for children, adults, and families.<br><br>Safeguarding Children and Adults: Shared Principles, Unique Frameworks<br>Safeguarding is underpinned by a shared commitment to protecting individuals from harm. However, the legal frameworks for children and adults differ:<br><br>**Safeguarding Children**<br>• Governed by:<br>➢ Working Together to Safeguard Children (2026) – The key statutory guidance for multi-agency safeguarding.<br>➢ Children Act (1989, 2004) – Places a statutory duty on NHS Trusts under Section 11 to safeguard and promote children's welfare<br>➢ Children and Social Work Act (2017) – Supports multi-agency safeguarding arrangements.<br>➢ Promoting the Health and Wellbeing of Looked After Children (2022) – Statutory guidance on planning, commissioning and delivery of health services for looked after children.<br><br>**Safeguarding Adults**<br>• Governed by the Care Act (2014), which:<br>➢ Sets out a legal framework for protecting adults at risk of abuse or neglect.<br>➢ Focuses on personalised, outcome-focused care, ensuring adults are seen as experts in their own lives.<br>➢ Emphasises working with the adult, not for them.<br><br>**Equality and Inclusion: Promoting Fairness and Access**<br>The Equality Act (2010) is central to the Trust's commitment to equality, diversity, and inclusion. It:<br>• Protects individuals from discrimination based on nine protected characteristics, including disability.<br>• Requires reasonable adjustments to be made for disabled individuals to ensure fair access to services.<br>• Addresses unfavourable treatment arising from disability, ensuring actions are proportionate and justified.<br><br>Learning Disability and Autism Training: Meeting National Standards<br>The Health and Care Act (2022) introduced a mandatory requirement for CQC-registered providers to ensure staff receive appropriate training on learning disability and autism. Key points include:<br>• Training must be role-appropriate and aligned with the Oliver McGowan Mandatory Training (OMMT). |

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| | • A Code of Practice to guide was published in September 2025 following consultation.<br><br>These frameworks provide the foundation for delivering safe, person-centered care across all services. |
| **1.2** | **Safeguarding Children**<br><br>**Wirral Safeguarding Children Partnership (WSCP)**<br>The Wirral Safeguarding Children Partnership (WSCP) brings together key partners to ensure the safety and wellbeing of children in Wirral. Led by the Local Authority, Police, and Cheshire and Merseyside Integrated Care Board (CMICB), the partnership has expanded to include Education as a strategic partner, further enhancing collaboration.<br><br>The Trust plays an active role in WSCP subgroups, represented by:<br>• Named professionals for safeguarding children and children looked after.<br>• The Named Midwife.<br>(See Appendix 3 for the WSCP structure.)<br><br>**Section 11 Audit**<br>The Section 11 Audit is a statutory tool used by the WSCP to assess safeguarding arrangements across agencies in Wirral. Issued under the Children Act (2004) and reinforced in Working Together to Safeguard Children (2026), it places a legal duty on organisations to ensure their functions and services safeguard and promote the welfare of children.<br><br>**Audit Process and Themes**<br>The WSCP conducts six audits annually, covering:<br>• Policies, procedures, and thresholds.<br>• Early help and prevention.<br>• Multi-agency training.<br>• Safe and confident workforce.<br>• Systemic practice.<br>• Daily lived experiences of children and local priorities.<br><br>**Accountability and Outcomes**<br>• Following the completion of all six audits, the WSCP holds annual accountability meetings with all agencies.<br>• These meetings are chaired by a multi-agency panel and provide an opportunity for:<br>➢ Reviewing evidence of effective safeguarding arrangements.<br>➢ Demonstrating compliance with legislation.<br>➢ Identifying areas of good practice and opportunities for improvement.<br><br>The Named Nurse for Safeguarding Children and Children Looked After completed and returned these audits, ensuring the Trust's robust safeguarding practices are recognised and aligned WSCP with Section 11, no gaps for the organisation were identified.<br><br>**Multi Agency Reviews**<br>The Trust is deeply committed to protecting children using our services, conducting thorough analyses of serious incidents to understand what went wrong and why, and |

learning from these cases to strengthen safeguarding. When abuse or neglect is suspected, the Wirral Safeguarding Children Partnership (WSCP) undertakes either a Child Safeguarding Practice Review or a local learning review to ensure a robust, multi-agency response.

In 2025/26, the Trust completed four chronologies for children aged two and under who died with neglect as a factor, with these chronologies collated by the Named Nurse for Safeguarding Children and Children Looked After on behalf of the Trust. Learning review/circles were held and were attended by frontline staff involved in the identified cases. Feedback from staff was positive and enabled reflection and improvement on safeguarding practice.

Additionally, one case of potential child sexual abuse was referred to the WSCP by the Named Nurse for consideration of a learning review, as potential child sexual abuse had occurred while the child was known to children's services in March 2026. This review met the threshold for a learning review, which will take place in July 2026.

These reviews underscore the Trust's dedication to collaboration, continuous improvement, and ensuring the highest standards of care and protection for vulnerable children in our community.

**Sudden Unexpected Death in Infancy and Childhood (SUDIC)**

Sudden Unexpected Death in Infancy and Childhood (SUDIC) refers to the sudden and unexpected death of a child under 18 years old, where the death was not anticipated 24 hours prior. The SUDIC process is a multi-agency approach to investigating these cases, ensuring a thorough and coordinated response.

The Safeguarding Team plays a key role in:

- Notifying partner agencies of unexpected child deaths in line with the Pan Merseyside SUDIC Joint Agency Protocol.
- Completing Child Death Overview Panel (CDOP) notifications.
- Attendance at SUDIC strategies and review meetings for information sharing and to contribute to multi-agency decision making.

**SUDIC statistics**

In 2025/26, there were 14 recorded child deaths, the same number as in 2024/25**.** However, there was an increase in sudden unexpected deaths, with **9 cases** compared to **5** in the previous year. All **9** SUDIC cases were managed via the SUDIC process. All 9 child deaths were in the community setting and not the acute Trust.

The table highlights yearly comparisons for child deaths

| | **2022/23** | **2023/24** | **2024/25** | **2025/26** |
|---|---|---|---|---|
| **SUDIC** | 7 | 15 | 5 | 9 |
| **Medical cause/reason** | 5 | 4 | 8 | 5 |
| **Total number per annum** | 12 | 19 | 13 | 14 |

**Child Death Overview Panel (CDOP)**

To fulfil the statutory child death duty, the Trust has two representatives who attend the panel - a Consultant Paediatrician and a Consultant Neonatologist.

- All child deaths are reviewed by the CDOP panel to identify any preventable or modifiable factors.

- Learning from these reviews is shared with local, regional, and national partnerships to prevent similar deaths in the future.

**Child Protection Information Sharing (CP-IS)**

The Child Protection Information Sharing (CP-IS) service from NHS England enables secure, real-time information sharing between children's social care and healthcare providers. Utilised by 100% of local authorities in England, it is the only national register of social care status and the sole system providing out-of-area visibility for those children subject to a child protection plan or child looked after. CP-IS ensures healthcare professionals immediately access a child's safeguarding status, make informed decisions at the point of care, and automatically notify social care teams via the National Care Records Service (NCRS) of attendance. This real-time visibility supports early intervention and protects vulnerable children from harm.

**Data Governance & System Enhancements**

To strengthen oversight, divisions monitor and report CP-IS compliance through quarterly assurance reports. Reviewed by the CP-IS lead, these updates include targeted action plans to address non-compliance. This year, the organisation transitioned from manual auditing to standardised, automated tracking via a dedicated BI Portal launched in Q2.

The new portal automatically identifies time-critical checks within 12 hours of admission and enforces a rule requiring checks for newborn babies 12 hours prior to maternity discharge. In Q4, the system was refined to separate baby compliance data from maternal records, ensuring highly precise and isolated reporting for this specific cohort.

**Operational Progress & Performance Trends**

CP-IS is currently embedded across 18 active wards and departments, supported by a network of local CP-IS champions who meet quarterly to share best practices and overcome operational barriers. Core areas—including the Children's Emergency Department, Paediatric Outpatient Department, Hospital at Home, and Paediatric Assessment Unit—demonstrated consistent excellence, maintaining data compliance rates above 90%.

Improvements in data alignment were observed within the Paediatric Outpatient Department. Specifically, the number of discrepancies between CP-IS and electronic medical record safeguarding flags decreased from 139 cases in 2024/2025 to 120 cases in the current period - all of which were rectified upon identification.

Additionally, further discrepancies were uncovered, including safeguarding alerts that were not recorded on CP-IS despite being required, this was an improvement from 2024/25 (24) to 17 in the current reporting period. The fact that all identified discrepancies were rectified demonstrates compliance with safeguarding protocols. Staff are not only spotting errors but also taking immediate action to resolve them, which reflects a high standard of diligence.

**Compliance Challenges & Targeted Interventions**

While core paediatric areas performed strongly, compliance declines occurred in other divisions due to specific operational bottlenecks:

- **Women and Children's Division:** Reductions were driven by staff bypassing the BI Portal in favour of legacy manual processes, alongside continuity challenges in Gynaecology Outpatients where young patients were reviewed by consultants who may not have received CP-IS training. The collaboration

between the CP-IS lead and maternity matrons led to a significant improvement in the safeguarding reporting system. By working together, they identified and fixed flaws in the process, which resulted in higher compliance across both inpatient and outpatient services.

- **Acute & Emergency Services:** The Emergency Department (ED), Acute Medicine Unit (AMU), and Urgent Medical Assessment Centre (UMAC) experienced quarter-on-quarter declines. Key barriers included high clinical demands on training staff, outstanding smart card allocations, missing data returns, and structural reorganisations. Crucially, area missed the mandatory 12-hour attendance check window, and UMAC lacked an automated screening prompt on the Cerner electronic patient record system.

**Remediation and Future Outlook**

To resolve these deficiencies, targeted BI Portal training was delivered to the Surgical Assessment Unit (SEU) and the Surgical Elective Admissions Lounge (SEAL) - the latter after fixing an incorrect daily reporting feed in Q3—resulting in verified compliance gains by Q4. Looking ahead to Q1 2026/2027, the AMU has mitigated risk by making the CP-IS check a mandatory component of their admission assessments. Concurrently, ward managers are collaborating with the IT team to build a mandatory CP-IS prompt directly into the Cerner system for UMAC.

A comprehensive rollout to all remaining wards and departments will commence immediately upon Spine integration approval. This digital development keeps the Trust fully on track to meet the NHS England mandate requiring all NHS-funded and CQC-regulated services to launch CP-IS by December 2026.

**Paediatric Themes and Trends: Annual Overview**

**Emergency Department Attendance**

- 23,615 children attended the ED in 2025/26, an increase of 264 from the previous year.
- 1,970 children aged 16/17 were seen in adult areas, reflecting the transition to adult services.

**Children Open to Social Care**

- 801 children were open to children's social care, with increases across all categories:
  - 208 via a Child in Need plan.
  - 184 via a Child Protection plan.
  - 409 as Children Looked After (CLA).

**Safeguarding Incidents**

- 586 safeguarding incidents were recorded, a reduction from the previous year despite increased attendance.

**Multi-Agency Referrals**

- 275 MAR forms were submitted to the Integrated Front Door, an increase of 190 from the previous year.

**Child Exploitation (MACE)**

- 301 cases were discussed at Multi-Agency Child Exploitation meetings, a slight decrease from the previous year.
- Staff training on child exploitation and bespoke sessions were well-received

**Assault-Related Attendances**

- Assault-related attendances decreased by 38%, dropping to 64 cases from 170 in the previous year.
- Alcohol was the most common substance (61% of cases), overtaking Ketamine.

**Mental Health and Self Harm**

- 475 children attended for mental health, overdose, or self-harm concerns—a 21% reduction from the previous year.
- Overdose remained the highest theme.
- Robust processes ensured every child received a pre-discharge review and follow-up support.

**Key Achievements**

- Reduced assault-related attendances and mental health crises
- Increased referrals to early help services
- Enhanced multiagency collaboration to address safeguarding and exploitation risks.

**1.3**

## Children Looked After (CLA) and Initial Health Assessments (IHAs)

As a contractually responsible provider, the Trust ensures that all Children Looked After (CLA) receive an Initial Health Assessment (IHA) within 20 working days of becoming looked after. This statutory requirement is critical to safeguarding and supporting the health and wellbeing of some of the most vulnerable children in our care.

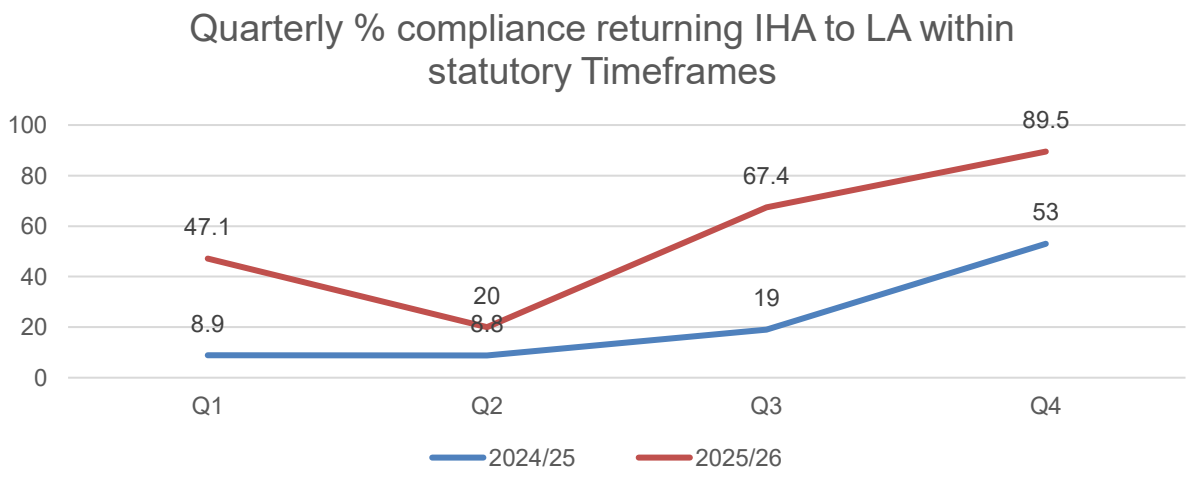
**Monitoring and Improving Compliance**

The Trust has implemented robust systems to monitor and improve IHA compliance:

**IHA Tracker**

- A joint Health and Social Care IHA tracker, launched in Q3 2024/25, continues to monitor compliance with statutory timeframes.
- Weekly joint meetings are held to:
  - Address barriers to completing IHAs.
  - Escalate non-attendance issues with social workers and operational leads.
- Once the tracker is fully embedded and compliance remains at or above 85%, the focus will expand to developing a similar tracker for Out of Borough Children entering Wirral.

**Performance Overview**



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| | **Addressing Challenges**<br>In Q2 (July–September), compliance dropped to 20% due to several challenges:<br>• Limited clinic capacity.<br>• Staff shortages in Community Paediatrics due to sickness and annual leave.<br>• Increased number of children entering care.<br>• High non-attendance rates at appointments.<br><br>**Actions Taken**<br>• Weekly meetings in Community Paediatrics to plan clinic capacity for statutory IHAs.<br>• Business support team has an escalation process to arrange extra clinics if more than 3 children are awaiting an IHA.<br><br>**Enhancing the Quality of IHAs**<br>A quality audit by the Named Nurse for Children and CLA in Q1 identified issues with the completion of Coram BAAF B (baby) and M (mother) forms, which are essential for comprehensive IHAs.<br><br>**Actions Taken**<br>• Women and Children Division, supported by governance teams, has now identified the appropriate professionals to complete and return these forms.<br>• This process began in Q4 and will continue to be monitored and audited to ensure high-quality IHAs and determine if additional resources are required.<br><br>**Key Achievements**<br>The Trust has made significant progress in ensuring timely and high-quality IHAs for CLA, with a dedicated IHA tracker successfully monitoring compliance and addressing barriers. Through collaborative working, processes have improved, and targeted actions have been taken to resolve challenges such as clinic capacity and non-attendance. Quality improvements have also been achieved in IHA documentation and completion. Looking ahead to 2026/27, the Trust remains committed to sustaining these improvements by continuing to monitor compliance, developing a tracker for Out of Borough Children, refining the Coram BAAF form process, and maintaining enhancements in clinic capacity and non-attendance rates. This ensures the Trust continues to prioritise the health and wellbeing of CLA while fulfilling its statutory responsibilities. |
| **1.4** | **Safeguarding our children to be (Unborn)**<br><br>The Wirral Pre Birth Liaison meeting (PBLM) is a pathway to share information to develop a coordinated plan to safeguard children and unborn babies; this multiagency group is co-chaired by the Trust's Named Midwife. The main purpose is to obtain multi-agency information and develop a support plan for the unborn and parents. The threshold and criteria are women who are known to services, for reasons such as safeguarding, mental health issues, substance misuse and those who disclose any form of domestic abuse as well as those who are identified as requesting or requiring additional support due to learning needs or have limited support networks in place to support the transition into parenthood.<br><br>**Referral Trends and Outcomes** |

In 2025/26, 142 referrals were submitted to the Pre-Birth Liaison Meeting (PBLM) by midwives (141 in 2024/25), with 132 meeting the criteria to progress (116 in 2024/25). A total of 209 cases were discussed at PBLMs (161 in 2024/25), reaffirming midwives as the highest referrers into the process.

Key referral themes (consistent with previous years):

- Previous social care involvement (75 cases)
- Known domestic abuse concerns (23 cases)

**Pre-Birth Tracking and Multi-Agency Collaboration**

The Named Midwife continues to work closely with Children's Social Care (CSC) to develop and refine the Pre-Birth Tracking (PBT) meeting. This proactive system:

- Monitors case progression and ensures all required multi-agency actions and care plans are completed before birth.
- Provides formal assurance of early risk management.
- Saw a significant increase in cases discussed, rising to 187 in 2025/26 (up from 104 in 2024/05).

Feedback from professionals highlights that PBLM provides a structured approach for early intervention**,** supporting parents within agreed timeframes.

**Audit and Operational Effectiveness**

A sample audit of 24 cases was conducted to evaluate the impact of the newly implemented case tracker. Findings confirmed:

- The tracker is fully embedded into daily workflows.
- Maternity services remain the highest referrers into PBLM.
- Demonstrated multi-agency collaboration, focusing on quality, timely care planning**,** and safety for newborns and mothers**.**

**Support for Care Leavers and Vulnerable Parents**

The Trust continues to provide HOPE (Hold on Pain Eases) boxes to mothers and babies separated due to CSC proceedings. A recent PBLM audit identified care leavers as a recurring theme. In response:

- Training was delivered to the Local Authority (LA) Leaving Care Team on HOPE boxes and early pathways.
- This initiative aims to widen support for this vulnerable cohort.

**Innovation in Accessible Maternity Care**

The Trust successfully adopted the Maternity Passport, developed by Sussex University, marking a significant milestone in accessible maternity care. To address local needs:

- The Named Midwife collaborated with internal and external partners to identify service gaps.
- The resource was adapted into a comprehensive, multi-agency pathway to support parents with learning needs throughout their pregnancy journey. The pathway is scheduled for official launch during Learning Disabilities Week (Q1 2026/27).

**Key Achievements**

- Strengthened multi-agency collaboration and early risk management through PBLM and PBTM.

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| | • Improved operational effectiveness with the case tracker audit confirming successful integration.<br>• Expanded support for care leavers and parents with learning needs.<br>• Launched innovative pathways to enhance accessibility and inclusivity in maternity care. |
| **1.5** | **Safeguarding Adults**<br><br>The Care Act (2014) mandates adult safeguarding as a core function of every LA. It provides the legal framework to protect adults with care and support needs from abuse, neglect, and exploitation. Each LA must maintain a Safeguarding Adults Board (SAB) comprising statutory and non-statutory partners, including the LA, Police, NHS, emergency services, probation, and the voluntary sector. The SAB's primary objective is to design, monitor, and update localised policies. This ensures statutory duties translate into practical, frontline safeguarding actions across all partner agencies.<br><br>Locally, the Wirral Safeguarding Adults Partnership Board (WSAPB) is responsible for ensuring adults at risk in Wirral live free from abuse and neglect. It holds a statutory duty to monitor and evaluate the individual and collective actions of all partner agencies to promote adult welfare (see Appendix 4).<br><br>The WSAPB delivers its agenda through multi-agency subgroups. The Trust maintains active representation across these structures to support regional accountability and practice development. The Named Nurse for Safeguarding Adults represents the Trust on two permanent subgroups: Operational Safeguarding and Quality and Performance.<br>The subgroups provide opportunities to review practice, identify and share good practice and to drive areas requiring improvement, to highlight safeguarding priorities and to provide peer challenge to collectively improve arrangements to safeguard adults at risk.<br><br>The WSAPB meets quarterly, including two annual development days. Executive-level oversight and strategic alignment are maintained by the Trust's Associate Director of Nursing for Safeguarding. The WSAPB collaborates with three other Merseyside adult boards to oversee Safeguarding Adult Reviews (SARs). During 2025/26, the Trust provided information for 9 SAR considerations: 6 cases did not meet the statutory threshold, 1 case progressed to a joint SAR and Domestic Abuse Related Death Review (DARDR), 2 cases progressed to a single joint SAR, as both were involved in the same incident.<br><br>The Trust continues to implement 2 legacy action plans from previous thematic SARs. These focus on, Mental Capacity Act (MCA), Discharge pathways and Self Neglect. Once finalised in 2026/27, learning will be shared across agencies to assure practice improvements. Trust specific learning will be monitored via the Safeguarding Assurance Group (SAG).<br><br>**Performance, Challenges and Progress**<br>**Policy and Legislative Alignment**<br>In 2025/26, there were no legislative changes in national safeguarding policy or guidance. However, the Trust updated its internal policy to align with the Patient Safety |

Incident Review Framework (PSIRF), ensuring robust processes for managing externally raised concerns.

**Referrals, trends and compliance**

- 716 safeguarding referrals were received, an increase from 605 2024/25.
- 205 referrals were submitted to Adult Social Care (ASC):
  - 71 (35%) progressed to statutory Section 42 (S42) enquiries.
  - 134 referrals did not meet the statutory threshold for a formal safeguarding enquiry but were identified as requiring lower-level intervention. To ensure patient safety and continuity of care, alternative support pathways outside the safeguarding arena were actively explored.

**Key Themes of Concern**

Consistent with 2024/25, the highest causes of concern were:

- Neglect (highest cause each quarter).
- Physical abuse.
- Self-neglect.
- Financial abuse.

These themes are shared quarterly with the WSAPB Quality and Performance subgroup.

**Compliance and Improvement Initiatives**

As part of the annual Safeguarding Assurance and Accountability Framework and Safeguarding (SAAF) Policy KPIs audit cycle, quality audits were conducted to evaluate the standard of referrals made into ASC and ensure robust compliance with policy requirements. Central to this process was assessing adherence to Making Safeguarding Personal (MSP) - a core Care Act principle requiring adults to be actively involved in their care, provide informed consent, or have an independent advocate appointed if they lack mental capacity.

**Compliance with policy KPIs**

- 87% of referrals were submitted directly to ASC via the electronic Multi Agency Adult Referral (MAR) at the point of concern.
  - Overall compliance with policy procedures remained static at 56% (unchanged from 2024/25), prompting:
  - Targeted interventions and leadership escalation through SAG.
  - Reinforced awareness during Safeguarding Adults Week (Q3) and face-to-face training.

**Making Safeguarding Personal (MSP)**

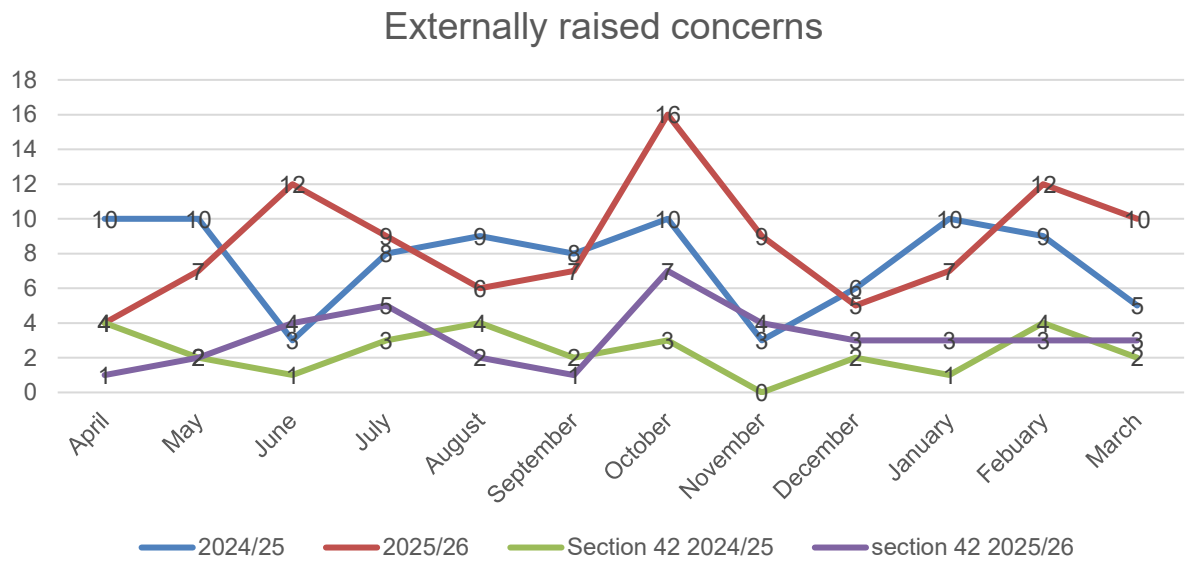
- 55% (113) of ASC referrals involved individuals lacking capacity or too unwell to engage.
- 78% (72 referrals) of remaining patients were informed of the referral, though desired outcomes were not always documented.

To improve outcome recording, the Named Nurse for Safeguarding Adults took the opportunity to redesign the MAR process in Q4 as part of the wider Urgent and Emergency Care Upgrade Programme re-configuration of the Emergency Department

and closer working with Urgent Treatment Care. This was also supported by the Wirral Community Health and Care Trust as part of the wider integration across both organisations to align systems and processes.

**Externally raised concerns**

Externally raised concerns against the Trust directly from the ASC continue to be managed through the governance divisional leads using the safeguarding rapid evaluation of care (REC) template. The Named Nurse for Safeguarding Adults provides oversight. Learning and subsequent actions are monitored by the divisions involved. Themes and trends are reported through SAG feeding into the Patient Safety and Quality Board (PSQB) for wider learning and assurance.




The graph details the number of externally raised concerns in 2025/26 period (Red) compared to the previous 12 months (Blue). The Purple line is the actual number of concerns which were progressed to a Section 42 (S42) investigation compared to previous 12 months (green).

**Volume and Trends**

- 101 externally raised concerns were received, an 11% increase from 2024/25.
  - 31 (30%) were closed as initial enquiries (no concerns identified)
  - 33 (33%) were logged as clinical incidents for divisional review
  - 37 (37%) progressed to statutory S42 investigation (up from 32% in 2024/25)

**Key Themes of Section 42 investigations**

- **Discharge processes** (14 referrals), including:
  - Inadequate assessments.
  - Failures in arranging care packages.
  - Poor communication between services.
- **Pressure sores** (18 referrals).
- **Care issues or acts of omission** (5 referrals)

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| | To address identified issues, they were escalated through the SAG which supports divisional targeted improvement plans. Moving forwards these plans will be monitored via the PSIRF to ensure monitoring and oversight of themes and trends.<br><br>**Section 42 Investigation outcomes**<br>Of the **37 S42 investigations**:<br><br>• **27%** were unsubstantiated or inconclusive.<br>• **38%** were substantiated.<br>• **35%** were partially substantiated (an increase from previous years).<br><br>**73%** of reviews identified learning points, with actions monitored by divisions.<br><br>**Governance and System Improvements**<br>The Named Nurse for Safeguarding Adults collaborated with divisional governance teams to:<br>• Improve review processes and assurance mechanisms.<br>• Align safeguarding reviews with PSIRF, promoting a consistent, learning-focused approach.<br><br>**System Enhancements: Safeguarding Governance S42 Tracker**<br>• System issues identified in Ulysses in partnership with the Quality & Safety Analyst, challenges remain due to capacity constraints within the governance unit however moving forwards upcoming reports will enable divisions to:<br>➢ Monitor concerns.<br>➢ Track learning and actions.<br>➢ Provide clearer evidence of progress to the SAG.<br><br>**Moving into 2026/27**<br>• Continue to monitor and improve compliance with safeguarding policies.<br>• Focus on documenting desired outcomes for individuals involved in safeguarding referrals.<br>• Strengthen discharge processes and pressure sore prevention through targeted divisional action plans.<br>• Embed learning from S42 enquiries across divisions to drive continuous improvement. |
| **1.6** | **The Mental Capacity Act (2005) and Deprivation of Liberty (2007)**<br><br>The Mental Capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care, and treatment to people aged 16 and over who live in England and Wales.<br>The five principles of the MCA are:<br>• Presume capacity unless proven otherwise<br>• Support autonomy – help individuals to make their own decisions<br>• Respect unwise decisions – capacity isn't lost due to poor choices<br>• Act in best interests if someone lacks capacity<br>• Use the least restrictive option to uphold rights |

The MCA allows people to express their care preferences and appoint a trusted decision maker should they lack capacity to make decisions in the future. A person lacks capacity if they cannot:

- Understand, retain or weigh up relevant information or
- Use or as part of the process of making the decision
- Communicate their decision in any form

Restraint or restrictions may be used only if necessary and proportionate. If these measures deprive someone of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). Following 2014 Cheshire West Supreme court ruling, an acid test was established describing a deprivation of liberty as:

- Someone lacking mental capacity to consent to their arrangement,
- Not free to leave
- Under continuous Supervision and control

In October 2025, the Attorney General for Northern Ireland challenged the application of the Cheshire West 'acid test' in the Supreme Court, arguing that the definition of deprivation of liberty may be overly broad and insufficiently clear in certain circumstances. The case was heard by the Supreme Court in October 2025, and judgment remained pending as at 31 March 2026. Pending the outcome of the Supreme Court case and further national guidance, the Trust continued to operate in accordance with the Deprivation of Liberty Safeguards (DoLS) framework and prepared to implement any necessary changes to policies, training and practice to ensure ongoing compliance with legislative requirements.

Following the Government's announcement in October 2025 of a consultation on the implementation of Liberty Protection Safeguards (LPS), outcomes were anticipated during 2026 but remained outstanding at the end of the reporting period. The proposed LPS framework is intended to simplify and streamline the authorisation process, reduce the backlog of DoLS applications and strengthen safeguards for individuals who are most vulnerable.

The 'Supervisory Body' (Adult Social Care) assesses and authorises deprivations of liberty. However, the Trust (Managing Authority) are required to grant 7-day authorisations completed via the Ulysses system for immediate action completed by frontline staff, with the option to extend if approved by the supervisory body.

**Regulatory and Legal Changes**

The Trust remains committed to upholding the MCA 2005 and DoLS, ensuring compliance with legal requirements and best practices. In 2025/26, significant progress was made in training, process improvements, and alignment with judicial guidance, these included:

- Alignment with Judicial Guidance - updated electronic MCA/Best Interests (BI) templates to reflect the Supreme Court's Local Authority v JB UKSC 52 ruling, introducing a 3-stage assessment process with 'Causative Nexus' to strengthen decision-making. Positive feedback from staff highlighted improved usability and clarity, alongside enhanced quality of assessments.

**DoLS Activity & Operational Metrics**

During the 2025/26 financial year, the Trust processed 2,729 DoLS Urgent authorisations and standard requests, representing a stable position compared to the 2,739 processed in 2024/25.

Out of these, 2,333 applications were fully processed and forwarded to the Supervisory Body. The Supervisory Body officially granted 12 Standard Authorisations, marking a positive increase from the 2 granted in 2024/25.

**Unauthorised DoLS Backlog Risk**
A total of 1,588 "7-day Urgent" authorisations expired purely due to operational delays by external Supervisory Bodies in meeting statutory timeframes. This created technical compliance breaches of unauthorised DoLS, resulting in an average overstay duration of 19 days and a recorded maximum breach of 225 days. This remains a persistent, systemic national challenge affecting acute care settings since the *Cheshire West* ruling.

**Quality Assurance & Internal Gaps**
**Application Data Deficits**
Incomplete or invalid submissions from frontline staff continue to add heavy administrative pressure to the Safeguarding Team, creating processing delays and potential patient safety risks. The five most frequent recurring data omissions identified are:

- **Missing Patient Data:** Incorrect or entirely absent demographic information.
- **Absence of Capacity Appraisals:** Lack of legally required, documented mental capacity assessments.
- **Unclear Care Pathways:** Omission of definitive clinical care plans.
- **Vague Supervision Specs:** Unspecified or poorly defined supervision levels.
- **Omitted Restraint Records:** Missing or incomplete logs of restraint episodes.

**Relevant Person's Representative (RPR) Booklet Provision**
Providing RPR booklets is a statutory requirement under DoLS to ensure patients and families clearly understand their legal rights and care options. While distribution progress was made in 2025/26, overall compliance sits below expected standards. The Trust issued 999 booklets, 69 were declined by family representatives, and 410 were not provided. Non-provision was primarily driven by representatives being physically absent during BI decision-making windows.

**Restrictive Practices Monitoring**
The Trust strengthened oversight of restrictive practices by integrating compliance documentation directly into patient Adult Daily Goals. A Q2 audit of 332 patients revealed that 31% (99 cases) exhibited data inconsistencies between Daily Goals, active DoLS applications, and general patient records.

These findings were immediately addressed via SAG updates, ward-level meetings, and targeted crib sheets developed by the MCA Lead. Daily Goals tracking accuracy has now been fully integrated into regular DoLS compliance monitoring frameworks. To drive continuous improvement, a new Enhanced Therapeutic Observation and Care (ETOC) policy is being actively developed by the Dementia Matron.

**Independent Mental Capacity Act Advocate (IMCA) Referrals**
The Trust executed 62 IMCA referrals during 2025/26. However, inappropriate referrals persisted, particularly for social care-led discharges or cases lacking finalised clinical decisions where the external Supervisory Body holds legal responsibility. A critical compliance gap was identified in Serious Medical Treatment SMT provisions: out of 48 eligible DoLS patients, only 23 referrals were executed. To address this deficit, operational guidance was reshared and a focused safety bulletin was published during Safeguarding Adults Week in November 2025. Encouragingly, baseline staff

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| | awareness remains strong, with WISE accreditation audits confirming that over 90% of staff know the correct referral pathway.<br><br>**Governance, Remediation & Workforce Education**<br>**Strategic Governance Interventions**<br>• **Policy Ownership**: Operational practices remain strictly governed by a designated Trust MCA/DoLS Lead, who maintains active oversight and updates Policy 237 ('Role of the Mental Capacity Act 2005 in Acute Healthcare') and Policy 217 ('Deprivation of Liberty Safeguards') against changing case law.<br>• **Target Benchmarking**: The internal three-day submission standard has been strictly monitored since 2023 to minimise application delays and protect patient rights. In 2025/26, 87% of applications successfully met this target.<br>• **Incident Escalation**: Any delayed application identified without a verified, valid clinical justification automatically triggers a formal clinical incident report to drive ward-level accountability and share organisational learning.<br>• **Workflow Automation**: To close the RPR booklet distribution gap, the DoLS Administrator embedded a hard mandatory prompt into active electronic DoLS documentation to force consistent staff recording and booklet issuance.<br><br>**Training and Education Delivery**<br>A comprehensive training programme was delivered trust-wide to support frontline staff competencies. Education modules covered the refusal of medications and treatment, restrictive practices, consent, supervision, and statutory documentation requirements. This training was systematically embedded into:<br>• Mandatory training tracks (Safeguarding and Do Not Attempt Cardiopulmonary Resuscitation DNACPR).<br>• Specialist divisional programmes (Medical, Surgical, and Nursing).<br>• Corporate Patient Safety training tracks.<br>Additionally, the Trust launched two specialised MCA learning vodcasts in 2025/26 to provide flexible, accessible digital education for frontline staff.<br><br>**System-Wide Harm Audits & Key Successes**<br>To drive system-wide quality improvements, core MCA compliance questions have been integrated into key clinical harm audits, including Falls Prevention, Nutrition and Hydration, Catheter Insertion, and Pressure Area Care. Ongoing governance and assurance are provided through the newly established Fundamentals of Care Group, launched in Q1 2025/26.<br>• **Lasting Power of Attorney (LPA)**: Compliance rose significantly to 47.2% in 2025/26 (up from 31.8% in 2024/25) following the integration of LPA verification fields into electronic BI forms and mandatory training.<br>• **Treatment and Medication Refusals**: Documented incidents of non-compliance decreased from 75 in 2024/25 to 70 in 2025/26.<br>• **DNACPR Compliance**: Continuous improvements were maintained through dedicated clinical training and collaborative partnerships with the Resuscitation Services Lead. |
| **1.7** | **The Counter Terrorism and Security Act (2015)**<br><br>The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components:<br>• **Pursue** - to disrupt terrorist activity and stop attacks. |

- **Prevent** - to stop people becoming or supporting violent extremists and build safer and stronger communities.
- **Protect** - strengthening the UK's infrastructure to stop or increase resilience to any possible attack.
- **Prepare** - should an attack occur then ensure prompt response and lessen the impact of the attack.

The NHS and its partners continue to play a key role in delivering the Prevent agenda. The NHS England Data Collections Framework (DCF) is now the established mechanism for Prevent data reporting, providing a single source of assurance information for providers, Integrated Care Boards, regional safeguarding teams and the National Safeguarding Steering Group.

The Counter Terrorism and Security Act (2015), places a specific duty on statutory bodies including the police, LA's and health organisations to have 'due regard' to help prevent people being drawn into terrorism. The Channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) is a legal requirement for public bodies across the country.

**Policy and Governance**

The Trust maintains a standalone Prevent Policy - Protecting Those Vulnerable to Exploitation and Radicalisation Through a Multi-Agency Approach (Policy Reference 305). In 2025/26, the policy was reviewed and updated to reflect:

- Changes to the Prevent agenda, including emerging ideologies.
- Improvements to the structure and flow of the document.

The revised policy is awaiting ratification in 2026/27.

**Information Requests and Referrals**

**Requests for Information**

Relevant information is requested by the police on behalf of the Channel Panel Chair from partner agencies to assess referred individuals and determine appropriate support. In 2025/26:

- 39 requests for information were received and responded to—a continued increase compared to previous years.
  - 18 requests related to children.
  - 20 requests related to adults.
  - 8 requests were associated with routine six-monthly reviews.

**Prevent Referrals**

- 3 Prevent concerns raised by frontline practitioners resulted in referrals to the police via the Prevent pathway.
- No outcome feedback was received for these referrals, limiting assurance regarding subsequent actions.

**Training and Compliance**

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| | • Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP) training remains integral to all levels of Protecting Vulnerable People (PVP) training.<br>• Compliance is monitored via PVP through SAG and PSQB.<br>• Quarterly submissions on Prevent training compliance have continued throughout 2025/26, with all returns submitted within the required timescales.<br><br>The Trust achieved full compliance for all levels of Prevent training by the end of 2025/26.<br><br>**Multi-Agency Collaboration**<br>The Named Nurse for Safeguarding Adults continues to attend quarterly Wirral Prevent Strategic Partnership meetings. These meetings:<br>• Identify local risks and priorities.<br>• Support the development and delivery of the multi-agency Wirral Prevent Strategic Partnership Delivery Plan.<br><br>**Key Achievements and Next Steps**<br>Achievements<br>• Updated the Prevent Policy to reflect emerging ideologies and improve structure.<br>• Responded to 39 requests for information, demonstrating proactive engagement with the Prevent agenda.<br>• Achieved full compliance for Prevent training across all levels.<br>• Strengthened multi-agency collaboration through active participation in Wirral Prevent Strategic Partnership meetings.<br><br>**Next Steps**<br>• Await ratification of the revised Prevent Policy in 2026/27.<br>• Explore ways to improve feedback mechanisms for Prevent referrals to enhance assurance following compliance with the pathway.<br>• Continue to monitor and improve compliance with Prevent training and multi-agency collaboration. |
| **1.8** | **Multi-Agency Public Protection Arrangements (MAPPA)**<br><br>Multi-Agency Public Protection Arrangements (MAPPA) is a process through which the Police, Probation and Prison Services work together with other agencies to assess and manage the risks posed by individuals convicted of serious violent, sexual and terrorism offences living in the community to protect the public. They were established by the Criminal Justice Act 2003 and are operated locally by 42 Strategic Management Boards across England and Wales.<br><br>MAPPA are not a statutory body but are a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner by working together, sharing information and joint planning. Agencies at all times retain their full statutory responsibilities and obligations.<br><br>Professionals assess all MAPPA managed individuals to establish the risk of harm they pose to the public and develop individual risk management plans to minimise those risks. |

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| | There are four categories of individuals who are managed through MAPPA:<br>**Category 1** - Those subject to notification requirements under Sexual Offences Act 2003.<br>**Category 2** - Those convicted of mainly violent offences who have been sentenced to 12 months or more in custody or to detention in hospital and are now living in the community.<br>**Category 3** - Other dangerous individuals who have committed an offence in the past and are considered to pose a risk of serious harm to the public.<br>**Category 4** - Those subject to notification requirements under the Counter-Terrorism Act 2008<br><br>The Trust is classed as a DTC agency (Duty to co-operate) and may have a role to play in protecting the community from the risks presented by individual MAPPA offenders and therefore attend as a core panel member.<br><br>**Performance and Activity**<br>In 2025/26, the safeguarding team attended 69 MAPPA meetings, covering 35 individual cases - a significant increase from 40 meetings for 17 individuals in 2024/25. This rise reflects the growing complexity of cases and the increased need for multi-agency collaboration to manage high-risk individuals within Wirral.<br><br>**Risk profiles and case characteristics**<br>The 35 cases discussed at MAPPA meetings involved individuals with diverse risk factors, including:<br>• 20 perpetrators of domestic abuse.<br>• 8 individuals with known sexual offences or posing a risk to women.<br>• 9 individuals assessed as high risk to staff.<br>• 9 individuals with links to organised crime groups.<br>• 6 individuals with known mental health conditions.<br>• 14 individuals known to carry weapons, including firearms.<br>• 3 individuals who had previously caused injury to children.<br><br>These profiles underscore the significant responsibility placed on the Trust to work collaboratively with partner agencies to mitigate risks and ensure public safety.<br><br>**Safeguarding Measures**<br>To enhance staff safety and awareness, the Trust has implemented the following measures:<br>• Electronic record flags: All identified patients subject to MAPPA have a flag applied to their electronic medical record, clearly indicating their risk level.<br>• Staff guidance: Flags advise staff to contact the safeguarding team for further information and advice, ensuring appropriate precautions and support are in place. |
| **1.9** | **The Domestic Abuse Act (2021)**<br>The Domestic Abuse Act (2021) aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. Most of the provisions in the Act will be brought into force by commencement regulations, once the necessary preparatory work has been completed, for example, the making of court rules or the issue of guidance. |

**Training and Policy Framework**

Domestic abuse and harmful practices are fully embedded across all levels of Protecting Vulnerable People (PVP) training, equipping staff with the skills to risk assess victims of domestic abuse effectively.

The Trust has two dedicated policies to support both patients and staff:

- Domestic Violence and Abuse Policy (Reference: 035) – Guides staff in supporting patients.
- Domestic Abuse Workplace Policy: Support for Staff (Reference: 344) – Provides guidance for staff experiencing domestic abuse.

A dedicated lead for Domestic Abuse and Harmful Practices (Named Midwife for Unborn) ensures both patients and staff receive support following disclosures or concerns.

**Referrals and Staff Support**

- 264 referrals related to domestic abuse were received by the Safeguarding Team in 2025/26 - a slight increase from 248 in 2024/25.
- 8 members of staff were supported by the Safeguarding Team following disclosures of domestic abuse in 2025/26—a slight decrease from 10 in 2024/25.

**Key Trends and Data**

- Physical abuse was the most common disclosure of domestic abuse (100 referrals).
- 146 Police notifications were received for information-sharing purposes with maternity staff. These notifications relate to patients who are pregnant or have given birth within 4 weeks of a domestic abuse police call-out, enabling the Trust to offer safeguarding support to these individuals and their unborn or newly born babies.

**Embedding Domestic Abuse Routine Enquiry**

The domestic abuse routine enquiry questions have been embedded within Cerner since 2019/20, ensuring all patients aged 16 and above are given the opportunity to disclose concerns. Compliance is monitored through:

- Daily IT reports.
- The Trust audit programme.
- Compliance in Emergency Departments continues to require improvement and is monitored by the division and reported into the SAG. Despite minimal improvement over the last three years, an improvement plan has been requested to ensure consistent implementation.

**Risk Assessment and Multi Agency Risk Assessment Conference (MARAC) Referrals**

The domestic abuse CAADA-DASH risk assessment is embedded within Cerner, enabling practitioners to:

Identify high-risk cases of domestic abuse, stalking, and honour-based violence.

Support decision-making for referrals to the MARAC.

In 2025/26, the Trust referred 35 high-risk domestic abuse victims to MARAC—an increase from 25 in 2024/25.

**Domestic Abuse Related Death Reviews (DARDR)**

The Trust contributed to 7 new Domestic Abuse Related Death Reviews (DARDR) in Wirral. These reviews:

- Are first discussed at a consideration panel to determine if they meet the threshold for a full review.
- Await Home Office approval and publication; identified learning specific to the Trust will be shared, implemented, and monitored through the SAG and mandatory/bespoke training.
- The Domestic Abuse Lead attended review meetings for 3 DARDR cases that opened in 2025/26. Each case involves multiple meetings before the report is finalised and submitted to the Home Office.

**Domestic Abuse and Suicide Pilot**

In 2025/26, the Safer Wirral Partnership Board requested agencies to participate in a pilot to review records and identify any known concerns relating to domestic abuse for individuals who have died by suicide. The pilot:

- Commenced in February 2026.
- 3 referrals were received and reviewed in 2025/26.

**Digital Improvements**

Work has commenced with the IT department and WCHC Safeguarding Team to develop domestic abuse documentation within Cerner. The aim is to:

- Complete and implement the work by the go-live date for the Urgent and Emergency Care Upgrade Programme in 2026/27.
- Provide staff with better tools to offer and implement safeguarding measures for patients disclosing domestic abuse.

**Harmful Practices: Protecting Vulnerable Individuals**

**Understanding Harmful Practices**

Harmful traditional practices are forms of violence, primarily committed against women and girls, which have been accepted as cultural norms in certain communities. Common forms include:

- Forced or early marriage
- ‘Honour’-based violence
- Female Genital Mutilation (FGM)

**Trust Position on Harmful Practices**

- 16 referrals relating to identified cases of FGM were received in 2025/26—a decrease from 21 in 2024/25. All referrals were identified by midwifery services at the point of women booking into maternity care.

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| | • The Urology department has implemented FGM routine enquiry questions within their services. Quarterly audits will monitor compliance with results reported to the SAG. To date, no referrals have been received from Urology in 2025/26.<br>• No referrals were received for harmful practices outside of FGM during the year.<br><br>**Key Achievements and Next Steps**<br>• Increased referrals to MARAC, improving support for high-risk victims.<br>• Active participation in DARDR.<br>• Pilot initiative launched to review domestic abuse concerns in suicide cases.<br>• Digital improvements underway to enhance documentation and support for staff and patients.<br>• FGM routine enquiry implemented in Urology, with compliance monitoring in place.<br><br>**Next Steps**<br>• Improve compliance with domestic abuse routine enquiries in ED through targeted action plans.<br>• Monitor and implement learning from DARDR and pilot initiatives.<br>• Complete and roll out the digital improvements for domestic abuse documentation in Cerner.<br>• Continue to strengthen multi-agency collaboration to support victims of domestic abuse and harmful practices. |
| **1.10** | **People in Positions of Trust (PiPOT) Managing Staff Allegations Trust Approach to Staff Allegations**<br><br>The Trust is committed to taking all incidents or allegations of abuse seriously, treating them in accordance with WSCP and WSAPB procedures. Allegations against staff are managed through the PiPOT policy and process, ensuring a structured, transparent, and safeguarding-focused response.<br><br>Allegations that do not require safeguarding involvement are managed via the divisions and Human Resources. Bi-weekly meetings are held with Human Resources and the Risk Manager to monitor the progress of cases and ensure all required actions are completed.<br><br>**Trust Position and Performance**<br>**Staff Allegations Overview**<br>• 93 staff allegations were received during 2025/26 - an increase of 5 compared to 2024/25.<br><br>**Safeguarding and Reporting Processes**<br>• Allegations requiring safeguarding reporting processes are also reported to:<br>➢ The Designated Nurse/Professional Lead for Adults/Children.<br>➢ The Local Authority Designated Officer (LADO) for children's concerns.<br>• Staff allegations data and information are reported via the SAG for wider learning and assurance and with exception to the PSQB. |

**Management and Coordination of Staff Allegations**

- Divisions are responsible for the management and coordination of staff allegations.
- Safeguarding representation are invited to participate in fact-finding meetings to determine if the PiPOT criteria are met and to initiate any required safeguarding actions.
- This process is audited quarterly by the Associate Director of Nursing for Safeguarding to ensure compliance and is shared via SAG.
- Audit findings continue to identify areas for improvement, including:
  - Meeting timeframes for completing fact-finds.
  - Ensuring timely recording of minutes.

**Key Achievements**

- Increased reporting and transparency in managing staff allegations, with 93 allegations received in 2025/26.
- Strong multi-agency collaboration by involving safeguarding in fact-finding processes and reporting to the LADO and Designated Nurse/Professional Lead.
- Improved compliance monitoring through annual audits and action plans, ensuring adherence to safeguarding procedures.
- Enhanced learning and assurance by sharing staff allegations data with the PSQB and SAG for wider organisational learning.

**Next Steps**

- Continue to monitor and improve compliance with PiPOT processes, ensuring timely completion of fact-finds and recording.
- Review and update PiPOT policies and processes to align with evolving safeguarding best practices.

## 2 Protecting Vulnerable People Mandatory Training (PVP)

The Trust's PVP Strategy ensures all staff receive role-specific safeguarding training aligned with national frameworks and legislative requirements. This includes:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Intercollegiate Document, 2025).
- Safeguarding Adults: Roles and Competencies for Healthcare Staff (Intercollegiate Document, 2024).

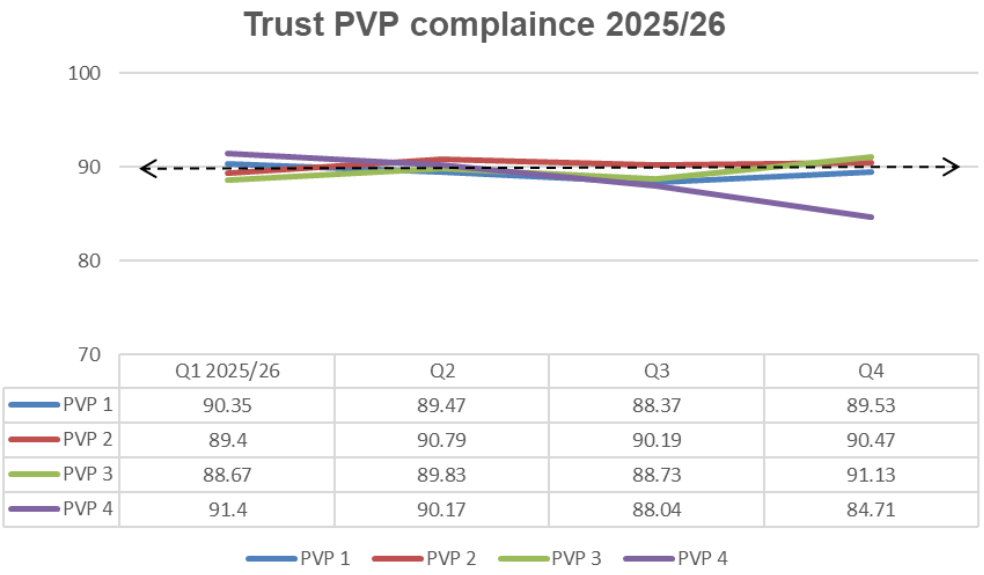
By embedding these standards, the Trust ensures staff are equipped with the knowledge and skills to safeguard patients effectively.

**Training Delivery and Compliance**

- PVP Levels 1–3 is delivered via eLearning.
- Level 3 (PVP 4) includes face-to-face training to meet additional requirements as outlined in the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Intercollegiate Document, 2025).

**Compliance Performance (2025/26)**

The Trust's mandatory training compliance target is 90% for all PVP levels which is set as part of the CMICB commissioning standards contract. While Levels 2 and 3 met this target, Levels 1 and 4 fell short. (See the graph below for detailed compliance data.)




| | Q1 2025/26 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| PVP 1 | 90.35 | 89.47 | 88.37 | 89.53 |
| PVP 2 | 89.4 | 90.79 | 90.19 | 90.47 |
| PVP 3 | 88.67 | 89.83 | 88.73 | 91.13 |
| PVP 4 | 91.4 | 90.17 | 88.04 | 84.71 |

**Divisional Performance**

At the end of Q4 2025/26, 12 divisional areas achieved compliance. Divisional performance is summarised below:

| Division | PVP 1 | PVP 2 | PVP 3 | PVP 4 |
|---|---|---|---|---|
| **Surgery** | 91.90% | 95.82% | 91.72% | 90.00% |
| **Medicine** | 88.68% | 91.11% | 90.14% | 83.21% |
| **Emergency Department** | 85.19% | 78.18% | N/a | 77.11% |
| **Women's and Children** | 88.68% | 85.45% | 89.66% | 88.60% |
| **Diagnostics & Clinical Support** | 86.83% | 89.27% | 94.38% | 85.71% |
| **Corporate** | 87.50% | 75.00% | 89.58% | 100.00% |
| **Estates & Facilities** | 92.19% | 96.30% | 100.00% | N/a |
| **Volunteers** | 92.97% | N/a | N/a | N/a |

**Focused Training and Support**

Throughout the year, the Trust provided bespoke training to address specific needs, including:

- Lessons learned from incidents and multi-agency reviews.

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| | • Findings from WISE audits.<br>• Requests from managers, particularly around the Mental Capacity Act (MCA).<br><br>**Assurance and Quality Monitoring**<br>**Wirral Individual Safe Care Every Time Accreditation Programme (WISE) Audits**<br>(Note: PVP compliance impacted overall scores)<br>• 32 inspections/audits were completed in 2025/26 (up from 27 in the previous year).<br>• Focused support and training were provided in areas requiring improvement.<br>• The average audit score was 92.4%, an improvement from 88% the previous year.<br><br>**Aligning with National Standards**<br>In May 2024, NHS England mandated the adoption of the Core Skills Training Framework (CSTF) and eLearning for healthcare content. The Trust has made progress by:<br>• Agreeing a memorandum of understanding to recognise staff as compliant for Trust PVP training if they provide evidence of national package training and competencies, along with completion of a Training Needs Analysis (TNA).<br>• The Associate Director of Nursing for Safeguarding is leading this work in collaboration with the Learning and Development Manager via the Trust's Subject Matter Experts Network Group.<br>• The project was expected to be completed by October 2025, however NHS England packages remaining the development stages, once available the Trust will transition over which is expected 2026/27.<br><br>**Priorities for 2026/27**<br>• Achieve 90% compliance for PVP Levels 1 and 4.<br>• Expand bespoke training to address specific learning needs and gaps.<br>• Monitor progress on the CSTF alignment project and ensure timely implementation.<br>• Continue to drive divisional performance through targeted support and accountability. |

| 3 | Governance Arrangements for Safeguarding |
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| 3.1 | **Safeguarding Assurance: Strengthening Oversight and Accountability**<br>The SAG and PSQB play a pivotal role in ensuring the Trust's safeguarding arrangements are robust, compliant, and effective. Through quarterly meetings, SAG provides challenge, assurance, and oversight, monitoring compliance with safeguarding standards, including the SAAF and mandatory training requirements.<br><br>Chaired by the Director of Nursing, the SAG includes divisional representation and safeguarding leads, fostering a collaborative and Trust-wide approach. The Associate Director of Nursing for Safeguarding provides quarterly oversight reports to the SAG, subsequent chairs report to the PSQB for further assurance and governance oversight. |

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| | In 2025/26, the Trust held 3/4 SAG meetings, ensuring regular monitoring and accountability. This structured approach reinforces the Trust's commitment to safeguarding excellence and continuous improvement.<br><br>(See Appendix 5 for the Trust's governance structure.) |
| **3.2** | **Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults and NHS England's Data Collections Framework (DCF) for Prevent, Children Looked After and the Safeguarding Commissioning Assurance Toolkit (SCAT).**<br><br>The SAAF clearly defines the safeguarding roles and responsibilities for all individuals working in NHS-funded care settings and commissioning organisations. This framework ensures that safeguarding is embedded as a core function of the Trust's operations.<br>• Quarterly submissions are made to the CMICB, providing assurance of compliance with safeguarding responsibilities.<br>• The SAAF commissioning standards support a consistent, high-quality approach to safeguarding across the region.<br>• Compliance is monitored via the SAG, with any areas of non-compliance escalated to the PSQB as required.<br><br>**Data-Driven Safeguarding Assurance**<br>The Trust participates in NHS England's Data Collections Framework (DCF), submitting data for:<br>• Prevent.<br>• Children Looked After.<br>• Safeguarding Commissioning Assurance Toolkit (SCAT).<br><br>Trust continues with quarterly submissions and achieved compliance with 27 out of 28 standards of the SCAT. An action plan has been developed to address the remaining gaps, focusing on training and patient engagement. Progress is actively monitored through the SAG.<br><br>**Addressing Key Areas for Improvement**<br>A6: Patient Engagement<br>A6.1: The Trust ensures it provides appropriate and accessible information about its safeguarding duties to the public.<br>**Gap identified**: Accessible Information Standards (AIS) remain a Trust-wide challenge.<br>**Action taken**: The Associate Director of Nursing for Safeguarding escalated challenges in AIS at the Patient Experience Group with a view to drive improvements. Further exploration to be undertaken as part of the organisational changes and merges with WHCH.<br><br>As art of the SCAT analysis (although not a direct action of the SCAT) the Associate Director of Nursing identified VIP Celebrity and Representative Policy (302) as requiring a strengthened processes for monitoring visitors on-site.<br><br>**Actions taken:** |

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| | Initial discussions held with the Head of Communications and Director of Corporate Affairs.<br>Agreed to include a visitor event record as part of the policy review.<br>The policy was ratified and published in October 2025, with safeguarding input to ensure alignment with best practices.<br><br>The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB. The Cheshire and Merseyside SAAF commissioning standards support a consistent approach to quality assurance. |
| **3.3** | **Safeguarding Incident Reporting**<br><br>**Integrated Safeguarding Incident Management**<br>The Trust has implemented a robust system for recording and managing safeguarding incidents, ensuring compliance with national reporting requirements and facilitating multi-agency learning. All safeguarding incidents—both internal and external—are recorded in the Trust's Safeguard database, providing a centralised and secure record.<br><br>Once received, incident documentation is logged into Cerner, ensuring that all staff have access to safeguarding information and can respond appropriately to identified risks.<br><br>**National Reporting and Escalation**<br>The Safeguard system automatically reports relevant safeguarding incidents to the National Reporting and Learning System. This ensures that the Trust contributes to national learning and continuous improvement in safeguarding practices.<br>Where necessary, alerts are escalated to:<br>• CMICB.<br>• CQC.<br>This ensures that serious incidents receive appropriate oversight and action at a regional and national level.<br><br>**Expert Oversight in PSIRF Meetings**<br>The Associate Director of Nursing for Safeguarding (or a deputy) attends the Trust's weekly PSIRF meetings. This ensures:<br>• Safeguarding and MCA expertise is integrated into incident reviews.<br>• A comprehensive overview of safeguarding incidents is provided.<br>• Learning and actions are identified to prevent recurrence and improve patient safety.<br><br>**Clinical Incident Management for Non-Safeguarding Concerns**<br>For concerns that do not meet the thresholds for statutory safeguarding investigations, the safeguarding team completes clinical incident forms. These are sent directly to the divisions for investigation and review, enabling them to:<br>• Identify potential gaps in processes outside safeguarding.<br>• Implement corrective actions to improve care and safety. |

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| **3.4** | **Safeguarding Supervision and Support**<br><br>Safeguarding supervision is a formal, structured process that supports practitioners by enhancing their knowledge, skills, and confidence in managing complex safeguarding cases. The Trust utilises two key mechanisms: providing case-specific advice and ensuring practitioners have the necessary expertise to handle safeguarding issues effectively.<br>This approach is underpinned by national guidance, including Working Together to Safeguard Children (2026), which highlights supervision as essential for maintaining a focus on a child's welfare and enabling practitioners to reflect critically on their decisions. Similarly, the Care Act (2014) emphasises that skilled supervision is vital for adult safeguarding, supporting practitioners to deliver high standards of practice while acknowledging the emotional demands of this work.<br><br>The Trust ensures safeguarding supervision is provided to all practitioners handling safeguarding cases, supported by the Safeguarding Supervision Policy (Reference 247), which was reviewed in Q4 2024/25 and is next due for review in December 2027. Supervision is delivered through monthly drop-in sessions in the Emergency Department for both adults and children. The Trust also offers quarterly group supervision through peer reviews in Paediatrics and Women's and Children's divisions, attended by the Named Nurse for Safeguarding Children and CLA.<br><br>All Named Professionals access supervision from Designated Professionals and are 100% compliant with SAAF KPIs. Since 2023/24, the Women and Children's Division has led on ensuring compliance with safeguarding supervision, reporting progress to the SAG. Supervision has been redistributed to include newly trained supervisors from April 2025, and the safeguarding team currently supports 30 staff members in this division. |
| **3.5** | **Care Quality Commission (CQC)**<br><br>We are delighted to celebrate the service's Level 3 rating for Safeguarding in the Care Quality Commission (CQC) report published on 24 October 2025, following an onsite inspection of our Urgent and Emergency Services carried out from 12 to 14 May 2025. Scoring a 3 out of 4 (Good), the report highlights that our staff consistently respond quickly and appropriately to safeguarding concerns while working effectively with healthcare partners to protect individuals' right to live in safety. |

| **4** | **Complex Care** |
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| | Complex Care within Wirral University Teaching Hospital includes Learning Dusabilties (LD), Autism Spectrum Disorder (ASD) and Motor Neurone Disease (MND). The Safeguarding and Complex Care Practitioners, part of the Trusts wider all age Safeguarding Team, play a dual role supporting patients, families, carers and specialist teams during our patient's journey through the hospital.<br><br>Their work includes: |

- Reasonable adjustments and person-centered care planning, utilising tools like Hospital Passports.
- Collaboration with multi-agency partners, such as the Local Authority and Community Learning Disability Services.

Additional support includes:

- MCA advice.
- Liaising with community teams to address barriers like prolonged discharge.
- Admission avoidance planning and dispute resolution when local efforts are insufficient.
- Specialist advice to support complaint responses.

This ensures tailored, compassionate care for some of the most vulnerable patients.

The Complex Care Team plays a vital role in meeting a number of National Quality requirements indicators as set out in the CMICB quality schedule contract. To uphold this commitment, the Trust submits a biannual compliance report which includes Reasonable Adjustments, Learning Disability Improvement standards, Equity of access, mortality reviews and learning from deaths (LeDeR).

**Learning Disability Improvement Standards**

The Trust participates in the Learning Disability Improvement Standards review, a national data collection commissioned by NHS Improvement and managed by the NHS Benchmarking Network. This initiative assesses the Trust's compliance with the Learning Disability Improvement Standards and identifies opportunities for improvement.

In Round 8 (2025/26), the focus was on four key standards:

- Respecting and protecting rights.
- Inclusion and engagement
- Workforce
- Learning disability services (for specialist mental health trusts)

The benchmarking exercise for Round 8 was successfully completed in Q4 (March 2026), setting the foundation for future improvements.

- A draft toolkit is expected in Q1 2026/27, enabling a detailed analysis of the Trust's performance before final results are released.

**Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) overview**

The Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) programme, funded by NHS England and NHS Improvement, aims to improve care, reduce health inequalities, and prevent premature deaths for people with a learning disability and/or autism. The Trust conducts mortality reviews for all such deaths in hospital, presenting findings at the Mortality Review Group (MRG) and sharing them with LeDeR.

During 2025/26, CMICB LeDeR did not hold any Community of Practice forums to share regional learning or service updates. However, regular LeDeR resources, communications and briefing updates continued to be circulated to participating organisations to support ongoing learning and service development.

Across the Northwest region, the three Integrated Care Boards have collectively reviewed future arrangements for the delivery of the LeDeR programme. Following this review, a single Northwest LeDeR Shared Service has been identified as the preferred and most sustainable model for implementation during 2026/27.

To support the transition and reduce the backlog of reviews, a GP record review has been introduced for all deaths as a triage process to identify cases requiring a more detailed review where new learning may be identified.

**Trust Position (2025/26)**

During 2025/26, the Trust reported 20 deaths and completed 24 MRGs, including retrospective reviews from the previous year.

The analysis of these reviews revealed that 83% (20/24) were graded 0 or 1, indicating that care was appropriate or that any concerns identified were unlikely to have affected the outcome. Two cases (8.3%) identified concerns that may have impacted outcomes; these have been escalated through the Trust's governance processes to support organisational learning.

Respiratory conditions accounted for 62.5% of the deaths reported in 2025/26. Recurring themes included gaps in MCA documentation, DNACPR recording, and reasonable adjustment compliance and record-keeping.

Despite these challenges, the reviews highlighted several areas of positive practice. There was strong evidence of compassionate, patient-centered end-of-life care, with families actively involved and early interventions from palliative care teams. The Trust also demonstrated commitment to reasonable person-centered adjustments, enhancing dignity and experience through measures such as the use of familiar carers, funded by the Trust during admissions. Furthermore, where Complex Care Teams were involved, patients experienced improved outcomes and care experiences.

The Trust has made meaningful progress in aligning with LeDeR's objectives, using insights from mortality reviews to drive improvements in care. While recurring themes such as documentation and compliance require continued focus, the identification of positive practices—particularly in end-of-life care and reasonable adjustments—reflects a dedication to delivering high-quality, person-centered services.

**Complex Care: Progress, Challenges, and Future Plans**

In 2025/26, the Trust launched a bi-annual complex care report to provide a Trust-wide overview of complex care activity. The report:

- Highlights alignment with quality schedule indicators.
- Is shared with the SAG and PSQB to ensure transparency and accountability.

**Strengthening Data Collection and collaboration**

Data collection for complex care began in Q3 2025/26, with ongoing development to improve quality and accuracy. Moving into 2026/27, enhanced data will support the design of improved services for LD and ASD.

To further expand collaboration across the Cheshire and Mersey footprint, a Cheshire & Wirral Acute LD Liaison and LD Services Network meeting has been established. Scheduled to commence in 2026/27 and aims to connect services, share priorities, resources and agree collective areas for improvement.

**Patient Attendance Trends**

In 2025/26, 427 patients with LD and/or ASD attended the hospital. Analysis for the second half of the year revealed that 35% of the 226 attendances were frequent attenders, with common presentations including respiratory distress, seizures, or behavioral crises.

**Supporting Staff with Daily Flagged Patient Lists**

A daily list of flagged patients is shared with the Complex Care Team via the BI portal. This list includes patients with a learning disability or difficulty, Cerebral palsy and Autism. The list enables the team to review medical notes, add documentation to prompt staff to complete Reasonable Adjustment risk assessments and care plans and consider MCA assessments, which also acts as a prompt to contact the team for advice or support during admissions.

**Raising awareness**

The Trust proudly participated in Learning Disability Week 2025/26, hosting a series of engaging and informative events to promote awareness, inclusion, and understanding:

- Mencap's interactive visit, which included staff surveys and a tour of the Surgical Elective Admissions Lounge sensory room, fostering greater awareness among staff.
- The first walkabout with the Community LD Team, designed to promote their services and highlight referral pathways for smoother patient discharges.
- An LD health promotion stall in the main entrance, attended by key partners such as the Chesire and Wirral Partnership Community LD Team, Healthwatch, and Postivitree, which provided valuable insights and resources.

These events not only raise awareness but also strengthened collaboration within the Trust and the wider community.

**Oliver McGowan Mandatory Training (OMMT) – Annual Report Summary (2025/26)**

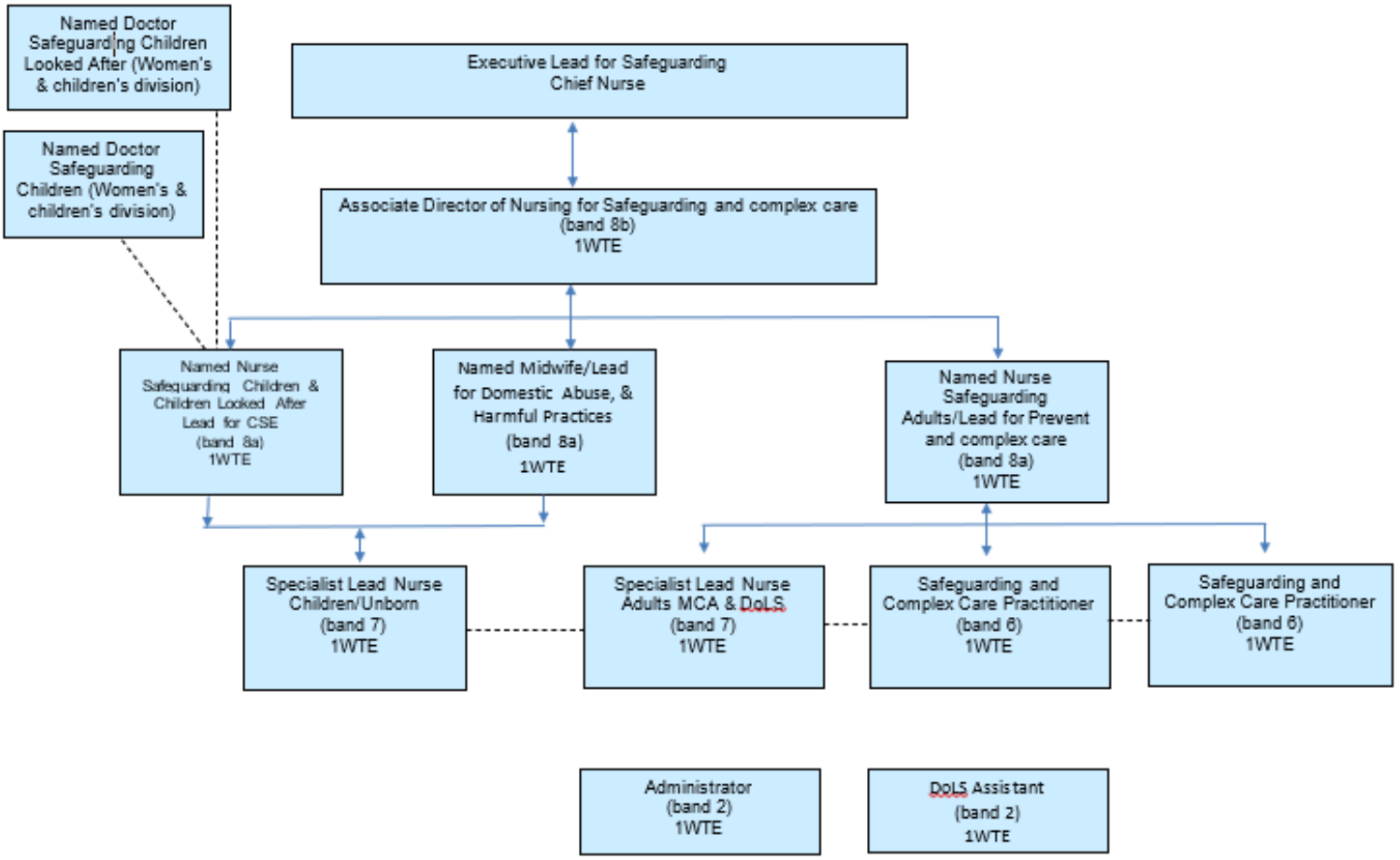
The Oliver McGowan Mandatory Training (OMMT) on Learning Disability and Autism is a legal requirement for all CQC-regulated service providers in England, mandated since 1 July 2022 under the Health and Social Care Act 2022. Named after Oliver McGowan, the training aims to improve care for autistic people and individuals with learning disabilities. It consists of Part A, a 90-minute eLearning module for all staff, and Part B, which includes a 1-hour webinar (Tier 1) or a full-day face-to-face session (Tier 2) for staff with direct care responsibilities.

By the end of Q4 2025/26, the Trust achieved an 83.1% compliance rate, with 5,306 staff completing the training. Since September 2025, 10 Part B Tier 2 sessions have been delivered, supported by CPD funds, benefiting 155 staff. An additional 20 sessions have been commissioned with Wirral Autism Together, prioritising registered nurses, nursing associates, midwives, and AHPs.

| | |
|---|---|
| | While progress is strong, Estates and Facilities lag behind with 39.74% compliance. The Trust is addressing this through targeted interventions and is monitoring progress under Trust risk 1366.<br><br>Overall, the Trust remains committed to embedding OMMT, ensuring high-quality, person-centred care for autistic people and individuals with learning disabilities. Focus will continue on improving compliance and expanding training opportunities in 2026/27. |

| 5 | Forward Look – Strategic Priorities and recommendations 2026/27 |
|---|---|
| | To build upon the successes of 2025/2026 and address identified delivery gaps, the Safeguarding and Complex Care teams will prioritize the following workstreams for the upcoming reporting period:<br><br>**Regulatory Compliance & National Mandates**<br>• **NHS England CP-IS Mandate**: Complete the full organisational rollout of the Child Protection Information Sharing system to all remaining wards immediately upon IT Spine integration approval. This keeps the Trust on track to achieve full compliance ahead of the national December 2026 mandate.<br>• **Oliver McGowan Training Recovery**: Target interventions within the Estates and Facilities division to improve their baseline compliance - eLearning part A (currently 39.74%), driving the overall Trust framework toward the national 90% target.<br>• **PVP Training Alignment**: Achieve the strict 90% contract target for PVP Level 1 and Level 4 training tiers across underperforming clinical divisions.<br>• **Core Skills Training Framework (CSTF)**: Monitor and implement the delayed NHS England national package transition to align internal Training Needs Analysis (TNA) configurations directly with CSTF guidelines.<br><br>**Local Process Optimisation & Governance**<br>• **Emergency Department Routine Enquiries**: Design and implement a targeted action plan within the Emergency Department (ED) to improve static compliance rates for domestic abuse routine enquiries.<br>• **Discharge and Pressure Sore Mitigation**: Embed the learning points from statutory S42 investigations into divisional workflows. This will specifically target and strengthen acute discharge assessments and pressure sore prevention pathways.<br>• **Complex Care Network Expansion**: Officialise the launch of the Maternity Passport pathway during Learning Disabilities Week (Q1) and activate the newly established Cheshire & Wirral Acute LD Liaison and Services Network to share regional resources.<br>• **Refinement of Legal Documentation**: Continue to improve the recording of explicit desired outcomes for individuals involved in adult safeguarding referrals and monitor the upcoming Supreme Court ruling regarding the Deprivation of Liberty "acid test" parameters.<br>• **Drive Compliance and MSP Principles:** Bridge the gap between policy and frontline practice by leveraging the newly redesigned MAR process—integrated with the UECUP Programme and Wirral Community Health and Care Trust to improve patient outcome recording and push overall compliance beyond the 56% baseline. |

## Appendices
## Appendix 1 – Team Structure



## Appendix 2 – Key Definitions

### Definitions

Safeguarding: The Care Quality Commission (CQC) states; ‘Safeguarding means protecting people's health, wellbeing, and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care’ (CQC, 2022).

Safeguarding Children: A child is defined within the Children Act 1989 as “an individual who has not reached their 18th birthday”, the fact that a child may:

- Live independently
- Is a parent themselves
- Is in custody
- Is a member of the armed forces

does not change their entitlement to protection under The Children Act (1989). This is important because young people aged 16 and 17 years with safeguarding needs access, ‘adult’ services in the Trust and are seen and treated by adult trained and registered staff who may not acknowledge this entitlement.

Safeguarding Adults: An adult is an individual aged 18 years or over.

The Care Act (2014) defines an ‘adult at risk’ as:

- An adult who has care and support needs (whether the needs are being met or not).
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All Wirral University Teaching Hospital NHS Foundation Trust (WUTH) all staff have a statutory responsibility to safeguard and protect those who access their care regardless of their position in the organisation. However, some defined named safeguarding roles exist, they include:

### Named Professionals.

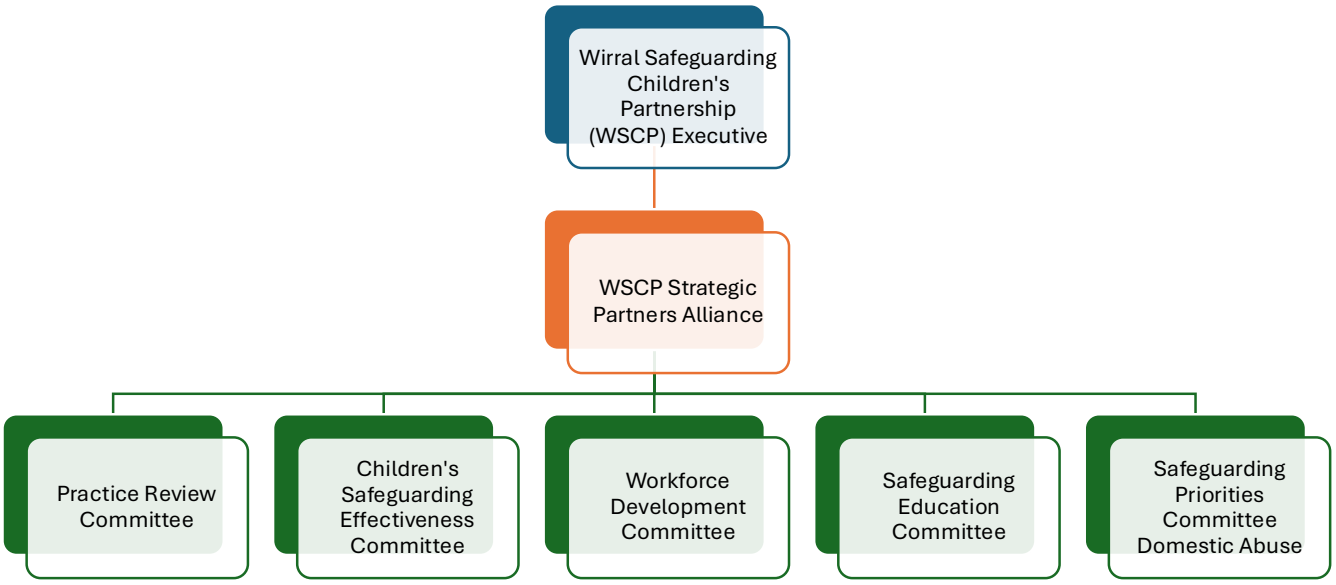
Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2024) and Children (2025).

All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

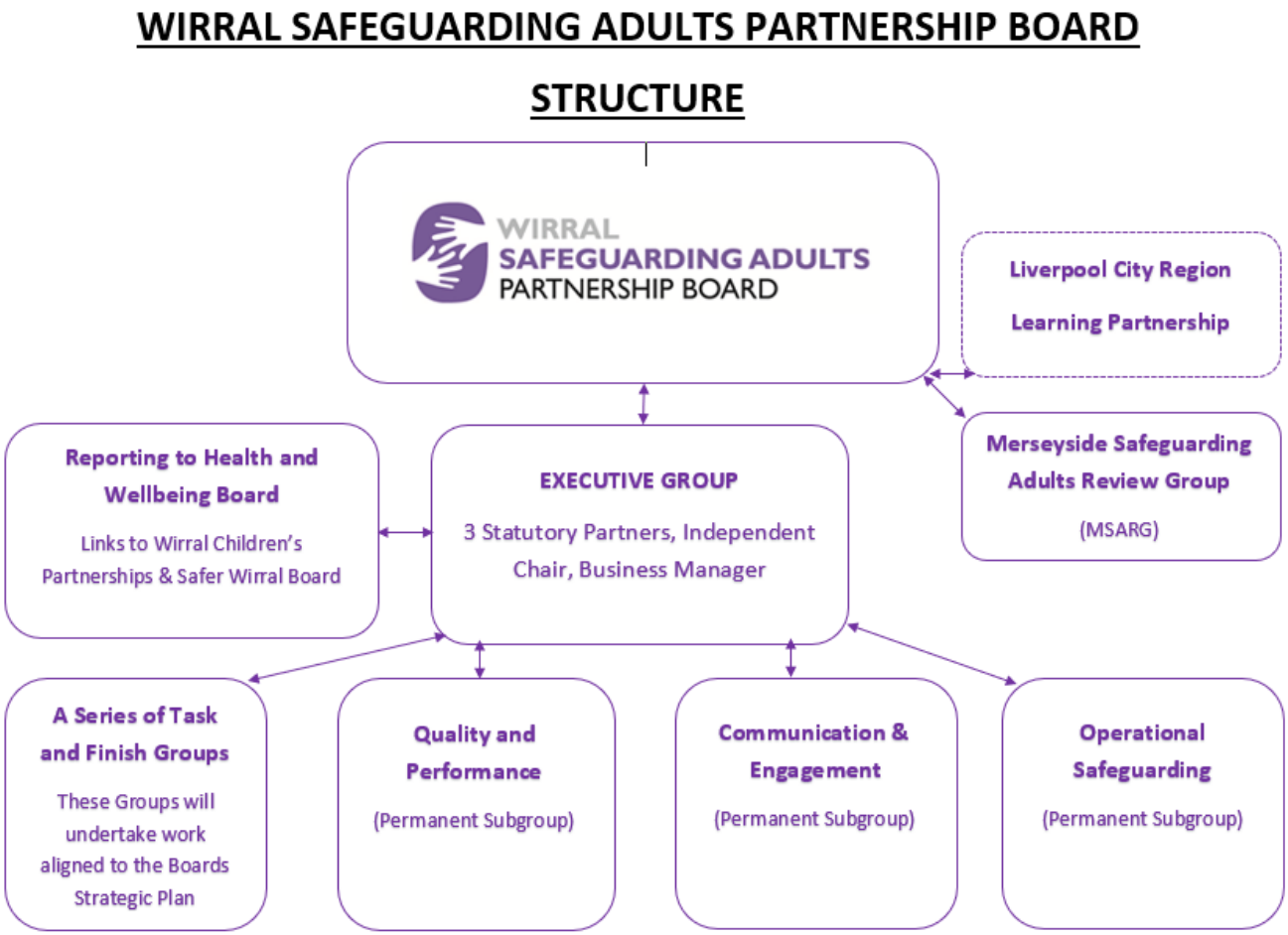
From April 2025 - March 2026 the WUTH named professionals were:
- Named Doctor for Children and Young People – Dr Lauren Edwards
- Named Doctor for Children Looked After – Dr Halycon Royden
- Named Nurse for Children and Children Looked After – Nicola Denton
- Named Professional (Nurse) for Adults – Helen Newell
- Named Midwife – Michelle Beales

## Appendix 3 – Wirral Safeguarding Children's Partnership Structure

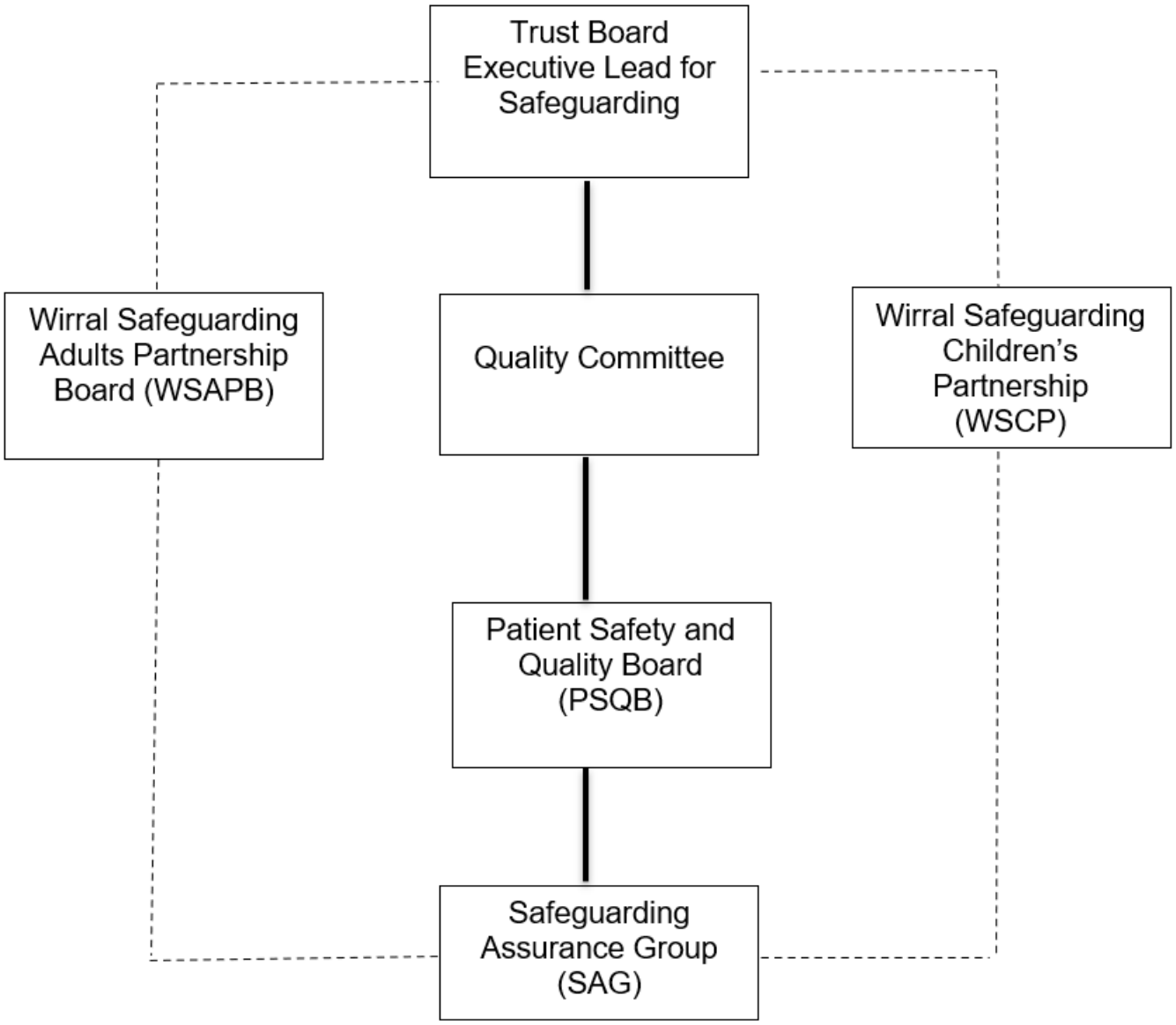
### Wirral Safeguarding Children's Partnership Structure



## Appendix 4 – Wirral Safeguarding Adults Partnership Board Structure



## Appendix 5 – Trust Governance Structure



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

**04 November 2026**

| | |
|---|---|
| **Title** | WCHC Safeguarding Annual Report 2025/26 |
| **Area Lead** | Chris Doulas, Joint Chief Nursing Officer |
| **Author** | Jude Blease, Head of Safeguarding |

| **Purpose of the Report and Recommendation** | |
|---|---|
| **Report For** | Assurance |

The purpose of this report is to present the Wirral Community Health and Care NHS Foundation Trust (WCHC) Annual Safeguarding Report: 01 April 2025 – 31 March 2026 to the Group Board for assurance.

It is recommended that the Board:

- Be assured by the 2025/26 Annual Safeguarding Report

## Key Points to Note

- Note and approve action update from previous committee
- The annual report highlights achievements during 2025-2026
- The report provides a synopsis of the excellent work completed by the Safeguarding Team throughout the year including an overview of our daily business activities to ensure our communities remain safe
- The report also contains future priorities for 2026-2027

## Key Risks

This report relates to the following BAF risks:

- The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks
- 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 | No |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 21.09.26 | Safeguarding Assurance Group | Annual Safeguarding Report | Approved |
| 28.09.26 | Quality and Safety Committee | Annual Safeguarding Report | Approved |

| 1 | Narrative |
|---|---|
| 1.1 | **Annual Safeguarding Report**<br>WCHC is committed to ensuring that all staff are aware of their role in relation to safeguarding vulnerable children and adults.<br><br>The Safeguarding Service provides a comprehensive proactive provision, which responds to the needs of staff and individuals. The service is committed to the promotion of safeguarding within everyday practice, focusing upon prevention and early intervention, ensuring that all statutory functions are discharged, and that best practice is adhered to, thereby equipping the workforce to undertake their duties and fulfil personal and organisational responsibilities with regards to safeguarding the public.<br><br>The annual report highlights achievements during 2025/2026. It provides a synopsis of the excellent work completed by the Safeguarding Team throughout the year including an overview of our daily business activities to ensure our communities remain safe |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• No identified implications for the reporting period 2025-2026 |
| 2.2 | **People**<br>• No identified implications for the reporting period 2025-2026 |
| 2.3 | **Finance**<br>• No financial implications |

| | |
|---|---|
| **2.4** | **Compliance**<br>• As part of our Safeguarding Children, Young People, Children in Care and Adults at Risk Commissioning Standards the Annual Report should be presented at Board level with the expectation that this will be made public |

NHS

Wirral Community Health and Care

NHS Foundation Trust



# Safeguarding Annual Report 2025/26

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## Introduction

1. The purpose of this report is to provide assurance to Wirral Community Health and Care NHS Foundation Trust (WCHC) Board regarding activity in relation to safeguarding governance for the reporting period 01 April 2025 - 31 March 2026.

2. This report demonstrates continued organisational compliance with statutory duties and local safeguarding frameworks. A full index of abbreviations is listed in **Appendix 1**.

3. WCHC is committed to everyone, ensuring that safeguarding principles are placed at the heart of everything we do. We have an excellent reputation for safeguarding standards, and we take a proactive approach to promoting the wellbeing and welfare of the populations we serve.

4. Wirral Community Health and Care NHS Foundation Trust Safeguarding Teams provide support, advice, education, and training in safeguarding matters, to all our staff. Our aim is to ensure the prevention of harm, exploitation, and abuse of everyone, through the provision of high-quality care, responding effectively to concerns and allegations whilst working collaboratively with our partner agencies.

5. The Safeguarding Team assures, that all statutory functions are achieved, and that best practice is adhered to. This is to guarantee that all quality care delivered by our organisation promotes a safety culture that supports our vision. It places safeguarding and promotion of the welfare of children, young people, and adults at risk, above all other aims.

## Leadership & Governance

6. The Chief Nurse is the Executive Lead for Safeguarding providing strategic leadership across the organisation. The Executive Lead is responsible for ensuring that safeguarding is recognised as a key organisational priority and that it is embedded across all areas of service provision within the organisation.

7. All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children, a Named Nurse for Children Looked After, and a named professional (Named Nurse) for Adults to provide expert advice and support to Trust employees and promote good practice within the organisation as per the Children Act (2004) and Care Act (2014).

8. The Trust's Safeguarding Team is led by Head of Safeguarding, supported by named professionals who have specific roles for Safeguarding Adults and Children as described in the Intercollegiate Safeguarding Competencies for Adults (2024) and Children (2025). The team is supported by specialist nurses and administration staff across both adults and children.

9. Each operational team is supported by Safeguarding Link professionals for children and adult Safeguarding Champions.

## Key Achievements 01 April 2025 – 31 March 2026 - Time to Shine

### Trust wide:

10. The Safeguarding Team is committed to ensuring that all staff are aware of their role in relation to Safeguarding Children and Adults at Risk and consistently demonstrate organisational compliance with statutory duties and local safeguarding frameworks.

11. During 2025 and 2026, we have supported and successfully submitted evidence of compliance to Commissioners and Designated Professionals in relation to:

    - Section 11 of the Children Act 2004 for Wirral, Cheshire East, Knowsley and St Helens Place.

    - The Safeguarding Accountability and Assurance Framework (SAAF) for Safeguarding Children and Safeguarding Adults and the Quarterly KPI Reporting SAAF for Children in Care. During this period, we have received positive feedback from the Integrated Care Board (ICB) and our Public Health Commissioners.

    - In Q3 2023-2024 a two-year Commissioning Standards document was submitted to the ICB, and the Trust successfully showed a compliance RAG rating of 62 green areas and 1 amber rated area against 63 standards.

    - In Q3 2025-2026 a new two-year Commissioning Standards document was completed, and our self-assessment remains unchanged with a compliance of 62 green and 1 amber against 63 standards, giving an overall compliance rate of 98.4%. We are waiting for this latest process to be quality assured by the ICB for confirmation of our rating.

    - We have provided data to the NHSE data collection framework for our Looked After Children (Children in Care) and Prevent datasets to support the counter terrorism strategy. All identified Female Genital mutilation (FGM) has also been reported via the NHSE FGM dataset.

    - We participated in one SEND inspection. We have also continued to support three ILACS outcomes and participated in follow up inspections, which have provided plans to build on achievements and allow us to work towards further improved services across the partnership.

    - The Safeguarding Team have completed 17 audits throughout 2025-2026 to measure our continuous quality improvement, identify any learning and provide assurance.

12. Throughout the year, the Safeguarding Team has also worked to support all Trust services and our partner agencies to ensure our staff provide the best possible service, to continue to keep our communities safe.

    - Our Safeguarding Strategic Plan 2025-2027 was updated with four goals identified. Good assurance has been evidence against these goals and approved by the Trust's Quality and Safety Committee.

- As part of Safeguarding Adult Week November 2025, the Safeguarding Adults Team hosted an online training event on ‘Cuckooing’ and held a Safeguarding adult stall in the foyer of St Catherines to create awareness.

- We represented the Trust at a multi-agency Safeguarding Adults Partnership Board event.

- The Safeguarding Adult Team have led three campaigns to raise awareness to Trust staff during 2025-2026:

    - ‘Adult abuse has an offline Impact’
    - ‘Domestic Abuse support’ and
    - ‘No excuse for Adult Abuse’

- We have completed a Trust wide Mental Capacity Act Audit and 193 responses across all adult services. The audit showed a strong level of understanding of the Mental Capacity Act. A Mental Capacity Act Audit for children was also completed across the four places which provided good assurance.

- An annual walkabout was completed with staff within the Community Intermediate Care Centre by the Safeguarding Adult Team to provide assurance around Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Bespoke visits have been conducted by Safeguarding Adult Team to Trust teams including Sexual Health, Community Nursing, Wheelchair Service and Rehab at Home to allow for question and answers on ‘Safeguarding, Mental Capacity Act and Domestic Abuse.

- During November, the Adult Team held a Safeguarding Champion celebration event. Certificates and badges were presented for those staff that achieved their competency.

- We have continued to work in partnership with Merseyside Police with preventative measures to support safer sleep across Wirral, St Helens and Knowsley Place. WCHC have shared information with Cheshire Constabulary for consideration of implementation in their area working in collaboration with Cheshire East Partnership.

- We have represented the Trust at a Wirral multi-agency Safeguarding Children's Partnership learning event which saw over 300 professionals attend and 30 agencies promote their services including WCHC Safeguarding Team, Family Nurse Partnership and Sexual Health Wirral.

- Throughout the year Wirral Place has delivered training sessions to over 30 foster carers covering the teenage brain and sexual health information.

- The Safeguarding Children Team have developed a programme of bitesize training sessions and delivered 45 of these sessions across the Trust including; bespoke training to support services, professional meetings and individual learning events covering various subjects, including but not exhaustive: Child Sexual Abuse (CSA), the Mental Capacity Act (MCA), Voice of the Child, Domestic Abuse and Neglect.

- Together the Safeguarding Team have trained 887 staff across the Trust to a Level 3 standard for Adults and Children.

- The Safeguarding Team assumed responsibility for attendance at Channel Panel for Wirral Place and a similar process has been adopted across Cheshire East, St Helens Place and Knowsley in support of the Prevent programme to address the causes of radicalisation, in support of the 0-19 and 0-25 services that we offer.

- The Named Nurse Knowsley has worked with the Dynamic Support Database Team (DSD) to support sibling groups presenting with significant Mental Health difficulties to ensure best outcomes.

- Children's Safeguarding has conducted visits to nine teams across Wirral, four teams in Cheshire East, four in St Helens and two in Knowsley, to support the walkabout audit.

- The Specialist Children's Safeguarding Nurses were recognised for their outstanding work in St Helens Place winning the Trusts "Stand Out Award."

- In 2025 the Named Nurse in St Helens has delivered two lunch and learn sessions to the 0-19 workforce and to the wider Trust in support of the Patient Safety Incident Response Framework (PSRIF) on Family M and Child O following Local Child Safeguarding Practice Reviews (LCSPR) sharing learning to support practice.

- The Head of Safeguarding and the Named Nurses have supported the changes across the four Local Authorities as part of the Families First Partnership Programme representing the Trust at the operational Multi-Agency Child Protection and Board meetings. Wirral Place have been instrumental with the specialist nurse post who is co -located within the Local Authority and works in collaboration with all health provisions for Wirral and alongside our partners, Merseyside Police, Wirral Local Authority and education colleagues.

- Neglect is a key priority for St Helens and Knowsley Children's Partnership. The Safeguarding Teams have worked collaboratively as part of the working group developing a new Neglect screening tool to support the identification and response to tackling Neglect across the two Boroughs.

- The Named Nurse for Knowsley has supported the revision of a Standard Operating Procedure and Memorandum of Understanding for Children Looked After, working with our 0-25 Service Lead, Merseycare NHS Foundation Trust and the Public Health Commissioners to ensure a more effective service is delivered to the children of Knowsley.

- Cheshire East Cared for Team have attended the Safeguarding Partnership Learning Week to promote and educate other professionals on the roles of Safeguarding Specialist Nurses, Child Exploitation Nurse and Children in Care Nurses

- WCHC have continued to support the delivery of multi-agency child exploitation training for the Cheshire East Partnership throughout the year delivering training to over 175 multi-agency professionals.

- Cheshire East Safeguarding Team have supported the development and implementation of a strategy plus process. This new process has enabled actions to be completed at an early stage for families where there is significant cause for concern. This has also allowed for reactive supervision sessions to take place in a timelier manner for such occurrences.

- Following the changes to both the process and documentation of Initial Health Assessments, the Named Nurse has supported with the delivery of training on the Initial Health Assessment Checklist with Child Social Care.

- The quality initiative continues to support robust data collection. A monthly meeting is held between Safeguarding, Business Intelligence and System Support representatives to identify and improve data collection for audits, and reporting both locally and nationally.

- Throughout the year the Head of Safeguarding has represented the Trust at the Wirral Safeguarding Adults Partnership Board, the newly formed Wirral Safeguarding Children Alliance Group, Cheshire East Safeguarding Children Partnership Board, St Helens Safeguarding Children Partnership Forum and Knowsley Safeguarding Children Partnership Forum.

- Compliance with safeguarding training and supervision remains positive across all services.

- Throughout the year the below safeguarding policies have been reviewed and updated to ensure they meet current legislation.

    - SG02 Safeguarding Children Policy and toolkit
    - SG06 Managing Allegations Policy

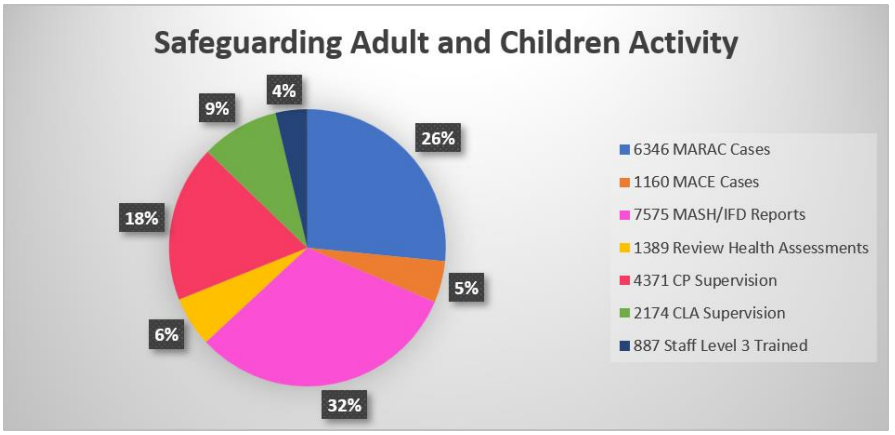
13. The Safeguarding Team provides a comprehensive proactive service, which responds to the needs of staff and individuals. We are committed to the promotion of safeguarding within everyday practice, focusing upon prevention and early intervention.

14. The table and pie charts below provide an overview of the range of our daily business activities as a Safeguarding Team. This data has also been captured under each place highlighting the bespoke work that is completed to continually safeguard our communities.

| Safeguarding Adult and Children 2025-2026 | Activities Trust Wide |
|---|---|
| **Number of cases heard and contribution to safety planning at MARAC** | **6346** |
| **Number of cases heard and contribution to safety planning at MACE** | **1160** |
| **Number of MASH / IFD requests** | **7575** |
| **Number of Review Health Assessments completed** | **1389** |
| **Number of supervision sessions completed for children on a Child Protection Plan** | **4371** |
| **Number of Child in Care cases discussed during supervision** | **2174** |
| **WCHC staff trained to Level 3 Safeguarding adult and children standard** | **887** |

15. The chart shows the range of some of the activities conducted by the Safeguarding Team as a percentage of their time throughout 2025-2026.

*MARAC – Multi Agency Risk Assessment Conference, MACE-Multi Agency Child Exploitation, MASH Multi Agency Safeguarding Hub, IFD Integrated Front Door



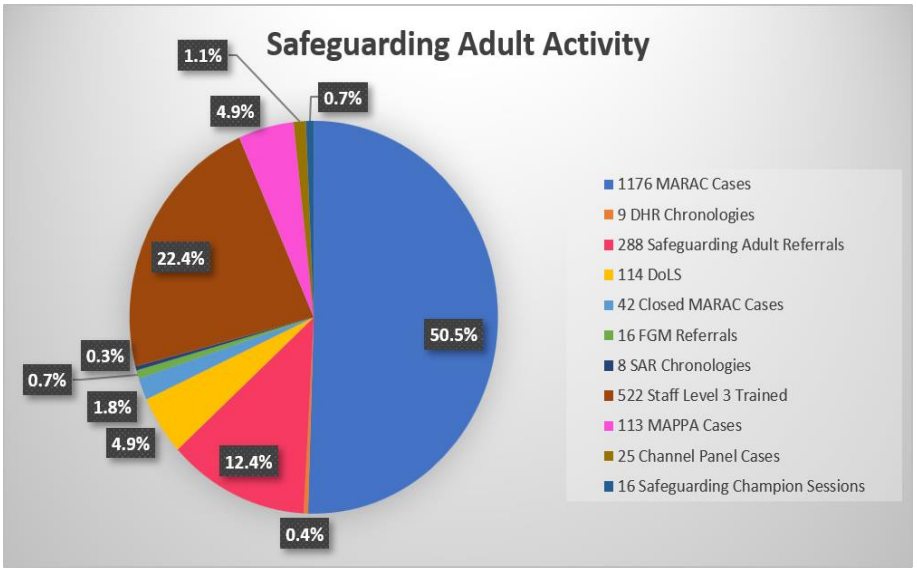

## Safeguarding Adults:

16. The table below shows a range of some of the activities conducted by the Adult Team throughout 2025-2026. There has been an increase in closed MARAC cases since 2024-2025 from 40 to 42. These cases are the highest risk and are often around honor-based abuse and forced marriage. The volume is increasing due to the criteria and Domestic Abuse legislation.

| Safeguarding Adults 2025-2026 | Activities |
|---|---|
| Number of cases heard and contribution to safety planning at MARAC | 1176 |
| Number of WCHC staff trained to Level 3 Safeguarding Adults standard | 522 |
| Number of safeguarding referrals into ASC CADT / MASH of these 25% were quality assured | 288 |
| Number of DoLS requested from CICC, which are monitored via Safeguarding Adults Team. | 114 |
| Number of heard cases and contributions to the safety planning within closed MARAC | 42 |
| Number of FGM referrals all of which were reported via NHS England dataset as required. | 16 |
| Number of SAR requests for chronologies for SAR consideration. | 8 |
| Number of DHR requests for chronologies for DHR consideration | 9 |
| Number of MAPPA meetings attended | 113 |
| Number of Safeguarding Champion sessions delivered including safeguarding supervision. | 16 |
| Number of cases researched to support Channel Panel | 25 |

17. The chart shows the range of some of the activities conducted by the Adult Team as a percentage of their time throughout 2025-2026.

*MARAC - Multi Agency Risk Assessment Conference, ASC - Adult Social Care, CADT - Central Advice and Duty Team, MASH - Multi Agency Safeguarding Hub, DoLS - Deprivation of Liberty Safeguards, CICC - Community Integrated Care Centre, FGM - Female Genital Mutilation, SAR Safeguarding Adult Review, DHR - Domestic Homicide Review.




## Safeguarding Children Wirral Place:

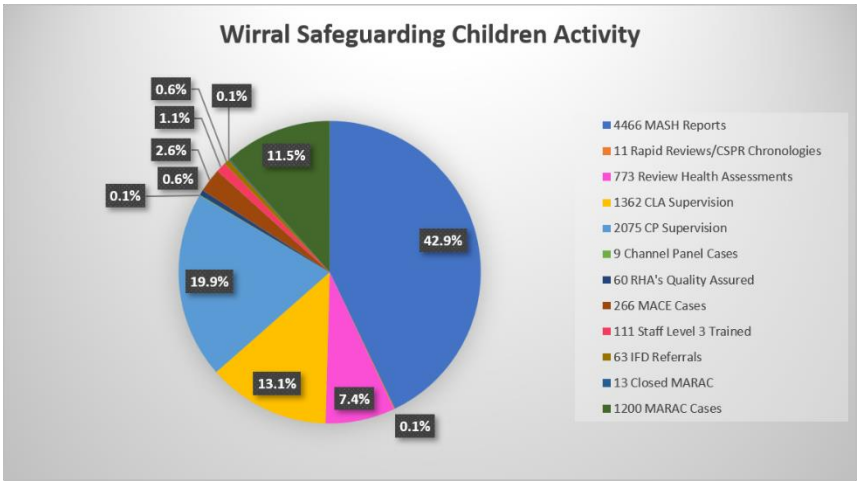
18. The table below shows a range of some of the activities conducted by Wirral Place Children Safeguarding Team throughout 2025-2026. There has been a significant increase in MASH requests rising from 2401 in 2024-2025, to 4466 MASH requests for 2025-2026, however this is predominately due to previous long-term sickness and more efficient recording processes that have since been put in place. The latter figure equates to 8166 service user (parties) records accessed. If we included all records accessed - GP, Cheshire Wirral Partnership Trust (CWP), and Wirral University Teaching Hospital (WUTH) systems, this would increase the number to approximately 17,864 requests or up to 32,664 service user records accessed adding significantly more time on each individual MASH screening.

| Safeguarding Children Wirral Place 2025-2026 | Activities |
|---|---|
| Number of MASH requests completed | 4466 |
| Number of WCHC services users records accessed for MASH requests | 8166 |
| Number of children researched to support the IDVA contribution to safety planning at MARAC | 1200 |
| Number of children discussed and contribution to safety plans at closed MARAC | 13 |
| Number of supervision sessions completed for Children Looked After | *1362 |
| Number of supervision sessions completed for children on a Child Protection Plan | 2075 |
| Number of Review Health Assessments completed | 773 |
| Number of Review Health Assessments quality assured | 60 |
| Number of cases heard and contribution to safety planning at MACE | 266 |
| Number of staff trained to Level 3 Safeguarding Children standard | 111 |
| Number of referrals made to IFD of which 100% are quality assured | 63 |
| Number of rapid reviews / CSPR chronologies completed | 11 |
| Number of cases researched to support Channel Panel | 9 |

19. The chart shows the range of some of the activities conducted by Wirral Place Childrens Team as a percentage of their time throughout 2025-2026.

*The data for CLA supervision includes where there has been twice yearly supervision.

* MASH Multi Agency Safeguarding Hub, MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door.




## Safeguarding Children Cheshire East Place:

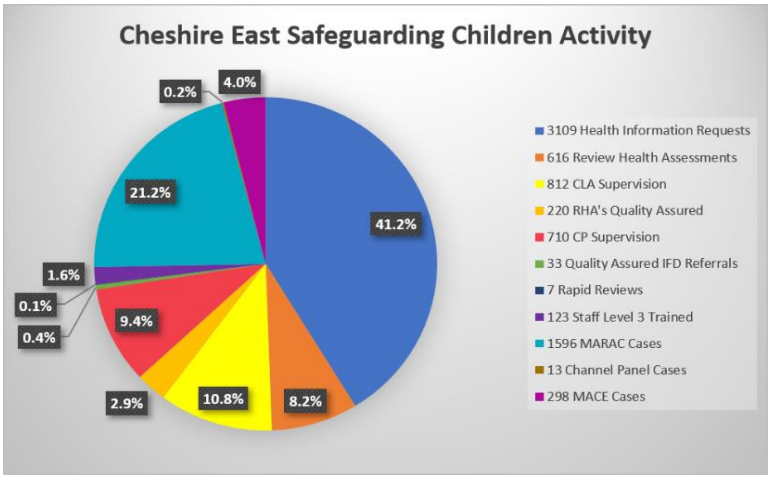
20. The table below shows a range of the activities conducted by Cheshire East Place Children Safeguarding Team throughout 2025-2026.

| Safeguarding Children Cheshire East Place 2025-20256 | Activities |
|---|---|
| **Number of IFD Health information requests completed with 0 breaches** | **3109** |
| **Number of children discussed and contribution to safety planning at MARAC** | **1596** |
| **Number of Review Health Assessments completed** | **616** |
| **Number of Supervision sessions completed for Cared for Children** | ***812** |
| **Number of Supervision sessions completed for children on a Child Protection Plan** | **710** |
| **Number of Review Health Assessments quality assured** | **220** |
| **Number of cases heard and contribution to safety planning at MACE** | **298** |
| **Number of staff trained to Level 3 Safeguarding Children standard** | **123** |
| **Number of referrals made to ChECS of which 100% quality assured** | **33** |
| **Number of rapid reviews / CSPR chronologies completed** | **7** |
| **Number of cases researched to support Channel Panel** | **13** |

21. The chart shows the range of some of the activities conducted by Cheshire East Place Safeguarding Childrens Team as a percentage of their time throughout 2025- 2026.

*The data for Cared for supervision includes where there has been twice yearly supervision

** MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door. CSPR Child Safeguarding Practice Reviews.



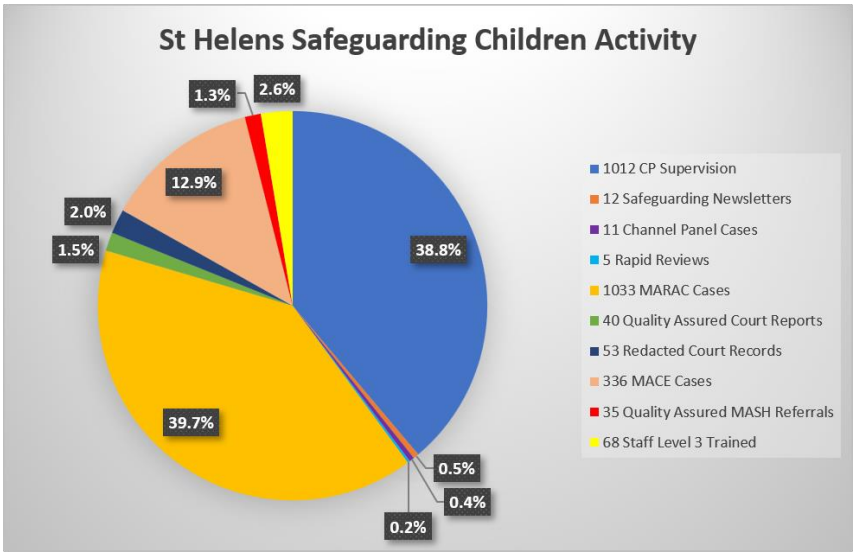

## Safeguarding Children St Helen's Place:

22. The table below shows a range of some of the activities conducted by St Helen's Place Children Safeguarding Team throughout 2025-2026.

| Safeguarding Children St Helens Place 2025-2026 | Activities |
|---|---|
| Number of children discussed and contribution to safety planning at MARAC | 1033 |
| Number of supervision sessions completed for children on a Child Protection Plan | 1012 |
| Number of cases heard and contribution to safety planning at MACE | 336 |
| Number of service user records redacted for court | 53 |
| Number of reports quality assured for 0-19 service for court | 40 |
| Number of staff trained to Level 3 Safeguarding Children standard | 68 |
| Number of referrals made to MASH of which 100% quality assured | 35 |
| Number of rapid reviews / CSPR chronologies completed | 5 |
| Number of Safeguarding Newsletters shared with 0-19 and Partner Agencies | 12 |
| Number of cases researched to support Channel Panel | 11 |

23. The chart shows the range of some of the activities conducted by St Helens Place Children's Safeguarding Team as a percentage of their time throughout 2025-2026.

*MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, MASH Multi Agency Safeguarding Hub, CSPR Child Safeguarding Practice Reviews



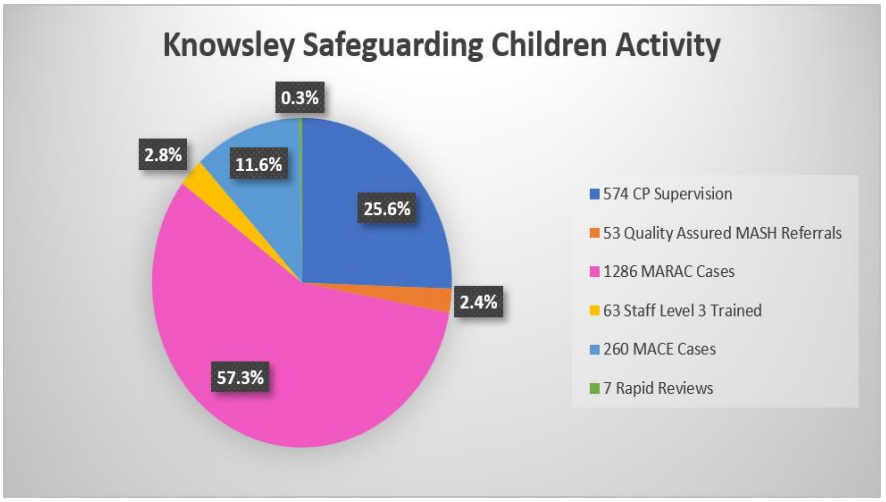

## Safeguarding Children Knowsley Place:

24. The table below shows a range of some of the activities conducted by Knowsley Place Children Safeguarding Team throughout 2025- 2026.

| Safeguarding Children Knowsley Place 2025-2026 | Activities |
|---|---|
| **Number of children discussed and contribution to safety planning at MARAC** | **1286** |
| **Number of supervision sessions completed for children on a Child Protection Plan** | **574** |
| **Number of cases heard and contribution to safety planning at MACE** | **260** |
| **Number of staff trained to Level 3 Safeguarding Children standard** | **63** |
| **Number of referrals made to IFD of which 100% are quality assured** | **53** |
| **Number of rapid reviews / CSPR chronologies completed** | **7** |

25. The chart shows the range of some of the activities conducted by Knowsley Place Childrens Safeguarding Team as a percentage of their time throughout 2025-2026.

*MARAC Multi Agency Risk Assessment Conference, MACE- Multi Agency Child Exploitation, IFD Integrated Front Door, CSPR Child Safeguarding Practice Reviews.



## Section 1: Analysis of Safeguarding Children Related Inspections

26. The below provides a summary of relevant inspections, none of which have taken place during 2025- 2026.

| Safeguarding Service | System wide Inspections | Outcome |
|---|---|---|
| **Wirral Safeguarding Children** | **ILACS<br>JTAI** | **Rated as Requires Improvement Sept 2023<br>Inspection Dec 2022** |
| **Cheshire East Safeguarding Children** | **ILACS<br>JTAI** | **Rated as Inadequate March 2024<br>Inspection July 2022 - Actions completed** |
| **Knowsley Safeguarding Children** | **ILACS<br>JTAI** | **Rated as Inadequate November 2024<br>Inspection July 2022** |
| **St Helens Safeguarding Children** | **ILACS<br>JTAI** | **Rated as Good July 2023<br>No JTAI – Joint Area Review 2008** |

27. In January 2018, Ofsted adopted the ILACS (Inspection of Local Authority Children's Services) framework for inspecting services for children in need of help and protection, children in care and care leavers. The framework outlines a system of inspection activity which focuses on the effectiveness of the following local authority services and arrangements;

- to help and protect children, and enable families to stay together and get the help they need
- the experiences and progress of children in care wherever they live, including those children who return home
- the arrangements for permanence for children who are looked after, in stable, loving homes, including adoption
- the experiences and progress of care leavers

Ofsted describes ILACS as a whole system of inspection which aims to apply a proportionate and risk-based approach.

28. Previously each organisation has been notified with details of the cases being reviewed and staff have formed part of any inspection, however more recent ILACS have concentrated on Local Authority staff only. All WCHC staff are briefed for any inspection and remain on standby throughout the whole process should the need arise for them to be called upon.

## Safeguarding Children Wirral Place:

29. **<u>Inspection of Local Authority Children's Services (ILACS)</u>**
Inspection dates: 18 to 29 September 2023
Graded: Requires improvement to be good in all areas.

30. What needs to improve – system wide actions:
- The response to 16- and 17-year-old homeless children, to ensure that they are made aware of their rights and entitlements.
- The awareness-raising and identification of, and response to, children living in private fostering arrangements.

- The quality of decision-making, to ensure that children come into care in a timely way.
- The timely progression of permanence plans for children, to ensure that they are not subject to statutory intervention for too long.
- Escalation by IROs, to robustly challenge plans for children.
- Transition planning for 16- and 17-year-old children in care, to ensure that they feel better prepared for leaving care.
- The offer to care leavers so that it is consistently accessible and understood to ensure that all care leavers receive their full entitlements.

31. WCHC are supporting the areas of improvement by ensuring the child's voice is always present and paramount to forming part of their care plan, for the future. WCHC 0-19 Teams complete the health assessments and complete the care leavers' health passport, empowering them with health information to take into the adult world of higher education, training or employment.

32. All practitioners are trained in the Systemic Practice model, looking at the family as a whole and focusing on early intervention. Wirral's Families First (Pathfinder) programme is part of wider government reform of children's services originally based on Stable Homes Built on Love and recently set out in the policy statement Keeping Children Safe, Helping Families Thrive.

33. There have been two focused inspections since the full inspection.

34. The first in September 2024 which found that whilst some progress has been made in relation to transition arrangements for 16–17-year-olds, provision of suitable accommodation, the complaints process and the accessibility of the local offer, there remains some variability in the quality of practice.

35. The second focused inspection took place in January 2026 and found that the Integrated Front Door continues to respond quickly and effectively to contacts regarding vulnerable children. Strategy discussions are well attended with effective information sharing. The profile and practice for children living in private fostering arrangements has been raised, joint processes for 16–17-year-olds presenting as homeless has strengthened and workforce stability has strengthened. However, there remains to be some delays in convening strategy discussions and initial child protection conferences for some children and inconsistencies exists in the quality and timeliness of assessments and management oversight.

36. **Joint Targeted Area Inspection (JTAI)**
The key findings from December 2022 JTAI of Early Help Services did not identify any actions directly for Health. As an integral part of the Wirral Childrens Safeguarding Partnership (WSCP), however, WCHC have worked closely with children's services to support changes to practice across 0-19 ensuring support for our families is identified at the earliest opportunity.

## Safeguarding Children Cheshire East Place:

37. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 26 February to 08 March 2024
Graded: Inadequate - Three areas require improvement to be good however the fourth area was rated as inadequate therefore the overall judgement is inadequate.

38. What needs to improve – system wide actions:
- Senior leaders' oversight of performance to ensure that there is a coherent approach to continuous improvement.
- The quality, consistency and responsiveness of support, advice and guidance for care leavers, including those who are homeless, with additional vulnerabilities, and those who are over 21 years of age.
- The quality of management oversight and supervision to ensure that consistent, good social work practice is in place.
- The quality of plans for children to ensure that they are more child-focused and drive forward positive change in a timely way.
- The quality and frequency of visits to children so that the visits are purposeful and in line with assessed needs.
- The sufficiency of suitable placements that can meet children and young people's assessed needs.
- The effectiveness of child protection chairs and independent reviewing officers (IROs) to escalate, challenge and scrutinise plans for children.

39. The inspection report was released in May 2024, and an action plan has been formulated and implemented, there are two main areas which relate to Health and the 0-19 Service:

- Health care summary passports
- Improvement in timely health assessments and information which includes initial health assessments and review health assessments.

40. Extensive work has been undertaken in relation to the Health Care summaries, including gathering children and young people's views on the document and their insight and ideas for improvement has continued. The Health Care summaries have been renamed for Cheshire East as "My Health Care Summary" and the document has been modernised to include QR codes to support services both locally and nationally. To further strengthen this, the My Health Care Summary is also now shared with the GP and submitted to the NHS App.

41. Monitoring visits – There have been two monitoring visits in June which identified areas of improvement such as, quality of plans, regular supervision, frequency of visits to children and challenge from child protection chairs and in October which demonstrated areas of improvement such as, children remaining with families. A positive shift in culture was also noted with people feeling listened to and an increased feeling of teamwork and optimism. It is recognised there is still some considerable work to be carried out.

42. **Joint Targeted Area Inspection (JTAI)**
Inspection dates: 11 to 15 July 2022. The report highlighted a heavy focus on processes rather than evaluation and systematic analysis of the frontline work across multi agency services. A comprehensive action plan for health was established in 2022 and completed during 2023.

43. In February 2024 the Department for Education DfE reported that systems and processes are in place to protect children who are at risk of, or are victims of, criminal and sexual exploitation and leaders are clear on their priorities to ensure the service continues to build on these foundations. As such, they were content to step down the specific JTAI related monitoring, provided that the Council maintained a tight grip on services and maintained the progress made so far.

## Safeguarding Children St Helen's Place:

44. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 10 to 21 July 2023
Graded: Good - Two areas good, experience and progress of children who need help and protection requires improvement and the experience and progress of care leavers is outstanding.

45. What needs to improve – system wide actions:
- The effectiveness of the response to children experiencing neglect.
- The timeliness of entering pre-proceedings for children who need this support.
- The response to 16- and 17-year-olds who are homeless.
- The stability and consistency of children's social workers.
- Safeguarding of disabled children.

46. WCHC continues to support 0-19 to attend appropriate training relating to Neglect. This ensures the workforce has the knowledge, skills and tools to respond to Neglect confidently and in a timely manner

47. The Safeguarding team have contributed and supported the development of a new Neglect screening tool with multi-agency professionals from St Helens & Knowsley. The tool will support 0-19 practitioners in their practice to recognise and respond to Neglect.

48. The 0-19 practitioners make certain the voice of the child and a child's lived experience is at the forefront of all decision-making securing positive outcomes for children in St Helens. The 0-19 Practitioners deploy professional challenges utilising the Safeguarding Children's Partnership multi-agency resolution procedure in order that best outcomes are achieved in a timely manner.

49. **Joint Targeted Area Inspection (JTAI)**
St Helens have not been subject of a JTAI in 2025-2026 the last being a Joint Area Review in 2008. The Safeguarding Children's Partnership alongside partner agencies have continued to prepare for any upcoming JTAI's with a focus on Child Sexual Abuse (CSA). Learning from recent Local Children's Safeguarding Practice Reviews (LCSPR) alongside resources from the Centre of Expertise on CSA are informing and supporting the work being completed.

## Safeguarding Children Knowsley Place:

50. **Inspection of Local Authority Children's Services (ILACS)**
Inspection dates: 18 to 29 November 2024.
Graded: Inadequate.

51. What needs to improve – system wide actions:
- The leadership capacity of social work practice which meets professional and practice standards, to drive the quality of social work interventions with children.
- The identification of, and response to, risk by social workers in relation to children in need and children subject to child protection plans.
- The quality of social work practice and management oversight for disabled children.
- The quality of social work practice, specifically assessments, plans and planning.
- The social work response to domestic abuse and neglect.
- The quality of help and support for children with vulnerabilities, specifically young carers and children aged 16 and 17 years who present as homeless.
- The quality of visiting and direct work with children and young people, including life-story work.
- The quality of support, advice and guidance for care-experienced young people, including those with additional vulnerabilities, to ensure that this is timely, consistent and responsive to levels of need, up to the age of 25.
- The caseloads of personal advisers (PAs), to enable them to provide timely advice, support and guidance to care-experienced young people.
- The quality of supervision and management oversight of social workers and PAs, so that children and young people receive a timely and consistent service that is responsive to their needs.

52. Monitoring visits – There have been two monitoring visits with a focus on Multi Agency Safeguarding the first visit report has not yet been published, and the second visit was in February 2026 which included the commitment of leaders to making the improvements needed, some firm foundations established to support the transformation of social work practice and more structured quality assurance processes underpinned by a new quality assurance framework. There is further improvement in the quality of social work practice with more work to do to achieve consistent outcomes.

53. **Joint Targeted Area Inspection (JTAI)**
Knowsley have not been subject of a JTAI in 2025-2026, the last being in 2022.

## Section 2: Statutory Framework and National Policy Drivers

54. There are significant differences in the laws and policies that shape how we safeguard children and adults. The legal framework to protect children is contained within the newly revised Working Together to Safeguard Children (2026) and for adults the Care Act (2014).

55. The overarching objective for both however is to enable children and adults to live a life free from harm, abuse, or neglect. The report provides a summary of how Wirral Community Health and Care discharges its statutory duties in relation to:

- Children Act (1989,2004)
- Working Together to Safeguard Children (2026)
- Section 11 of the Children Act (2004)
- Care Act (2014)
- Mental Capacity Act (2005),
- Deprivation of Liberty Safeguards amendment in (2007)
- Domestic Abuse Act (2021)
- Counter Terrorism and Security Act (2015)
- CQC Registration standards, Health and Social Care (2008) – Regulation 13: Safeguarding Service Users from abuse and improper treatment.

### Working Together to Safeguard Children (2026)

56. The Children Act (1989) and Section 11 of the Children Act (2004) places a statutory duty on all NHS Trusts to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions.

57. The statutory guidance, Working Together to Safeguard Children, was updated and the revised version published in December 2026.

- The guidance has reinforced expectations on leaders to create inclusive, anti-discriminatory cultures and that practitioners are expected to challenge racism and discrimination. There is strengthened guidance on certain types of harm such as, abusive behaviour in intimate relationships, coercive control, more hidden harms such as child sexual abuse (CSA) and teenage relationship abuse strengthens how safeguarding partners work together and with relevant agencies.

- It has clarified that Multi Agency Safeguarding Arrangements (MASA) responsibilities include children who are looked after and provided clearer detail on accountability structures and how safeguarding partners are inspected.

- New references address online harms and group-based exploitation. It reinforces that children may face multiple harms simultaneously and strengthened section 47 expectations for robust multi-agency assessments, direct work with the child and strategy discussions for child sexual abuse.

- Streamlining the chapter on learning from serious safeguarding incidents to provide clearer direction on when and how incidents should be notified and reviewed.

- Aligning with Families First Partnership programme reforms, including clarifying that Family Help now brings together Targeted Early Help and Section 17 support into a single, more seamless offer.

- Strengthening responses to child sexual abuse, domestic abuse and the safeguarding of babies, unborn children and children in any care arrangement, including those who are looked after.

## The Counterterrorism and Security Act (2015)

58. The Head of Safeguarding is the Organisational Lead for Prevent and attends the Prevent Board Meeting for Cheshire and will be attending the Prevent Strategic Partnership for Wirral 2026-2027. The Joint Chief Nurse is the Director Level Accountable Lead for Prevent.

59. There is a joined-up approach for Prevent with specialist leads from both Safeguarding Children and Safeguarding Adults within Wirral Place. There are further Specialist Child Safeguarding Leads in Cheshire East, St Helens and Knowsley who provide reports and attended meetings to support with Channel Panel on behalf of the Trust.

60. Preventing radicalisation training for the Trust includes Basic Prevent Awareness Level 1 and Prevent Awareness Level 3 training and has been designed to meet the relevant learning outcomes in the UK Core Skills Training Framework. Training is available to staff online via the Trust electronic training platform.

61. Prevent awareness training is also included within all levels of safeguarding adults and children training and the Trusts onboarding induction session. For 2026-2027 we are working to ensure all training levels are aligned to safeguarding adults and children training and recorded and included within the Trusts compliance reporting, specific to role required skills and knowledge.

62. Training compliance is provided on a quarterly basis to the ICB through the Safeguarding Accountability and Assurance Framework (SAAF) and nationally via the Prevent duty data set.

63. The Safeguarding Team provide advice and support for staff reporting cases and liaise with the Counter Terrorism Policing Northwest to share information to assist the Channel Panel process. The Trusts Prevent Lead ensures that staff are provided with the appropriate training in line with the contest framework.

64. Compliance for Prevent Training at the end of 2025-2026 reported at 96.6%.

65. In 2025-2026 information was shared from WCHC to Wirral Channel Panel regarding 25 adult cases and 9 children's cases have been referred to the panel

66. In 2025-2026 information was shared from WCHC to St Helens Channel Panel regarding 11 children's cases that have been referred to the panel.

67. In 2025-2026 information was shared from WCHC to Cheshire East Channel Panel regarding 13 children's cases have been referred to the panel.

## Section 3: Safeguarding Partnerships

### Wirral Safeguarding Adult Partnership Board (WSAPB)

68. Wirral Safeguarding Adults Partnership Board (WSAPB) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all adults at risk across Wirral. The partnership board includes senior managers from the Local Authority, local NHS services, Police, Fire and Rescue Services, Probation, Age UK Wirral, and Healthwatch.

69. The below diagram shows the Wirral Safeguarding Adults Partnership Board governance structure:




70. WSAPB developed three subgroups and a task and finish group to initiate key strands of the boards work.

71. The Named Nurse Safeguarding Adults attends the subgroups and the task and finish groups.

72. The Quality & Performance Group has made a commitment to look at qualitative data and develop a framework with Adult Social Care in order that the group will be able to identify themes and trends that will inform audit work.

73. The Communication and Engagement Group aims to ensure the experiences of local people, including adults at risk, carers, advocates, and those working with adults with care & support needs, are heard and used to improve the ways services work. A series of engagement sessions held with those that work within safeguarding on the Wirral which highlighted what is

working well and barriers that are faced with. The group also led on safeguarding adult week for WSAPB with a series of lunch and learn sessions delivered.

74. The Operational Subgroup aims to support the development and roll out of Adult Safeguarding policies and procedures and to ensure that partner agencies operate in accordance with them. It has been revised and will be publishing a new Multi-Agency Risk Assessment tool (MARAM). The group has overseen the roll out of Wirral Hoarding Improvement Project aimed at raising awareness of those that exhibit hoarding behaviours and hoarding hubs are now held to enable staff to present cases of concern. There is a plan to review the self-neglect toolkit and enable more support for staff around these very complex cases.

75. The Safeguarding Adults Review (SAR) sub-group is a collaboration between the Wirral, Knowsley, St Helens and Sefton Safeguarding Adults Boards. The group receives and considers all referrals and then makes a recommendation to the Chair of each Safeguarding Adults Board Chairs who will make the final decision.

76. In addition, the Board is keen to further develop its work with other partnerships on the Wirral such as the Children's Partnership, Safer Wirral Partnership and the Domestic Abuse Alliance for greater collaboration in the future to improve the support offered to all generations.

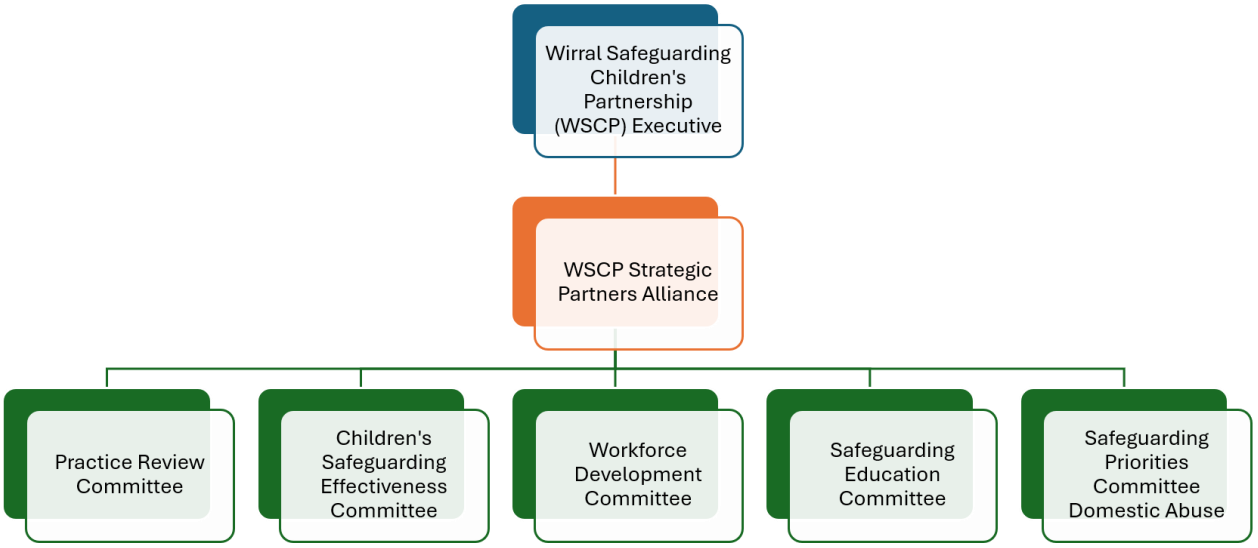
77. The Head of Safeguarding represents the Trust at the Wirral Safeguarding Adults Partnership Board.

## Wirral Safeguarding Children’s Partnership (WSCP)

78. Wirral Safeguarding Children's Partnership (WSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Wirral. The partnership consists of the Director of Children's Services, Superintendent Merseyside Police and the Associate Director Integrated Care Board.

79. The diagram below shows the Wirral Executive Committee governance structure: This has been updated to incorporate the Wirral Alliance Group, Families First and the merger of some committees.

## Wirral Safeguarding Children's Partnership Structure




80. WCSP has agreed shared priorities for the partnership for 2025-2026, which have been adopted by all areas to improve frontline multi-agency practice through working on the key identified priorities.

- Embedding Systemic Practice
- Strengthening the Relationship with the Education Sector
- Embedding Change: Working Together, Family Help, WSCP Structure and Social Work Framework.

81. The Named Nurse attends two of the Committees, Harm Outside the Home and Quality committee. The pre-birth liaison committee is attended by the 0-19 service, and the Case Review Committee is represented by the Designated Nurse and Doctor with named professionals attending by invitation. These meetings will change following the new structure as outlined above.

82. The Named Nurse has supported multi-agency audits as part of the Quality Committee with the most recent audit being Special Education Needs and Disabilities (SEND) and Education and Health Care Plan (EHCP)

83. The Head of Safeguarding represents the Trust at the Wirral Safeguarding Children Alliance and Strategic Pathfinders and Multi Agency Child Protections Team (MACPT).

84. Within Wirral Place the Section 11 Audit takes the form of six questionnaires over the year and evidence of compliance is included. The Named Nurses and Head of Safeguarding then attend a scrutiny panel to provide full assurance.

85. The Wirral Place Safeguarding Service have supported the introduction of the Families First Programme (Pathfinders), the new reforms across Child Social Care (CSC). The Head of Safeguarding and the Named Nurses are members of the Multi Agency Child Protection Team Operational, Strategic Groups and Families First for Children Board, writing terms of reference and shaping how the new team will function. As part of the funding a new post was created for

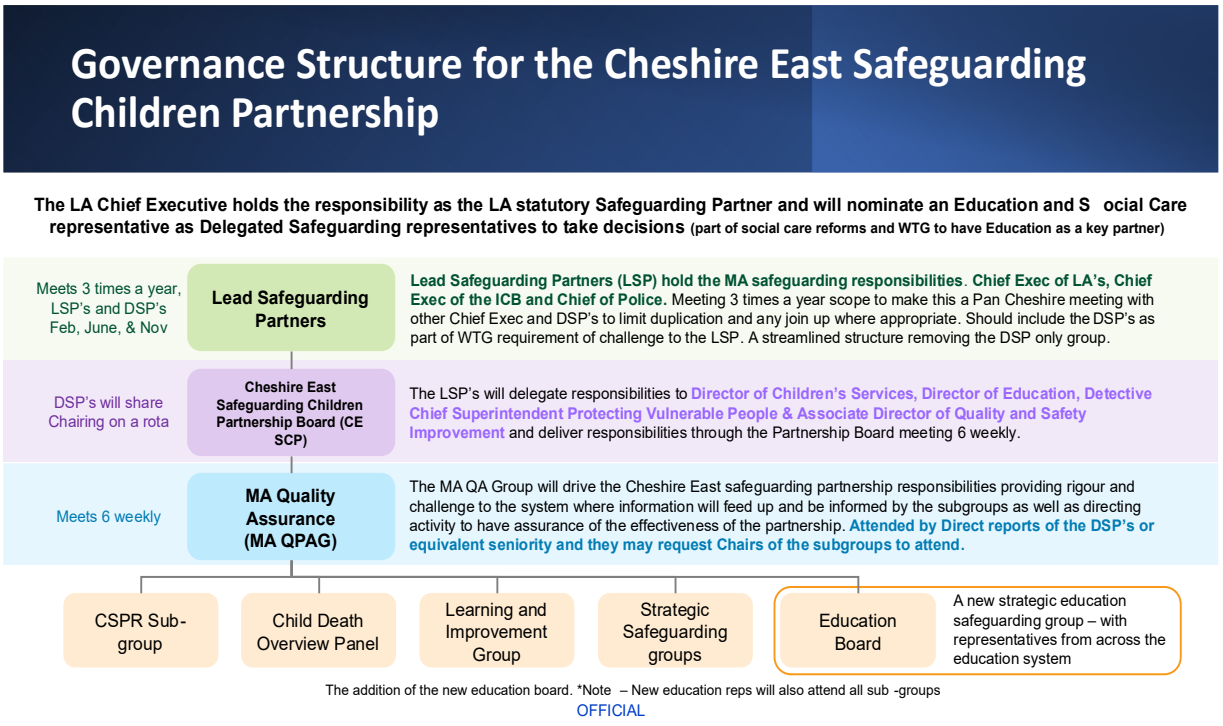
health hosted by WCHC and this saw a Specialist Nurse join the MACPT. A pilot covering East Wirral commenced will full role out expected late 2026.

86. During the reporting period, the WSCP held a very successful one day network event for all partner agencies on Wirral. This was attended by 300 staff with 30 partner agencies represented. The Safeguarding Children's Team attended supported by Sexual Health Wirral and the Family Nurse Partnership to raise awareness of the services offered by WCHC.

## Cheshire East Safeguarding Children's Partnership (CESCP)

87. Cheshire East Safeguarding Children's Partnership (CESCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Cheshire East. The partnership consists of the Director of Childrens Services, Chief Superintendent Cheshire Police and Associate Director Integrated Care Board.

88. The below diagram shows the Cheshire East Corporate Safeguarding governance structure.




89. CESCP agreed shared priorities for the partnership for supporting the protection and wellbeing of children and young people in Cheshire East:

- Contextual safeguarding
- Education as a protective factor
- Sexual abuse
- Neglect

90. WCHC has supported the priorities by the Named Nurse being an active part of the Neglect Strategic Board, Child Sexual Abuse Group, Child Exploitation Strategic Group, the Domestic Violence Partnership Task Group, and Learning and Improvement Group, Child Safeguarding Practice Review (CSPR) and Rapid Review sub-group.

91. Partnership Audits have been completed on contextual safeguarding, child protection, police protection powers and neglect. This is along with two further audits introduced last year examining adverse childhood experiences (ACE's) and child exploitation. These audits led to a larger piece of work to examine age of experiencing ACE's and if there is any correlation to vulnerability to exploitation. This work is ongoing through multi-agency collaboration, with the intention of identifying where distinct pieces of early help packages of care could be introduced to lower the risk factors.

92. The Head of Safeguarding represents the Trust at the Cheshire East Safeguarding Children Partnership Board, the Multi Agency Quality Assurance Group and the Integrated Front Door Board.

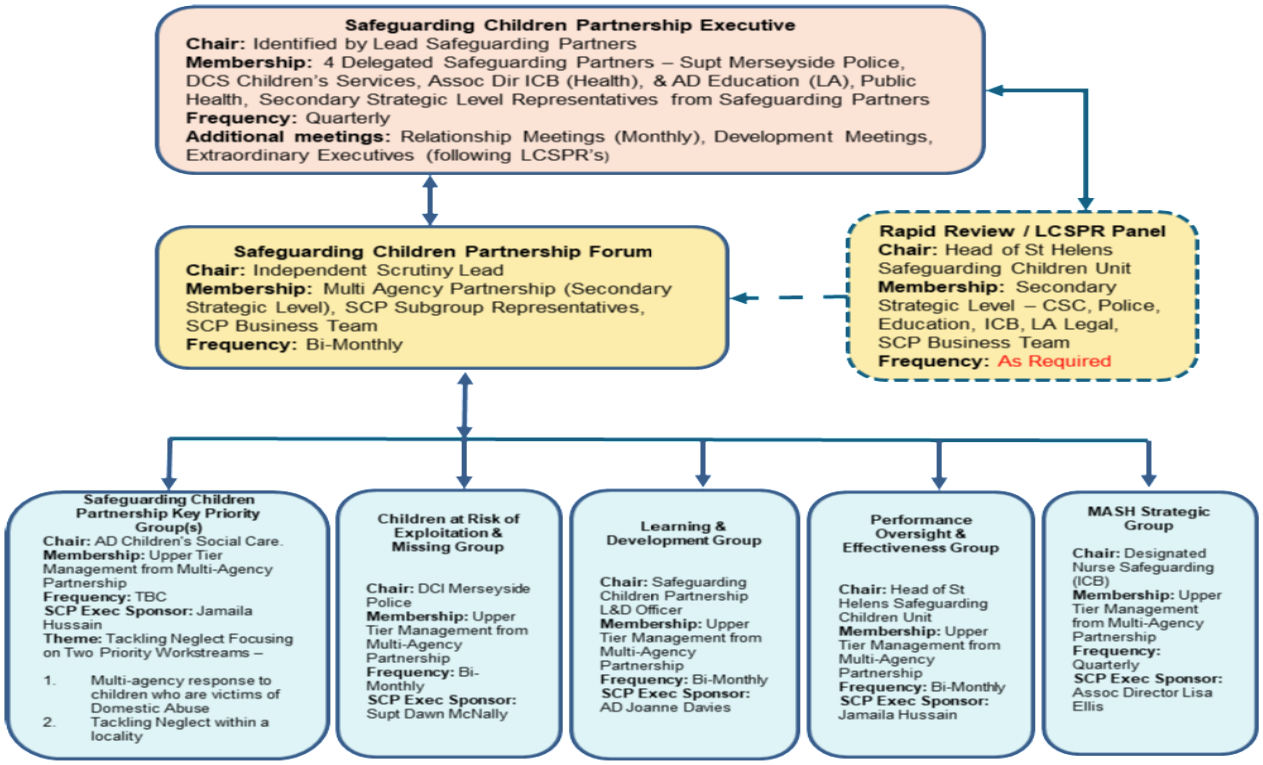
93. Cheshire East was subject of a Section 11 Audit which was completed by the CESCP, and no areas were identified that required further action.

94. Work has been undertaken with the Service Lead for elective home educated children to develop new processes and pathways to support how WCHT are notified children are home educated. This information is now provided through the CESCP Business Intelligence Team.

## St Helens Safeguarding Children's Partnership (SHSCP)

95. St Helens Safeguarding Children's Partnership (SHSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in St Helens. The partnership consists of the Director of Children's Services, Superintendent Merseyside Police and Associate Director Integrated Care Board.

96. The below diagram shows the St Helens Safeguarding Children Partnership Executive Committee governance structure.




97. St Helens SCP agreed the priority work for 2025-2026 is Neglect, owing to it being a continuing significant area of concern in the borough.

98. Neglect training created in 2023-2024 by the multi-agency partners continues to be delivered by the Named Nurse. A review of the training is underway to include the newly developed Neglect screening tool for St Helens.

99. The Named Nurse attends several partnership/subgroup meetings including Children at Risk of Exploitation (CARE) group, MASH Operational Group, Domestic Abuse Operational Group, Domestic Abuse Partnership Board, MACPT working group, Families First Board, Private Fostering Operational Group.

100. The Head of Safeguarding represents the Trust at the St Helens Safeguarding Children Partnership Forum, the Neglect Priority Strategic Group, MASH Board and Families First Board and MACPT working group.

101. The Named Nurse has supported several multi-agency audits in 2025-2026. These have included three collaborative case review audits, a repeat child protection plan audit, a MARAC audit reviewing the impact the process has on safeguarding children and young people and a child sexual abuse audit (CSA) where the Named Nurse was a facilitator at the audit day event.

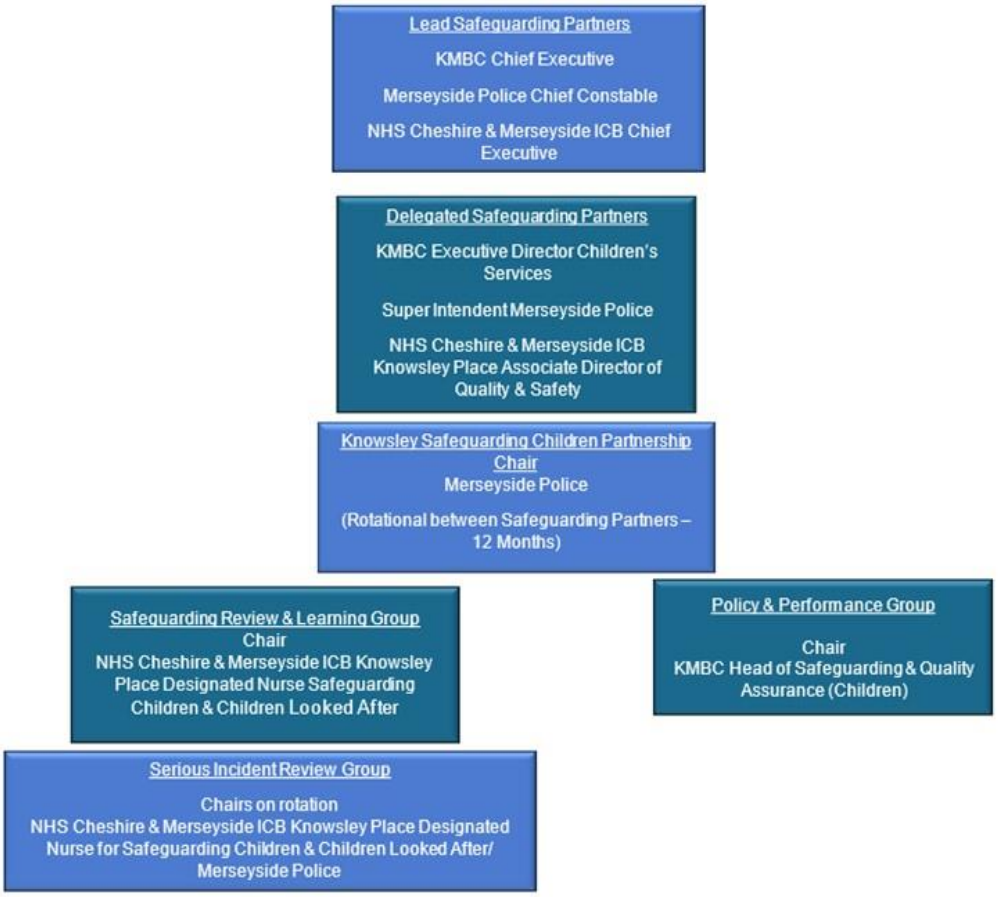
102. St Helens was subject of a Section 11 Audit, which was completed by the St Helens SCP using commissioning standards evidence, and no areas were identified that required further action.

103. St Helens Safeguarding partnership have completed preparation work for JTAI in the form of a True for Us exercise with the theme being Child Sexual Abuse (CSA) CSA will be a priority for CSC in 2026-2027.

## Knowsley Safeguarding Children's Partnership (KSCP)

104. Knowsley Safeguarding Childrens Partnership (KSCP) is the key statutory body for coordinating and ensuring effectiveness of arrangements to safeguard and promote the welfare of all children and young people in Knowsley. The partnership consists of the Director of Childrens Services, Superintendent Merseyside Police and the Associate Director Integrated Care Board

105. The below diagram shows the Knowsley Safeguarding Childrens Partnership governance structure:




106. KCSP has agreed shared priorities for the partnership to improve frontline multi-agency practice through working on the key identified priorities for 2025-2026:

- Provision of clear strategic leadership with focus on systems improvement.
- Early intervention in the identification and resolution of any barriers in safeguarding practice.
- Providing a clear line of sight to safeguarding practice.
- Development of scrutiny functions to monitor the effectiveness of multi-agency arrangements
- to safeguard and promote the welfare of all children.

107. To support these priorities the Named Nurse continues to work in partnership to review the Multi Agency Safeguarding Hub (MASH) process which will ensure the right services are provided to children and young people at the right time. WCHC continue to support the MASH Nurse employed by Merseycare by providing health updates for MASH strategy meetings, the daily morning meeting and MASH screenings.

108. The Knowsley Safeguarding Team has worked as part of a multiagency group to help develop the new neglect strategy which was identified as an area requiring improvement in the Ofsted Inspection. They have also supported the development of the new neglect screening tool and plans to deliver learning on its use to the 0-25 workforce. This will ensure 0-25 staff have the skills, knowledge and can evidence neglect

109. The Specialist Nurses attend or provide health updates for the Harmful Sexual Behaviour Panel to inform and contribute to plans ensuring appropriate decisions are made for young people.

110. The Head of Safeguarding represents the Trust at the Knowsley Safeguarding Childrens Partnership Forum.

111. The Named Nurse has completed internal audits including the walkabout audit which assesses staff skills and knowledge regarding safeguarding children, an audit to assess the quality of referrals to children's social care, and an audit of Level 3 Safeguarding Children training, MCA audit.

112. Knowsley was subject of a Section 11 Audit, which was completed by the KSCP using commissioning standards evidence, and no areas were identified that required further action.

113. In Q2 2025-2026, the Safeguarding Adults Team completed the annual Training Needs Analysis Audit to assess staff knowledge around Mental Capacity Act 2005 assessments, and this audit has provided good assurance around MCA 2005. Safeguarding L3 training Feedback Audit in Q3 and the Quality Assurance Audit of Safeguarding Adult referrals in Q4.

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## Section 4: Assurance and Compliance for Safeguarding

114. The purpose of the Safeguarding Accountability and Assurance Framework (SAAF) is to set out the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations and is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside Integrated Care Board (C&M ICB)

115. Compliance is measured through the following processes:
    - Submission of NHS C&M ICB two year Commissioning Standards self-assessment.
    - Safeguarding & CiC / CLA assurance frameworks (SAAF) submitted quarterly to the ICB with performance against key standards tracked.
    - Quarterly KPI Reporting Template submitted in conjunction with the Quality Report for Children in Care.
    - Compliance against Section 11 audits evaluated in each of our four places.
    - Compliance against Section 14 audit for adults.

116. WCHC Safeguarding is required to evidence assurance and compliance locally regionally and nationally, via the NHSE portal for Prevent and Child in Care. The portal is also used for Commissioning Standard actions however there are no action plans for the Trust following the last Inspection.

117. The Safeguarding Assurance Group (SAG) provides opportunity for challenge and assurance to the safeguarding arrangements within WCHC, monitoring compliance, benchmarking with external standards and clinical effectiveness indicators including Care Quality Commission (CQC) outcomes and addresses any gaps in service.

118. The SAG meets quarterly and is chaired by Chief Nurse/ Deputy Chief Nurse. Attendees include Head of Safeguarding, Named Nurses for children and adult safeguarding and Service Director 0-19. The SAG receives assurance regarding Trust wide and place-based updates with mandatory compliance, risks, tracking of action plans following audits alongside compliance with Safeguarding Commissioning Standards and the Accountability and Assurance Framework.

### Safeguarding Commissioning Standards

119. The NHS Cheshire and Merseyside Integrated Care Board Safeguarding Accountability and Assurance Framework (SAAF) outlines the core responsibilities in relation to safeguarding assurance and sets out a vision to improve the quality of safeguarding arrangements across Cheshire & Merseyside. The framework endeavors to keep the population at the heart of all safeguarding intentions and improvements. It maintains focus and takes a personalised approach to support meaningful improvements to individuals and make the most effective use of the expertise across safeguarding in Cheshire and Merseyside.

120. The commissioning standards which sit alongside the SAAF is a 63-point document with 10 key lines of enquiry. These include our leadership, accountability, policies and processes for safeguarding children and adults.

121. During Q3 2023-2024, the Trust completed a self-assessment against each of the 63 standards, providing a significant submission of supporting information to the ICB, to evidence compliance with each standard. The ICB have confirmed our assessment of the information provided supports the following compliance BRAG rating:

- 62 fully green BRAG rated areas.
- 1 amber BRAG rated area.

122. The one amber BRAG rated area relates to the identification of a named doctor and named nurse for child in care (CiC) which, in accordance with the standards should be dedicated posts and not combined with responsibilities for adult or child safeguarding.
In Wirral and Cheshire East Places the named nurses cover both the safeguarding role and the CiC role. This reflects the operational ICB model and the current commissioned services. Furthermore, and most importantly this position has not affected our service delivery.

123. In Q3 2025-2026 a new two-year Commissioning Standards document was completed, and our self-assessment remains unchanged with a compliance of 62 green and 1 amber against 63 standards, giving an overall compliance rate of 98.4%. We are waiting for this latest process to be reviewed and quality assured by the ICB for confirmation of our rating.

## Safeguarding Accountability and Assurance Framework – Children

124. The Safeguarding Accountability and Assurance Framework (SAAF) aimed at achieving consistency across the ICB. There are between forty and forty-seven indicators tracked with a range of eighteen to twenty-six RAG rated; these differ slightly across the Trust owing to commissioning placed based agreements. They are a combination of both quantitative and qualitative returns.

## Quarterly KPI Reporting Template – Children in Care (CiC)

125. The ICB Quarterly KPI Reporting Template for Children in Care (CiC) has fourteen indicators, all of these are RAG rated. Three indicators included in the return relate to children residing out of area which does not fall within WCHC responsibility and is therefore not included in this report.

126. Due to differences in Commissioning the CiC service, placed based agreements have been made in both Cheshire East and Wirral therefore data will vary going forward to reflect the Commissioning Service requirements.

127. In Cheshire East four indicators relate to Initial Health Assessments (IHA) which is not a requirement in Wirral as this is provided by Wirral University Teaching Hospital (WUTH).

The below data provides the number of review health assessments (RHAs) for Wirral and Cheshire East placed in borough and those placed in borough from other areas.

| Indicator | Tolerance | Wirral | Cheshire East |
|---|---|---|---|
| Percentage and number of RHAs due and completed within month (Wirral / CE child residing within borough) | 100% | 455<br>93% | 310<br>96.2% |
| Percentage and number of RHAs due and completed within month (out of borough child placed within area) | 100% | 94<br>79% | 158<br>94.6% |
| Number of RHAs Quality Assured and number that meet required standard (Wirral / CE child residing in borough) | 100% | 60<br>100% | 58<br>100% |
| Number of RHAs Quality Assured and number that meet required standard (Wirral /CE child residing out of borough) | 100% | 83<br>97.5% | 138<br>86.2% |

128. For those children placed in Wirral and Cheshire East, the Safeguarding Team are dependent on the assessments being requested; this can sometimes be late which will have a detrimental impact on our data. When our children are placed out of borough (OOB) WCHC is reliant on other area completing the relevant assessment. The Named Nurses have a clear escalation pathway and will highlight to the Designated Nurse when appropriate to do so. The Safeguarding Team have worked with 0-19 and deliver bitesize training sessions regarding what is expected for a good RHA, this work will continue into 2026-2027.

| Indicator | Tolerance | Wirral | Cheshire East |
|---|---|---|---|
| Number and percentage of Care Leaver health passports due and issued before/within month of 18th birthday (residing in borough) | 100% | 50<br>66.6% | 51<br>100% |
| Number and percentage of Care Leaver health passports due and issued before/within month of 18th birthday (residing out of borough) | 100% | 14<br>70% | 31<br>100% |

129. The above data demonstrates the number and percentage of care leaver passports issued. Care leavers have a choice to receive their health passport, whilst it is always encouraged, some will refuse, and their voice must be respected. For those care leavers residing out of borough Wirral Place has been reliant on other areas completing the health passports. Cheshire East Place owing to a difference in commissioning they have a dedicated specialist nurse to carry out this role, which has proved successful. Wirral Place developed a plan to replicate this work for 2025-2026. This was implemented in Q4 which has seen a significant increase in compliance. Any outstanding care leaver passports from previous quarters were completed retrospectively by the Child Looked After (CLA) Nurse.

## Safeguarding Accountability and Assurance Framework – Safeguarding Adults

130. The Safeguarding Accountability and Assurance Framework (SAAF) aimed at achieving consistency across ICB. There are thirteen indicators and eight are RAG rated.

131. This information has been included under key achievements, the training data below and Safeguarding Adults Health and Care Activity.

132. WSAPB specified that the Chapter 14 audit information from health providers can be obtained through the Safeguarding Accountability and Assurance Framework.

## Safeguarding Training

133. The tables below show the training data for WCHC staff for 2025-2026

| Measure | Tolerance | Wirral | Cheshire East | Knowsley | St Helens |
|---|---|---|---|---|---|
| Level 1 Adult Safeguarding Training for all staff | 90% | 96.4 | 100 | 97 | 100 |
| Level 2 Adult Safeguarding Training for eligible cohort | 90% | 99.5 | 100 | 100 | 100 |
| Level 3 Adult Safeguarding Training for eligible cohort | 90% | 96.1 | 96.7 | 96.3 | 94.6 |
| Level 4 Adult Safeguarding Training for eligible cohort | 90% | 100 | 100 | 100 | 95 |
| Mental Capacity Act & Deprivation of Liberty Safeguards | 90% | 96.1 | 96.7 | 96.3 | 94.6 |

| Measure | Tolerance | Wirral | Cheshire East | Knowsley | St Helens |
|---|---|---|---|---|---|
| Level 1 Children Training for all staff | 90% | 96.5 | 100 | 96.1 | 100 |
| Level 2 Children Training for eligible cohort | 90% | 94.6 | 100 | 100 | 100 |
| Level 3 children Training Core for eligible cohort | 90% | 92.7 | 95.9 | 95.2 | 94.3 |
| Level 4 Children Training for eligible cohort | 90% | 100 | 100 | 100 | 95 |
| Child Exploitation Awareness training | 90% | 94.9 | 94.7 | 97.2 | 94.3 |

| Measure | Tolerance | Wirral | Cheshire East | Knowsley | St Helens |
|---|---|---|---|---|---|
| Level 1 Children Looked After Training for all staff | 90% | 96.5 | 100 | 96.1 | 100 |
| Level 2 Children Looked After Training for eligible cohort | 90% | 94.6 | 100 | 100 | 100 |
| Level 3 Children Looked After Training for eligible cohort | 90% | 92.8 | 95.3 | 95.2 | 94.3 |
| Level 4 Children Looked After Training for eligible cohort | 90% | 100 | 100 | 100 | 95 |

134. All training for Adult and Childrens Safeguarding is above the 90% tolerance except for one Executive/Board member. This was owing to the appointment of a Joint Board following the start of the integration process, as there is a difference in training requirements for and WCHC and Wirral University Teaching Hospital (WUTH) Board members. The Training Needs Analysis (TNA) strategy will be reviewed to reflect the changes for 2026-2027.

| Measure | Tolerance | Trust wide 2025-2026 |
|---|---|---|
| Executive/Board Training | 90% | 62.5 |
| Prevent Strategy/Awareness Training | 90% | 96.6 |
| Prevent Strategy/Health WRAP Training | 90% | 96 |

## Safeguarding Supervision

135. Over the past year, the supervision compliance for staff carrying safeguarding children and children in need under 5 cases have been above the required compliance of 90%. This was apart from Knowsley Place owing to long term sickness within the 0-25 team and vacancies. 100% of staff in the workplace receive safeguarding supervision. For 2026-2027 we are working towards gathering data for the number of Safeguarding Child in Need Supervision sessions for children under the age of 5.

| Measure | Wirral | Cheshire East | Knowsley | St Helens |
|---|---|---|---|---|
| Number of child protection supervision completed | 2075 | 710 | 574 | 1012 |

## Look After Children (Wirral term for Child in Care)

136. The data (taken from Wirral Local Authority) in the reporting period shows that Wirral Children Looked After (CLA) has reduced which reflects the local authority's commitment to reduce the number of children in care. The number of children placed out of borough has remained static which is a positive trend in keeping children close to their birth area, however children placed in Wirral has risen again.

| Measure | 2024/2025 | 2025/2026 |
|---|---|---|
| Average number of Children Looked After by Wirral Local Authority | 723 | 664 |
| Average number of Wirral Children Looked After placed Out of Borough | 144 | 143 |
| Average number of Children Looked After placed in Wirral from Out of Borough | *313 | *323 |
| Average total number of Wirral Children Looked After living in Wirral | 579 | 521 |
| Average total number of all Children Looked After living in Wirral | 892 | 844 |
| Number and Percentage of supervisions completed for Children Looked After living on Wirral | **1376/ 95% | **1362/ 96% |

*Whilst these children are the responsibility of the out of borough Local Authority, for WCHC their health and care management is managed no differently, regardless of which LA has responsibility.

** All looked after children have supervision every six months hence the figure is increased from 844 however this data reflects the number of cases at time of reporting and owing to the movement of children in care, through placement or status these figures can rapidly change.

## Cared for Children (Cheshire East term for Child in Care)

137. Whilst there has been a decrease in the average number of Cared for Children in Cheshire East both placed out of borough and placed in borough there has been a significant increase in the amount of Cared for Children moving during each quarter. The transient movement of

places has created an increase in administration work to ensure the children's health needs are not missed. The impact of multiple moves is both emotionally overwhelming for the children and creates significant disruption to their physical health needs being addressed. There has been an increase in the number of RHA requests with late notification due to the moves and often once the RHA has been completed in Cheshire East the children have moved to another placement out of the area.

| Measure | 2024/2025 | 2025/2026 |
|---|---|---|
| **Average number of Cared for Children by Cheshire East Authority** | **539** | **568** |
| **Average number of Cheshire East Cared for Children placed Out of Borough** | **199** | **198** |
| **Average number of Cared for Children placed in Cheshire East from Out of Borough** | ***207** | ***198** |
| **Average total of Cheshire East Cared for Children living in Cheshire East** | **340** | **370** |
| **Average total of Cared for Children living in Cheshire East** | ****547** | ****568** |
| **Number and Percentage of supervisions completed for Cared for Children living in Cheshire East** | *****1109 / 102%** | **812 / 100%** |

*Whilst these children are the responsibility of the out of borough Local Authority, for WCHC their health and care management is managed no differently, regardless of which LA has responsibility.

** All looked after children have supervision every six months hence the figure is increased from 568 however this data reflects the number of cases at time of reporting and owing to the movement of children in care, through placement or status these figures can rapidly change.This is more prevalent within Cheshire East.

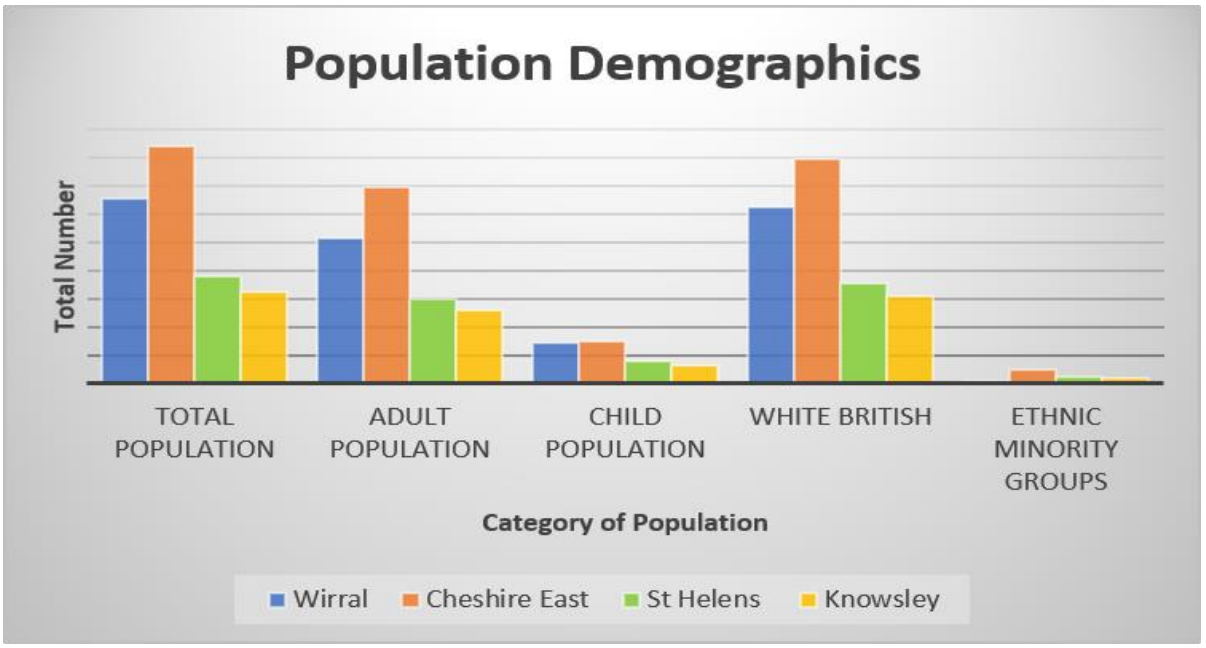
***Previous year's figures have included reactive supervision which is completed in real time. The figure for this year 2025-2026 now brings this in line with Wirral recording which does not include reactive supervision.

138. In Cheshire East, there has also been a decrease in the number of Unaccompanied Asylum-Seeking Children from the previous year however the previous UASC young people have now become care leavers and continue to require a bespoke needs led service.

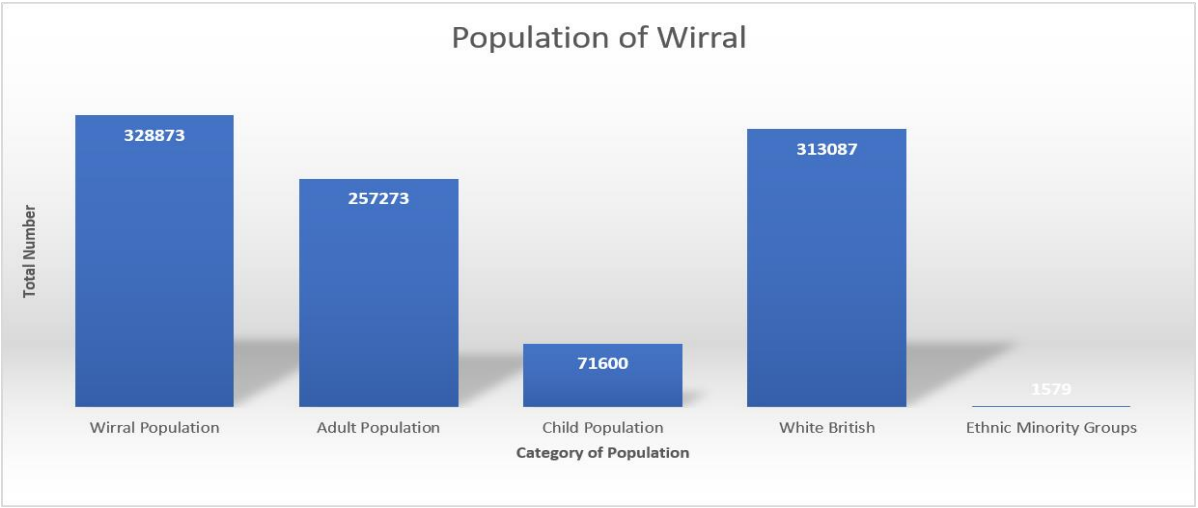
139. Cheshire East has ten neighboring local authorities and often children can live in one area and be registered with a GP in a different ICB area. This can present challenges in accessing services, particularly healthcare. WCHC Cared for Children's Team work closely with out of area teams and Cheshire Merseyside ICB to ensure that the NHS England Responsible Commissioning guidance is applied.

## Section 5: Safeguarding Children Activity

### Trust Wide:




### Safeguarding Children Wirral Place




140. The population of Wirral is 328,873 predominantly White British (95.2%) with ethnic minority groups existing, particularly Polish Indian and Chinese, and the main language being spoken excluding English is Polish. (Census, 2021).

141. There are approximately 71,600 children (0 to 19 years) therefore 22.3% of the population living in the borough. Of all children, 15.7% 16,056 live in poverty. The current rate of Children Looked After is 120 per 10,000.

142. The 2019 Indices of Deprivation ranked Wirral as the 77th most deprived authority in England.

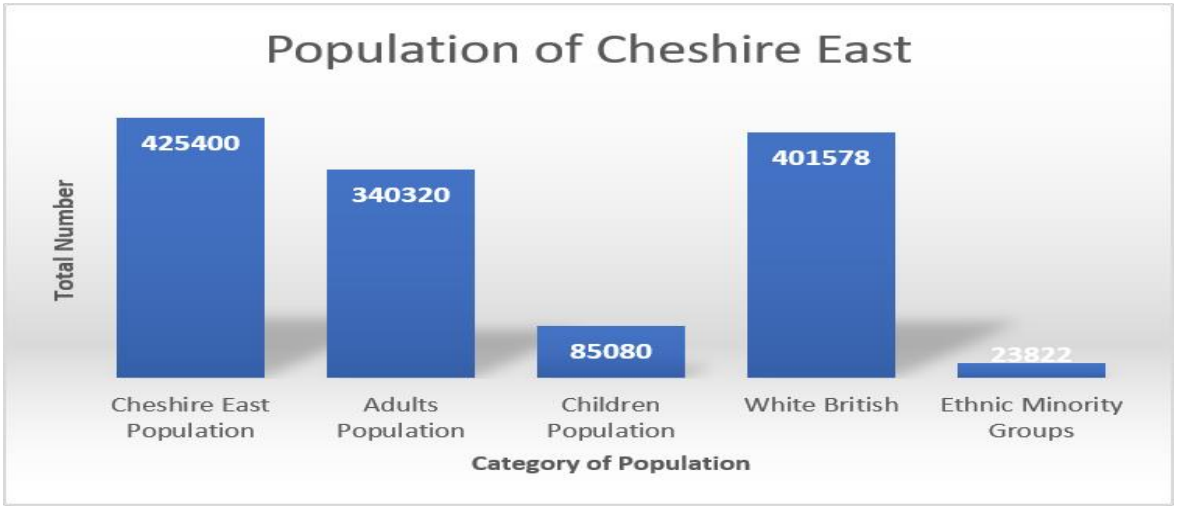
143. The most deprived areas are in the east of the Borough within the traditional industrial towns of Birkenhead and Wallasey. Most of the statutory work for partner agencies is with families from these areas. Challenges include high levels of poverty, a high prevalence of neglect and domestic abuse, and social and public health issues such as high rates of alcohol and substance misuse.

144. The table below shows a range of safeguarding children activity levels across Wirral for the reporting period 2025-2026

| Measure | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Number of Strategy Meetings attended (0-19 service) | 341 | 327 | 335 | 402 |
| Number of initial child protection case conferences attended | 81 | 82 | 86 | 81 |
| Number of children on a child protection plan | 376 | 389 | 431 | 448 |

145. The data shows an increase in Q4 of both strategy meetings and children on a plan. The Pathfinder model focuses on early intervention and supporting families to stay together so may account for a rise in Child Protection cases whilst this new process is embedded.

## Safeguarding Children Cheshire East




146. The population of Cheshire East is approximately 425,400 predominantly white British at 94.4%. Black and ethnic minority background residents form 5.6% of the population. Approximately 5% of the residents in Cheshire East are from European countries. Cheshire East also has a large travelling community with multiple permanent traveler sites throughout the area.

147. There are approximately 85,080 children (0 to 19 years) therefore 20% of the population being aged under 19 in the borough. The current rate of Children Looked After is 88 per 10,000.

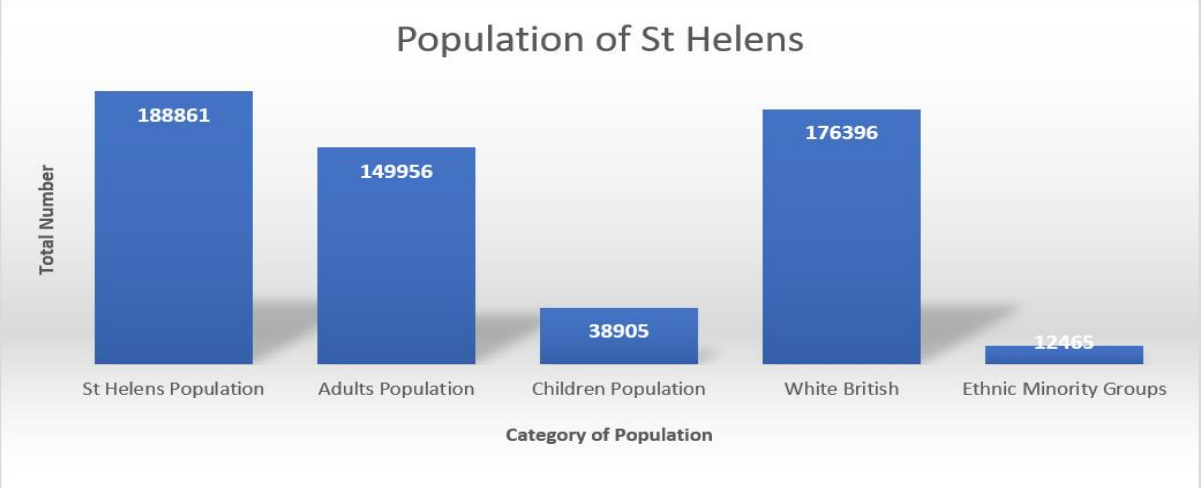
148. In Cheshire East, there are eighteen areas which are within the top 20% of the most deprived areas in England, affecting 33,350 people or 8.6% of Cheshire East's population.

149. The table below shows a range of the safeguarding children activity levels across Cheshire East for the reporting period 2025-2026

| Measure | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Number of Strategy Meetings attended (0-19 service) | 304 | 278 | 269 | 199 |
| Number of initial child protection case conferences attended | 50 | 54 | 52 | 44 |
| Number of children on a child protection plan | 224 | 208 | 186 | 186 |

150. The number of strategy meetings attended has slowly decreased during the year with the highest number recorded in Q1. The quality of the data collection has been strengthened throughout the year with the introduction of a child protection list supplied by the Local Authority this enables responsive data cleansing of flags.

## St Helens Safeguarding Children




151. The population of St Helens is 188,861 with 93.4% of the population predominately White British with 6.6% of the population ethnic minority groups particularly Asian.

152. There are approximately 38,905 children (0 to 19 years) therefore 20.5% of the population aged under 19 in the borough.

153. The most deprived areas are in the east of the Borough. This includes the Town Centre and Parr area. Most of the statutory work for partner agencies is with families from these areas. Challenges include high levels of poverty, a high prevalence of neglect and domestic abuse, and social and public health issues such as high rates of alcohol and substance misuse and obesity. Family hubs are now situated in these areas with preventative work ongoing to address identified issues.

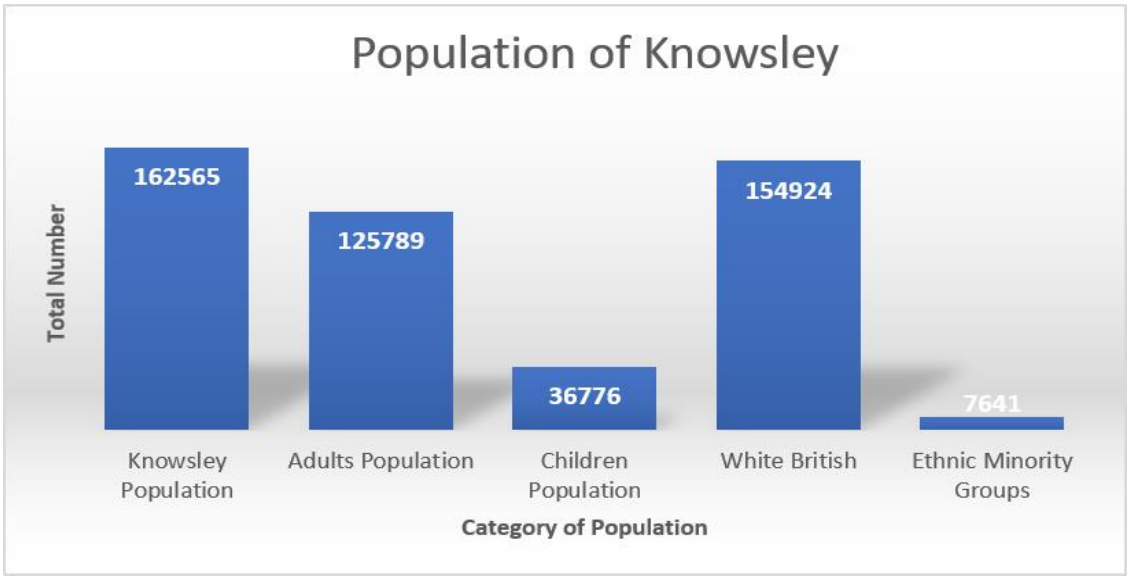
154. The 2019 Indices of Deprivation ranked St Helens is ranked as the 26th most deprived local authority in England out of 317. Almost a quarter of St Helens Residents live in the most 10% deprived areas in the country.

155. The table below shows a range of the safeguarding children activity levels across St Helens for the reporting period 2025-2026

| Measure | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Number of Strategy Meetings attended (0-19 service) | 82 | 97 | 82 | 137 |
| Number of initial child protection case conferences attended | 56 | 57 | 53 | 54 |
| Number of children on a child protection plan | 238 | 244 | 249 | 268 |

156. The number of children open on a Child Protection plan has steadily increased over the reporting period. The data for strategy meetings at the beginning of the reporting period did not reflect the increase in cases. An audit completed by the Named Nurse identified this was due to information on the Trust electronic record SystmOne being recorded in incorrect templates. Work has been completed by the Safeguarding Team with 0-19 to ensure correct templates are being checked, and the data is now reflective of the increase in cases.

## Knowsley Safeguarding Children




157. The population of Knowsley is 162,565, predominately White British 95.3%, with ethnic minority groups also existing, particularly Asian. (Census, 2024).

158. There are approximately 36,776 children (0 to 19 years) therefore 23.8 % of the population being aged under 19 in the borough.

159. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households which equates to 16,518 households.

160. The 2019 Indices of Deprivation ranked Knowsley as the 2nd most deprived authority in England.

| Measure | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Number of Strategy Meetings attended (0-19 service) | 178 | 186 | 188 | 239 |
| Number of initial child protection case conferences attended | 55 | 79 | 96 | 79 |
| Number of children on a child protection plan | 316 | 344 | 335 | 347 |

161. The data identifies an increase in strategy meetings each quarter, in particular Q4 which may be reflective following the Osted findings in January 2026 of delays in strategy meetings for some children.

## Child Sexual Exploitation and Criminal Exploitation

162. There is a dedicated multi–disciplinary team for Child Exploitation (CE) within the Integrated Front Door which supports the young people who are victims, and they will act as an expert resource across Wirral. The WSCP also has a dedicated committee for Harm Outside the Family Home (HOFH) which the Named Nurse attends. Its aim is to ensure the risk to Wirral young people is managed and has strategic oversight by all partners. There is a fortnightly Multi Agency Child Exploitation (MACE) meeting which the Specialist Children's Safeguarding Nurses (SCSN) attend.

163. Cheshire East Pace have one Child Exploitation Specialist Nurse. The nurse attends a bimonthly Contextual Safeguarding Operational (CEOPs) meeting. The nurses work regularly with all young people identified as medium to high risk, working alongside our partner agencies to ensure that all health needs are met.

164. In St Helens the SCSN attend MACE meetings twice monthly to support young people who are victims of CSE/CE. The Specialist Children's Safeguarding Nurses share proportionate health information and are part of the multi-agency partners making plans to keep the young people safe.

165. The Named Nurse continues to attend CARE group (Children at Risk of Exploitation). The multi-agency group continue to have a shared commitment to reducing and managing risk for young people in St Helens.

166. In Knowsley SCSN also attend MACE meetings twice monthly, where relevant health information is shared to support young people who are victims of CSE/CE. KSCP has a dedicated contextual safeguarding child exploitation and missing performance group which the Named Nurse attends.

167. There is an increase in the number of children being exploited for Organised Crime Gangs (OCGs) locally and unaccompanied asylum seeking children (UASC) being exploited in local businesses such as car washes, nail bars and cannabis farms. WCHC Safeguarding Team regularly supports ongoing partnership operations in order to continuously protect our communities.

## Safeguarding Liaison/CDRP (Child Death Review Panel)

168. All Local Safeguarding Children Partnerships (LSCPs) are required to have arrangements in place to review the reasons for all child deaths. This is done through information sharing between Child Death Review Partnerships (CDRP), with review of this information at Child Death Overview Panels (CDOP). Partnerships have a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy, and stillbirths) resident within their geographical footprint.

169. Due to the geographical areas within which Wirral Community Health and Care Trust provides services to children, there are two separate CDRPs and CDOPs.

170. The Pan Merseyside CDRP is a group of the five Local Safeguarding Children Partnerships, Knowsley, Liverpool, Sefton, St. Helens, and Wirral). The Pan Cheshire CDRP includes the LSCPs from Cheshire East, Cheshire West and Chester, Halton, and Warrington. Both CDRPs publish guidelines for the management of Sudden Unexpected Death in Children (SUDIC) which are broadly similar as they are based on national guidelines.

171. The focus of a Child Death Review Panel is on identifying any modifiable factors, such as smoking in pregnancy, smoking, high maternal BMI, low maternal BMI, unsafe sleeping, mental health, alcohol/substance use, domestic abuse and chaotic / poor home conditions that may help prevent unnecessary future child deaths or harm.

172. The below shows the number of child deaths across WCHC 2025-2026

| Measure | Wirral | Cheshire East | Knowsley | St Helens |
|---|---|---|---|---|
| Expected deaths | 10 | 8 | 6 | 11 |
| Unexpected deaths | 9 | 12 | 1 | 4 |
| Total of all child deaths | 19 | 20 | 7 | 15 |
| % of unexpected Deaths | 47% | 60% | 14% | 26% |
| Age Range of child – less than 1 week | 3 | 2 | 4 | 5 |
| Age Range of child – less than 1 year | 6 | 9 | 0 | 3 |
| Age Range of child – between 1 and 4 years | 2 | 0 | 1 | 1 |
| Age Range of child – between 5 and 14 years | 2 | 7 | 1 | 1 |
| Age Range of child – between 15 and 18 years | 6 | 2 | 1 | 5 |

173. All unexpected deaths are documented within the Trust reporting system Datix. They are discussed within the biweekly Clinical Risk Management Group (CRMG) and then further reviewed at the Mortality Review Group each quarter. All unexpected, child deaths will be subject of a SUDiC meeting / Joint Agency Review (JAR) meeting. The relevant Health

Practitioner will attend and is supported by the Safeguarding Team.

174. There is a Standard Operating Procedure (SOP) around the reporting of deaths within WCHC

175. The Trust continue to work in partnership with Merseyside Police Safer Sleep. This preventative partnership work will enable WCHC to offer further support to the family to reduce any risks.

## Child Safeguarding Practice Reviews

176. Please see summary of all cases referred through for consideration of rapid reviews and those meeting the threshold for a full Child Safeguarding Practice Review (CSPR)

* Pseudonym used to protect the child's identity

| Activities | Place | Child Safeguarding Practice Reviews 2025-2026 |
|---|---|---|
| Child 1 | Wirral | Rapid review submitted for 3 family members after SUDIC of child at 7 weeks. The review is now part of a thematic review looking at deaths of four children across Wirral |
| Child 2 | Wirral | Rapid review submitted for 4 children who attended a school on Wirral in relation to abuse. Independent reviewers have met the families. This review is still ongoing |
| Child 3 | Wirral | Rapid review submitted for 7 family members after ALTE/SUDIC of 12-week-old child. In the reporting year both parents went to trial and were found guilty of murder. The review is now part of a thematic review looking at deaths of four children across Wirral |
| Child 4 | Wirral | The review is part of a thematic review looking at deaths of four children across Wirral |
| Child 5 | Wirral | The review is part of a thematic review looking at deaths of four children across Wirral |
| Child Sophie* | Wirral | Learning has been shared across the Trust and a 7-minute briefing created by WSCP for staff |
| Child 1 | Cheshire East | Rapid Review submitted, and initial meeting completed, chronologies shared and viewed. CSPR held, learning identified |
| Child 2 | Cheshire East | Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Learning identified, 7 minute briefing shared. |
| Child 3 | Cheshire East | Rapid Learning Review submitted, and initial meeting completed, chronologies shared and viewed. Learning identified, 7 minute briefing shared. |
| Child S | St Helens | Rapid review submitted and initial meeting completed, chronologies shared and viewed. This met the threshold for a LCSPR. Decision made to be included in a thematic review of CSA as several cases identified within the borough. |
| Child R | St Helens | Rapid review submitted and initial meeting completed, chronologies shared and viewed. This met the threshold for a LCSPR. Decision made to be included in a thematic review of CSA as several cases identified within the borough |
| Child Q | St Helens | Rapid review submitted and initial meeting completed, chronologies shared and viewed. This met the threshold for a LCSPR. Review has now concluded and learning shared with agencies. Lunch and learn delivered to 0-19 and PSIRF with findings and learning from the review |
| Child Fifi* | St Helens | Low level learning review - initial scoping information and analysis submitted. Learning review concluded and findings shared with the Partnership for dissemination. Partnership learning identified and consideration being given to trauma informed training for practitioners. |
| Child Lee* | St Helens | Low level learning review - initial scoping information and analysis submitted. Lee 18+ years at time of incident, but due to the significant involvement from services a low-level learning review was completed to support practice. |
| Child K | Knowsley | Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies. |

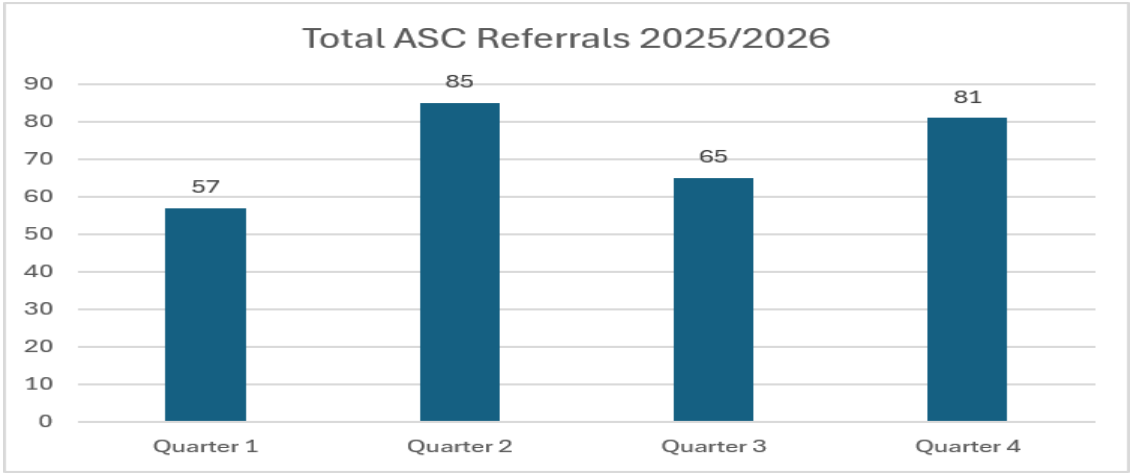
| | | |
|---|---|---|
| **Child L** | **Knowsley** | **Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |
| **Child M** | **Knowsley** | **Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Threshold met for Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |
| **Child P** | **Knowsley** | **Rapid review submitted and initial review meeting attended; chronologies shared and viewed. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |
| **Child R** | **Knowsley** | **Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |
| **Child O** | **Knowsley** | **Rapid review submitted, and initial review meeting attended; chronologies shared and viewed. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |
| **Child S+T (siblings)** | **Knowsley** | **Rapid review submitted, and initial chronologies shared and viewed, reflective learning session held. Threshold met for a Learning Review. KSCP risk and review group are currently developing learning for all agencies.** |

177. Following the completion of Rapid Reviews and Child Safeguarding Practice Reviews any learning and actions identified from these will be completed and shared across the whole Trust.

## Section 6: Safeguarding Adults Health and Care Activity

### Safeguarding Adults Referrals into Adult Social Care

178. The Safeguarding Adult Team Quality Assure and provide feedback on 25% of the referrals sent into Adult Social Care from WCHC staff. Data is also collated on the outcomes of all referrals. There has been a notable increase in staff now following the robust process of completing via the orange dot on SystmOne (S1) rather than a telephone contact to Central Advice and Duty Team (CADT).



## Safeguarding Adult Referrals for 2025-2026 Outcomes

| Measure | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| ASC Referral | 57 | 85 | 65 | 81 |
| No further action | 26 | 30 | 20 | 26 |
| Other | 0 | 0 | 1 | 2 |
| Sign Post | 5 | 6 | 5 | 4 |
| Case Management | 10 | 21 | 26 | 34 |
| Section 42 | 15 | 28 | 13 | 15 |
| Strategy Meeting requests | 1 | 3 | 0 | 1 |
| Attend Strategy Meetings | 1 | 3 | 0 | 1 |

## Domestic Abuse Agenda

179. The Domestic Abuse Agenda continues to be a significant priority area within WCHC. As an integrated health and care organisation, the Safeguarding team represents WCHC at daily MARAC on behalf of the organisation and for Wirral GP practices as outlined within the commissioned service specification. This representation ensures timely sharing of information. WCHC Domestic Abuse Practitioner has also supported a number of staff across the organisation who have been victims of Domestic Abuse.

## Domestic Abuse/Multi Agency Risk Assessment Committee (MARAC)

180. Daily MARAC continues due to the high prevalence of Domestic Abuse in Wirral. This enables a timelier approach in ensuring safety plans were in place for victims and children.

181. A 6-month review of Wirral MARAC has been commissioned and is being completed by Safelives, this commenced in March 2023, the outcome was shared and there were workshops and feedback following this in Q1 2025-2026

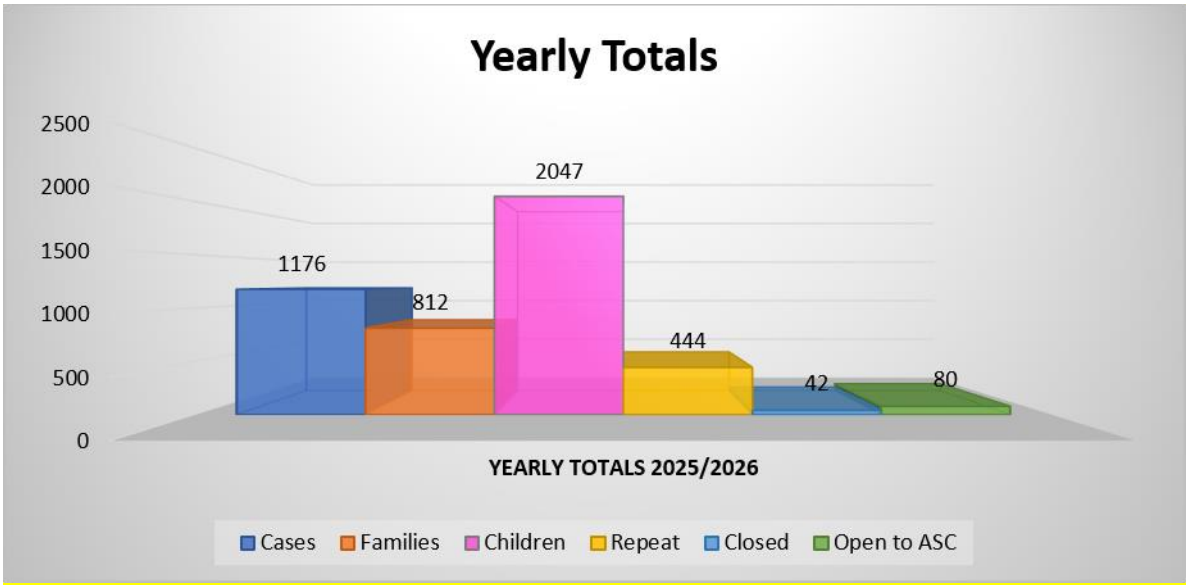
182. Domestic Abuse Alliance Committee and the Strategy ‘Domestic Abuse No Excuse’ was launched in November 2020-2025 with 5 key priorities:

    Priority 1: Be there when we are needed.
    Priority 2: Increase safety for those at risk, without adding to their trauma.
    Priority 3: Reduce opportunities for Perpetrators to abuse.
    Priority 4: support people to live the life they want after harm occurs.
    Priority 5: Create a kinder brighter future for the next generation

183. Representatives from WCHC are committed to working in partnership to ensure the strategy priorities are implemented across WCHC. The Named Nurse Safeguarding Adults is part of the Domestic Abuse Alliance workshops for the priorities for the 2026-2030 strategy, and this will be shared with the Trust when launched.

184. What we know about Domestic Abuse on Wirral in 2025-2026

- There were 1176 high risk cases discussed this is a 232 increase on 944 high risk cases heard from 2025-2026
- There were 2047 children discussed this is a 372 increase of the 1,675 children discussed in 2025-2026
- There was an increase in repeat cases with 444 cases heard compared to 338 heard in 2025-2026
- There were 42 closed MARAC cases compared to 40 closed MARAC cases in 2025-2026 with an increase of 2 closed MARAC on the previous year.




## Multi Agency Public Protection Arrangements (MAPPA)

185. WCHC Safeguarding Adults Team is the “single point of contact” (SPOC) ensuring that relevant information is shared between Wirral Community NHS Trust and Wirral GPs with regards to the Multi Agency Public Protection Arrangements (MAPPA) queries and actions.

186. This ensures that as a result of the potential risk an offender/ex-offender may pose information is shared appropriately in order to safeguard the public and any staff.

187. During the reporting period, WCHC attended 113 MAPPA meetings with an increase of 97 on 2024-2025. This equated to 247.5hrs of team time in MAPPA meetings and sharing appropriate information and contributing to risk management and completing actions as required. There was an increase of 16 meetings in the previous year and there has been a 100% increase in the last 2 years.

## Harmful Practices and Female Genital Mutilation (FGM)

188. There were 16 Female Genital Mutilation (FGM) cases reported from WCHC in 2025-2026 an increase of 8 reported in 2024-2025. The National reporting processes were followed and recorded on the NHS FGM dataset as required.

189. There were 42 closed MARAC cases discussed during 2025-2026; this was an increase of 2 on the previous year. These cases pose the highest risk and include the risk of Honor Based Abuse and forced marriage.

## Community Intermediate Care Centre (CICC)

190. Following the opening of the Inpatient beds at Community Intermediate Care Centre (CICC) during January 2021 the Safeguarding Adults Team has continued to support the staff with bespoke Safeguarding Training sessions around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Specific training sessions in Domestic Abuse was also delivered with the Therapy staff, this included asking about Domestic Abuse and the process to follow if recognising the increase in disclosure of Domestic Abuse within the elderly population.

191. Monitoring of the DoLS applications is undertaken by the Safeguarding Specialist Nurse utilising Trust Information Gateway (TIG) and Business Intelligence (BI)

## Safeguarding Adult Week 17 November 2025

192. Safeguarding Adults Governance team celebrated Safeguarding Adult Week by hosting an online event on ‘Cuckooing’) This was well received by Trust staff.

193. The Safeguarding Adult Team held a Safeguarding Awareness event with a Stall and resources for Staff to engage with in the foyer of St Catherines Health Centre and a ‘safeguarding matters’ newsletter was shared across the Trust.

194. Safeguarding Adults Team shared information via the Communications Team on Lunch and Learn sessions being held across all Adult Boards in Merseyside and Cheshire

195. During 2025 –2026 the Safeguarding Adult team led on three campaigns to keep Safeguarding Adults in the focus of Trust staff.

196. The campaigns were ‘Adult Abuse No excuse’ with a reminder to staff on recognising and correctly reporting Adult Safeguarding via the orange button and to record if invited and attended Section 42 strategy meetings. This message was shared via a newsletter and screensavers.

197. Also, a campaign on ’Online Abuse’ and how to recognise it, this was shared via a flyer, screensavers and newsletter.

198. Over Christmas 2025 a campaign on recognising Domestic Abuse and how to support any disclosures took place with the support from Communication team.

## Safeguarding Adult Champion Programme

199. The Safeguarding Champions play a crucial role across the organisation, supporting the Safeguarding specialists to promote the Safeguarding agenda within their teams, services and divisions.

200. In 2025-2026 there were 14 staff that completed the Champion Programme and were signed off as proficient. There are now 31 that are signed.

201. The programme offers 9 workshop sessions on a rolling programme cycle. Each session is held (approximately) every two weeks, for a maximum of 2 hours that incorporate a variety of safeguarding topics, including Safeguarding Supervision, Adult Safeguarding and Section 42 Enquiries, Mental Capacity & Best Interests, Deprivation of Liberty safeguards (DoLS), Domestic Abuse, Harmful Practice and Modern Slavery & Human Trafficking.

202. Each champion receives a Safeguarding Adults Champion Toolkit which provides opportunity for self-assessment, a variety of resources together with the competency framework. Following completion of the workshop sessions, champions will complete 15 competencies. Once the champion is successfully signed off, they will meet on a quarterly basis for safeguarding supervision with a safeguarding practitioner. The workshop sessions comprise of presentation and group discussion around key safeguarding themes:

203. All the Safeguarding Champions receive safeguarding supervision from the specialist nurses safeguarding adults, this is facilitated quarterly individually or as a group. The Champions then facilitate group safeguarding supervision within their area of work supported by a safeguarding adult specialist nurse.

204. A Celebration Day organised and attended by the Safeguarding Adults Team, took place in November 2025 as part of Safeguarding Adult Week. The Champions, who had completed the training, and the competency framework were presented with their certificates and badges.

205. A further Celebration Day will be scheduled to take place in Safeguarding Adult week in November 2026, for our new Safeguarding Adult Champions.

## Safeguarding Adult Reviews / Domestic Abuse Death Related Reviews (DARDR)

206. Eight requests for Chronologies for consideration of Safeguarding Adult Reviews (SAR) and nine requests for chronologies for Domestic Abuse Death Related Death Reviews (DARDR) have progressed during the reporting period any identified learning and actions will be monitored via WSAPB and the Community Safety Partnership and internally through the Safeguarding Assurance Group with escalations to Quality and Safety Committee.

| Activities | Safeguarding Adults 2025-2026 |
|---|---|
| SAR 25 | Commenced March 2024 and the final draft has been shared with the WSAPB Board but is not yet published. |
| SAR 28,31,32 | Thematic review of 3 cases around self-neglect and Hoarding, awaiting this to be published to enable sharing with Trust staff. |
| DHR 8 | This commenced March 2026 panel meetings in progress. |
| DHR 4 | Commenced November 2023 closed and sent to Home Office as no agency information and involvement. Home Office requested it be reopened so re-commenced November 2024 with completion in Q2 2025-26. Awaiting publication. |
| DHR 5 | Commenced November 2025 with the final draft sent to the Home Office in September 2024 and still awaiting the publication |
| DHR 6 | Commenced November 2023 the final draft is now with the Home Office and there was no learning for any agency and still awaiting the publication. |
| DHR 7 | Commenced in January 2025 and was completed and sent to the Home Office in April 2026 |

## Section 7: Future Priorities 2026-2027

207. Future priorities for 2026-2027 include.

- Safeguarding delivery plan including,
    - Safeguarding Goal 1: 90% of the Voice of the People to be captured.
    - Safeguarding Goal 2: 90% Attendance at Child Safeguarding Meetings
    - Safeguarding Goal 3: 90% Attendance at MAPPA MARAC and Channel Panel Meeting
    - Safeguarding Goal 4: 90% Attendance at Safeguarding Training

- To further embed a fully integrated approach to safeguarding governance supported by a safeguarding dashboard that can be interrogated at organisational, divisional, and service level.

- The Safeguarding Adult Team will continue to support staff with bespoke training with any gaps in knowledge around MCA and utilising the Safeguarding Champion Programme to share learning within the teams.

- A plan for a celebration event during Safeguarding Adult week in November 2026 for all the Champions who have successfully completed the programme and been signed off.

- To support the Wirral Safeguarding Children's Partnership ‘Big Learn’, in November 2026 to showcase WCHC services including Safeguarding, Sexual Health and Family Nurse Partnership.

- To further strengthen the Safeguarding Links role within Wirral teams and to roll this out to Knowsley teams. This was relaunched in April 2026 with a more robust set of competencies, and a name change to Safeguarding Children's Champions to fall in line with the Safeguarding Adults Team. The launch saw recruitment of new practitioners, and we look forward to developing their safeguarding knowledge.

- To support 0-19 to embed the Child in Need group supervision process within teams to build greater safeguarding resilience in the workforce and harness and develop the skills already gained.

- To work in partnership with WSCP to embed the Pathfinder changes into practice to improve outcomes for children and families including supporting to extend the MACPT Nurse roll to the whole of Wirral localities.

- To continue to work in partnership with Cheshire East, St Helens and Knowsley Place with Families First Programme to support the role out of the Multi Agency Child Protection Team.

- To increase staff confidence in understanding mental capacity when working with children.

- To support St Helens SCP & Knowsley SCP in implementation of the newly developed Neglect screening tool to support the recognition and response of Neglect in the Borough’

- To support Knowsley Safeguarding Children's Partnership in development of the new neglect Strategy and to support with the development of learning from statutory and local learning reviews.

- The St Helens Safeguarding Team will support St Helens SCP National Child Exploitation event in March 2027 and showcase the work of WCHC in supporting children and young people being exploited.

- To work in collaboration with WUTH to reduce areas of duplication and identify best practice. Reviewing vacancies and statutory responsibilities ensuring our compliance with national guidance and be assured that there are no gaps in our delivery of service. Review our policies and processes so they are consistent, capturing the needs of both the Acute and Community services in preparation for the safe merger of the two Trusts.

## Conclusion and Recommendations

208. The Annual Report demonstrates how WCHC continues to adapt to changing priorities and has achieved its statutory duties to effectively safeguard patients and staff that use our services.

209. The Quality and Safety Committee is asked to receive the content of the Safeguarding Annual Report, note the excellent achievements made over the past year and be assured of the Trust's commitment to continue to safeguard our communities.

**Chris Douglas**

**Joint Chief Nursing Officer**

**Author:**

Jude Blease

Head of Safeguarding

14 September 2026

## Appendix 1: Safeguarding Abbreviations

| | |
|---|---|
| ASC | Adult Social Care |
| BRAG | Blue, Red Amber Green rated |
| CADT | Central Advice and Duty Team |
| C4C | Cared for Child (Looked After Children in Children East) |
| CDOP | Child Death Overview Panel |
| CDRP | Child Death Review Panel |
| CE | Child Exploitation |
| CESCP | Cheshire East Safeguarding Children Partnership |
| CIC | Child in Care |
| CICC | Community Intermediate Care Centre |
| CLA | Children Looked After (local term) |
| CQC | Care Quality Commission |
| CSE | Child Sexual Exploitation |
| CSPR | Child Safeguarding Practice Review |
| CRMG | Clinical Risk Management Group |
| CWP | Cheshire Wirral Partnership Trust |
| DARDR | Domestic Abuse Related Death Review |
| DoLS | Deprivation of Liberty Safeguards |
| FGM | Female Genital Mutilation |
| GCP2 | Grade Care Profile 2 |
| ICB | Integrated Care Board |
| IFD | Integrated Front Door |
| ILACS | Inspection of Local Authority Children's Services |
| JAR | Joint Agency Review |
| JTAI | Joint Targeted Area Inspection |
| KPI | Key Performance Indicators |
| KSCP | Knowsley Safeguarding Children's Partnership |
| L&D | Learning & Development |
| LeDeR | Learning Disability Mortality Review |
| LPS | Liberty Protection Safeguards |
| LSCP | Local Safeguarding Children Partnership |
| MACE | Multi Agency Child Exploitation |
| MACPT | Multi Agency Child Protection Team |

| | |
|---|---|
| MAPPA | Multi Agency Public Protection Arrangements |
| MARAC | Multi Agency Risk Assessment Conference |
| MASH | Multi Agency Safeguarding Hub |
| MCA | Mental Capacity Act |
| MIAA | Mersey Internal Audit Agency |
| MRG | Mortality Review Group |
| MSARG | Merseyside Safeguarding Adult Review Group |
| NEET | Not in Education, Employment or Training |
| NHSE | National Health Service England |
| OCG | Organised Crime Group |
| OOB | Out of Borough |
| RAG | Red, Amber Green rated |
| RHA | Review Health Assessment |
| SAAF | Safeguarding Accountability and Assurance Framework |
| SAFE | Standards Assurance Framework for Excellence |
| SAG | Safeguarding Assurance Group |
| SAR | Safeguarding Adult Review |
| SEND | Special Educational Needs and Disabilities |
| SENDIAS | Special Educational Needs and Disability Information Advice and Support Services |
| SENDLO | Special Educational Needs and Disabilities Local Offer |
| SFEF | Supporting Families Enhancing Futures |
| SHSCP | St Helens Safeguarding Children's Partnership |
| SOP | Standard Operating Procedure |
| SOS | Signs of Safety |
| SPOC | Single Point of Contact |
| SUDiC | Sudden Unexpected Death in Childhood |
| S1 | SystmOne |
| UASC | Unaccompanied Asylum-Seeking Children |
| WCHC | Wirral Community Health and Care NHS Foundation Trust |
| WSAPB | Wirral Safeguarding Adult Partnership Board |
| WUTH | Wirral University Teaching Hospital |

**Group Board of Directors in Public** **Item No 20**

**04 November 2026**

| | |
|---|---|
| **Title** | WUTH Complaints Annual Report 2025/26 |
| **Area Lead** | Chris Douglas, Chief Nursing Officer |
| **Author** | John Molyneux, Head of Complaints |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Assurance |

This report provides the Board with assurance on concerns and complaints activity, performance, outcomes and learning at Wirral University Teaching Hospital NHS Foundation Trust (WUTH) for the year 1 April 2025 to 31 March 2026 and meets the annual reporting duty under the Local Authority Social Services and NHS Complaints (England) Regulations 2009.

It is recommended that the Board:

- Note the level of assurance provided on complaints handling, themes and learning during 2025/26

## Key Points to Note

- Demand increased significantly during 2025/26, with 293 formal complaints received, a 31% increase, alongside a 14% increase in Level 1 concerns.
- Complaint response output increased by 26% but did not keep pace with demand. The open caseload increased from 40 to 100 and performance against the 40-working-day response standard remained below target.
- The principal constraint remains the timeliness of divisional investigations, particularly for complaints requiring coordination across more than one division. Recovery actions for 2026/27 focus on divisional accountability, named lead investigators, training and active caseload management.
- Positive assurance is provided by timely acknowledgement, effective early resolution of Level 1 concerns and evidence of learning and service improvement arising from complaints.

## Key Risks

This report relates to the following BAF risks:

- The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks
- 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 | No |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| September 2026 | Joint Quality and Safety Committee | Complaints Annual Report, 2025/26 | Assurance |
| 20/08/2026 | Patient Safety Quality Board | Complaints Annual Report, 2025/26 | Assurance |

## 1 Executive Summary

### 1.1 Comparative Performance (Formal Complaints)

| | 2024/25 | 2025/26 | % Change Over Previous Year |
|---|---|---|---|
| **Formal Complaints Logged** | 224 | 293 | +31% |
| **Active Caseload (at Year End)** | 40 | 100 | +150% |
| **Ongoing Breaches (at Year End)** | 11 | 47 | +327% |
| **% Acknowledged in 3 Working Days** | 98% | 95% | -3pp |
| **% Responded to Within Original Timescale Agreed** | 37% (69/187 responses) | 36% (84/235 responses) | -1pp |
| **Avg. Response Time (Working Days)** | 53 | 56 | +6% |

| | | | |
|---|---|---|---|
| **Re-opened Cases** | 23 | 36 | +57% |
| **PHSO Cases Opened** | 7 | 10 | +43% |
| **PHSO Cases Closed** | 6 | 6 | No change |
| **PHSO Completed Investigations Upheld or Partially Upheld** | 1 | 4 | +300% |

Formal complaint performance deteriorated during 2025/26 as increased demand outpaced the growth in completed responses, resulting in a substantially larger open and overdue caseload at year end.

'Communication' and 'Treatment & Procedure' remained the dominant complaint themes, featuring in 62% and 53% of cases respectively. 'Documentation' showed the most notable increase, while 'Medication' and 'Tests & Results' reduced.

Medicine received the highest number of formal complaints, followed by Emergency Care and Surgery. At departmental level, the Emergency Department remained the most frequently cited area, with recurring concerns relating to treatment, communication, access and diagnosis.

Of the 235 complaints responded to, 72% were upheld or partially upheld, compared with 69% in 2024/25 and 66% nationally in the most recently available NHS England data.

**Comparative Performance (Level 1 Concerns)**

| | 2024/25 | 2025/26 | % Change Over Previous Year |
|---|---|---|---|
| **Level 1 Concerns Logged** | 2,884 | 3,279 | +14% |

Level 1 concerns also increased during the year. The falling proportion escalating to formal complaint suggests that early resolution continues to be effective, although the concurrent increase in both informal and formal activity indicates broader growth in patient concerns.

'Access & Admission' remained the leading theme, followed by 'Communication'.

Surgery recorded the highest volume, overtaking Medicine, with increases also evident across most other divisions.

At departmental level, the Emergency Department remained the highest-volume area. Particularly notable increases were recorded in Colorectal & Upper GI and Radiology General, while Community Child Health reduced significantly.

**Overall assurance**

Positive assurance is provided by continued timely acknowledgement of complaints, increased response output, effective early resolution of Level 1 concerns and evidence that complaints are generating learning and service improvement.

Assurance is reduced by deterioration in formal complaint timeliness, the growth in the open and overdue caseload and an increase in re-opened complaints. Divisional investigation delays, particularly where complaints span more than one division, remain the principal constraint on performance.

PHSO findings during the year reinforced themes already identified locally, particularly communication and documentation, with the failings identified by the Ombudsman consistent with those already recognised through the Trust's own investigations.

**Top risks and mitigations**

| Risk | Impact | Mitigation |
|---|---|---|
| Growing caseload | Delayed responses | Recovery plan and monitoring |
| Investigation delay | Breaches and dissatisfaction | Named investigator model |
| Multi-divisional complaints | Coordination failures | Single accountable lead |
| Recurring communication and documentation failures | Poor patient experience and repeat concerns | Targeted divisional learning and monitoring of completed actions |

## 2 Implications

**2.1 Patients**

- Analysis of complaints themes and trends, and improvement action taken as a result of complaints, feeds into and supports the Trust's patient safety and patient experience agendas. It also may highlight potential inequalities of service and lack of reasonable adjustments.

- This annual report therefore provides assurance of such themes and trends, as well as highlighting any specific and substantive actions or learning resulting from service user (patients and relatives) complaints and feedback.

**2.2 People**

- An effective complaint process should ensure that staff are enabled to give a fair and balanced account of what happened and what conclusions they reached on every complaint. The wellbeing of staff involved in a complaint should be supported via a culture of fairness, openness, and learning, with staff feeling confident to acknowledge when things go wrong, promoting a culture of psychological safety.

- Equally, where complaints are not upheld, staff should feel supported during the complaints process, the outcome of which should be both timely and fairly explained.

| | |
|---|---|
| **2.3** | **Finance**<br>• Although there are no direct financial implications arising from most complaints, where there has been a finding by the PHSO of maladministration or service failure, financial remedy may be recommended. Poor and untimely complaints handling may also be followed by litigation, with associated costs incurred in defence or compensation.<br><br>• Conversely, service and process improvements made because of learning from complaints may have a positive fiscal impact. |
| **2.4** | **Compliance**<br>• As per The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, healthcare bodies are required to prepare an annual report that must:<br><br>o specify the number of complaints received;<br>o specify the number of complaints that were decided to be well-founded;<br>o specify the number of complaints referred to the Health Service Commissioner (PHSO) or Local Commissioner (LGSCO); and<br>o summarise the subject matter of the complaints received; any matters of general importance arising out of those complaints, or the way in which the complaints were handled; and any matters where action has been or is to be taken to improve services as a consequence of those complaints.<br><br>• This annual report is therefore in line with those regulations and provides assurance of compliance. |

## Purpose

This report summarises the concerns and complaints activity and performance at WUTH for the financial year April 2025 to March 2026.

## Introduction / Background

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 outline a two-stage complaints process: local resolution by the NHS body, followed by referral to the Parliamentary and Health Service Ombudsman (PHSO) if the complainant remains dissatisfied.

The Trust's Concerns and Complaints Policy emphasises early resolution by frontline staff to prevent unnecessary escalation to formal complaints. Where a formal complaint is raised, a complaints specialist in the central Complaints and PALS Team manages the process end to end, serving as the point of contact for both the complainant and divisional investigation leads.

As part of the registration process, the Complaints and PALS Team confirms each issue the complainant wishes to raise and agrees a likely timescale for completion of the investigation.

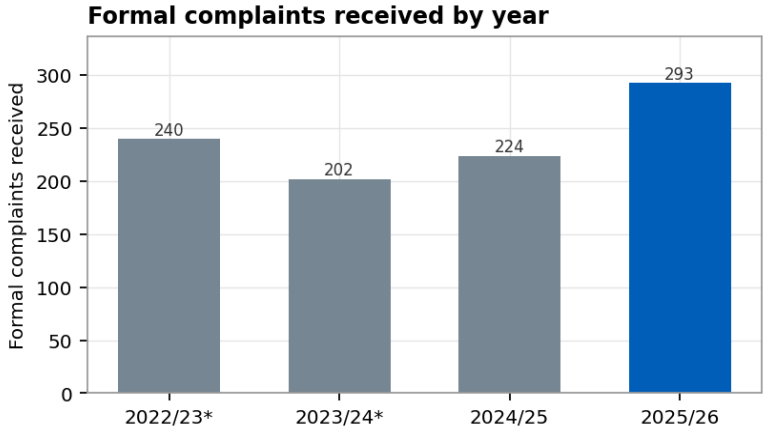
While the 2009 Regulations removed national response timescales in favour of individually agreed deadlines, WUTH's policy supports timely resolution by grading concerns and complaints on a scale of 1 to 2, with associated timescales.

| Level 1 | Level 2 |
|---|---|
| This will be investigated as an informal concern that has the potential to be resolved quickly by front line staff within three working days. Level 1 concerns may be resolved verbally and do not require a written response unless requested by the enquirer. Any such written response may be signed off at departmental / divisional level. | This is a formal complaint that should be acknowledged within three working days of receipt and responded to within 40 working days via a written response signed off by the Trust's CEO. In the absence of the CEO, level 2 complaint responses may be signed off by the CEO's deputy. |

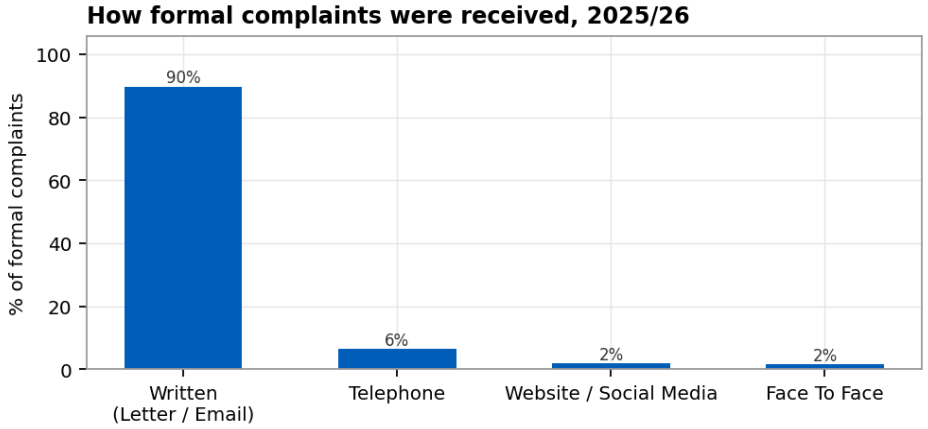
## Complaint Activity

### Volume and Trend

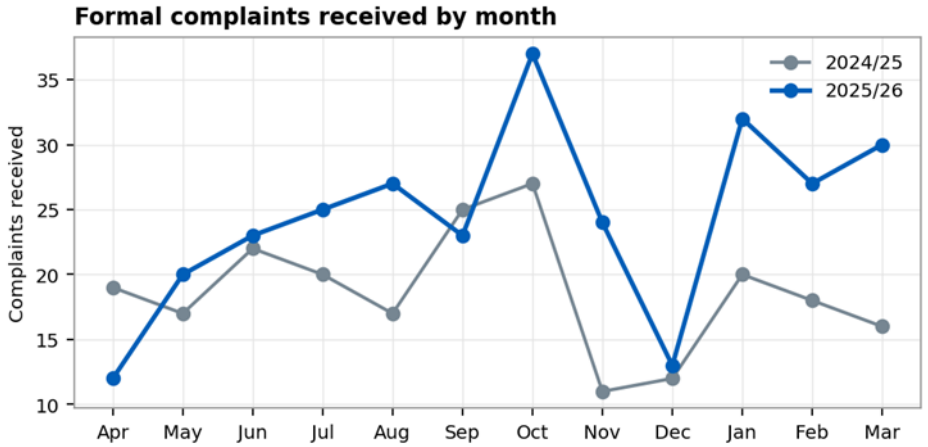
A total of 293 formal complaints were registered in 2025/26, averaging 24 per month. This equates to 4.2 formal complaints per 1,000 staff per calendar month, above the Trust performance metric of 3.1, and a 31% increase compared to the 224 complaints received in 2024/25.




The overwhelming majority of complaints were submitted in writing (90%), with a further 6% made by telephone.




Growth was concentrated in the second half of the year. Quarter 1 was slightly below the equivalent quarter in 2024/25 (55 against 58), with each subsequent quarter exceeding it (75, 74 and 89, against 62, 50 and 54).




At the time of writing, NHS England's KO41a performance data for 2025/26 had not yet been published. The most recent available data covers 2024/25, when hospital and community health services in England received 113,780 written complaints – a 5.6% increase on the 107,745 recorded in 2023/24.

WUTH's own year-on-year increase in 2024/25 (11%) was therefore around twice the national rate of growth, and the 31% increase recorded in 2025/26 is steeper again.

## Understanding the Increase

It is not possible to say definitively why formal complaints rose by 31%.

The rise was progressive, building through the year. It was also broad-based: 84 departments received a complaint, against 85 last year, with the same concentration among the largest, so this is not one failing service.

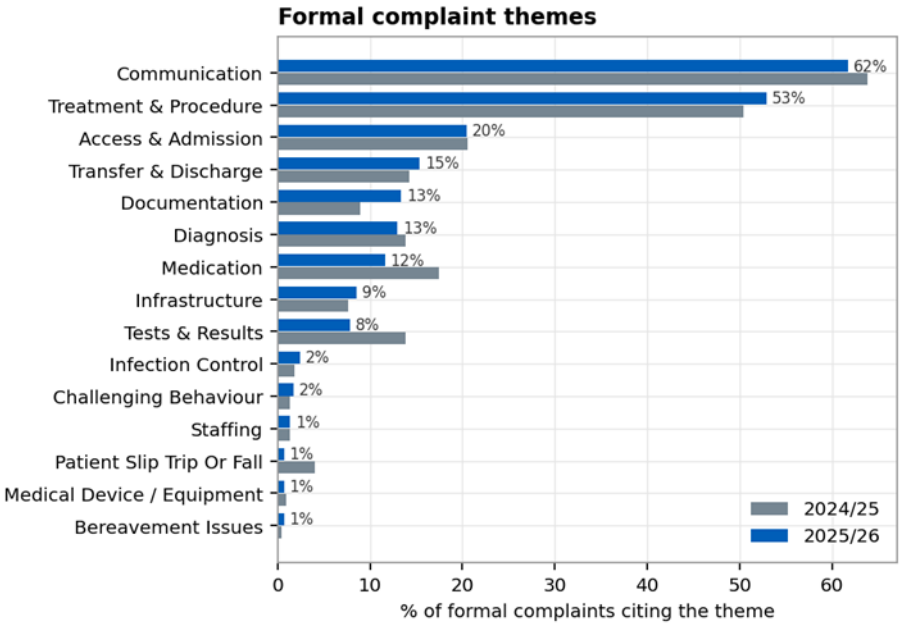
Informal concerns escalating is not the cause, since the conversion rate fell from 2.9% to 2.4%.

The themes point to where the pressure lies. Growth came from 'Treatment & Procedure', 'Communication' and 'Documentation', while 'Tests & Results', 'Medication' and patient falls all fell. Access and waiting times dominate informal concerns but do not appear to be the principal driver of the increase in formal complaints.

Greater visibility of the complaints process is unlikely to be the main driver on its own. Informal concerns rose 14% over the same period; had improved access to the process been the principal factor, both would be expected to grow at a similar rate. Formal complaints grew more than twice as fast.

## Themes

Nationally, 'Communications' was the most frequently recorded subject area in 2024/25, which is in line with WUTH, where communication issues featured in 62% of formal cases, marginally down on the previous year.




The majority of such concerns related to communication failure with patients, visitors, or carers (36%), followed by staff attitude issues – nursing (13%), medical (7%), and other staff (4%). Lesser but notable subthemes included communication failures within the immediate team (8%) and consent issues (4%).

‘Treatment and Procedure’ continued to be a prominent category, recorded in 53% of cases (up by 3%). The dominant subtheme was delays or failures in treatment (29%), with additional issues around inappropriate or wrong treatment (7%), post-operative complications (4%), failures to monitor (4%), and failure to assist with personal care (4%) or nutrition (3%). Several complaints also highlighted end-of-life care (3%) and privacy and dignity (2%).

‘Access and Admission’ featured in 20% of complaints, broadly unchanged on last year. These focused on delays or failures in accessing care (10%) and outpatient cancellations or delays (8%), reflecting sustained pressure across referral and appointment pathways.

‘Transfer and Discharge’ accounted for 15% (up by 1%), most commonly citing inappropriate discharge (7%) and discharge planning failures (3%).

‘Documentation’ rose notably to 13% (up by 4%), driven by poor record keeping (4%), access to personal and medical records (4%), and inadequate or missing discharge summaries (2%).

‘Diagnosis’ concerns were raised in 13% of complaints (down by 1%), primarily around delays or failures to diagnose (11%).

‘Medication’ accounted for 12% of complaints, down by 5%. Most were centred around delays or failures to administer (6%) and to prescribe (3%), with prescribing errors (3%) also reported. ‘Tests and Results’ fell to 8% (down by 6%), with complaints including failures to undertake tests (3%) and delays in receiving results.

Other notable themes included:

- ‘Infrastructure’ (9%, up by 1%), particularly unsafe or inappropriate clinical environments and patient property issues.

- Categories such as ‘Staffing’, ‘Infection Control’, ‘Challenging Behaviour’ and ‘Medical Device / Equipment’ each remained at or below 2% but featured in specific individual complaints.

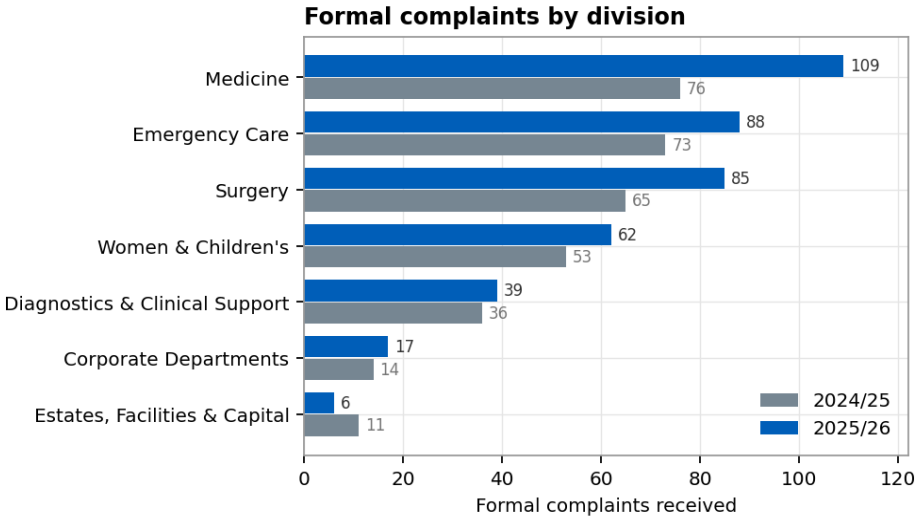
All thematic categories have been recorded and are presented in the following table, along with comparative data from previous years. (Please note that a single complaint may comprise – and often does comprise – multiple issues, which may span several categories.)

| Safeguard Category | 2023/24 | 2024/25 | 2025/26 |
|---|---|---|---|
| **Communication** | 63% | 64% | 62% |
| **Treatment & Procedure** | 52% | 50% | 53% |
| **Access & Admission** | 19% | 21% | 20% |
| **Transfer & Discharge** | 15% | 14% | 15% |
| **Documentation** | 9% | 9% | 13% |
| **Diagnosis** | 15% | 14% | 13% |
| **Medication** | 17% | 17% | 12% |
| **Infrastructure** | 7% | 8% | 9% |

| Safeguard Category | 2023/24 | 2024/25 | 2025/26 |
|---|---|---|---|
| **Tests & Results** | 14% | 14% | 8% |
| **Challenging Behaviour** | 4% | 1% | 2% |
| **Infection Control** | 1% | 2% | 2% |
| **Patient Slip Trip Or Fall** | 4% | 4% | 1% |
| **Staffing** | 1% | 1% | 1% |
| **Medical Device / Equipment** | 1% | 1% | 1% |
| **Bereavement Issues** | 1% | 0% | 1% |

## Complaints by Division

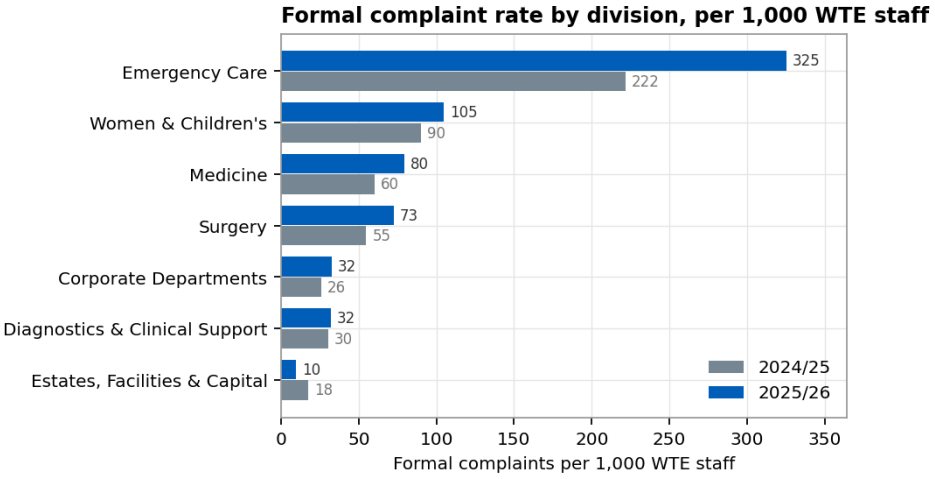
During 2025/26, the highest number of complaints was received by the Medicine Division, which was involved in 109 cases, a substantial increase from 76 in the previous year. This was followed by Emergency Care with 88 cases (up from 73) and Surgery with 85 cases (up from 65).




Women & Children's Services were involved in 62 complaints, up from 53, while Diagnostics & Clinical Support rose slightly to 39 from 36. Corporate Departments received 17 complaints (up from 14) and Estates, Facilities & Capital 6 (down from 11).

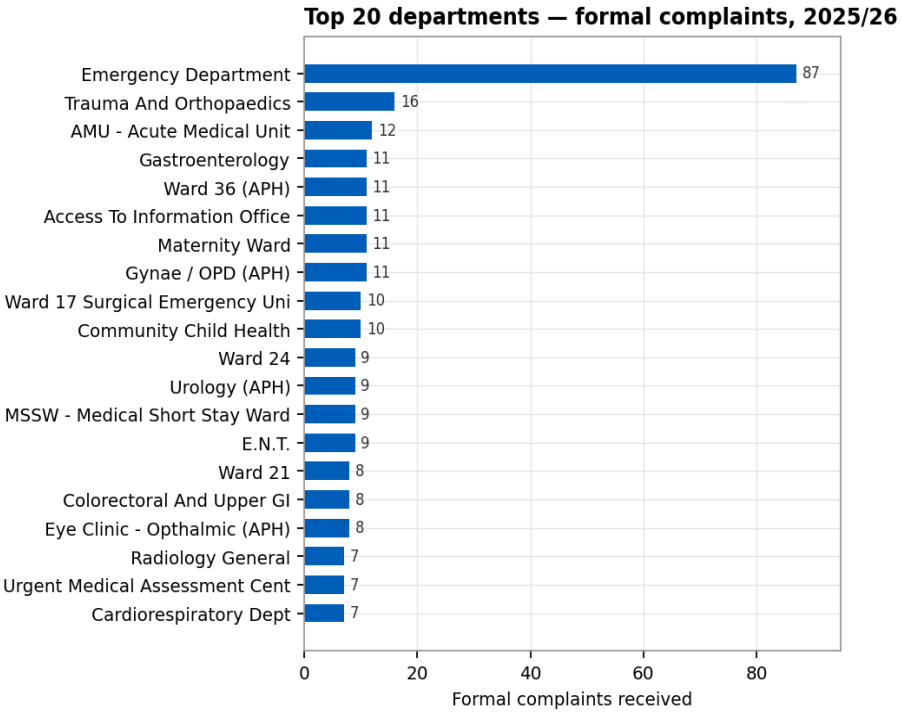
Overall, the distribution of complaints remains broadly consistent with prior years.

Raw complaint counts reflect the size of a division as much as the quality of its service. Adjusting for divisional workforce gives a different ranking. Medicine received the most complaints in absolute terms (109), but at 80 per 1,000 WTE its rate sits close to Surgery's (73) and below Women & Children's (105). Emergency Care is the clear outlier at 325 per 1,000 WTE, three times the next-highest division. Diagnostics & Clinical Support, by contrast, handled 39 complaints across a workforce comparable in size to Surgery's, giving a rate of 32.




## Complaints by Department

The top 20 individual areas and departments to receive a complaint are shown in the following chart.




This year's complaint data reveals key thematic patterns across the Trust's five most frequently cited departments.

### 1. Emergency Department (87 complaints)

- 'Treatment & Procedure' (41 cases)
- 'Communication' (36 cases)
- 'Access & Admission' (22 cases)
- 'Diagnosis' (15 cases)
- 'Infrastructure' (9 cases)
- 'Transfer & Discharge' (7 cases)

- ‘Documentation’ (6 cases)
- ‘Medication’ (6 cases)

**2. Trauma and Orthopaedics (16 complaints)**

- ‘Treatment & Procedure’ (8 cases)
- ‘Communication’ (4 cases)
- ‘Access & Admission’ (3 cases)

**3. Acute Medical Unit (12 complaints)**

- ‘Communication’ (5 cases)
- ‘Treatment & Procedure’ (5 cases)
- ‘Medication’ (3 cases)
- ‘Infrastructure’ (2 cases)

**4. Maternity Ward (11 complaints)**

- ‘Treatment & Procedure’ (9 cases)
- ‘Communication’ (7 cases)
- ‘Medication’ (3 cases)

**5. Gastroenterology (11 complaints)**

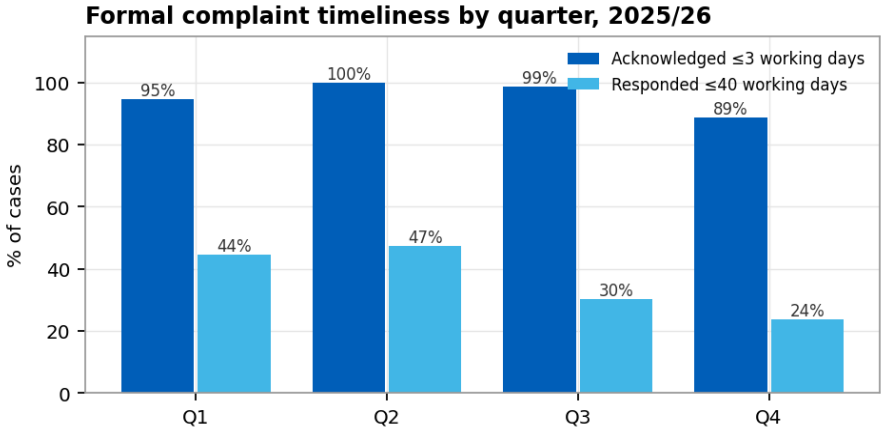
- ‘Communication’ (4 cases)
- ‘Treatment & Procedure’ (4 cases)
- ‘Access & Admission’ (3 cases)

## Complaint Response Timeliness

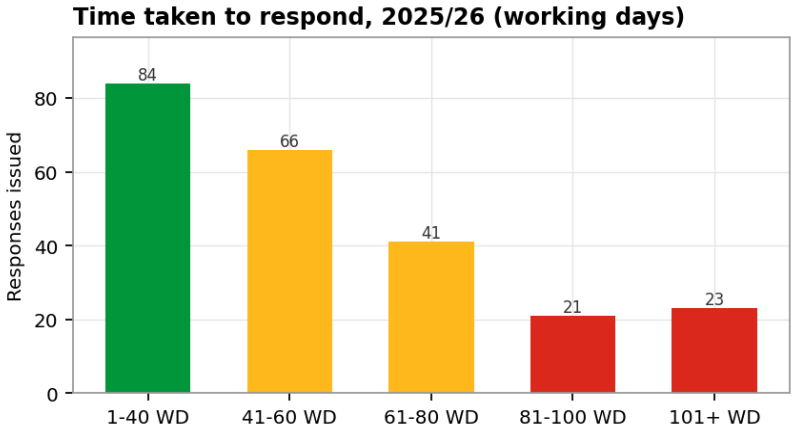
From October 2020, the Trust’s Concerns and Complaints Policy established a standard timescale of 40 working days for responding to complainants. Internal divisional response times are currently set at 23 working days, running concurrently with an initial acknowledgement target of three working days. The remaining time is allocated to finalising the response letter by the Complaints and PALS Team after receipt of the divisional investigation, followed by executive quality assurance and sign-off by the Chief Executive Officer or deputy.

During 2025/26, 95% of formal complaints were registered and acknowledged within the national target of three working days, a 3 percentage point reduction on the previous year. Performance was strongest in Quarters 2 and 3 and weakest in Quarter 4, when the rising volume of new registrations began to affect turnaround.

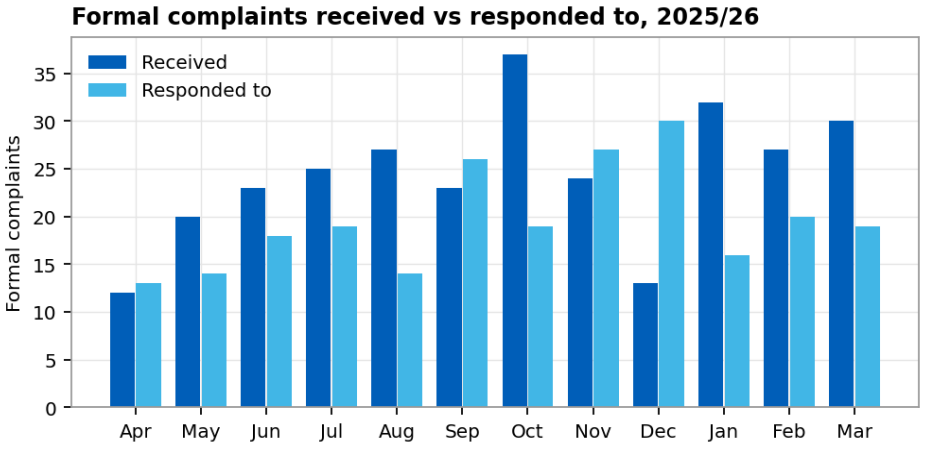
Only 36% of complaints received a response within the local target of 40 working days, representing a 1 percentage point decrease compared to the previous year.




The average response time increased from 53 to 56 working days. The distribution of response times shows that, while 84 responses were issued within the 40-working-day target, 44 took more than 80 working days.




There was nevertheless a 26% increase in productivity in terms of completed investigations, with 235 cases closed in 2025/26, compared to 187 in 2024/25.

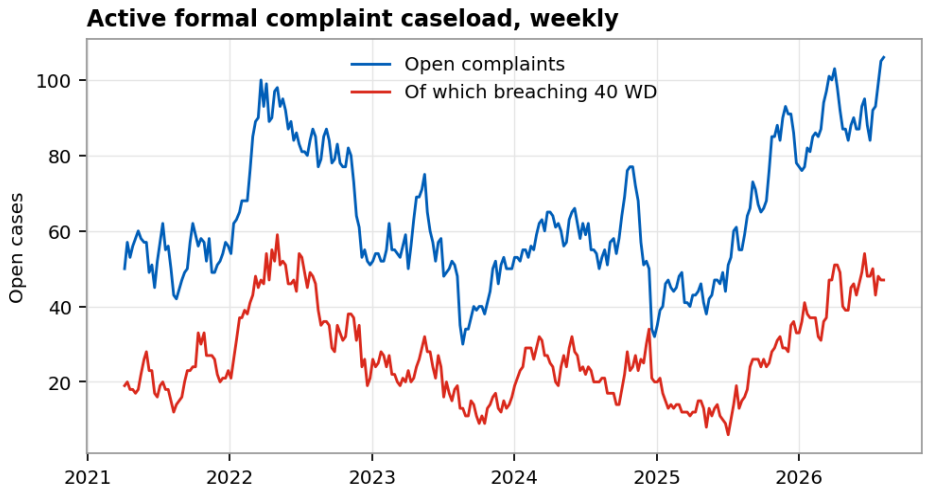



However, complaints were received faster than they could be responded to for most of the year, and the Trust ended 2025/26 with a materially larger open caseload than it began with.

## Open Caseload

WUTH began 2025/26 with an active caseload of 40 complaints, 11 of which had exceeded the 40-working-day timescale. By the end of the year, this had risen to 100 active complaints, with 47 breaching the timescale – representing a 150% increase in overall caseload and a more than fourfold increase in overdue cases. This is the single most significant deterioration in the year and reverses the improvement achieved in 2024/25.

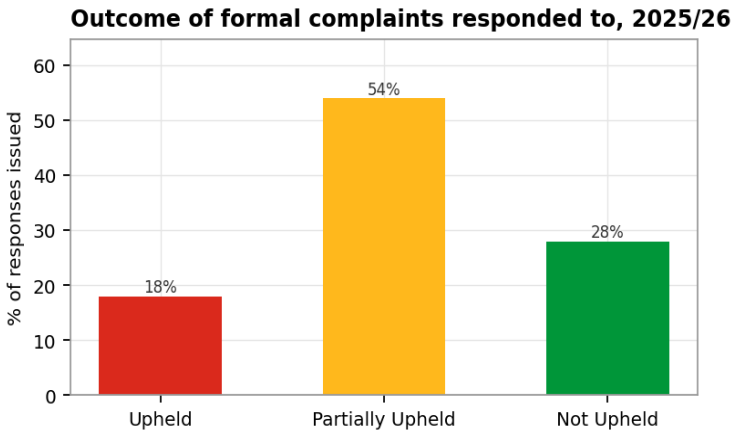
The following chart shows the weekly fluctuations in active caseload over the past five years.




Analysis of the end-to-end complaints process continues to highlight the complexity of clinical divisional investigations, resulting in protracted timescales that frequently exceed the internal deadline of 23 working days.

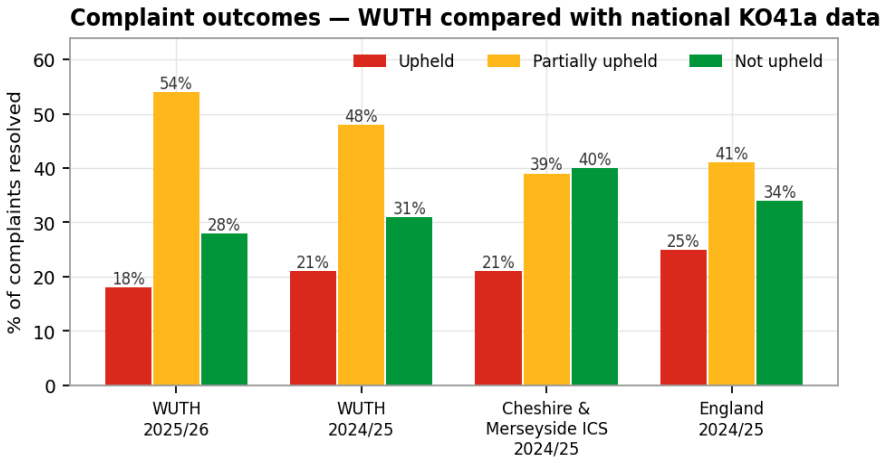
## Complaint Outcomes

During 2025/26, a total of 235 complainants received a first response to their concerns – representing a 26% increase compared to the 187 responses issued in 2024/25. Of these responses, 18% of complaints were upheld, 54% were partially upheld, and 28% were not upheld.




For comparison, NHS England KO41a data for 2024/25 (covering all hospital and community health services in England) recorded 106,608 resolved complaints, with the following

outcomes: 25% upheld, 41% partially upheld and 34% not upheld. Within the Cheshire and Merseyside Integrated Care System, 2,898 complaints were resolved, of which 21% were upheld, 39% partially upheld and 40% not upheld.




The combined total of upheld and partially upheld complaints was 66% nationally and 60% across Cheshire and Merseyside, compared with 72% at WUTH in 2025/26 and 69% in 2024/25. WUTH therefore sits above both comparators, and the gap is wider against the ICS than against England as a whole.

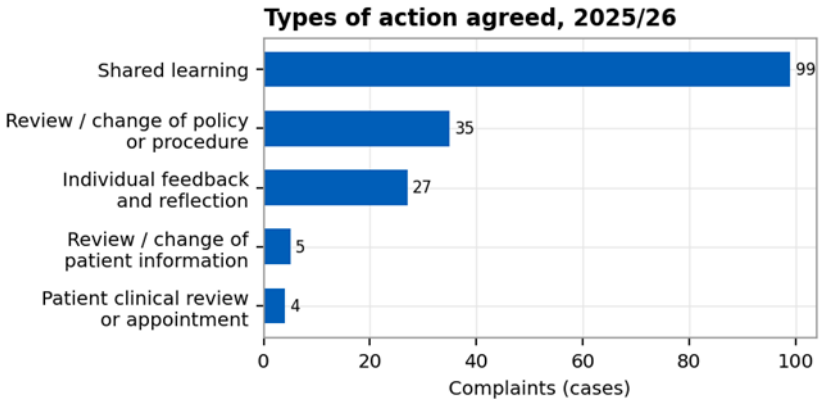
This variance may indicate a greater number of areas for improvement within our organisation, or alternatively, it may reflect a more reflective and patient-centred approach to complaint review – one in which we recognise and respond to partial service failings more readily than some peers.

The majority of upheld or partially upheld complaints related to communication and appointment or treatment delays. Communication concerns frequently involve differing recollections and, where contemporaneous evidence cannot resolve those differences, investigations take account of the complainant's reported experience alongside the available evidence, which may result in that aspect of the complaint being partially upheld.

## Learning from Complaints

Since October 2020, all divisions have been required to submit an action plan alongside each complaint response, detailing identified leads and timescales for completion. These are intended to support the tracking of actions via the Ulysses Safeguard system.

Of the 235 complaint responses issued in 2025/26, 65 cases were judged not to require any formal actions. Where actions were agreed, the most frequently recorded categories were shared learning (99 cases) and individual feedback and reflection (27 cases).




Of greater significance are those complaints that produced a tangible change to services. In 44 cases – 19% of all responses issued – the agreed action went beyond feedback and reflection: 35 involved a review of or change to a policy or procedure, five a change to patient information, and four a direct clinical review or appointment. Examples from each division are set out below, showing the concern raised and the change made in response.

| Ref | Concern raised | Change made |
|---|---|---|
| **Medicine** | | |
| **24942** | A patient discharged from a medical ward left without critical medication, with no discharge summary provided. He was readmitted four days later. | The Pharmacy Medicines Safety Team revised the discharge procedure for patients leaving before it is complete. It now requires medication locker checks, verification of home medicines with the patient, correct storage or disposal, placement of intended medicines in labelled pharmacy bags, sign-out on the electronic record, and confirmation with nursing staff. A ‘Failed Check at Discharge’ audit now monitors compliance. |
| **28508** | A patient with a haematology condition went more than a year without monitoring or follow-up. | An additional specialist nurse is being recruited, regular clinics reinstated and additional clinics continued to reduce the backlog. Virtual appointments have been introduced so patients and blood results can be reviewed remotely. The patient’s results were clinically reviewed and a follow-up arranged. |
| **27375** | Permission to administer end-of-life medication was sought from a distant relative rather than the patient’s recorded next of kin. | The Trust confirmed that ‘welcome calls’ must verify next-of-kin details and put arrangements in place to ensure this happens for late and weekend admissions when ward clerks are unavailable. |
| **23310** | A family raised concerns about a relative’s care on a medical ward, | Clearly labelled stickers are now placed on bags containing soiled clothing so that |

| Ref | Concern raised | Change made |
|---|---|---|
| | including missing jewellery and the return of soiled clothing during a norovirus outbreak. | staff and families are alerted to the contents, and a standard process has been established for the ward clerk to telephone next of kin during any infection outbreak. |
| **Emergency Care** | | |
| **24054** | A patient remained on an x-ray trolley in a corridor for around 40 hours without pressure-relieving equipment, call buzzers, curtains for privacy or the ability to dim lighting. | Standard ED mattresses have been replaced with memory foam and 350 high-specification dynamic mattresses rolled out, with refurbishment to increase space for trolleys. Dignity screens, designated private care areas and amenity packs have been introduced, portable call bell provision in escalation areas reviewed, and an Acute Frailty Unit established as part of an executive-led programme to reduce delays. |
| **26341** | A patient in a corridor escalation area had no call bell and waited at length for assistance, was placed beside doors that banged constantly, and was not seen by a doctor for 13 hours despite presenting with chest pain. | A corridor care checklist and daily senior nurse reviews have been introduced for patients in escalation areas, alongside recruitment of additional Clinical Support Workers, increased medical staffing, and work to provide call-bell alternatives for patients in corridor areas. |
| **23438** | A family questioned why no ECG or blood tests were undertaken when a young patient attended having lost consciousness, and asked what guidance the Trust followed. | The Trust's syncope guidance is being updated to align with current NICE recommendations. As an interim measure the NICE guidance was circulated to ED clinicians to ensure referral triggers are recognised. |
| **25631** | A patient seated near the door did not hear her name called three times and was subsequently refused an appointment slot, then treated dismissively at reception. | The triage team now calls patients from both waiting areas rather than a single location, and installation of a hearing loop is being considered as part of the Urgent and Emergency Care Upgrade Programme. |
| **23132** | A joint complaint with the mental health trust regarding a patient detained under the Mental Health Act, raising concerns about the appropriateness of the care environment, privacy and dignity. | A major redevelopment of the Emergency Department is underway, including refurbishment of the mental health unit rooms to create a more therapeutic environment, with staffing and support arrangements enhanced in the interim. |
| **Surgery** | | |
| **28063** | A patient received several incorrect appointment dates and letters, | A new call-back management process has been introduced in Ophthalmology, |

| Ref | Concern raised | Change made |
|---|---|---|
| | causing confusion and missed attendances. | comprising a daily allocation log and senior oversight to ensure return calls are completed within 24 hours. Text message reminders are being introduced as standard for Ophthalmology appointments, staff must now use telephone or text alongside letters whenever short-notice or time-sensitive appointments are arranged, and use of email for families preferring digital contact is being reviewed. |
| **22433** | A patient wrote to raise concerns about the care and treatment she received following an emergency admission, including pain management and the information given to her. | New patient information materials have been introduced explaining the triage and discharge processes, alongside strengthened comfort checks and documentation requirements on the ward. |
| **26309** | A patient raised concerns about an intimate examination, including the information and consent obtained beforehand. | A safeguarding review found the examination clinically appropriate but identified communication and consent issues. Changes were implemented to improve patient information, explicit consent and communication prior to intimate examinations. |
| **27678** | An elective laparoscopic procedure was abandoned, followed by further cancellations and delays, with the patient questioning the explanation given. | Availability of additional specialist equipment has been increased so that alternative approaches can be considered should similar intra-operative difficulties arise. |
| **Women & Children's** | | |
| **23199** | A woman raised multiple concerns about her care in labour, including delays in pain relief, the way she was spoken to during an epidural, and the support offered afterwards. | A new Perinatal Pelvic Health Service has been introduced, with structured information now provided to all women from booking through to postnatal care. The role of the Perineal Clinic has been embedded, supporting earlier referral and management of wound healing concerns, and midwifery training on pelvic health assessment strengthened. |
| **26595** | A woman experiencing bleeding in early pregnancy could not get through to the early pregnancy unit and was twice directed to the Emergency Department; a scan was subsequently cancelled. | Enhanced telephone triage training has been developed and implemented for early pregnancy and gynaecology staff, an automated telephone messaging system introduced to direct patients to the correct service, and referral pathways and communication guidance reviewed and reinforced. |

| Ref | Concern raised | Change made |
|---|---|---|
| **Diagnostics & Clinical Support** | | |
| **22849** | A patient attending for breast screening was seen in a room too small for her husband to accompany her, and raised concerns about dignity during the mammogram and about how biopsy findings were communicated. | A larger consultation room has been allocated and partners are now invited in after checks; gowns are offered to maintain dignity during mammograms; and a breast care nurse is now present when biopsy findings are shared, to ensure consistency. |
| **23734** | A patient was told she would not need intravenous access for an MRI scan, then found on arrival that she did. She had previously experienced difficulties with IV access, and was left alone in a cubicle for an hour. | IV access protocols have been reviewed, with work underway to improve the visibility of previous access difficulties within the patient record, alongside reinforced expectations on patient communication and welfare monitoring. |
| **Corporate Departments** | | |
| **25660** | One of several complaints about delays in responding to subject access requests, in this case a request for medical records that had gone unanswered for months. | A new case management system has been introduced for tracking and managing subject access requests, together with an online request form and a secure digital download site to reduce administrative burden. Additional staff have been recruited, monthly capacity and demand reviews established through the Information Assurance Group with escalation to senior governance committees, and standard operating procedures reviewed by the Service Improvement Team. |
| **Estates, Facilities & Capital** | | |
| **25037** | A disabled visitor found all accessible bays full, with the only dropped kerb suitable for wheelchair access located in the ambulance bay, no wheelchair available on arrival, and a 20-minute wait for porter assistance. | The Trust has confirmed plans to increase the number of disabled bays with dropped kerb access, together with a review of porter rotas, wheelchair provision and reception staffing. |

## Re-opened Complaints

In 2025/26, 36 complaints were re-opened for further local resolution or clarification – a 57% increase on the 23 re-opened cases in 2024/25. Re-opened cases were spread across all divisions, with Surgery accounting for 11, Women & Children's 8, Medicine 7 and Emergency Care 5.

Complaints were re-opened primarily because complainants either disagreed with the original investigation findings or proposed actions, or because they were seeking further explanation or clarification regarding the response.

## Parliamentary and Health Service Ombudsman (PHSO)

During 2025/26, the Parliamentary and Health Service Ombudsman (PHSO) contacted the Trust for the records of ten cases for consideration of independent investigation, compared with seven in 2024/25 (of which, at the time of writing, three were closed without progression to detailed investigation).

Six PHSO cases relating to the Trust were closed during the year. Two were closed without progression to detailed investigation and required no further action by the Trust. Of the remaining four, two were partially upheld and two were upheld.

One of the upheld cases did not proceed to detailed investigation: the PHSO was satisfied with the quality of the Trust's local investigation and the case was concluded at the early resolution stage, with a recommendation for financial remedy. This is a positive reflection on the standard of local investigation, notwithstanding the failings identified.

Six cases were also closed in 2024/25, of which one was upheld or partially upheld. The number of cases in which the PHSO identified failings has therefore risen from one to four.

Although the number of upheld or partially upheld PHSO cases increased from one to four, the Ombudsman's findings were consistent with those already identified through the Trust's local investigations, indicating that local investigations are generally identifying failings accurately. This is reinforced by the case concluded at early resolution, where the PHSO was sufficiently satisfied with the local investigation not to progress to a detailed investigation at all. The main difference lay in the remedy, with the PHSO recommending additional actions or financial remuneration.

The numbers involved are also very small – a movement of three cases – so the year-on-year change should not be read as a trend.

The four cases in which failings were identified are summarised below.

| **22/045 – partially upheld: Care of a patient in the Emergency Department** | |
|---|---|
| **PHSO findings** | The complaint concerned the care of a patient who presented with catatonia and who subsequently died from a pulmonary embolism. The PHSO found that clinical assessment, investigation, physical examination, placement in a mental health room and the decisions taken on VTE assessment were all appropriate. A service failure was identified because there was no documented discussion with the patient about the benefits and risks of refusing intravenous fluids and medication, and no evidence of multidisciplinary consideration of alternative treatment options. The PHSO concluded that this caused uncertainty and additional distress to the family, although there was insufficient evidence to conclude that the outcome would have been different. |

| | |
|---|---|
| **Recommended actions** | A written apology to the family; a financial remedy of £800 for the distress and uncertainty caused; and an action plan to improve shared decision-making, capacity and consent assessment, and the documentation of treatment refusals and the clinical rationale for them, together with associated staff awareness and training. |

| **23/115 – partially upheld: Nutritional monitoring during an admission** | |
|---|---|
| **PHSO findings** | The complaint related to the care of a patient admitted with COPD and metastatic cancer. The prescribing of levofloxacin, management within the ED and support with mobilisation were all found to be appropriate and in line with clinical guidance. A failing was identified in the inconsistent completion of food charts and monitoring of nutritional intake. While there was no evidence that this affected the clinical outcome, the omission caused avoidable distress and fell below the expected standard of nutritional monitoring. |
| **Recommended actions** | A written apology to the complainant, and a formal action plan addressing compliance with nutritional monitoring requirements, the reasons for the failure, the resulting learning and service improvements, and clear accountability, monitoring arrangements and implementation timescales. |

| **23/066 – upheld: Delayed diagnosis of endometrial cancer** | |
|---|---|
| **PHSO findings** | Initial investigations were considered appropriate but following unsuccessful diagnostic procedures the patient was not referred to a specialist gynaecological cancer multidisciplinary team when this was clinically indicated. The absence of MDT review delayed appropriate imaging and diagnosis by approximately ten weeks. The PHSO found that the delay caused avoidable uncertainty, unnecessary preparation for major surgery, delayed access to end-of-life support, and lost time for the patient and family to prepare for a terminal diagnosis. |
| **Recommended actions** | Formal acknowledgement and apology for the failure to seek MDT input in a complex presentation and for the delayed diagnosis and its impact on the patient and family; the sharing of learning with the staff involved in the patient's care; and demonstration of the actions taken to embed that learning and improve future practice. |

| **Closed 2025/26 – upheld: Post-operative care following a hysterectomy** | |
|---|---|
| **PHSO findings** | During primary investigation the PHSO identified indications of failings in post-operative care, as set out in the Trust's investigation. These included the earlier recognition and management of infection risk in an immunocompromised patient; delays in recognising and managing post-operative ileus; inconsistent fluid management, including delays in reconnecting intravenous fluids; inappropriate use of oral medication during periods of vomiting; delays in escalating and optimising pain relief; and inadequate nursing escalation, documentation and clinical monitoring. The PHSO considered that these failings were likely to have prolonged |

| | |
|---|---|
| | pain, nausea, distress, recovery time and length of stay, although no permanent physical harm was identified. |
| **Recommended actions** | A financial remedy of £600 reflecting the avoidable pain, distress and prolonged recovery. |

Although small in number, the cases closed this year point consistently to the same set of issues, each of which also features in the Trust's own complaint themes:

- Escalation and timely review of deteriorating or complex patients.
- The quality of documentation, and the recording of clinical decision-making.
- Shared decision-making, consent, and communication with patients and families.
- Monitoring and supportive care – nutrition, fluids and symptom management.
- Early multidisciplinary involvement in complex cases.

Documentation and communication feature in all four cases, mirroring their position among the most frequently cited themes in formal complaints during 2025/26.

## Complaint Demographics

In 2025/26, 51% of complaints were raised on behalf of the patient, with the remaining 49% raised by the patient themself – a slight shift towards patients raising complaints directly compared with previous years.

| **Sex of patient (293 of 293 cases recorded)** | **%** |
|---|---|
| Female (178 cases) | 61% |
| Male (115 cases) | 39% |

Ethnicity is recorded as 'not stated' in 54 cases (18% of the total), so the comparison above is drawn from the 239 cases where an ethnic group is known. On that basis the profile of complainants closely tracks the ethnic composition of the Wirral resident population, with no group materially over- or under-represented. No demographic group appears disproportionately represented within available complaints data, although completion rates for ethnicity data on Cerner Millennium remain an area for improvement.

| **Ethnic group** | **WUTH Complaints (of 239 stated)** | **Wirral Census 2021** |
|---|---|---|
| White | 94.1% (225 cases) | 95.2% |
| Asian, Asian British | 2.9% (7 cases) | 2.3% |
| Other ethnic group | 1.7% (4 cases) | 0.6% |
| Mixed or multiple | 0.8% (2 cases) | 1.5% |
| Black, Black British, Caribbean or African | 0.4% (1 case) | 0.4% |

The complainant profile is broadly even across the adult age range, with the 36–53 band the largest at 25% and no single band accounting for more than a quarter of cases. Patients aged 54 and over account for 46% of complaints, and those aged 18–35 for 21%. Complaints

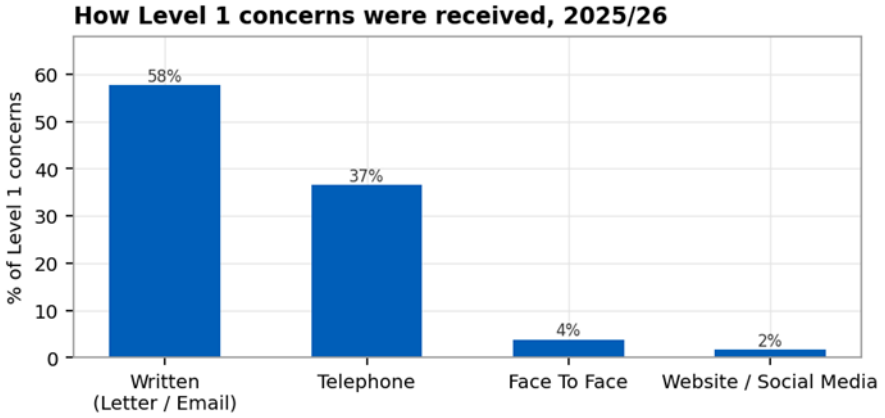
relating to children and young people represent 7%, concentrated in Women & Children's Services.

| Age range of patient (273 of 293 cases recorded) | % |
|---|---|
| 0–17 (20 cases) | 7% |
| 18–35 (58 cases) | 21% |
| 36–53 (68 cases) | 25% |
| 54–71 (60 cases) | 22% |
| 72–89 (55 cases) | 20% |
| 90+ (12 cases) | 4% |

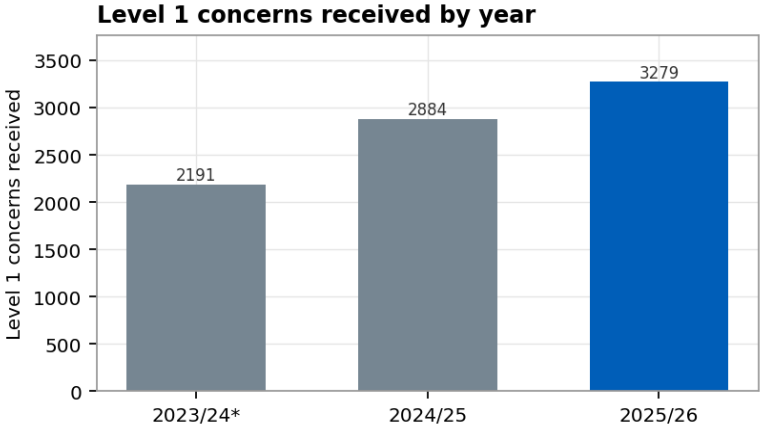
# Level 1 (Informal Concerns)

## Volume and Trend

In 2025/26, WUTH received a total of 3,279 informal concerns, averaging 273 cases per month – well above the Trust performance metric of 173 per calendar month. The majority were received in writing (58%), with a further 37% by telephone.

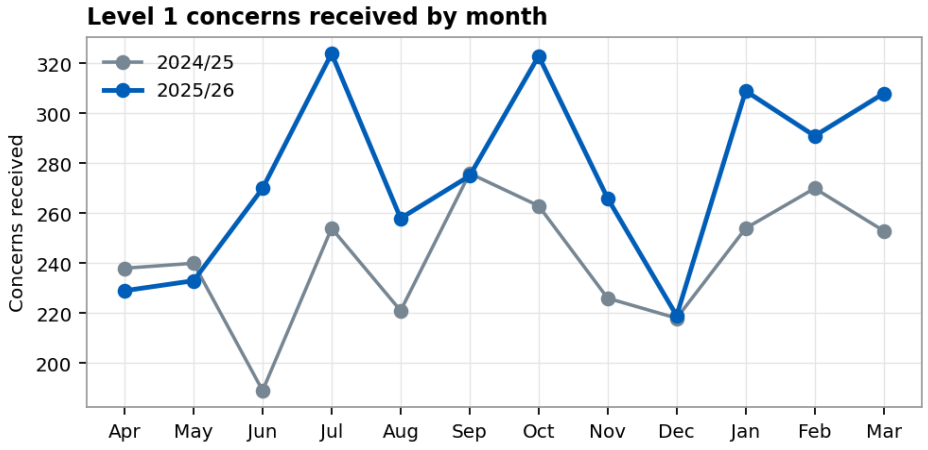



This was a 14% increase compared to the 2,884 concerns received in 2024/25.



A month-by-month comparison between the two most recent years further illustrates this growth. Each quarter in 2025/26 recorded higher volumes than the corresponding quarter in the previous year.

| Quarter | 2024/25 | 2025/26 | % Change |
|---|---|---|---|
| **Q1** | 666 | 724 | +9% |
| **Q2** | 745 | 854 | +15% |
| **Q3** | 701 | 804 | +15% |
| **Q4** | 772 | 897 | +16% |



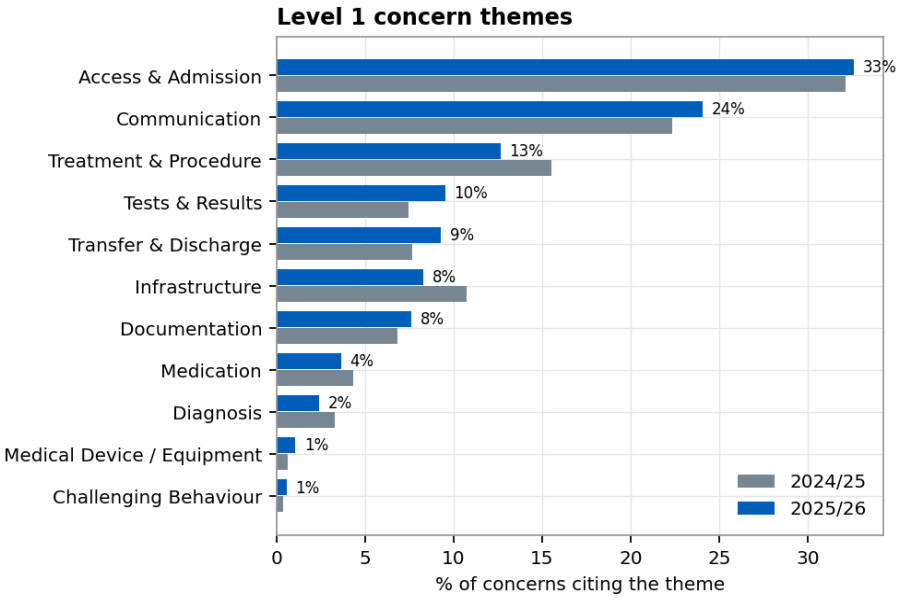

This upward trend may reflect a combination of both positive and negative factors.

Positive drivers could include greater visibility of how to raise concerns, and a deliberate emphasis on resolving concerns informally, where appropriate. This is supported by the fall in the proportion of concerns escalating to formal complaints, from 2.9% to 2.4%.

Conversely, the increase could also suggest a rise in dissatisfaction with elements of care or service, particularly as the trend has been accompanied by a 31% rise in formal complaints.

## Themes

Informal concerns recorded through the year showed a distinct thematic profile compared to formal complaints, with a strong emphasis on service access, responsiveness, and operational issues.




‘Access and Admission’ represented the highest thematic category at 33% (up by 1% from last year), reflecting concerns with delays in accessing care (15%), follow-up appointment delays or failures (9%), and outpatient appointment delays and cancellations (7%). These figures are notably higher than the equivalent themes in formal complaints and continue to reflect frustration with capacity and scheduling challenges.

‘Communication’ featured in 24% of informal concerns (up by 2%), notably around failures in communication with patients or carers (17%). Compared to the 62% in formal complaints, this suggests that many communication concerns are initially managed at an informal level. Staff attitude still featured (6% in total).

‘Treatment and Procedure’ accounted for 13% (down by 3%), largely relating to treatment delays (4%) and delays in recognising complications (4%).

‘Tests and Results’ rose to 10% (up by 3%), driven by failures or delays in receiving test results and reports (6%) – a pattern strongly associated with the sharp rise in concerns recorded against Radiology.

‘Transfer & Discharge’ (9%, up by 1%) and ‘Infrastructure’ (8%, down by 3%) reflected concerns about referral processes, discharge planning, patient property and the ward environment.

Smaller but notable themes included:

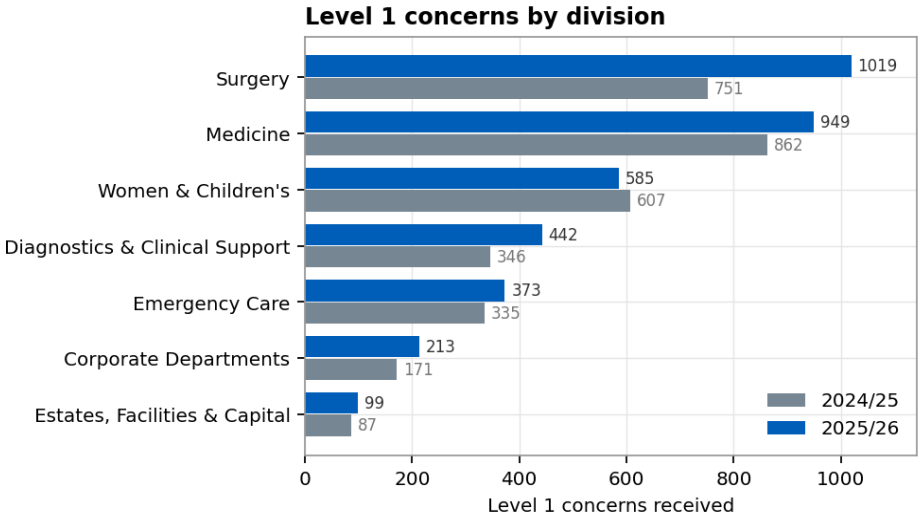
- ‘Documentation’ (8%, up by 1%), especially around access to personal and medical records.
- ‘Medication’ (4%, no change), typically involving delays in issuing or advice.
- ‘Diagnosis’ (2%, down by 1%).

Although many concerns are resolved effectively without escalation, others – particularly those involving treatment or diagnosis – may convert into formal complaints if not addressed to the satisfaction of the individual.

| Safeguard Category | 2023/24 | 2024/25 | 2025/26 |
|---|---|---|---|
| **Access & Admission** | 24% | 32% | 33% |
| **Communication** | 32% | 22% | 24% |
| **Treatment & Procedure** | 19% | 16% | 13% |
| **Tests & Results** | 6% | 7% | 10% |
| **Transfer & Discharge** | 8% | 8% | 9% |
| **Infrastructure** | 14% | 11% | 8% |
| **Documentation** | 4% | 7% | 8% |
| **Medication** | 3% | 4% | 4% |
| **Diagnosis** | 3% | 3% | 2% |
| **Medical Device / Equipment** | 1% | 1% | 1% |
| **Challenging Behaviour** | 1% | 0% | 1% |

## Concerns by Division

During 2025/26, the Surgery Division received the highest number of informal concerns, with 1,019 cases, overtaking Medicine, which had been the most reported division in the previous year. This represents a 36% increase from the 751 concerns recorded for Surgery in 2024/25.

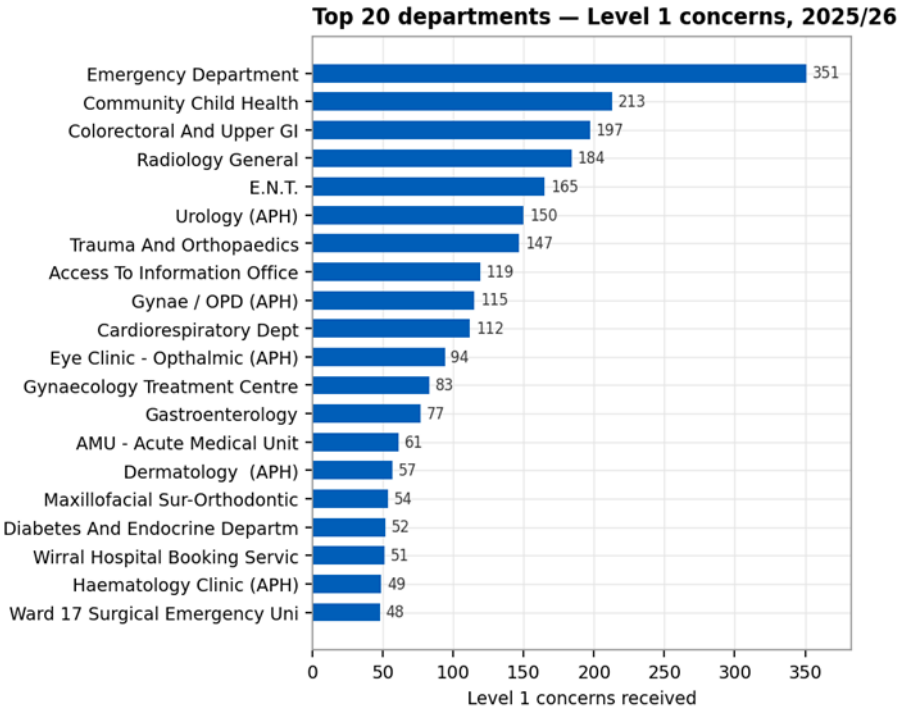



Medicine followed closely with 949 concerns, an increase from 862 last year. Diagnostics and Clinical Support recorded 442 concerns, up from 346, and Emergency Care 373, up from 335. Corporate Departments received 213 concerns, up from 171, and Estates, Facilities & Capital 99, up from 87.

Women and Children's Services was the only division to record a reduction, falling to 585 concerns from 607 in 2024/25 – a positive development given the sharp rise recorded in that division in the previous year.

## Concerns by Department

The top 20 departments and areas to receive a concern are shown in the following chart.




An examination of the figures highlights significant increases across the majority of the top 20 departments compared with the previous year, and growing pressures and patient dissatisfaction in several key areas.

Foremost among these is the Emergency Department, which continues to attract the highest volume of informal concerns. This year, concerns have risen from 313 to 351, an increase of 12%.

Two departments saw concerns almost double: Colorectal and Upper GI rose from 104 to 197, and Radiology General from 95 to 184. The ENT Department also saw a steep rise, from 101 to 165.

Of particular note is Community Child Health, which fell from 274 to 213 – a reduction of 22% and a reversal of the sharp rise recorded in 2024/25.

The top themes in the top five departments receiving the highest volumes of concerns were as follows.

**1. Emergency Department (351 concerns)**

The Emergency Department continued to face high-volume and wide-ranging concerns. The predominance of concerns about ‘Communication’ and ‘Treatment & Procedure’ reflects both clinical delivery pressures and dissatisfaction with how care is explained or coordinated. ‘Infrastructure’ largely related to missing patient property, while ‘Access & Admission’ and ‘Transfer & Discharge’ reflect systemic pressures in managing capacity and patient flow.

- ‘Communication’ (89 cases)
- ‘Treatment & Procedure’ (84 cases)
- ‘Infrastructure’ (61 cases, mainly lost property)
- ‘Access & Admission’ (48 cases)
- ‘Transfer & Discharge’ (24 cases)
- ‘Documentation’ (20 cases)
- ‘Medication’ (18 cases)
- ‘Tests & Results’ (15 cases)

**2. Community Child Health (213 concerns)**

Concerns fell by 22% year on year but remain heavily concentrated on access – waiting times, referral routes and appointment systems. Concerns about ‘Diagnosis’ continue to reflect anxiety around the ADHD pathway.

- ‘Access & Admission’ (132 cases)
- ‘Communication’ (19 cases)
- ‘Medication’ (18 cases)
- ‘Diagnosis’ (17 cases)
- ‘Transfer & Discharge’ (13 cases)
- ‘Treatment & Procedure’ (9 cases)

**3. Colorectal and Upper GI (197 concerns)**

Colorectal and Upper GI volumes almost doubled year on year.

- ‘Access & Admission’ (107 cases)
- ‘Communication’ (38 cases)
- ‘Treatment & Procedure’ (27 cases)
- ‘Tests & Results’ (19 cases)
- ‘Documentation’ (7 cases)

**4. Radiology General (184 concerns)**

Again, concerns almost doubled.

- ‘Tests & Results’ (129 cases)
- ‘Communication’ (27 cases)
- ‘Access & Admission’ (16 cases)
- ‘Infrastructure’ (7 cases)

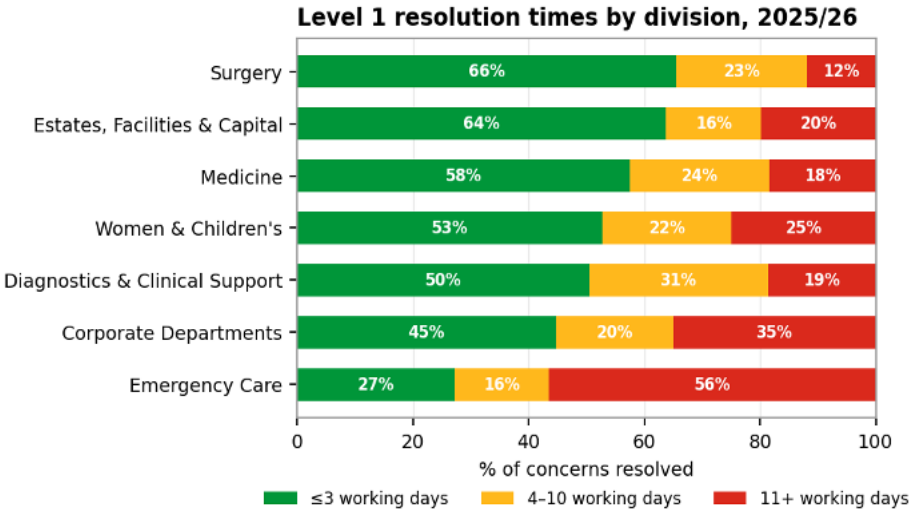
**5. ENT (165 concerns)**

ENT saw a 63% increase in concerns, again driven principally by access issues.

- ‘Access & Admission’ (95 cases)
- ‘Communication’ (23 cases)
- ‘Transfer & Discharge’ (16 cases)
- ‘Treatment & Procedure’ (15 cases)
- ‘Tests & Results’ (10 cases)

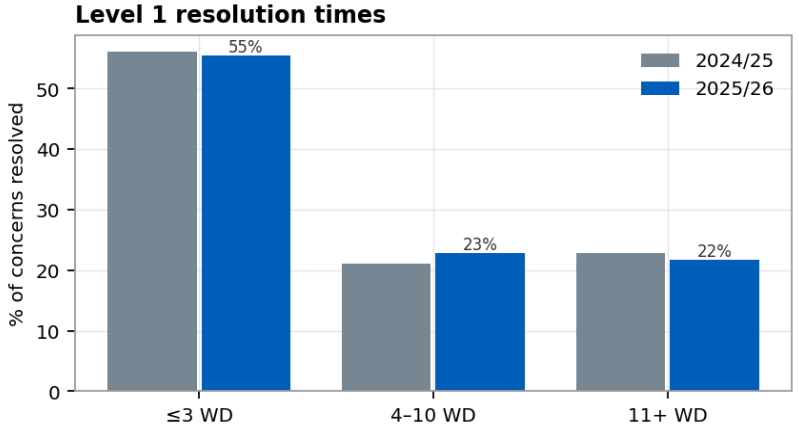
## Resolution Times

The following chart illustrates the varying resolution timescales across divisions, categorised into three brackets: resolved in fewer than three working days, within four to ten working days, and in more than ten working days.




Of all concerns resolved during the year, 55% (1,770 cases) were resolved within three working days, demonstrating a continued focus on early, timely resolution and broadly holding against the 56% achieved in 2024/25 despite a further increase in caseload.

A further 23% (730 cases) were resolved within 4 to 10 working days, meaning that 78% of all concerns were resolved within ten working days – a small improvement on the 77% achieved in 2024/25.




This overall profile suggests a generally responsive complaints-handling process, although the remaining 22% (692 cases) took more than 10 working days, suggesting more complex issues requiring extended resolution or operational delays in some areas.

Performance varies considerably by division. Surgery resolved two thirds of concerns within three working days (66%), followed by Estates, Facilities & Capital (64%) and Medicine (58%). Emergency Care resolved only 27% within that timescale, with 56% taking longer than ten working days – by some distance the weakest divisional position and a clear priority for

2026/27. Corporate Departments also showed a high proportion of extended resolutions (35%), reflecting the volume of subject access request enquiries handled by the Access to Information Office.

Encouragingly, the rate at which informal concerns escalated to formal complaints has decreased again, with only 2.4% of Level 1 concerns progressing in 2025/26, compared to 2.9% in the previous year.

## Conclusion

The 2025/26 position is one of a complaints service performing well in the areas it directly controls but overtaken by demand.

Moderate assurance is provided regarding complaints governance, learning and quality of investigation. Assurance is reduced by deterioration in response timeliness, growth in the active caseload and the increase in overdue complaints.

Acknowledgement, registration and the quality assurance of final responses were all maintained. Informal concerns continued to be resolved early and the proportion escalating to a formal complaint fell for a second successive year to 2.4%.

Demand nevertheless outstripped capacity. The Complaints and PALS Team increased its output by 26%, but against a 31% rise in formal complaints this meant responses were issued more slowly rather than more quickly: the average lengthened to 56 working days and the active caseload more than doubled over the year. The binding constraint is not the productivity of the central team, but the time taken to complete divisional investigations, particularly where a complaint spans more than one division and the lead-division model is not consistently applied.

The consequences are already visible. Re-opened complaints rose by 57%, reversing last year's improvement, and referrals to the Ombudsman also increased. Delay is a recognised driver of complainant dissatisfaction irrespective of the quality of the eventual response.

Reducing the open caseload to a sustainable level and restoring performance against the 40-working-day standard are therefore the Trust's principal objectives for complaints handling in 2026/27.

## Next Steps for 2026/27

- **Caseload recovery:** Agree a recovery trajectory with each division for both the open caseload and the number of breaching cases, with progress reported to the Patient Safety Quality Board against quarterly milestones rather than the year-end position alone, so that slippage is visible early enough to act on.[1] Assuming complaint volumes stabilise, the following aims are proposed:

[1] Two points should be noted. Delivering this requires around 320 responses during 2026/27, against 235 in 2025/26 (an increase of roughly 37%, above the 26% improvement achieved this year). Timeliness will also worsen before it improves: clearing the cases already in breach means those responses will be recorded as late, so performance against the 40-working-day standard is expected to dip before recovering. This is a consequence of caseload recovery rather than a failure of it.

| Measure | 2025/26 position | Aim for 2026/27 |
|---|---|---|
| Open formal complaints at year end | 100 | Fewer than 70 |
| Of which breaching 40 working days | 47 | Fewer than 15 |
| Responded to within 40 working days | 36% | 50 to 55% |
| Average response time | 56 working days | Below 45 working days |

- **Divisional focus:** Medicine, Emergency Care, Surgery and Women & Children's to prioritise the timeliness, coordination and quality of complaint investigations.

- **Named lead investigator:** Appointment of a single named lead per complaint, responsible for coordinating all clinical and managerial input, to become standard practice. This is the principal remedy for delay in multi-divisional cases.

- **Training:** The Complaints and PALS Team to continue monthly investigation and response-writing training for divisional managers, with uptake integrated into leadership development programmes.

- **Learning and tracking:** Divisions to evidence that agreed actions are completed, with formal tracking to demonstrate change and improvement over time.

- **Staff support:** Divisions to review how staff are supported during investigations, ensuring they are debriefed and informed of the resulting learning.

- **Complainant communication:** Maintain proactive contact where delay is unavoidable. Setting realistic expectations and providing regular updates remains central to maintaining confidence in the process.

**Group Board of Directors in Public** **Item No 21**

**04 November 2026**

| | |
|---|---|
| **Title** | WCHC Complaints Annual Report 2025/26 |
| **Area Lead** | Chris Douglas, Joint Chief Nursing Officer |
| **Author** | Ian Salisbury, Senior Complaints Officer |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Assurance |

The purpose of this report is to assure the Group Board of concerns and complaints activity, performance, outcomes and learning at Wirral Community Health and Care NHS Foundation Trust (WCHC) for the year 01 April 2025 to 31 March 2026. The reports meets the annual reporting duty under the Local Authority Social Services and NHS Complaints (England) Regulations 2009.

It is recommended that the Board:

- Note the level of assurance provided on complaints handling, themes and learning during 2025/26

## Key Points to Note

- The 2025/2026 Complaints and Concerns Annual Report provides an overview of complaints and concerns received during the reporting period, including activity, performance, outcomes, themes, trends and learning identified from patient and service-user feedback
- The report provides assurance regarding the management and oversight of complaints and concerns and demonstrates how learning and improvement actions are identified and monitored through the Trust's governance arrangements
- Equality and diversity information is also considered to support understanding of the experiences of people using Trust services

## Key Risks

This report relates to the following BAF risks:

- The Trusts quality governance and patient safety arrangements and assurance mechanisms are not sufficiently effective, responsive or consistently supported across the organisation to provide timely identification, escalation and management of quality and patient safety risks
- Failure to comply with relevant codes of governance, regulation and legislative requirements
- These risks are mitigated through established complaints governance arrangements, monitoring of performance, identification of themes and trends, and oversight of learning and associated improvement actions.

| 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 | No |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| September 2026 | Joint Quality and Safety Committee | As above | As above |

| 1 | Narrative |
|---|---|
| • | **Background and Purpose**<br>• The Complaints and Concerns Annual Report provides an overview of complaints and concerns activity for the period 1 April 2025 to 31 March 2026. It provides assurance regarding the Trust's arrangements for managing complaints and concerns and includes analysis of activity, performance, outcomes, themes, trends and learning<br>• The report also demonstrates how learning arising from complaints is identified, shared and monitored through the Trust's governance arrangements, supporting continuous improvement in patient experience, quality and safety<br>• The Joint Quality and Safety Committee is asked to receive assurance from the report and approve its submission to the Board of Directors |
| • | **Key Findings**<br>• During 2025/26, the Trust received 39 formal complaints compared with 36 in the previous year, alongside 156 informal concerns.<br>• 32 complaints were closed during 25/26, of these 13 (41%) were upheld, 7 (22%) partially upheld and 12 (38%) not upheld<br>• Of the 39 complaints received, 36 (92%) were acknowledged within three working days<br>• Complaint response timeliness remains an area for improvement, with 12 (31%) responded to within the agreed timescale and 24 (62%) outside the agreed timescale. Delays were primarily attributable to the complexity of investigations |

| | |
|---|---|
| | and the time required to obtain information from multiple services and partner organisations<br>• The most frequently reported complaint themes related to clinical treatment, communication and information provided to patients, and delays in assessment or response times |
| • | **Learning and Improvement**<br>• Learning is identified from all complaints, regardless of outcome. Where appropriate, services complete an After-Action Complaint Review (AACR) and develop action plans to ensure learning is implemented, monitored and embedded within practice<br>• Learning is monitored through the Trust's governance arrangements, with themes and trends reviewed through the Clinical Risk Management Group (CRMG) and triangulated with incidents, concerns, patient safety intelligence and patient experience feedback through the Safety Risk and Learning Review Panel (SRLaRP). This supports identification of emerging risks, organisational learning and continuous quality improvement |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• Complaints and concerns provide important insight into patient experience and opportunities to improve the quality and safety of care. Learning identified during 2025/26 has resulted in improvements to clinical guidance and pathways, clinical assessment and safety-netting, documentation, communication, appointment processes and patient engagement<br>• Equality and diversity information is collected and monitored to support an equitable complaints process. Where required, reasonable adjustments are made to the communication or format of complaint responses |
| 2.2 | **People**<br>• Learning from complaints is shared with relevant staff and services through team meetings, safety bulletins, supervision and local governance arrangements. Complaint investigations support reflective practice and learning in relation to compassionate communication, professional behaviours, clinical decision-making and documentation<br>• The Complaints Team provides advice and support to staff involved in complaint investigations and responses. Bespoke complaints training can also be provided for services where a specific need is identified |
| 2.3 | **Finance**<br>• There are no specific financial implications identified within this report. |
| 2.4 | **Compliance**<br>• The annual report provides assurance regarding the Trust's compliance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009<br>• Complaints are managed in accordance with Trust policy and the principles of good complaints handling set out by the Parliamentary and Health Service Ombudsman |

NHS
Wirral Community Health and Care
NHS Foundation Trust

Compassion Open Trust



# Complaints and Concerns Annual Report 2025/26

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## Introduction

1. The purpose of this annual report is to provide assurance to the Trust Board regarding complaints and concerns activity across Wirral Community Health and Care NHS Foundation Trust during the reporting period 01 April 2025 to 31 March 2026. The report demonstrates compliance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and summarises complaint themes, learning, service improvements and organisational assurance.

## Principles

2. The NHS Complaint Regulations state that arrangements for dealing with complaints must ensure that:
   - Complaints are dealt with efficiently
   - Complaints are thoroughly investigated
   - Complainants are treated with respect and courtesy
   - Complainants receive as far as is practical:
     (i) Assistance to enable them to understand the complaints procedure
     (ii)Advice on where they may obtain such assistance
   - Complainants receive a timely and appropriate response
   - Complainants are told the outcome of the investigation and actions taken, if appropriate

3. Complaints should be managed in the spirit of the Parliamentary and Health Service Ombudsman's (PHSO) principles – Principles of Good Administration, Principles of Good Complaints Handling and Principles for Remedy. The PHSO recommends NHS organisations follow these principles to ensure effective complaints handling:

   - Getting it Right
   - Being Customer Focused
   - Being Open and Accountable
   - Acting Fairly and Proportionately
   - Putting Things Right
   - Seeking Continuous Improvement

## Overview of Trust Services

4. Trust services are local and community-based, provided from around 50 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.

5. We also provide integrated 0-19 services in Cheshire East, Knowsley and St Helens comprising health visiting, school nursing, enhanced and family nurse partnership (FNP) and breastfeeding support services from 17 bases.

6. The Trust is commissioned to provide care across three in-patient wards at the Community Intermediate Care Centre: Bluebell, Iris and Aster wards.

7. The wards operate a multi-disciplinary and integrated approach to care, with teams consisting of physiotherapists, occupational therapists, social workers, nurses, health care assistants, administrative staff as well as an extended workforce consisting of students and volunteers.

8. The Trust actively encourages feedback from patients, service users, carers and families to ensure that experiences of care directly inform service improvement, organisational learning and quality governance. Feedback received through complaints, concerns, compliments and the Friends and Family Test is triangulated to identify themes and opportunities for improvement.

9. Experience is a standard agenda item throughout all team meetings and all managers are actively encouraged to share and learn, looking for continuous opportunities to identify quality improvements.

10. The Trust is committed to the principles as outlined in a user-led vision for raising concerns and complaints (PHSO and Healthwatch). This ensures that people:

    1. Feel confident to speak up
    2. Feel that making a complaint was simple
    3. Feel listened to and understood
    4. Feel that their complaint made a difference
    5. Would feel confident making a complaint in the future




## Organisational Analysis of Complaints and Concerns

11. The Trust currently have two types of investigation, which are discussed and agreed with the person intending to raise a concern or complaint with the Trust. These are as follows:

| Concerns Process (Local Resolution) | Complaints (Full Investigation) |
|---|---|
| Concerns are a way of handling complaints by resolving or clarifying the matter directly with the complainant through discussion in a meeting arranged for the purpose, service responding direct by phone call or in writing.<br><br>This can be a more proportionate, flexible and responsive way to resolve concerns that do not require a full review/investigation. The complaints process is fully explained and made accessible to all individuals raising a concern with the Trust. | Complaints are subject to full investigation in accordance with Trust policy and national guidelines. This includes, but is not limited to, a review of written records and procedures, interview with the staff involved and where applicable, witnesses to the event.<br><br>Services are required to complete an After-Action Complaint Review (AACR), which is reviewed by the Deputy Chief Nurse and the Your Experience Team to identify learning, patient safety concerns and any actions required.<br><br>At the conclusion of the review/investigation, the complainant receives a response from the |

| | |
|---|---|
| | Chief Executive or nominated Executive Director.<br><br>For complex complaints, meetings are also offered with a Senior Manager within the Trust, to provide feedback directly to the complainant.<br><br>Complaints, concerns, incidents, patient safety intelligence and Friends and Family Test feedback are triangulated through the Safety Risk and Learning Review Panel (SRLaRP) to identify emerging themes, organisational risks and opportunities for quality improvement. |

12. Wirral Community Health and Care NHS Foundation Trust (WCHC) received 39 formal complaints during the reporting period 01 April 2025 – 31 March 2026 compared with 35 received for the previous year.

13. There were 33 complaints closed during 01 April 2025 – 31 March 2026 of these 14 (42%) were upheld and 7 (21%) were partially upheld by the trust. The remaining 12 (36%) were not upheld.

14. Analysis of patient and service user contacts received and recorded on Datix are as follows:

    - 39 formal complaints
    - 156 informal NHS concerns.

15. The Trust received experience feedback from 25,335 people who accessed services, with an average of 90% of those people reporting a very good or good experience.

16. Analysis of complaints received over the last six years demonstrates that complaint volumes have remained relatively stable following the transfer of Adult Social Care complaints back to the Local Authority in 2023/24. During 2025/26 the Trust received 39 complaints, representing a small increase compared with 35 complaints received during 2024/25.

| 01 April – 31 March | Total number of complaints received |
|---|---|
| 2020/2021 | 69 |
| 2021/2022 | 74 |
| 2022/2023 | 79 |
| 2023/2024 | 47 |
| 2024/2025 | 35 |
| 2025/2026 | 39 |

## Complaint responses and number of patient contacts recieved

17. There were 39 Health Complaints received during the period of 01 April 2025 – 31 March 2026.

18. Of the 39 complaints received during this reporting period, 15 remained open into 2026/27, 4 have been closed during quarter one 2026/27, and 4 remain open.

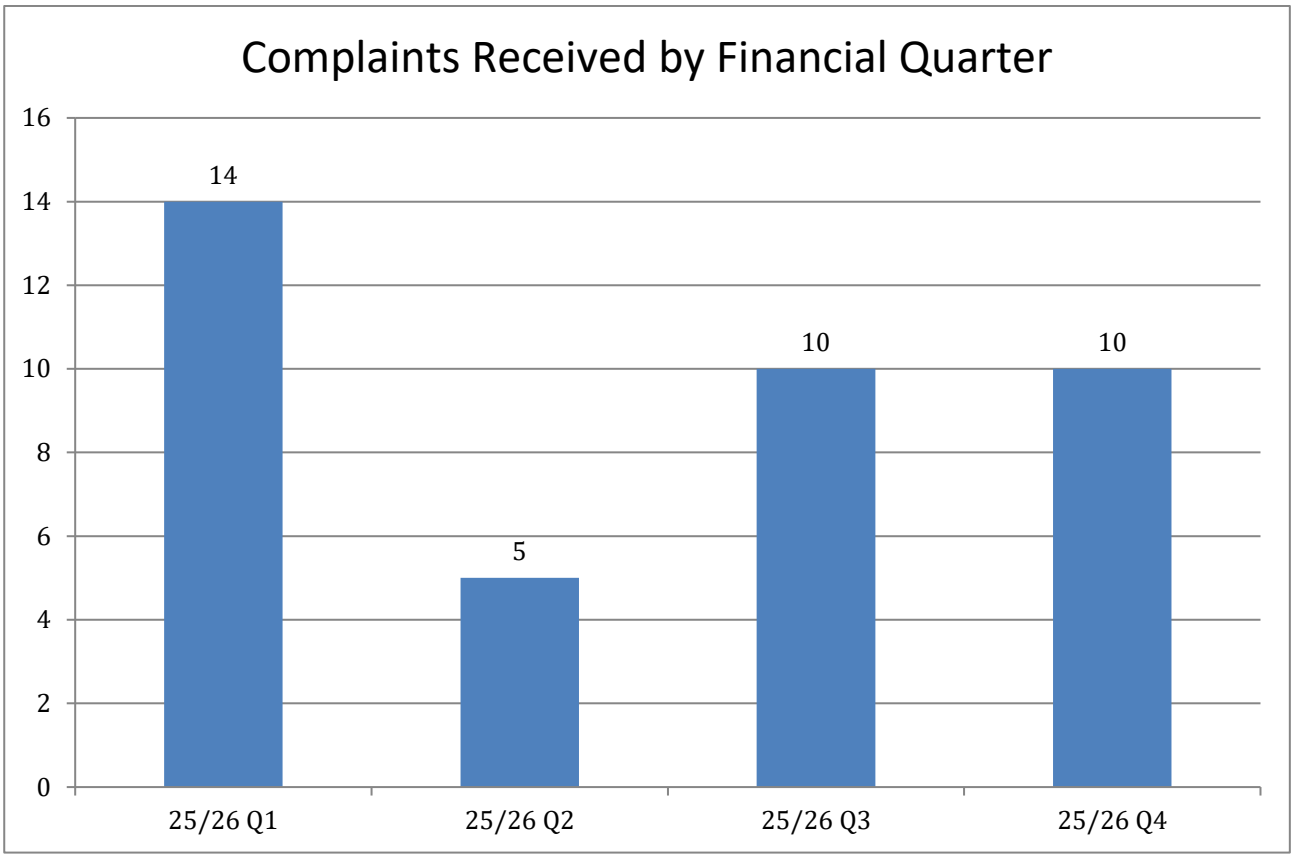
19. Of the 39 health complaints received, 37 (95%) were acknowledged within three working days. The two complaints (5%) that were not acknowledged within the required timescale were due to reduced capacity within the complaints team. A review of team capacity and business continuity arrangements has been completed to strengthen resilience and support compliance with the Trust's acknowledgement timescales.

20. NHS Complaint Standards recommend that complaint responses are provided within 40 working days where possible. However, an extended timescale may be required where complaints are particularly complex or involve information from multiple Trust services or external organisations. Complainants are kept informed throughout the investigation and revised response dates are agreed where necessary. Of the 39 complaints received, 11 (28%) were responded to within the agreed timescale, 24 (62%) were responded to outside the agreed timescale and four complaints (10%) remained open at the end of the reporting period. Delays were primarily attributable to the complexity of investigations and the time required to obtain information from multiple services and partner organisations. Throughout these delays, complainants were kept informed of progress. No concerns or complaints regarding the management of response times were raised with the Trust or external bodies during the reporting period.

21. It is important to contextualise the number of complaints and concerns received in relation to patient contacts. In 2025/2026 there were a total of 1,055,856 contacts delivered across Trust services.

22. Chart 1 demonstrates the total number of complaints received by quarter during 2025/26:

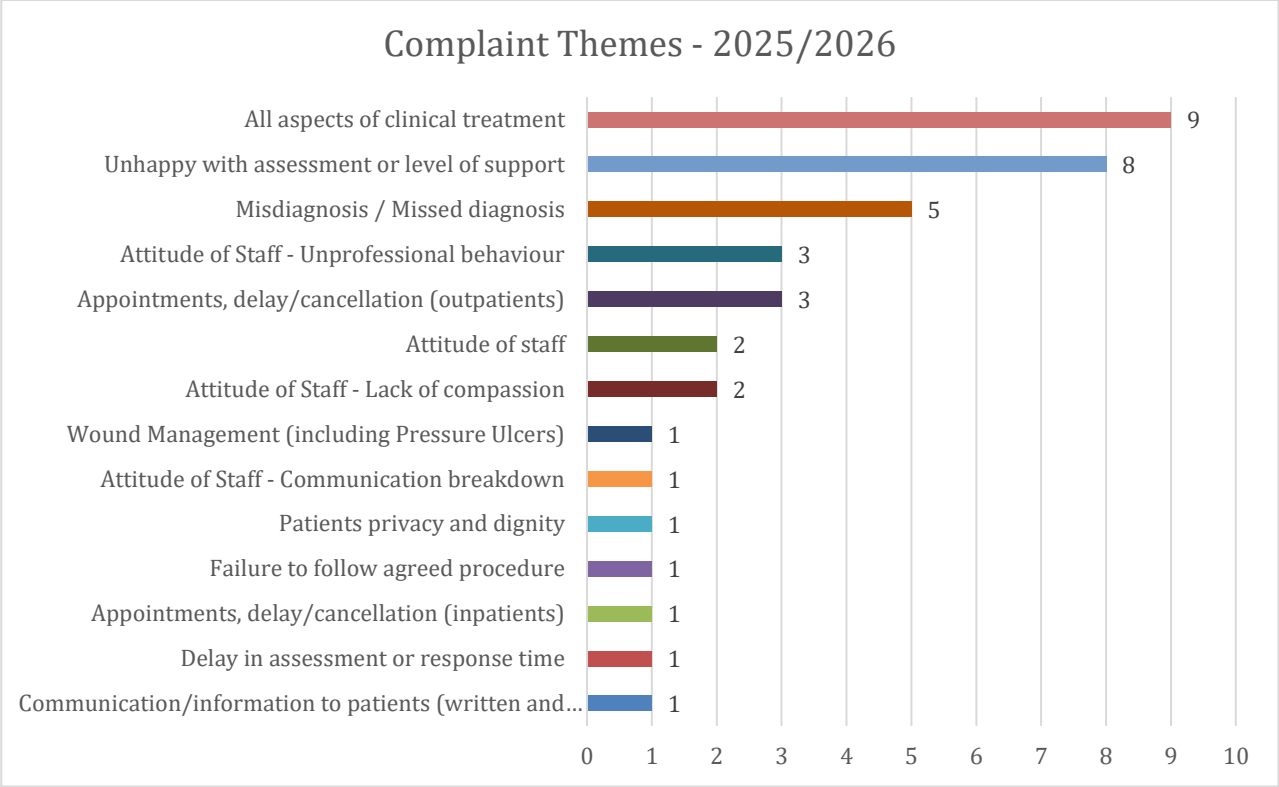
**Chart 1: Comparison of complaints received by quarter**




## Total number of 2025/2026 complaints received by theme

23. Chart 2 summarises the primary themes identified from complaints received during the reporting period. The most frequently reported themes related to all aspects of clinical treatment, communication and information provided to patients, and delays in assessment or response times.

**Chart 2 – Complaints received by theme**



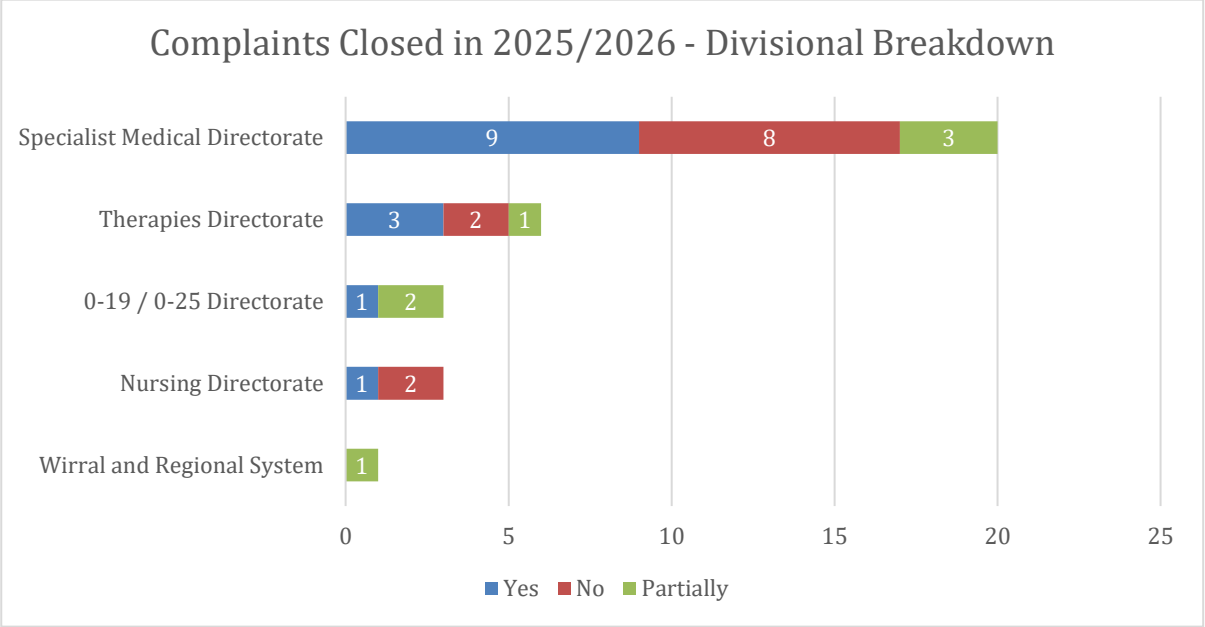

24. Analysis of complaint outcomes demonstrates that, of the 33 complaints closed during the reporting period, 14 (42%) were upheld, 7 (21%) were partially upheld and 12 (36%) were not upheld. Where learning was identified, services developed action plans and implemented service improvements to reduce the likelihood of recurrence.

| Closed 2025/2026 Complaints | | |
|---|---|---|
| **Upheld** | **Not Upheld** | **Partially Upheld** |
| 14 | 12 | 7 |

25. Of the 33 complaints closed during 2025/26, 9 were carried over from the 2024/25 annual period.

26. Chart 3 provides a breakdown of the 33 complaints closed during 2025/2026 by Directorate, including whether complaints were upheld, partially upheld or not upheld.

**Chart 3: Upheld/Partially Upheld and not Upheld complaints by Locality**




27. Learning is identified from all complaints, regardless of outcome. Where appropriate, services complete an After Action Complaint Review (AACR) and develop action plans to ensure learning is implemented, monitored and embedded within practice.

28. Learning identified through complaints is monitored through the Trust's governance arrangements to ensure actions are completed and improvements are embedded within services. Themes and trends are reviewed through the Clinical Risk Management Group (CRMG) and triangulated with incidents, concerns, patient safety intelligence and patient experience feedback through the Safety Risk and Learning Review Panel (SRLaRP). This enables the Trust to identify emerging risks, share organisational learning and support continuous quality improvement across services.




## Learning and Improvements made from Upheld and Partially Upheld complaints:

29. This section summarises the principal complaint themes identified during the reporting period and the learning and service improvements arising from complaint investigations. Learning is shared within the relevant service and, where appropriate, with other affected services to support continuous improvement.

## Complaint Theme: All aspects of clinical treatment

30. There were 13 complaints received where ‘all aspect of clinical treatment ‘was recorded as the primary subject of concern - 3 were upheld, 1 partially upheld and 9 were not upheld.

**Learning**

- Comprehensive clinical assessments should be supported by clear documentation of clinical decision-making, presenting symptoms and rationale for treatment.
- The importance of effective safety-netting, recognising deteriorating patients and considering alternative diagnoses has been reinforced.
- Staff have reflected on clinical decision-making and the need to seek specialist advice or escalate care where clinically indicated.
- Learning from complaints has been shared within the relevant services to support reflective practice and improve patient care.

**Improvements made**

- Clinical guidance, pathways and standard operating procedures have been reviewed and strengthened to support consistent clinical assessment and safety-netting.
- Targeted education, case-based learning and reflective discussions have been delivered to reinforce clinical decision-making and documentation standards.
- Electronic documentation templates have been enhanced to improve the recording of assessments and safety-netting advice.
- Service-specific learning has been embedded through supervision, governance meetings and local quality improvement processes.

## Complaint Theme - Unhappy with assessment or level of support

31. There were 5 complaints received categorised as ‘unhappy with assessment or level of support’ , 3 were upheld, and 2 not upheld.

**Learning**

- Staff were reminded of the importance of undertaking holistic assessments, considering the patient's individual circumstances, previous medical history and presenting symptoms.
- The importance of involving senior colleagues and discussing more complex presentations within the wider clinical team was reinforced.
- Learning highlighted the need to communicate clinical pathways, treatment options and the reasons for decisions clearly, ensuring patients feel informed and supported throughout their care.
- Staff were reminded to communicate sensitively and explain the rationale for assessment questions, particularly where discussions may be distressing or personal.

**Improvements made**

- Learning has been shared within the relevant clinical teams through local governance arrangements and safety bulletins.
- Clinical documentation and electronic templates have been strengthened to prompt clinicians to review relevant medical history during assessment.
- Staff have received reminders regarding compassionate communication, explaining clinical decision-making and ensuring patients understand the purpose of assessments and treatment options.
- Services have reflected on complex cases to strengthen multidisciplinary discussion, clinical supervision and consistent application of clinical pathways.

## Complaint Theme: Attitude of Staff

32. There were 5 complaints received where ‘Attitude of Staff’ was listed as the primary subject of concern – 3 were upheld, 1 partially upheld, and 1 not upheld.

**Learning**

- Staff reflected on the importance of communicating with compassion, empathy and professionalism to ensure patients feel listened to, respected and supported throughout their care.
- Learning reinforced the need to explain decisions clearly, manage difficult conversations sensitively and maintain patients' dignity and respect at all times.
- Individual reflective practice was undertaken where staff interactions did not meet the Trust's expected standards of patient experience.
- Feedback from complaints has been used to reinforce the importance of patient-centred communication and positive patient experience across the relevant services.

**Improvements made**

- Learning from complaints was shared through team meetings, safety bulletins and local governance processes to reinforce compassionate communication and professional behaviours.
- Staff participated in reflective discussions and received targeted feedback to support improvements in communication and patient interactions.
- Services strengthened local communication guidance and reinforced expectations regarding patient communication, discharge discussions and managing patient expectations.
- Ongoing monitoring of complaints and concerns has been used to identify any recurring themes relating to staff attitude and patient experience

## Complaint Theme: Appointments delay / cancellation

33. There were 3 complaints received where ‘Appointments delay / cancellation’ was recorded as the primary subject of concern – 2 were upheld, and 1 was partially upheld.

**Learning**

- Services reinforced the importance of timely communication with patients, parents and carers regarding appointment changes, cancellations and any unavoidable delays.
- Learning highlighted the need to ensure appointment information, locations and correspondence are accurate to minimise avoidable disruption to patient care.
- The importance of maintaining effective engagement with patients and families throughout periods of service pressure was reinforced to ensure expectations are managed appropriately.
- Services reflected on the need for robust administrative processes to support continuity of care and minimise missed appointments.

**Improvements made**

- Appointment booking and communication processes were reviewed and strengthened, including the introduction of standardised appointment letters, text messages and email confirmations.
- Administrative procedures were updated to improve the accuracy of appointment information, including clinic locations and confirmation processes.
- Services reviewed communication and engagement with patients, parents and carers to improve collaborative working and ensure timely updates regarding appointments and ongoing care.
- Local processes were strengthened to improve oversight of appointments and support continuity of care where service pressures or staffing challenges affected delivery.

## Parliamentary and Health Service Ombudsman (PHSO)

34. There have been 0 referrals to the PHSO during the reporting period.

35. All complaints were responded to and managed in accordance with WCHC's Complaints Policy (GP1).

36. Lessons learned from complaints are a valuable tool to assist in the quality of services provided and improve the patient's overall experience.

37. For upheld or partially upheld complaints where learning for the Trust has been identified, action plans are developed by the service and monitored at locality SAFE/OPG meetings and at the Trust-wide CRMG and Safety Risk and Learning Review Panel.

## Concerns, Patient Contacts, and Friends and Family Test received

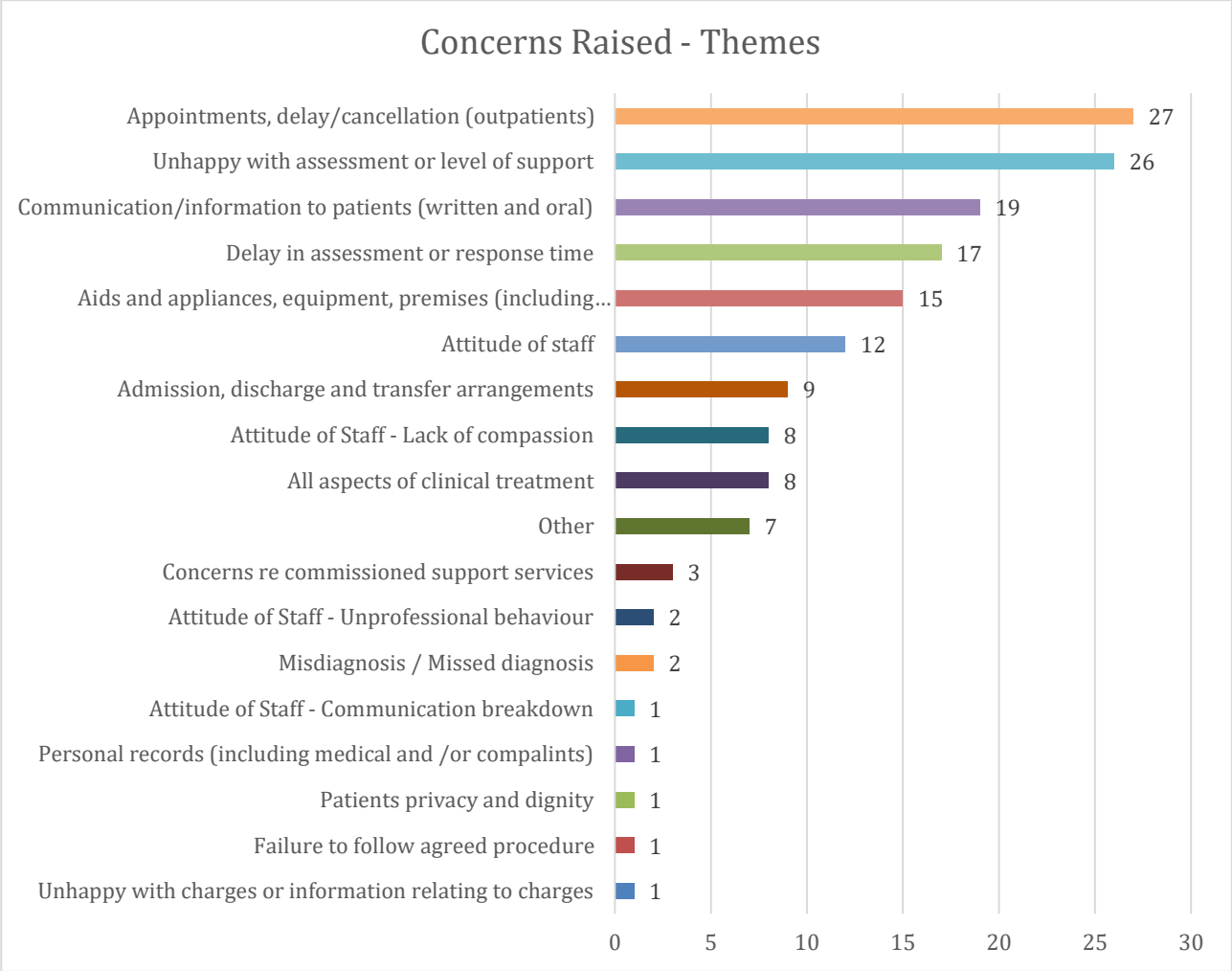
38. A Total of 1,055,856, patient contacts were recorded in 2025/2026 and are detailed below:

| | | |
|---|---|---|
| **0-19 / 25** | Cheshire East Health Visiting & School Nursing Service | 75,900 |
| | Knowsley 0-25 Service | 37,294 |
| | Let's Talk Service | 717 |
| | School Nursing - Wirral | 14,266 |
| | St Helens 0-19 Service | 28,523 |
| | Wirral Health Visiting Service | 42,471 |
| **Community Response** | Community Intermediate Care Centre (CICC) | 183,853 |
| | Community Integrated Response Team (CIRT) | 96,236 |
| | Single Point of Access (SPA) | 9,963 |
| | Teletriage | 2,612 |
| **Nursing** | Community Nursing | 257,887 |
| | Parkinson's / Alzheimer's | 1,925 |
| | Specialist Palliative Care | 9,038 |
| | Tissue Viability | 521 |
| **Specialist Medical** | Community Cardiac Service & Diagnostics | 34,998 |
| | Deep Vein Thrombosis | 10,041 |
| | Dental Service | 10,510 |
| | Ophthalmology | 2,384 |
| | Sexual Health Wirral | 16,875 |
| | Urgent Treatment Centre / Walk-in Centre's | 83,882 |
| **Therapies** | Adult Bladder & Bowel | 12,117 |
| | Adult Dietetics | 9,452 |
| | Adult Speech & Language | 5,118 |
| | Ageing Well & Frailty | 6,436 |
| | Musculoskeletal & Pelvic Health | 34,512 |
| | Paediatric Bladder & Bowel | 3,677 |
| | Paediatric Dietetics | 2,405 |
| | Paediatric Speech & Language | 9,725 |
| | Podiatry | 28,235 |
| | Rehabilitation at Home | 14,718 |
| | Weight Management Service | 7,145 |
| | Wheelchair Service (West Cheshire & Wirral) | 2,420 |
| **Total** | | **1,055,856** |

39. All concerns are subject to local management by the relevant service, facilitating a prompt, proportionate flexible response, which is agreeable with the complainant. The formal complaints process is fully explained and made accessible to all individuals raising a concern with the Trust, to ensure escalation if initial local resolution cannot be achieved.

40. There were 156 concerns received in 2025/2026.

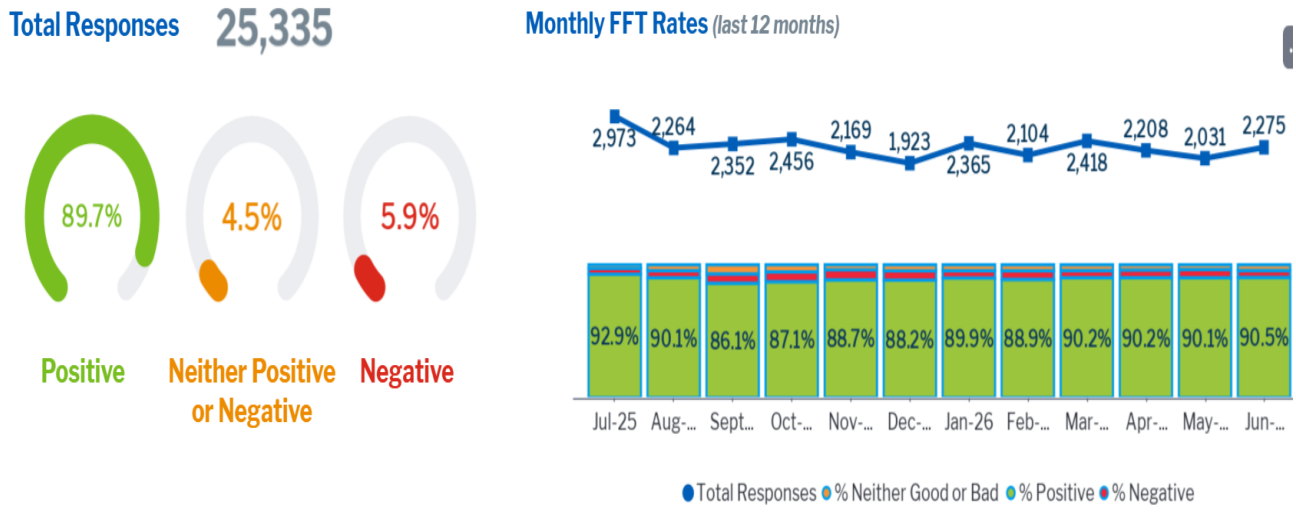
**Chart 4: Total number of concerns received by subject**



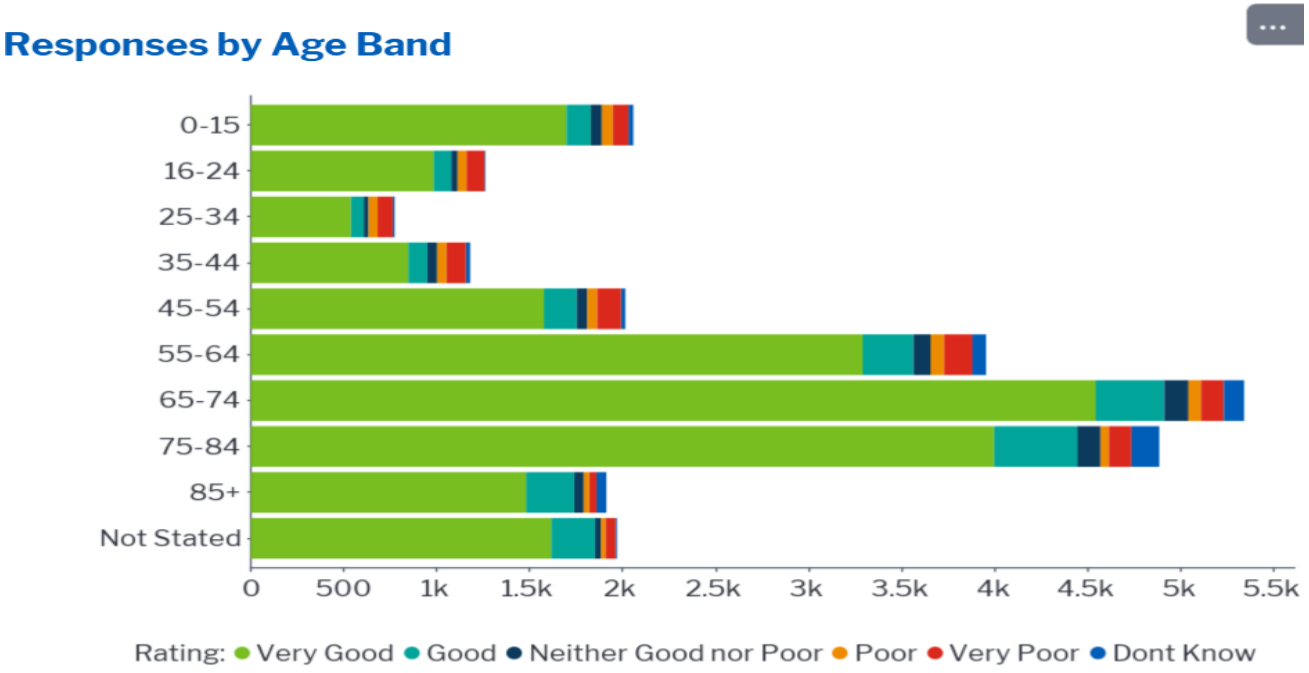

NB Please note that there can be multiple themes for concerns

41. All concerns are resolved at local service level and are monitored for themes and trends both at team level and at CRMG.

42. The below graphic shows Friends and Family test (FFT) across the trust for the period 2025/2026. 25,335 were completed with positive feedback equating to 90%.




## Age of patients completing the Friends and Family test




## Equality and Diversity Monitoring

43. All complainants are offered the opportunity to provide equality and diversity information at the point of acknowledgment of their complaint. These are recorded on Datix and where required reasonable adjustments are made to the communication or format of the response.

44. 0 people shared they had a disability

45. No complainants requested or indicated a preference for Reasonable Adjustments.

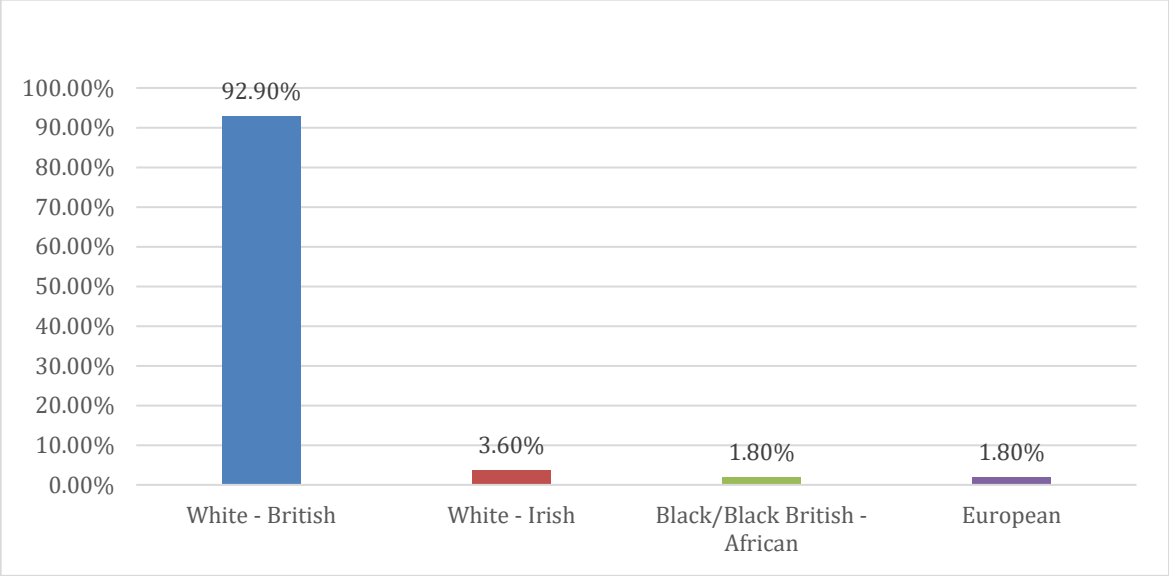
46. All People who access Trust services have the right to be treated fairly and routinely involved in decisions about their treatment and care. They can expect to be treated with dignity and respect and will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

47. Ethic Origin is actively collected for complaints and concerns. The chart below reflects the local demographic; however, it may also show that further work is required to ensure the complaints process is equitable.

48. The Trust's Equality Delivery System (EDS) 2025-2026, is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England, in active conversations with patients, public, staff, staff networks, community groups and trade unions and to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

**Chart 5: Ethnic Origin**

Ethnic origins shared by patients for Complaints and Concerns




**Better Health Outcomes**

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
- When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse
- Screening, vaccination and other health promotion services reach and benefit all local communities

**Improved access and experience**

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences of the NHS
- People's complaints about services are managed respectfully and efficiently

49. The Trust analyses complaints equality data to ensure that there is no evidence that individuals with protected characteristics are unfairly treated or disadvantaged.

## Priorities for 2026/27

50. Improving complaint responsiveness is a key priority for 2026/27. The Trust will conduct a review of the complaints processes, identifying areas for improvement including increasing engagement with patient and family members. An improvement plan with clear timescales will be developed, tracked via the Trust's governance framework with close monitoring of impact and outcomes.

51. As part of the Trust's Quality Strategy, the Trust are committed to further strengthen and embed existing processes to better understand people's experiences of care, collaborating with patients, service users, families, carers and frontline staff to improve the quality-of-service delivery. The Patient Safety Partners will continue to visit services and talk to patients in receipt of care provided by the trust to understand what is working well and where improvement is required.

52. The Complaints Team will introduce and review processes and procedures and will align this to Patient Safety Incident Response Framework (PSIRF) principles. This will be from the beginning of the process when receiving the complaint right through to the release of the final complaint response letter.

53. We will triangulate and analyse data through attending the Patient Risk and Learning Review Panel each month.

54. For the Complaints Team to attend 'Your Voice' group each month and present information in relation to Friends and Family Test, Complaints and Concerns.

55. The PSIRF methodology will support the understanding of what matters most to the person. We will learn from people's experiences of care and embed this into both learning and development across the Trust.

56. In line with the NHS Complaint Standards document (2022), the Trust's approach to this will continue to proactively consider:

- A person's confidence in raising concerns or a complaint
- A person's knowledge in how to raise a complaint or concern
- Engage with the person raising the complaint to make sure they fully understand
- Making information available in a format that people find easy to understand
- What matters most to the person aligning this to PSIRF methodology
- Making sure that there is a strong commitment to the duty of candour so there is a culture of being open and honest when something goes wrong
- Signpost the person to support and advice services, including independent advocacy services, at an early stage
- Ensure that any staff members specifically complained about are made aware at the earliest opportunity
- Staff involved in carrying out complaint investigation are properly trained to do so and have the level of authority and autonomy to carry out a fair investigation
- A person's feelings around the response they have received, including the overall outcome and whether their complaint has made a difference. if something went wrong, an explanation of the impact it had
- To provide an explanation of any wider learning we have acted on/will act on to improve our service for other users
- A meaningful apology for any failings
- A person's overall experience with regards to how their complaint was managed
- Provide details of how to contact the Parliamentary and Health Service Ombudsman if the individual is not satisfied with our final response

57. Trust learning will consider equality and inclusion to ensure we have considered individual rights and needs as part of the Trust's management of care and complaints. Learning from experiences and engagement will form part of all Trust-wide governance processes.

58. To ensure that all equality and diversity forms sent to patients when complaining have a direct link to your experience email inbox. This will ensure that forms will be completed and managed by the complaints team centrally.

59. A new complaint handling training course will continue to be delivered in 2025/2026 to all relevant staff that investigate and respond to complaints and concerns. This will support and enhance staff knowledge and skills in relation to complaints. We will be looking to incorporate identified learning by introducing 'Martha's Rule' to the training to ensure staff have full understanding of why this is important.

60. We will continue to align our system and processes with Patient Safety Incident Response Framework (PSIRF) principles, working closely and compassionately with patients and families.

61. We will utilise Patient Safety Partners to quality assure a sample of anonymised complaints response letters. This will ensure they are personalised and clearly communicated.

## Committee action

62. The Quality and Safety Committee is asked to be assured that the Trust is committed to improving response times and implementing the learning from complaints. This improvement will continue to be monitored to ensure delivery of safe, effective, quality services across the organisation.

**Chris Douglas**
**Joint Chief Nursing Officer**

**Contributors:**
Ian Salisbury Senior Complaints Officer
Ben Bowsley Datix and Compliance Manager

15 July 2026

**Group Board of Directors in Public** **Item 22**

**04 November 2026**

| | |
|---|---|
| **Title** | WUTH Emergency Preparedness, Resilience and Response (EPRR) Core Standards |
| **Area Lead** | Hayley Kendall – Joint Executive Managing Director |
| **Author** | Hayley Kendall – Joint Executive Managing Director |

| **Purpose of the Report and Recommendation** | |
|---|---|
| **Report For** | Assurance |

It is recommended that the Board:

- Note the summary report outlining the outputs of the core standards review
- Note and agree the information set out in Appendix one which is the detailed assurance of the core standards

## Key Points to Note

The Department of Health and Social Care and NHS England require all Trusts to undertake an annual self-assessment of their Core Standards for Emergency Preparedness, Resilience and Response as defined in the NHS Emergency Preparedness, Resilience and response Framework, July 2022.

For any standard that is not Fully Compliant the required actions to improve its position are added to the action plan contained within the Core Standards spreadsheet.

A Trust self-assessment has been undertaken and has confirmed full compliance with 59 of the 62 standards which provides a compliance rating of 95% and substantially compliant. This cover reports provides an overview of the detailed submission which is attached at appendix one.

## Key Risks

This report relates to these key risks:

- BAF Risk 11 - Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the ability to deliver services to patients'

| **Contribution to Integrated Care System objectives (Triple Aim Duty):** | |
|---|---|
| **Better health and wellbeing for everyone** | No |
| **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 | 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 | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | No |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| September 2026 | Joint Finance and Performance Committee | As above | As above |

| 1 | Narrative |
|---|---|
| 1.1 | **Core Standards**<br><br>As part of the Core Standards declaration the standards are required to be signed off by the Trust Accountable Emergency Officer and Executive Managing Director, Hayley Kendall, then presented to a public board meeting, the date of which needs to be documented on the Trust declaration. This will be on the 4th November 2026.<br><br>EPRR Core Standards consist of 66 standards, of which 62 are applicable to WUTH. The standards are spreadsheet based with columns for standard detail, supporting information examples and organisational evidence along with RAG status and actions to be taken. The Trust uploaded 212 supporting documents to the standards with some documents being referenced in multiple standards.<br><br>For 2025/26 the Trust declared full compliance with 59 of the 62 standards for an overall rating of 95% - 'Partially Compliant'. For 2026/27 we have declared full compliance with 59 of the 62 standards for a 95% rating which rates at 'Substantially Compliant'. The table below is the extract from the submission: |

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 11 | 10 | 1 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 4 | 3 | 1 | 0 |
| Response | 7 | 7 | 0 | 0 |
| Warning and informing | 4 | 4 | 0 | 0 |
| Cooperation | 4 | 3 | 1 | 0 |
| Business Continuity | 10 | 10 | 0 | 0 |
| Hazmat/CBRN | 12 | 12 | 0 | 0 |
| CBRN Support to acute Trusts | 0 | 0 | 0 | 0 |
| Total | 62 | 59 | 3 | 0 |

As in the previous years Standard 16 – evacuation and shelter is partially compliant as the working group for the subject has been paused with no guidance to Trusts available. This is expected to be the same position for all Trusts.

With progression from last year, core standard 25 is currently at a position where we have produced a staff training package that has received funding to be converted into an ESR formal training package and it is hoped that this will be on line in the coming months enabling us to declare full compliance with the standard in the future.

An improvement was made to core standard 53 in that assurance of commissioned providers was achieved as the Trust uses the standard NHS supply contract for these providers.

Core standard 37 has seen a slip in our compliance which was due to a scheduled regional meeting being a direct clash with the guests the Trust hosted from the MV Hondius. The inability to attend this meeting has taken us below the threshold for compliance (more than 75% attendance for 2 scheduled meetings).

The action plan for any standards to be improved will be worked through by the Head of EPRR who will identify any additional resources required to ensure that the Trust continue to evolve and improve its position for emergency preparedness. These will be reported to the Trust Executive Assurance and Risk Committee as part of the EPRR quarterly report. A monthly update report is also required to be sent to NHS Cheshire and Merseyside.

In addition to the main core standards, normally a deep dive investigation into a specialist area takes place. This year however, due to the position with ICB's and NHSE there was no deep dive subject. The current core standards are due to updated and the Trust awaits the revised standards to work towards.

| 2 | Implications |
|---|---|
| 2.1 | **Patients** |

| | |
|---|---|
| | • There is no direct link to patient safety or experience. Failure to prepare for an emergency and therefore not be ready to respond is when patients may be impacted. |
| **2.2** | **People**<br>• In the event of a major emergency staff will be pivotal to the response. There are specific action cards in place to follow that show how roles may vary and evolve during a response.<br>• External stakeholders are integral to the trust preparedness and response and are included in the regional planning for incidents |
| **2.3** | **Finance**<br>• Financing of the EPRR function is done within the trust budget. Any specific or additional resources required will be subject to a business case. Response to a major incident has set procedures within the trust policies. |
| **2.4** | **Compliance**<br>• Achieving compliance with the EPRR core standards will ensure the trust meets the requirements of its NHS contract and also the requirements of the NHSE Framework for EPRR, thereby leading to meeting its obligations under the Civil Contingencies Act. |

Please select type of organisation: **Acute Providers**
Click button to format the workbook

**Publishing Approval Reference: 000719**

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 11 | 10 | 1 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 4 | 3 | 1 | 0 |
| Response | 7 | 7 | 0 | 0 |
| Warning and informing | 4 | 4 | 0 | 0 |
| Cooperation | 4 | 3 | 1 | 0 |
| Business Continuity | 10 | 10 | 0 | 0 |
| Hazmat/CBRN | 12 | 12 | 0 | 0 |
| CBRN Support to acute Trusts | 0 | 0 | 0 | 0 |
| Total | 62 | 59 | 3 | 0 |

| **Overall assessment:** | Substantially compliant |
|---|---|

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

| | Core standards | Interoperable capabilities |
|---|---|---|
| Fully compliant | 62 | 135 |
| Substantially compliant | 55 | 120 |
| Partially compliant | 48 | 104 |
| Non compliant | | |

**Group Board of Directors in Public** **Item 23**

**04 November 2026**

| | |
|---|---|
| **Title** | WCHC Emergency Preparedness, Resilience and Response (EPRR) Core Standards |
| **Area Lead** | Hayley Kendall – Joint Executive Managing Director |
| **Author** | Hayley Kendall – Joint Executive Managing Director |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Assurance |

The Department of Health and Social Care and NHS England require all Trusts to undertake an annual self-assessment of their Core Standards for Emergency Preparedness, Resilience and Response as defined in the NHS Emergency Preparedness, Resilience and response Framework, July 2022.

For any standard that is not Fully Compliant the required actions to improve its position are added to the action plan contained within the Core Standards spreadsheet.

A Trust self-assessment has been undertaken and has confirmed full compliance with 54 of the 58 standards which provides a compliance rating of 95% and substantially compliant. This cover reports provides an overview of the detailed submission which is attached at appendix one.

It is recommended that the Board:

- Note the summary report outlining the outputs of the core standards review
- Note and agree the information set out in Appendix one which is the detailed assurance of the core standards

## Key Points to Note

- There are 58 standards applicable to WCHC and the Trust is declaring compliance with 54
- The 4 areas rated as partial compliance relate to 24/7 communications, fit testing, compliance with the data protection toolkit and attendance at the local health resilience forums.
- The appendix contains the full self-assessment, overview and action plan to address areas of partial compliance.

## Key Risks

This report relates to these key risks:

- BAF Risk 11- ‘Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the ability to deliver services to patients’

| Contribution to Integrated Care System objectives (Triple Aim Duty): | |
|---|---|
| **Better health and wellbeing for everyone** | No |
| **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 | 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 | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | No |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| September 2026 | Joint Finance and Performance Committee | As above | As above |

| 1 | Compliance position |
|---|---|
| | As part of the Core Standards declaration the standards are required to be signed off by the Trust Accountable Emergency Officer and Executive Managing Director, Hayley Kendall, then presented to a public board meeting, the date of which needs to be documented on the Trust declaration. This will be on the 4th November 2026.<br><br>EPRR Core Standards consist of 66 standards, of which 58 are applicable to WCHC. The standards are spreadsheet based with columns for standard detail, supporting information examples and organisational evidence along with RAG status and actions to be taken.<br><br>For 2025/26 the Trust declared full compliance with 56 of the 58 standards for an overall rating of 'Substantially Compliant'. For 2026/27 we have declared full compliance with 54 of the 58 standards for a rating of 'Substantially Compliant'. The table below is the extract from the submission: |

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 11 | 11 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 4 | 4 | 0 | 0 |
| Response | 5 | 5 | 0 | 0 |
| Warning and informing | 4 | 3 | 1 | 0 |
| Cooperation | 4 | 3 | 1 | 0 |
| Business Continuity | 10 | 9 | 1 | 0 |
| Hazmat/CBRN | 10 | 9 | 1 | 0 |
| CBRN Support to acute Trusts | 0 | 0 | 0 | 0 |
| Total | 58 | 54 | 4 | 0 |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• There is no direct link to patient safety or experience. Failure to prepare for an emergency and therefore not be ready to respond is when patients may be impacted. |
| 2.2 | **People**<br>• In the event of a major emergency staff will be pivotal to the response. There are specific action cards in place to follow that show how roles may vary and evolve during a response.<br>• External stakeholders are integral to the trust preparedness and response and are included in the regional planning for incidents |
| 2.3 | **Finance**<br>• Financing of the EPRR function is done within the trust budget. Any specific or additional resources required will be subject to a business case. Response to a major incident has set procedures within the trust policies. |
| 2.4 | **Compliance**<br>• Achieving compliance with the EPRR core standards will ensure the trust meets the requirements of its NHS contract and also the requirements of the NHSE Framework for EPRR, thereby leading to meeting its obligations under the Civil Contingencies Act. |

Please select type of organisation: **Community Service Providers**
Click button to format the workbook

**Publishing Approval Reference: 000719**

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 6 | 0 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 11 | 11 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 4 | 4 | 0 | 0 |
| Response | 5 | 5 | 0 | 0 |
| Warning and informing | 4 | 3 | 1 | 0 |
| Cooperation | 4 | 3 | 1 | 0 |
| Business Continuity | 10 | 9 | 1 | 0 |
| Hazmat/CBRN | 10 | 9 | 1 | 0 |
| CBRN Support to acute Trusts | 0 | 0 | 0 | 0 |
| Total | 58 | 54 | 4 | 0 |

| **Overall assessment:** | Substantially compliant |
|---|---|

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

| | Core standards | Interoperable capabilities |
|---|---|---|
| Fully compliant | 58 | 135 |
| Substantially compliant | 52 | 120 |
| Partially compliant | 45 | 104 |
| Non compliant | | |

**Group Board of Directors in Public** **Item No 24**

**04 November 2026**

| | |
|---|---|
| **Title** | WUTH Guardian of Safe Working Report Q1 2026/27 |
| **Area Lead** | Dr Nikki Stevenson, Chief Medical Officer |
| **Author** | 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).

This report covers the period 1st April to 30th June 2026 (Q1 2026-2027) and outlines the following:

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

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

It is recommended that the Board:

- Note the report

## Key Points to Note

There have been a high number of exception reports in the quarter particularly within the specialty of medicine. These were primarily from the Foundation Year 1 workforce but also from the Tier 1 workforce within the specialty. There have been ongoing discussions to try to improve workforce planning in the specialty but more work is required to resolve this ongoing and longstanding issue.

Additionally, timely discussions around staffing and work schedule reviews have rapidly resolved a staffing issue in Urology which resulted in a high number of working hours breach penalty being levied in a short period of time.

We continue to encourage and act on Exception Reports to improve the working lives of doctors within the Trust and to maintain Patient Safety.

There have been breaches to working hours which have resulted in penalty rates being raised but no finable breaches within the quarter.

## Key Risks

This report relates to these key Risks:

- BAF Risk 3: Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

| 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 | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | Yes |

| Governance journey | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| September 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<br>2016 Terms and Conditions of Service.<br><br>**High level data for Wirral University Teaching Hospital NHS Foundation Trust**<br><br>Number of doctors / dentists in training (total): **296 (286.6 WTE)**<br>Number of doctors / dentists in training on 2016 TCS (total): **420 (390.4 WTE)**<br>Amount of time available in job plan for guardian to do the role: **1 PA/4 hrs per wk.**<br>Admin support provided to the guardian (if any): **Access to 1.0 WTE**<br>Amount of job-planned time for educational supervisors: **0.25 PAs per trainee** |
| **1.2** | **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 |
| Acute Internal Medicine | 0 | 23 | 23 | 0 |
| Cardiology | 0 | 3 | 3 | 0 |
| Colorectal | 0 | 1 | 1 | 0 |
| Emergency Medicine | 0 | 2 | 2 | 0 |
| Endocrinology and Diabetes | 0 | 8 | 8 | 0 |
| Gastroenterology | 0 | 10 | 10 | 0 |
| General Medicine | 0 | 35 | 35 | 0 |
| General Surgery | 0 | 1 | 1 | 0 |
| Geriatric Medicine | 0 | 6 | 6 | 0 |
| Haematology | 0 | 4 | 4 | 0 |
| Paediatrics | 0 | 1 | 1 | 0 |
| Psychiatry | 0 | 5 | 5 | 0 |
| Renal Medicine | 0 | 5 | 5 | 0 |
| Respiratory Medicine | 0 | 3 | 3 | 0 |
| Stroke | 0 | 4 | 4 | 0 |
| Trauma & Orthopaedics | 0 | 2 | 2 | 0 |
| Upper GI | 0 | 1 | 1 | 0 |
| Urology | 0 | 9 | 9 | 0 |
| **Total** | **0** | **123** | **123** | **0** |

| Exception reports by Grade | | | | |
|---|---|---|---|---|
| Grade | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| F1 | 0 | 79 | 79 | 0 |
| F2 | 0 | 10 | 10 | 0 |
| CT1-2 / ST1-2 | 0 | 20 | 20 | 0 |
| ST3-8 | 0 | 14 | 14 | 0 |
| **Total** | **6** | **123** | **123** | **0** |

| Exception reports by Rota | | | | |
|---|---|---|---|---|
| Rota | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| Acute Medicine Fellows | 0 | 1 | 1 | 0 |

| | | | | |
|---|---|---|---|---|
| CGH Fellow | 0 | 3 | 3 | 0 |
| Emergency Surgery SHO | 0 | 1 | 1 | 0 |
| General Paediatrics SpR | 0 | 1 | 1 | 0 |
| Medicine F1 | 0 | 73 | 73 | 0 |
| Medicine IMY2 | 0 | 13 | 13 | 0 |
| Medicine IMY3 | 0 | 3 | 3 | 0 |
| Medicine SHO | 0 | 11 | 11 | 0 |
| Medicine SpR 2025 | 0 | 1 | 1 | 0 |
| Psych F1 | 0 | 1 | 1 | 0 |
| Renal T1 | 0 | 1 | 1 | 0 |
| Surgical F1 | 0 | 5 | 5 | 0 |
| Urology Tier 2 | 0 | 9 | 9 | 0 |
| **Total:** | **0** | **123** | **123** | **0** |

| Exception reports (response time) | | | | | | |
|---|---|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed in 8-14 days | Addressed in 15-30 days | Addressed in 31-50 days | Still open |
| F1 | 36 | 29 | 14 | 0 | 0 | 0 |
| F2 | 3 | 3 | 4 | 0 | 0 | 0 |
| CT1-2 / ST1-2 | 10 | 10 | 1 | 0 | 0 | 0 |
| ST3-8 | 7 | 6 | 0 | 0 | 0 | 0 |
| **Total** | **56** | **48** | **19** | **0** | **0** | **0** |

**Exception Reports**

As is the usual pattern the highest reporting group were the Foundation doctors in Medicine. There were also high numbers of Exception Reports from Tier 1 doctors in Medicine. There have been ongoing discussions regarding staffing in Medicine with a view to improving staffing on the wards to try to improve this situation going forwards.

There were also a cluster of Exception Reports from Tier 2 Urology which were addressed as detailed in work schedule reviews.

We continue to encourage Exception Reporting through the induction process for resident doctors, through resident doctors forum and through direct communication with residents and their supervisory processes.

**Work schedule reviews**

There have been 3 work schedule reviews in the quarter – all in Tier 2 Urology which resulted in locum cover being instated at Tier 1 and remuneration of additional hours worked for those individuals affected at Tier 2 prior to the locum being put into place to cover shifts.

**Vacancies and rota gaps**

There have been a number of vacancies, both predicted and due to sick leave which have resulted in Exception Reports being submitted. There have been discussions with Medical Staffing and Medical Managers to try to minimise the impact of any vacancies on existing resident and to resolve vacancies.

| Vacancies by Grade & Specialty | | | | | | |
|---|---|---|---|---|---|---|
| Specialty | F1 | F2 | CT1-2 / ST1-2 | ST3+ | Total vacant shifts sent to bank | Number of shifts remaining uncovered |
| A&E | 0 | 65 | 724 | 583 | 1372 | 526 |
| Medicine | 273 | 1 | 504 | 446 | 1224 | 583 |
| Surgery | 27 | 49 | 108 | 240 | 424 | 26 |
| Women's and Children's | 0 | 0 | 65 | 102 | 167 | 6 |
| Total | 300 | 115 | 1401 | 1371 | 3187 | 1141 |

**Safe Working Hours Breaches**

There were 11 reports against which a penalty rate was raised in the quarter, all of which were for exceeding a 13 hour working day. These were, in the main, for residents being unable to leave on time from a resident on-call shift. There were a minority due to non-resident on-call shifts residents being asked to be present to cover evening gaps and then continuing into the NROC portion of their on-call. The latter issue has been resolved. The penalties raised will be distributed through the Resident Doctors Forum process.

**Missed Break Breaches**

There have been a number of exception reports submitted for missed breaks. Some of these have been in conjunction with overruns whilst six were reported for missed breaks in isolation. The majority of these have been in medicine and the processes being undertaken to review staffing would hope to improve this.

**Information Breaches**

There were no fines required to be levied during the reporting period under the framework.

**Access and completion Breaches**

There were no fines required to be levied during the reporting period under the framework.

**Detriment and Perceived Detriment Survey**

A survey sent to out to resident doctors during the quarter had a very limited response but no issues of detriment or perceived detriment to Exception Reporting.

**1.3** **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 | 0 | 14 | 14 | 0 |
| F2 | 0 | 2 | 2 | 0 |
| CT1-2 / ST1-2 | 0 | 3 | 3 | 0 |
| ST3-8 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **19** | **19** | **0** |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• 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**<br>• 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.<br>• 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**<br>• The Guardian distributes monies received as a consequence of financial penalties to improve the training and working experience of all doctors. There have been 11 exception reports which triggered a penalty rate in this quarter. |
| 2.4 | **Compliance**<br>• This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers. |

**WUTH Board of Directors** **Item 25**

**04 November 2026**

| | |
|---|---|
| **Title** | Extended Monthly Maternity and Neonatal Services Report |
| **Area Lead** | Chris Douglas, Chief Nurse<br>Nikki Stevenson, Chief Medical Officer |
| **Author** | Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's') |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Discussion |

The last update on Maternity and Neonatal Services was reported to the Board of Directors at the beginning of September 2026, and an extended monthly report was submitted to the Quality Committee meeting held at the end of September 2026. There were no meetings in October 2026.

Included within this paper is the monthly Perinatal Quality Oversight Model (PQOM) Assurance Report, which provides an overview of the latest key quality and safety metrics for September 2026, together with the current position regarding patient safety incidents. The report has been revised in line with NHS England recommendations and provides comprehensive oversight and assurance of maternity and neonatal service performance.

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). It includes progress updates relating to Maternity Incentive Scheme (MIS) Year 8 compliance, the 10-Point Plan and Maternity Triage Specification. Together with the monthly Perinatal Quality Oversight Model (PQOM) Assurance Report, this paper provides comprehensive assurance regarding service quality, safety, performance, and improvement activity across maternity and neonatal care.

## Key Points to Note

**Recommendations**

The Trust Board is asked to note: -

- No maternity or neonatal Patient Safety Incident Investigations (PSIIs) or Maternity and Newborn Safety Investigations (MNSI) referrals were declared during September 2026.
- The Perinatal Quality Oversight Model (PQOM) demonstrates continued oversight of quality, safety, workforce, patient experience and improvement activity across maternity and neonatal services.
- Delivery of the Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards remains on track, including successful achievement of the national Training Compliance Touch Point.
- The regional review of the NHS England Three-Year Delivery Plan (10-Point Plan) identified a number of areas where further evidence and demonstration of Board oversight are required; however, the majority of issues relate to evidencing compliance rather than an absence of activity.

- A comprehensive review of the Homebirth Service has been completed in line with regional requirements and recommendations have been incorporated into local governance and service improvement arrangements.
- Quarter 2 maternity activity, gestational outcomes and ethnicity data demonstrate stable service demand and continued monitoring of health inequalities

**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 |
|---|---|---|---|
| October 2026 | Patient Safety and Quality Board | Extended Monthly Maternity and Neonatal Services Report (Draft as not all data available) | For discussion and approval |
| October 2026 | Maternity and Neonatal Assurance Meeting | Extended Monthly Maternity and Neonatal Services Report | For discussion and approval |
| October 2026 | Divisional Quality Board (DQB) | Extended Monthly Maternity and Neonatal Services Report | For discussion and approval |

| 1 | Perinatal Quality Oversight Model (PQOM) Assurance Report |
|---|---|
| 1.1 | The Perinatal Quality Oversight Model (PQOM) is reported at **Appendix 1** and provides the latest September 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 Trust Board in maintaining effective oversight of performance, risk, quality, safety, and improvement activity across the perinatal pathway.<br><br>For this reporting cycle, information is presented in a revised slide-pack format aligned with NHS England's recommended reporting approach for maternity and neonatal services. This format has been developed to enhance clarity, improve the visual interpretation of key information, and provide comprehensive oversight of quality and safety metrics, including patient safety incidents, clinical outcomes, harms, workforce measures, patient experience, and improvement activity.<br><br>The revised presentation is intended to support more focused discussion, strengthen assurance processes, and improve the accessibility of information for Trust Board members. The presentation will consistently be presented as **Appendix 1** and will serve as a high-level summary of the full Board report and any supporting appendices. This approach enables Board members to quickly identify key issues, assurances, risks, and decisions, while retaining access to detailed narrative, analysis, and supporting evidence contained within the accompanying report and appendices.<br><br>The slide-pack provides a summary of:<br>• Performance against national, regional, and local expectations.<br>• Areas demonstrating sustained improvement and good practice.<br>• Emerging concerns and areas requiring escalation or focused intervention.<br>• Key risks, mitigating actions, and improvement plans.<br>• Trends and themes across patient safety incidents, clinical outcomes, workforce indicators, and patient experience measures.<br>• Progress against key maternity and neonatal improvement programmes, including AMOS, Ockenden actions, Maternity Incentive Scheme (MIS) Year 8 requirements, and recommendations arising from Perinatal Mortality Review Tool (PMRT) reviews.<br><br>*The Board of Directors is requested to note the position.* |

| 2 | Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI) |
|---|---|
| 2.1 | Patient Safety Incident Investigations (PSIIs) continue to be reported monthly via the regional maternity safety dashboard by all maternity providers across Cheshire and Merseyside and Lancashire and South Cumbria (Northwest Coast). This reporting arrangement supports regional oversight, benchmarking, and the identification of shared themes and learning across maternity services.<br><br>There were no Patient Safety Incident Investigations (PSIIs) declared within maternity services during September 2026.<br><br>All relevant cases arising during the reporting period have been appropriately assessed and referred to the Maternity and Newborn Safety Investigations (MNSI) Programme in |

| | |
|---|---|
| | line with national requirements and the Trust's internal governance processes. There were no MNSI referrals in September 2026, and there are currently no active MNSI investigations.<br><br>There were also no Patient Safety Incident Investigations (PSIIs) declared within neonatal services September 2026.<br><br>*The Board of Directors is requested to note the position.* |

| 3 | **Maternity Incentive Scheme (MIS) Year 8** |
|---|---|
| 3.1 | The Trust continues to make good progress towards compliance with all six revised Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards. Robust governance arrangements are in place, with monthly oversight through the Maternity and Neonatal Quality Assurance Meeting and regular reporting to the Quality and Safety Committee and Board of Directors.<br><br>A refreshed gap analysis **(Appendix 2)** has been completed to reflect the updated position of the MIS requirements. Evidence collection, validation processes and assurance mechanisms have been strengthened to ensure audit readiness and support completion of the annual self-declaration. Cross-divisional collaboration between Maternity, Neonatal, Governance and Quality teams continue to support delivery of the programme, with targeted actions in place to address any remaining areas for improvement.<br><br>As part of the national validation process, Wirral University Teaching Hospital was selected by the NHS England review team for a review of Safety Action B (Training), undertaken on 25 August 2026. The outcome of this review is detailed within **Appendix 3** and provides additional assurance regarding the Trust's training governance and compliance arrangements.<br><br>Board oversight remains a mandatory requirement of the MIS programme. The Board is required to maintain oversight of progress against all six Safety Action Standards, ensure evidence is complete and robust, and approve the final declaration submitted to NHS Resolution. Successful compliance will secure the refund of the Trust's additional CNST maternity contribution and any associated incentive payment, while continuing to support the delivery of safe, high-quality maternity and neonatal services.<br><br>The Trust remains on track to achieve compliance with the applicable Year 8 requirements and to submit its final declaration to NHS Resolution by 2 March 2027.<br><br>*Board of Directors is asked to:*<br>1. *Note the current position and progress against the Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards.*<br>2. *Receive assurance regarding the outcome of the NHS England validation review of Safety Action B: Training, detailed in Appendix 3.* |

| | |
|---|---|
| | 3. *Receive assurance that appropriate governance, monitoring and evidence validation processes are in place to support compliance with all applicable Safety Action Standards.*<br>4. *Note that the Trust remains on track to submit its final MIS Year 8 declaration to NHS Resolution by 2 March 2027.* |

| 4 | Regional Review of 10 Point Plan Submission (October 2026) |
|---|---|
| 4.1 | The regional assessment identified a number of areas where the level of assurance was lower than the Trust self-assessment. Whilst several elements were confirmed as compliant, some deliverables require strengthening through additional evidence, enhanced Board oversight, and clearer demonstration of compliance.<br><br>**Key Issues Requiring Attention**<br>The review identified the following areas where further assurance is required:<br><br>• Health inequalities reporting (2.3): Insufficient evidence demonstrating analysis of maternity outcomes by ethnicity and deprivation, together with Board scrutiny and resulting actions (included within Board report for discussion).<br>• Health inequalities dashboard review (5.2): Evidence was not available for regional review.<br>• Homebirth service review (7.1): Evidence suggests the review was undertaken; however, there was no evidence demonstrating Board consideration and scrutiny of the findings (included within Board report).<br>• Family engagement and debriefing provision (8.3): Evidence demonstrated the availability of a debrief service but did not fully evidence the broader requirements of the deliverable.<br><br>**Clarification Regarding Deliverables 10.1 and 10.2**<br><br>The regional review identified Post-Death Care Assurance (10.1) and Mortuary Governance and Oversight (10.2) as non-compliant due to an apparent absence of submitted evidence. Following review, it has been confirmed that the required evidence was uploaded within the submission portal. The regional team has acknowledged this as a reviewer oversight. Consequently, these standards will be subject to further review and reassessment during the next regional review cycle in December 2026.<br><br>**Areas Requiring Further Assurance**<br>Several standards were assessed as partially compliant, primarily due to limitations in the evidence submitted:<br>• Martha's Rule implementation requires a more detailed implementation plan and confirmation of sustainable funding arrangements.<br>• Patient experience and outcome measures require clearer evidence of routine analysis, triangulation of themes and regular Board reporting.<br>• Evidence of neonatal representation within Board quality discussions requires strengthening.<br>• Anaesthetic workforce compliance was evidenced through a limited rota sample and requires additional assurance. |

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|---|---|
| | • Board oversight of workforce pressures and escalation processes requires stronger demonstration, particularly in relation to divisional and corporate risk management arrangements.<br>• Triage audit evidence appears to have been uploaded to an incorrect location and will require resubmission.<br><br>**Areas of Good Assurance**<br>The review provided positive assurance regarding:<br>• Joint executive accountability arrangements.<br>• Board-level maternity governance and oversight structures.<br>• Safety champion arrangements.<br>• A number of workforce, governance and quality improvement standards where evidence demonstrated compliance.<br><br>*Recommended Board Actions*<br>*The Board is asked to:*<br>1. *Note the outcome of the regional review and the variance between the Trust self-assessment and regional assessment.*<br>2. *Note that the ratings for Deliverables 10.1 and 10.2 are currently under reconsideration following confirmation that evidence had been appropriately submitted.*<br>3. *Support completion of an action plan to address all remaining areas assessed as non-compliant or partially compliant.*<br>4. *Ensure additional evidence is submitted where compliance has been achieved but not fully evidenced.*<br>5. *Receive a further progress update following the regional reassessment and review in December 2026.*<br><br>**Overall assessment:** The review indicates that a significant proportion of the identified gaps relate to evidencing and demonstrating compliance rather than an absence of activity. Subject to resolution of the outstanding evidence queries and implementation of targeted actions, there remains an opportunity to improve the Trust's overall assurance position ahead of the next regional review in December 2026. |

| **5** | **Homebirth Service Review** |
|---|---|
| 5.1 | Prior to the publication of the NHS England Three-Year Delivery Plan for Maternity and Neonatal Services (10 Point Plan), the Northwest Region commenced a regional review of Homebirth Services to assess the safety, governance and operational delivery of care across provider organisations. As part of this regional initiative, a Northwest Homebirth Task and Finish Group was established, with the Trust's Consultant Midwife participating in the review. The Trust completed the regional audit tool and undertook a comprehensive local assessment of its Homebirth Service, the findings of which informed both the regional review and the Trust's ongoing assurance and improvement programme.<br><br>The Trust's Consultant Midwife actively participated in the Northwest Regional Homebirth Task and Finish Group, established following regional correspondence issued on 26 November 2025. As part of this work, the Trust completed and submitted the regional homebirth audit tool, which informed both the regional review and the Trust's local assurance processes. |

| | |
|---|---|
| | The original NHS England correspondence setting out the requirements for the regional review is provided at **Appendix 4**. The findings and recommendations arising from the Northwest Regional Homebirth Review are provided at **Appendix 5**. The Trust's completed submission to the Northwest Regional Homebirth Toolkit Benchmarking Exercise, which informed the regional review findings, is attached at **Appendix 6.**<br><br>The review considered all domains identified within the regional framework and evidence requirements, including:<br>• Operational delivery of the Homebirth Service.<br>• Care planning and risk assessment processes.<br>• Governance arrangements and executive oversight.<br>• Safe staffing and workforce capacity.<br>• Education, training and competency of midwives.<br>• Availability, maintenance and assurance of homebirth equipment and emergency kits.<br>• Escalation processes and clinical decision-making.<br>• Compliance with local and national guidance.<br><br>The review concluded that all areas identified within the regional assessment had been considered locally and incorporated into service development and assurance arrangements. This included a review of workforce training and upskilling, equipment and emergency kit provision, care planning and escalation pathways, staffing arrangements, governance processes and supporting clinical guidelines.<br>To strengthen oversight and support personalised care planning, a monthly multidisciplinary team (MDT) review meeting was introduced for women and birthing people requesting birth outside local guidance. This provides enhanced scrutiny of individual care plans, supports informed decision-making, ensures appropriate risk assessment and escalation, and strengthens governance oversight of higher-risk or complex cases.<br><br>The outcomes of the review have been considered through the Trust's maternity governance structures and provide assurance that the Homebirth Service has been reviewed in line with both the Northwest Regional recommendations and the requirements of the 10-Point Plan. The Board is therefore asked to note that a comprehensive review has been undertaken, the recommendations have been implemented through local service improvements, and ongoing governance arrangements are in place to monitor compliance and service safety.<br><br>*The Board of Directors is requested to note the review of the home birth service.* |

| **6** | **Maternity Data Collection: Live Births and Ethnicity by Gestation (Quarter 2 2026/27)** |
|---|---|
| 6.1 | During Quarter 2 (July to September 2026), Wirral Women and Children's Hospital recorded 743 live births, with activity increasing steadily across the quarter from 238 births in July to 257 births in September. Birth numbers remain consistent with expected maternity activity levels and demonstrate stable demand across maternity services. |

The majority of births (92.5%; n=687) occurred at term (37 weeks' gestation or above), while 7.5% (n=56) occurred preterm. Of the preterm births, 16 births (2.2%) occurred before 34 weeks' gestation and 40 births (5.4%) occurred between 34+0 and 36+6 weeks' gestation. The proportion of preterm births remains low, with fewer than one in ten births occurring before 37 weeks.

Ethnicity reporting demonstrates a population profile that remains broadly consistent with the local communities served by the Trust. Continued monitoring of maternity outcomes by ethnicity supports the Trust's commitment to reducing health inequalities and improving equity of access and outcomes for women, birthing people and babies.

**Activity and Gestational Profile**
Birth activity remained stable throughout the quarter, with an average of approximately 248 births per month. The gestational profile continues to demonstrate that the vast majority of babies are born at term, reflecting a generally low-risk maternity population.

| Gestation Category | Births | % of Total Births |
|---|---|---|
| <34 weeks | 16 | 2.2% |
| 34-36+6 weeks | 40 | 5.4% |
| 37+ weeks | 687 | 92.5% |
| Total | 743 | 100% |

There were no significant variations in gestational age distribution across the reporting period.

**Ethnicity Profile**
Ethnicity data is collected for babies born at 34 weeks' gestation and above, with births below 34 weeks reported separately through BadgerNet.
Of the 727 births included within ethnicity reporting:

- White: 623 (85.7%)
- Asian or Asian British: 42 (5.8%)
- Black, Black British, Caribbean or African: 19 (2.6%)
- Mixed or Multiple Ethnic Groups: 15 (2.1%)
- Other Ethnic Groups: 15 (2.1%)
- Not Stated/Unknown: 13 (1.8%)
-

The ethnicity profile remains stable and broadly reflective of the local population. Ongoing ethnicity monitoring forms part of the Trust's wider equity and health inequalities work programme and supports compliance with national maternity safety and quality requirements.

**Assurance**
No significant variation in birth activity, gestational age distribution or ethnicity profile was identified during Quarter 2. The data demonstrates:

- Stable maternity activity across the reporting period.
- A predominantly term birth population.
- Low levels of preterm birth.
- Consistent ethnicity reporting.

| | |
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| | • Continued oversight of maternity outcomes through routine governance arrangements.<br><br>The data provides assurance that maternity services continue to monitor activity, outcomes and population demographics, enabling early identification of trends and supporting targeted quality improvement activity where required.<br><br>**Recommendation**<br>*The Board of Directors is asked to:*<br>1. *Note the Quarter 2 maternity activity, gestational age distribution and ethnicity profile.*<br>2. *Receive assurance that maternity outcomes, activity trends and demographic data continue to be monitored through established governance and performance reporting arrangements.*<br>3. *Support the ongoing use of maternity demographic and outcome data to inform service planning, quality improvement and the reduction of health inequalities.* |

| 7 | Conclusion |
|---|---|
| 7.1 | The Board of Directors is asked to:<br>1. Note the contents of the report and the assurances provided regarding maternity and neonatal quality, safety, performance and governance.<br>2. Note that no maternity or neonatal PSIIs were declared during September 2026.<br>3. Receive assurance that delivery of MIS Year 8 remains on track, including achievement of the Training Compliance Touch Point and progress towards the March 2027 submission.<br>4. Note the outcome of the regional review of the NHS England Three-Year Delivery Plan (10-Point Plan), including areas requiring further evidence and strengthened Board oversight.<br>5. Receive assurance that actions are in place to address all identified gaps and that progress will continue to be monitored through established governance arrangements.<br>6. Note the findings from the regional Homebirth Service Review and the actions implemented to strengthen assurance and service delivery.<br>7. Receive assurance that maternity activity, outcomes and demographic data continue to be monitored to support quality improvement and reduction of health inequalities. |

| 8 | Implications |
|---|---|
| 8.1 | **Patients**<br>• The appendices demonstrate the standards, performance measures and governance arrangements in place to support the delivery of safe, effective and high-quality maternity and neonatal services.<br>• The Perinatal Quality Oversight Model (PQOM), PMRT reviews, patient safety reporting and quality metrics provide assurance regarding patient safety, clinical outcomes and continuous improvement.<br>• Learning from Ockenden, AMOS, PMRT reviews and national maternity safety initiatives continues to be embedded to improve outcomes and experience for women, babies and families. |

| | |
|---|---|
| | • The introduction of enhanced multidisciplinary reviews for neonatal deaths strengthens organisational learning and supports improvements in patient care.<br>• The recent Human Tissue Authority inspection provided positive assurance regarding the quality and safety of maternity services, with only minor recommendations identified and addressed immediately. |
| 8.2 | **People**<br>• The Trust continues to progress delivery of the Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards, supported by strengthened governance, training oversight and evidence assurance processes.<br>• Strong partnership working with the Maternity and Neonatal Voices Partnership (MNVP) continues to support co-production, service user engagement and the incorporation of patient feedback into service improvement.<br>• The Trust remains committed to implementing recommendations arising from the Ockenden, AMOS and Nottingham reviews, alongside the newly published national maternity and neonatal priorities.<br>• An Organisational Development support programme has commenced to strengthen leadership, multidisciplinary working, psychological safety and team culture across maternity services.<br>• Progress continues across key improvement programmes, including Saving Babies' Lives Care Bundle Version 3, Perinatal Equity initiatives, workforce development and patient safety programmes.<br>• Monthly governance and assurance processes continue to support staff engagement, learning from incidents and the delivery of safe, personalised and equitable care. |
| 8.3 | **Finance**<br>• Continued investment is required to support maternity and neonatal service delivery, workforce sustainability, training requirements, quality improvement programmes and implementation of national safety priorities.<br>• Financial commitment will be required to support delivery of MIS Year 8 requirements, Ockenden and AMOS recommendations, Organisational Development interventions, and future NHS England maternity and neonatal safety initiatives.<br>• Effective governance and assurance arrangements help mitigate financial risk associated with CNST compliance and support the Trust's ability to secure the associated financial reimbursement. |
| 8.4 | **Compliance**<br>• This report supports assurance against several statutory, regulatory and national requirements, including:<br>• NHS England Perinatal Quality Oversight Model reporting.<br>• Maternity Incentive Scheme (MIS) Year 8 Safety Action Standards.<br>• Ockenden recommendations and national maternity safety requirements.<br>• AMOS review recommendations.<br>• Saving Babies' Lives Care Bundle Version 3.<br>• Perinatal Mortality Review Tool (PMRT) requirements.<br>• Maternity and Newborn Safety Investigation requirements.<br>• NHS England maternity and neonatal quality governance standards. |

| | |
|---|---|
| | The report provides assurance to the Trust Board and Board regarding oversight, compliance, risk management and continuous improvement across maternity and neonatal services. |

**Group Board of Directors in Public** **Item 26**

**04 November 2026**

| | |
|---|---|
| **Title** | WUTH Antimicrobial Stewardship Annual Report 2025/26 |
| **Area Lead** | Chris Green, Director of Pharmacy and Medicines Optimisation |
| **Author** | Helen Stevens, Lead Antimicrobial Pharmacist |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Assurance |

It is recommended that the Board:

- Note the contents of this report and the actions being taken to drive improvements in antibiotic prescribing.
- Note the positive outcomes from the work described.
- Endorse the AMS priorities

## Key Points to Note

This report aims to describe the position against the Trust Antimicrobial Stewardship (AMS) priorities for 2025-6, and significant achievements, which include:

- Reduced total antibiotic consumption that supports the overall National Action Plan (NAP) target.
- Reduced overall broad-spectrum antibiotic use to align with the NAP target to increase use of 'Access' category antibiotics.
- Surpassed reduction target of usage of IV antibiotics
- Maintaining strong ASPIRE audit results.
- Benchmarking well both locally and nationally
- Widespread proactive AMS ward rounds across the Trust
- Good compliance with quinolone audit standards

The AMS mPage requires fixes or an alternative AMS solution, we are scoping out options with the informatics team, however, funding may be required to support any further work required. We understand the competing priorities that the informatics team have but a workable solution would support improvement in the quality of clinical review of antibiotics; reduction of broad-spectrum antibiotics and IV to oral switches (IVOS).

The report will also describe Trust AMS priorities for the coming year 2026-27.

## Key Risks

- Broad engagement with prescribers of key principles of AMS may be a challenge due to competing priorities at ward level, however, the AMS team approach individuals for input with specific projects as and when required.

- The pilot antibiotic duration audit demonstrated suboptimal compliance with formulary approved treatment durations for key infections, including pneumonia and urinary tract infections. It also highlighted a high prevalence of broad-spectrum antibiotic prescribing in these cases.
- Optimising Cerner AMS tools would, for example, give us the opportunity to improve our antibiotic reviews and increase IV to oral switches which would lead to reduced antibiotic use, reduced inpatient stays, reduced nursing time required (for IVs), and improved reporting capability.
- Additional laboratory IT upgrades/resources are needed to be able to review local resistance rates, as suggested by NICE guideline 15. Risk register entry DRR/0177.

| **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** |
| September 2026 | Joint Quality and Safety Committee | Antimicrobial Stewardship Annual Assurance Report 2024-25 | For information |
| May 2026 | MSOP/IPCG | Antimicrobial Stewardship Annual Assurance Report 2024-25 | For information |

# ANTIMICROBIAL STEWARDSHIP: ANNUAL REPORT AND PRIORITIES FOR 2025/26

In the absence of specific antimicrobial CQUIN targets for the 2025/26 financial year, antimicrobial stewardship priorities were aligned with national contractual and strategic drivers. The NHS Standard Contract service condition SC21.3 requires providers to use all reasonable endeavours, consistent with good practice, to minimise broad-spectrum antibiotic use in line with the UK National Action Plan (NAP) for Antimicrobial Resistance. In response, the Trust's antimicrobial stewardship programme for 2025/26 focused on supporting delivery of the UK 5-year National Action Plan 2024–2029 (NAP), which sets out key ambitions to reduce antimicrobial use and resistance. The following priorities were identified for the 25/26 financial year:

## Priority 1: Reduce total antibiotic consumption to support overall NAP target.

**Target:** Reduce total consumption of antibiotics by 1.5% by March 2026 compared with last financial year 24/25, measured in DDDs per 1000 admissions *(NAP).*

Our 2019 baseline is 3865 DDDs per 1000 admissions[1] and our total antibiotic DDDs per 1000 admissions for 24/25 was reported at 4083. The target for 25/26 was <4021 DDDs per 1000 admissions equating to a 1.5% reduction and over the next 5 years we aim to continue this work in order to reach the NAP target of a 5% reduction.

## Priority 2: Reduce unnecessary broad spectrum antibiotic use.

**Target:** Reduce broad spectrum antibiotics (Watch & Reserve antibiotics) by 1% compared to last financial year 24/25, measured in DDDs per 1000 admissions. *(NAP).*

This supports the NAP target 4b, as by reducing our broad-spectrum usage, our proportion of Access antibiotics will increase. Our proportion of total antibiotics from the Access category for 24/25 was 46%. Our Watch & Reserve antibiotic DDDs per 1000 admissions for 24/25 were 2144 while the target for 25/26 was <2122 DDDs per 1000 admissions, a 1% reduction.

## Priority 3: Reduce unnecessary IV antibiotics.

**Target:** Reduce IV antibiotics, measured in DDDs per 1000 admissions, by 1% compared to last financial year 24/25. *(Local priority)*

## Priority 4: Assurance of compliance with best practice AMS principles outlined by *'Start Smart Then Focus'.*

**Target:** To achieve >95% compliance with all indicators from the Antibiotic Safe Prescribing Indicators Report' (ASPIRE)

1. Data provided by the 'Define' and 'Refine' software packages, supplied via RX-Info.

### Priority 5: Assurance of appropriateness of prescribing of restricted antibiotics

**Target:** To achieve >95% compliance with formulary or otherwise appropriate

## Data sources

To provide assurance of good AMS practices, national benchmarking databases supplied via Rx-Info[1,] and data sets published by UKHSA Fingertips are used to track progress against the AMS priorities and benchmark against similar organisations. We also actively participate in regional NW Antibiotic Pharmacist group to share and acquire good practice. The AMS audit plan to provide assurance is set out below:

| Quarter | Audit | To provide assurance for: |
|---|---|---|
| Q1 | Antibiotic Duration Audit | Compliance with antimicrobial formulary and best practice AMS principles |
| Q2 | Antibiotic Point Prevalence Audit | Compliance with best practice AMS principles outlined by *'Start Smart Then Focus'* |
| Q2 | Quinolone prescribing re-audit | Re-audit of compliance with appropriateness of prescribing of quinolone antibiotics in line with Trust guidance and MHRA restrictions |
| Q3 | Antibiotic Surgical Prophylaxis Audit | Compliance with best practice AMS principles outlined by *'Start Smart Then Focus'* |
| Q3/4 | ED co-amoxiclav use re-audit | Re-audit of co-amoxiclav use in line with antimicrobial formulary |
| Rolling quarterly audits | ASPIRE audit | Compliance with best practice AMS principles outlined by *'Start Smart Then Focus'* |
| | Restricted antibiotic audit | Compliance with appropriateness of prescribing of restricted antibiotics |

## 25/26 Position and Benchmarking

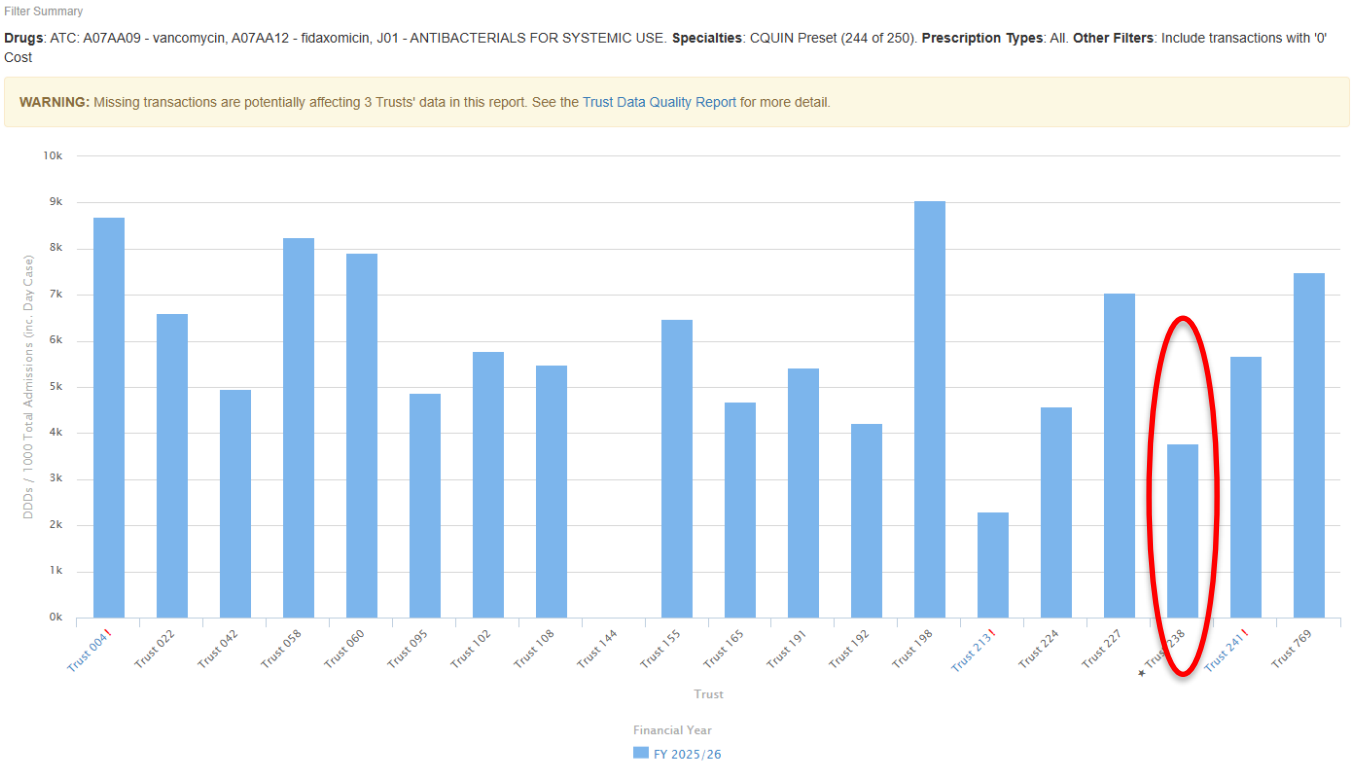
See section 4 for commentary & actions.

| Table 1: Assurance position | | Data source | Target | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|---|---|
| 1 | Reduce total antibiotic consumption compared to last financial year (DDDs/1000 admissions).<br>Baseline: 4083 | Define | 1.5% reduction (<4021) | 11% decrease (3625)* | 6% decrease (3846) | 7.5% decrease (3719) | 6% decrease (3783) | 7.6% decrease YTD |
| 2 | Reduce usage of broad-spectrum antibiotics (Watch & Reserve) compared to last financial year (DDDs/1000 admissions).<br>Baseline: 2144 | Define | 1% reduction (<2122) | 8% decrease (1978)* | 8.7% decrease (1966) | 7.7% decrease (1958) | 7.4% decrease (1966) | 8% decrease YTD |
| 3 | Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly).<br>Baseline: 1178 | Define | 1% reduction (<1166) | 4% increase (1226)* | 3.5% decrease (1137) | 3% decrease (1129) | 3.6% decrease (1124) | 1.5% decrease YTD |
| 4 | Antibiotic Safe Prescribing Indicators Report' (ASPIRE) Quality indicators:<br>Local audit | | | | | | | |
| 4.1 | Compliance with antibiotic formulary | Local audit | ≥95% compliance | 98% | 98% | 96% | 97% | 97% |
| 4.2 | Documentation of indication for antibiotics on prescription | Local audit | ≥95% compliance | 96% | 96% | 95% | 95% | 95.5% |
| 4.3 | Stop / review date on antibiotic prescription | Local audit | ≥95% compliance | 100% | 100% | 100% | 99% | 99.75% |
| 4.4 | Antibiotic clinical review undertaken within 72 hours of initiation | Local audit | ≥95% compliance | 96% | 96% | 98% | 97% | 97% |
| 5 | Assurance of appropriateness of prescribing of restricted antibiotics | Local audit | ≥95% compliance | 97% | 97% | 98% | 99% | 98% |

*Using proxy June admissions data

## Priority 1:

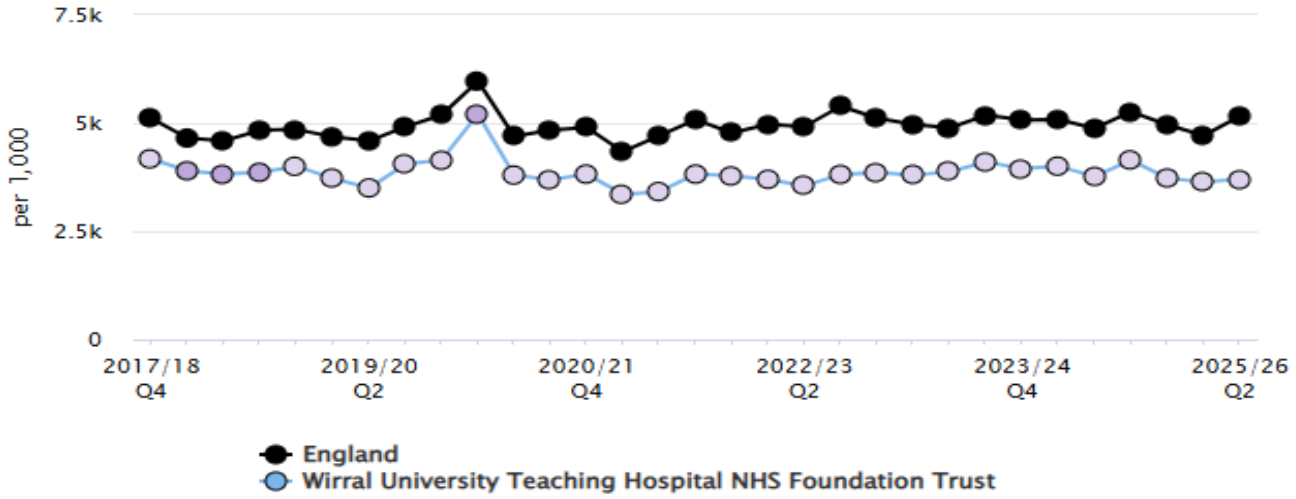
### Figure 1. WUTH Total antibiotic consumption (DDDs per 1000 admissions), financial year 25/26, compared to similar NW Trusts.




We have surpassed our target to reduce total antibiotic use by 1.5% and have achieved a reduction of 7.6% year to date.

As can be seen from the graph, the Trust continues to benchmark favourably within the region with total antibiotic use remaining comparatively low.

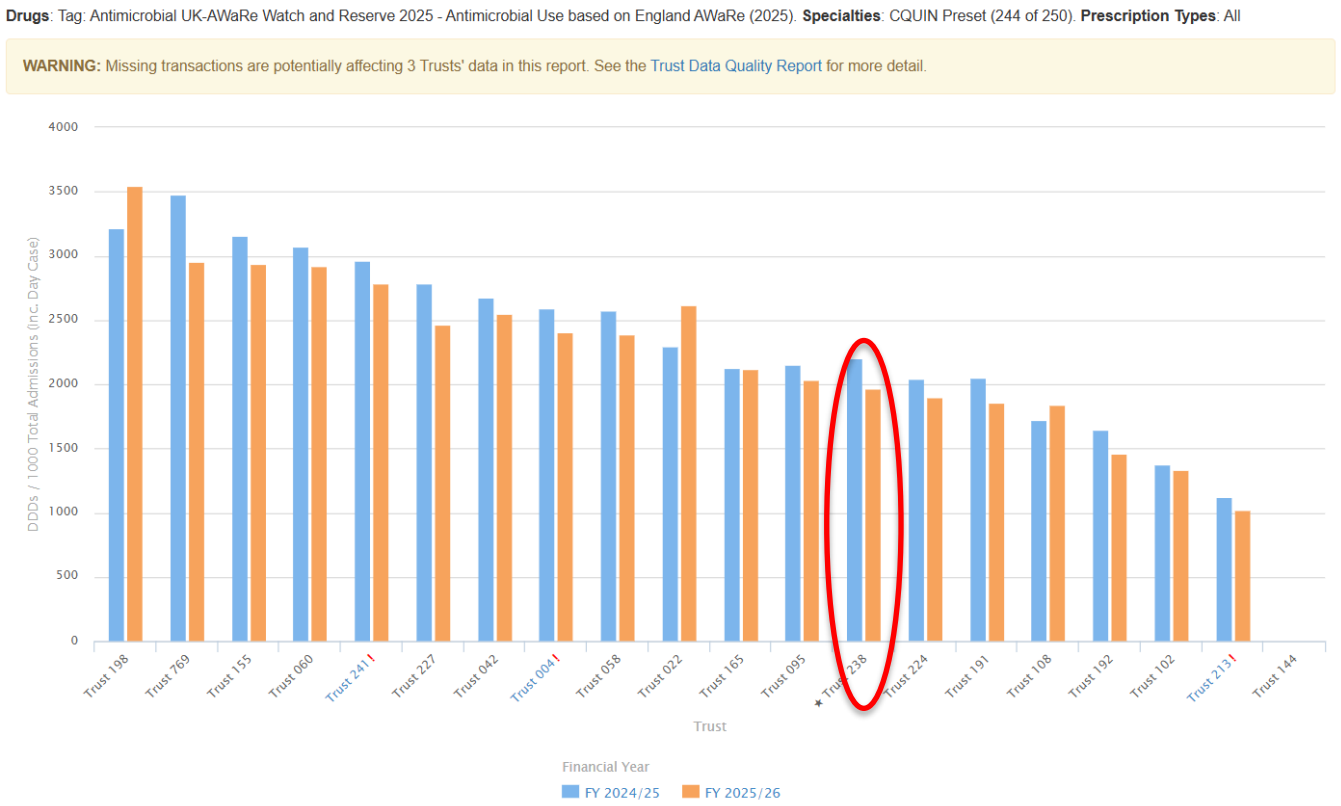
**Figure 2. WUTH Total antibiotic consumption (DDDs per 1000 admissions) data until the end of Q2 25/26. Data from UKHSA (fingertips), benchmarking compared to England.**




As can be seen in the graph, the Trust continues to maintain a comparatively low level of total antibiotic use compared to other acute trusts across England.

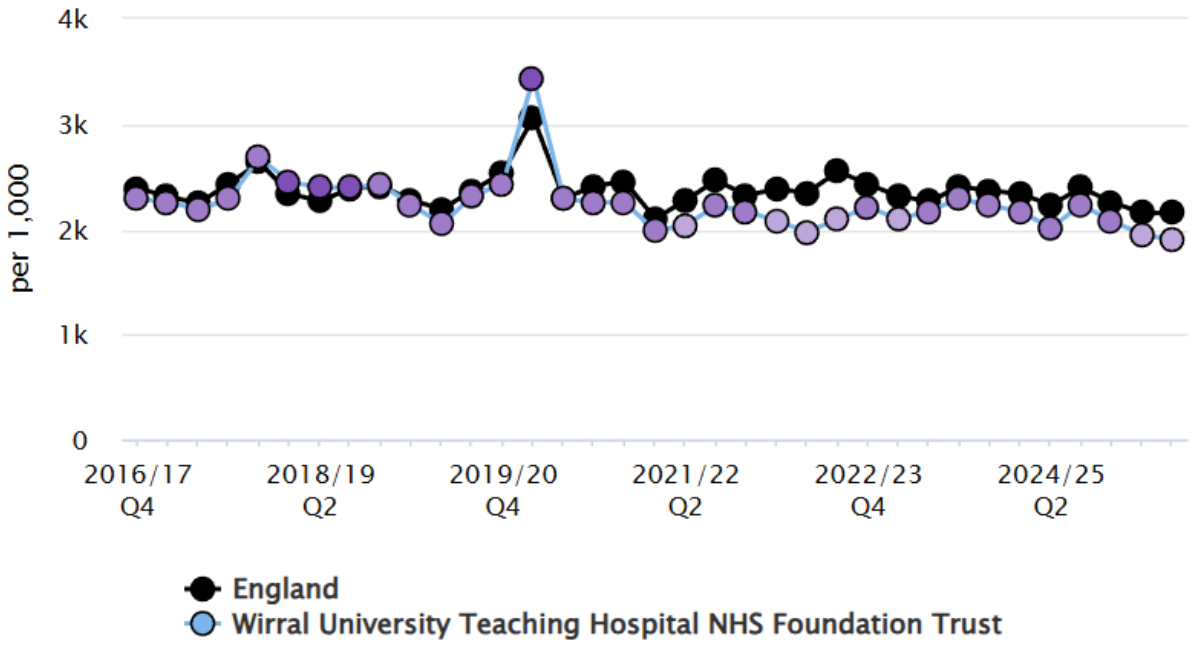
## Priority 2

### Figure 3. WUTH usage of Watch & Reserve antibiotics (DDDs per 1000 admissions), financial year 24/25 and 25/26, compared to similar NW Trusts:



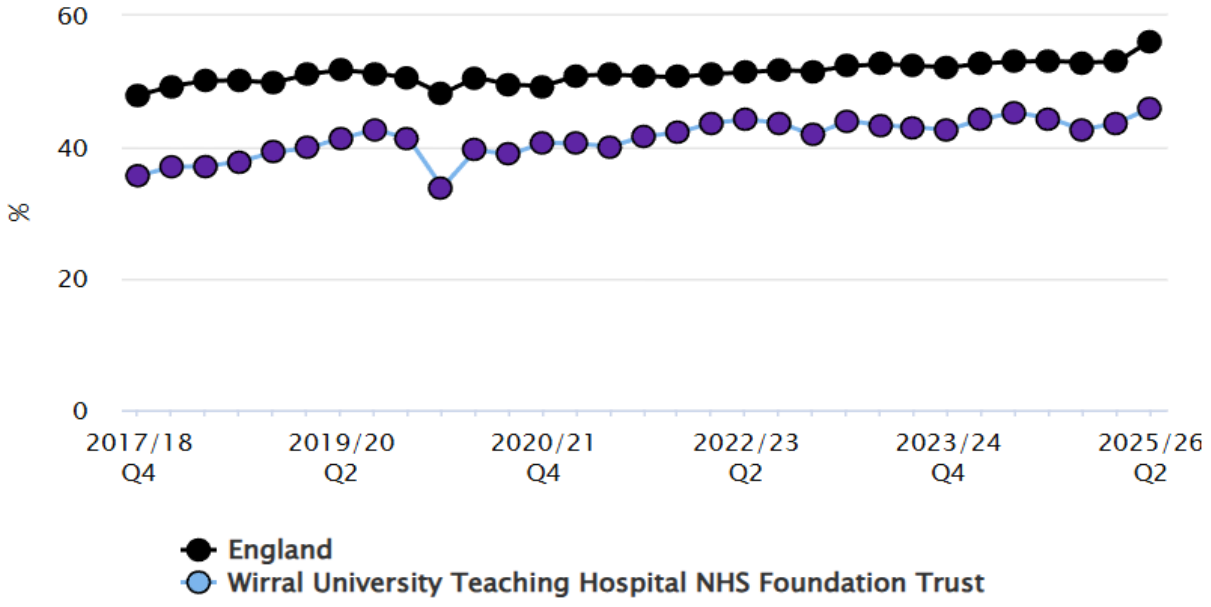

Watch and Reserve antibiotic use has reduced by 8% compared to the previous financial year. The Trust also continues to benchmark favourably, with prescribing generally falling within the lower half of comparable North West organisations.

**Figure 4. WUTH usage of broad-spectrum, Watch & Reserve antibiotics, DDDs per 1000 admissions by quarter, up to end of Q2 25/26. Data from UKHSA (fingertips), benchmarking compared to England.**




Whilst not fully reflected in the UKHSA data presented above, which extends only to Q2 2024/2025, the Trust continues to demonstrate lower Watch and Reserve antibiotic use than the national average.

**Figure 5. WUTH proportion of total antibiotic prescribing from the "Access" category, data until the end of Q2 25/26. Data from UKHSA (fingertips), benchmarking compared to England.**



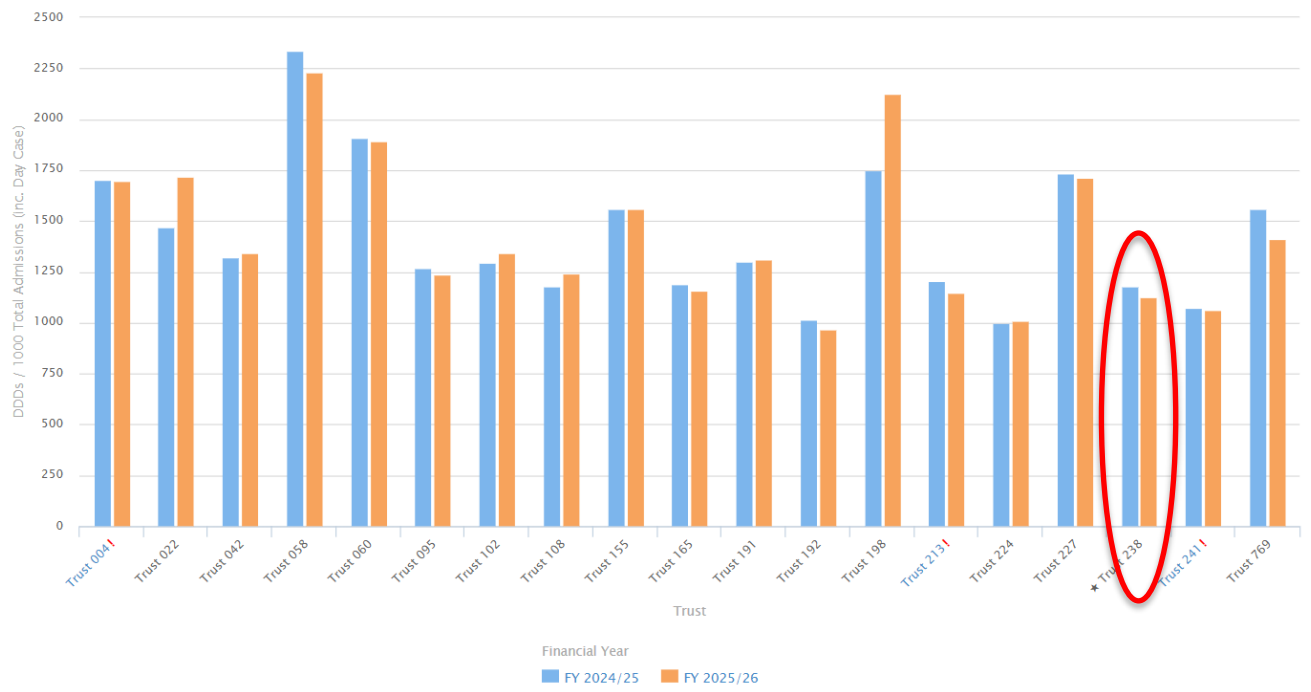

Access antibiotic use is slightly lower than the national average, this could be attributable to the Trust's overall lower total antibiotic use compared both regionally and nationally.

## Priority 3.

### Figure 6. WUTH usage of IV antibiotics (DDDs per 1000 admissions), financial year 24/25 and 25/26, compared to similar NW Trusts:

**Drugs**: ATC: A07AA09 - vancomycin, A07AA12 - fidaxomicin, J01 - ANTIBACTERIALS FOR SYSTEMIC USE, Route: Intravenous. **Specialties**: CQUIN Preset (244 of 250). **Prescription Types**: All. **Other Filters**: Include transactions with '0' Cost

**WARNING:** Missing transactions are potentially affecting 3 Trusts' data in this report. See the Trust Data Quality Report for more detail.




IV antibiotic use has reduced by 3% compared to the previous financial year. The Trust also continues to perform well compared to other North West trusts, with IV antibiotic use in falling within the lower half.

## 4. Action and Delivery Plans

**4.1 Audit Plan.** The AMS team provide assurance by delivery of the audit plan (Table 2).

**Table 2. 2024/5 AMS Audit Plan**

| Quarter | Audit | Relevant priority | Progress |
|---|---|---|---|
| Q1 | Antibiotic Duration audit | Priority 4 | Data collected in Q1, see below |
| Q1 | Antibiotic Point Prevalence Audit | Priority 4 | Data collected in Q3, see below |
| Q1 | Quinolone prescribing re-audit | Local priority | Data collected, see below |
| Q2 | Antibiotic Surgical Prophylaxis Audit | Priority 4 | Delayed due to formulary updates. This will be reviewed in 2026/2027 financial year |
| Q4 | ED co-amoxiclav use re-audit | Priority 1 & 2 | Delayed due to UECUP project. Will be reviewed following completion of UECUP and merger with UTC & OOH |
| Quarterly audits | ASPIRE audit | Priority 4 | Ongoing |
| | Restricted antibiotic audit | Priority 5 | Ongoing |

### 4.1.1 Antibiotic Duration Audit

A pilot duration audit of antibiotics was conducted in Q1 of the 25/26 financial year. Data were extracted from the Trust antibiotic report, which captures all patients prescribed antibiotics within the preceding 24 hours. From this dataset, 15 patients were selected at random to provide a representative sample. In addition, two ward areas known to be high users of antibiotics were specifically included to ensure capture of higher prescribing activity. As a result of this targeted approach, there was a higher proportion of medical patients compared to surgical patients within the sample.

The findings of the audit demonstrated that compliance with recommended antimicrobial duration was 57% (26/46), falling well below the standard of 90% or higher. This indicates that almost half of all prescriptions deviated from expected course lengths, with seventeen prescriptions (37%) extended and 3 prescriptions (6%) shorter than recommended.

Extended courses formed most non-compliant prescriptions. The most common clinical reason for extension was non-resolving pneumonia, accounting for eleven of the seventeen extended courses. Of the seventeen prescriptions identified with extended course durations, 76% were for broad-spectrum antibiotics, with the majority being co-amoxiclav or piperacillin/tazobactam. This is particularly significant in the context of our National Action Plan (NAP) targets, which aims to reduce both overall antibiotic consumption and the use of broad-spectrum agents. In addition to the recommended duration of antibiotic therapy, other parameters were assessed. Documentation of review within 48–72 hours achieved 100% compliance, however, recording of a stop/review date at the time of prescribing did not meet the 100% target, with compliance at 48%.

The point prevalence audit data is in contrast to this. The discrepancy is likely due to differences in the methodology and audit criteria used. The antibiotic duration audit specifically assessed whether a stop or review data had been documented at the time or prescribing, reflecting the prescriber's initial decision regarding intended duration of therapy. In contrast, the point prevalence audit assesses whether a stop of review data was present on the prescription at the time of data collection. By this stage, many antibiotic prescriptions will have had a course length, stop data or review data added or amended following subsequent clinical review. As a result, compliance is typically much higher and often approaches 100% Therefore, whilst both audits examine the aspects of antimicrobial duration management, they measure different stages of the prescribing process. The duration audit provides insight in to initial prescribing practice and the low rate of documented stop dates and poor adherence to recommended durations at this stage highlight key areas for improvement and contribute to prolonged antibiotic courses. Overall, the findings demonstrate a need for targeted antimicrobial stewardship interventions to improve documentation and ensure prescribing aligns with local and national guidance.

### 4.1.2 Annual Antibiotic Point Prevalence Audit Summary

Data were collected in Q3 October 2025 for 766 inpatients across the APH and CGH sites. Across both sites, 305 (40%) inpatients were prescribed a total of 358 antibiotics. The audit did not include the Emergency Department.

**Table 3 – Antibiotic Overview by Division and Trust-wide (compared to August 24 audit figures).**

| Division | % of patients on antibiotics | | % of antibiotics that were IV | | % of antibiotics with course length / review date | | % of antibiotics with a documented indication in notes | | % of antibiotics with correct indication on prescription | | % of antibiotics compliant with formulary / otherwise appropriate | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Oct-25 | Aug-24 | Oct-25 | Aug-24 | Oct-25 | Aug-24 | Oct-25 | Aug-24 | Oct-25 | Aug-24 | Oct-25 | Aug-24 |
| **Surgery** | 34 | 32 | 53 | 63 | 88 | 83 | 92 | 88 | 86 | 89 | 72 | 97 |
| **Medicine and Acute** | 42 | 36 | 53 | 55 | 86 | 93 | 88 | 96 | 80 | 76 | 72 | 94 |
| **Women and Children's** | 38 | 35 | 65 | 69 | 87 | 76 | 91 | 100 | 70 | 100 | 87 | 100 |
| **Trust wide** | 40 | 35 | 54 | 58 | 86 | 90 | 89 | 94 | 80 | 81 | 73 | 91 |

### Antibiotic review

In total, 283/358 (79%) antibiotics had received a review. For the seventy-five prescriptions that had not been reviewed, twenty-three had been prescribed within 72 hours, and so were still eligible for a review. A further forty-one prescriptions were for prophylaxis and therefore not reviewed. Therefore, of eligible prescriptions (347) 97% were reviewed.

We have observed a reduction in the proportion of IV prescriptions compared with last year. This change is likely multifactorial, influenced by antimicrobial stewardship (AMS) ward rounds, increased promotion of IV-to-oral switching, and targeted educational interventions for new doctors and pharmacists. The remaining AMS indicators are largely unchanged from the previous year, with the exception of compliance with the local microbiology formulary.

It is important to note that the point prevalence audit provides only a snapshot of antibiotic prescribing on a single day. While it offers useful insight into prescribing patterns, it should not be relied upon as a sole indicator. As shown in Table 1 above, quarterly reporting of these indicators demonstrates sustained performance above 95% across all measures.

The audit has, however, identified areas for improvement, particularly in relation to piperacillin/tazobactam prescribing. This remains a key focus for targeted AMS ward rounds, as it is a restricted antibiotic within the Trust. Audit data indicate that 20% of these prescriptions were considered inappropriate, highlighting the need for continued focus on this area.

## 4.1.3 Quinolone Prescribing Re-audit.

In April 2024, in response to the MHRA alert published in January 2024: *'Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate'*, an audit was conducted to gain local assurance of quinolone prescribing practices. It was re-audited in June 2025 to ensure ongoing compliance with the alert.

Systemic fluroquinolones can cause long-lasting, disabling and potentially irreversible side effects, sometimes affecting multiple body systems and senses.

The UK indications for systemic fluoroquinolones have been updated so they must only be used in situations when other antibiotics, which are commonly recommended for the infection, are inappropriate.

Situations in which other antibiotics are considered to be inappropriate and where a fluroquinolone may be indicated:

- ❒ There is resistance to other first-line antibiotics recommended for the infection.
- ❒ Other first-line antibiotics are contraindicated in an individual patient.
- ❒ Other first-line antibiotics have caused side effects in the patient requiring treatment to be stopped.
- ❒ Treatment with other first-line antibiotics has failed.

All fluoroquinolone prescriptions from 1 week in Q1 (April 2024) in the first audit were reviewed and re-reviewed for 1 week in Q2 (June 2025) for the re-audit. Compliance against the standards are listed below:

**Table 4. Compliance with quinolone audit standards**

| | Compliance 2025 | Compliance 2024 |
|---|---|---|
| Prescription in line with formulary for the given indication (Standard 1) | 70% (44/63) | 65% (42/65) |
| Usage as per MHRA recommendations list (Standards 2a-2d) | 60% (38/63) | 72% (47/65) |
| Prescriptions on specific microbiology advice (Standard 1) | 6% (4/63) | 5% (3/65) |
| Total prescriptions compliant with Standards 1 & 2 | 92% (58/63) | 92% (60/65) |

This would suggest that MHRA advice is being followed, guided mainly by the formulary, but also specific microbiologist advice in some cases and microbiology results in others.

### 4.1.4 Antibiotic Surgical Prophylaxis Audit

The surgical prophylaxis audit was not completed this year due to delays in the implementation of the updated surgical prophylaxis formulary. As a result, it was not feasible to undertake a meaningful audit against a standard that was still under development. The new formulary is now live, and an audit will be considered in the next financial year, subject to prioritisation and assessment of need.

### 4.1.5 Emergency Department co-amoxiclav re-audit

A re-audit of co-amoxiclav use in the Emergency Department has not been undertaken during this financial year, as focus has been directed towards other key priorities, including the UECUP project and the wider redesign of the Emergency Department. Antimicrobial stewardship efforts have instead centred on ensuring alignment of formularies in preparation for the integration of the community trust into WUTH, with the aim of harmonising antibiotic use across services. This approach supports consistent application of stewardship principles and promotes safe, effective antimicrobial use for all patients across care settings.

## 4.2 Reduction of total antibiotic consumption to support overall NAP target (Priority 1)

We have surpassed our target to reduce total antibiotic use by 1.5% and have achieved a reduction of 7.6% year to date. Actions we have undertaken to achieve this target include:

- ❒ Introduction of 3-day antibiotic pre-pack sizes for prophylactic indications, in addition to the increased use of 5-day pre-packs
- ❒ Continuation of AMS ward rounds and focused interventions on high users of broad-spectrum or restricted agents.
- ❒ Updates to antibiotic formularies, including introduction of breast surgical prophylaxis formulary.

## 4.3 Reduction in usage of broad-spectrum antibiotics (Priority 2)

We have reduced our use of broad-spectrum antibiotics by 8% compared to last year, which exceeds our target of a 1% reduction. This reduction reflects the impact of multiple stewardship interventions. As highlighted above, changes to antibiotic pre-pack durations have contributed significantly, as the majority of these agents fall within the Watch and Reserve categories. In addition, enhanced monitoring, and

oversight of restricted antibiotics, all of which are broad spectrum agents, has strengthened prescribing scrutiny and supported reductions in use.

Ongoing antimicrobial stewardship ward rounds, with a specific focus on patients receiving broad spectrum antibiotics and high-risk agents, have also contributed to this positive reduction in broad spectrum antibiotic consumption.

### 4.4 Reduce unnecessary IV antibiotics (Priority 3)

There has been a 3% decrease in our use of IV antibiotics (DDDs/1000 admissions including day case) for this financial year compared to the 24/25 financial year. There are many benefits of timely IV to oral switch which include reduced inpatient stay, reduced nursing time required, reduced bloodstream infections, reduced carbon footprint & reduced cost.

The sustained reduction observed in this area is likely multifactorial and reflects the impact of previously implemented interventions. Ongoing education is delivered through regular antimicrobial stewardship (AMS) ward rounds, supported by resources available via the antimicrobial formulary webpage. The importance of IV to oral switch is reinforced through annual teaching sessions for Foundation Year 1 (F1) doctors and Non-Medical Prescribers (NMPs). In addition, nursing staff receive further education through Infection Prevention and Control (IPC) link sessions and the IPC WEPP education programme delivered to newly appointed nurses.

### 4.5 ASPIRE results (Priority 4)

Data are collected for 3–5 patients per ward each quarter, selected at random from a daily list of patients receiving antibiotics. Each prescription is assessed against the *'Start Smart Then Focus'* principles. Overall, results from the Antibiotic Safe Prescribing Indicators Report remained consistently above 95% throughout the year.

For the 2026/27 financial year, directorate and divisional structures will be updated to reflect organisational changes within the Trust. The Emergency Department (ED) will not be included in the reported results. Although there has been an increase in the length of stay for patients with a decision to admit, this typically does not exceed 72 hours, making it challenging to capture meaningful review data within this setting. Instead, more focused interventions will be explored within ED, including targeted work on co-amoxiclav prescribing and the use of pre-packs.

### 4.6 Restricted antibiotics (Priority 5)

Restricted antibiotic prescriptions from Thursday to Sunday are reviewed on a Monday for formulary compliance, approval by Microbiology or otherwise appropriateness. This is to assess prescribing during periods with reduced access to in-house microbiology and pharmacy support. As clinical teams utilise on call services and have fewer opportunities for multidisciplinary review, these periods carry a higher risk of inappropriate restricted antibiotic use. Prescriptions that are not in line with formulary or as per microbiology are flagged to ward pharmacists or antimicrobial pharmacists for review.

The prescribing of restricted antibiotics this year shows that compliance remained above 97%. Most inappropriate restricted antibiotic prescriptions were for piperacillin/tazobactam that had not been discussed with Microbiology or as per formulary. This may be because while its use is restricted at WUTH, it is not at other local hospitals in the area, so prescribers transferring to WUTH may continue using as per their previous hospital.

## 4.7 *Clostridioides difficile*

Reducing rates of *Clostridioides difficile* infection continues to be a priority across the organisation and Wirral-wide. It is an important area of focus for the AMS team, given the significant impact on patient experience and associated morbidity and mortality.

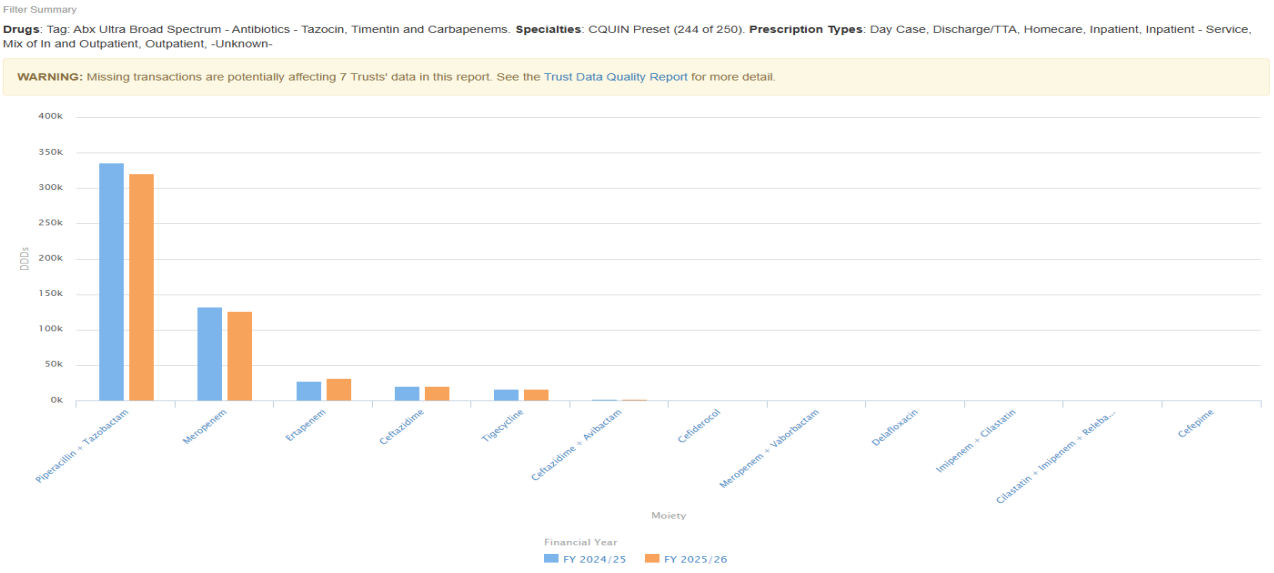
Our overarching aim continues to be the improvement of AMS practices across the Trust, which would then minimise the potential for avoidable cases of *C. difficile.* Key priorities to underpin this include reduction of broad-spectrum antibiotic use, optimisation of IV antibiotic prescribing, and maintaining compliance with *'Start Smart Then Focus'* principles. To support this, the AMS team has continued to focus on several key areas, including review of high antibiotic use clinical areas, implementation of targeted audits, ongoing review and update of antimicrobial formularies, delivery of education, and continuation of AMS ward rounds.

Actions supporting a reduction in *C. difficile* risk, while aligning with wider Trust priorities, include:

- ❒ Introduction of smaller 3-day antibiotic pre-packs in ED for prophylaxis following human and animal bites
- ❒ Ongoing review of antimicrobial formulary chapters to ensure alignment with current evidence and stewardship principles.
- ❒ Continued monitoring of ASPIRE compliance to support adherence *to 'Start Smart Then Focus'* principles.
- ❒ Ongoing review of restricted antibiotic use to ensure appropriate prescribing and minimise unnecessary exposure to high-risk agents.

The AMS team will continue to build on this work and encourages ongoing engagement across the Trust to support improvements in antimicrobial use. Reassuringly, there is a continued downward trend in the use of antibiotics associated with a higher risk of *C. difficile*, as demonstrated in the data below.

**Figure 7. Graph showing ultra broad-spectrum antibiotic use in DDDs per 1000 admissions, comparing 24/25 and 25/26. Data from DEFINE.**



## 5. Compliance with Board Assurance Framework

There are two areas where the Trust is declaring non-compliance. The first is: "Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay."

The microbiology laboratory has been without the capacity to help extract data to monitor trends or organisms and resistances. The post is to be advertised/filled in near future which should address monitoring infective organisms. While the ASPIRE audits address as best we can or as far as is reasonable the early accurate diagnosis, the outcomes and length of stays aspect is extremely challenging to deliver. Early, accurate diagnosis is somewhat subjective as a measure and then marrying this up to outcomes and length of stay which are often affected by several different factors, would be very difficult to deliver in a robust and meaningful way.

The second is: "Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- ❒ total antimicrobial prescribing
- ❒ broad-spectrum prescribing
- ❒ intravenous route prescribing
- ❒ treatment course length."

While the Trust is compliant with most of this section, measuring adherence to the recommended course length has proved challenging, both from a technological perspective and in terms of manual data collection required to generate robust evidence. The Trust has a well-established clinical pharmacy service that actively monitors antimicrobial prescribing, supporting regular review of antibiotic use with the aim of ensuring timely discontinuation or optimisation of therapy.

To address this gap, a pilot audit of antibiotic course length was undertaken on selected wards in Q1 2025/26 to provide baseline insight into prescribing practices and assess the feasibility of routine data collection. Further detail is provided in section 4.1.1 above. The audit identified suboptimal adherence to recommended treatment durations, with evidence of prolonged courses and poor documentation of stop or review dates.

Overall, these findings highlight the need for targeted antimicrobial stewardship interventions to improve documentation and ensure prescribing aligns with both local and national guidance.

## 6. Priorities for 2026/2027

In response to the NHS England call to action on antimicrobial resistance (AMR), the Trust has identified a focused set of antimicrobial stewardship priorities for 2026/27. These priorities align with the UK National Action Plan (2024–2029) targets to reduce total antibiotic use and increase the proportion of Access antibiotics, while reflecting local workforce and resource considerations.

The Trust will prioritise reducing overall antibiotic consumption, minimising the use of broad-spectrum (Watch and Reserve) agents, improving timely IV to oral switch, and increasing compliance with guideline recommended treatment durations. Collectively, these actions are expected to reduce unnecessary antimicrobial exposure, thereby lowering the risk of *Clostridioides difficile* infection, reducing selection pressure for antimicrobial resistance, and contributing to reductions in Gram-negative bloodstream

infections. In parallel, a programme of formulary and guideline review will ensure prescribing remains aligned with current evidence and national guidance, supporting consistent, safe, and effective antimicrobial use across clinical areas.

The NAP, *'Confronting Antimicrobial Resistance 2024-2029'* includes two targets related directly to antibiotic use:

- ❒ target 4a: by 2029, aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
- ❒ target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system.

The NAP also includes a target to reduce AMR infections:

- ❒ target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year (FY) baseline.

There is no specified target to achieve but this will be supported by the above targets, 4a & 4b. Based on the above, three priority areas for antimicrobial stewardship improvement for 2026/27 have been identified:

### Priority 1a- Reduce total antibiotic consumption by 5% from our 2019 baseline by 2029. Aim to reduce by 1.5% by March 2027 to support overall target (DDDs per 1000 admissions, reported quarterly).

Our 2019 baseline is 3865 DDDs per 1000 admissions (figure from DEFINE software). Our total antibiotic DDDs per 1000 admissions for 24/25 were 4083; target for this year was <4021 DDDs per 1000 admissions (1.5% reduction). Our total antibiotic DDDs per 1000 admissions for this year is 3864, which has surpassed our annual target, achieving a reduction of 7.6%. Over the next 5 years we aim to continue reducing to reach the NAP target of 5% reduction from the baseline of 3865.

Plan to deliver:

- ❒ Promote early cessation of clarithromycin prescriptions.
- ❒ Promote 5-day course lengths and look at introducing measures within the trust electronic prescribing system to deliver this.
- ❒ Continue to monitor areas that are high users of antibiotics.

### Priority 1b- Reduce unnecessary broad spectrum (Watch & Reserve) antibiotic usage by 1% compared to last financial year (reported quarterly, DDDs per 1000 admissions)

The Trust set a target for 2025/26 to reduce Watch and Reserve antibiotic use by 1% compared to 2024/25, measured as DDDs per 1,000 admissions. In 2024/25, Watch and Reserve antibiotic use was 2144 DDDs per 1,000 admissions, equating to a target of <2122 DDDs per 1,000 admissions for 2025/26. The proportion of total antibiotic use from the Access category in 2024/25 was 46%.

For 2025/26, the Trust achieved 1995 DDDs per 1,000 admissions, representing an 8% reduction year to date, significantly exceeding the 1% target. For 2026/27, the Trust will aim to achieve a further 1% reduction in Watch and Reserve antibiotic use, using the 2025/26 position as the new baseline.

The proportion of total antibiotic use from the Access category for 2025/26 is not yet available, as national data has not been published by the UK Health Security Agency. However, the observed reduction in Watch and Reserve antibiotic use is expected to correspond with an increase in Access antibiotic

prescribing. Continued focus on reducing broad spectrum antibiotic use will support progress towards the UK National Action Plan target 4b (70% Access antibiotic use by 2029).

Planned actions to deliver the 2026/27 target include:

- ❒ Target unnecessary co-amoxiclav use:
  - Promote switching from co-amoxiclav to amoxicillin in cases of pneumococcal pneumonia.
  - Re-audit co-amoxiclav use in ED following implementation of 5-day pre-packs and 3-day prophylaxis packs.
- ❒ Review the reintroduction of elastomeric devices to support outpatient IV flucloxacillin therapy (subject to funding approval)
- ❒ Promote early cessation of clarithromycin in pneumonia where atypical infection is unlikely.
- ❒ Review and improve adherence to formulary-recommended durations for common infections (e.g. pneumonia, urinary tract infections)

During 2026/27, the final stages of the Urgent and Emergency Care Upgrade Programme (UECUP) will be completed, incorporating the Urgent Treatment Centre (UTC) into a revised care model. This is expected to impact antimicrobial usage and expenditure, as UTC prescribing activity, which is not currently included in Trust figures, will be incorporated going forward. The Emergency Department and microbiology pharmacy teams are working collaboratively to mitigate this impact and implement measures to manage associated risks.

### Priority 2- Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly)

We achieved a 1.5% reduction in 25/26, and the aim is to reduce this further by another 1% as there may be further opportunity to support timely IV to oral switches.

### Priority 3 - Strengthen clinical governance and prescribing guidance.

**Local antimicrobial formulary guidelines will be reviewed and updated to ensure alignment with current evidence, NICE guidance, and national stewardship priorities.**

This will be delivered through a prioritised approach, focusing on:

- ❒ Guidelines that are due for scheduled review, based on existing review timelines.
- ❒ Clinical areas where new evidence or national guidance has emerged, requiring updates to current practice.
- ❒ Specialties or infection types associated with higher antimicrobial use or variation in prescribing, identified through audit and surveillance data.

This approach ensures that available resources are directed towards areas of greatest clinical impact, while maintaining a sustainable and realistic programme of work.

A key component of this priority will be to strengthen formulary compliance, ensuring that antimicrobial prescribing aligns with agreed first line choices, durations, and stewardship principles. This will be supported through improved accessibility of guidelines, education, and feedback to clinical teams.

To ensure a consistent, system-wide approach, work will also be undertaken to align antimicrobial practices across the wider healthcare system. This will include collaboration with community services to review and update:

- ❒ Community Trust antimicrobial formularies

- ❒ Patient Group Directions (PGDs)
- ❒ Antibiotic pre-pack arrangements across Emergency Department (ED), Urgent Treatment Centres (UTC), and Out of Hours (OOH) services

Aligning these elements will support standardisation of prescribing across care settings, reduce variation, and ensure that antimicrobial stewardship principles are applied consistently throughout the patient pathway.

Collectively, these actions will strengthen governance and oversight of antimicrobial use, improve compliance with best practice, and contribute to achieving both local and national antimicrobial stewardship objectives.

## Priority 4. Implement a Penicillin Allergy Delabelling Programme

Develop and implement a system wide penicillin allergy delabelling programme to improve antimicrobial stewardship, optimise antibiotic selection, and reduce the use of broad spectrum agents in patients with inaccurate penicillin allergy labels.

**Key Enablers:**

- Securing funding through local and/or national antimicrobial stewardship incentives.
- Recruitment of a dedicated interface antimicrobial stewardship pharmacist to coordinate and deliver the programme across organisational boundaries.
- Development of governance arrangements, referral pathways, patient information resources, and outcome measures.
- Collaboration between acute, community, and primary care services to ensure consistency of approach.

**Potential barriers**

Implementation of the penicillin allergy delabelling programme is dependent on securing adequate workforce funding. Recruitment to the interface pharmacist post has been challenging due to financial constraints and limited availability of funding across the health economy. Without this resource delivery of the programme across primary and secondary care may be delayed.

## Priority 5. Improve Compliance with Antimicrobial Formulary Treatment Durations

Improve adherence to local antimicrobial formulary duration recommendations by optimising prescribing within the electronic prescribing system.

### Key Actions:

- Develop and implement prescription plans within the electronic prescribing system for commonly prescribed antimicrobials (co-amoxiclav, doxycycline, flucloxacillin)
- Configure default treatment durations in line with local formulary guidance.
- Introduce shorter default durations for intravenous antimicrobial prescriptions to encourage timely review and promote oral use

## 7. Good practice to build on

- ❒ Reduced total antibiotic consumption that supports overall NAP target.
- ❒ Reduced overall broad-spectrum antibiotic use to align with NAP target to increase use of 'Access' category antibiotics.
- ❒ Surpassed reduction target of usage of IV antibiotics
- ❒ Maintaining good ASPIRE audit results.
- ❒ Benchmarking well both locally and nationally
- ❒ Widespread proactive AMS ward rounds across the Trust
- ❒ Good compliance with quinolone audit standards

## 8. Risks and Issues

- ❒ Broad engagement with prescribers of key principles of AMS may be a challenge due to competing priorities at ward level, however, the AMS team approach individuals for input with specific projects as and when required.
- ❒ The pilot antibiotic duration audit demonstrated suboptimal compliance with formulary approved treatment durations for key infections, including pneumonia and urinary tract infections. It also highlighted a high prevalence of broad-spectrum antibiotic prescribing in these cases.
- ❒ Optimising Cerner AMS tools would, for example, give us the opportunity to improve our antibiotic reviews and increase IV to oral switches which would lead to reduced antibiotic use, reduced inpatient stays, reduced nursing time required (for IVs), and improved reporting capability.
- ❒ Additional laboratory IT upgrades/resource are needed to be able to review local resistance rates, as suggested by NICE guideline 15. Risk register entry DRR/0177.

## 9. Recommendations

The AMS team asks for the contents of this report, and the actions being taken to drive improvements in antibiotic prescribing to be noted. In particular, we request support for the following key pieces of work:

- ❒ Ensuring resources to support AMS and the UK NAP are sufficient to deliver the work programme set out in this report.
- ❒ Developing the AMS mPage which requires fixes or an alternative AMS solution. Options are being explored; however, funding may be required to support any further work required. We appreciate the competing priorities that the Health Informatics team have, but a solution within Cerner would support improvement in the quality of clinical review of antibiotics; reduction of broad-spectrum antibiotics and IV to oral switches (IVOS).

## 10. References


- ❒ National Action Plan for Antimicrobial Resistance 2024-2029. Available at: Confronting antimicrobial resistance 2024 to 2029 (publishing.service.gov.uk)
- ❒ Start Smart Then Focus. Available at: Antimicrobial stewardship: start smart then focus - GOV.UK

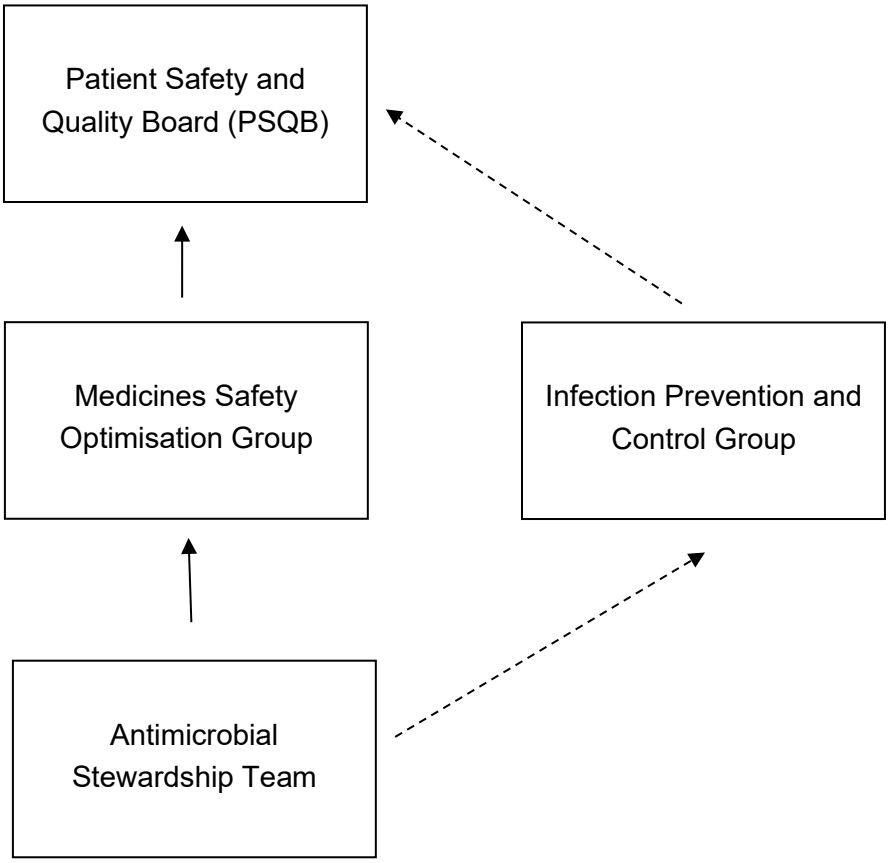
# APPENDIX 1. AMS GOVERNANCE FRAMEWORK

The governance framework for AMS at WUTH is based on the recommendations in NICE guideline NG15: *Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use* (2015)

## AMS Team

The Antimicrobial Stewardship Team develops and supports the implementation of policies, procedures, and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners, and junior doctors. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care, and Respiratory Consultant. Wider attendance remains a challenge; however, the team engages directly with specific teams when required for certain pieces of work.

**Chart 1: Antimicrobial Stewardship Team within Trust Organisational Governance Structure.**




The AMS Team has the following strategies to improve AMS at WUTH:

- ❒ Prescriber education training program
- ❒ Maintaining an evidence-based antimicrobial formulary

- ❒ Audit program to monitor antimicrobial prescribing and identify areas for improvement
- ❒ Ward-based AMS Team
- ❒ The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers.
- ❒ Areas which are high-users of broad-spectrum antibiotics and areas with patients with complex infections requiring long-courses of treatment have been identified by point prevalence audits and prioritised for visitation by the ward focused AMS Team (see appendix A)
- ❒ Service improvements to improve antimicrobial prescribing (new treatments and diagnostic tests, developments to the e-prescribing system, etc).

## AMS Team ward rounds

The ward-focused AMS team consists of a CMM and/or Clinical Scientist in Microbiology and a specialist antimicrobial pharmacist to undertake ward rounds with the aim of providing patient specific interventions but also provision of case-based teaching to prescribers. Areas which are high-users of broad-spectrum antibiotics or high incidence of *C. difficile* infections have been identified by point prevalence audits and prioritised for visitation in addition to areas with critical or complex infections requiring long-courses of treatment:

- ❒ Critical care (five times weekly)
- ❒ Acute Care (five times weekly) – AMU, MSSW, UMAC
- ❒ Acute Frailty Unit (weekly)
- ❒ Gastroenterology ward (weekly) – W33
- ❒ Elderly Care wards (weekly) W21, 22, 23 and 27
- ❒ Respiratory Unit (weekly) – W37 and 38
- ❒ Orthogeriatric wards/T&O – W10,11,12, and WAFFU (weekly)
- ❒ SEU (weekly)
- ❒ Colorectal unit (weekly)
- ❒ General medicine W19 (weekly) & ward 24 (weekly)

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues.

Microbiology +/- AMS Pharmacist also attend the following weekly MDTs:

- ❒ Renal
- ❒ Haematology
- ❒ Endocarditis
- ❒ OPAT MDT and “virtual” ward round
- ❒ *C, difficile* infection MDT
- ❒ Prosthetic Joint MDT

**WUTH Board of Directors** **Item 27**

**04 November 2026**

| | |
|---|---|
| **Title** | WCHC Accountable Officer Controlled Drugs Annual Report 2025/26 |
| **Area Lead** | Dr Ranjeev Mehra, Trust Medical Director |
| **Author** | Dr Ranjeev Mehra, Trust Medical Director<br>Lisa Knight, Lead Pharmacist, WCHC |

| **Purpose of the Report and Recommendation** | |
|---|---|
| **Report For** | Assurance |
| It is recommended that the Board:<br>• Is assured that controlled drugs are handled safely across the organisation. | |

## Key Points to Note

This report from the Trust's Controlled Drugs Accountable Officer (CDAO) covers the period 1 April 2025 to 31 March 2026 and provides assurance that the Trust is compliant with updated controlled drug legislation and that controlled drug systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs safety and governance.

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

The report outlines:

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

## Key Risks

- There are currently no risks active on the register relating to the management of controlled drugs within WCHC services

| **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** |
| n/a | | | |

| **1** | **Narrative** |
|---|---|
| **1.1** | **Report**<br>Accountability for the safe management of controlled drugs sits with the Trust Board via the Controlled Drugs Accountable Officer (CDAO). This report from the Trust's CDAO provides assurance that the Trust is compliant with updated controlled drugs legislation and that controlled drugs systems, procedures and incidents are regularly reviewed and actions are taken as necessary to strengthen controlled drugs safety and governance. |

| **2** | **Implications** |
|---|---|
| **2.1** | **Patients**<br>• Controlled drugs is of benefit to all including those with protected characteristics. |
| **2.2** | **People**<br>• There are no associated people implications to this report. |
| **2.3** | **Finance**<br>• There are no associated financial implications to this report. |
| **2.4** | **Compliance**<br>• This report will not affect compliance with legislation, however following the listed policy and procedures will promote compliance with legislation surrounding controlled drugs. |

Wirral Community Health and Care NHS Foundation Trust

**Controlled Drug Accountable Officer's Annual Report**

**1 April 2025- 31 March 2026**

## Introduction

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

## Responsibilities

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

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

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

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

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

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

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

   All the guidance documents are in date.

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

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

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

**Adequate destruction and disposal arrangements are in place for CDs**

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

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

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

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

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

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

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

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

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

9. Opioid medication administered within community nursing is prescribed by the patients' GP. Community nurses are responsible for reporting inappropriate dosing and titrating doses to individual patient needs. During 2025-2026, a member of the Specialist Palliative Care Team performed a retrospective review of 40 patient records who received end of life care via community nursing from December 2024 to November 2025 (5 patients from each of the community nursing teams). Records were scrutinised to identify if initial doses were appropriate and if escalating doses were within the recommended maximum of up to the equivalent of 30% of the previous daily dose. The audit findings showed that no excessive high doses were prescribed. Dose escalation was in line with the recommended maximum). 83% (33/40) syringe pumps starting prescriptions were in line with best practice. Of the 7 initial prescriptions for syringe pumps that were not in line with best practice, two were identified by the community nursing teams and amended by the prescribers following advice from specialist palliative care. Other prescriptions not initially in line with best practice did not take into account previous oral or subcutaneous stat doses of opioids and therefore the patients were initially underdosed. There was also one incident where the opioid of choice was not initially selected for a patient with severe renal impairment. Learning was included in the July 2026 Medicines Management Bulletin.

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

11. Controlled drug prescribing continued to be audited by reviewing ePACT prescribing data. Controlled drug prescribing data for the Trust was presented each quarter at the Medicines Governance Group. Most controlled drug prescribing occurred within GP Out of Hours and the Urgent Treatment Centre. Trust procedure dictate that quantities should be sufficient only to allow the patient time to obtain further supplies from their own GP. ePACT data was therefore reviewed to identify any prescribing of larger than expected quantities which were then challenged and fed back to the prescriber via line management. Analysis of the data evidenced that most prescriptions issued were less than 7 days supply and therefore in line with recommendations.

12. ePACT data was also reviewed to identify any prescribing that was out of scope for the service or individual prescriber. Prescriptions for methadone were found to be attributed to Trust prescribers during the reporting period. As a specialist service is commissioned to supply medication to treat addiction, the prescriptions for methadone were recalled from the Business

Services Authority. The methadone prescriptions were found to be attributed to the Trust in error.

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

14. In February 2026, the Medicines Management Team completed the annual CD LIN Assurance framework self-assessment. The framework allowed organisations to reflect on their arrangements for CDs. Following the self-assessment, there were no actions for the Trust due to work completed in previous years.

**Relevant individuals receive appropriate training surrounding the use and handling of CDs**

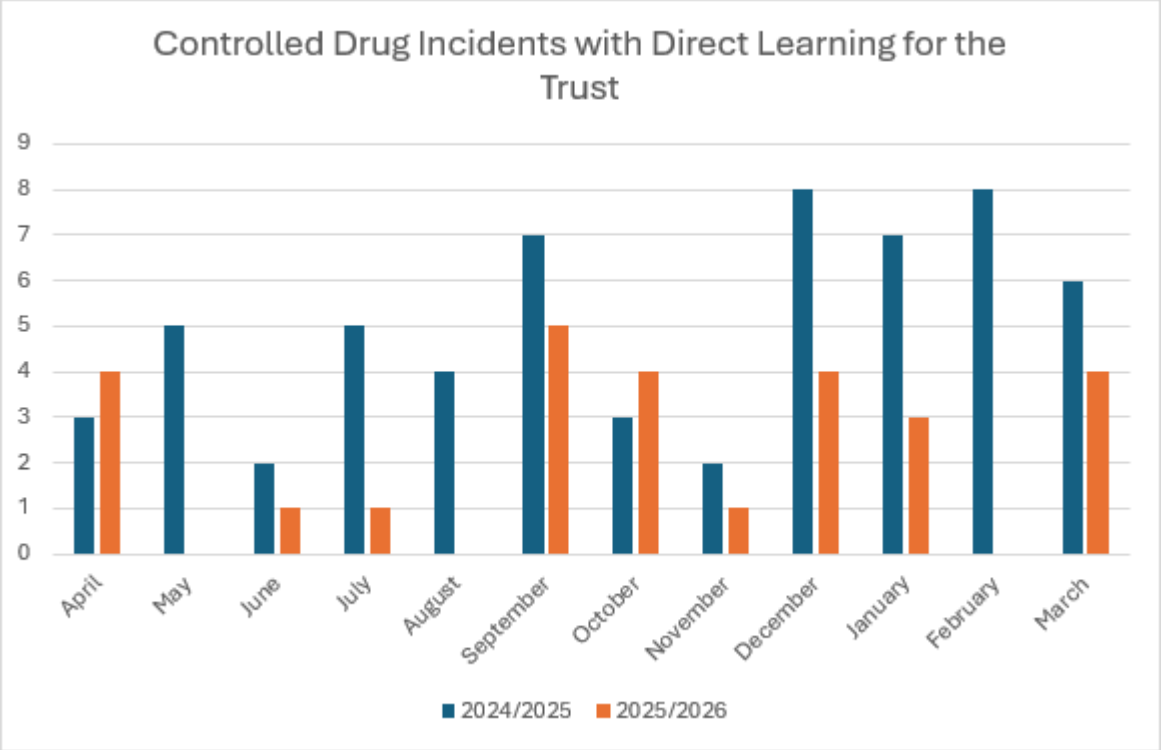
15. Community Nurses when joining the Trust attended end of life training, regular updates on palliative care were also available to staff. Nursing staff were trained to convert oral doses of opioids to equivalent subcutaneous doses and were therefore able to challenge inappropriate dosing. In addition, the handling of controlled drugs is now incorporated into mandatory refresher Medicines Management training for community nurses. Where gaps in knowledge are identified via incidents or via audit, staff are supported by additional learning opportunities via the Medicines Management Bulletin and advice from the Specialist Palliative Care Team.

16. The Trust's CDAO and/or a pharmacist from the Trust's Medicines Management Team attended Mersey Regional Local Intelligence Network (LIN) meetings. These meeting are a forum for different health care providers to meet and discuss controlled drug incidents with a view to implement lessons learnt throughout the region. The Trust was therefore kept up to date with current best practice surrounding the handling of CDs.

**A system is in place to assess and investigate incidents regarding the use and handling of CDs and appropriate action is taken**

17. All medication incidents including controlled drug incidents were monitored via the monthly Medicines Governance Meeting, any outstanding actions following investigations were also monitored via this group.

    The graph below indicates the number of controlled drug incidents reported as having direct learning for Trust services during 2025-2026. Incidents reported 2024-2025 are included for comparison.




18. There were 27 controlled drug incidents reported during 2025 /2026 (compared with 60 reported 2024 /2025). All the reported CD incidents were low or no harm. This is a reduction of over 50% in comparison to the previous year. This reduced reporting is a concern, however incident reporting rates for 2026 2027 have recovered, with 13 controlled drug incidents reported for quarter 1 2026 2027.

19. 30% (8/27) of the reported involved documentation errors with no actual loss of controlled drugs. When a patient is under the care of community nursing for end-of-life care, all the controlled drugs and other medication used in the syringe pumps are stored in Envopaks sealed with a numbered tag. The packs are therefore tamper-evident. A running balance is kept of each medication Additionally, within Urgent Primary Care, controlled drugs are monitored in line with legislation, but medicines that are of potential abuse, that are not legally required to be recorded in a register (for example codeine tablets) are carefully recorded with a running total maintained. Incidents of potential loss are recorded via Datix. These incidents evidence that community nurses and Urgent Primary Care are following agreed processes and investigating stock discrepancies.

20. Of the remaining reported controlled drug incidents, there were 3 incidents where the wrong opiate was originally recommended or prescribed, in all cases the patient was swapped over to the recommended opiate and learning was fed back to the prescriber for learning. Two of these incidents involved not picking the optimum opiate for patients with renal impairment.

**CD incidents are reported to the regional CDAO via the local intelligence network (LIN) to which the Trust is an active member**

21. The criteria for reporting incidents to CD LIN changed in December 2022. Incidents and concerns were only be reported if the following criteria was met:
    - Real or perceived staff diversion of CDs
    - Real or perceived staff substance misuse of CDs
    - Patients with drug seeking behaviours that might require an NHSE alert to be issued to health and care settings.
    - Severe harm issues

    There was one incident reported to CD LIN during the reporting period:

22. In March 2026 controlled drugs were given to patient in the out of hours period, prescribed by doctor, but signed out of the register and witnessed by staff who were not healthcare professionals. This incident was identified during a routine controlled drug audit. The incident occurred whilst the clinician was visiting patients off site. The controlled drugs were issued to the patient's representative to avoid a delay in treatment. Although the staff acted in the patient's best interest, the supply was not in line with legislation or Trust policy. A repeat of this incident type will no longer be possible as the keys to the controlled drug cabinet are now kept in the Omnicell cabinet and only registered healthcare professionals will have access to this cabinet.

**National Recommendations from CQC**

23. CQC's Controlled drugs annual update report for 2025, "The safer management of controlled drugs 2025" published July 2026 gives an outline of themes regarding controlled drugs that were identified by CQC inspectors during the calendar year of 2025. The report was scrutinised for relevance to Trust services.

    The following areas were considered relevant to the Trust

    - Diversion of controlled drugs in the lower schedules
    - Access to controlled drugs for end-of-life symptom management

24. Potential diversion of controlled drugs from lower schedules was considered at a previous Mersey Region LIN meeting. Following this meeting a system was put in place to monitor stocks of drugs of potential abuse stocked within urgent primary care services. The risk of diversion is therefore reduced.

25. Lack of access to the right medicines at night can lead to avoidable hospital admissions. Although the Trust is unable to influence the number of community pharmacies who are open in the out of hours period, the risk of end-of-life medicines not being available is reduced by the Trust stocking over-labelled pre-packs of commonly used palliative care medicines which are available to be prescribed and issued to patients.

## Conclusion

26. This report provides an overview of how the Trust has engaged fully with the local healthcare community and the Mersey Regional Local Intelligence Network and carefully considered national learning from CQC inspections, ensuring the governance arrangements surrounding the handling of controlled drugs comply with best practice.

Ranjeev Mehra – Trust Medical Director & Trust CDAO

Lisa Knight - Lead Pharmacist

August 2026

References

Controlled drugs annual update report for 2024 published - Care Quality Commission

The Gosport Independent Panel

**Appendix 1**

**STANDARD OPERATING PROCEDURES (SOPS) AND POLICIES OUTLINING HANDLING OF CONTROLLED DRUGS**

The following procedures and policies are available to all staff via the Staff Zone of the Wirral Community NHS Foundation Trust's website

**General Policies:**

- GP11 Policy for the Safe Handling and Administration of Medicines is applicable to all trust services who are involved in the handling of medicines. The policy includes sections on the following:

    - Administration of Controlled Drugs
    - Disposal of Controlled Drugs
    - Ordering Controlled Drugs from Wirral University Teaching Hospital
    - Receipt of Controlled Drugs
    - Storage of Controlled Drugs
    - Controlled Drugs stock reconciliation
    - Procedure for missing Controlled Drugs

**Community Nursing Procedures:**

- MMSOP04 Standard Operating Procedure for McKinley Syringe Driver for Administration of Palliative Care Medicines

- MMSOP09 Standard Operating Procedure for Transport of Prescribed Controlled Drugs

- MMSOP17 Standard Operating Procedure for Destruction of Patients' Own Controlled Drugs in the Community

- MMSOP18 Standard Operating Procedure for Administration of Opioid Medicines

**GP Out of Hours**

- MMSOP34 Standard Operating Procedure for the Management of Controlled Drugs within Primary Care Division

- SOP10 GP Out of Hours Prescribing Policy (This procedure outlines appropriate prescribing of controlled drugs within GP Out of Hours)

**Specialist Palliative Care Team**

- MMCP07 Clinical Protocol for Providing Specialist Palliative Care Medicines Advice from the Integrated Specialist Palliative Care Team

- MMCP13 Clinical Protocol for Non-Medical Prescribing within Palliative Care

**Community Dental Services**

- MMSOP21 Standard Operating Procedure for the Administration of Intravenous Midazolam for Conscious Sedation.

- MMSOP41 Procedure for the Administration of Oral, Buccal or Intranasal Midazolam for Premedication prior to Dental Conscious Sedation

- MMSOP37 Standard Operating Procedure for the safe and secure management of Midazolam within Community Dental Services

**Community Integrated Care Centre (CICC)**

- MMSOP56 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Care Centre. This procedure includes a section on the management of controlled drugs within the centre. All controlled drugs are prescribed for individual patients, there are no stock controlled drugs held on the unit.

**Community Intermediate Response Team (CIRT)**

- MMSOP59 Standard Operating Procedure for safe handling and administration of medicines within Community Intermediate Response Team (CIRT). This procedure includes a section on CDs highlighting the fact that CDs must never be removed from patient's homes.

**Trust Wide**

- MMSOP28 Standard Operating Procedure for witnessing the destruction of Controlled Drugs within Community Trust Services

- MMSOP120 Remote Prescribing Policy

**WUTH Board of Directors in Public** **Item No 28**
**4 November 2026**

| | |
|---|---|
| **Title** | Equality, Diversity and Inclusion (EDI) Bi-Annual Report including: Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) |
| **Area Lead** | Carla Burns, Associate Chief People Officer |
| **Author** | Sharon Landrum, Head of Culture and Workforce Experience |
| **Report for** | Information |

## Executive Summary and Report Recommendations

This report provides assurance that Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is meeting its statutory, regulatory and contractual equality, diversity and inclusion (EDI) reporting requirements, including those arising from the Equality Act 2010, the Public Sector Equality Duty (PSED), the NHS Standard Contract, NHS England EDI Improvement Plan requirements and associated workforce equality standards.

The report also sets out progress against the Trust's People Strategy and underpinning EDI Strategic Commitment 2022–2026:

**"To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated".**

The report confirms that the Trust is currently compliant with completed and ongoing EDI reporting requirements. WRES and WDES data returns have been submitted nationally, and the full narrative reports are included for approval ahead of the required national upload by 31 October 2026.

Key findings include:

- Workforce demographic declaration rates continue to improve, supporting more accurate monitoring and assurance against PSED requirements.
- Representation of Black, Asian and other ethnic group staff, disabled staff and LGB staff has increased, although continued work is required to address remaining gaps and improve staff experience.
- WRES findings show improvement in global majority representation, appointment from shortlisting and relative likelihood of entering formal disciplinary processes; however, staff survey results indicate continued concerns relating to harassment, bullying, abuse, discrimination and perceived equality of career progression.
- WDES findings show improvement in disabled staff representation, reported experience of bullying and harassment from some sources, reasonable adjustments and Board representation; however, areas requiring further focus include engagement, feeling valued, presenteeism, capability processes and recruitment outcomes.
- The EDI dashboard identifies priority areas for 2026/27, including improving experiences for LGB+ and disabled staff, supporting internationally recruited staff and strengthening the Trust's anti-racism approach.

During 2026/27, the Trust will continue to focus on improving the experience of disabled staff, strengthening combined WUTH and WCHC staff networks, supporting LGB+ staff, progressing anti-racism activity, supporting internationally recruited colleagues and achieving Veteran Aware reaccreditation.

It is recommended that the Board:

- Note the assurance provided within the report in relation to statutory, regulatory and contractual EDI reporting requirements.
- Note the report for publication, including the WRES and WDES narrative reports.
- Note adoption of the antisemitism and anti-Muslim hostility definitions set out in section 7.7.
- Note adoption of the NHS Race and Health Observatory seven anti-racism principles set out in section 7.7 and Appendix 6.
- Acknowledge the forthcoming EDI calendar of events and consider ways to support and observe these locally.

| **Key Risks** |
|---|
| This report relates to these key risks:<br>• 397 – Increased Sickness Absence<br>• BAF Risk – Failure of the Trust to have the right organisational culture, staff experience and organisational conditions to deliver our priorities for our patients and service users |

| **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 | No |

| **Governance journey** | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 22/07/26 | EDI Steering Group | EDI Biannual Report | Review |
| 30/07/26 | Workforce Steering Board | EDI Biannual Report | Approval |
| September 2026 | Joint People Committee | EDI Biannual Report | Approval |

| **1** | **Background and Introduction to EDI Requirements** |
|---|---|
| **1.1** | Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations:<br>• To eliminate unlawful harassment and victimisation. |

- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED.

The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate.

This report is one of two EDI specific bi-annual report. We report as follows:

**Biannual report one** – Submission in Q1 and will include updates on:

- Trust led EDI projects and progress towards EDI strategic commitment and activities to underpin our PSED commitment.
- Annual WRES data and summary for noting.
- Annual WDES data and summary for noting.
- Workforce demographics

**Biannual report two** – Submission in Q3 and will include updates on:

- Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment.
- Gender Pay Gap reporting.
- Equality Delivery System (EDS).

Reports seek to provide updates on regulatory and statutory requirements and work undertaken to advance the EDI agenda.

## 2 Statutory / Regulatory Reporting Requirements Update

To follow are legislative and contractual workforce EDI reporting requirements:

| Reporting Element | Required by | Progress Update | Comments |
|---|---|---|---|
| Workforce Race Equality Standards (WRES) – Part 1 | National data upload required by 31 May | Completed | |
| Workforce Race Equality Standards (WRES) – Part 2 | Narrative report required by 31 October | On track | Reports contained within this paper, for approval |
| Workforce Disability Equality Standards (WDES) – Part 1 | National data upload required by 31 May | Completed | |
| Workforce Disability Equality Standards (WDES) – Part 2 | Narrative report required by 31 October | On track | |
| Public Sector Equality Duty (PSED) | Included within biannual reports | Completed and ongoing | Activities detailed within both EDI biannual reports highlight the work WUTH is doing to uphold the principles of the Public Sector Equality Duty. This includes publication of Trust workforce demographics. |
| Gender Pay Gap Reporting (GPG) | 30 March 2026 (for March 2025 data) | Completed for 2025 | Currently compliant with 2025/26 reporting. |

| | | | |
|---|---|---|---|
| | and<br>30 March 2027 (for March 2026 data) | On track for 2026 | 2026/27 data will be included within biannual report 2, scheduled for Q3 2026/27. |
| Equality Delivery System (EDS) | 28 Feb each year | Completed for 2025<br>On track for 2026 | Currently compliant with reporting, next report scheduled for inclusion within biannual report 2 |
| NHS EDI Improvement Plan | Q2 and Q4 | Completed for Q4 and ongoing | Included within EDI dashboard of this report. |
| Updates to be provided on equality analysis process and progress of equality objectives | Annually | Completed and ongoing | Feedback integrated within last EDI report and further review to be undertaken and included within biannual report 2. |

All regulatory and statutory reporting requirements are therefore complete or online to meet the requirements listed above.

## 3 Workforce Demographics

In line with specific duties under the Equality Act 2010, the Trust is required to publish information relating to employees who share protected characteristics.

3.1 **Sex / Gender**

77.6% of the WUTH workforce is female and 22.4% is male. The number of male staff has increased from 21.8% in 2025/6. The numbers continue to reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts.

The chart below highlights the breakdown of staff compared with community and demographics.

| | Workforce | LA: Wirral | Region: North West |
|---|---|---|---|
| **Male** | 22.4% | 48.11% | 49.13% |
| **Female** | 77.6% | 51.89% | 50.87% |

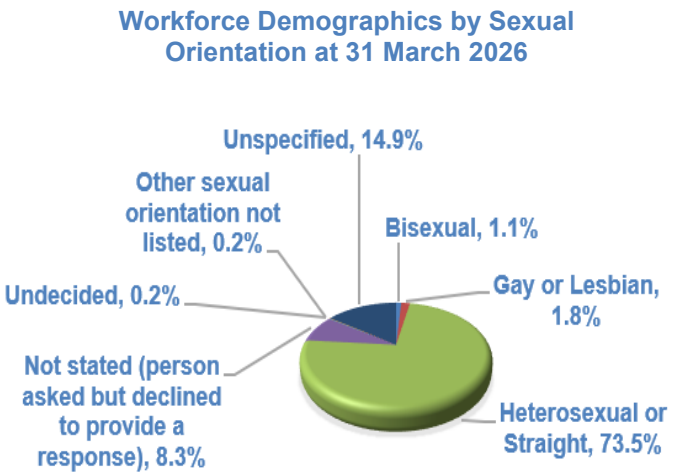
3.2 **Sexual Orientation**

Charts below highlight the workforce sexual orientation data on 31 March 2026, along with comparative data for community members within the North West. Data this year sees a further slight increase in the % of LGB staff at WUTH. Increases have been seen year on year, however whilst still increasing, is only by 0.1% this year. This is still however positive due to the small numbers employed. The number of LGB staff is also higher than those declared within the Northwest region.

It is also pleasing to see a continued reduction in 'unknown' data, reducing by 2% this year.

| Sexual Orientation | % of Workforce |
|---|---|
| **Bisexual** | 1.1% |
| **Gay or Lesbian** | 1.8% |
| **Heterosexual or straight** | 73.5% |
| **Not stated (person asked but declined to provide a response)** | 8.3% |

| | |
|---|---|
| **Other sexual orientation not listed** | 0.2% |
| **Undecided** | 0.2% |
| **Unspecified** | 14.9% |
| **Grand Total** | **100.00%** |




3.3

| Sexual Orientation Data Comparison with Community Demographics | | |
|---|---|---|
| | **Workforce** | **Region: North West** |
| **Gay / Lesbian / Bisexual** | 2.9% | 1.66% |
| **Heterosexual / straight** | 73.5% | 94.89% |
| **Unknown** | 23.4% | 3.45% |

**Gender Reassignment / Identity**

ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed.

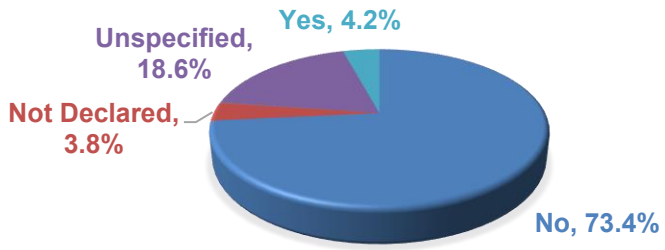
3.4 A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area.

The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

The Trust is however aware of and has supported staff in their transition journey this year and continues to support staff who's gender isn't the same as assigned at birth. 3 staff completed the 2025 staff survey, identifying that their gender was different to the one assigned at birth.

**Disability**

As of 31st March 2026, the self-reporting rate for those staff with a disability within WUTH is 4.2%, 294 people (as entered on staff ESR records). This has continued to improve on a marginal basis each year, rising from 3.8% (263 people) last year. Whilst it is positive to see continued improvements in declaration rates, rates continue to still be low, with 18.6% of staff ESR records still remining unspecified. This element is however continuing to reduce gradually year on year from 20.5% last year. Work will therefore continue to support improvements in declaration rates.




**Workforce Disability Status as at 31 March 2026**

Breakdown of Non-Clinical and Clinical Staff by Pay Band:

Clinical Staff

| | # Disabled | % Disabled | # Non-disabled | % Non-disabled | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 2 | 14 | 4.35% | 278 | 86.34% | 30 | 9.32% | 322 |
| Bands 3 | 25 | 3.18% | 584 | 74.39% | 176 | 22.42% | 785 |
| Bands 4 | 11 | 6.40% | 113 | 65.70% | 48 | 27.91% | 172 |
| Bands 5 | 54 | 4.37% | 964 | 77.93% | 219 | 17.70% | 1237 |
| Bands 6 | 32 | 3.67% | 630 | 72.33% | 209 | 24.00% | 871 |
| Bands 7 | 12 | 2.45% | 341 | 69.73% | 136 | 27.81% | 489 |
| Bands 8a | 5 | 2.39% | 145 | 69.38% | 59 | 28.23% | 209 |
| Bands 8b | 2 | 3.57% | 38 | 67.86% | 16 | 28.57% | 56 |
| Bands 8c | 0 | 0.00% | 13 | 76.47% | 4 | 23.53% | 17 |
| Bands 8d | 0 | 0.00% | 4 | 100.00% | 0 | 0.00% | 4 |
| Bands 9 | 0 | 0.00% | 2 | 100.00% | 0 | 0.00% | 2 |
| VSM | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Other. Please specify in notes. | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 50 | 3.9% | 975 | 76.2% | 254 | 19.9% | 1279 |
| Cluster 2: AfC bands 5 to 7 | 98 | 3.8% | 1935 | 74.5% | 564 | 21.7% | 2597 |
| Cluster 3: AfC bands 8a and 8b | 7 | 2.6% | 183 | 69.1% | 75 | 28.3% | 265 |
| Cluster 4: AfC bands 8c to VSM | 0 | 0.0% | 19 | 82.6% | 4 | 17.4% | 23 |
| Total Clinical | 155 | 3.7% | 3112 | 74.7% | 897 | 21.5% | 4164 |
| Medical & Dental Staff, Consultants | 4 | 1.21% | 252 | 76.13% | 75 | 22.66% | 331 |
| Medical & Dental Staff, Non-Consultants career grade | 2 | 3.23% | 45 | 72.58% | 15 | 24.19% | 62 |
| Medical & Dental Staff, Medical and dental trainee grades | 15 | 6.20% | 214 | 88.43% | 13 | 5.37% | 242 |
| Total Medical and Dental | 21 | 3.31% | 511 | 80.47% | 103 | 16.22% | 635 |
| Number of staff in workforce | 294 | 4.20% | 5134 | 73.41% | 1566 | 22.39% | 6994 |

Non-Clinical Staff

| | # Disabled | % Disabled | # Non-disabled | % Non-disabled | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Bands 1 | 1 | 1.3% | 26 | 32.5% | 53 | 66.3% | 80 |
| Bands 2 | 51 | 5.2% | 687 | 70.2% | 241 | 24.6% | 979 |
| Bands 3 | 20 | 5.4% | 248 | 67.4% | 100 | 27.2% | 368 |
| Bands 4 | 14 | 4.7% | 197 | 66.8% | 84 | 28.5% | 295 |
| Bands 5 | 7 | 4.9% | 108 | 75.0% | 29 | 20.1% | 144 |
| Bands 6 | 8 | 8.2% | 69 | 70.4% | 21 | 21.4% | 98 |
| Bands 7 | 7 | 7.9% | 62 | 69.7% | 20 | 22.5% | 89 |
| Bands 8a | 6 | 11.3% | 39 | 73.6% | 8 | 15.1% | 53 |
| Bands 8b | 1 | 2.3% | 38 | 88.4% | 4 | 9.3% | 43 |
| Bands 8c | 1 | 5.3% | 16 | 84.2% | 2 | 10.5% | 19 |
| Bands 8d | 0 | 0.0% | 12 | 85.7% | 2 | 14.3% | 14 |
| Bands 9 | 1 | 33.3% | 2 | 66.7% | 0 | 0.0% | 3 |
| VSM | 1 | 10.0% | 7 | 70.0% | 2 | 20.0% | 10 |
| Other. Please specify in notes. | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 86 | 5.0% | 1158 | 67.2% | 478 | 27.8% | 1722 |
| Cluster 2: AfC bands 5 to 7 | 22 | 6.6% | 239 | 72.2% | 70 | 21.1% | 331 |
| Cluster 3: AfC bands 8a and 8b | 7 | 7.3% | 77 | 80.2% | 12 | 12.5% | 96 |
| Cluster 4: AfC bands 8c to VSM | 3 | 6.5% | 37 | 80.4% | 6 | 13.0% | 46 |
| Total Non-Clinical | 118 | 5.4% | 1511 | 68.8% | 566 | 25.8% | 2195 |

**Religion or Belief**

The chart below highlights the religious beliefs of our workforce compared with the community demographics as of 31 March 2026. The categories are grouped together so as to aid ease of comparison; however it is important to recognise some of the heading below subgroup heading eg Christianity include Catholicism, Anglican etc

3.5

| | *Workforce* | *LA: Wirral* | *Region: North West* |
|---|---|---|---|
| *Atheism / Not religious* | 13.7% | 21.33% | 19.82% |
| *Buddhism* | 0.6% | 0.28% | 0.29% |
| *Christianity* | 45.4% | 70.41% | 67.25% |
| *Hinduism* | 1.7% | 0.23% | 0.54% |
| *Islam* | 1.9% | 0.57% | 5.05% |
| *Judaism* | 0.0% | 0.08% | 0.43% |
| *Other* | 8.0% | 0.26% | 0.27% |
| *Sikhism* | 0.1% | 0.07% | 0.13% |
| *Jainism* | 0.0% | Unknown | unknown |
| *Unknown* | 28.4%* | 6.77% | 6.20% |

**Includes 13.6% of staff who do not wish to disclose*

There are differences in this area when compared to the local community, with more Hindu and Muslim staff and staff who have other religions or beliefs. More staff are also declaring their status within ESR this year (from 30.1% last year).

3.6

**Ethnicity**

83.0% of WUTH staff are white, 15.2% of staff are Black, Asian, or other Ethnic Group and 1.8% of staff have not stated their ethnic group on ESR. The following chart shows the breakdown of the workforce by ethnicity and annual comparative data from 2024.

| Ethnicity Group | Headcount | % in Trust 2026 | % in Trust 2025 | % in Trust 2024 |
|---|---|---|---|---|
| **BAME** | 1066 | **15.2%** | 14.7% | 13.7% |
| **Not Stated** | 123 | **1.8%** | 1.7% | 1.8% |
| **White** | 5801 | **83.0%** | 83.6% | 84.6% |
| **Grand Total** | **6990** | **100.0%** | 100.0% | 100.0% |

It is pleasing to see a year-on-year increase in the representation of Black, Asian and other Ethnic (BAME) staff at WUTH, with a 0.6% increase seen this year. That said, there continues to be a significant disparity between the levels of BAME staff within clinical and non-clinical roles, however increases can be seen in both areas.

Representation however continues to be significantly different across clinical (20.4%, (Medical and dental and non-clinical)) and non-clinical roles (3.9%). Increases can however be seen in both areas with a 0.5% increase in clinical staff and 0.6% increase in non-clinical.

Breakdown of Non-Clinical and Clinical Staff by Pay Band:

Non-clinical staff

| | # BME | % BME | # White | % White | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Bands 1 | 0 | 0.0% | 79 | 98.8% | 1 | 1.3% | 80 |
| Bands 2 | 48 | 4.9% | 922 | 94.2% | 9 | 0.9% | 979 |
| Bands 3 | 13 | 3.5% | 354 | 96.2% | 1 | 0.3% | 368 |
| Bands 4 | 7 | 2.4% | 286 | 96.9% | 2 | 0.7% | 295 |
| Bands 5 | 4 | 2.8% | 138 | 95.8% | 2 | 1.4% | 144 |
| Bands 6 | 5 | 5.1% | 88 | 89.8% | 5 | 5.1% | 98 |
| Bands 7 | 6 | 6.7% | 83 | 93.3% | 0 | 0.0% | 89 |
| Bands 8a | 1 | 1.9% | 52 | 98.1% | 0 | 0.0% | 53 |
| Bands 8b | 2 | 4.7% | 41 | 95.3% | 0 | 0.0% | 43 |
| Bands 8c | 0 | 0.0% | 19 | 100.0% | 0 | 0.0% | 19 |
| Bands 8d | 0 | 0.0% | 14 | 100.0% | 0 | 0.0% | 14 |
| Bands 9 | 0 | 0.0% | 3 | 100.0% | 0 | 0.0% | 3 |
| VSM | 0 | 0.0% | 10 | 100.0% | 0 | 0.0% | 10 |
| Cluster 1: AfC Bands <1 to 4 | 68 | 3.9% | 1641 | 95.3% | 13 | 0.8% | 1722 |
| Cluster 2: AfC bands 5 to 7 | 15 | 4.5% | 309 | 93.4% | 7 | 2.1% | 331 |
| Cluster 3: AfC bands 8a and 8b | 3 | 3.1% | 93 | 96.9% | 0 | 0.0% | 96 |
| Cluster 4: AfC bands 8c to VSM | 0 | 0.0% | 46 | 100.0% | 0 | 0.0% | 46 |
| Total Non-Clinical | 86 | 3.9% | 2089 | 95.2% | 20 | 0.9% | 2195 |

Clinical Staff

| | # BME | % BME | # White | % White | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 2 | 68 | 21.12% | 246 | 76.40% | 8 | 2.48% | 322 |
| Bands 3 | 103 | 13.12% | 677 | 86.24% | 5 | 0.64% | 785 |
| Bands 4 | 11 | 6.40% | 158 | 91.86% | 3 | 1.74% | 172 |
| Bands 5 | 382 | 30.88% | 822 | 66.45% | 33 | 2.67% | 1237 |
| Bands 6 | 96 | 11.02% | 763 | 87.60% | 12 | 1.38% | 871 |
| Bands 7 | 32 | 6.54% | 448 | 91.62% | 9 | 1.84% | 489 |
| Bands 8a | 18 | 8.61% | 188 | 89.95% | 3 | 1.44% | 209 |
| Bands 8b | 4 | 7.14% | 51 | 91.07% | 1 | 1.79% | 56 |
| Bands 8c | 2 | 11.76% | 15 | 88.24% | 0 | 0.00% | 17 |
| Bands 8d | 0 | 0.00% | 4 | 100.00% | 0 | 0.00% | 4 |
| Bands 9 | 0 | 0.00% | 2 | 100.00% | 0 | 0.00% | 2 |
| VSM | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 182 | 14.2% | 1081 | 84.5% | 16 | 1.3% | 1279 |
| Cluster 2: AfC bands 5 to 7 | 510 | 19.6% | 2033 | 78.3% | 54 | 2.1% | 2597 |
| Cluster 3: AfC bands 8a and 8b | 22 | 8.3% | 239 | 90.2% | 4 | 1.5% | 265 |
| Cluster 4: AfC bands 8c to VSM | 2 | 8.7% | 21 | 91.3% | 0 | 0.0% | 23 |
| Total Clinical | 716 | 17.2% | 3374 | 81.0% | 74 | 1.8% | 4164 |
| Medical & Dental Staff, Consultants | 114 | 34.44% | 201 | 60.73% | 16 | 4.83% | 331 |
| of which Senior Medical Managers | 4 | 22.22% | 11 | 61.11% | 3 | 16.67% | 18 |
| Medical & Dental Staff, Non-Consultants career grade | 30 | 48.39% | 30 | 48.39% | 2 | 3.23% | 62 |
| Medical & Dental Staff, Medical and dental trainee grades | 120 | 49.59% | 108 | 44.63% | 14 | 5.79% | 242 |
| Medical & Dental Staff, Other | 0 | | 0 | | 0 | | 0 |
| Total Medical and Dental | 264 | 41.57% | 339 | 53.39% | 32 | 5.04% | 635 |
| Number of staff in workforce | 1066 | 15.24% | 5802 | 82.96% | 126 | 1.80% | 6994 |

To follow is a full breakdown of staff compared with community demographics. No major changes can be seen in the demographics this year, when compared to last year.

| | Workforce | LA: Wirral | Region: North West |
|---|---|---|---|
| *White - British (inc English, Scottish & Cornish)* | **80.2%** | 94.97% | 87.08% |
| *White - Irish* | **0.9%** | 0.83% | 0.92% |
| *White Traveller / Gypsy / Irish Traveller* | **0.00%** | 0.02% | 0.06% |
| *White - other* | **1.9%** | 1.17% | 2.15% |
| *Mixed - White & Black Caribbean* | **0.2%** | 0.30% | 0.56% |
| *Mixed - White & Black African* | **0.2%** | 0.17% | 0.26% |
| *Mixed - White & Asian* | **0.3%** | 0.30% | 0.43% |
| *Mixed - Any other mixed background* | **0.2%** | 0.25% | 0.32% |
| *Asian or Asian British - Indian* | **7.5%** | 0.42% | 1.52% |
| *Asian or Asian British - Pakistani* | **0.7%** | 0.07% | 2.69% |
| *Asian or Asian British - Bangladeshi* | **0.4%** | 0.27% | 0.65% |
| *Asian / Asian British: Chinese* | **0.4%** | 0.52% | 0.68% |
| *Asian or Asian British - Any other Asian background* | **1.4%** | 0.33% | 0.66% |
| *Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean* | **2.2%** | 0.18% | 1.17% |
| *Any other Black African / Caribbean* | **0.2 %** | 0.04% | 0.22% |
| *Arab* | **0.0 %** | 0.07% | 0.35% |
| *Any Other* | **1.4%** | 0.10% | 0.28% |

**Age**

The following chart highlights the age profile within WUTH as of 31 March 2026.

| Age Band | % in Trust 2026 |
|---|---|
| <=20 Years | 1.4% |
| 21-25 | 6.1% |
| 26-30 | 10.6% |
| 31-35 | 11.4% |
| 36-40 | 13.3% |
| 41-45 | 12.0% |
| 46-50 | 10.8% |
| 51-55 | 11.7% |
| 56-60 | 10.6% |
| 61-65 | 8.8% |
| 66-70 | 2.3% |
| >=71 Years | 1.0% |
| Grand Total | 100.0% |

3.7 Age demographics have remained similar to last year, with slight reductions in staff numbers from <=20 years to 35 years and then increased number in all order age ranges with the exception of 61-65 years which has reduced by 0.1%.

**Key Findings**

3.8 The Trust has seen improvements in workforce demographics in a number of areas that have been a priority. This includes increased representation of Black, Asian and Minority Ethnic staff, disabled staff and LGB staff. It is pleasing to see more staff are specifying their demographic data and thus allowing more accurate monitoring information. Workforce demographics are broadly aligned to those of the local community.

## 4 EDI Dashboard

In order to more effectively monitor and review performance and progress with the EDI agenda, a key objective of the 2025/26 People Strategy key deliverables was to develop an EDI dashboard that would identify key metrics and provide Trust progress against these.

This was developed and approved via the workforce governance structure last year and is now updated with final data for 2025/26 and is attached at appendix 1.

Metrics seek to provide a greater understanding of EDI related aspects in the employee life cycle (as requested by People Committee) along with monitoring data to support NHS England EDI

Improvement Plan reporting requirements and quarterly reporting requirements and seeks to highlight areas of inequality and support identification of overarching priority areas for the EDI Agenda moving forwards.

As previously reported via People Experience updates, staff survey findings highlight continued declining staff engagement scores; less satisfaction with opportunities for career progression and staff thinking of leaving, with a number of areas scoring below the national average. However, whilst these are of concern and have been considered as part of the Trust's overarching actions to improve staff experience, this report seeks to provide areas where particular staff groups may be experiencing a more negative experience than others.

Key areas of focus for 2026/27:

1) Continued work to support inclusive recruitment processes. Whilst improvements can be seen in appointment of global majority applicants, disabled staff are less likely to be appointed this year and further support is required to support recruiters.
2) Understanding areas to further improve experiences for LGB+ staff as they are thinking of leaving the most.
3) Ensuring WUTH is anti-racist. Whilst a number of improvements can be seen for global majority staff, equality and diversity scores are the lowest for this staff group and have declined albeit slightly this year and also fall below the national average.
4) Development of programme to further support internationally recruited staff.
5) Sexual safety data is now also included in the dashboard with a mixture of results. Key findings are that although results have improved from last year, more LGB+ staff are experiencing unwanted experiences of a sexual nature, closely followed by disabled staff.

## 5 Workforce Race Equality Standards (WRES)

**Summary of Findings**

The full narrative report is available at appendix 2.

Appendix A within the narrative report provides a summary of the Trust's performance against the WRES indicators, compared with national and regional averages.

Performance has improved in only 3 of the 8 comparable WRES indicators:

- Global majority representation increased from 14.70% to 15.24%, with improvement across both clinical and non-clinical roles despite continuing gaps.
- The relative likelihood of global majority applicants being appointed from shortlisting improved from 2.23 to 1.89.
- The relative likelihood of entering the formal disciplinary process improved, although continued monitoring is needed to ensure equity. Although progress is evident, further work is needed to sustain improvement and ensure equal likelihood across these areas.

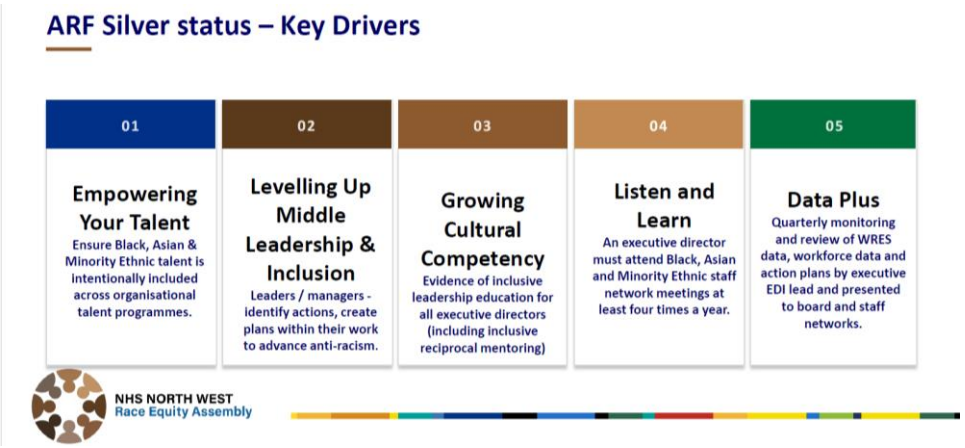
However, staff survey results show deterioration in several staff experience indicators for global majority colleagues:

- Harassment, bullying or abuse from patients, relatives or the public increased from 28.15% to 30.42%, now above the national average.
- Harassment, bullying or abuse from staff increased from 22.01% to 22.73%, while white staff reported improvement.
- Reported discrimination from managers, team leaders or colleagues increased from 16.89% to 20.07%, significantly above the national average.

Only 47.68% of global majority staff believe the Trust provides equal opportunities for career progression or promotion. Due to a national question change, annual comparison is not available, but results for both global majority and white staff sit below the national average.

Findings have been reviewed alongside wider EDI dashboard metrics, the North-west Race Equity Assembly Anti-racism framework, the Lord Mann review recommendations and guidance

| | |
|---|---|
| | from the NHS Race and Health Observatory and new requirements detailed in the NHS Staff Standards.<br><br>Priority actions include:<br>1) Adoption of the Lord Mann review recommendations which is currently progressing through workforce policy approval processes;<br>2) Establishing an anti-racism co-creation group;<br>3) Strengthening the integrated multicultural and BAME staff network;<br>4) Triangulating staff experience data with employee relations and FTSU information where possible;<br>5) Providing further manager and staff training on identifying and addressing racist attitudes and behaviours. |
| **6** | **Workforce Disability Equality Standards (WDES)** |
| | WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.<br><br>The full WDES narrative report is attached at appendix 3 for review and approval.<br><br>An overview of the metrics are contained within the report at appendix i and appendix ii of that report provides a summary overview of the Trust's performance against the required indicators, compared to national averages.<br><br>Data shows improvements in 6 of 12 comparable WDES indicators this year:<br><br>1) Representation of disabled staff continues to increase year on year, increasing from 3.8% to 4.2%. Representation does however continue to be low and therefore work will continue to encourage and support staff to update ESR records.<br>2) Less disabled staff are experiencing bullying, harassment and abuse from patients, relatives or the public and also from managers and colleagues this year. All three of these elements are also better than the national average scores.<br>3) More disabled staff feel that adequate adjustments have been made to enable them to carry out their work.<br>4) Disabled representation at Board level has increased this year to 13.45%.<br><br>However, areas of decline this year are:<br><br>1) Staff engagement scores continue to decline;<br>2) Disabled staff are less satisfied with the extent to which the organisation values their work;<br>3) Disabled staff feel more pressure to come to work when not feeling well enough this year.<br><br>Results for all three areas have also declined for non-disabled staff, however all are also below national average scores.<br><br>Additional areas of decline are:<br>1) Less staff are reporting experiences of bullying, harassment or abuse at work, with reductions seen for both disabled and non-disabled staff.<br>2) There is an increased likelihood of staff entering the capability procedure this year, although numbers are extremely small and therefore should be monitored closely for 2026.<br>3) Disabled applicants are less likely to be appointed than non-disabled applicants, reducing from 1.0 to 1.46 this year.<br><br>One metric is unable to be compared to previous annual data (% of staff believing the Trust provides equal opportunities for career progression or promotion), due to changes in the question. Data is however low and below the national average. |

| | |
|---|---|
| | Board membership remains the same.<br><br>The report contains the action plan for 2026/27 to support further improvements in the experiences of disabled staff. |
| **7** | **Advancing the EDI Agenda** |
| 7.1 | **People Strategy and EDI Strategic Commitment**<br><br>Since the launch of the People Strategy and underpinning EDI Strategic Commitment, the Trust continues to strive to ensure EDI is embedded within all our people processes and practices.<br><br>As the two trusts are working towards merger, the EDI strategic commitments will be reviewed and considered following the development of the organisational joint strategy.<br><br>The joint strategy sessions and consultation process held during summer 2025 encompassed inclusion principles and consideration of the health inequalities of our community and patients we provide services for when in the acute setting and within their own homes.<br><br>Regular updates are reported to PCOG and People & Culture Committee as part of People Strategy Updates.<br><br>A summary of key EDI activities undertaken along with next steps are attached at appendix 4. |
| 7.2 | **NHS North West submission of EDI LEAF report Q4 requirements**<br><br>NHS North West Trusts are requried to completed a quarterly data submission, to highlight progress against a number of EDI workstreams including NHS England's EDI Improvement Plan and 6 High Impact Actions.<br><br>The EDI dashboard is attached as appendix 1 and contains updates on all key components. |
| 7.3 | **Trust Accreditations**<br><br>**Anti-Racist Framework – Bronze Award**<br>WUTH were one of the first four organisations to receive the NHS England and NHS Norht West Race Equite Assembly Anti-Racism Framework Bronze Award.<br><br>This Award is given in recognition of our commitment to anti-racism and the time, effort and dedication that has felt to be instrumental in making a positive impact.<br><br>WCHC have now also receive this award and as we work towards integration, we must continue to build upon progress made so far. In order to meet the seven NHSRHO anti-racist principles detailed in section 7.7, WUTH must continue to strive for improvement and progression to the silver award requires organisations to:<br><br> |

**Forthcoming Accreditation Review – Veteran Aware**

WUTH will undergo an accreditation review this year, which will be held in conjunction with WCHC.

7.4 **Staff Network Update**

WUTH has six staff networks as detailed below. Networks have now combined with WCHC networks, with joint meetings in place for staff within both organisations.

New Executive partners have also now been aligned and are detailed below:

| Network | Executive Partner |
|---|---|
| PRIDE Network | Ali Hughes |
| Ability and Sunflowers Network | Chris Douglas |
| Armed Forces | Hayley Kendall |
| Multicultural and BAME | Nikki Stevenson |
| Menopause | Jo Chwalko |
| Volunteer network | Matthew Swanborough |
| Working Carers network | Mark Chidgey |

A number of Executives have already shared public messages of support for their respective networks, due to events held as part of the Trusts EDI Calendar of Events and arrangements are now underway to ensure Executive partners are linked with network members, meetings and associated activities.

Communication assets are also now in development and when finalised will support a refreshed promotional campaign to promote support available to staff and encourage staff to get involved.

**Network Activities**

- **Armed Forces** – As part of Armed Forces Week
  - Flag raising ceremony held at St Catherines Hospital and flags raised at different sites.
  - Drop-in session for staff
  - Trustwide and social media campaign to promote the week and share experiences of staff within WUTH and WCHC's armed forces community.
- **BAME Staff network**
  - Attended team meeting to promote key messages regarding anti-racism, inclusion and appropriate usage of social media
  - Supported Trustwide communications to highlight local protests and ensure support for staff
  - Supported Trust drop-n support sessions for staff post local protests
  - Shaped and supported Trust race equality workshops and masterclasses
  - Shaped and supported race equality week, sharing experiences, support for staff and even arranging local ethnic ice cream van on site.
- **All staff networks**
  - Have held joint WUTH and WCHC network meetings

Have promoted awareness of the networks as part of national Staff Network Day – holding stalls to meet staff and offer advice and support.

7.5 **Equality Analysis**

Equality Analysis is required in the following circumstances:

- When policies are being developed or renewed.
- Development of business cases impacting on service users or staff.
- Service redesign/reviews impacting on service users or staff – organisational change.

| | |
|---|---|
| | • Changes that may impact on service users or staff.<br><br>Completed analysis should also be shared publicly as appropriate and are available on request.<br><br>A review of the equality analysis process will be undertaken and update provided in biannual report 2. |
| 7.6 | **Education and Training**<br><br>There are a range of education and training opportunities currently available for staff to build further understanding of the EDI agenda and support knowledge gaps.<br><br>Compliance with Level 1 EDI mandatory training is 94.3% at 30 June 2026.<br><br>Dedicated EDI sessions continue to take place as part of Leadership for all programmes accessible for WUTH and WCHC colleagues, and include “Inclusive Leadership”, “Inclusive Recruitment” sessions. Additional inclusive recruitment sessions will be advertised shortly.<br><br>Sessions for Board and senior leaders have been held with BRAP, a charity that specialises on working with public sector organisations to challenge and refresh their understanding of human rights, equity/ equality, diversity and inclusion.<br><br>Leadership masterclasses have also been held with BRAP in March 2026 along with a workshop to support HR and staffside when dealing with employee relations cases.<br><br>Deaf awareness sessions continue to be delivered by the Deafness Resource Centre in conjunction with WUTH and are open to all staff.<br><br>Funding has now also been sourced to support a suite of EDI sessions for 2026/27 and further details will follow in due course. This will include:<br>• Neurodiversity awareness<br>• Supporting staff with disabilities and reasonable adjustments<br>• Trans awareness<br>• Active bystander training is currently under consideration. |
| 7.7<br><br>7.7.1 | **Anti-Racism, including Antisemitism and Islamophobia**<br><br>**Lord Mann Review**<br>There are new and strengthened national and regional mandates to become an anti-racist organisation. The recent publication of the **Lord Mann Review** and subsequent directives from NHS England and NHS North-West mark a significant shift, placing explicit requirements on all NHS Trusts to take urgent and sustained action to tackle racism, including antisemitism and Islamophobia.<br><br>The review confirmed that racism and discrimination are persistent and systemic challenges within the NHS. Its recommendations aim to **strengthen leadership**, **improve accountability**, **enhance staff training**, **standardise support for staff who experience racism**, and **improve the use of data**.<br><br>Lord Mann is clear in his review that NHS employers must take responsibility for tackling anti-Jewish racism and other forms of racism urgently. In a letter sent from NHS England’s Chief Executive Sir Jim Mackey and People Director, Danny Mortimer, NHS England will support this work by:<br><br>• Signing up to the seven anti-racism principles of the NHS Race and Health Observatory (see appendix 6) and encouraging all NHS organisations to do the same.<br>• Set clear Staff Standards relating to experience of racism<br>• Support NHS improvement and assurance through the NHS Oversight Framework<br>• Strengthen accountability for racial inclusion through our appraisals<br>• Consult on adding Jewish and Sikh to NHS protected characteristic datasets |

- Develop bespoke eLearning for NHS PALS and complaints handlers
- Ensure all NHS boards and system leaders complete regular anti-racism training

NHS organisations are being asked to undertake a series of actions, and a plan has therefore been developed and is attached at appendix 5 along with an update on progress against actions so far.

WCHC and WUTH have accepted Lord Manns recommendations and declared this to all staff in a global email on 10 June 26 by Dr Nikki Stevenson, Executive partner for the BAME and Multicultural staff network.

The wider response of the NHS was also shared with staff, citing a letter received from Sir Jim Mackey, Chief Executive at NHS England, and Danny Mortimer, Director General for People at NHS England, which is provided here.

Key actions for Trusts as requested by NHS England following the Lord Mann review included:

1. Adoption of the **NHS Race and Health Observatory Seven Anti-Racism Principles** (see image opposite) and NHS Race and Health Observatory infographic (appendix 6).

2. Adoption of the **new government definition of antisemitism and anti-Muslim hostility:**

Antisemitism definition

*"Antisemitism is a certain perception of Jews, which may be expressed as hatred towards Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and / or their property, toward Jewish community institutions and religious facilities".*

Anti-Muslim hostility definition

*"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts - including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.*

*It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by their fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals. It is engaging in unlawful discrimination where the relevant conduct including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life".*

3. Board and senior leader training - The Trust Board and senior leaders have recently completed anti-racism training by BRAP, leading charity experts and a further national training package is awaited.

WUTH and WCHC have both adopted the above definitions (no. 1 and 2) and included within appropriate workforce policies. These are currently progressing through governance approval processes. They have been discussed at various forums, including partnership steering group and has been met by approval throughout.

Appendix 5 provides the Trust action plan in response to the Lord Mann review and updates on progress made to date. It is also important to note that some actions cannot currently be progressed until further national guidance or training resources are received.

Implementation of the Violence Prevention and Reduction Standard has however been stalled and is currently therefore flagged as an areas of concern.

| | |
|---|---|
| 7.7.2 | **NHS Staff Standards**<br>In addition to the above, new **NHS staff standards** have now been launched by NHS England and also include requirements to 'Tackle Racism' as a core strand. |
| 7.7.3 | **NHS North-West Race Equity Assembly**<br>In a letter also received from co-chairs of the **NHS North-West Race Equity Assembly**, Trusts are asked to reflect on local progress, consider future priorities and consider how Trusts can strengthen their contribution to creating equitable experiences and outcomes for staff and communities. The Assembly calls for Board members to review the Assembly's annual report and a local No Space for Racism campaign and to adopt where possible. |
| 7.7.4 | **Next Steps**<br>The following is recommended:<br>• Establishment of a race equity co-creation group to work together on identifying and progressing key actions necessary to ensure meaningful change. It is proposed that this group would then consider the recommendations made by the NHS North-West Race Equity Assembly, including the No Space for Racism Campaign highlighted in section 7.7.1.<br>• Anti-semitism awareness sessions.<br>• Ongoing anti-racist communication<br>• Implementation of further national guidance as it arises. |

| 8 | **Report Summary and next steps** |
|---|---|
| | A range of actions and activities continue to be undertaken to ensure WCHC is an inclusive place to work and receive treatment.<br><br>Key areas of focus for the EDI agenda in 2026/27 will be:<br>• Improve experiences of disabled staff, through enhanced education and training and providing easier access of information and support to line managers, with a particular focus on reasonable adjustments.<br>• Creating further opportunities to celebrate our LGB+ staff and further understanding key actions needed to support improvements in staff experience.<br>• Further support and build combined WUTH and WCHC staff networks to become established and impactful<br>• Being an anti-racist organisation<br>• Achieving Veteran Aware reaccreditation<br><br>Members are asked to:<br>1) Ratify contents of the report for publication, including WRES and WDES narrative reports.<br>2) Ratify adoption of the antisemitism and anti-Muslim hostility definitions (section 7.7)<br>3) Ratify adoption of the Race Health observatory seven principles of anti-racism (section 7.7)<br>4) Acknowledge and share forthcoming EDI calendar of events and consider ways to support / observe locally. |

| 9 | **Implications** |
|---|---|
| 9.1 | **Patients**<br>The work undertaken to advance the EDI agenda aims to improve awareness of a range of aspects and celebrate diversity for all. Whilst this should be a positive experience for all, there is also recognition of the diverse nature of our workforce and community and promotion and celebration of some areas, may not be in line with individual values, beliefs and behaviours. |

| | |
|---|---|
| | Whilst we strive to ensure appropriate values and behaviours are upheld for our workforce, this can be more challenging for our patients. |
| 9.2 | **People**<br>As also detailed in section 2.1. |
| 9.3 | **Finance**<br>Whilst a small budget has been ringfenced for network activities, the Trust financial position is acknowledged, and network co-chairs remain committed to avoiding costs where possible and thinking creatively about alternative options. |
| 9.4 | **Compliance**<br>This report seeks to provide assurance that WUTH is currently in line with EDI reporting requirements for 2026/7. |

**EDI Monitoring Dashboard - June 2026**

Key:

- ≥ last year and ≥ the national average
- ≥ last year < national average **or** < last year ≥ national average
- < last year and < national average

| Element | Area of measurement | KPI | Demographic | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Compliance | Trend | Summary |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Recruitment & Progression | RP1 - Relative likelihood of appointment from shortlisting | Ratio between 0.8 and 1.2:1 | BAME | 0.96 | 1.28 | 2.02 | 2.23 | 1.89 | | | * Monitoring now in place and data shows likelihood of each characteristic for comparator grouping<br>* Applicants across all PC's listed generally have an equal likelihood of appointment from shortlisting, with the exception of Global majority applicants. However, results have improved from last year. Disabled applicants are less likely to be appointed this year too. |
| | | | Disabled | 1.80 | 1.30 | 1.19 | 1.00 | 1.46 | | | |
| | | | Female | | | | 0.87 | 1.16 | | | |
| | | | LGB+ | | | | 0.95 | 0.87 | | | |
| | | | Other religions | | | | | 0.91 | | | |
| | RP2 -Staff satisfaction with opportunities for career progression (Q24b from NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | **47.8%** | **49.8%** | **48.2%** | **46.3%** | **42.3%** | | | * Scores for the organisation and the national comparator groups have all declined. A decline in experience can be seen for most staff apart from Disabled and LGB groups with scores for LGB+ staff above the national average . |
| | | | **Nat. Ave** | **52.2%** | **53.5%** | **55.2%** | **54.3%** | **50.4%** | | | |
| | | | BAME | 62.0% | 61.5% | 56.6% | 54.6% | 49.8% | | | |
| | | | White | 46.2% | 48.6% | 48.3% | 45.6% | 41.3% | | | |
| | | | Disabled | 38.7% | 41.9% | 41.0% | 36.0% | 36.8% | | | |
| | | | Non-disabled | 50.2% | 52.4% | 52.1% | 50.5% | 44.4% | | | |
| | | | Female | 47.7% | 50.1% | 48.7% | 46.0% | 42.3% | | | |
| | | | Male | 48.2% | 51.9% | 54.7% | 50.3% | 43.4% | | | |
| | | | LGB+ | 45.0% | 53.5% | 48.9% | 45.0% | 52.3% | | | |
| | | | Straight | 47.8% | 50.5% | 49.9% | 47.4% | 42.3% | | | |
| | | | Christian | 46.5% | 49.9% | 48.9% | 46.7% | 42.9% | | | |
| | | | Other Religions | 58.0% | 57.0% | 54.0% | 51.8% | 50.8% | | | |
| | RP3: Staff feeling the organisation acts fairly with regards to career progression (Q15 from NSS)<br>Survey changes to the wording of the question so results from 2021-4 not available | ≥ national average<br>Improvement from last year | **Org. Ave** | | | | | **51.5%** | | | * As previous data is non-comparable, colour rating has been applied based on above organisatinal and national average. Above the national and organsiational averages are geen; below both of these averages is red and above theorganisation however below the national average is amber.<br><br>A mixture of results can be seen with the majority of groups falling below the organisation and national averages, however disabled staff are the least satisfied staff group. |
| | | | **Nat. Ave** | | | | | **53.1%** | | | |
| | | | BAME | | | | | 52.5% | | | |
| | | | White | | | | | 47.7% | | | |
| | | | Disabled | | | | | 46.3% | | | |
| | | | Non-disabled | | | | | 54.1% | | | |
| | | | Female | | | | | 52.7% | | | |
| | | | Male | | | | | 51.2% | | | |
| | | | LGB+ | | | | | 50.0% | | | |
| | | | Straight | | | | | 52.1% | | | |
| | | | Christian | | | | | 54.3% | | | |
| | | | Other Religions | | | | | 49.1% | | | |
| Staff Satisfaction - What's it like to work at WUTH | S1: Staff engagement score | ≥ national average<br>Improvement from last year | **Org. Ave** | **6.67** | **6.69** | **6.67** | **6.56** | **6.35** | | | *Staff engagement scores have declined at an organisational and national level this year and has declined for all staff groups. All groups also fall below the national average with the exception of Global Majority staff who also have the highest staff engagement score.<br>Disabled staff have the lowest staff engagement score. |
| | | | **Nat. Ave** | **6.84** | **6.80** | **6.91** | **6.84** | **6.74** | | | |
| | | | BAME | 7.22 | 7.30 | 7.17 | 7.08 | 6.95 | | | |
| | | | White | 6.63 | 6.62 | 6.62 | 6.51 | 6.28 | | | |
| | | | Disabled | 6.28 | 6.26 | 6.19 | 6.07 | 5.92 | | | |
| | | | Non-disabled | 6.80 | 6.82 | 6.86 | 6.75 | 6.52 | | | |
| | | | Female | 6.70 | 6.71 | 6.73 | 6.61 | 6.44 | | | |
| | | | Male | 6.67 | 6.71 | 6.74 | 6.61 | 6.25 | | | |
| | | | Straight | 6.72 | 6.77 | 6.77 | 6.64 | 6.43 | | | |
| | | | LGB+ | | 6.08 | 6.02 | 6.26 | 6.15 | | | |
| | | | Christian | 6.79 | 6.86 | 6.86 | 6.72 | 6.57 | | | |
| | | | Other Religions | 6.96 | 7.13 | 7.19 | 6.85 | 6.63 | | | |
| | S2: Equality and Diversity sub-score (NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | **8.20** | **8.26** | **8.18** | **8.18** | **8.47** | | | * The majority of staff groups have seen an increase in experiences relating to equality and diversity this year and are above the national average.<br>*Particular improvements can be seen in experiences for disabled and LGB+ staff, with both now above 8.0. Global majority staff however have declined and whilst the decline is only minor, scores are also below the national average. |
| | | | **Nat. Ave** | **8.13** | **8.10** | **8.12** | **8.08** | **8.37** | | | |
| | | | BAME | 7.96 | 7.93 | 7.43 | 7.50 | 7.46 | | | |
| | | | White | 8.61 | 8.66 | 8.67 | 8.67 | 8.64 | | | |
| | | | Disabled | 7.73 | 7.96 | 7.90 | 7.89 | 8.24 | | | |
| | | | Non-disabled | 8.35 | 8.36 | 8.34 | 8.34 | 8.62 | | | |
| | | | Female | 8.23 | 8.30 | 8.27 | 8.27 | 8.56 | | | |
| | | | Male | 8.20 | 8.26 | 8.25 | 8.26 | 8.45 | | | |
| | | | LGB+ | | 8.00 | 8.05 | 7.90 | 8.06 | | | |
| | | | Straight | 8.25 | 8.32 | 8.28 | 8.30 | 8.56 | | | |
| | | | Christian | ed and LGB+ st | 8.25 | 8.25 | 8.22 | 8.49 | | | |
| | | | Other Religions | 8.02 | 8.30 | 8.19 | 7.91 | 7.90 | | | |
| | S3: Inclusion sub-score (NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | **6.84** | **6.92** | **6.83** | **6.81** | **6.84** | | | *All groups have improved in scores this year with the majority above the national average. Satisfaction for LGB+ staff has increased the most. Only two groups have declined this year with scores for non-disabled staff reducing by 0.01 and male staff by 0.09. |
| | | | **Nat. Ave** | **6.78** | **6.84** | **6.86** | **6.81** | **6.80** | | | |
| | | | BAME | 6.78 | 7.08 | 6.70 | 6.67 | 6.82 | | | |
| | | | White | 6.80 | 6.89 | 6.85 | 6.85 | 6.86 | | | |
| | | | Disabled | 6.50 | 6.60 | 6.49 | 6.39 | 6.52 | | | |
| | | | Non-disabled | 6.90 | 6.99 | 6.95 | 6.98 | 6.97 | | | |
| | | | Female | 6.80 | 6.92 | 6.85 | 6.85 | 6.93 | | | |
| | | | Male | 6.83 | 7.00 | 6.95 | 6.92 | 6.81 | | | |
| | | | LGB+ | | 6.40 | 6.31 | 6.57 | 6.84 | | | |
| | | | Straight | 6.82 | 6.96 | 6.91 | 6.89 | 6.92 | | | |
| | | | Christian | 6.84 | 6.98 | 6.91 | 6.86 | 6.92 | | | |
| | | | Other Religions | 6.83 | 6.89 | 7.11 | 6.92 | 6.95 | | | |
| Retention | R1: Turnover | ≥ org average<br>Improvement from last year | BAME | | | | | 11.96% | | | * Turnover data is deemed to be healthy, with no additional concerns presented |
| | | | White | | | | | 10.40% | | | |
| | | | Disabled | | | | | 19.36% | | | |
| | | | Non-disabled | | | | | 11.10% | | | |
| | | | Female | | | | | 10.48% | | | |
| | | | Male | | | | | 11.66% | | | |
| | | | LGB+ | | | | | 16.86% | | | |
| | | | Straight | | | | | 10.91% | | | |
| | | | Christian | | | | | 9.71% | | | |
| | | | Other Religions | | | | | 13.91% | | | |
| | R2: Thinking of leaving (NSS score) | ≥ national average<br>Improvement from last year | **Org. Ave** | **5.99** | **5.91** | **5.82** | **5.79** | **5.63** | | | * Trend analysis shows a continued reducing picture.<br><br>* Only two staff groups have seen improvements in this area, with less Global Majority and LGB+ staff thinking of leaving. However, LGB+ staff have the lowest scores in this area. |
| | | | **Nat. Ave** | **5.97** | **5.86** | **6.06** | **6.04** | **6.00** | | | |
| | | | BAME | 6.55 | 6.41 | 6.13 | 6.11 | 6.15 | | | |
| | | | White | 6.00 | 5.86 | 5.86 | 5.84 | 5.65 | | | |
| | | | Disabled | 5.53 | 5.39 | 5.38 | 5.34 | 5.35 | | | |
| | | | Non-disabled | 6.21 | 6.08 | 6.07 | 6.04 | 5.85 | | | |
| | | | Female | 6.05 | 5.97 | 5.95 | 5.90 | 5.79 | | | |
| | | | Male | 6.15 | 5.90 | 5.87 | 5.93 | 5.64 | | | |
| | | | LGB+ | | 5.51 | 5.12 | 4.99 | 5.18 | | | |
| | | | Straight | 6.09 | 5.98 | 5.97 | 5.97 | 5.80 | | | |
| | | | Christian | 6.16 | 6.06 | 6.08 | 6.02 | 5.93 | | | |
| | | | Other Religions | 6.37 | 6.10 | 6.39 | 6.49 | 6.21 | | | |

**NHS EDI Improvement Plan**

| | | | | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | | Progress Rating | Summary |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **HIA 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. | **Success Metric 1** - Annual chair and chief executive appraisals on EDI objectives | | | | | | | | Very Good Progress | * Board members all now have EDI objectives and these are monitored through appraisals |
| | | **HIA 1: Progress overall** | | | | | | | | **Very Good Progress** | |
| | | **Success Metric 1** Relative likelihood of staff being appointed from shortlisting across all posts | BAME | 0.96 | 1.28 | 2.02 | 2.23 | 1.89 | | | * Monitoring now in place<br>* Applicants across all PC's listed have an equal likelihood of appointment from shortlisting, with the exception of BAME applicants. This has declined and is a cause for concern. A recruitment audit has been developed and piloted, with findings under review. |
| | | | Disabled | 1.80 | 1.30 | 1.19 | 1.00 | 1.46 | | | |
| | | | Female | | | | 0.87 | 1.16 | | | |
| | | | LGB+ | | | | 0.95 | 0.87 | | | |
| | | | Other religions | | | | 1.08 | 0.91 | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS EDI Improvement Plan | **HIA 2:** Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. | | **Success Metric Overall** | | | | | | | **Very Good Progress** | |
| | | **Success Metric 2** Access to career progression, training and development opportunities. (Q24b NSS) | **Org. Ave** | **47.8%** | **49.8%** | **48.2%** | **46.3%** | **42.3%** | | | * A decline in experience can be seen for all staff apart from Disabled and LGB. Findings for LGB are above the national average. |
| | | | **Nat. Ave** | **52.2%** | **53.5%** | **55.2%** | **54.3%** | **50.4%** | | | |
| | | | BAME | 62.0% | 61.5% | 56.6% | 54.6% | 49.8% | | | |
| | | | White | 46.2% | 48.6% | 48.3% | 45.6% | 41.3% | | | |
| | | | Disabled | 38.7% | 41.9% | 41.0% | 36.0% | 36.8% | | | |
| | | | Non-disabled | 50.2% | 52.4% | 52.1% | 50.5% | 44.4% | | | |
| | | | Female | 47.7% | 50.1% | 48.7% | 46.0% | 42.3% | | | |
| | | | Male | 48.2% | 51.9% | 54.7% | 50.3% | 43.4% | | | |
| | | | LGB+ | 45.0% | 53.5% | 48.9% | 45.0% | 52.3% | | | |
| | | | Straight | 47.8% | 50.5% | 49.9% | 47.4% | 42.3% | | | |
| | | | Christian | 46.5% | 49.9% | 48.9% | 46.7% | 42.9% | | | |
| | | | Other Religions | 58.0% | 57.0% | 54.0% | 51.8% | 50.8% | | | |
| | | | **Success Metric Overall** | | | | | | | **Limited progress** | |
| | | **Success Metric 3 -**Improvement in race and disability representation leading to parity over the life of the plan. | Disability | 2.0% | 2.8% | 3.6% | 3.8% | 4.2% | | | * Year on year improvement in representation of both disabled and BAME staff.<br>* Self declaration rates still remain low however for disabled staff, with 20% of staff still remaining undefined<br>* Whilst BAME representation is increasing, this is not equal across all areas, with significantly higher levels of BAME clinical staff compared to non-clinical. |
| | | | Race | 10.4% | 12.3% | 13.7% | 14.7% | 15.2% | | | |
| | | | **Success Metric Overall** | | | | | | | **Very Good Progress** | |
| | | **Success Metric 4 -** Improvement in representation of senior leadership (Band 8C and above) over the life of the plan. | Disability | | | 0.98% | 1.07% | 4.35% | | | * Whilst bands 8c and above have increased I disabled representation, disabled representation is low, with the exception of Board members. |
| | | | Race | | | 3.45% | | 2.90% | | | |
| | | | **Success Metric Overall** | | | | | | | **Good Progress** | |
| | | **Success Metric 5 -** HEE National Education and Training Survey (NETS) Score metric on quality of training. | | | 69.24% | 70.48% | 71.54% | 73.17% | | Excellent progress | * Year on year improvement in NETS results |
| | | **Success Metric 6 -** Diversity in shortlisted candidates. | Data to be included moving forwards | | | | | | | Limited progress | Data presented at EDI Steering Board and Workforce Steering Board and analysis undertaken to be included in dashboard |
| | | **HIA 2: Progress overall** | | | | | | | | **Good progress** | Progress is varied across the metrics, with focus to be placed on areas of improvement for 2025/26 |
| | **HIA 3:** Develop an improvement plan to eliminate pay gaps. | **Success metric 1** - Improvement in the gender, race and disability pay gaps (Mean average used) | Gender | 21.1% | 21.2% | 19.4% | 20.1% | Not required yet | | | * Whilst reporting commenced in 2023 as a pilot, full reporting has been completed this year and published as part of Gender pay gap reporting.<br>* Whilst gender pay gap has increased slightly this year, the median pay gap has improved, along with bonus gaps and the gap has reduced over a number of years. |
| | | | Ethnicity | | | -11.7% | -14.9% | Not required yet | | | |
| | | | Disability | | | 10.2% | 10.2% | Not required yet | | | |
| | | | Sexual Orientation | | | 7.8% | 6.1% | Not required yet | | | |
| | | | **HIA 3: Progress overall** | | | | | | | **Very Good Progress** | |
| | HIA 4: Develop an improvement plan to address health inequalities within their workforce. | **Success Metric 1** - Organisation action on staff health and wellbeing (NSS Q 11a) | | | 50.01% | 52.94% | 49.18% | 46.51% | 43.02% | | Limited progress | * WUTH staff experiences have been reducing for Q11a, the Trust has launched a health inequalities plan and has seen improvements in experiences from immediate managers regarding action on health and wellbeing. |
| | | **Success Metric 2** - HEE National Education & Training Survey (NETS) Separate Indicator Score metric on quality of training. | | | 69.24% | 70.48% | 71.54% | 73.17% | | Excellent progress | |
| | | **HIA 4: Progress overall** | | | | | | | | **Limited progress** | |
| | HIA 5: Develop a comprehensive induction, onboarding and development programme for internationally recruited staff. | **Success Metric 1 -** Sense of belonging for internationally recruited staff (Inclusion sub score used from NSS) | | | 7.05 | 6.82 | 6.55 | 6.5 | 6.52 | | Limited progress | * There is no specific question regarding "sense of belonging" in the staff survey. The people promise "Inclusion" score has therefore been used as an alternative and feedback provided as part of reporting processes<br>* Despite an increase last year, an improvement in experiences can be seen over the last four years.<br>* WUTH has been awarded a pastoral certificate for its onboarding and development programme for IR staff.<br>* Listening events held with staff; staff network support in place and surveys sent to staff to understand experiences with a range of Trust activities to support improvements |
| | | **Success Metric 2 -** Reduction in instances of bullying and harassment from team/line manager experienced by (internationally recruited staff). | By colleagues | | 26.00% | 21.69% | 26.95% | 22.67% | 23.00% | | Limited progress |
| | | | By line manager | | 16.00% | 8.48% | 12.69% | 13.91% | 12.75% | | Limited progress |
| | | **HIA 5: Progress overall** | | | | | | | | **Limited progress** | |
| | HIA 6: Create an environment which eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occurs | **Success Metric 1** - Improvement in staff survey results of bullying and harassment from line managers or teams | % of staff experiencing bullying, harassment or abuse from managers in the last 12 months (NSS Q14b) | | 13.91% | 11.56% | 11.34% | 10.33% | 9.68% | | Excellent progress | * Excellent progress made following a series of actions to understand staff experiences and support improvements |
| | | | % of staff experiencing bullying, harassment or abuse from colleagues in the last 12 months (NSS Q14c) | | 20.23% | 16.79% | 19.16% | 16.99% | 15.65% | | Excellent progress |
| | | **Success Metric 2** - Improvement in National Education and Training Survey (NETS) bullying and harassment score metric | | | | 92.40% | 83.73% | 86.46% | 88.94% | | Very Good Progress |
| | | **Success Metric 3 -** Improvement in staff survey results of discrimination from line managers or teams (All staff NSS results) | No. of staff experiencing discrimination at work from colleagues/managers/team leaders (NSS Q16b) | | 6.80% | 6.70% | 7.34% | 7.18% | 6.73% | | Excellent progress |
| | | **HIA 6: Progress overall** | | | | | | | | **Excellent progress** | |

Wirral University Teaching Hospital
NHS Foundation Trust

# Workforce Race Equality Standards (WRES) Report

July 2026

Sharon Landrum, Head of Culture and Workforce Experience

together we will

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# Background

All the available evidence shows that Black, Asian and Ethnic Minority (BAME) staff have a significantly inferior experience of the NHS as employees when compared to white staff. This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

The aim of the WRES is to improve the experience of Black, Asian and Ethnic Minority (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

**In the context of the WRES, "white staff" comprises of white British, white Irish and white other, whereas "BAME staff" comprise all other categories with the exception of "not stated".**

The Trust has also adopted the recommended 'global majority' term that replaces 'BAME'.

The report shows annual comparisons to assess whether any improvements have been achieved.

# Executive Summary

Appendix A summarises the Trust's performance against the WRES indicators, compared with national and regional averages.

Performance improved in 3 of 8 comparable WRES indicators:

- Global majority representation increased from 14.70% to 15.24%, with improvement across both clinical and non-clinical roles despite continuing gaps.
- The relative likelihood of global majority applicants being appointed from shortlisting improved from 2.23 to 1.89.
- The relative likelihood of entering the formal disciplinary process improved, although continued monitoring is needed to ensure equity.

Although progress is evident, further work is needed to sustain improvement and ensure equal likelihood across these areas.

However, staff survey results show deterioration in several staff experience indicators for global majority colleagues:

- Harassment, bullying or abuse from patients, relatives or the public increased from 28.15% to 30.42%, now above the national average.
- Harassment, bullying or abuse from staff increased from 22.01% to 22.73%, while white staff reported improvement.
- Reported discrimination from managers, team leaders or colleagues increased from 16.89% to 20.07%, significantly above the national average.

Only 47.68% of global majority staff believe the Trust provides equal opportunities for career progression or promotion. Due to a national question change, annual comparison is not available, but results for both global majority and white staff sit below the national average.

**Next Steps**

Findings will be reviewed alongside wider EDI dashboard metrics, the North-west Race Equity Assembly Anti-racism framework, the Lord Mann review recommendations and guidance from the NHS Race and Health Observatory.

Priority actions include:

1) Adopting the Lord Mann review recommendations;
2) Establishing an anti-racism co-creation group;
3) Strengthening the integrated multicultural and BAME staff network;
4) Triangulating staff experience data with employee relations and FTSU information where possible;
5) Providing further manager and staff training on identifying and addressing racist attitudes and behaviours.

Appendix B provides an update on actions identified for 2024/5.

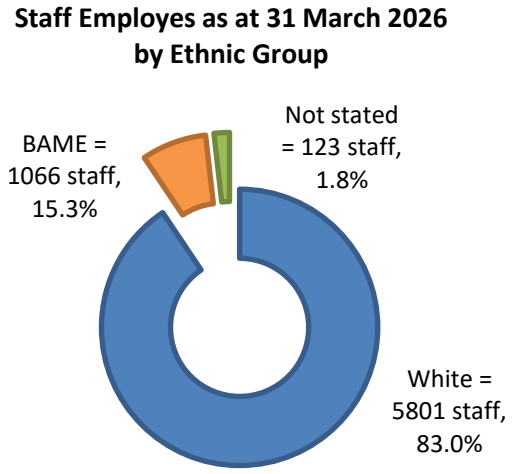
## Total Staff by Ethnicity 31 March 2026

83.0% of WUTH staff are white, 15.3% of staff are Black, Asian, or other Ethnic Group and 1.8% of staff have not stated their ethnic group on ESR. The following chart shows the breakdown of the workforce by ethnicity and compared to community demographics since 2024.

| Ethnicity Group | Headcount | % in Trust 2026 | % in Trust 2025 | % in Trust 2024 |
|---|---|---|---|---|
| **BAME** | 1066 | **15.3%** | 14.7% | 13.7% |
| **Not Stated** | 123 | **1.8%** | 1.7% | 1.8% |
| **White** | 5801 | **83.0%** | 83.6% | 84.6% |
| **Grand Total** | **6990** | **100.0%** | 100.0% | 100.0% |

As at 31 March 2026, a total of 6990 staff were employed by WUTH. Of these, 1066 (15.3%) were BAME and 5801 (83.0%) were white. 123 staff however, (1.8%) were unstated for their ethnicity.

The results highlight therefore that there continues to be a significant increase in the number of global majority staff within the Trust, with numbers remaining higher than that within the local population (95.2% of residents identified as “white” in the 2021 census). That said, there is a significant disparity between the levels of global majority staff within clinical and non-clinical roles, however increases can be seen in both areas.




The definitions of “Black, Asian and Minority Ethnic” and “White” used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. “White” staff includes White British, Irish and Any Other White. The “Black, Asian and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated.”

WUTH has also adopted the recommended term ‘global majority’ staff to replace ‘Black, Asian and Ethnic Minority’ and ‘BAME’.

## Section One

# The WRES Standard Indicators

| Table 1. The Workforce Race Equality Standard Indicators | |
|---|---|
| **Workforce Indicators**<br>For each of these four workforce indicators, compare the data for White and Global Majority staff. | |
| **1** | Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (*including executive Board members*) compared with the percentage of staff in the overall workforce disaggregated by:<br>• Non-clinical staff<br>• Clinical staff – of which<br>  • Non-medical staff<br>  • Medical and Dental staff |
| **2** | Relative likelihood of staff being appointed from shortlisting across all posts. |
| **3** | Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*<br>**Note:** *this indicator will be based on data at 31 March.* |
| **4** | Relative likelihood of BAME staff accessing non-mandatory training and CPD. |
| **National NHS Staff Survey findings (or equivalent)**<br>For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff. | |
| **5** | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. |
| **6** | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. |
| **7** | Percentage believing that trust provides equal opportunities for career progression or promotion. |
| **8** | In the last 12 months have you personally experienced discrimination at work from any of the following?<br>b) manager/team leader or other colleagues |
| **Boards representation indicator**<br>For this indicator, compare the difference for White and BAME staff | |
| **9** | Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:<br>• By voting membership of the Board<br>• By executive membership of the Board |

# Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WUTH broken down by clinical and non-clinical staff for 2025/6.

Table 1 - Non-clinical staff breakdown for 2025/26 (by pay band)

| | # BME | % BME | # White | % White | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Bands 1 | 0 | 0.0% | 79 | 98.8% | 1 | 1.3% | 80 |
| Bands 2 | 48 | 4.9% | 922 | 94.2% | 9 | 0.9% | 979 |
| Bands 3 | 13 | 3.5% | 354 | 96.2% | 1 | 0.3% | 368 |
| Bands 4 | 7 | 2.4% | 286 | 96.9% | 2 | 0.7% | 295 |
| Bands 5 | 4 | 2.8% | 138 | 95.8% | 2 | 1.4% | 144 |
| Bands 6 | 5 | 5.1% | 88 | 89.8% | 5 | 5.1% | 98 |
| Bands 7 | 6 | 6.7% | 83 | 93.3% | 0 | 0.0% | 89 |
| Bands 8a | 1 | 1.9% | 52 | 98.1% | 0 | 0.0% | 53 |
| Bands 8b | 2 | 4.7% | 41 | 95.3% | 0 | 0.0% | 43 |
| Bands 8c | 0 | 0.0% | 19 | 100.0% | 0 | 0.0% | 19 |
| Bands 8d | 0 | 0.0% | 14 | 100.0% | 0 | 0.0% | 14 |
| Bands 9 | 0 | 0.0% | 3 | 100.0% | 0 | 0.0% | 3 |
| VSM | 0 | 0.0% | 10 | 100.0% | 0 | 0.0% | 10 |
| Cluster 1: AfC Bands <1 to 4 | 68 | 3.9% | 1641 | 95.3% | 13 | 0.8% | 1722 |
| Cluster 2: AfC bands 5 to 7 | 15 | 4.5% | 309 | 93.4% | 7 | 2.1% | 331 |
| Cluster 3: AfC bands 8a and 8b | 3 | 3.1% | 93 | 96.9% | 0 | 0.0% | 96 |
| Cluster 4: AfC bands 8c to VSM | 0 | 0.0% | 46 | 100.0% | 0 | 0.0% | 46 |
| Total Non-Clinical | 86 | 3.9% | 2089 | 95.2% | 20 | 0.9% | 2195 |

Table 2 - Clinical staff breakdown for 2025/ (by pay band)

| | # BME | % BME | # White | % White | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 2 | 68 | 21.12% | 246 | 76.40% | 8 | 2.48% | 322 |
| Bands 3 | 103 | 13.12% | 677 | 86.24% | 5 | 0.64% | 785 |
| Bands 4 | 11 | 6.40% | 158 | 91.86% | 3 | 1.74% | 172 |
| Bands 5 | 382 | 30.88% | 822 | 66.45% | 33 | 2.67% | 1237 |
| Bands 6 | 96 | 11.02% | 763 | 87.60% | 12 | 1.38% | 871 |
| Bands 7 | 32 | 6.54% | 448 | 91.62% | 9 | 1.84% | 489 |
| Bands 8a | 18 | 8.61% | 188 | 89.95% | 3 | 1.44% | 209 |
| Bands 8b | 4 | 7.14% | 51 | 91.07% | 1 | 1.79% | 56 |
| Bands 8c | 2 | 11.76% | 15 | 88.24% | 0 | 0.00% | 17 |
| Bands 8d | 0 | 0.00% | 4 | 100.00% | 0 | 0.00% | 4 |
| Bands 9 | 0 | 0.00% | 2 | 100.00% | 0 | 0.00% | 2 |
| VSM | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 182 | 14.2% | 1081 | 84.5% | 16 | 1.3% | 1279 |
| Cluster 2: AfC bands 5 to 7 | 510 | 19.6% | 2033 | 78.3% | 54 | 2.1% | 2597 |
| Cluster 3: AfC bands 8a and 8b | 22 | 8.3% | 239 | 90.2% | 4 | 1.5% | 265 |
| Cluster 4: AfC bands 8c to VSM | 2 | 8.7% | 21 | 91.3% | 0 | 0.0% | 23 |
| Total Clinical | 716 | 17.2% | 3374 | 81.0% | 74 | 1.8% | 4164 |
| Medical & Dental Staff, Consultants | 114 | 34.44% | 201 | 60.73% | 16 | 4.83% | 331 |
| of which Senior Medical Managers | 4 | 22.22% | 11 | 61.11% | 3 | 16.67% | 18 |
| Medical & Dental Staff, Non-Consultants career grade | 30 | 48.39% | 30 | 48.39% | 2 | 3.23% | 62 |
| Medical & Dental Staff, Medical and dental trainee grades | 120 | 49.59% | 108 | 44.63% | 14 | 5.79% | 242 |
| Medical & Dental Staff, Other | 0 | | 0 | | 0 | | 0 |
| Total Medical and Dental | 264 | 41.57% | 339 | 53.39% | 32 | 5.04% | 635 |
| Number of staff in workforce | 1066 | 15.24% | 5802 | 82.96% | 126 | 1.80% | 6994 |

**Key Findings:-**

- The percentage of global majority staff employed at WUTH continues to increase, rising again from 14.7% last year to 15.2% this year.
- There continues to be significant variance between representation across clinical and non-clinical roles however both continue to improve.

# Indicator 2

This indicator relates to the relative likelihood of global majority staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

**Key Findings**
Results have improved in this area this year, reducing from a likelihood of 2.23 last year to 1.89 this year. Whilst global majority applicants are still less likely to be appointed than white applicants, efforts have been focused on trying to ensure inclusive recruitment processes are in place and positive progress can therefore be seen this year. Efforts will continue in this area to support further improvements and strive for equity of likelihood.

# Indicator 3

This indicator relates to the relative likelihood of global majority staff entering the formal disciplinary process, compared with that of white staff.

**Key Findings:**
In 2025/26, 69 people entered the disciplinary process. 7 staff were global majority, 55 were white (including any “white ethnic group”) and 12 people have an undisclosed ethnicity.

This data highlights that global majority staff are less likely to enter the disciplinary process than white staff, with a relative likelihood of 0.69, reducing further from 0.87.

# Indicator 4

**Relative likelihood of global majority staff accessing non-mandatory training and CPD.**

**Key Findings**

Data highlights that global majority staff have an equal likelihood (1.0) of accessing non-mandatory training and CPD as with white colleagues.

# National NHS Staff Survey Findings

The next 4 indicators are taken directly from the staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

# Indicator 5

**The chart below highlights the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.**

| | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|
| Global Majority Staff | 27.80% | 25.60% | 30.03% | 28.15% | 30.42% |  | 28.98% |
| White staff | 23.40% | 22.80% | 21.25% | 21.32% | 21.91% |  | 22.93% |

# Indicator 6

**The chart below highlights the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.**

| | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|
| Global Majority Staff | 26.20% | 21.57% | 28.93% | 22.01% | 22.73% |  | 24.06% |
| White staff | 24.80% | 21.48% | 22.35% | 19.98% | 19.33% | | 20.48% |

# Indicator 7

**The chart below shows the percentage believing that the Trust provides equal opportunities for career progression or promotion.**

Annual data is however not available due to a change in the national question.

| | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|
| Global Majority Staff | Data not comparable | | | | 47.68% | | 47.68% |
| White staff | | | | | 52.47% | | 52.47% |

# Indicator 8

**In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**

| | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|
| Global Majority Staff | 15.60% | 13.60% | 17.36% | 16.89% | 20.07% |  | 14.70% |
| White staff | 6.00% | 5.60% | 5.86% | 5.12% | 4.65% | | 6.40% |

# Indicator 9

**Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:**

- **By voting membership of the Board**
- **By executive membership of the Board**

**Key Finding:**
The Trust has 17 Board members, 12 of whom are voting members and 11 identify as white (which includes all white categories as defined within ESR).

This gives a percentage difference for both the Trust boards voting and executive membership and its overall workforce of – 9.0%, as the overall workforce representation is increasing, the gap has widened from -7.6% last year.

# Conclusion and Next Steps

Data shows improvement in 3 of 8 comparable WRES indicators:

- Global majority representation increased from 14.70% to 15.24%, with improvements across clinical and non-clinical roles despite ongoing gaps.
- The relative likelihood of global majority applicants being appointed from shortlisting improved from 2.23 to 1.89.
- The relative likelihood of entering the formal disciplinary process improved from 0.87 to 0.69, however now suggests global majority staff are less likely to be disciplined. Further work is needed to sustain progress and move towards equal likelihood across these indicators.

Staff survey data shows decline in several staff experience indicators for global majority colleagues:

- Harassment, bullying or abuse from patients, relatives or the public increased from 28.15% to 30.42%, now above the national average.
- Harassment, bullying or abuse from staff increased from 22.01% to 22.73%, while white staff reported improvement.
- Reported discrimination from managers, team leaders or colleagues increased from 16.89% to 20.07%, significantly above the national average.

Only 47.68% of global majority staff believe the Trust provides equal opportunities for career progression or promotion. Annual comparison is unavailable due to a national question change, but results for global majority and white staff remain below the national average.

**Next Steps**

Findings will be reviewed alongside wider EDI dashboard metrics, the North-west Race Equity Assembly Anti-racism framework, the Lord Mann review recommendations and NHS Race and Health Observatory guidance.

Priority actions include:

1) Adopting the Lord Mann review recommendations;
2) Establishing an anti-racism co-creation group;
3) Supporting and growing the integrated multicultural and BAME staff network;
4) Triangulating staff experience data with employee relations and FTSU information where possible;
5) Providing further training and support on identifying and addressing racist attitudes and behaviours.

Appendix A

# WRES Indicator Summary table for NHS trusts in England compared to WUTH

| WRES Indicator | | | Acute Average 2025 | WUTH 2023-24 | WUTH 2024-25 | WUTH 2025-26 |
|---|---|---|---|---|---|---|
| 1 | % of BME staff | **Overall** | | 13.66% | 14.70% | **15.24%** |
| | | **VSM** | | 0% | 13.80% | **0.00%** |
| | | **Clinical** | | 18.75% | 19.86% | **20.42%** |
| | | **Non-Clinical** | | 3.01% | 3.31% | **3.90%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | | 2.02 | 2.23 | 1.89 |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff (metric definition method changed) | | | 0.6 | 0.87 | 0.69 |
| 4 | Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff | | | 1 | 1 | 1 |
| 5 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | **BME** | **28.98%** | 30.03% | 28.15% | **30.42%** |
| | | White | 22.93% | 21.25% | 21.32% | **21.91%** |
| 6 | % of staff experiencing harassment, bullying or abuse from staff in the last 12 months | **BME** | **24.06%** | 28.93% | 22.01% | **22.73%** |
| | | White | 20.48% | 22.35% | 19.98% | **19.33%** |
| 7 | % of staff believing that the Trust provides equal opportunities for career progression or promotion | **BME** | **49.11%** | Data not comparable | | **47.68%** |
| | | White | 55.46% | | | **52.47%** |
| 8 | % of staff personally experiencing discrimination at work from a manager, team leader or other colleagues | **BME** | **14.70%** | 17.36% | 16.89% | **20.07%** |
| | | White | 6.40% | 5.86% | 5.12% | **4.65%** |
| 9 | Board membership (Total) | | | | -7.60% | **-9.00%** |

Key:

| | |
|---|---|
| | ≥ last year and ≥ the national average |
| | ≥ last year < national average **or** < last year ≥ national average |
| | < last year and < national average |

Appendix B

# Workforce Race Equality Standard (WRES) Objectives 2025/26 - Update

Wirral University Teaching Hospital NHS Foundation Trust

| Objective | Deliverable / Output | Progress | Comments |
|---|---|---|---|
| Deliver the 2025 elements of the NHS England EDI High Impact Actions | 1) Development of an EDI Dashboard that incorporates NHSE High Impact Actions | Complete | |
| | 2) Robust reporting of High Impact Actions through workforce governance | Complete | |
| | 3) Recruitment audit undertaken on a quarterly basis | Complete | Audit completed however due to complications, agreement reached at Workforce Steering Board not to continue and to focus on inclusive recruitment support for managers. |
| | 4) Relative likelihood of staff being appointed from shortlisting, monitored for all protected characteristics | Complete | Included in dashboard and improvement seen in the relative likelihood of appointment for global majority applicants. |
| | 5) Undertake a review to identify the experience of career progression for staff who hold protected characteristics | Red | Action postponed |
| | 6) Development and implementation of an inclusive recruitment toolkit | Complete | Action reviewed and recruitment guidelines in place and emphasis placed on inclusive recruitment sessions. Sessions incorporated within manager essentials programme and standalone sessions scheduled. |
| Implement regular Cultural assessment at Trust and divisional level. | 1) Agree a methodology for assessing and monitoring culture<br>2) Monitoring tool / dashboard developed<br>3) Divisions are engaged and understand framework for assessing and monitoring culture<br>4) Data triangulation undertaken, with key findings and analysis embedded within Trust reporting processes. | Red | Number of options reviewed and considered however postponed until 2026/26 following Corporate Service organisational change. |
| Work with BAME Staff to support speaking upon bullying and harassment | 1) Increase in number of BAME FTSU Champions with particular targeting wards / services with higher number of internationally recruited staff | Complete and ongoing | |
| | 2) Facilitate a number of BAME staff to become "role models" sharing key messages to encourage colleagues to speak up - One role model per division | Complete and ongoing | Reviewed with EDI Steering group and agreed that role is the same as FTSU Champion and numbers increased. |
| | 3) BAME staff representation at Trust violence and aggression working group to ensure lived experience is represented | Complete | Staff experiences shared as part of listening events and network meetings. V&A working group stalled due to change in executive lead, however feedback captured and shared as able. |
| | 4) Series of listening events for BAME staff with Chief People Officer to continue to identify opportunities to address bullying and harassment | Complete | Events held and feedback shared with network co-chairs and members and actions ongoing. |

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

# Workforce Disability Equality Standards (WDES) Report

July 2026

Sharon Landrum, Head of Culture and Workforce Experience

together we will

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# Background

Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that have been reviewed as part of a consultation process with NHS staff across the country and seek to enable Trust to compare the experiences of disabled and non-disabled staff.

Full details of the metrics are attached at Appendix i.

The WDES has been mandated by the NHS Standard Contract since 1 April 2019 and all Trusts must ensure data is uploaded to a government portal by no later than 31 May each year. Detailed reports including action plans to address areas of further work needed must also be developed and made public by no later than 31 October.

WUTH has declared its commitment to supporting staff to feel they belong in our organisation as outlined in our People Strategy 2022 – 2026 and to address areas of inequality. This is delivered through our equality, diversity and inclusion strategic commitment:

**"To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated".**

WUTH is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- To eliminate unlawful harassment and victimisation.
- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

WDES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

# Executive Summary

WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.

Appendix i outlines the national indicators that the Trust is required to submit data for and monitor progress against.

Appendix ii provides a summary overview of the Trust's performance against the required indicators, compared to national averages.

Data shows improvements in 6 of 12 comparable WDES indicators this year:

1) Representation of disabled staff continues to increase year on year, increasing from 3.8% to 4.2%. Representation does however continue to be low and therefore work will continue to encourage and support staff to update ESR records.
2) Less disabled staff are experiencing bullying, harassment and abuse from patients, relatives or the public and also from managers and colleagues this year. All three of these elements are also better than the national average scores.
3) More disabled staff feel that adequate adjustments have been made to enable them to carry out their work.
4) Disabled representation at Board level has increased this year to 13.45%.

However, areas of decline this year are:

1) Staff engagement scores continue to decline;
2) Disabled staff are less satisfied with the extent to which the organisation values their work;
3) Disabled staff feel more pressure to come to work when not feeling well enough this year.

Results for all three areas have also declined for non-disabled staff, however all are also below national average scores.

Additional areas of decline are:

4) Less staff are reporting experiences of bullying, harassment or abuse at work, with reductions seen for both disabled and non-disabled staff.
5) There is an increased likelihood of staff entering the capability procedure this year, although numbers are extremely small and therefore should be monitored closely for 2026.
6) Disabled applicants are less likely to be appointed than non-disabled applicants, reducing from 1.0 to 1.46 this year.

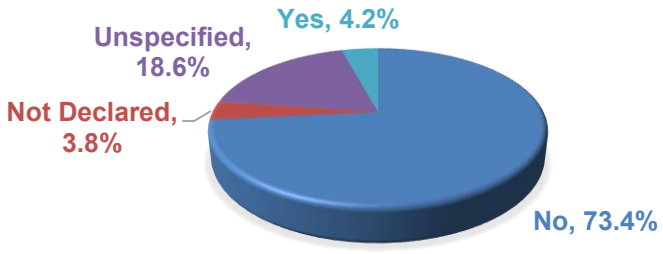
One metric is unable to be compared to previous annual data (% of staff believing the Trust provides equal opportunities for career progression or promotion), due to changes in the question. Data is however low and below the national average.

Appendix iii provides a summary overview of key actions required to sustain and improve further the experiences of our disabled staff.

# Metric 1

### Staff breakdown for 2025/26 (all staff)

As of 31st March 2026, the self-reporting rate for those staff with a disability within WUTH is 4.2%, 294 people (as entered on staff ESR records). This has continued to improve on a marginal basis each year, rising from 3.8% (263 people) last year. Whilst it is positive to see continued improvements in declaration rates, rates continue to still be low, with 18.6% of staff ESR records still remining unspecified. This element is however continuing to reduce gradually year on year from 20.5% last year. Work will therefore continue to support improvements in declaration rates.




**Workforce Disability Status as at 31 March 2026**

Data shows slight improvements in representation of disabled staff across both clinical and non-clinical roles, with the biggest improvement seen however within non-clinical roles, improving from 4.2% (94 staff) in 2023/4 to 4.9% (104 staff) this year. Clinical staff representation has increased from 3.2% (150 staff) to 3.4% (159 staff) this year.

Breakdown of workforce data by disability status as of 31 March 2025 and compared to 2023/4 data.

**Chart 2 - Breakdown of disability declaration categories by clinical and non-clinical as of 31 March 2025.**

| | Total Clinical Staff | % of clinical | Total non-clinical | % of non-clinical | Combined 2026 | % overall 2026 | % overall 2025 |
|---|---|---|---|---|---|---|---|
| **Disabled** | 155 | 3.7% | 118 | 5.4% | 294 | 4.2% | 3.8% |
| **Non-disabled** | 3112 | 74.7% | 1511 | 68.8% | 5134 | 73.41% | 71.7% |
| **Unknown** | 897 | 21.5% | 566 | 25.8% | 1566 | 22.4% | 20.5% |
| **Total** | 4164 | 100.0% | 2195 | 100.0% | 6994 | 100.0% | 100.0% |

Whilst numbers of disabled staff continue to increase year on year, work continues to encourage and support staff to update their disability status within ESR to ensure a fully reflective position.

**Percentage of staff in A4C paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce as of 31 March 2026.**

*Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.*

## Clinical Staff

| | # Disabled | % Disabled | # Non-disabled | % Non-disabled | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 1 | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Bands 2 | 14 | 4.35% | 278 | 86.34% | 30 | 9.32% | 322 |
| Bands 3 | 25 | 3.18% | 584 | 74.39% | 176 | 22.42% | 785 |
| Bands 4 | 11 | 6.40% | 113 | 65.70% | 48 | 27.91% | 172 |
| Bands 5 | 54 | 4.37% | 964 | 77.93% | 219 | 17.70% | 1237 |
| Bands 6 | 32 | 3.67% | 630 | 72.33% | 209 | 24.00% | 871 |
| Bands 7 | 12 | 2.45% | 341 | 69.73% | 136 | 27.81% | 489 |
| Bands 8a | 5 | 2.39% | 145 | 69.38% | 59 | 28.23% | 209 |
| Bands 8b | 2 | 3.57% | 38 | 67.86% | 16 | 28.57% | 56 |
| Bands 8c | 0 | 0.00% | 13 | 76.47% | 4 | 23.53% | 17 |
| Bands 8d | 0 | 0.00% | 4 | 100.00% | 0 | 0.00% | 4 |
| Bands 9 | 0 | 0.00% | 2 | 100.00% | 0 | 0.00% | 2 |
| VSM | 0 | 0.00% | 0 | 0.00% | 0 | 0.00% | 0 |
| Other. Please specify in notes. | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 50 | 3.9% | 975 | 76.2% | 254 | 19.9% | 1279 |
| Cluster 2: AfC bands 5 to 7 | 98 | 3.8% | 1935 | 74.5% | 564 | 21.7% | 2597 |
| Cluster 3: AfC bands 8a and 8b | 7 | 2.6% | 183 | 69.1% | 75 | 28.3% | 265 |
| Cluster 4: AfC bands 8c to VSM | 0 | 0.0% | 19 | 82.6% | 4 | 17.4% | 23 |
| Total Clinical | 155 | 3.7% | 3112 | 74.7% | 897 | 21.5% | 4164 |
| Medical & Dental Staff, Consultants | 4 | 1.21% | 252 | 76.13% | 75 | 22.66% | 331 |
| Medical & Dental Staff, Non-Consultants career grade | 2 | 3.23% | 45 | 72.58% | 15 | 24.19% | 62 |
| Medical & Dental Staff, Medical and dental trainee grades | 15 | 6.20% | 214 | 88.43% | 13 | 5.37% | 242 |
| Total Medical and Dental | 21 | 3.31% | 511 | 80.47% | 103 | 16.22% | 635 |
| Number of staff in workforce | 294 | 4.20% | 5134 | 73.41% | 1566 | 22.39% | 6994 |

## Non-clinical Staff

| | # Disabled | % Disabled | # Non-disabled | % Non-disabled | # Unknown/Null | % Unknown/Null | Total |
|---|---|---|---|---|---|---|---|
| Under Band 1 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Bands 1 | 1 | 1.3% | 26 | 32.5% | 53 | 66.3% | 80 |
| Bands 2 | 51 | 5.2% | 687 | 70.2% | 241 | 24.6% | 979 |
| Bands 3 | 20 | 5.4% | 248 | 67.4% | 100 | 27.2% | 368 |
| Bands 4 | 14 | 4.7% | 197 | 66.8% | 84 | 28.5% | 295 |
| Bands 5 | 7 | 4.9% | 108 | 75.0% | 29 | 20.1% | 144 |
| Bands 6 | 8 | 8.2% | 69 | 70.4% | 21 | 21.4% | 98 |
| Bands 7 | 7 | 7.9% | 62 | 69.7% | 20 | 22.5% | 89 |
| Bands 8a | 6 | 11.3% | 39 | 73.6% | 8 | 15.1% | 53 |
| Bands 8b | 1 | 2.3% | 38 | 88.4% | 4 | 9.3% | 43 |
| Bands 8c | 1 | 5.3% | 16 | 84.2% | 2 | 10.5% | 19 |
| Bands 8d | 0 | 0.0% | 12 | 85.7% | 2 | 14.3% | 14 |
| Bands 9 | 1 | 33.3% | 2 | 66.7% | 0 | 0.0% | 3 |
| VSM | 1 | 10.0% | 7 | 70.0% | 2 | 20.0% | 10 |
| Other. Please specify in notes. | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Cluster 1: AfC Bands <1 to 4 | 86 | 5.0% | 1158 | 67.2% | 478 | 27.8% | 1722 |
| Cluster 2: AfC bands 5 to 7 | 22 | 6.6% | 239 | 72.2% | 70 | 21.1% | 331 |
| Cluster 3: AfC bands 8a and 8b | 7 | 7.3% | 77 | 80.2% | 12 | 12.5% | 96 |
| Cluster 4: AfC bands 8c to VSM | 3 | 6.5% | 37 | 80.4% | 6 | 13.0% | 46 |
| Total Non-Clinical | 118 | 5.4% | 1511 | 68.8% | 566 | 25.8% | 2195 |

# Metric 2

This refers to the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Data for this indicator has declined slightly this year reducing from an equal likelihood last year to 1.46 this year, with disabled applicants less likely to be appointed at interview this year.

# Metric 3

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year.

Results this year have seen a decline, reducing from 0 to 5.82 this year. Number of staff entering the formal capability process during the last two years has however been particularly low, with only one disabled staff member identified. Further work will be undertaken this year to improve recoding data for Employee relations cases.

# National NHS Staff Survey Findings

Metrics 4 - 8 are taken directly from the staff survey results and relate to staff experiences of bullying and harassment, career progression opportunities and personally experienced discrimination. A summary overview can also be found at appendix ii.

# Metric 4

Results of this metric are based on Q14 of the National Staff survey.

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months (chart 1)
   ii) Managers (chart 2)
   iii) Other colleagues (chart 3)

*Chart 1 (4a.1) - Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months*

| Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 34.40% | 31.86% | 24.85% | 27.54% | 28.63% | 28.83% | 28.68% | 28.37% | | 29.14% |
| | Non-disabled staff | 23.90% | 23.95% | 20.60% | 22.64% | 21.68% | 20.17% | 19.79% | 20.82% | | 22.64% |

*Chart 2 (4a.2) - % of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months*

| Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 26.30% | 23.65% | 18.09% | 18.64% | 15.88% | 14.98% | 14.72% | 11.02% | | 14.12% |
| | Non-disabled staff | 15.50% | 14.59% | 12.26% | 11.64% | 9.89% | 9.32% | 8.00% | 8.60% | | 7.60% |

*Chart 3 (4a.3) - Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months*

| Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 34.90% | 28.74% | 25.40% | 25.19% | 21.87% | 24.72% | 24.09% | 20.86% | | 24.45% |
| | Non-disabled staff | 19.50% | 19.35% | 15.61% | 17.49% | 14.92% | 16.25% | 13.56% | 12.80% | | 15.57% |

*Chart 4 (4b) - % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it*

| Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 34.90% | 28.74% | 25.40% | 25.19% | 21.87% | 24.72% | 24.09% | 20.86% | | 24.45% |
| | Non-disabled staff | 19.50% | 19.35% | 15.61% | 17.49% | 14.92% | 16.25% | 13.56% | 12.80% | | 15.57% |

# Metric 5

This metric is also taken from the national staff survey results and is the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Q15).

Changes were made to the question this year and therefore annual comparative data is unavailable.

| Percentage believing that trust provides equal opportunities for career progression or promotion | 2025 | National Average 2025 |
|---|---|---|
| Disabled staff | 46.28% | 47.70% |
| Non-disabled staff | 54.09% | 55.09% |

# Metric 6

This metric is again taken from the national staff survey results (Q11e) and looks at the percentage of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties.

| % of of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 39.90% | 35.13% | 30.00% | 32.15% | 30.67% | 27.84% | 25.57% | 27.74% | | 27.19% |
| | Non-disabled staff | 26.80% | 23.44% | 27.56% | 25.74% | 25.29% | 21.62% | 19.03% | 21.85% | | 18.19% |

# Metric 7

This metric looks at the percentage of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work (Q4b).

| % of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work (Q4b). | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 29.10% | 32.48% | 30.12% | 28.85% | 32.42% | 30.43% | 31.53% | 26.67% | | 32.09% |
| | Non-disabled staff | 40.80% | 44.13% | 44.30% | 40.20% | 41.23% | 42.93% | 41.44% | 36.63% | | 45.10% |

# Metric 8

This metric is also taken from the national staff survey results and seeks to identify the number of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b)

| % of disabled staff compared with non-disabled staff saying saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b) | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 66.50% | 72.90% | 75.40% | 70.20% | 71.10% | 70.80% | 70.40% | 72.39% | | 73.65% |

# Metric 9

This metric is also taken from the national staff survey results and comprises of two elements:

a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall staff engagement score for the organisation.

b) Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?

**Part a - Staff Engagement Scores**

| Staff Engagement Score | | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Trend | National Average 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Disabled staff | 6.3 | 6.39 | 6.45 | 6.28 | 6.26 | 6.19 | 6.07 | 5.92 | | 6.40 |
| | Non-disabled staff | 6.8 | 6.93 | 6.94 | 6.8 | 6.82 | 6.86 | 6.75 | 6.52 | | 7.00 |

**Part b**

A number of actions have taken place to facilitate the voices of disabled staff.

The Trust has a Sunflowers Staff network for staff with disabilities and long-term conditions. The network has two staff co-chairs and an Executive Sponsor.

In May 2026, as part of National Staff Network Day, information was shared across the Trust to promote the network, with stalls held to reach out and engage with staff.

The trust continues to approve half a day per month per network for all network co-chairs, with a toolkit developed including terms of reference for each group and a development plan for co-chairs. A small budget is allocated for network activities as part of the Inclusion budget.

Staff network leads continue to meet with co-chairs of other networks, to ensure support and also an intersectional approach is fostered. Network leads are also members of the Trusts EDI steering group, coming together to share updates on network activities and contribute to shaping policies and processes and ultimately working together for a more inclusive culture.

The network has now integrated with Wirral Community Health and Care Trust's Ability network and new Executive Sponsor has been identified. 2026/27 will focus on building the integrated network further.

Regular communications are produced to raise awareness of key national and international awareness days and links made to areas for consideration, action needed and support services available for both staff and patients.

The Trust's EDI strategic commitment underpins the Trust's People Strategy and seeks to ensure that Inclusion is a golden thread throughout all our people practices and processes.

EDI sessions are also held as part of Manager Essential and Leading Teams programmes, within the themes of Compassionate Leadership and Inclusive Recruitment being delivered, along with neurodiversity awareness; deaf awareness and dedicated session for coaches on supporting neurodiverse staff.

# Metric 10

**Percentage difference between the organisations Board voting membership and its overall workforce disaggregated:**

- **By voting membership of the Board**
- **By executive membership of the Board**

The Trust has 17 Board members 12 of whom are voting members. 3 have declared a disability status and 1 does not have a disability status recorded. This gives a percentage difference for the Trust board overall as 13.45%.

# Conclusion

Data shows improvements in 6 of 12 comparable WDES indicators this year:

1) Representation of disabled staff continues to increase year on year, increasing from 3.8% to 4.2%. Representation does however continue to be low and therefore work will continue to encourage and support staff to update ESR records.
2) Less disabled staff are experiencing bullying, harassment and abuse from patients, relatives or the public and also from managers and colleagues this year. All three of these elements are also better than the national average scores.
3) More disabled staff feel that adequate adjustments have been made to enable them to carry out their work.
4) Disabled representation at Board level has increased this year to 13.45%.

However, areas of decline this year are:

1) Staff engagement scores continue to decline;
2) Disabled staff are less satisfied with the extent to which the organisation values their work;
3) Disabled staff feel more pressure to come to work when not feeling well enough this year.

Results for all three areas have also declined for non-disabled staff, however all are also below national average scores.

Additional areas of decline are:

4) Less staff are reporting experiences of bullying, harassment or abuse at work, with reductions seen for both disabled and non-disabled staff.
5) There is an increased likelihood of staff entering the capability procedure this year, although numbers are extremely small and therefore should be monitored closely for 2026.
6) Disabled applicants are less likely to be appointed than non-disabled applicants, reducing from 1.0 to 1.46 this year.

One metric is unable to be compared to previous annual data (% of staff believing the Trust provides equal opportunities for career progression or promotion), due to changes in the question. Data is however low and below the national average.

Appendix iii provides a summary overview of key actions required to sustain and improve further the experiences of our disabled staff.

# WDES Metrics

| | |
|---|---|
| **Workforce Metrics**<br>For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff. | |
| **Metric 1** | **Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.**<br>Organisations should undertake this calculation separately for non-clinical and for clinical staff.<br><br>Cluster 1: AfC Band 1, 2, 3 and 4<br>Cluster 2: AfC Band 5, 6 and 7<br>Cluster 3: AfC Band 8a and 8b<br>Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)<br>Cluster 5: Medical and Dental staff, Consultants<br>Cluster 6: Medical and Dental staff, Non-consultant career grade<br>Cluster 7: Medical and Dental staff, Medical and dental trainee grades<br><br>**Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes. |
| **Metric 2** | **Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.**<br><br>**Note:**<br>i) This refers to both external and internal posts.<br>ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations. |
| **Metric 3** | **Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**<br><br>**Note:**<br>i) This Metric will be based on data from a two-year rolling average of the current year and the previous year.<br>ii) This Metric is voluntary in year one. |
| **National NHS Staff Survey Metrics**<br>For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff. | |
| **Metric 4**<br>Staff Survey Q13 | **a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:**<br>i. Patients/service users, their relatives or other members of the public<br>ii. Managers<br>iii. Other colleagues<br><br>**b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** |

# WDES Metrics

| | |
|---|---|
| Metric 5<br>Staff Survey<br>Q14 | **Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.** |
| Metric 6<br>Staff Survey<br>Q11 | **Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** |
| Metric 7<br>Staff Survey<br>Q5 | **Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.** |
| **The following NHS Staff Survey Metric only includes the responses of Disabled staff** | |
| Metric 8<br>Staff Survey<br>Q28b | **Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.** |
| **NHS Staff Survey and the engagement of Disabled staff**<br>For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score<br>For part b) add evidence to the Trust's WDES Annual Report | |
| Metric 9 | **a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**<br><br>**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)**<br><br>**Note: For your Trust's response to b)**<br>**If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no,** please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance. |
| **Board representation Metric**<br>For this Metric, compare the difference for Disabled and non-disabled staff. | |
| Metric 10 | Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:<br><br>• By voting membership of the Board.<br>• By Executive membership of the Board. |

Appendix ii

# 2025/6 WDES Indicator Summary of Indicators Compared to Regional and National Comparators

| WDES Indicator | | | Acute Average 2025 where available / Aim | WUTH 2023-24 | WUTH 2024-25 | WUTH 2025-26 |
|---|---|---|---|---|---|---|
| 1 | % of disabled staff | | | 3.6% | 3.8% | **4.2%** |
| 2 | Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts | | | 1.19 | 1 | **1.46** |
| 3 | Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process (metric definition method changed) | | | 0 | 0 | **5.82** |
| 4a.1 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | **Disabled** | **29.14%** | 28.83% | 28.68% | **28.37%** |
| | | Non-Disabled | 22.64% | 20.17% | 19.79% | 20.82% |
| 4a.2 | % of staff experiencing harassment, bullying or abuse from managers in the last 12 months | **Disabled** | **14.12%** | 14.98% | 14.72% | **11.02%** |
| | | Non-Disabled | 7.60% | 9.32% | 8.00% | 8.60% |
| 4a.3 | % of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months | **Disabled** | **24.45%** | 24.72% | 24.09% | **20.86%** |
| | | Non-Disabled | 15.57% | 16.25% | 13.56% | 12.80% |
| 4b | % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it | **Disabled** | **53.16%** | 53.07% | 58.77% | **56.84%** |
| | | Non-Disabled | 52.89% | 49.32% | 54.27% | 51.41% |
| 5 | % of staff believing that the Trust provides equal opportunities for career progression or promotion* (previous years not comparable) | **Disabled** | **47.79%** | | | **46.28%** |
| | | Non-Disabled | 55.09% | | | 54.09% |
| 6 | % of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties | **Disabled** | **27.19%** | 27.84% | 25.57% | **27.74%** |
| | | Non-Disabled | 18.19% | 21.62% | 19.03% | 21.85% |
| 7 | % of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work. | **Disabled** | **32.09%** | 30.43% | 31.53% | **26.67%** |
| | | Non-Disabled | 45.10% | 42.93% | 41.44% | 36.63% |
| 8 | % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work | **Disabled** | **73.69%** | 70.79% | 70.40% | **72.39%** |
| 9a | Staff engagement score | **Disabled** | **6.29%** | 6.19 | 6.07 | **5.92** |
| | | Non-Disabled | 6.91% | 6.86 | 6.75 | 6.52 |
| 9b | Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard? | | N/A | Yes | Yes | Yes |
| 10 | Board membership (difference) | | | -4% | -4% | **13.45%** |

Key:

| | |
|---|---|
| | ≥ last year and ≥ the national average |
| | ≥ last year < national average **or** < last year ≥ national average |
| | < last year and < national average |

# WDES Action Plan for 2026-27

| Elements | | Action | Deadline |
|---|---|---|---|
| **Seek to Understand** | 1 | Build new joint WCHC and WUTH staff network to support staff meeting together; sharing experiences, seeking support and empowering staff to speak up. | 31/12/2026 |
| | 2 | Positive action to be taken in areas of low satisfaction with reasonable adjustments and higher levels of bullying, harassment or abuse and lower levels of satisfaction with speaking up. | 30/09/2026 |
| **Support** | 3 | Review Trust policy and processes in conjunction with WCHC to ensure accessible support. | 31/03/2027 |
| | 4 | Undertake case reviews to support wider learning and share best practice | 31/03/2027 |
| **Educate and Develop** | 5 | Deliver enhanced training and awareness opportunities including e.g. Deaf awareness; inclusive recruitment; access to work; neurodiversity and autism awareness and advice and support for managers on implementing reasonable adjustments. | 31/03/2027 |
| | 6 | Review integration of access to work processes and recommendations with a particular focus on procurement of items to support reasonable adjustments. | 31/03/2027 |
| **Celebrate and Promote** | 7 | Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support | Ongoing |
| | 8 | Launch and promote actions achieved by the ability network as part of the wider campaign of inclusion network achievements | Ongoing |

# Appendix 4 - Workforce Equality, Diversity and Inclusion (EDI) Update Summary – Sep 2026

## Setting Direction

- EDI Strategic Commitment (including objectives) launched for 2022- 2026 and underpins WUTH's People Strategy with annual key deliverables
- Staff networks involved in decision making processes and shaping future improvements at WCHC
- Member of regional network to support collaborative working across the ICB.
- EDI Objectives set for all Exec and Non-Exec Directors
- NHSE EDI Improvement actions integrated with existing EDI actions
- Menopause Policy and Preventing Sexual Misconduct Policy.
- Listening events held for Global Majority staff
- EDS 2025 assessment completed and published
- WRES and WDES data reviewed with staff networks

**What's next…**

- Anti-racism co-creation group
- Development of new integrated strategic priorities
- Building integrated staff networks

## Development, Education and Awareness

- 93% compliance with EDI mandatory training (Aug)
- MHFA programme launched
- Deaf awareness offered to staff
- Race equality masterclasses and workshops held and guest speakers at networks
- Launch of mandatory sexual safety training
- Reasonable adjustments and supporting staff with disabilities sessions held
- EDI embedded within all leadership and management programmes - Inclusive Recruitment and Inclusive Leadership sessions delivered.
- Coaching conference held with focus on neurodiversity and menopause
- Crucial conversations
- Career clinics held for global majority staff

**What's next…**

- Neurodiversity awareness
- Trans awareness
- Active Bystander

## Monitoring and Assurance

- Annual monitoring of workforce demographics
- EDS and Gender pay gap reporting completed
- New reporting cycle implemented and working well, with EDI Bi-Annual reporting commenced
- New EDI dashboard
- Veteran Aware review approved
- Board EDI objectives in place
- Revised staff survey campaign approach to increase staff voice
- Staff experience triangulation methodology developed to further understand experiences of non-white staff
- Quarterly LEAF reporting to NHS North West

**What's next…**

- Focus on workforce culture and identification of key metrics

## Communications

- Regular Trust communications to promote key events , and information and key messages from the Board
- Staff networks included in Get Together briefs
- EDI webpages updated with key reports
- Reachdeck software installed on Trust website
- Comms campaigns to promote Race equality, Sexual Safety and Staff Safety

**What's next…**

- Enhanced promotion of staff networks

## Events

- Flag raising for PRIDE month and armed forces week
- Range of events that support awareness raising for patient and staff support
- Support of various national and international awareness days/weeks and months e.g. International Women and Mens Day, Race Equality Week and menopause month
- Departmental events e.g. Culture Days
- Remembrance Day events, including service on site and at local Cenotaph
- National Day of staff networks promotional stalls
- WCHC and WUTH stall at New Brighton pride event

## Staff Support

- Six staff networks in place
- Armed Forces network refreshed and working across both trusts
- Network chairs "buddying" with colleagues from WUTH
- Staff sharing experiences to help others
- New staff menopause leaflet launched
- OH service, including 24/7 employee assistance programme
- Access to online wellbeing app Pleaz (pilot)
- New process and support pathway for disabled staff
- Listening events held for non-white staff

**What's next…**

- Demographic monitoring at directorate level to be developed

- Veteran Aware Accreditation
- Merseyside In Touch Navajo LGBTIQA+
- Defence Employer Recognition Scheme (DERS)Silver Level Achieved
- Disability Confident Employer
- Anti-Racist Framework Bronze status

**What's next…**

- Re-accreditation of Veteran Aware

**Anti-Racism, Antisemitism and Anti-Muslim Hostility Action Plan, in Response to Lord Mann's Review and NHS England Request**

| No | Recommendation | Responsibility | Date | Progress | Comments |
|---|---|---|---|---|---|
| 1 | To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles | People Experience | 30/09/2026 | Green | Included within EDI Biannual report 1 for review and approval |
| 2 | Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework | H&S | tbc | Red | Implementation stalled. |
| 3 | Prepare to implement the forthcoming NHS Staff Standards | People Experience | 31/03/2027 | Green | Standards reviewed and key areas identified and currently under review with workforce leads. |
| 4 | Adopt the new government definition of anti-Muslim hostility | People Experience | 31/07/2026 | Green | Recommended as part of EDI Biannual report 1 and approved at EDI steering group and WSB and progressing through workforce governance structures as part of appropriate workforce policies. |
| 5 | Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia | People Experience & L&D | 31/09/2026 | Complete | 93% for WUTH and 97% for WCHC |
| 6 | Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months) | People Experience & L&D | | | Awaiting publication |
| 7 | Ensure Board agreement to undertake new anti-racism training when it becomes available. | Chief People Officer | 31/09/2026 | Green | Request included as part of EDI Biannual report 1 for review and discussion with Board. Agreement can be reached in principle, however would need to be further considered following the programme launch. |
| 8 | Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally | People Experience | Ongoing | Green | Initial statement issued on 10.06.26 promoting the recommendations and the Trusts commitment to adopting. Ongoing communications to be completed |
| 9 | Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress. | Chief People Officer | 31/03/27 | Green | Staff survey 2025 data presented as standalone updates and as part of Staff Experience and EDI update reports. Further review to be undertaken with 2026 data. |

**WCHC Board of Directors in Public** **Item No 29**
**4 November 2026**

| | |
|---|---|
| **Title** | Equality, Diversity and Inclusion (EDI) Bi-Annual Report including: Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) |
| **Area Lead** | Carla Burns, Associate Chief People Officer |
| **Author** | Sharon Landrum, Head of Culture and Workforce Experience |
| **Report for** | Information |

## Executive Summary and Report Recommendations

This bi-annual EDI report provides assurance that WCHC is meeting its statutory and regulatory equality obligations, including requirements under the Equality Act 2010, Public Sector Equality Duty, WRES and WDES reporting. All current reporting requirements are complete or on track, with WRES and WDES narrative reports requiring approval for publication.

The report highlights progress in workforce representation, including increased representation of Global Majority staff, disabled staff and LGB staff. However, workforce demographics remain significantly female, and further focus is needed on increasing representation of male staff and younger staff aged 20 and under.

The EDI dashboard identifies mixed performance across staff experience measures. Positive progress includes improved likelihood of appointment for Global Majority applicants and continued reporting of disabled staff representation. However, concerns remain around declining staff experience for LGB+ staff, disabled staff and male staff, including lower inclusion, engagement and career progression scores, as well as increased reports of bullying, harassment, discrimination and experiences of a sexual nature for some groups.

WRES data shows improvement in representation, recruitment outcomes and disciplinary likelihood for Global Majority staff, but worsening staff experience indicators relating to harassment, bullying and discrimination.

WDES data shows some improvements, including increased disability declaration and reduced harassment from patients/public and managers, but also highlights concerns around engagement, reasonable adjustments, presenteeism, colleague harassment and reduced reporting.

The Trust continues to advance its EDI agenda through staff networks, training, accreditation work, equality analysis, anti-racism activity and alignment with WUTH as part of wider organisational integration.

Key priorities for 2026/27 include improving disabled staff experience, better understanding and supporting LGB+ staff, strengthening joint staff networks, embedding anti-racism, and securing Veteran Aware reaccreditation.

Board members are asked to note the current position regarding race equity, the action plans developed in response to the Lord Mann review, and the new national and regional requirements, including the inclusion of tackling racism within the new NHS staff standards.

Board members are also asked to note the progress made to date and to ratify adoption of the antisemitism and anti-Muslim hostility definitions and the Race and Health Observatory seven anti-racism principles.

Board members are asked to note the report for publication, including WRES and WDES narrative reports.

| Key Risks |
|---|
| This report relates to the following key risks:<br>Board Assurance Framework ID08: Our People inclusion intensions are not delivered; people are not able to thrive as employees of our trust and the workforce is not representative of our population – 3x4 (12)<br>Risk Appetite: Moderate<br>There are no new risks identified based on the content of this report. |

| Contribution to Integrated Care System objectives (Triple Aim Duty): | |
|---|---|
| **Better health and wellbeing for everyone** | Yes |
| **Better quality of health services for all individuals** | 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 | No |

| 1 | Background and Introduction to EDI requirements |
|---|---|
| **1.1** | Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations:<br>• To eliminate unlawful harassment and victimisation.<br>• To foster good relations between people who share a protected characteristic and those who do not.<br>• To advance equality of opportunity between people who share a protected characteristic and those who do not. |

In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED.

The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate.

This report is one of two EDI specific bi-annual reports. We report as follows:

**Biannual report one** – Submission in Q1 and will include updates on:

- Trust led EDI projects and progress towards EDI strategic commitment and activities to underpin our PSED commitment.
- Annual WRES data and summary for noting.
- Annual WDES data and summary for noting.
- Workforce demographics

**Biannual report two** – Submission in Q3 and will include updates on:

- Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment.
- Gender Pay Gap reporting.
- Equality Delivery System (EDS).

Reports seek to provide updates on regulatory and statutory requirements and work undertaken to advance the EDI agenda.

## 2. Statutory / Regulatory Reporting Requirements Update

2.1 To follow are legislative and contractual workforce EDI reporting requirements :

| Reporting Element | Required by | Progress Update | Comments |
|---|---|---|---|
| Workforce Race Equality Standards (WRES) – Part 1 | National data upload required by 31 May | Completed | |
| Workforce Race Equality Standards (WRES) – Part 2 | Narrative report required by 31 October | On track | Reports contained within this paper, for approval |
| Workforce Disability Equality Standards (WDES) – Part 1 | National data upload required by 31 May | Completed | |
| Workforce Disability Equality Standards (WDES) – Part 2 | Narrative report required by 31 October | On track | |
| Public Sector Equality Duty (PSED) | Included within biannual reports | Completed and ongoing | Activities detailed within both EDI biannual reports highlight the work WUTH is doing to uphold the principles of the Public Sector Equality Duty. This includes publication of Trust workforce demographics. |

| | | | | |
|---|---|---|---|---|
| | Gender Pay Gap Reporting (GPG) | 30 March 2026 (for March 2025 data) and 30 March 2027 (for March 2026 data) | Completed for 2025<br>On track for 2026 | Currently compliant with 2025/26 reporting. 2026/27 data will be included within biannual report 2, scheduled for Q3 2026/27. |
| | Equality Delivery System (EDS) | 28 Feb each year | Completed for 2025<br>On track for 2026 | Currently compliant with reporting, next report scheduled for inclusion within biannual report 2 |
| | NHS EDI Improvement Plan | Q2 and Q4 | Completed for Q4 and ongoing | Included within EDI dashboard of this report. |
| | Updates to be provided on equality analysis process and progress of equality objectives | Annually | Completed and ongoing | Feedback integrated within last EDI report and further review to be undertaken and included within biannual report 2. |

All regulatory and statutory reporting requirements are therefore complete or online to meet the requirements listed above.

2.3 **New Reporting Requirements**

As part of changes to the Employment Rights Act, in 2027, menopause and gender pay gap action plans will become mandatory for employers with 250 or more workers. Whilst the exact date has not as yet been confirmed, WCHC already publishes its gender pay gap plans and steps are underway to ensure an overarching equalities action plan (incorporating menopause) is collated and shared as part of regular EDI governance reporting.

## 3. Workforce Demographics

3.1 In line with specific duties under the Equality Act 2010, the Trust is required to publish information relating to employees who share protected characteristics.

**Sex / Gender**

90.3% of the WUTH workforce is female and 9.7% is male. The number of male staff have decreased 11.5% in 2025/6. The numbers continue to reflect that WCHC is predominately female. This is significantly different to the community demographics.

The chart below highlights the breakdown of staff compared with community and demographics.

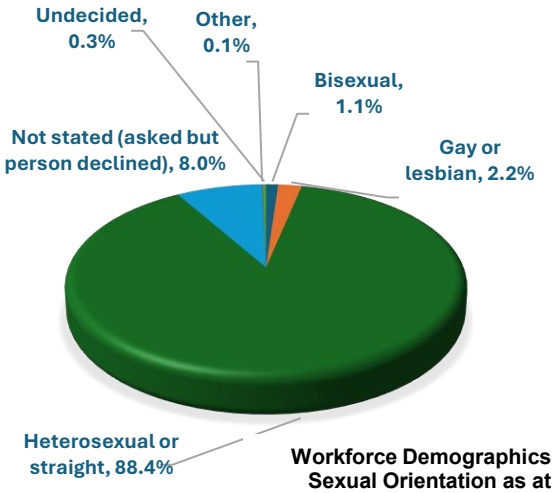
| | Workforce | LA: Wirral | Region: North West |
|---|---|---|---|
| **Male** | 9.7% | 48.11% | 49.13% |
| **Female** | 90.3% | 51.89% | 50.87% |

**Sexual Orientation**

Charts below highlight the workforce sexual orientation data on 31 March 2026, along with comparative data for community members within the North-West. Data this year sees further increases in the % of LGB staff at WCHC this year with 3% LGB in 2024/25

compared to 3.3% this year. The % of LGB staff in WCHC is also higher than declared within the Northwest region (1.7%).

| Sexual Orientation | % of Workforce |
|---|---|
| **Bisexual** | 1.1% |
| **Gay or Lesbian** | 2.2% |
| **Heterosexual or straight** | 88.4% |
| **Not stated (person asked but declined to provide a response)** | 8.0% |
| **Other sexual orientation not listed** | 0.1% |
| **Undecided** | 0.3% |
| **Unspecified** | 0.0% |
| **Grand Total** | **100.00%** |



Workforce Demographics by Sexual Orientation as at 31 March 2026

| Sexual Orientation Data Comparison with Community Demographics | | |
|---|---|---|
| | **Workforce** | **Region: North West** |
| **Gay / Lesbian / Bisexual** | 3.3% | 1.7% |
| **Heterosexual / straight** | 88.4% | 94.9% |
| **Unknown** | 8.4% | 3.5% |

**Gender Reassignment / Identity**

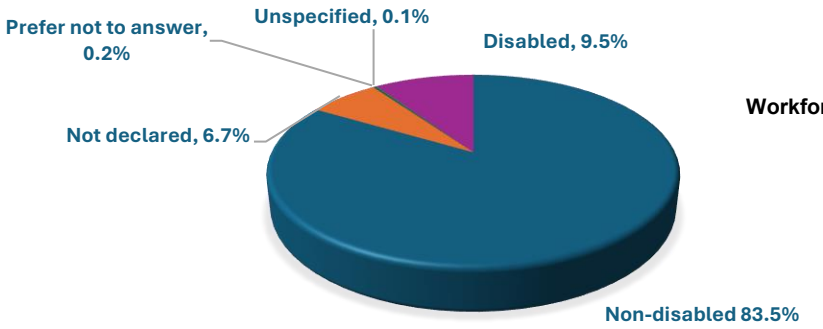
ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed.

A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area.

The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

The Trust is however aware of and has supported staff in their transition journey this year and continues to support staff whose gender isn't the same as assigned at birth. 3 staff completed the 2025 staff survey, identifying that their gender was different to the one assigned at birth.

## Disability




**Workforce Disability Status as at 31 March 2026**

As of 31st March 2026, the self-reporting rate for those staff with a disability within WCHC is 9.5% (as entered on to staff ESR records). This continues to increase each year, rising from 8.8% last year.

Less non-clinical staff are reporting having a disability, with 8.0% non-clinical staff reporting having a disability, compared with 9.7% of clinical colleagues.

Breakdown of Non-Clinical and Clinical Staff by Pay Band:

*Figure 1 - Non- Clinical Staff*

| | % Disabled |
|---|---|
| 1a) Non Clinical Staff | |
| Under Band 1 | 0.0% |
| Bands 1 | 0.0% |
| Bands 2 | 0.0% |
| Bands 3 | 0.0% |
| Bands 4 | 15.8% |
| Bands 5 | 5.0% |
| Bands 6 | 33.3% |
| Bands 7 | 66.7% |
| Bands 8a | 0.0% |
| Bands 8b | 0.0% |
| Bands 8c | 0.0% |
| Bands 8d | 0.0% |
| Bands 9 | 0.0% |
| VSM | 0.0% |
| Other. Please specify in notes. | 0.0% |
| Cluster 1: AfC Bands <1 to 4 | 5.6% |
| Cluster 2: AfC bands 5 to 7 | 15.4% |
| Cluster 3: AfC bands 8a and 8b | 0.0% |
| Cluster 4: AfC bands 8c to VSM | 0.0% |
| Total Non-Clinical | 8.0% |

*Figure 2 - Clinical Staff*

| | % Disabled |
|---|---|
| 1b) Clinical Staff | |
| Under Band 1 | 0.00% |
| Bands 1 | 0.00% |
| Bands 2 | 8.20% |
| Bands 3 | 10.17% |
| Bands 4 | 6.25% |
| Bands 5 | 12.07% |
| Bands 6 | 10.21% |
| Bands 7 | 6.49% |
| Bands 8a | 11.63% |
| Bands 8b | 0.00% |
| Bands 8c | 0.00% |
| Bands 8d | 0.00% |
| Bands 9 | 0.00% |
| VSM | 0.00% |
| Other. Please specify in notes. | 0.0% |
| Cluster 1: AfC Bands <1 to 4 | 8.6% |
| Cluster 2: AfC bands 5 to 7 | 10.2% |
| Cluster 3: AfC bands 8a and 8b | 10.6% |
| Cluster 4: AfC bands 8c to VSM | |
| Total Clinical | 9.7% |

## Religion or Belief

The chart below highlights the religious beliefs of our workforce compared with the community demographics as of 31 March 2026. The categories are grouped together so as to aid ease of comparison; however it is important to recognise some of the heading below subgroup heading e.g. Christianity include Catholicism, Anglican etc

| | ***Workforce*** | ***LA: Wirral*** | ***Region: North West*** |
|---|---|---|---|
| *Atheism / Not religious* | 14.9% | 21.33% | 19.82% |
| *Buddhism* | 0.3% | 0.28% | 0.29% |
| *Christianity* | 57.3% | 70.41% | 67.25% |
| *Hinduism* | 0.3% | 0.23% | 0.54% |

| | | | |
|---|---|---|---|
| *Islam* | 0.6% | 0.57% | 5.05% |
| *Judaism* | 0.0% | 0.08% | 0.43% |
| *Other* | 10.5% | 0.26% | 0.27% |
| *Sikhism* | 0.1% | 0.07% | 0.13% |
| *Jainism* | 0.0% | Unknown | unknown |
| *Unknown* | 16.2%* | 6.77% | 6.20% |

**Staff have indicated they do not wish to disclose*

There are significantly more staff declaring 'Other' than in the local community and less Christian and non-religious / atheist staff.

**Ethnicity**

93.0% of WCHC staff are white, 6.1% of staff are Black, Asian, or other Ethnic Group and 0.9% of staff have not stated their ethnic group on ESR.

It is pleasing to see a year-on-year increase in the representation of Black, Asian and other Ethnic (BAME) staff at WCHC, rising from 4.42% in 2023/24, to 5.3% in 2024/25 and now to 6.1% in 2025/26.

Representation in clinical staff is 5.7% compared with 3.4% in non-clinical staff.

Breakdown of Non-Clinical and Clinical Staff by Pay Band:

*Figure 1 - Non- Clinical Staff*

| | % BME |
|---|---|
| **1a) Non Clinical Staff** | |
| Under Band 1 | 0.0% |
| Bands 1 | 0.0% |
| Bands 2 | 5.6% |
| Bands 3 | 0.0% |
| Bands 4 | 0.0% |
| Bands 5 | 5.0% |
| Bands 6 | 33.3% |
| Bands 7 | 0.0% |
| Bands 8a | 0.0% |
| Bands 8b | 0.0% |
| Bands 8c | 0.0% |
| Bands 8d | 0.0% |
| Bands 9 | 0.0% |
| VSM | 0.0% |
| Cluster 1: AfC Bands <1 to 4 | 1.9% |
| Cluster 2: AfC bands 5 to 7 | 7.7% |
| Cluster 3: AfC bands 8a and 8b | 0.0% |
| Cluster 4: AfC bands 8c to VSM | 0.0% |
| Total Non-Clinical | 3.4% |

*Figure 2 - Clinical Staff*

| | % BME |
|---|---|
| **1b) Clinical Staff** | |
| Under Band 1 | 0.0% |
| Bands 1 | 0.0% |
| Bands 2 | 18.9% |
| Bands 3 | 4.2% |
| Bands 4 | 0.8% |
| Bands 5 | 6.9% |
| Bands 6 | 4.3% |
| Bands 7 | 2.7% |
| Bands 8a | 7.0% |
| Bands 8b | 25.0% |
| Bands 8c | 0.00% |
| Bands 8d | 0.00% |
| Bands 9 | 0.00% |
| VSM | 0.00% |
| Cluster 1: AfC Bands <1 to 4 | 7.0% |
| Cluster 2: AfC bands 5 to 7 | 4.9% |
| Cluster 3: AfC bands 8a and 8b | 8.5% |
| Cluster 4: AfC bands 8c to VSM | |
| Total Clinical | 5.7% |

To follow is a full breakdown of staff compared with community demographics. No major changes can be seen in the demographics this year, when compared to last year.

| | ***Workforce*** | ***LA: Wirral*** | ***Region: North West*** |
|---|---|---|---|
| *White - British (inc English, Scottish & Cornish)* | **90.9%** | 94.97% | 87.08% |
| *White - Irish* | **0.9%** | 0.83% | 0.92% |
| *White Traveller / Gypsy / Irish Traveller* | **0.00%** | 0.02% | 0.06% |
| *White - other* | **2.2%** | 1.17% | 2.15% |

| | | | |
|---|---|---|---|
| *Mixed - White & Black Caribbean* | **0.2%** | 0.30% | 0.56% |
| *Mixed - White & Black African* | **0.2%** | 0.17% | 0.26% |
| *Mixed - White & Asian* | **0.4%** | 0.30% | 0.43% |
| *Mixed - Any other mixed background* | **0.1%** | 0.25% | 0.32% |
| *Asian or Asian British - Indian* | **1.8%** | 0.42% | 1.52% |
| *Asian or Asian British - Pakistani* | **0.2%** | 0.07% | 2.69% |
| *Asian or Asian British - Bangladeshi* | **0.2%** | 0.27% | 0.65% |
| *Asian / Asian British: Chinese* | **0.2%** | 0.52% | 0.68% |
| *Asian or Asian British - Any other Asian background* | **0.5%** | 0.33% | 0.66% |
| *Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean* | **2.0%** | 0.18% | 1.17% |
| *Any other Black African / Caribbean* | **0.1%** | 0.04% | 0.22% |
| *Arab* | **0.0 %** | 0.07% | 0.35% |
| *Any Other* | **0.3%** | 0.10% | 0.28% |

**Age**

The following chart highlights the age profile within WCHC as of 31 March 2026.

The largest group of staff is between 36-40 and the lowest is <=20 years.

| Age Band | % in Trust 2026 |
|---|---|
| <=20 Years | 0.1% |
| 21-25 | 3.7% |
| 26-30 | 7.1% |
| 31-35 | 12.3% |
| 36-40 | 15.0% |
| 41-45 | 12.4% |
| 46-50 | 11.0% |
| 51-55 | 13.3% |
| 56-60 | 11.6% |
| 61-65 | 10.9% |
| 66-70 | 2.3% |
| >=71 Years | 0.4% |
| Grand Total | 100.0% |

3.2 **Key Findings**

The Trust has seen improvements in workforce demographics in a number of areas that have been a priority. This includes increased representation of Global Majority staff, disabled staff and LGB staff.

Workforce demographics are broadly aligned to those of the local community however a focus should be placed on increased promotion of males and those who are <=20 years.

## 4 EDI Dashboard

In order to more effectively monitor and review performance and progress with the EDI agenda, a key objective of the 2025/26 People Strategy key deliverables was to develop an EDI dashboard that would identify key metrics and provide Trust progress against these.

In line with feedback received from People Committee, the dashboard has focussed on key areas of the employee lifecycle and is disaggregated by protected characteristic.

The dashboard seeks to provide a range of data to understand key trends and themes, with a focus on identifying areas of inequity that may require additional attention or support.

In line with NHS England guidance regarding elimination of sexual misconduct in the workplace; two additional questions have been added to the dashboard to ensure annual monitoring of experiences of staff disaggregated by protected characteristic.

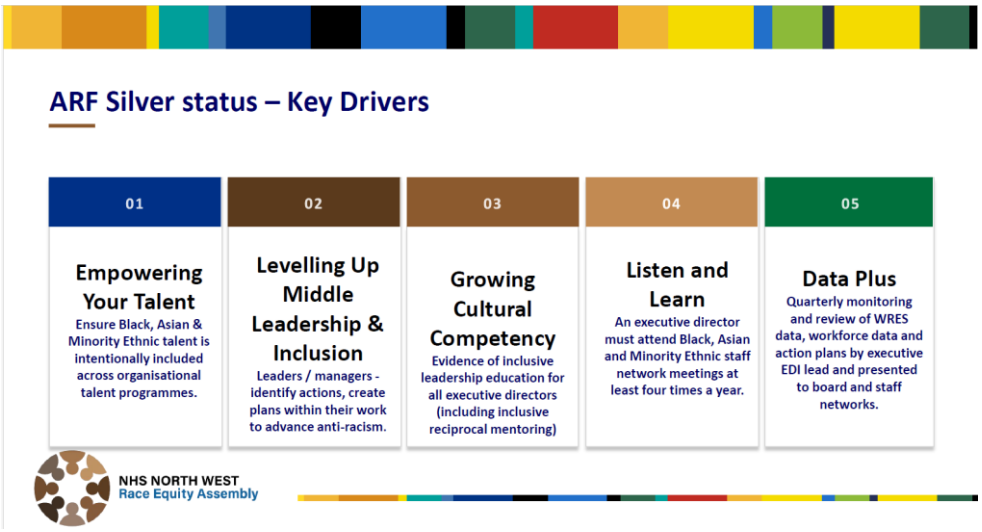
| | |
|---|---|
| | The dashboard is attached at appendix 1 and highlights key data from 2020/21 to 2025/26.<br><br>The key areas of note are:<br>1) Staff experience scores have seen a decline across the majority of staff groups and at a national and organisational level.<br>2) Whilst a reduction can be seen for the majority of staff, LGB+ and male staff are significantly lower in a number of areas e.g. career progression and overall staff engagement scores.<br>3) LGB+ staff feel significantly less included this year and are the least satisfied with inclusion and are the staff group thinking of leaving the most with scores significantly lower than other groups.<br>4) Global majority staff are the least satisfied with equality and diversity however have the highest staff engagement score overall, the highest for 5 years.<br>5) Improvements can however be seen in the relative likelihood of appointment for global majority staff and disabled staff are as likely to be appointed.<br><br>In summary, it is pleasing to see improvements in the areas of focus for 2025/26, with improved likelihood of appointment for Global majority applicants and improved staff engagement scores.<br><br>Focus should now be given on further understanding the experiences of our LGB+ staff and identifying key actions needed to support improvements.<br><br>Committee members should also note concerning results for male staff and when combined with lower levels of representation across the organisation, additional support should be considered e.g. mens network.<br><br>Members should also note the increased levels of experiences of a sexual nature for disabled, LGB+ and global majority staff and these will be reviewed further with associated staff networks. |
| **5** | **Workforce Race Equality Standards (WRES)** |
| | **Summary findings**<br>The aim of the WRES is to improve the experience of Global Majority staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes.<br><br>The full narrative report is attached at appendix 2 and outlines the national indicators that the Trust is required to submit data and monitor progress against, with a helpful summary overview contained within the appendices of the report.<br><br>Data shows improvements in 4 of the 8 comparable WRES indicators:<br>• Increased representation of Global Majority staff this year (from 5.3% last year to 6.1% this year).<br>• Global Majority applicants are more likely to be appointed from shortlisting when compared with white applicants this year (from 3.99 in 2025/26 to 2.00 this year).<br>• Global Majority staff are generally as likely to enter the formal disciplinary process this year as white colleagues (improving from 1.11 last year to 0.95 this year).<br><br>It is however disappointing to see a decline in staff experience metrics, with<br>• More Global Majority staff reporting experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This metric also declined for white staff; |

| | |
|---|---|
| | • More Global Majority staff experiencing harassment bullying or abuse from staff in the last 12 months. This metric however improved for white staff;<br>• More Global Majority staff reporting experiencing discrimination at work from a manager, team leader or other colleagues.<br><br>An additional question is also measured regarding Global Majority staff believing the Trust provides equal opportunities for career progression and promotion, however this question was re-worded in the 2025 staff survey and results are unfortunately not therefore comparable. However, only 55.3% of staff responded positively to this question.<br><br>The report outlines measures that have been taken to support improvements this year, along with key objectives for 2026/27. |
| **6** | **Workforce Disability Equality Standards (WDES)** |
| | WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.<br><br>The full narrative report is attached at appendix 3 and outlines the national indicators that the Trust is required to submit data and monitor progress against, with a helpful summary overview contained within the appendices of the report.<br><br>Data shows improvements in 4 of the 12 comparable WDES indicators this year:<br>• Increased representation of staff reporting they have a disability, from 7.3% last year to 9.5 this year;<br>• Less disabled staff a reporting experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (reducing from 26.57% last year to 25.09% this year);<br>• Less disabled staff are reporting experiencing harassment, bullying or abuse from managers in the last 12 months, reducing from 12.64% to 12.23%;<br>• More disabled staff are satisfied with the extent to which the organisation values their work, increasing from 34.93% last year to 37.05% this year. Interestingly, this element has declined for non-disabled staff.<br><br>A number of areas have however declined:<br>1) Staff engagement scores for disabled staff have fallen from 6.65 to 6.40. Engagement scores have unfortunately reduced for all except Global Majority staff this year;<br>2) Less disabled staff feel that adequate adjustment(s) have been made to enable them to carry out their work, reducing from 78.14% to 77.0%;<br>3) More disabled staff are reporting feeling pressure to come to work, despite not feeling well enough to perform their duties, increasing from 19.40% in 2025/26 to 23.44% this year.<br>4) More disabled staff are reporting experiencing bullying, harassment or abuse from colleagues in the last 12 months, increasing from 14.72% last year to 17.63% this year.<br>5) Of those that have experienced bullying, harassment or abuse, less disabled staff are unfortunately reporting it this year too (reducing from 65.98% to 56.60% this year).<br><br>Disabled staff are generally as likely to be appointed as they were last year and also have an equal likelihood of entering the formal capability procedure, when compared to non-disabled colleagues. This also remains the same position as last year. |

| | |
|---|---|
| | WDES results highlight a number of concerning factors and will therefore be identified as a priority area for 2026/27. |
| **7** | **Advancing the EDI Agenda** |
| **7.1** | **People Strategy and EDI Strategic Commitment**<br><br>Since the launch of the People Strategy and underpinning EDI Strategic Commitment, the Trust continues to strive to ensure EDI is embedded within all our people processes and practices.<br><br>As the two trusts are working towards merger, the EDI strategic commitments will be reviewed and considered following the development of the organisational joint strategy.<br><br>The joint strategy sessions and consultation process held during summer 2025 encompassed inclusion principles and consideration of the health inequalities of our community and patients we provide services for when in the acute setting and within their own homes.<br><br>Regular updates are reported to PCOG and People & Culture Committee as part of People Strategy Updates.<br><br>A summary of key EDI activities undertaken along with key next steps are attached at appendix 4. |
| **7.2** | **NHS North West submission of EDI LEAF report Q4 requirements**<br><br>NHS North West Trusts are requried to completed a quarterly data submission, to highlight progress against a number of EDI workstreams including NHS England's EDI Improvement Plan and 6 High Impact Actions.<br><br>The EDI dashboard is attached as appendix 1 and contains updates on all key components. |
| **7.3** | **Trust Accreditations**<br><br>**Anti-Racist Framework – Bronze Award**<br>On the 18 May 2026, WCHC were delighted to be awarded with the NHS England and NHS Norht West Race Equite Assembly Anti-Racism Framework Bronze Award.<br><br><br><br>This Award is given in recognition of our commitment to anti-racism and the time, effort and dedication that has felt to be instrumental in making a positive impact.<br><br>Feedback has been received from the assessors who highlighted a number of areas of good practice and also areas for improvement that will be considered and included within future EDI plans and accreditation submissions:<br>• A "more race-specific focus would be helpful";<br>• Inclusion of patient specific narrative / voice;<br>• Increased links / engagement between the BAME staff network and the Executive Partner and Non-Executive representative, with a development programme suggested.<br>• Understanding and highlighting measures of impact;<br>• Plans for upskilling and development of global majority staff<br>• Change of name from 'BAME' staff network as now outdated. |

- Ensuring ongoing activities are undertaken to promote anti-racism.

WCHC must continue to build upon progress made so far and in order to meet the seven NHSRHO anti-racist principles detailed in section 4, WCHC must continue to strive for improvement and progression to the silver award requires organisations to:




**Forthcoming Accreditation Review – Veteran Aware**

WCHC will undergo an accreditation review this year, which will be held in conjunction with WUTH.

**7.4**

**Staff Network Update**

WCHC has six staff networks as detailed below. Networks have now combined with WUTH networks, with joint meetings in place for staff within both organisations.

New Executive partners have also now been aligned and are detailed below:

| Network | Executive Partner |
|---|---|
| PRIDE Network | Ali Hughes |
| Ability and Sunflowers Network | Chris Douglas |
| Armed Forces | Hayley Kendall |
| Multicultural and BAME | Nikki Stevenson |
| Menopause | Jo Chwalko |
| Volunteer network | Matthew Swanborough |
| Working Carers network | Mark Chidgey |

A number of Executives have already shared public messages of support for their respective networks as part of the Trusts EDI Calendar of Events. Arrangements are now underway to ensure Executive partners are linked with network members, meetings and associated activities.

Communication assets are also now in development and when finalised will support a refreshed promotional campaign to promote support available to staff and encourage staff to get involved.

| | |
|---|---|
| | **Network Activities**<br>• **Armed Forces** – As part of Armed Forces Week<br>  o Flag raising ceremony held at St Catherines Hospital and flags raised at different sites.<br>  o Drop-in session for staff<br>  o Trustwide and social media campaign to promote the week and share experiences of staff within WUTH and WCHC's armed forces community.<br>• **BAME Staff network**<br>  o Attended team meeting to promote key messages regarding anti-racism, inclusion and appropriate usage of social media<br>  o Supported Trustwide communications to highlight local protests and ensure support for staff<br>  o Supported Trust drop-n support sessions for staff post local protests<br>  o Shaped and supported Trust race equality workshops and masterclasses<br>  o Shaped and supported race equality week, sharing experiences, support for staff and even arranging local ethnic ice cream van on site.<br><br>• **All staff networks**<br>  o Have held joint WUTH and WCHC network meetings<br>  o Have promoted awareness of the networks as part of national Staff Network Day – holding stalls to meet staff and offer advice and support |
| **7.5** | **Equality Analysis**<br><br>Equality Analysis is required in the following circumstances:<br>• When policies are being developed or renewed.<br>• Development of business cases impacting on service users or staff.<br>• Service redesign/reviews impacting on service users or staff – organisational change.<br>• Changes that may impact on service users or staff.<br><br>Completed analysis should also be shared publicly as appropriate and are available on request.<br><br>At WCHC In the trust the equality analysis forms part of the Quality and Equality Impact Assessment Policy and this has been used as the basis of the revised WUTH policy as part of sharing good practice across the two organisations. A review of the equality analysis process will be undertaken and update provided in biannual report 2. |
| **7.6** | **Education and Training**<br><br>There are a range of education and training opportunities currently available for staff to build further understanding of the EDI agenda and support knowledge gaps.<br><br>Compliance with Level 1 EDI mandatory training is 97.1% at 30 June 2026.<br><br>Dedicated EDI sessions continue to take place as part of Leadership for all programmes accessible for WUTH and WCHC colleagues, and include "Inclusive Leadership", "Inclusive Recruitment" sessions. Additional inclusive recruitment sessions will be advertised shortly.<br><br>Sessions for Board and senior leaders have been held with BRAP, a charity that specialises on working with public sector organisations to challenge and refresh their understanding of human rights, equity/ equality, diversity and inclusion.<br><br>Leadership masterclasses have also been held with BRAP in March 2026 along with a workshop to support HR and staffside when dealing with employee relations cases. |

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| | Deaf awareness sessions continue to be delivered by the Deafness Resource Centre in conjunction with WUTH and are open to all staff.<br><br>Funding has now also been sourced to support a suite of EDI sessions for 2026/27 and further details will follow in due course. This will include:<br>• Neurodiversity awareness<br>• Supporting staff with disabilities and reasonable adjustments<br>• Trans awareness<br>• Active bystander training is currently under consideration. |
| **7.7** | **Anti-Racism, including Antisemitism and Islamophobia**<br><br>**Lord Mann Review**<br>There are new and strengthened national and regional mandates to become an anti-racist organisation. The recent publication of the **Lord Mann Review** and subsequent directives from NHS England and NHS North-West mark a significant shift, placing explicit requirements on all NHS Trusts to take urgent and sustained action to tackle racism, including antisemitism and Islamophobia.<br><br>The review confirmed that racism and discrimination are persistent and systemic challenges within the NHS. Its recommendations aim to **strengthen leadership**, **improve accountability**, **enhance staff training**, **standardise support for staff who experience racism**, and **improve the use of data**.<br><br>Lord Mann is clear in his review that NHS employers must take responsibility for tackling anti-Jewish racism and other forms of racism urgently. In a letter sent from NHS England's Chief Executive Sir Jim Mackey and People Director, Danny Mortimer, NHS England will support this work by:<br><br>• Signing up to the seven anti-racism principles of the NHS Race and Health Observatory (see appendix 6) and encouraging all NHS organisations to do the same.<br>• Set clear Staff Standards relating to experience of racism<br>• Support NHS improvement and assurance through the NHS Oversight Framework<br>• Strengthen accountability for racial inclusion through our appraisals<br>• Consult on adding Jewish and Sikh to NHS protected characteristic datasets<br>• Develop bespoke eLearning for NHS PALS and complaints handlers<br>• Ensure all NHS boards and system leaders complete regular anti-racism training<br><br>NHS organisations are being asked to undertake a series of actions, and a plan has therefore been developed and is attached at appendix 5 along with an update on progress against actions so far.<br><br>WCHC and WUTH have accepted Lord Manns recommendations and declared this to all staff in a global email on 10 June 26 by Dr Nikki Stevenson, Executive partner for the BAME and Multicultural staff network.<br><br>The wider response of the NHS was also shared with staff, citing a letter received from Sir Jim Mackey, Chief Executive at NHS England, and Danny Mortimer, Director General for People at NHS England, which is provided here.<br><br>Key actions for Trusts as requested by NHS England following the Lord Mann review included: |

1. Adoption of the **NHS Race and Health Observatory Seven Anti-Racism Principles** (see image opposite) and NHS Race and Health Observatory infographic (appendix 6).

2. Adoption of the **new government definition of antisemitism and anti-Muslim hostility:**

Antisemitism definition

*"Antisemitism is a certain perception of Jews, which may be expressed as hatred towards Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and / or their property, toward Jewish community institutions and religious facilities".*

Anti-Muslim hostility definition

*"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts -including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.*

*It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by their fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals. It is engaging in unlawful discrimination where the relevant conduct including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life".*

3. Board and senior leader training - The Trust Board and senior leaders have recently completed anti-racism training by BRAP, leading charity experts and a further national training package is awaited.

WUTH and WCHC have both adopted the above definitions (no. 1 and 2) and included within appropriate workforce policies. These are currently progressing through governance approval processes. They have been discussed at various forums, including partnership steering group and has been met by approval throughout.

Appendix 5 provides the Trust action plan in response to the Lord Mann review and updates on progress made to date. It is also important to note that some actions cannot currently be progressed until further national guidance or training resources are received.

Implementation of the Violence Prevention and Reduction Standard has however been stalled and is currently therefore flagged as an area of concern.

**NHS Staff Standards**
In addition to the above, new **NHS staff standards** have now been launched by NHS England and also include requirements to 'Tackle Racism' as a core strand.

**NHS North-West Race Equity Assembly**
In a letter also received from co-chairs of the **NHS North-West Race Equity Assembly**, Trusts are asked to reflect on local progress, consider future priorities and consider how Trusts can strengthen their contribution to creating equitable experiences and outcomes

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| | for staff and communities. The Assembly calls for Board members to review the Assembly's annual report and a local No Space for Racism campaign and to adopt where possible.<br><br>**Next Steps**<br>The following is recommended:<br>• Establishment of a race equity co-creation group to work together on identifying and progressing key actions necessary to ensure meaningful change. It is proposed that this group would then consider the recommendations made by the NHS North-West Race Equity Assembly, including the No Space for Racism Campaign highlighted in section 7.7.1.<br>• Anti-semitism awareness sessions.<br>• Ongoing anti-racist communication<br>• Implementation of further national guidance as it arises. |

| 8 | Report Summary and next steps |
|---|---|
| | A range of actions and activities continue to be undertaken to ensure WCHC is an inclusive place to work and receive treatment.<br><br>Key areas of focus for the EDI agenda in 2026/27 will be:<br>• Improve experiences of disabled staff, through enhanced education and training and providing easier access of information and support to line managers, with a particular focus on reasonable adjustments.<br>• Creating further opportunities to celebrate our LGB+ staff and further understanding key actions needed to support improvements in staff experience.<br>• Further support and build combined WUTH and WCHC staff networks to become established and impactful<br>• Being an anti-racist organisation<br>• Achieving Veteran Aware reaccreditation<br><br>Members are asked to:<br>1) Ratify contents of the report for publication, including WRES and WDES narrative reports.<br>2) Ratify adoption of the antisemitism and anti-Muslim hostility definitions<br>3) Ratify adoption of the Race Health observatory seven principles of anti-racism<br>4) Acknowledge and share forthcoming EDI calendar of events and consider ways to support / observe locally. |

| 9 | Implications |
|---|---|
| 9.1 | **Quality/Inclusion**<br>This report demonstrates how the trust meeting its inclusion requirements as an employer and to receive treatment. |
| 9.2 | **Finance**<br>N/A |
| 9.3 | **Compliance**<br>This report seeks to provide assurance that WCHC is currently in line with EDI reporting requirements and outlines key areas of priority for 2026/27. |

**EDI Monitoring Dashboard - Jun 26**

Key:

- ≥ last year and ≥ the national average
- ≥ last year < national average **or** < last year ≥ national average
- < last year and < national average

| Element | Area of measurement | KPI | Demographic | | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Compliance | Trend | Summary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recruitment & Progression | RP1 - Relative likelihood of appointment from shortlisting, compared to minority group | Ratio between 0.8 and 1.2:1 | Global Majority | | 4.3 | 6.1 | 1.8 | 2.2 | 2.0 | | | Monitoring of data has now commenced to support heightened focus.<br>Global majority (BAME) staff are more likely to be appointed this year, however further work still to be done to ensure an equal likelihood.<br>Disabled staff are as likely to be appointed as non-disabled staff this year. |
| | | | Disabled | | 1.2 | 1.0 | 1.5 | 1.3 | 1.3 | | | |
| | | | Female | | | | | 0.52 | 0.51 | | | |
| | | | LGB+ | | | | | 0.74 | 0.00 | | | |
| | | | Christian | | | | | 0.96 | 0.59 | | | |
| | RP2 -Staff satisfaction with opportunities for career progression (Q24b from NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | | **45.2%** | **44.1%** | **47.3%** | **42.1%** | **35.3%** | | | A decline in experience can be seen for all staff even at a national and organisational level too. Particular areas of decline and lower levels of satisfaction for males and LGB staff. |
| | | | **Nat. Ave** | | **54.2%** | **57.0%** | **55.6%** | **52.1%** | **51.6%** | | | |
| | | | Global Majority | | 55.0% | 54.6% | 46.8% | 53.2% | 44.7% | | | |
| | | | White | | 46.1% | 45.0% | 49.0% | 43.6% | 36.6% | | | |
| | | | Disabled | | 38.7% | 38.0% | 43.3% | 36.1% | 34.2% | | | |
| | | | Non-disabled | | 48.9% | 48.3% | 51.3% | 47.2% | 38.4% | | | |
| | | | Female | | 46.9% | 44.6% | 48.5% | 43.8% | 39.3% | | | |
| | | | Male | | 46.4% | 56.8% | 55.8% | 50.0% | 27.6% | | | |
| | | | LGB+ | | 27.8% | 50.0% | 63.6% | 64.7% | 25.0% | | | |
| | | | Heterosexual or Straight | | 46.9% | 45.5% | 48.6% | 44.4% | 38.2% | | | |
| | | | Christian | | 45.1% | 44.0% | 48.4% | 44.4% | 37.2% | | | |
| | | | Other Religions | | 63.6% | 0.0% | 45.5% | 0.0% | 44.4% | | | |
| | RP3: Staff feeling the organisation acts fairly with regards to career progression (Q15 from NSS)<br><br>NB: Results from 2021-24 are not available for q15 due to changes in the 2025 survey question | ≥ national average<br>Improvement from last year | **Org. Ave** | | | | | | **56.4%** | | | Due to changes in the 2025 question, comparisons cannot be made to previous years. Rating is provided compared to the national average for comparator Trusts which has also seen a decline.<br><br>LGB+staff are the most satisfied staff group and male staff are the least. |
| | | | **Nat. Ave** | | | | | | **58.1%** | | | |
| | | | Global Majority | | | | | | 55.3% | | | |
| | | | White | | | | | | 57.5% | | | |
| | | | Disabled | | | | | | 53.8% | | | |
| | | | Non-disabled | | | | | | 59.2% | | | |
| | | | Female | | | | | | 59.2% | | | |
| | | | Male | | | | | | 52.3% | | | |
| | | | LGB+ | | | | | | 70.0% | | | |
| | | | Straight | | | | | | 58.7% | | | |
| | | | Christian | | | | | | 57.2% | | | |
| | | | Other Religions | | | | | | 61.1% | | | |
| Staff Satisfaction - What's it like to work at WCHC | S1: Staff engagement score | ≥ national average<br>Improvement from last year | **Org. Ave** | | **6.95** | **6.96** | **7.18** | **7.02** | **6.85** | | | Staff engagement scores have declined at an organisational and national level this year, with the lowest scores for 5 years.. This can also be seen in all staff groups except Global Majority staff which are the highest for the last 5 years.<br><br>LGB+ staff, staff with other religions and male staff have the lowest staff engagement scores overall. |
| | | | **Nat. Ave** | | **7.24** | **7.21** | **7.26** | **7.23** | **7.09** | | | |
| | | | Global Majority | | 6.95 | 6.84 | 7.33 | 7.02 | 7.36 | | | |
| | | | White | | 6.96 | 6.96 | 7.18 | 7.06 | 6.82 | | | |
| | | | Disabled | | 6.64 | 6.68 | 6.93 | 6.65 | 6.40 | | | |
| | | | Non-disabled | | 7.05 | 7.07 | 7.28 | 7.22 | 7.07 | | | |
| | | | Female | | 7.03 | 7.03 | 7.21 | 7.11 | 6.97 | | | |
| | | | Male | | 6.71 | 6.75 | 7.33 | 6.91 | 6.29 | | | |
| | | | Straight | | 7.01 | 7.00 | 7.23 | 7.12 | 6.93 | | | |
| | | | LGB+ | | 5.91 | 6.96 | 7.51 | 6.60 | 6.16 | | | |
| | | | Christian | | 7.09 | 7.06 | 7.29 | 7.29 | 7.05 | | | |
| | | | Other Religions | | 6.59 | 0.00 | 7.78 | 0.00 | 6.20 | | | |
| | S2: Equality and Diversity sub-score (NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | | **8.81** | **8.82** | **8.92** | **8.86** | **8.85** | | | The majority of staff groups have seen an decline in experiences relating to equality and diversity this year and are below the national average.<br><br>Global majority staff are the least satisfied in this area. |
| | | | **Nat. Ave** | | **8.85** | **8.85** | **8.85** | **8.84** | **8.83** | | | |
| | | | Global Majority | | 7.85 | 7.74 | 8.32 | 7.94 | 7.83 | | | |
| | | | White | | 8.83 | 8.86 | 8.95 | 8.92 | 8.88 | | | |
| | | | Disabled | | 8.40 | 8.62 | 8.69 | 8.53 | 8.40 | | | |
| | | | Non-disabled | | 8.90 | 8.90 | 9.00 | 9.02 | 9.04 | | | |
| | | | Female | | 8.82 | 8.89 | 8.95 | 8.91 | 8.91 | | | |
| | | | Male | | 8.56 | 8.47 | 8.90 | 8.58 | 8.74 | | | |
| | | | LGB+ | | 8.82 | 8.85 | 8.94 | 8.92 | 8.93 | | | |
| | | | Straight | | 8.24 | 8.22 | 9.02 | 8.28 | 8.50 | | | |
| | | | Christian | | 8.77 | 8.88 | 8.98 | 8.94 | 8.87 | | | |
| | | | Other Religions | | 7.95 | 0.00 | 8.86 | 0.00 | 8.24 | | | |
| | S3: Inclusion sub-score (NSS) | ≥ national average<br>Improvement from last year | **Org. Ave** | | **7.15** | **7.20** | **7.22** | **7.30** | **7.20** | | | Staff satisfaction has reduced for all staff this year including at an organisational and national level, with the exception of non-disabled staff.<br><br>LGB+ staff have however declined significantly this year and are the least satisfied with inclusion. |
| | | | **Nat. Ave** | | **7.32** | **7.43** | **7.32** | **7.31** | **7.26** | | | |
| | | | Global Majority | | 6.81 | 7.11 | 6.70 | 6.57 | 6.49 | | | |
| | | | White | | 7.18 | 7.22 | 7.28 | 7.32 | 7.21 | | | |
| | | | Disabled | | 6.81 | 6.91 | 6.85 | 6.96 | 6.67 | | | |
| | | | Non-disabled | | 7.27 | 7.33 | 7.40 | 7.40 | 7.43 | | | |
| | | | Female | | 7.25 | 7.30 | 7.32 | 7.37 | 7.30 | | | |
| | | | Male | | 6.73 | 6.88 | 7.07 | 6.99 | 6.86 | | | |
| | | | LGB+ | | 7.01 | 7.19 | 7.71 | 7.33 | 6.12 | | | |
| | | | Straight | | 7.20 | 7.25 | 7.28 | 7.35 | 7.29 | | | |
| | | | Christian | | 7.24 | 7.29 | 7.31 | 7.54 | 7.36 | | | |
| | | | Other Religions | | 6.53 | | 7.90 | | 6.28 | | | |
| | R2: Thinking of leaving (NSS score) | ≥ national average<br>Improvement from last year | **Org. Ave** | | **5.85** | **5.84** | **6.19** | **5.95** | **5.90** | | | All groups have seen a decline in this area including at a national and organisatinal level, with the exception of female and disabled staff who are less likely to leave this year and global majority scores remain the same.<br><br>LGB+ staff are the staff group thinking of leaving the most, with scores considerably lower than other groups. |
| | | | **Nat. Ave** | | **6.28** | **6.23** | **6.38** | **6.35** | **6.16** | | | |
| | | | Global Majority | | 6.10 | 5.44 | 6.04 | 5.66 | 5.66 | | | |
| | | | White | | 5.84 | 5.90 | 6.22 | 5.97 | 5.89 | | | |
| | | | Disabled | | 5.37 | 5.50 | 5.91 | 5.31 | 5.44 | | | |
| | | | Non-disabled | | 6.00 | 6.02 | 6.34 | 6.24 | 6.12 | | | |
| | | | Female | | 5.95 | 5.96 | 6.24 | 6.10 | 6.40 | | | |
| | | | Male | | 5.60 | 5.74 | 6.36 | 5.23 | 5.19 | | | |
| | | | LGB+ | | 4.35 | 6.17 | 6.54 | 4.86 | 4.80 | | | |
| | | | Straight | | 5.89 | 5.96 | 6.25 | 6.06 | 6.01 | | | |
| | | | Christian | | 5.99 | 6.04 | 6.36 | 6.30 | 6.20 | | | |
| | | | Other Religions | | 4.85 | | 5.53 | | 5.42 | | | |

**NHS EDI Improvement Plan**

| | | | | | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Trend | Progress Rating | Summary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **HIA 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. | **Success Metric 1** - Annual chair and chief executive appraisals on EDI objectives | | | | | | | | | **Very Good Progress** | * Board members all now have EDI objectives, with appraisals scheduled to review progress. Including non executives |
| | | **HIA 1: Progress overall** | | | | | | | | | **Very Good Progress** | |
| | **HIA 2:** Embed fair and inclusive recruitment processes and talent management strategies | **Success Metric 1** Relative likelihood of staff being appointed from shortlisting across all posts | Global Majority | | 4.3 | 6.1 | 1.8 | 2.2 | 2.0 | | **Good progress** | Monitoring of data has now commenced to support heightened focus.<br><br>Global majority (BAME) staff are more likely to be appointed this year, however further work still to be done to ensure an equal likelihood.<br><br>Disabled staff are as likely to be appointed as non-disabled staff this year.<br><br>Christian staff are less likely to be appointed this year |
| | | | Disabled | | 1.2 | 1.0 | 1.5 | 1.3 | 1.3 | | **Good progress** | |
| | | | Female | | | | | 0.52 | 0.51 | | **Limited progress** | |
| | | | LGB+ | | | | | 0.74 | 0.00 | | **Limited progress** | |
| | | | Christian | | | | | 0.96 | 0.59 | | **Limited progress** | |
| | | | **Success Metric Overall** | | | | | | | | | |
| | | **Success Metric 2** Access to career progression, training and development opportunities. | **Org. Ave** | | **45.1%** | **44.0%** | **47.2%** | **42.1%** | **35.3%** | | | All areas have declined and are below the natonal average with the exception of BME staff and those from other religions |
| | | | **Nat. Ave** | | **54.1%** | **56.9%** | **55.4%** | **51.8%** | **51.6%** | | | |
| | | | Global Majority | | 55.0% | 54.6% | 49.0% | 43.6% | 44.7% | | | |
| | | | White | | 55.0% | 54.5% | 46.8% | 53.2% | 36.6% | | | |
| | | | Disabled | | 38.7% | 38.0% | 43.3% | 36.1% | 34.2% | | | |
| | | | Non-disabled | | 48.9% | 48.3% | 51.3% | 47.2% | 38.4% | | | |
| | | | Female | | 46.9% | 44.6% | 48.5% | 43.8% | 39.3% | | | |
| | | | Male | | 46.4% | 56.8% | 55.8% | 50.0% | 27.6% | | | |
| | | | LGB+ | | 27.8% | 50.0% | 63.6% | 64.7% | 25.0% | | | |
| | | | Straight | | 46.9% | 45.5% | 48.6% | 44.4% | 38.2% | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | that target under-representation and lack of diversity. | | Christian | | 45.1% | 44.0% | 48.4% | 44.4% | 37.2% | | | |
| | | | Other Religions | | 63.6% | 0.0% | 45.5% | 0.0% | 44.4% | | | |
| | | | **Success Metric Overall** | | | | | | | | **Good progress** | |
| | | **Success Metric 3 -**Improvement in race and disability representation leading to parity over the life of the plan. | Disability | | 4.6% | 6.2% | 7.3% | 8.3% | 9.5% | | **Excellent progress** | Year on year increase in representation, with representation for disabled staff above the national average |
| | | | Race | | 0.0% | 3.6% | 4.4% | 5.3% | 6.1% | | **Excellent progress** | |
| | | | **Success Metric Overall** | | | | | | | | **Excellent progress** | |
| | | **Success Metric 4 -** Improvement in representation of senior leadership (Band 8C and above) over the life of the plan. | Disability | | | | 3.1% | 7.0% | 0.0% | | **No progress** | Due to the TUPE process with corporate roles transferring this number has decreased |
| | | | Race | | | | -4.1% | -5.0% | 0.0% | | **No progress** | |
| | | | **Success Metric Overall** | | | | | | | | **No progress** | |
| | | **Success Metric 5 -** HEE National Education and Training Survey (NETS) Score metric on quality of training. | | | | | 84.26% | 83.15% | 77.59% | | **No progress** | A reduction has unfortuantely been seen this year but more students did complete this survey |
| | | **Success Metric 6 -** Diversity in shortlisted candidates. | Data to be included moving forwards | | | | | | | | N/A | N/A this year |
| | | **HIA 2: Progress overall** | | | | | | | | | | |
| | **HIA 3:** Develop an improvement plan to eliminate pay gaps. | **Success metric 1** - Improvement in the gender, race and disability pay gaps (Mean average used) | Gender | | | 8.7% | 10.4% | 8.6% | | | | Data not due - scheduled for review as part of biannual report 2. |
| | | | Ethnicity | | | | | | | | | |
| | | | Disability | | | | | | | | | |
| | | | Sexual Orientation | | | | | | | | | |
| | | **HIA 3: Progress overall** | | | | | | | | | **Limited progress** | |
| | HIA 4: Develop an improvement plan to address health inequalities within their workforce. | **Success Metric 1** - Organisation action on staff health and wellbeing (NSS Q 11a) | | | 54.5% | 56.2% | 61.1% | 58.3% | 55.3% | | **Limited progress** | |
| | | **Success Metric 2** - HEE National Education & Training Survey (NETS) Separate Indicator Score metric on quality of training. | | | | | 84.3% | 83.2% | 77.6% | | **No progress** | |
| | | **HIA 4: Progress overall** | | | | | | | | | **Limited progress** | |
| | HIA 5: Develop a comprehensive induction, onboarding and development programme for internationally recruited staff. | **Success Metric 1 -** Sense of belonging for internationally recruited staff (Inclusion sub score used from NSS) | | | | | 6.62 | 7.42 | * | | **No progress** | There is no specific question regarding "sense of belonging" in the staff survey. The people promise "Inclusion" score has therefore been used as an alternative and feedback provided as part of reporting processes. Thereare however insufficient respondents to the survey this year to provide data.<br><br>Listening events have been held with staff to better understand experiences and staff network has merged with WUTH network to provide wider support. |
| | | **Success Metric 2 -** Reduction in instances of bullying and harassment from team/line manager experienced by (internationally recruited staff). | By colleagues | | | | 17.7% | 31.3% | * | | **No progress** | |
| | | | By line manager | | | | 0.0% | 6.7% | * | | **No progress** | |
| | | **HIA 5: Progress overall** | | | | | | | | | **No progress** | |
| | HIA 6: Create an environment which eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occurs | **Success Metric 1** - Improvement in staff survey results of bullying and harassment from line managers or teams | % of staff experiencing bullying, harassment or abuse from managers in the last 12 months (NSS Q14b) | 8.1% | 7.0% | 6.3% | 5.9% | 6.0% | 6.1% | | **Limited progress** | With the exception of this years results for success metric 3, improvements in this area have reduced over the last 5 years. |
| | | | % of staff experiencing bullying, harassment or abuse from colleagues in the last 12 months (NSS Q14c) | 13.2% | 12.9% | 12.0% | 12.8% | 11.5% | 10.0% | | **Good progress** | |
| | | **Success Metric 2** - Improvement in National Education and Training Survey (NETS) bullying and harassment score metric | | | | | 100.0% | 91.3% | 100.0% | | **Good progress** | |
| | | **Success Metric 3 -** Improvement in staff survey results of discrimination from line managers or teams (All staff NSS results) | No. of staff experiencing discrimination at work from colleagues/managers/team leaders (NSS Q16b) | 5.2% | 4.9% | 4.5% | 3.9% | 4.6% | 4.8% | | **Limited progress** | |
| | | **HIA 6: Progress overall** | | | | | | | | | **Good progress** | |
| **Additional Element** | | | | | | | | | | | | |
| **Additional Element - Sexual Safety** | Q17a - In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public? | ≥ national average<br>Improvement from last year | **Org. Ave** | | | | **5.76%** | **9.19%** | **7.16%** | | | Improvements can be seen in the majority of areas with the exception of Christian and disabled staff, however results for disabled staff are also higher than the national average.<br><br>Whilst scores for LGB+ staff are combined, data shows a particular concern for bisexual staff in this area, from 7.14% in 2023; 36.36% in 2024 and 27.27% in 2025 staff survey data. Numbers of bisexual staff are low which could account for the signfiicant difference, however should be reviewed with the Trusts PRIDE network. |
| | | | **Nat. Ave** | | | | **6.52%** | **6.88%** | **7.43%** | | | |
| | | | Global Majority | | | | 6.52% | 8.51% | 5.26% | | | |
| | | | White | | | | 5.07% | 7.59% | 7.13% | | | |
| | | | Disabled | | | | 7.84% | 8.82% | 10.39% | | | |
| | | | Non-disabled | | | | 3.95% | 7.04% | 5.38% | | | |
| | | | Female | | | | 5.26% | 7.92% | 7.58% | | | |
| | | | Male | | | | 2.65% | 5.00% | 4.60% | | | |
| | | | LGB+ | | | | 12.66% | 27.01% | 18.64% | | | |
| | | | Straight | | | | 4.38% | 6.98% | 6.73% | | | |
| | | | Christian | | | | 4.42% | 4.14% | 5.80% | | | |
| | | | Other Religions | | | | 0.00% | | 17.00% | | | |
| | Q17b - In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues? | ≥ national average<br>Improvement from last year | **Org. Ave** | | | | **1.42%** | **1.46%** | **1.30%** | | | Improvements can be seen for the organisation as a whole and the national averages however there is a mixed picture for staff across different protected characteristics.<br><br>Non-disabled, male and LGB+ staff have improved since last year however LGB+ staff data shows as 0.0% and it is recommended that this is rewviewed in line with the PRIDE network to understand experiences, as numbers of LGB+ staff in WCHC are low.<br><br>Results for Global majority and white staff have both declined this year and are above the national average however the global majority score for last year was 0.0% and again, should be reviewed in line with the BAME staff network as whilst both groups have increased, the results are worse for global majority staff. |
| | | | **Nat. Ave** | | | | **1.58%** | **1.43%** | **1.34%** | | | |
| | | | Global Majority | | | | 6.38% | 0.00% | 2.63% | | | |
| | | | White | | | | 1.12% | 1.15% | 1.35% | | | |
| | | | Disabled | | | | 1.64% | 1.48% | 2.51% | | | |
| | | | Non-disabled | | | | 1.27% | 1.10% | 0.72% | | | |
| | | | Female | | | | 0.92% | 0.90% | 1.08% | | | |
| | | | Male | | | | 2.65% | 4.00% | 2.30% | | | |
| | | | LGB+ | | | | 10.39% | 5.88% | 0.00% | | | |
| | | | Straight | | | | 0.86% | 0.95% | 1.30% | | | |
| | | | Christian | | | | 0.71% | 0.44% | 0.70% | | | |
| | | | Other Religions | | | | 0.00% | | 0.00% | | | |

Wirral Community Health and Care NHS Foundation Trust

# Workforce Race Equality Standards (WRES) Report

July 2026

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# Background

This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

All the available evidence shows that Black, Asian and Ethnic Minority (BME) staff have a significantly inferior experience of the NHS as employees when compared to white staff.

The WRES has been mandated by the NHS Standard Contract since 1 April 2019 and all Trusts must ensure data is uploaded to a government portal by no later than 31 May each year. Detailed reports including action plans to address areas of further work needed must also be developed and made public by no later than 31 October.

The aim of the WRES is to improve the experience of Black, Asian and Ethnic Minority (BME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BME people who want to work in the NHS.

The WRES action plan forms one of the key ambitions within the People Strategy and Inclusion and Health Inequality Strategy with the aim of improving both access to work for people from black and minority ethnic BME communities as well as their staff experience.

WCHC is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- eliminate unlawful harassment and victimisation.
- foster good relations between people who share a protected characteristic and those who do not.
- advance equality of opportunity between people who share a protected characteristic and those who do not.

WRES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

In the context of the WRES, “white staff” comprises of white British, white Irish and white other, whereas “BME staff” comprise all other categories with the exception of “not stated”.

# Executive Summary

The aim of the Workforce Race Equality Standard is to improve the experience of Black, Asian and Minority Ethnic (BME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BME people who want to work in the NHS.

The Trust (WCHC) has seen a mixture of results this year with some improvements and areas of decline.

2025/26 data highlights improvements in:

- Trust demographics – with increases in non-white staff across clinical and non-clinical roles.
- The likelihood of BME staff entering the formal disciplinary process
- The likelihood of BME staff being appointed from shortlisting compared to the previous year

However, the majority of metrics related to staff survey results have unfortunately declined this year which include:

- the percentage of staff experiencing harassment from patients, relatives or members of the public
- the percentage of staff experiencing harassment, bullying and abuse from staff
- the percentage of staff believing that their equal opportunities for career progression/ promotion
- experiencing discrimination from any of the following: manager/ team leader or other colleagues.

An additional question is also measured regarding BME staff believing the Trust provides equal opportunities for career progression and promotion, however this question was re-worded in the 2025 staff survey and results are unfortunately not therefore comparable. However, only 55.3% of staff responded positively to this question

The Trust has been awarded the bronze level of the North-West Anti-Racist framework and has publicly declared its commitment to being an anti-racist organisation.

The BAME Staff Network has merged with WUTH's Multicultural staff network and now has commenced joint meetings and special thanks is noted to its chair Millie Williams who has successfully led the group for the last few years. The network has an executive sponsor Dr Nikki Stevenson.

The Trust's Inclusion and Health Inequalities strategic commitment underpins the Trust's People Strategy and seeks to ensure that Inclusion is a golden thread throughout all our people practices and processes.

Appendix A provides a summary overview of the Trust's performance and comparisons to community trust comparators.

Appendix B provides a summary overview of key actions required to sustain and improve further the experiences of our BME staff.

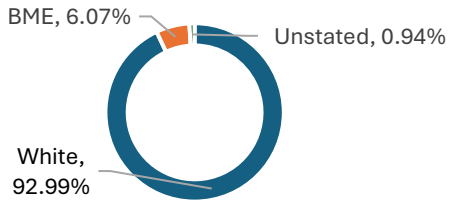
All actions identified in the 2025/26 action plan have been completed.

## Total Staff by Ethnicity 31 March 2026

As of 31 March 2026, a total of 1,589 staff were employed by WCHC. Of these, 97 (6.07%) were BME and 1,486 (92.99%) were white. 15 staff however, (0.94%) were unstated for their ethnicity, as per our electronic staff record (ESR). This figure has increased slightly since 2025. To note there has been a significant decrease in the total number of employees due to the TUPE transfer of staff to WUTH in December 2025.

The results highlight therefore that there continues to be an increase in the number of BME staff within the Trust, with numbers higher than that within the local population (95.2% of residents identified as "white" in the 2021 census[1], although it is recognised that the WCHC also has staff working in services across Cheshire East, St Helen's and Knowsley).

**Staff Employees as of 31 March 2026 by Ethnic Group**




The definitions of "Black, Asian and Minority Ethnic" and "White" used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. "White" staff includes White British, Irish and Any Other White. The "Black, Asian and Minority Ethnic" staff category includes all other staff except "unknown" and "not stated."

The data within this report excludes bank workers.

[1] https://www.ons.gov.uk/census/maps/choropleth/identity/ethnic-group/ethnic-group-tb-6a/white?lad=E08000015

# WRES Standard Indicators

## Table 1. The Workforce Race Equality Standard Indicators

**Workforce Indicators**
For each of these four workforce indicators, compare the data for White and BME staff.

**1** Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (*including executive Board members*) compared with the percentage of staff in the overall workforce disaggregated by:

- Non-clinical staff
- Clinical staff – of which
- Non-medical staff
- Medical and Dental staff

**2** Relative likelihood of staff being appointed from shortlisting across all posts.

**3** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*
**Note:** *this indicator will be based on data at 31 March.*

**4** Relative likelihood of BME staff accessing non-mandatory training and CPD.

**National NHS Staff Survey findings (or equivalent)**
For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.

**5** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

**6** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

**7** Percentage believing that trust provides equal opportunities for career progression or promotion.

**8** In the last 12 months have you personally experienced discrimination at work from any of the following?
b) manager/team leader or other colleagues

**Boards representation indicator**
For this indicator, compare the difference for White and BAME staff

**9** Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

# Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WCHC as a whole workforce as of 31 March 2026.

## Clinical staff breakdown by pay band

| Pay Band | White | BME | Not Stated | Grand Total | % BME staff in band 2025/26 | % BME staff in band 2024/25 |
|---|---|---|---|---|---|---|
| Band 2 | 99 | 23 | 0 | 122 | 18.85%↓ | 30.36% |
| Band 3 | 225 | 10 | 1 | 236 | 4.24%↑ | 3.65% |
| Band 4 | 124 | 1 | 3 | 128 | 0.78% | 1.64% |
| Band 5 | 316 | 24 | 8 | 348 | 6.90%↑ | 6.07% |
| Band 6 | 401 | 18 | 2 | 421 | 4.25%↑ | 3.84% |
| Band 7 | 179 | 5 | 1 | 785 | 2.70% | 2.99% |
| Band 8A | 40 | 3 | 0 | 43 | 6.98%↑ | 4.17% |
| Band 8B | 3 | 1 | 0 | 3 | 25.00%↑ | 16.67% |
| Band 8C | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| Band 8D | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| Band 9 | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| VSM | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| M&D – Consultant | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| M&D – Career Grade | 15 | 9 | 0 | 24 | 37.50% | 37.50% |
| M&D – Trainee | 0 | 0 | 0 | 0 | 0.00% | 0.00% |
| M&D – Other | 0 | 0 | 0 | 0 | 0.00% | 27.78% * |
| Grand Total | 1486 | 97 | 15 | 1598 | 6.07%↑ | 5.6% |
| % of clinical staff | 92.99% | 6.07% | 0.94% | 100% | | |

**difference is due to categorisation of medical and dental staff based on technical guidance*

## Non-clinical staff breakdown by pay band

| Pay Band | White | BME | Not Stated | Grand Total | % BME staff in band 2025/26 | % BME staff in band 2024/25 |
|---|---|---|---|---|---|---|
| Band 1 | 4 | 0 | 0 | 4 | 0.00% | 0.0% ↔ |
| Band 2 | 17 | 1 | 0 | 18 | 5.60% ↑ | 4.9% ↑ |
| Band 3 | 13 | 0 | 0 | 13 | 0.00% | 2.7% ↓ |
| Band 4 | 19 | 0 | 0 | 19 | 0.00% | 2.0% ↔ |
| Band 5 | 19 | 1 | 0 | 20 | 5.00% ↑ | 4.4% ↓ |
| Band 6 | 2 | 1 | 0 | 3 | 33.33% ↑ | 9.5% ↑ |
| Band 7 | 3 | 0 | 0 | 3 | 0.00% | 3.7% ↑ |
| Band 8A | 1 | 0 | 0 | 1 | 0.00% | 7.7% ↓ |
| Band 8B | 4 | 0 | 0 | 4 | 0.00% | 0.0% ↔ |
| Band 8C | 1 | 0 | 0 | 1 | 0.00% | 0.0% ↔ |
| Band 8D | 1 | 0 | 0 | 1 | 0.00% | 0.0% ↔ |
| Band 9 | 0 | 0 | 0 | 0 | 0.00% | 0.0% ↔ |
| Other Incl VSM | 0 | 0 | 0 | 0 | 0.00% | 0.0% ↔ |
| Grand Total | 84 | 3 | 0 | 87 | 3.4% | 3.9% ↑ |
| % of non-clinical | 96.6% | 3.4% | 0.0% | 100.00% | | |

### Key Findings:-

The number of staff employed in the trust has reduced due to the TUPE transfer of corporate staff into WUTH.

- The percentage of non-white staff employed at WCHC has increased from 5.26% last year to 6.07% this year with increases seen across clinical and non-clinical roles. Representation continues to be higher within clinical roles.
- The percentage of non-white clinical bands have increased, except for bands 4 and 7. For non-clinical roles, we have seen an increase in bands 2, 5 and 6.
- The percentage of non-white staff employed at WCHC (6.07%) is greater than the population of Wirral as a whole (4.8%, 2021 Census), although it is recognised that the WCHC also has staff working in services across Cheshire East, St Helens and Knowsley.
- The number of clinical BME staff is higher than non-clinical BME staff, with 5.7% (5.6% last year) of BME staff being clinical and only 3.4% non-clinical (3.9% last year).

## Indicator 2

This indicator relates to the relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

**Key Findings:**
BME applicants are less likely to be appointed from shortlisting than white applicants this year, with a relative likelihood of 2.03, however this is in improvement on last year.

## Indicator 3

This indicator relates to the relative likelihood of BME staff entering the formal disciplinary process, compared with that of non-BME staff.

**Key Findings:**
Within 2025/26, 17 people (0.95%) entered the disciplinary process. 1 staff were BME (0.01% of workforce numbers), 16 were white (including any “white ethnic group”)

This data therefore highlights that BME staff are slightly more likely to enter the disciplinary process than white staff, with a relative likelihood of 0.95 which is an improvement on 1.1 last year.

## Indicator 4

This indicator relates to the relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

**Key Findings :**
Data highlights that in 2024/5 this score was 0.82 and in 2025/26 this score was 0.003.
To note with the reduction of non-clinical staff this seems to have impacted on this data field.
As in line with the WRES technical guidance a figure below “1” would indicate that white staff members are less likely to access non mandatory training and CPD than BME staff.

# National NHS Staff Survey Findings

The next 4 indicators are taken directly from the 2024 staff survey report and relate to staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

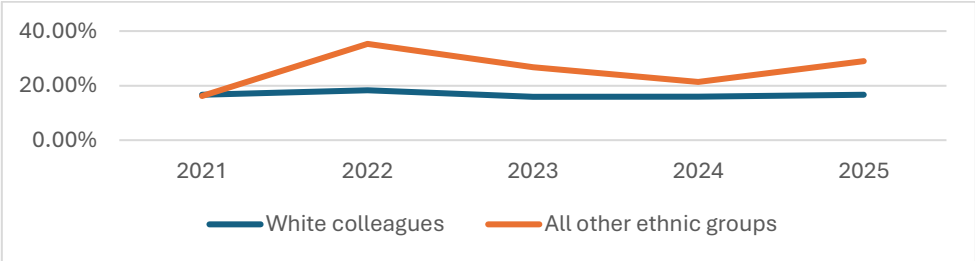
# Indicator 5

21.28% of our BME staff have indicated that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months compared to 16% of white colleagues. The chart below highlights for BME staff this is below the percentage Community Trust (CT) average that experienced harassment, bullying or abuse patients, relatives or the public in the last 12 months.

**Table 1 - Annual Data Comparison**

| | 2021 | 2022 | 2023 | 2024 | 2025 | **CT Average 2025** |
|---|---|---|---|---|---|---|
| **White colleagues** | 16.6% | 18.3% | 15.9% | 16.0% | 16.71% | **17.78%** |
| **All other ethnic groups** | 16.2% | 35.3% | 26.8% | 21.3% | 28.95% | **22.22%** |
| ***Difference (+/-)*** | *-0.4%* | *17.0%* | *10.9%* | *5.3%* | *12.24%* | *4.44%* |

**Chart 1 - Annual Comparison Graph**




# Indicator 6

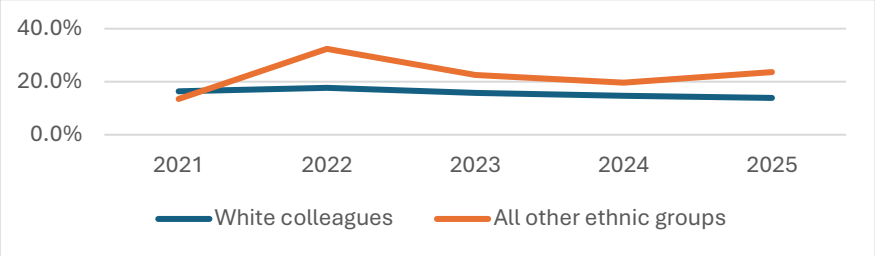
**Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.**

23.68% of our BME staff have indicated that they have experienced harassment, bullying or abuse from staff in the last 12 months compared to 13.90% of white colleagues. The chart below highlights that this year the year-on-year improvement trend has halted.

**Table 2 - Annual Data Comparison**

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 20245 |
|---|---|---|---|---|---|---|
| White colleagues | 16.4% | 17.7% | 15.8% | 14.7% | 13.90% | **13.90%** |
| All other ethnic groups | 13.5% | 32.4% | 22.5% | 19.6% | 23.68% | **17.65%** |
| *Difference (+/-)* | *-2.9%* | *14.7%* | *6.7%* | *4.9%* | *9.78%* | ***3.75%*** |

**Chart 2 – Annual Comparison Graph**




# Indicator 7

**Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.**

Due to the question changing the data is not comparable with previous years.

52.91% of BME staff believe that the trust provides equal opportunities for career progression or promotion compared to 60.20% of white colleagues. The chart below highlights this is figure for BME staff is above the comparator trust average and the differential is lower.

**Table 3 - Annual Comparison**

| | 2025 | CT Average 2025 |
|---|---|---|
| White colleagues | 57.53% | **60.20%** |
| All other ethnic groups | 55.26% | **52.91%** |
| *Difference (+/-)* | *2.27%* | *7.29%* |

# Indicator 8

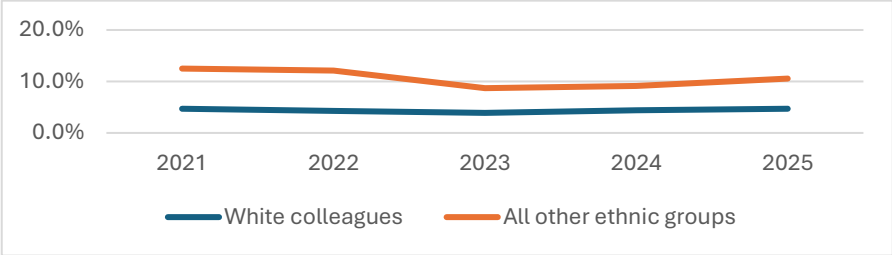
**Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues**

10.53% of BME staff have experienced discrimination at work from manager/ team leader or other colleagues which is equal to the community average however this is an increase on the previous year.

**Table 4 - Annual Data Comparison**

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| White colleagues | 4.7% | 4.3% | 3.9% | 4.4% | 4.70% | **4.70%** |
| All other ethnic groups | 12.5% | 12.1% | 8.7% | 9.1% | 10.53% | **10.53%** |
| *Difference (+/-)* | *7.8%* | *7.9%* | *4.8%* | *4.7%* | *5.83%* | *5.83%* |

**Chart 4 – Annual Data Graph**




# Indicator 9

**Percentage difference between the organisations' board voting membership and its overall workforce disaggregated:**

This indicator compares the percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

**Key Finding:**

The Trust has 17 Board members, 12 of whom are voting members. 16 identify as white (which includes all white categories as defined within ESR) and 1 BME and 0 recorded as unstated.

This gives a percentage difference for both the Trust boards voting and overall workforce as 2% and executive membership and its overall workforce of –6%.

To note the board has increased its membership and is a joint board with WUTH and have appointed during this reporting year a non-executive member from a BME background.

# Conclusion

The Trust has seen a mixture of improvements and areas of decline this year.

Improvements can be seen in:

- Trust demographics – with increases in non-white staff across clinical and non-clinical roles.
- The likelihood of BME staff entering the formal disciplinary process
- The likelihood of BME staff being appointed from shortlisting compared to the previous year

However, all other areas of staff survey results have unfortunately declined this year which include

- the percentage of staff experiencing harassment, bullying and abuse from patients
- the percentage of staff experiencing harassment, bullying and abuse from staff
- the percentage of staff believing that their equal opportunities for career progression/ promotion
- experiencing discrimination from any of the following: manager/ team leader or other colleagues.

The Trust has been awarded the bronze level of the North-West Anti-Racist framework and has publicly declared its commitment to being an anti-racist organisation.

The BAME Staff Network has merged with WUTH's Multicultural staff network and now has commenced joint meetings and special thanks is noted to its chair Millie Williams who has successfully led the group for the last few years. The network has an executive sponsor Dr Nikki Stevenson.

The scores have been shared with the network chair and joint group and actions have been developed in partnership. The action plan will continue to be reviewed on a regular basis to track progress and monitor the expected improvements for BME staff in their experiences at work.

## Appendix A - WRES Indicator Summary table for WCHC 2025/26 compared to previous year and national comparators

| WRES Indicator | | | Community Average 2025 | WCHC 2023-24 | WCHC 2024-25 | WCHC 2025-26 |
|---|---|---|---|---|---|---|
| 1 | % of BME staff | Overall | | 4.40% | 5.26% | **6.07%** |
| | | VSM | | | | **0.00%** |
| | | Clinical | | | | **5.70%** |
| | | Non-Clinical | | | | **3.40%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | | 6.1 | 3.99 | **2.00** |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | | | 6.57 | 1.11 | **0.95** |
| 4 | Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff | | | 0.99 | 0.82 | **0** |
| 5 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | **BME** | **22.22%** | **26.83%** | **21.28%** | **28.95%** |
| | | White | 17.78% | 15.91% | 16.01% | 16.71% |
| 6 | % of staff experiencing harassment, bullying or abuse from staff in the last 12 months | **BME** | **17.65%** | **22.47%** | **19.57%** | **23.68%** |
| | | White | 13.90% | 15.77% | 14.71% | 13.90% |
| 7 | % of staff believing that the Trust provides equal opportunities for career progression or promotion (previous years data not comparable) | **BME** | **52.91%** | | | **55.26%** |
| | | White | 60.20% | | | 57.53% |
| 8 | % of staff personally experiencing discrimination at work from a manager, team leader or other colleagues | **BME** | **10.53%** | **8.70%** | **9.09%** | **10.53%** |
| | | White | 4.70% | 3.89% | 4.41% | 4.70% |
| 9a | Board membership (voting board - workforce) | | | | | -5.00% | 2.00% |
| 9b | Board membership (exec board - workforce) | | | | | **-5%** | **-6%** |

Key:
- Improved from last year and above the national average
- Improved from last year however below the national average **or** reduced from last year however above the national aver
- Reduced from last year and below the national average

# Appendix B - Workforce Race Equality Standard (WRES) Action Plan 2026/27

**WRES Action Plan for 2026-27**

*For review with EDI Steering Group*

Wirral Community Health and Care
NHS Foundation Trust

# Workforce Disability Equality Standards (WDES) Report

July 2026

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# Background

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that have been reviewed as part of a consultation process with NHS staff across the country and seek to enable Trust to compare the experiences of disabled and non-disabled staff. Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff.

The WDES has been mandated by the NHS Standard Contract since 1 April 2019 and all Trusts must ensure data is uploaded to a government portal by no later than 31 May each year. Detailed reports including action plans to address areas of further work needed must also be developed and made public by no later than 31 October.

The WDES action plan forms one of the key ambitions within both the People Strategy and Inclusion and Health Inequality Strategy with the aim of improving both access to work for people with disabilities as well as their staff experience.

WCHC is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- To eliminate unlawful harassment and victimisation.
- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

WDES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

# Executive Summary

WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias, conscious or unconscious, is shown during key Trust processes such as recruitment, capability and career progression.

There are several positive results this year, with improvements seen in:

Data shows improvements in 4 of the 12 comparable WDES indicators this year:

- Increased representation of staff reporting they have a disability, from 7.3% last year to 9.5 this year;
- Less disabled staff a reporting experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (reducing from 26.57% last year to 25.09% this year);
- Less disabled staff are reporting experiencing harassment, bullying or abuse from managers in the last 12 months, reducing from 12.64% to 12.23%;
- More disabled staff are satisfied with the extent to which the organisation values their work, increasing from 34.93% last year to 37.05% this year. Interestingly, this element has declined for non-disabled staff.

A number of areas have however declined:

1) Staff engagement scores for disabled staff have fallen from 6.65 to 6.40. Engagement scores have unfortunately reduced for all except Global Majority staff this year;
2) Less disabled staff feel that adequate adjustment(s) have been made to enable them to carry out their work, reducing from 78.14% to 77.0%;
3) More disabled staff are reporting feeling pressure to come to work, despite not feeling well enough to perform their duties, increasing from 19.40% in 2025/26 to 23.44% this year.
4) More disabled staff are reporting experiencing bullying, harassment or abuse from colleagues in the last 12 months, increasing from 14.72% last year to 17.63% this year.
5) Of those that have experienced bullying, harassment or abuse, less disabled staff are unfortunately reporting it this year too (reducing from 65.98% to 56.60% this year).

Disabled staff are generally as likely to be appointed as they were last year and also have an equal likelihood of entering the formal capability procedure, when compared to non-disabled colleagues. This also remains the same position as last year.

WDES results highlight a number of concerning factors and will therefore be identified as a priority area for 2026/27.

The Ability Staff Network continues to meet on a regular basis and special thanks is noted to its chair Laura Kennedy. The network is working with co-chairs from the Sunflowers staff network at Wirral University Teaching Hospital (WUTH) to bring networks together and offer a combined approach and support to staff across both organisations.

Appendix A provides a summary overview of the Trust's performance.

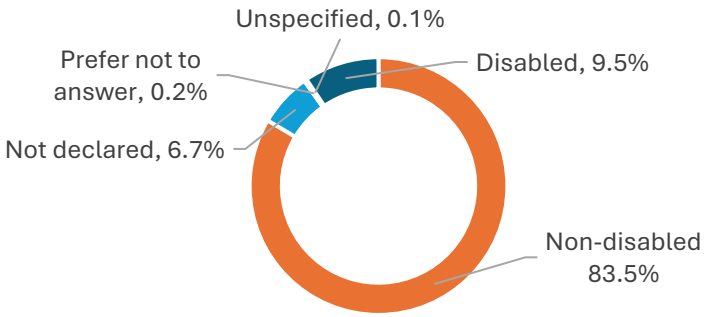
Appendix B provides a summary overview of key actions required to sustain and improve further the experiences of our disabled staff.

All actions identified in the 2025/6 action plan have been completed.

# Total Staff Breakdown 31 March 2026

As of 31st March 2026, the self-reporting rate for those staff with a disability within WCHC is 9.5% (as entered on to staff ESR records). This continues to increase each year, rising from 8.8% last year.

**Disability Status as of 31 March 2026**




# WDES Standard Indicators

There are 10 indicators which form the WDES metrics and these are as follows

| Indicator | Description |
|---|---|
| Metric 1 | Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce. |
| Metric 2 | Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. |
| Metric 3 | Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. |
| Metric 4 | Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse. |
| Metric 5 | Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion. |
| Metric 6 | Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. |
| Metric 7 | Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. |
| Metric 8 | Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work<br>** Prior to 2022, the term "adequate adjustments" was used* |
| Metric 9 | Engagement of disabled staff. |
| Metric 10 | Percentage difference between the organisation's board voting membership and its organisation's overall workforce. |

# Metric 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WCHC as a whole workforce as of 31 March 2026.

## Clinical staff breakdown by pay band

| Pay Band | Disabled | Non-disabled | Unknown/ NULL | Grand Total | % disabled staff in band 2025/26 | % disabled staff in band 2024/25 |
|---|---|---|---|---|---|---|
| **Band 2** | 10 | 104 | 8 | 122 | **8.2% ↓** | 8.93% |
| **Band 3** | 24 | 205 | 7 | 236 | **10.17% ↑** | 9.90% |
| **Band 4** | 8 | 111 | 9 | 128 | **6.25% ↓** | 7.38% |
| **Band 5** | 42 | 271 | 35 | 348 | **12.07% ↑** | 8.96% |
| **Band 6** | 43 | 353 | 25 | 421 | **10.21% ↑** | 9.71% |
| **Band 7** | 12 | 156 | 17 | 185 | **6.49% ↑** | 4.98% |
| **Band 8A** | 5 | 38 | 0 | 43 | **11.63% ↑** | 10.42% |
| **Band 8B** | 0 | 3 | 1 | 4 | **0.00%** | 0.00% |
| **Band 8C** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **Band 8D** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **Band 9** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **VSM** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **M&D – Consultant** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **M&D – Career Grade** | 0 | 24 | 0 | 24 | **0.00%** | 0.00% |
| **M&D – Trainee** | 0 | 0 | 0 | 0 | **0.00%** | 0.00% |
| **Grand Total** | **151** | **1340** | **107** | **1598** | **9.5% ↑** | 8.4% |
| **% of clinical staff** | **9.7%** | **83.5%** | **6.9%** | **100%** | | |

## Non-clinical staff breakdown by pay band

| Pay Band | Disabled | Non-disabled | Unknown/ NULL | Grand Total | % disabled staff in band 2025/26 | % disabled staff in band 2024/25 |
|---|---|---|---|---|---|---|
| **Band 1** | 0 | 4 | 0 | 0 | **0.00%** | 0.0% |
| **Band 2** | 0 | 18 | 0 | 4 | **0.00% ↓** | 6.6% |
| **Band 3** | 0 | 12 | 1 | 18 | **0.00% ↓** | 6.8% |
| **Band 4** | 3 | 13 | 3 | 13 | **15.8% ↑** | 12.0% |
| **Band 5** | 1 | 18 | 1 | 19 | **5.0% ↓** | 6.7% |
| **Band 6** | 1 | 2 | 0 | 20 | **33.3% ↑** | 9.5% |
| **Band 7** | 2 | 1 | 0 | 3 | **66.7% ↑** | 14.8% |
| **Band 8A** | 0 | 1 | 0 | 3 | **0.00% ↓** | 7.7% |
| **Band 8B** | 0 | 4 | 0 | 1 | **0.00% ↓** | 8.3% |
| **Band 8C** | 0 | 1 | 0 | 4 | **0.00%** | 0.0% |
| **Band 8D** | 0 | 1 | 0 | 1 | **0.00%** | 0.0% |
| **Band 9** | 0 | 0 | 0 | 1 | **0.00%** | 0.0% |
| **Other Incl VSM** | 0 | 0 | 0 | 0 | **0.00%** | 0.0% |
| **Grand Total** | **7** | **75** | 5 | 87 | **8.0% ↑** | 7.9% |
| **% of non-clinical** | **8.0%** | **86.2%** | **5.7%** | **100.00%** | **8.0%** | |

### Key Findings:-

- The percentage of self-declared disabled staff employed at WCHC has increased again this year from 8.8% to 9.5% this year with an increase across clinical and non-clinical roles.
- The majority of clinical bands have increased, with the exception of bands 2 and 4 however the % of staff in bands 8A and above continues to remain at 0%.
- For non-clinical roles, there have been improvements in representation of disabled staff in bands 4, 6 and 7, however reductions can be seen in bands 2, 3, 5, 8A and 8B
- There has been an increase in bands 3, 4, 5 and 8B, but a decrease in band 2, 6, 7, 8A, with no disabled staff representation now in bands 8A and above.
- The number of clinical disabled staff is higher than non-clinical disabled staff, with 8.4% (6.9% last year) of disabled staff being clinical and 7.9% non-clinical (8.5% last year).

Further work is still required to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

# Metric 2

This refers to the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

**Key Findings:**
Data for this indicator has declined slightly this year from a likelihood of 0.88 last year to 1.3 this year. Disabled applicants are less likely to be appointed this year.

# Metric 3

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

**Key Findings:**
No disabled staff entered the formal capability processes consistent with previous years.

# National NHS Staff Survey Findings

The next 6 metrics are taken directly from the staff survey results and relate to staff experiences of bullying and harassment, career progression opportunities and personal experience of discrimination. A summary overview can also be found at appendix A.

# Metric 4

Results of this metric are based on Q14 of the National Staff survey:

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months (table 1)
   ii) Managers (table 2)
   iii) Other colleagues (table 3)

b) looks at the percentage of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it

*Figure 1: % of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 20.0% | 24.3% | 19.2% | 26.6% | **25.09%** | 23.55% |
| **Non-disabled staff** | 15.4% | 16.9% | 14.6% | 11.8% | **13.44%** | 15.69% |
| ***Difference (+/-)*** | *-4.60%* | *-7.40%* | *-4.60%* | *-14.80%* | *-11.65%* | *-7.86%* |

Less disabled staff are experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months however results still fall above the national average for community Trusts. It is also interesting to see improvements in this area for disabled staff, particularly when this trend is not consistent for non-disabled staff.

*Figure 2: % of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 14.9% | 8.% | 8.4% | 12.6% | **12.23%** | 9.42% |
| **Non-disabled staff** | 4.7% | 6.1% | 5.2% | 3.3% | **3.24%** | 4.4% |
| ***Difference (+/-)*** | *-10.20%* | *-1.90%* | *-3.20%* | *-9.30%* | *-8.99%* | *-5.02%* |

Less disabled staff are experiencing harassment, bullying or abuse at work from managers in the last 12 months however results still fall above the national average for community Trusts. This trend is also consistent for non-disabled staff.

*Figure 3: % of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 18.3% | 21.5% | 19.3% | 14.7% | **17.63%** | 15.85% |
| **Non-disabled staff** | 11.2% | 8.4% | 9.9% | 10.6% | **7.57%** | 9.42% |
| ***Difference (+/-)*** | *-7.10%* | *-13.10%* | *-9.40%* | *-4.10%* | *-10.06* | *-6.43%* |

More disabled staff are reporting experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months and this falls negatively above the national average for community Trusts. It is also concerning to see that this is not the trend for non-disabled staff whose experience has improved and is at the lowest level since 2021 and is below the national average.

*Figure 4: % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it*

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 54.3% | 59.3% | 60.4% | 66.0% | **56.60%** | 61.85% |
| **Non-disabled staff** | 60.5% | 58.7% | 60.3% | 64.8% | **66.67%** | 61.15% |
| ***Difference (+/-)*** | *6.20%* | *-0.60%* | *-0.10%* | *-1.20%* | *-10.07%* | *0.7%* |

The scores have declined in this area for disabled staff this year, with results unfortunately below the national average. This is a different trend than for non-disabled staff who have higher levels of reporting this year and scores are above the national average.

# Metric 5

This metric is also taken from the national staff survey results and is the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Q15).

| | 2025 | CT Average 2025 |
|---|---|---|
| **Disabled staff** | **53.76%** | 54.82% |
| **Non-disabled staff** | 59.17% | 61.90% |
| ***Difference (+/-)*** | *-5.41%* | *-7.08%* |

To note that the previous year's data is no longer comparable so have been excluded from the report. This score is below the national average for community Trusts.

# Metric 6

This metric is again taken from the national staff survey results (Q11e) and looks at the percentage of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties (NB: a lower score is better).

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2024 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 25.5% | 20.8% | 18.9% | 19.4% | **23.44%** | 22.33% |
| **Non-disabled staff** | 16.4% | 15.6% | 12.8% | 15.3% | **13.93%** | 13.19% |
| ***Difference (+/-)*** | *-9.10%* | *-5.20%* | *-6.10%* | *-4.10%* | *-9.51%* | *-9.14%* |

Experiences in this area have unfortunately declined, with disabled staff feeling more pressure to come to work this year. Results are also above the national average. In comparison, results for non-disabled staff have improved.

# Metric 7

This metric looks at the percentage of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work (Q4b).

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 34.9% | 38.7% | 42.5% | 34.9% | **37.05%** | 41.11% |
| **Non-disabled staff** | 44.1% | 45.2% | 52.6% | 52.0% | **44.34%** | 54.29% |
| ***Difference (+/-)*** | *-9.20%* | *-6.50%* | *-10.10%* | *-17.10%* | *-7.29%* | *-13.18%* |

Disabled staff feel more satisfied this year with the extent to which the organisation values their work, however results still fall below the national average. In comparison, non-disabled staff are less satisfied.

# Metric 8

This metric is also taken from the national staff survey results and seeks to identify the number of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b)

| | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|
| **Disabled staff** | 84.0% | 79.3% | 78.1% | **77.05%** | 80.51% |

This score has continued to decline over the last 4 years for disabled staff and is below the national average.

# Metric 9

This metric is also taken from the national staff survey results and comprises of two elements:

a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall staff engagement score for the organisation.

b) Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?

**Part a - Staff Engagement Scores**

| | 2021 | 2022 | 2023 | 2024 | 2025 | CT Average 2025 |
|---|---|---|---|---|---|---|
| **Disabled staff** | 6.64 | 6.68 | 6.93 | 6.65 | **6.40** | 6.74 |
| **Non-disabled staff** | 7.05 | 7.07 | 7.28 | 7.22 | **7.07** | 7.24 |
| ***Difference (+/-)*** | *-0.41* | *-0.39* | *-0.35* | *-0.57* | ***-0.67*** | *-0.5* |

For both disabled and non-disabled staff the engagement scores have declined and the difference between disabled and non-disabled staff has also declined.

**Part b -** *Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?*

Several actions have taken place to facilitate the voices of disabled staff.

The Trust has an Ability Staff network for staff with disabilities and long-term conditions. The network has a staff chair Laura Kennedy and an Executive Sponsor.

In May 2026, as part of National Staff Network Day, information was shared across the Trust to promote the network, with stalls held to reach out and engage with staff.

The trust has agreed for half a day per month to be granted for all network chairs, with a toolkit developed including a terms of reference for each group and enabling a development plan for chairs. There has been recruitment for replacement co-chairs for other inclusion network groups and a budget allocated for network activities as part of the Inclusion budget. Building capacity and capability of our network will be a focus for 2025/26.

Staff network leads continue to meet with chairs of other networks, to ensure support and also an intersectional approach is fostered.

Network leads are also members of the Trusts EDI steering group, coming together to share updates on network activities and contribute to shaping policies, processes, support and ultimately working together for a more inclusive culture.

Regular communications are produced to raise awareness of key national and international awareness days and links made to areas for consideration, action needed and support services available for both staff and patients.

The Trust's Inclusion and Health Inequalities strategic commitment underpins the Trust's People Strategy and seeks to ensure that Inclusion is a golden thread throughout all our people practices and processes.

EDI sessions are also held as part of Manager Essential and Leading Teams programmes, within the themes of Compassionate Leadership and Recruitment being delivered.

# Metric 10

**Percentage difference between the organisations Board voting membership and its overall workforce disaggregated:**

- **By voting membership of the Board**
- **By executive membership of the Board**

The Trust has 17 Board member, 12 of whom are voting members. 3 have declared disability status and 1 does not have disability status recorded.

This gives a percentage difference for both the Trust boards and the overall workforce 8%, voting 16% and executive membership and its overall workforce of -9%.

# Conclusion

Data shows improvements in 4 of the 12 comparable WDES indicators this year:

- Increased representation of staff reporting they have a disability, from 7.3% last year to 9.5 this year;
- Less disabled staff a reporting experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (reducing from 26.57% last year to 25.09% this year);
- Less disabled staff are reporting experiencing harassment, bullying or abuse from managers in the last 12 months, reducing from 12.64% to 12.23%;
- More disabled staff are satisfied with the extent to which the organisation values their work, increasing from 34.93% last year to 37.05% this year. Interestingly, this element has declined for non-disabled staff.

A number of areas have however declined:

6) Staff engagement scores for disabled staff have fallen from 6.65 to 6.40. Engagement scores have unfortunately reduced for all except Global Majority staff this year;
7) Less disabled staff feel that adequate adjustment(s) have been made to enable them to carry out their work, reducing from 78.14% to 77.0%;
8) More disabled staff are reporting feeling pressure to come to work, despite not feeling well enough to perform their duties, increasing from 19.40% in 2025/26 to 23.44% this year.
9) More disabled staff are reporting experiencing bullying, harassment or abuse from colleagues in the last 12 months, increasing from 14.72% last year to 17.63% this year.
10) Of those that have experienced bullying, harassment or abuse, less disabled staff are unfortunately reporting it this year too (reducing from 65.98% to 56.60% this year).

Disabled staff are generally as likely to be appointed as they were last year and also have an equal likelihood of entering the formal capability procedure, when compared to non-disabled colleagues. This also remains the same position as last year.

WDES results highlight a number of concerning factors and will therefore be identified as a priority area for 2026/27.

The Ability Staff Network continues to meet on a regular basis and special thanks is noted to its chair Laura Kennedy. The network is working with co-chairs from the Sunflowers staff network at Wirral University Teaching Hospital (WUTH) to bring networks together and offer a combined approach and support to staff across both organisations.

Appendix A provides a summary overview of the Trust's performance.

Appendix B provides a summary overview of key actions required to sustain and improve further the experiences of our disabled staff.

All actions identified in the 2025/6 action plan have been completed.

Appendix A

## 2025/26 WDES Indicator Summary of Indicators Compared to previous year and national comparators

| WDES Indicator | | | Community Average 2025 where available / Aim | WCHC 2023-24 | WCHC 2024-25 | WCHC 2025-26 |
|---|---|---|---|---|---|---|
| 1 | % of disabled staff | | | 6.8% | 7.3% | **9.45%** |
| 2 | Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts | | | 1.5 | 0.88 | **1.3** |
| 3 | Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. | | | 0 | 0 | **0** |
| 4a.1 | % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | **Disabled** | **23.55%** | **19.24%** | **26.57%** | **25.09%** |
| | | Non-Disabled | 15.69% | 14.63% | 11.76% | 13.44% |
| 4a.2 | % of staff experiencing harassment, bullying or abuse from managers in the last 12 months | **Disabled** | **9.42%** | **8.39%** | **12.64%** | **12.23%** |
| | | Non-Disabled | 4.40% | 5.18% | 3.33% | 3.24% |
| 4a.3 | % of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months | **Disabled** | **15.85%** | **19.34%** | **14.72%** | **17.63%** |
| | | Non-Disabled | 9.42% | 9.94% | 10.62% | 7.57% |
| 4b | % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it | **Disabled** | **61.85%** | **60.39%** | **65.98%** | **56.60%** |
| | | Non-Disabled | 61.15% | 60.25% | 64.80% | 66.67% |
| 5 | % of staff believing that the Trust provides equal opportunities for career progression or promotion* (previous years not comparable) | **Disabled** | **54.82%** | | | **53.76%** |
| | | Non-Disabled | 61.90% | | | 59.17% |
| 6 | % of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties | **Disabled** | **22.33%** | **18.84%** | **19.40%** | **23.44%** |
| | | Non-Disabled | 13.19% | 12.77% | 15.31% | 13.93% |
| 7 | % of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work. | **Disabled** | **41.11%** | **42.48%** | **34.93%** | **37.05%** |
| | | Non-Disabled | 54.29% | 52.62% | 52.04% | 44.34% |
| 8 | % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work | **Disabled** | **80.51%** | **79.29%** | **78.14%** | **77.05%** |
| 9a | Staff engagement score | **Disabled** | **6.74** | **6.93** | **6.65** | **6.40** |
| | | Non-Disabled | 7.24 | 7.28 | 7.22 | 7.07 |
| 9b | Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard? | | N/A | Yes | Yes | Yes |
| 10 | Board membership (Voting board - workforce) | | | | 17% | 16% |
| 10 | Board membership (exec board - workforce) | | | | -7% | -9% |

Key:

Improved from last year and above the national average

Improved from last year however below the national average **or** reduced from last year however above the national average

Reduced from last year and below the national average

Appendix B

**WDES Action Plan for 2026-27**

| Elements | | Action | Deadline |
|---|---|---|---|
| **Seek to Understand** | 1 | Build new joint WCHC and WUTH staff network to support staff meeting together; sharing experiences, seeking support and empowering staff to speak up. | 31/12/2026 |
| | 2 | Positive action to be taken in areas of low satisfaction with reasonable adjustments and higher levels of bullying, harassment or abuse and lower levels of satisfaction with speaking up. | 30/09/2026 |
| **Support** | 3 | Review Trust policy and processes in conjunction with WUTH to ensure accessible support. | 31/03/2027 |
| | 4 | Undertake case reviews to support wider learning and share best practice | 31/03/2027 |
| **Educate and Develop** | 5 | Deliver enhanced training and awareness opportunities including e.g. Deaf awareness; inclusive recruitment; access to work; neurodiversity and autism awareness and advice and support for managers on implementing reasonable adjustments. | 31/03/2027 |
| | 6 | Review integration of access to work processes and recommendations with a particular focus on procurement of items to support reasonable adjustments. | 31/03/2027 |
| **Celebrate and Promote** | 5 | Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support | Ongoing |
| | 6 | Launch and promote actions achieved by the ability network as part of the wider campaign of inclusion network achievements | Ongoing |

# Appendix 4 - Workforce Equality, Diversity and Inclusion (EDI) Update Summary – Sep' 2026

## Setting Direction

- New Trust strategy
- Inclusion and Health Inequalities Strategy in place
- Staff networks involved in decision making processes and shaping future improvements at WCHC
- Member of regional network to support collaborative working across the ICB.
- EDI Objectives set for all Exec and Non-Exec Directors
- NHSE EDI Improvement actions integrated with existing EDI actions
- Menopause and Preventing Sexual Misconduct Policy.
- Listening events held for Global Majority staff
- EDS 2025 assessment completed and published
- WRES and WDES data reviewed with staff networks
- Combined WUTH and WCHC staff networks and identified executive partners

**What's next…**

- EDS 2026
- Implementation of staff standards and Lord Mann review

## Development, Education and Awareness

- 97.1% compliant with EDI mandatory training (Jun)
- MHFA programme launched
- Deaf awareness offered to staff
- Race equality masterclasses and workshops held and guest speakers at networks
- Launch of mandatory sexual safety training
- Reasonable adjustments and supporting staff with disabilities sessions held
- EDI embedded within all leadership and management programmes - Inclusive Recruitment and Inclusive Leadership sessions delivered.
- Coaching conference held with focus on neurodiversity and menopause
- Crucial conversations

**What's next…**

- Neurodiversity awareness
- Trans awareness

## Monitoring and Assurance

- Annual monitoring of workforce demographics
- EDS and Gender pay gap reporting completed
- New reporting cycle implemented and working well, with EDI Bi-Annual reporting commenced
- New EDI dashboard
- Veteran Aware review approved
- Board EDI objectives in place
- Revised staff survey campaign approach to increase staff voice
- Staff experience triangulation methodology developed to further understand experiences of non-white staff
- Quarterly LEAF reporting to NHS North West

**What's next…**

- Focus on workforce culture and identification of key metrics

## Communications

- Regular Trust communications to promote key events , and information and key messages from the Board
- Staff networks included in Get Together briefs
- EDI webpages updated with key reports
- Comms campaigns to promote Race equality, Sexual Safety and Staff Safety

**What's next…**

Enhanced promotion of staff networks

## Events

- Flag raising for PRIDE month and armed forces week
- Range of events that support awareness raising for patient and staff support
- Support of various national and international awareness days/weeks and months e.g. International Women and Mens Day, Race Equality Week and menopause month
- Range of activities to support religious festivals
- Departmental events e.g. Culture Days
- Remembrance Day events, including service on site and at local Cenotaph
- National Day of staff networks promotional stalls

## Staff Support

- Six staff networks in place
- Armed Forces network refreshed and working across both trusts
- Network chairs "buddying" with colleagues from WUTH
- Staff sharing experiences to help others
- New staff menopause leaflet launched
- OH service, including 24/7 employee assistance programme
- Access to online wellbeing app Pleaz (pilot)
- New process and support pathway for disabled staff
- Listening events held for non-white staff

**What's next…**

- Demographic monitoring at directorate level to be developed

## Accreditations

- Recent achievement of NHS England's Anti-Racism Bronze Award
- Veteran Aware
- Defence Employer Recognition Scheme (DERS) Silver Level Achieved
- Re-accredited as a Disability Confident Employer

**What's next…**

- Veteran Aware re-accreditation this year
- Re-accreditation as a Disability Confident Employer

**Anti-Racism, Antisemitism and Anti-Muslim Hostility Action Plan, in Response to Lord Mann's Review and NHS England Request**

| No | Recommendation | Responsibility | Date | Progress | Comments |
|---|---|---|---|---|---|
| 1 | To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles | People Experience | 30/09/2026 | Green | Included within EDI Biannual report 1 for review and approval |
| 2 | Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework | H&S | tbc | Red | Implementation stalled. |
| 3 | Prepare to implement the forthcoming NHS Staff Standards | People Experience | 31/03/2027 | Green | Standards reviewed and key areas identified and currently under review with workforce leads. |
| 4 | Adopt the new government definition of anti-Muslim hostility | People Experience | 31/07/2026 | Green | Recommended as part of EDI Biannual report 1 and approved at EDI steering group and WSB and progressing through workforce governance structures as part of appropriate workforce policies. |
| 5 | Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia | People Experience & L&D | 31/09/2026 | Complete | 93% for WUTH and 97% for WCHC |
| 6 | Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months) | People Experience & L&D | | | Awaiting publication |
| 7 | Ensure Board agreement to undertake new anti-racism training when it becomes available. | Chief People Officer | 31/09/2026 | Green | Request included as part of EDI Biannual report 1 for review and discussion with Board. Agreement can be reached in principle, however would need to be further considered following the programme launch. |
| 8 | Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally | People Experience | Ongoing | Green | Initial statement issued on 10.06.26 promoting the recommendations and the Trusts commitment to adopting. Ongoing communications to be completed |
| 9 | Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress. | Chief People Officer | 31/03/27 | Green | Staff survey 2025 data presented as standalone updates and as part of Staff Experience and EDI update reports. Further review to be undertaken with 2026 data. |

**Group Board of Directors in Public** **Item 30**

**04 November 2026**

| | |
|---|---|
| **Title** | Fit and Proper Persons Annual Update and Policy |
| **Area Lead** | Ali Hughes, Joint Director of Corporate Affairs and Communications |
| **Author** | Cate Herbert, Company Secretary |

| **Purpose of the Report and Recommendation** | |
|---|---|
| **Report For** | Approval |

This report provides an annual update confirming completion of the Fit and Proper Persons checks and ongoing compliance, as well as the joint policy for approval

It is recommended that the Committee

- Takes assurance that the Fit and Proper Persons annual tests have been completed and submitted successfully; and
- Approves the Joint Fit and Proper Persons Policy
- Approves the principle for application of the policy to additional roles.

## Key Points to Note

All members of the Board and any individual with "significant influence" over Board decision making are subject to the Fit and Proper Persons Test. The annual cycle of tests has been undertaken for all individuals and no areas of concern have been highlighted. The annual return was submitted to NHSE within the timescale of 30 June 2026.

## Key Risks

This report relates to these key risks:

- BAF ID07 - 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 | 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 | Yes |
| Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future | No |

| **Governance journey** | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 16 July 2026 | People Committee | Draft Fit and Proper Persons Policy | Approval of draft policy for submission to staff consultation |
| 30 September 2026 | People Committee | Fit and Proper Persons Annual Update and Policy | Approval of policy for submission to the Board.<br>Assurance on completion of checks. |

| **1** | **Narrative** |
|---|---|
| **1.1** | **Fit and Proper Persons Annual Checks**<br>The Fit and Proper Persons Test consists of a series of checks that must be carried out on senior decision makers to ensure their integrity and fitness to discharge their office. The requirements were revised in 2023 to strengthen the NHS approach following the Kark review, and both WUTH and WCHC have policies which comply with these requirements. |
| **1.2** | The Fit and Proper Persons requirement applies to all permanent and interim Executive and Non-Executive appointments, and those who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>WCHC has historically interpreted the requirement and Regulation 5 to mean all Board members, and WUTH has extended the definition to include deputies to Executives.<br><br>All Executive and Non-Executives, and all Deputies who are employed by WUTH, are therefore subject to this requirement. These individuals were tested at the point either of recruitment or TUPE to WUTH, and then again as part of the annual cycle undertaken in May/June 2026. |
| **1.3** | The annual series of checks was undertaken in May/June 2026, in line with the WUTH and WCHC policies. Each individual's checks were signed off by the Director of Corporate Affairs and Communications and the Senior Independent Director (or the CEO and Chair for those two post holders). No concerns were raised as part of the process.<br><br>The annual return confirming compliance was provided to NHSE on 25th June 2026, meeting the deadline of the 30th June. The return has been acknowledged, with no further queries raised at the time of writing this report. |
| **1.4** | **Joint Fit and Proper Persons Policy** |

| | |
|---|---|
| | A joint Fit and Proper Persons policy has been drafted as attached at the appendix. This policy takes into account the changes to NHSE guidance on Fit and Proper Persons tests, removed outdated references from both Trusts' policies, and strengthens the oversight and processes for ongoing assessment and assurance.<br><br>The policy was reviewed by the People Committee in both July and September 2026. That Committee has recommended the policy to the Board for approval.<br><br>Since the People Committee approved this policy, two sections have been amended to address a recently completed MIAA audit on Fit and Proper Persons.<br>These are:<br>• the Duties and Responsibilities section, which now includes specific duties for the Council of Governors, People Committee and Company Secretary. Some minor amends have been added to clarify the roles of the Chair, Chief People Officer, and Director of Corporate Affairs and Communications<br>• the Dispute Resolution section, which now includes further detail on the means by which an internal investigation of a dispute on FPP might be carried out.<br><br>The Board are therefore requested to approve this policy. The policy will then go to the wider staff body for consultation, and any substantial amends requested by that group would be brought back to the Board for consideration. |
| **1.5** | **Application of the policy**<br>As referenced in section 1.2, there is a discrepancy between the Trusts' application of the policy, as the definition of "directors" within Regulation 5 is left open to interpretation. The policy allows the Trusts to determine additional roles – meaning those who are not permanent or interim Executive and Non-Executive Directors, but who may exercise significant influence over Board decision making.<br><br>It is proposed that both Trusts adopt the same principle for application, and defines these additional roles as:<br>• Deputies for those Executive Directors who have a vote on the Board<br>• Company Secretary<br><br>This principle was tested within the recent MIAA audit and found to be reasonable. It was also tested with system partners and found to be a good balance.<br><br>It is requested that the Board approve this principle for application. This can be expanded at any point in the future should the Trust deem it necessary. |

| **2** | **Implications** |
|---|---|
| **2.1** | **Patients** |

| | |
|---|---|
| | • Supports the delivery of safe, effective and well-governed services by ensuring that individuals in Board-level positions are suitably qualified, competent and fit to undertake their responsibilities. |
| **2.2** | **People**<br>• Provides a fair, transparent and consistent framework for the recruitment, assessment and ongoing review of Board members and senior leaders. |
| **2.3** | **Finance**<br>• No direct financial implications. |
| **2.4** | **Compliance**<br>• Assists the Trust to meet its statutory obligations under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and aligns with NHS England, CQC and internal audit expectations relating to the Fit and Proper Persons Test. |

Policy Reference: TBC

# Fit and Proper Persons Policy

## Version: 1

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| | | | |
|---|---|---|---|
| **Author(s) Name:** | Catherine Herbert | **Author(s) Designation:** | Company Secretary |
| **Author(s) Dept** | Trust Governance | | |
| **Co-Author(s) Name:** | | **Co-Author(s) Designation:** | |
| **Co-Author(s) Dept** | | | |
| **Approval Date:** | | **Approval Group:** | |
| **Ratification Date:** | | **Ratification Group:** | |
| **Published Date:** | | **Review Date:** | |
| **Target Audience:** | All individuals deemed to be subject to the FPPT including all Board members both permanent and interim. | | |
| **Links to other Policies, Strategies, Procedures etc.** | Conflicts of Interest policies<br>Professional Codes of Conduct | | |

## Key Points for Staff

- The Fit and Proper Persons Test (FPPT) applies to all individuals within the scope of this policy and must be satisfied on appointment and throughout the duration of their tenure.

- All Board members and individuals covered by this policy are required to complete an annual self-attestation and participate in the annual FPPT review process.

- Individuals must immediately declare any matter that may affect their fitness to hold office, including criminal investigations, regulatory action, professional conduct matters, insolvency events, or allegations of serious misconduct.

- The Trust will undertake appropriate checks on appointment and annually thereafter to ensure continuing compliance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Any concerns regarding an individual's fitness will be reviewed fairly, proportionately and in accordance with this policy before any determination is made

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## 1 Introduction & Purpose

Wirral University Teaching Hospital and Wirral Community Health and Care NHS FTs are responsible for determining whether individuals in key positions as defined by Regulation 5 of the Health and Social Care Act are fit and proper to undertake their role and hold authority within their Trust.

The Fit and Proper Persons requirement applies to all permanent and interim Executive and Non-Executive appointments, and those who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Trusts may determine additional roles to be within scope where the postholder exercises significant influence over Board decision-making.

Individuals in these roles must meet the requirements on appointment, and continue to meet these requirements whilst holding office as a director.

This policy outlines both Trusts' responsibilities in relation to the Fit and Proper Persons Test and to outline the processes that will ensure the test is correctly applied and regularly monitored.

## 2 Definitions

| | |
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| **Board Member** | Any individual serving as a Chair, Non-Executive Director or Executive Director of the Trust, and any other individual determined by the Trust to fall within the scope of the Fit and Proper Persons Test. |
| **CQC** | The Care Quality Commission, the independent regulator of health and social care services in England. |
| **Director** | An individual who performs the functions of, or functions equivalent or similar to, those of a director within the meaning of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |
| **ESR** | Electronic Staff Record, the NHS workforce management system used to record and maintain FPPT information and compliance evidence. |
| **Fit and Proper** | The statutory requirement under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that directors are of good character and have the competence, qualifications, experience and integrity required to hold office. |
| **Good Character** | The requirement set out in Schedule 4 of the Regulations relating to matters such as criminal convictions, professional conduct, honesty, integrity and suitability for the role. |
| **NHS England (NHSE)** | The national body responsible for oversight of the NHS in England and for issuing the NHS England FPPT Framework for Board Members. |
| **Open-Source Media Search** | A search of publicly available information to identify relevant matters that may affect an individual's suitability to hold office, |

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| | undertaken proportionately and in accordance with data protection requirements. |
| **Self-Attestation** | A formal declaration completed by an individual confirming that they continue to meet the requirements of the FPPT and disclosing any matter that may affect their fitness to hold office. |
| **Unfit** | A person who does not satisfy one or more of the requirements of Regulation 5 and therefore may be unsuitable for appointment to, or continuation in, a role within the scope of the FPPT. |

## 3 Duties & Responsibilities

| | |
|---|---|
| **Board** | The Board has overall responsibility for ensuring compliance with the Fit and Proper Persons Regulations and receiving assurance that all individuals within scope continue to meet the requirements. |
| **Chair** | The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test, which shall be independently verified by the SID, and the Chair shall independently verify the SID's FPPT checks.<br>The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e., are deemed 'unfit') do not continue in their role. |
| **Senior Independent Director** | The Senior Independent Director is responsible for undertaking independent verification on Fit and Proper Persons checks. The SID will support the Board in reviewing any concerns relating to the Chair and provide independent assurance regarding the robustness of the process. |
| **Chief Executive** | The Chief Executive although subject to the requirements of the test is also accountable to the Board for compliance with statute and regulation. |
| **Chief People Officer** | The Chief People Officer is responsible for ensuring that all employment, recruitment and workforce checks required under the Fit and Proper Persons Test (FPPT) are undertaken in accordance with Trust policies relevant legislation. The Chief People Officer shall ensure that all records relating to these pre-employment checks are maintained appropriately. |
| **Director of Corporate Affairs & Communications** | The Director of Corporate Affairs & Communications is the Executive Lead for the Fit and Proper Persons Test and is responsible for oversight of the Trust's compliance with the FPPT Regulations, ensuring appropriate processes, policies and controls are in place. The Director will confirm the completion of checks, escalate concerns where necessary, and report compliance to the Council of Governors, Board, and relevant Committees. |
| **Company Secretary** | The Company Secretary is responsible for the administration of the Fit and Proper Persons Test process, including coordinating pre-appointment and annual checks for all individuals within scope of the regulations. The Company Secretary will maintain the registers and |

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| | |
|---|---|
| | evidence of all tests, and will support the Chair and SID in the management of any concerns regarding FPP. |
| **Executive and Non-Executive Directors** | All Executive and Non-Executive Directors as outlined in the scope of this policy are accountable for ensuring they meet the requirements of the Fit and Proper Persons Test on appointment and complete annual self-attestation. They are also responsible for informing the Chair if during the course of employment or term of office they no longer meet the requirements of the Fit and Proper Persons Test and therefore are deemed "unfit." |
| **People Committee** | The People Committee provides oversight of compliance with the Fit and Proper Persons Test requirements on behalf of the Board, including review of the policy and receiving annual assurance regarding completion of checks. |
| **Council of Governors** | The Governors will receive the annual update confirming completion of the annual checks. Governors will be responsible for signing off on the appointment of new NEDs, which will include confirmation of satisfactory FPPT completion. |

## 4 Regulation 5

4.1 Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care.

4.2 The regulation requirements are that:

a. the individual is of good character
b. the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed.
c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
d. the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
e. none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

4.3 The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a. the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
b. the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
c. the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
d. the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

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e. the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
f. the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment

4.4 The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a. whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence
b. whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

4.5 Serious misconduct or mismanagement

a. Serious misconduct, as referenced in 4.2 (d), is defined by the CQC as as a breach of "a legal or contractual obligation imposed on the director," for example an employment contract, regulatory requirements, criminal law or engaging in activities which are morally reprehensible or likely to undermine public confidence. Examples of serious misconduct include assault, fraud and theft

b. Mismanagement, as referenced in 4.2 (d), is defined by the CQC as "being involved in the management of an organisation in such a way that the quality of decision-making and actions of the managers falls below any reasonable standard of competent management." Examples of serious mismanagement include any dishonest conduct, continued failure to develop and manage business, financial or clinical plans, and having no regard to appropriate standards of governance.

While serious misconduct tends to be a single incident, serious mismanagement is likely to refer to actions over a period of time.

4.6 Further guidance from NHSE and the CQC can be found via the below links. The NHS Framework link below includes the template for self-attestations and Board member references:

Fit and proper persons: directors - Care Quality Commission
NHS England » NHS England fit and proper person test framework for board members
NHS England » Fit and Proper Person Test for board members: guidance on electronic staff record

## 5 New Appointments

5.1 The Trusts' pre-employment checking processes are determined by the NHS employment standards and include the following:

- Employment history and reference checks, one of which must be the most recent employer (including validation of a minimum period of six consecutive years of continuous employment or training and details of any gap) and including reasons for leaving;

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- Qualification and professional registration checks (as relevant to post).
- Right to work checks.
- Proof of identity checks.
- Occupational Health Assessment.
- Different types of criminal record check, including the Disclosure and Barring Service (DBS), where relevant to the post and where eligibility criteria are met.
- Details of most recent appraisals
- Details of formal learning and development

5.2 In addition, the following checks shall be carried out for Director appointments:

- Search of the insolvency and bankruptcy register by individual's name
- Search of the insolvency and bankruptcy register by individual's company name, where appropriate
- Search of the disqualified directors register and the removed trustee register
- Search for any county court judgements or adverse financial judgements
- Search for any judgement in an employment tribunal
- Search of open source media

5.3 The Regulations include the requirement to complete a self-attestation form for new employees. This form will be required as part of the recruitment process and pre-employment checks, and will be sourced from the NHSE guidance.

5.4 When recruiting an individual currently at Board level into a Board level role, at least one reference should be obtained on the standardised reference template. This applies to permanent, temporary, and internal appointments. It also applies where a Board member from another organisation joins the Trust in a non-Board level role.

5.4 While the Trusts will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent,' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

5.5 No offers of employment shall be confirmed until the Fit and Proper Persons process has been complied with and evidenced, with input from the Director of Corporate Affairs & Communications and the Chair.

A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit.

5.6 Any executive or non-executive appointment will take into account the Trusts' obligations under the Regulations. Where a Trust makes a decision on the suitability of an individual, the reasons will be appropriately documented.

5.7 Where information is identified that may call into question whether an individual meets the good character requirement, the Trusts will undertake a documented and proportionate assessment before determining whether the individual satisfies the requirements of Regulation 5.

5.8 Information identified through an open-source media search will be considered where it is relevant to the requirements of Regulation 5. Findings will be assessed

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taking account of source credibility, verifiability, relevance, seriousness, recency and any explanation provided by the individual concerned.

5.9 Any significant concerns will be managed in accordance with the Trust's Concerns Regarding Fitness process outlined in Section 9.

5.10 Where specific qualifications are deemed by the Trusts as necessary for a role, the Trusts will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

5.11 The Trusts will carry out employment checks (as far as reasonably practicable) on a candidate's qualifications and employment records.

5.12 If the Director has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

## 6 Annual Review Process

6.1 The Trusts are responsible for ensuring the continued "fitness" of those persons to whom the requirements apply. The Trusts will therefore undertake the following on an annual basis after the end of each financial year:

a) The completion of an annual self-attestation form by all those named within the scope of this policy and returned to the Director of Corporate Affairs & Communications.

b) The completion of annual checks of:
- The insolvency and bankruptcy register
- The disqualified directors register
- The removed trustees register
- The county court judgements registers
- Employment tribunal registers
- Open-source media

c) The formal appraisal process, enhanced to address the Fit & Proper Persons requirements, will be undertaken by the appropriate person with line management responsibility.

d) It is the responsibility of the Director of Corporate Affairs & Communications to escalate any non-compliance to the Chair.

e) In the case that there is a non-compliance matter relating to the Director of Corporate Affairs & Communications, the matter will be overseen by the CEO in liaison with the Chair. In the case that there is a non-compliance matter relating to the Chair, the matter will be overseen by the SID.

## 7 Record Retention

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7.1 All records will be held by the Director of Corporate Affairs and Communications, including all new starter and annual checks and declarations. These will be retained in accordance with the Records Management Code of Practice and Trust retention schedule.

7.2 ESR will be used by the Trust to record that FPPR tests have been undertaken and to produce reports to support audit trails of completed testing, sign off and annual assessment. Information held in ESR will only be accessible by a limited number of senior individuals within the Trust, including Recruitment.

7.3 ESR will be updated:

- For all new and existing board members/executive directors
- Whenever there has been a change to relevant FPPT information held on ESR.
- For annual completion of the full FPPT; and
- For annual completion of FPPT confirmed by Chairs.

7.4 Further information on data recorded on ESR can be found in section 3.10 of the Framework and in the FPPT for Board members: Guidance on electronic staff record.

## 8 Joint Appointments

8.1 Where an individual is appointed to both WUTH and WCHC in a joint role, the employing entity will complete the Fit and Proper Persons test in full, and seek sign off from the Chair as usual. The employing entity will then provide a letter of confirmation (template within the NHSE guidance) to confirm that the individual in question has met the requirements of the FPPT.

8.2 Should an individual be employed by both Trusts in different roles, each entity must complete the FPPT for the respective roles.

8.3 Where there is a joint appointment, the employing entity will lead on the joint appraisal and ensure appropriate input is provided from the other contracting organisation.

8.4 The employing entity will be responsible for the update of ESR as laid out in Section 7.

## 9 Concerns regarding fitness

9.1 Individuals subject to FPPT must immediately notify the Director of Corporate Affairs & Communications and the Chair of any matter that may affect their fitness to hold office, including criminal investigations, regulatory sanctions, insolvency events, exclusion from professional registers, safeguarding concerns, or allegations of misconduct.

9.2 Any concern raised regarding the fitness of an individual within the scope of this policy will be considered promptly and fairly. Concerns may arise through self-disclosure, internal reporting, whistleblowing processes, regulatory notifications, employment proceedings, media reports, or information received from external organisations. The existence of a concern does not automatically indicate that an

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individual has failed the Fit and Proper Persons Test, and no conclusion will be reached until the matter has been appropriately reviewed.

9.3 Where a concern is identified, the Director of Corporate Affairs & Communications will undertake an initial assessment in conjunction with the Chair, Chief Executive, or Senior Independent Director, as appropriate to the circumstances. The purpose of the assessment will be to determine whether further investigation is required and whether the matter has the potential to affect the individual's fitness to hold office under Regulation 5. The Trusts may seek advice from Human Resources, legal advisers, NHS England, regulators, or other appropriate bodies where necessary. All concerns, assessments, investigations, decisions and actions will be documented and retained in accordance with the records management arrangements.

9.4 Following review of all available information, the Trusts will determine whether:

- No further action is required;
- improvement, development or monitoring actions are required;
- there has been a breach of the Fit and Proper Persons requirements; or
- the matter should be referred to NHS England, the Care Quality Commission, a professional regulator or another appropriate authority.

9.5 Where a concern relates to the Chair, it will be considered by the Senior Independent Director. Where a concern relates to the Chief Executive, it will be considered by the Chair. Concerns relating to any other Board member will be considered by the Chair in consultation with the Chief Executive as appropriate.

## 10 Breaches

10.1 The Regulation will be breached if an individual subject to FPPT:

a. Is unfit on the grounds of character, such as:
   - An undischarged conviction
   - Being erased, removed or struck off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - Being prohibited from holding a relevant office or position.

b. Is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity

c. Is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.

d. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.

e. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.

f. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

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10.2 With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

10.3 In such circumstances there should be a documented explanation, approved by the Chair, as to why the individual in question is deemed fit to be appointed as a Board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director.

10.4 Furthermore, there may be a limited number of exceptional cases where a Board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but a Trust appoints them or allows them to continue their current employment as a Board member.

10.5 In such circumstances there should be a documented explanation as to why the Board member is unfit and the mitigations taken, which is approved by the Chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the Trust, or on an ad hoc basis as a case arises.

10.6 The Trusts shall determine breaches based on points 8.1(a) to (d), whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 8.1 (e) and (f).

10.7 In the event of a breach based on points 8.1 (a) to (d), an initial assessment will be undertaken by the Director of Corporate Affairs & Communications in consultation with the Chair, Chief Executive or Senior Independent Director, as appropriate. The purpose of the assessment is to determine the nature of the concern, whether further investigation is required, and whether immediate action is necessary.

10.8 Where appropriate, a formal investigation will be undertaken and advice sought from Human Resources, legal advisers, NHS England, regulators or other external bodies. Following consideration of all relevant information, the Trust will determine whether the individual continues to meet the requirements of Regulation 5 and whether any further action is necessary.

10.9 Outcomes may include:

- No breach identified and no further action required;
- An agreed improvement, development or monitoring plan;
- Referral to an external body or regulator;
- A determination that the individual no longer meets the requirements of the Fit and Proper Persons Test; or
- Removal from office or termination of appointment, subject to the relevant contractual, statutory and employment processes.

10.10 All decisions and actions taken will be appropriately documented and retained in accordance with the records management arrangements.

10.11 All breaches will be escalated through the Trust Governance structure, and reported to the Audit Committee and then to the Board.

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## 11 Dispute Resolution

11.1 Where a board member or executive director identifies an issue with data held about them in relation to the FPPT or disagrees with the outcome of a FPPT, they should submit a written request for review to the Director of Corporate Affairs & Communications or the Company Secretary. Where either individual has been directly involved in the decision under review, an alternative senior officer will be nominated to coordinate the process.

11.2 The Trust will undertake a proportionate review of the concerns raised. The review process will be agreed with the individual where appropriate and may include consideration of additional evidence, verification of information held by the Trust, and meetings with relevant parties. A written outcome will be provided, setting out the findings of the review and any actions arising.

11.3 Where information is found to be inaccurate, incomplete or incapable of verification, the Trust will take appropriate steps to correct or update its records and, where necessary, amend any FPPT documentation or submissions.

11.4 Where the individual remains dissatisfied with the outcome of the review, they may request that the matter is considered by the Chair, Senior Independent Director or another appropriately independent reviewer, depending on the circumstances of the case and the office held by the individual concerned.

11.5 Where this internal process is either not appropriate, or where it does not lead to a satisfactory resolution, alternative routes may be available. These may include:

- For Chairs – referral to the NHS England Appointments Team
- Referral to the Information Commissioner's Office where concerns relate to the processing or accuracy of personal data;
- (for executive director roles only) the use of relevant employment procedures or statutory employment rights
- Other remedies available in law

## 12 Assurance and Governance

12.1 To ensure compliance with the Regulation, quality assurance checks may be conducted by the Care Quality Commission (CQC), NHS England and/or an external/independent review.

12.2 CQC

- Whilst it is the Trusts' duty to ensure that they have fit and proper persons in post, the CQC has the power to take regulatory action against a Trust if it considers that it has not complied with the requirements of the Regulation. This may come about if concerns are raised to the CQC about an individual or during the annual review. During its inspections, the CQC will consider the following:
    - Quality of processes and controls supporting the FPPT
    - Quality of individual FPPT assessments
    - Board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
    - Collation and quality of data within the database and local FPPT records

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- This may involve checking the following forms of evidence:
    - That the Trust is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
    - Personnel files of recently appointed board members (including internal appointments of existing staff).
    - Information or records relating to appraisals for board members.
    - References and personal development plans.

12.3 NHS England

- NHSE will quality assure the Trusts through receipt and review of the annual submission to the regional director. The Trusts will submit this return in accordance with national guidance and timescales.

12.4 Internal Audit

- Every 3 years, the Trusts will undertake an internal audit/independent review of its FPPT processes, controls and compliance.

12.5 Board

- An Annual Report will be presented to a public Board meeting annually confirming that all individuals within the scope of the regulations have been assessed, and noting whether any breaches have been identified in year.

## 13 Downtime Plan

Downtime is not applicable to this policy.

## 14 References

**Acts of Parliament**
Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**Regulations**
Care Quality Commission (CQC) Guidance for NHS bodies November 2014 - Regulation 5: Fit and proper persons: Directors.

**Websites**
Care Quality Commission - www.cqc.org.uk

**NHS Sources**
NHSE - https://www.england.nhs.uk/

**Regulatory Bodies**
Care Quality Commission (CQC)

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## 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**

| | | | | |
|---|---|---|---|---|
| **Title** | Joint Fit and Proper Persons Policy | | | |
| **Policy Reference** | 282 | | | |
| **Lead Assessor** | Catherine Herbert | | | |
| **Date Completed** | 02/07/2026 | | | |
| **What groups have you consulted with? Include details of involvement in the EA process** | Staff in area concerned | ☐ | Staff side colleagues | ☐ |
| | Service users | ☐ | HR | ☐ |
| | Other | ☑ | Other | ☐ |
| | Please Give Details<br><br>Consultation with People Commitee | | | |
| **What is being assessed?** Please provide a brief description and overview of the aims and objectives | | | | |
| The processes in place to ensure that the Fit and Proper Persons Tests are applied correctly and that the Trust is able to discharge its responsibilities in relation to the regulations. | | | | |
| **Who will be affected** (Staff, patients, wider community?) | | | | |
| Those staff set out in section 1 of this policy. | | | | |

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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:**<br>• Advance equality of opportunity<br>• Foster good relations between different groups<br>• Address explicit needs of equality target groups | **Negative:**<br>• Unlawful discrimination, harassment and victimisation<br>• Failure to address explicit needs of equality target groups | **Neutral:**<br>• It is quite acceptable for the assessment to come out as Neutral impact<br>• 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) | Neutral | |
| **Age** | Neutral | |
| **Race** (all ethnic groups) | Neutral | |
| **Religion or belief** | Neutral | |
| **Sexual Orientation** | Neutral | |
| **Pregnancy & Maternity** | Neutral | |
| **Gender** | Neutral | |
| **Gender Re-assignment** | Neutral | |
| **Human Rights** | Neutral | |
| **Mental Health** | Neutral | |
| **Other e.g. Carers** | Neutral | |

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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.

| **Who and how have you engaged to gather evidence to complete your full analysis? (List)** | |
|---|---|
| **Name & Job Title** | **Name & Job Title** |
| | |
| **What are the main outcomes of your engagement activity?** | |
| | |
| **What is your overall analysis based on your engagement activity?** | |
| | |

## 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.

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## Consultation, Communication and Implementation

| Consultation Required | Authorised By | Date Authorised | Comments |
|---|---|---|---|
| **Equality Analysis** | To be completed by the author | To be completed by the author | This document is embedded within the Policy template |
| **Policy Author Checklist** | To be completed by the author | To be completed by the author | Checked for workforce / development, medicines, finance or wider corporate implications. |
| **Other Stakeholders / Groups Consulted as Part of Current Version Development** | To be completed by the author | | |
| **Trust Staff Consultation via Intranet** | To be completed by the Governance Support Unit (GSU) | | |

| | | | |
|---|---|---|---|
| **Date notice posted in the News Bulletin.** | N/A | **Date notice posted on the intranet** | To be completed by the GSU |

| **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?** |
|---|---|
| The policy will be published on the intranet. | Catherine Herbert |

### Version History

| Date | Ver | Author Name and Designation | Summary of Main Changes |
|---|---|---|---|
| 16/07 | 1 | Catherine Herbert, Company Secretary | Initial draft of a joint policy to cover both WUTH and WCHC |
| | | | |
| | | | |
| | | | |
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## 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 |
|---|---|---|---|---|---|
| Complete FPPT for all individuals who fall within the scope of this policy prior to employment | 100% | Via report to the Board | Group Board | Annually | Catherine Herbert |
| Annual assessments completed for all individuals who fall within the scope of this policy | 100% | Via return to NHSE and subsequent report to the Board | Group Board | Annually | Catherine Herbert |
| | | | | | |
| | | | | | |
| | | | | | |

## Performance Management of the Policy

| Who is Responsible for Producing Action Plans if KPIs are Not Met? | Which Committee Will Monitor These Action Plans? | Frequency of Review (To be agreed by Committee) |
|---|---|---|
| Catherine Herbert | People Committee | Bi-monthly |

## 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* | |

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**Group Board of Directors in Public** **Item 31**

**04 November 2026**

| | |
|---|---|
| **Title** | Managing Conflicts of Interest Bi-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 Committees with a mid-year update on the register of interest, gifts, and hospitality for both Trusts.<br><br>It is recommended that the Board<br>• Note the current position | |

| **Key Points to Note** |
|---|
| Both Trusts have good levels of compliance at the mid-year point. Work continues on increasing awareness of gifts and hospitality reporting figures. |

| **Key Risks** |
|---|
| This report relates to these key risks:<br>• 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** | 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** |
| 9th September 2026 | WUTH Audit and Risk Committee<br>WCHC Audit and Risk Committee | Managing Conflicts of Interest Bi-annual Update | Provide assurance on the mid-year position |

| 1 | Narrative |
|---|---|
| 1.1 | **Conflicts of Interest Current position**<br><br>**WUTH Declarations**<br>WUTH uses the digital Civica Declare solution for managing declarations of interest, and at the time of writing this report, there were 1649 staff who fall within the categories outlined in the Trust policy and 1375 of those completed their annual declaration/review. This is 83% of those required which is just below the sector's best practice figure of 85%.<br><br>**WCHC Declarations**<br>WCHC currently operates a paper based system for managing declarations of interest, as there are 54 individuals who fall within the policy's scope. Current compliance for the year is 94.4%. The outstanding declarations are being chased.<br><br>Further discussion is also ongoing with Civica Declare to determine if the solution can accommodate the WCHC declarations process. If not, the paper-based solution will continue until the point of transaction.<br><br>It should be noted that national guidance is for staff in band 8+ should submit declarations of interest, which is what WCHC adhere to. However, WUTH has historically required these from staff at band 7+, which is partly why the numbers are significantly higher within that Trust. |
| 1.2 | **Gifts and Hospitality**<br><br>**WUTH**<br>The current register of gifts and hospitality has been appended to this report.<br><br>**WCHC**<br>It was noted as part of the recent MIAA audit of WCHC Declarations of Interest that the Gifts and Hospitality register had not been sent through the governance process in the last financial year. Therefore the 2025/26 WCHC register has been attached to this report. No gifts or hospitality reports have been received at WCHC so far in year, and therefore no register is provided for WCHC for 2026/27.<br><br>There was one reported gift in 2025/26 at WCHC and no reported hospitality.<br><br>**Continued Reporting** |

| | |
|---|---|
| | The levels of gifts and hospitality declarations are low, as mentioned in the recent MIAA audits for both Trusts. Some of this is because gifts below the £50 value are not required to be declared in line with national guidance. However, there is a piece of work being undertaken by the Corporate Governance team to ensure that awareness of Gifts and Hospitality Declarations is raised across both Trusts, and these communications campaigns are generally targeted at key points in the year i.e. peak holiday seasons. This work will continue to boost reporting numbers. |

| 2 | Implications |
|---|---|
| 2.1 | **Patients**<br>• No direct implications on patients |
| 2.2 | **People**<br>• This report applies to all staff (gifts and hospitality), and those individuals identified in the Managing Conflicts of Interest policy. |
| 2.3 | **Finance**<br>• No direct financial implications. |
| 2.4 | **Compliance**<br>• The Trusts have 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 Trusts' policies. |

| Date Declared | Interest Type | Employee | Year | Role | CSU | User Type | Date Incurred | Provider | Provider Type | Interest Description (Abbreviated) | Frequency | Value £'s | Declined | Donate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25/04/2026 | Gifts | Cherish Cadelina | 2026/27 | Trusted Assessor (J2843) | 408 Transfer of Care Hub Team | Contracted Staff | 08/04/2026 | Overwritten for Data Protection | Family of Patient | Mowgli's gift voucher | Single | 100 | No | No |

| Date Declared | Interest Type | Employee | Year | Role | CSU | User Type | Date Incurred | Provider | Provider Type | Interest Description (Abbreviated) | Value £'s | Declined | Question 1 | Field 15 Label Text | Question 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | 1 night in hotel<br>Dinner, breakfast, lunch and snacks<br>Late entry from 6/10/25 | | | | | |
| 06/08/2026 | Hospitality | Nicola Breen | 2026/27 | Highly Specialist Pharmacis | 408 Pharmacy - Dispensary | Contracted Staff | 01/04/2026 | Ferring Pharma | Commercial Compa | IBD pharmacist conference<br>Travel expenses, accommodation and meals/drinks/refreshments | 235 | No | Yes | Authorised by | mcmanus aine |
| 06/08/2026 | Hospitality | Alexandra Soderbe | 2026/27 | Highly Specialist Pharmacis | 408 Pharmacy - Pharmacy | Contracted Staff | 01/04/2026 | Ferring Pharma | Commercial Compa | Late entry from 06/10/2026 IBD pharmacist conference | 279.1 | No | Yes | Authorised by | Aine McManus |
| | | | | | | | | | | Eylea eye conference learning event. 2 day Event Overnight<br>accommodation provided. | | | | | |
| 31/07/2026 | Hospitality | Jake Oliver | 2026/27 | Retinal Nurse Specialist (J2 | 408 Head & Neck - Ophthalmolog | Contracted Staff | 31/07/2026 | Novaritis Eylea | Commercial Compa | 21/03/25 date of provided hospitality | 125 | No | Yes | Authorised by | Leona Battrim-mercer |
| | | | | | | | | | | i attended the Procurement and Distribution Interest group (PDIG)<br>conference in Birmingham on 11.11.2025. I was offered a place as a guest<br>to go by Pfizer UK LTD, a pharmacy supplier. The price of the ticket was<br>£90 however I am unsure if Pfizer paid a different/ discounted price. The<br>sponsorship place included attendance, lunch, snacks and tea/coffee that<br>was provided for by the venue. | | | | | |
| 30/07/2026 | Hospitality | Lindsey Coppell | 2026/27 | Senior Pharmacy Technicia | 408 Pharmacy - Procurement Stor | Contracted Staff | 01/04/2026 | Pfizer uk | Supplier | It did not include travel.<br>Attendance of Procurement and Distribution Interest Group ( PDIG)<br>Autumn Symposium November 2025.<br>Date 11/11/2025 | 90 | No | Yes | Authorised by | Amy Janvier |
| 30/07/2026 | Hospitality | Sarah Davies-Peerl | 2026/27 | Clinical IT Systems Analyst | 408 Pharmacy - Procurement Stor | Contracted Staff | 01/04/2026 | PFIZER | Commercial Compa | Cost to the Trust would have been £90 but I don't know whether Pfizer<br>would have received a discounted price. | 90 | No | Yes | Authorised by | Amy Janvier |
| 13/04/2026 | Hospitality | Elizabeth Jones | 2026/27 | Consultant Haematologist | 408 Haematology - Haem IP | Contracted Staff | 13/04/2026 | Attendance at BSH Conference | Commercial Compa | Roche - paid for my attendance at the BSH conference<br>cost for member approx £200<br><br>Conference is sponsored bu multiple pharmacy companies<br><br>Cardiovascular Summit 2025<br><br>Bayer's Cardiovascular Summit took place in London on the 3rd and 4th of<br>October 2025. Designed to offer education including expert perspectives<br>and discussions on the management of Heart Failure, including differential<br>diagnoses such as Cardiomyopathy and Amyloidosis, with a focus on<br>Transthyretin Amyloid Cardiomyopathy (ATTR-CM).<br><br>One night accommodation in London and meals paid by Bayer company. | 200 | No | No | Authorised by | |
| 12/04/2026 | Hospitality | Heidar Zafarani Za | 2026/27 | Consultant | 408 Cardiology - Cardiology | Contracted Staff | 01/04/2026 | Bayer | Commercial Compa | Sponsorship for UK Kidney Week Conference in Harrogate 10/3/26 - | 250 | No | No | Authorised by | Approved Study leave |
| 11/04/2026 | Hospitality | Lucy Williams | 2026/27 | Clinical Lead - Renal | 408 Therapies - Dietetics | Contracted Staff | 01/04/2026 | Stanningley Pharma Limited | Commercial Compa | 12/3/26<br>Work for BMA at times involves travel to London. the BMA will pay for<br>train travel and accommodation if required to stay overnight. Amount<br>variable depending on whether in active negotiations with government or | 554.8 | No | Yes | Authorised by | AHP Education Committee |
| 09/04/2026 | Hospitality | Denise Langhor | 2026/27 | Consultant | 408 ED - Emergency Department | Contracted Staff | 09/04/2026 | BMA | Other | not. Approx. estimate around £2000 per annum though may be more or<br>less than this. | 2000 | No | No | Authorised by | |

## Gift and Hospitality Register April 2025 - March 2026

| Date item was declared | Description | Reason for gift/hospitality | Value/est. value | Accepted or declined |
|---|---|---|---|---|
| 09/10/2025 | Family have given a donation of £150 for staff night out and a toaster to be given for CSPCT charitable funds to account via Finance | Gift to Team | £150 & (cost of toaster) | Accepted |

Wirral Community Health and Care NHS Foundation Trust

| Role of staff member | Name of staff member- not to be published |
|---|---|
| CSPCT & EOL Manager | Charlotte Botes |

**Group Board of Directors in Public** **Item 32**

**04 November 2026**

| | |
|---|---|
| **Title** | 2025-2026 Annual Submission to NHS England Northwest Appraisal and Revalidation |
| **Area Lead** | Dr Paul Jeanrenaud, Medical Appraisal Lead |
| **Authors** | Dr Paul Jeanrenaud, Medical Appraisal Lead &<br>Cheryl Chaffe, Medical Appraisal & Revalidation Manager |

## Purpose of the Report and Recommendation

| | |
|---|---|
| **Report For** | Information |

The purpose of this report is to provide assurance to the Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies.

WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2025 - March 2026.

It is recommended that the Board

- Note the report

## Key Points to Note

- WUTH has an established process for Medical Appraisal and Revalidation.
- The appraisal process is quality assured, meaning it is subject to checks and review to ensure consistency and effectiveness.
- The process is compliant with the RO regulations.
- The standards are monitored by NHS England, providing external oversight and assurance.
- The report covers the appraisal year from April 2025 to March 2026.
- The purpose of the report is likely to demonstrate that WUTH's appraisal arrangements meet the required national standards for medical revalidation and governance.

## Key Risks

This report relates to these key risks:

- None to note.

| 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** |
| 09/09/2026 | Discussion with CH at RO Meeting. | 2025-2026 Annual Submission to NHS England North West WUTH | Obtain agreement of report content. |
| September 2026 | People Committee | 2025-2026 Annual Submission to NHS England North West WUTH | To present information to the People Committee for review, discussion, and assurance. |
| October 2026 | Group Board of Directors in Private | 2025-2026 Annual Submission to NHS England North West WUTH | Approval |

| 1 | Narrative |
|---|---|
| **1.1** | On an annual basis, Designated Bodies have been required to complete an Annual Organisational Audit (AOA) which is an element of the Framework of Quality Assurance for Responsible Officers.<br><br>Each designated body is expected to submit a report to their own board or equivalent management team; where a Responsible Officer and supporting team have responsibility for more than one designated body, separate reporting is required to ensure each board is sighted on the information specific to their organisation. In essence, one separate report should be completed for each individual Designated Body as registered with the General Medical Council.<br><br>Attached at Appendix 1 is the report due to be submitted on behalf of WUTH.<br><br>This template for an Annual Submission to NHS England Northwest is used as evidence for the Board of compliance with The Medical Profession (Responsible Officers) |

| | |
|---|---|
| | Regulations 2010 (as amended in 2013) or appended to own board report where a local template exists, to give clear guidance on the structure, roles and process to deliver an appraisal system which is quality assured and fit for revalidation.<br><br>Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service and training. Regular successful annual appraisal will provide the foundation stone upon which a positive affirmation of continued fitness to practice can be made every five years by the doctor's Responsible Officer to the General Medical Council.<br><br>For the individual, appraisal is based on the domains in "Good Medical Practice" (General Medical Council) [1]. This describes the standards of competence, care and conduct expected of doctors in all aspects of their professional work.<br><br>These seven domains are:<br>• good clinical care<br>• maintaining good medical practice<br>• teaching and training<br>• relationship with patients<br>• working with colleagues<br>• probity<br>• health<br>To be revalidated a doctor must collect a folder of supporting information, participate in annual appraisal in the workplace and collect independent feedback from colleagues and patients (where applicable). This multi-source feedback or 360 degree feedback must be completed at least once in a 5 year revalidation cycle. The doctor must declare all the roles they have and organisations they work in as the appraisal must cover all aspects of their work (Whole Practice Appraisal). Supporting information must be provided for all roles so that the appraiser can review this. This is the appraisal process which over a five year period will enable the Responsible Officer to make a positive recommendation of fitness to practise to the General Medical Council. |
| **1.2** | The statement of compliance should be signed off by the Chief Executive of the Designated Body's Board and submitted by 31st October 2026 |

| **2** | **Implications** |
|---|---|
| | **Patients**<br>A robust medical appraisal process supports patient care by ensuring doctors remain up to date, reflective, accountable, and committed to continuous improvement. This helps maintain high professional standards, enhances patient safety, and ultimately leads to better patient outcomes and higher-quality care. |
| **2.1** | **People**<br>The A&R Team provide leadership within the Trust regarding all aspects of medical appraisal, supporting the Responsible Officer to ensure all connected doctors are up to date and fit to practise. |
| **2.2** | **Finance** |

| | |
|---|---|
| | The appraisal process is supported by a team of trained medical appraisers who volunteer for this role alongside their substantive clinical responsibilities. This provides significant value to the Trust ensuring the delivery of a high-quality and effective appraisal service.<br>Investment in appraiser training is essential to recruit, develop and retain skilled medical appraisers. Maintaining a sufficient pool of trained appraisers supports consistently high appraisal completion rates, ensures compliance with core standards, and contributes to improved doctor engagement and professional development. |
| **2.3** | **Compliance**<br>The Responsible Officer has a statutory duty to ensure that the designated body has access to an adequate number of suitably trained appraisers to undertake annual medical appraisals for all doctors with a prescribed connection to the organisation. |

# 2025-2026 Annual Submission to NHS England Northwest: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England Northwest at england.nw.hlro@nhs.net by **30 October 2026.**

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

## 2025-2026 Annual Submission to NHS England North West:

### Appraisal, Revalidation and Medical Governance

Please complete the tables below:

| | |
|---|---|
| **Name of Organisation:** | Wirral University Teaching Hospital, NHS Foundation Trust. |
| **What type of services does your organisation provide?** | Wirral University Teaching Hospitals (WUTH) is a busy Acute NHS Foundation Trust. The Trust comprises of Arrowe Park and Clatterbridge Hospitals, and the Wirral Women and Children's Hospital. |

| | **Name** | **Email** |
|---|---|---|
| Responsible Officer | Dr Catherine Hayle | catherine.hayle@nhs.net<br>Direct dial: 0151 604 7710<br>Internal extension: 8912 |
| Chief Medical Officer & Deputy CEO | Dr Nikki Stevenson | n.stevenson2@nhs.net<br>0151 604 7710 |
| Medical Director | Dr Ranj Mehra | ranjeevmehra@nhs.net<br>Direct dial: 0151 604 7710<br>Internal extension: 8912 |
| Medical Appraisal Lead | Dr Paul Jeanrenaud | p.jeanrenaud@nhs.net<br>0151 678 5111<br>Internal extension: 8993 |
| Appraisal and Revalidation Manager | Cheryl Chaffe | cheryl.chaffe@nhs.net<br>Medical Appraisal & Revalidation Team.<br>Ext:2740<br>DD 0151 604 7461 |
| Additional Useful Contacts | Anita Kane | anitakane@nhs.net<br>Medical Appraisal Coordinator<br>Ext:8580<br>DD 0151 604 7461 |
| | | |

**Service Level Agreement**

Do you have a service level agreement for Responsible Officer services?

| |
|---|
| **Yes** |

If yes, who is this with?

| |
|---|
| Organisation: Dr Catherine Hayle is also Responsible Officer for Wirral Community Health & Care NHS Foundation Trust (WCHC) and Wirral Hospice, St John's. |
| Please describe arrangements for Responsible Officer to report to the Board:<br><br>RO Board reports are prepared each year, in collaboration with the respective Medical Directors of each Designated Body. Dr Hayle visits Wirral Hospice St John's regularly to meet with Dr Longford and review the Hospice's clinical governance processes. WUTH and WCHC are currently in the process of merging, and have a single Executive Team. |
| Date of last Responsible Officer Report to the Board: October 2025. |
| Action from last year: None required. |

# Annex A

## Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

### Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

### 1A – General

The board/executive management team of: Wirral University Teaching Hospitals NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | Ongoing engagement with RO Network events. |
| Comments: | Dr Hayle has accessed all necessary training and engages regularly with the Responsible Officers Network via NHS England Northwest. |
| Action for next year: | Ongoing engagement with RO Network events. |

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | To support the Responsible Officer, we have a well-resourced Appraisal & Revalidation Department, comprising the Medical Appraisal Lead, Appraisal & Revalidation Manager, 3 Senior Appraisers and an Appraisal Administrator. |
| Action for next year: | No action required this year. |

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | To continue to monitor agreed processes. |
| Comments: | The Trust Workforce Information Dept provides a monthly starter & leavers report taken from ESR to ensure accurate checks can be completed to validate connections.<br><br>With the above processes in place a SOP has been created for accurately managing connections, which are reviewed at least monthly.<br><br>This year we have introduced a full check following each resident doctor rotation, whereby we run a GMC connection report and compare this with an ESR report to identify any outliers. |
| Action for next year: | To continue to monitor agreed processes. No new action required. |

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | WUTH's Senior Medical Staff Appraisal Policy was updated, ratified, and approved in 2025. |

| | |
|---|---|
| | All appraisers and doctors were informed of the changes to the policy via email, and in-person updates at Appraiser Support Groups. The Medical Appraisal Lead presented the new policy to JLNC and sought feedback on proposed changes in advance.<br><br>A copy was emailed to all senior medical staff and uploaded on the Trust Intranet site, also under the resource section of L2P (our appraisal platform). The policy is regularly monitored for accuracy along with local processes and standard operating procedures (SOPs). |
| Action for next year | Policy review and update is planned for 2028/2029 appraisal year, and will undergo an interim update in 2026/7 following updated QA processes. |

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | We have been participating in a 3-way peer support process with Mid Cheshire Hospitals NHS Foundation Trust & Countess of Chester Hospital NHS Foundation Trust. This has recently extended to 4 Trusts with East Cheshire NHS Trust joining. We participated in self-assessments against the RO Regulations, identifying key themes with a commitment to challenge each other. We also share internal quality assurance/audit outcomes and useful SOPs or policies. During each meeting, interesting or challenging cases are presented for discussion and shared learning, and to promote consistency of approach between NHS organisations.<br>This year, the collaboration has enabled shared training with NHS Resolution (focused on responding to concerns), allowing us to share costs while fostering valuable, positive networking across our organisations. |
| Action for next year: | Encourage continued engagement to maximise these benefits and strengthen our collective learning. |

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | The A&R team will continue to work closely with the Medical Education Team to ensure all doctors are included in the appropriate appraisal system.<br><br>Review feedback from the jointly delivered education session on revalidation for our locally employed doctors, and consider any updates to the programme as required. |
| Comments: | The A&R Team has joined with the Medical Education Team to deliver a joint education session on revalidation for our locally-employed resident doctors (LEDs).<br>Resident doctors within WUTH participate in an annual local Annual Review of Competency Progression (ARCP) process. This includes review of consultant supervisor report, personal development plan, participation in CPD, reflection on clinical cases (including clinical incidents if applicable) and learning events attended, yearly multi-source feedback, participation in quality improvement and review of mandatory training. Additionally, if in revalidation year, a patient survey is carried out. LEDs receive induction through the Medical Education department and subsequent local departmental induction processes. |
| Action for next year | To keep working in close partnership. |

## 1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | The doctor must declare all the roles they have, and organisations they work within, as the appraisal must cover their whole scope of work (i.e., a whole practice appraisal).<br><br>Supporting information must be provided for all roles. Doctors should maintain an evidence log or portfolio relating to their whole scope of practice and use this to populate their appraisal documentation.<br><br>The A&R Team will upload WUTH risk management reports for each doctor. The report covers a two-year window detailing any reported incidents, complaints, and legal claims. Evidence for external roles must also be provided. If this is not included in appraisal documentation, the appraisal will be referred back to the doctor with a request to include this.<br><br>If a doctor has been involved in a clinical incident or received a complaint relating to their practice, they should provide a written reflection on this in advance of the appraisal meeting. If this is not done, a verbal reflection within the appraisal meeting must be carefully recorded by the appraiser.<br><br>Any doctor undergoing an MHPS investigation, GMC investigation, remediation process or participating in a grievance procedure will be asked to reflect on this in their appraisal. The appraisal also offers an important opportunity to ensure that doctors going through these stressful processes are provided with the appropriate level of support. |
| Action for next year: | Continue with current process. |

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | If the appraisal cannot go ahead within the timescales described in the Trust policy, the A&R Team are informed as soon as possible. The Medical Appraisal Lead will consider whether the appraisal month should be adjusted (due to exceptional circumstances), or whether an 'approved missed' appraisal should be recorded (e.g., due to sickness absence or maternity leave). Detailed records are kept by the A&R Team in relation to delayed and missed appraisals.<br><br>If it becomes apparent during the appraisal that there is a serious health, performance or conduct issue (not previously identified) that requires further investigation, the appraisal meeting is stopped. The appraiser confirms the reason why the meeting is being stopped, and that the matter will be referred to the CL, AMD or the RO immediately. The Medical Appraisal Lead or a Senior Appraiser may also be informed.<br><br>Maintaining the safety of patients, the doctor and other staff members is paramount. It is crucial that the doctor is provided with immediate support from their line manager (or other appropriate medical manager), a trusted colleague or mentor, and healthcare services as appropriate (including Occupational Health). |
| Action for next year: | No action required this year. |

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | Senior Medical Staff Appraisal - Policy Reference: 215<br>Ratified By: Joint Local Negotiating Committee, November 2025. |
| Action for next year: | Policy review and update planned for 2028/2029 appraisal year. |

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | To maintain delivery of Appraiser Training Workshops twice a year. |
| Comments: | WUTH has 80 trained medical appraisers. All appraisers attend a locally delivered one-day training course before they can appraise.<br><br>Training days are scheduled twice a year to ensure appraiser capacity is maintained. Each trained appraiser completes 4-6 appraisal per year. |
| Action for next year: | To maintain delivery of Appraiser Training Workshops twice a year.<br><br>The Trust will continue to invest in high-quality CPD opportunities to support Medical Appraisers in carrying out their responsibilities effectively. |

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | Training and Development: Provide regular training, quality CPD opportunities and updates for our Medical Appraisers. |
| Comments: | Wirral University Teaching Hospital NHS Foundation Trust (WUTH) has several quality assurance and performance measures in place to ensure high standards in appraisal and revalidation processes.<br>Appraisers' outputs are routinely reviewed by either a Senior Appraiser or the Medical Appraisal Lead. These reviews assess quality and ensure suitability for revalidation. Constructive feedback is provided where appropriate.<br><br>All appraisers receive an annual performance report. This documentation should be used as supporting evidence within the appraiser's own appraisal process.<br><br>Newly appointed appraisers undergo a face-to-face performance review with a senior appraiser after completing their first three appraisals. In addition, they are observed once by the Appraisal and Revalidation (A&R) Manager.<br><br>All appraisers are required to attend at least one of the two Appraiser Support Group (ASG) meetings held each year.<br><br>High-quality CPD is provided at least twice annually through the Trust's Appraiser Refresher Training days. Each session is delivered twice to maximise attendance, and all appraisers are encouraged to participate.<br><br>Attendance is monitored and referenced in appraisers annual feedback letters.<br><br>Additionally, appraisers will have an annual review of their appraisal write-up, which is benchmarked using a quality assurance tool. |
| Action for next year: | Continue to deliver a structured programme of training and development for Medical Appraisers, including regular updates, access to high-quality CPD opportunities, and tailored learning sessions to ensure consistency, compliance, and continuous improvement in appraisal practice. |

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | An annual report is presented at Trust Board each year, and progress is reviewed at the monthly Responsible Officer's meeting.<br><br>The annual NHS England Benchmarking report is presented to Workforce Steering Board with our Trust identification number to review our regional position. |
| Action for next year: | No action required this year. |

## 1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | GMC Connections are monitored regularly by the Trust's A&R Manager via GMC Connect.<br><br>Revalidation dates are also recorded on L2P and flag on the L2P dashboard via a traffic light system.<br><br>All doctors under notice of revalidation are discussed in the monthly RO Meeting as a standing agenda item.<br><br>Revalidation evidence is reviewed by the RO in advance of the submission date to ensure timely recommendations are submitted. Confirmation of the decision is recorded in writing by the RO. |
| Action for next year: | No action required this year. |

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | Revalidation evidence is reviewed by the RO in advance of submission date. If a deferral is suggested, reasons are recorded, and the doctor is invited to meet and discuss with the MAL prior to the recommendation being submitted. During this meeting an action plan will be put in place to support the doctor to take the appropriate action. |
| Action for next year: | No action required this year. |

## 1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | The Trust has established a mature and effective clinical governance framework that supports doctors to deliver safe, high-quality care and to continuously improve practice.<br><br>There is clear evidence of an embedded governance infrastructure, including a comprehensive annual clinical audit programmeand a well-utilised incident reporting system. The high rate of incident reporting but relatively low harm reflects a positive safety culture and strong staff engagement with governance processes.<br><br>Risk management arrangements are well developed, with an actively maintained Board Assurance Framework (BAF) that provides oversight of principal risks and ensures appropriate mitigation and escalation. Governance structures allow for regular review of risks, incidents, complaints, and learning, with clear routes for escalation to senior leadership and the Board.<br><br>There is strong organisational commitment to an open and learning culture. Freedom to Speak Up Guardians are established and accessible, and there is visible Board-level support for raising concerns, leadership development, and staff engagement. This contributes to an environment where doctors feel supported to speak up, and where learning from concerns is prioritised.<br><br>Overall, the Trust demonstrates an effective clinical governance environment characterised by strong leadership, clear systems and processes, and a culture that supports safety, learning, and continuous improvement. |
| Action for next year: | No action required this year. |

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

| | |
|---|---|
| Y/N | **Yes** |
| Action from last year: | None |
| Comments: | The Trust has a policy in place – the 'Procedure for handling concerns about the conduct, performance and health of medical and dental staff'. This implements the framework as set out in 'Maintaining High Professional Standards in the Modern NHS', issued under the direction of the Secretary of State for Health on 11 February 2005. This policy has been agreed between the Trust and the Local Negotiating Committee.<br><br>The Trust has a Responsible Officer Advisory Group (ROAG) which reports to the People Committee via the Head of HR. The statutory responsibilities remain with the Responsible Officer with regards to the Medical Workforce. This relates to the appraisal, revalidation, and fitness to practise concerns.<br><br>The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. The advisory group will support the role of the RO and provide the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to complex decision-making arising from appraisal, revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO.<br><br>The Responsible Officer Advisory Group will consider key items requiring decision-making to support the role of the RO, including:<br><br>Concerns regarding a doctor and the application of the Trusts MHPS or other, relevant policies, including but not limited to:<br>• Police investigations<br>• Safeguarding<br>• Behaviour/Conduct<br>• Fitness to practise<br>• Health matters<br>• Capability<br><br>The Appraisal and Revalidation Team are made aware of any concerns regarding an individual doctor during the monthly RO Meeting and they ensure that this is covered during their appraisal.<br><br>Furthermore, if required, a letter is sent from the RO requiring the individual to reflect on a specific incident or concern, this is uploaded on to their appraisal record in L2P. |

| | |
|---|---|
| Action for next year: | Continue with current process |

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | The A&R team populate L2P six weeks in advance of the appraisal month with relevant appraisal Trust reports; i.e. risk management and research reports. The appraisal platform is web-based and accessible to doctors to populate at any time. |
| Action for next year: | Continue with current process |

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | Review and publish the Medical Staff Remediation Policy |
| Comments: | Procedure for handling concerns about conduct, performance, and health of Medical and Dental staff – reviewed and up-dated 24th June 2022. Policy has been granted an extension until September 2026.<br><br>The Medical Staff Remediation Policy (Medical Staff) – was published in October 2025. Next review is due in June 2028. |
| Action for next year: | No action required this year. |

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | The Trust has the Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff in place which is currently being reviewed.<br><br>The policy sets out the role of the RO and the Responsible Officer Advisory Group who meet quarterly. The policy is consistent with the application of 'just culture principles'.<br><br>The number of cases was too small to support robust trend analysis. Nevertheless, we reviewed the type and outcome of concerns taking into consideration any protected characteristics. The information is also collected by Practitioner Performance Advice (PPA, part of NHS Resolution), which allows benchmarking between NHS Trusts. |
| Action for next year: | Consider recording the country of primary medical qualification on the relevant registers. |

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | Under WUTH Policy, information flows to support governance and Responsible Officer Statutory Function are facilitated by the A&R Team via the NHS Medical Practice Information Transfer form. There is an established and agreed process for handling both push and pull information flows between RO teams. |

| | |
|---|---|
| | A welcome letter is sent to all new doctors joining the Trust from the RO informing them of the specific responsibilities to obtain information about doctors taking up new posts and as such, the need to formally request confirmation of the following details from their previous Responsible Officer:<br>- Revalidation date<br>- The date of their last appraisal<br>- Any previous concerns that have now been resolved<br>- Any current investigation about your practice in progress<br>- Any current restrictions on practice<br>- Any unresolved actions/referrals in relation to the GMC |
| Action for next year: | No action required this year. |

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | None |
| Comments: | All serious concerns are raised with the RO as per the Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff Policy and discussed at the Responsible Officer Advisory Group (ROAG).<br><br>The Trust's Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff Policy was recently updated in June 2024 and is consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps.<br><br>Formal meetings are supported by HR who support management to ensure reasonable adjustment are in place as required, and help identify and remove barriers which may impact on engagement.<br>Policies and practices are also reviewed in line with current and emerging EDI challenges and risks.<br>All cases are discussed with a PPA advisor, who supports the RO to deliver a approach which would be consistent with that taken by other NHS Trusts. Complex cases are discussed (anonymously) at peer review meetings to allow shared learning and assess consistency of approach. |
| Action for next year: | Continue with current process. |

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

| | |
|---|---|
| Y/N | Yes |

| | |
|---|---|
| Action from last year: | No action required this year. |
| Comments: | WUTH has policies in place to ensure we are compliant with national guidelines. Regular Clinical Advisory Group that reviews latest guidance/ reports and incorporates learning into Trust policies and procedures. Annual appraisal for all doctors where CPD is reviewed and a PDP set for following year based on individual and organisational development needs.<br><br>There is clear evidence of an embedded governance infrastructure, including a comprehensive annual clinical audit programme, and a well-utilised incident reporting system. The high rate of incident reporting but relatively low harm reflects a positive safety culture and strong staff engagement with governance processes. |
| Action for next year: | No action required this year. |

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

| | |
|---|---|
| Action from last year: | Continue to follow the actions as set out in the People Strategy |
| Comments: | WUTH recognises the importance of an effective induction for all new employees into the Trust. A structured induction programme consisting of both Corporate and Local induction elements ensures that new employees receive the essential information they require to enable them to operate effectively as quickly as possible and in doing so ensures their safety, the safety of patients and minimises the risk to the organisation. Our Trust values and expected behaviours are emphasised throughout.<br><br>The Trust believes that harnessing the talents of our workforce is essential to providing the best care and being a great place to work.<br><br>Since the launch of our People Strategy in 2022 we have invested in talent management and development in a range of ways, all aligned to our Leadership for All principle. Leadership for All means that every member of staff in the Trust has the potential to develop and display the qualities that make great leaders at WUTH.<br><br>The Trust's Leadership Development programme is inspired the principles of 'Leadership for All' and aligned to our Leadership Qualities Framework (LQF) our leadership development programmes offer something for everyone.<br><br>• Leading Self Programme: Cultivate self-awareness, the cornerstone of effective leadership.<br>• Leading Team: Unite and inspire colleagues.<br>• Leading Service Programme: Elevate patient care with excellence.<br>• Leading Organisation Programme: Thinks strategically and act decisively.<br>• Leading System Programme: Collaborating for system transformation.<br>• Management Essentials: Foundation knowledge and skills for all managers.<br>• Leadership Master Class: Bitesize development opportunities from a diverse range of experts.<br><br>Good quality appraisal and check in conversations help our staff to identify development needs and aspirations. There is a huge offering that staff can choose from to meet their needs. Based on staff feedback, and in response to the findings in the 2022 staff survey, a collaborative team of people from different parts of the workforce came together and designed an approach to Appraisal |

| | |
|---|---|
| | and Management Supervision (Check In) that focusses on Contribution, Wellbeing and Development. The process is person centred, with lots of flexibility, enabling meaningful discussions about performance in the areas that most matter. The Trust is always striving to continuously improve our processes to ensure that they provide the most benefit for our staff. In 2025, following feedback from our staff, a collaborative approach was taken to streamline the documentation in relation to Appraisal and Check-in, involving a diverse team of people from across the Trust. Additional learning has been designed to support the quality of Appraisal and Check-in conversations, and an audit has been introduced to further identify and support improvements in both compliance and quality in this area.<br><br>The EDI strategic commitment has also been developed to ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported, and celebrated, as referenced further in this report under section 1F(ii).<br><br>As we continually strive to be a high performing Trust, we follow the NHS England, Executive Support Offer Guidance, for senior leadership onboarding and support. Exploring national onboarding resources that have been curated for newly appointed Chairs and Non-Executive Directors. These resources are designed to support senior leaders in developing leadership in a complex and changing landscape. |
| Action for next year: | No action required this year. |

## 1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

| | |
|---|---|
| Y/N | Yes |
| Action from last year: | To maintain compliance with the evolving legal and regulatory landscape |
| Comments: | To maintain compliance with the evolving legal and regulatory landscape, WUTH will: |

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| | Conduct periodic reviews of the Safe Recruitment and Selection Policy (392) and the Safe Employment Policy (136) to identify areas for improvement and ensure they reflect current best practices and legal requirements.<br><br>Legislative Updates: Monitor changes in employment legislation, NHS Employers guidelines, and other relevant regulatory updates. This proactive approach will ensure that any new legal requirements are promptly incorporated into the Trust's policies and procedures. This is monitored on a regular basis.<br><br>Stakeholder Involvement: Engage with key stakeholders, including HR personnel, legal advisors, and department managers, to gather insights and feedback on the effectiveness of current policies and identify any gaps or areas needing adjustment. The team actively seeks feedback from managers on their recruitment process and receive regular feedback from HR Personnel. Legal advice is requested where needed.<br><br>Training and Development: Provide regular training and updates for HR staff and managers involved in recruitment. This will ensure they are well-informed about any changes in legislation and understand how to implement new requirements effectively. – Recruitment partakes within three Trust training courses:<br>1. Managers Essentials – the team hold a 1-hour recruitment session for managers enrolled onto this course – programme is hosted by the OD team.<br>2. Safe Recruitment & Selection Training – managed and delivered by the recruitment team every quarter, this is a full one-day course.<br>3. Effective Recruitment – Managed and delivered by the recruitment team – bite sized recruitment sections for 1 hour every month focusing on a particular topic.<br>Effective Advertising and Attraction<br>Effective Shortlisting and interview<br>Effective Offer and Employment Checks |
| Action for next year: | No action required this year. |

## 1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

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| Y/N | Yes |
| Action from last year: | Consider whether the Medical Engagement Survey should be repeated |
| Comments: | The Trust attaches the greatest importance to the continuing education and training of its professional staff and values education as an integral part of delivering excellent care. The Trust has a study & professional leave policy for medical staff. There is a robust system in place across all specialties to manage requests for study & professional leave in line with Trust policy.<br><br>The Director of Education (DME) is supported by the deputy DME and three Clinical Tutors work alongside Educational Supervisors and Senior Clinicians, to ensure all training grade staff receive the support and guidance they require. Teaching sessions are run within the Education Centre, in addition to a full lunchtime teaching programmes open to all postgraduate trainees.<br><br>The Clinical Skills Lab offers dedicated training programmes to all trainees.<br><br>An OD Development Programme has been launched in 2024 which is available to all clinical leaders.<br><br>Training days have been scheduled covering the below topics.<br><br>• Essentials for Management<br>• Duty of a Doctor Programme<br><br>WUTH encourages a wide range of general and professional training opportunities for all our staff. As a Trust we want to make sure everyone has access to leadership development, so we have created a Leadership Qualities Framework (LQF). This Framework will provide the basis for our extensive development opportunities, not only for staff in management roles, but for all staff to be able to broaden their personal leadership skills or who aspire to progress into a management role. We want to nurture our future leaders and ensure we grow and support leadership talent.<br><br>WUTH Improvement launched as an approach to team-working for our Trust's ambitious programme of developing services, patient |

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| | experience, clinical quality, and ways of working. This project comprises of three teams handing different aspects of service transformation, quality improvement, efficiency and change projects across the Trust. |
| Action for next year: | No action required this year. |

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

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| Y/N | Yes |
| Action from last year: | Continue with current process |
| Comments: | A number of aspects are in place at WUTH including:<br><br>Trust core values are 'Caring for everyone', 'Respect for all', 'Embracing Teamwork' and 'Committed to Improvement'. These were developed following extensive engagement with staff across the organisation, with behavioural expectations of our staff, also developed and regularly promoted.<br><br>Trust core values are embedded in all aspects of the Trust, including recruitment and selection processes – with interview questions to be aligned to our values and behaviours<br><br>The Trust People Strategy 2022 – 2026 is underpinned by the Core values and NHS People Plan with equality, diversity and inclusion embedded as a golden thread. An EDI strategic commitment has also been developed to 'ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated'.<br><br>A leadership qualities framework has been developed which comprises of a suite of programmes aimed at leaders at all levels, 'leadership for all'. The framework focuses on key themes of supporting leaders to become 'compassionate and inclusive', 'self-aware', 'transformational', 'outcome focussed' and 'enabling people', to support and develop leaders in role modelling the required behaviours and supporting others to do the same. Dedicated EDI sessions are held on all leadership and management programmes, with an introduction to EDI also contained on our induction programme for all new starters.<br><br>A robust governance structure is in place for monitoring and reviewing progress of the EDI agenda and shaping the Trust's |

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| | future direction and key priorities. From a workforce perspective, this includes the EDI Steering Group that comprises of a range of key stakeholders to lead and shape the EDI agenda, with biannual EDI update reports shared with the group on a variety of key areas including national and statutory reporting regulations, Public Sector Equality Duty and activities to advance the EDI agenda at WUTH. The EDI Steering Group feeds into the Workforce Steering Board, with final assurance and oversight provided by the People Committee. Biannual reports are shared at Board meetings, with Board seminars held to focus on key areas of focus. Five staff networks are also currently in place, to allow additional opportunities for staff feedback to be shared as part of the EDI steering group. As part of the Trust's People Strategy, a focus was placed on supporting staff with disabilities and long-term conditions for 2023-24. As such, an additional Action on Disability Task and Finish group was established, and also reported progress into the EDI Steering Group.<br><br>From a patient perspective, EDI is also integrated within the Trust's Patient Experience Strategy, with inclusion identified as one of its main pillars. As part of this strategy, a number of task and finish groups have been established to focus on key priorities, all feeding into an Inclusive Promise Group. This group is accountable to the Patient and Family Experience Group which reports into a wider Patient Safety and Quality Board and is included as part of the biannual EDI update to Board.<br><br>An Annual EDI calendar of events is maintained with regular Trust-wide promotion of information, support, activities and events.<br><br>Staff experiences are also monitored via the annual staff survey and quarterly pulse surveys and as part of a range of engagement and feedback events held across the Trust.<br><br>A new staff engagement framework has been developed, with enhancements made in our staff recognition schemes. Compassion, respect diversity and inclusion have been integrated as part of the criteria for our annual awards, with a new dedicated EDI award category introduced this year. A new monthly staff recognition scheme has also been launched, with areas also included as part of the criteria.<br><br>All staff must also complete their mandatory training module on equality and diversity, with compliance monitored and currently achieving compliance. |
| Action for next year: | No action required this year. |

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

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| Y/N | Yes |
| Action from last year: | Continue with current process |
| Comments: | At WUTH, we are committed to achieving the highest possible standards of service for the benefit of our patients and staff. However, when standards are met, we expect staff to be able to raise concerns.<br><br>We are supportive of colleagues who have concerns regarding possible dangers, risks, wrongdoing, or malpractice in the workplace. Therefore, we promote an open and transparent culture which encourages staff to act promptly, and report concerns appropriately.<br><br>We have a number of support mechanisms for staff who would want to raise a concern, all of which are outlined in the Trusts Raising Concerns Policy. This policy is for all staff. The NHS People Promise commits to ensuring that 'we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words.'<br><br>Trust employees are required to complete the eLearning modules on speaking up, which can be found within their electronic staff record (ESR).<br><br>In relation to our Freedom to Speak Up (FTSU) processes:<br>• The Trust has a Lead FTSU Guardian with a network of FTSU champions in place.<br>• A tracking system is in operation by the Lead FTSU Guardian who monitors a range of elements, including the number and themes of people speaking up, occupational groups, demographics and whether there are patient safety concerns, elements of bullying, harassment or abuse and whether staff have suffered detriment because of speaking up. This data is monitored regularly for themes and trends and forms part of a lessons learned forum, where data is triangulated with other sources to identify wider areas of learning or intervention needed.<br>• Biannual FTSU reports are produced and shared as part of the Workforce Governance structure. This includes presentation by the FTSU Guardian at Workforce Steering Board, People Committee and at Board. |

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| | • Regular meetings are held with the FTSU Guardian and both Executive and non-Executive FTSU Leads to review the FTSU agenda and further actions needed.<br>• All staff must complete mandatory training that encompasses Duty of Candour along with role essential sessions on the FTSU agenda. WUTH have integrated the national learning package as part of our role essential training matrix with compliance continuing to increase.<br>• The Lead FTSU Guardian delivers dedicated speak up sessions from induction of new recruits (including resident doctors) and on all leadership and management programmes.<br>• Staff experience data is regularly reviewed, with annual staff survey data and quarterly pulse survey information reviewed and themes identified and triangulation of key areas of focus.<br>• Regular walkabouts are undertaken by Lead FTSU Guardian and support within departments / service areas as necessary to promote speaking up.<br><br>The Lead FTSU Guardian is a member of the regional and National Guardians Office forum and submits quarterly data for national review as part of agreed reporting requirements. |
| Action for next year: | No action required this year. |

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

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| Y/N | Yes |
| Action from last year: | None |
| Comments: | All doctors are invited to provide formal structured feedback at the conclusion of the appraisal process. This is collated, and anonymised data is provided to appraisers at the end of the appraisal year. If any significant issues were raised in this way, the A&R Team would take appropriate action at the time. The mechanism for raising concerns about the appraisal process is described within the 'Senior Medical Staff Appraisal Policy'.<br><br>The 'Fairness at Work Policy' applies to all staff employed by WUTH, including connected doctors. This provides a clear mechanism for raising such issues.<br><br>All doctors being investigated under the 'Procedure for Handling Concerns about the Conduct, Performance, or Heath of Medical |

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| | and Dental Staff' are given the name of a Non-Executive Director to whom they can escalate concerns or delays. |
| Action for next year: | No action required this year. |

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

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| Y/N | Yes |
| Action from last year: | None |
| Comments: | A disciplinary register is kept of all cases. The register logs the nature of allegation, the case manager, names of investigators, welfare and support contact, a record of the case progress and outcome along with the ED&I information.<br><br>The country of primary medical qualification is not currently reported via the disciplinary register however this information can be provided if required as it can be obtained from the GMC register.<br><br>All concerns are discussed at ROAG, to ensure a consistent and fair approach across the organisation. In addition, the RO discusses any concerns which may result in a disciplinary process with a Practitioner Performance Advice (PPA) advisor, who supports the RO in ensuring a consistent approach across the NHS. |
| Action for next year: | No action required this year. |

**1G – Calibration and networking**

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

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| Y/N | Yes |
| Action from last year: | Ongoing attendance at regional meetings, working closely with our neighboring Trusts and sharing best practice. |
| Comments: | We have formed close links within our peer support group of Countess of Chester Hospital NHS Foundation Trust, Mid Cheshire & East Cheshire NHS Trusts. |

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| | We routinely complete a review of our departmental processes against the Framework of Quality Assurance for Responsible Officer Regulations.<br><br>NHS England Northwest RO Network events are regularly attended by the RO, MAL & A&R Manager.<br><br>The Medical Appraisal Lead has joined the regional MAL Network group and feeds back to the A&R Manager important updates or interesting discussion topics following these meetings.<br><br>The A&R Manager is a member of the regional A&R Network group. The group meets four times a year for 2-3 hours at various locations/via teams. Members are required to attend at least two meetings per year.<br><br>The role of the ARM and MAL network groups are to act as a forum to discuss issues surrounding medical appraisal and revalidation for doctors working in any healthcare environment in the region to encourage consistency in approach.<br><br>To foster and assist NHS England and the GMC's work in relation to Medical Appraisal and Revalidation compliance and quality improvement.<br><br>Feedback is provided at the monthly departmental meeting and issues to note or updates following the meeting. |
| Action for next year: | Ongoing attendance. |

## Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

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| The number of doctors with a prescribed connection to the designated body on the last day of the year under review | 516 |
| Total number of appraisals completed.<br><br>*NB: The number of doctors with a prescribed connection to the designated body on the last day of the year under review may not directly correlate with reported figures in this section, as agile resident doctors employed on local contracts may have joined or left the organisation on 31 March.*<br>f | **Total 501**<br>**380** consultants, SAS doctors, post-CCT fellows and locum consultants within the appraisal process<br><br>**121** Resident doctors with the local ARCP process. Resident doctors are overseen by the Director of Medical Education (DME) and Deputy DME who hold an ARCP each June for these doctors. |
| Total number of appraisals approved missed<br><br>*Approved missed are due to maternity leave or long-term sickness.* | 10 |
| Total number of unapproved missed<br><br>*Appraisal delayed into next appraisal year following miss communication between doctor & appraiser. This was an isolated case which has been resolved.* | 1 |
| The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle | 51 |

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| Total number of late recommendations | 0 |
| Total number of positive recommendations | 45 |
| Total number of deferrals made<br><br>*Insufficient evidence or ongoing process reasons.* | 6 |
| Total number of non-engagement referrals | 0 |
| Total number of doctors who did not revalidate | 6 |
| Total number of trained case investigators | 16 |
| Total number of trained case managers<br><br>*Case Manager training has been booked with NHS Resolution for November 2026 to increase this number.* | 10 |
| Total number of concerns received by the Responsible Officer[2]<br><br>*The RO meets regularly with the GMC ELA to discuss all concerns.* | 4 |
| Total number of concerns processes completed | 1 |
| Longest duration of concerns process of those open on 31 March (working days) This is not correct. Who provided this information? There is one case which must be at least 90 days more than that. | 364 |
| Median duration of concerns processes closed (working days)[3] | 211 |
| Total number of doctors excluded/suspended during the period | 0 |
| Total number of doctors referred to GMC | 0 |
| Total number of appeals against the designated body's professional standards processes made by doctors | 0 |
| Total number of these appeals that were upheld | 0 |
| Total number of new doctors joining the organisation | 145 |
| Total number of new employment checks completed before commencement of employment. | 140 |

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

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| *4 started pending pre-employment checks who had undergone a risk assessment to commence in post prior to checks being completed.*<br><br>*1 started in post prior to checks being completed and no risk assessment. The recruitment team submitted an incident to enable an internal review and identification of any lessons learned. Managers are notified when an incident is raised and are encouraged to attend one of the effective recruitment training sessions delivered throughout the year. These workshops are designed to improve understanding of safe recruitment requirements and promote best practice.* | |
| Total number claims made to employment tribunals by doctors | 0 |
| Total number of these claims that were not upheld[4] | N/A |

## Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

| General review of actions since last Board report |
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| Strong performance has been maintained across the RO function since the past Board Report. Our focus during the year ahead will be on continuing to maintain this position while we merge with WCHC to form one larger designated body with a single People function. |
| Actions still outstanding |
| The only action not achieved during the year was the completion of the Medical Engagement Survey. Further consideration will be given to this for the year ahead. |
| Current issues |
| **Preparing for Our Next Strategic Cycle: Our Joint Strategy 2026–2032**<br><br>As the five-year 2021–2026 strategy concludes, we move into the next phase of our strategic journey with the development of Our Joint Strategy 2026–2032, created in partnership with Wirral Community Health and Care NHS Foundation Trust. This shared strategy sets the direction for both organisations as we come together to form a single, integrated organisation for Wirral.<br><br>It represents a major step towards delivering more coordinated, sustainable, and seamless care across acute and community services, building on the strong foundations that will support our strategic journey. |

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

| Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1): |
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| • Senior Medical Appraisal policy review scheduled for 2028/2029 appraisal year but will undergo an interim update in 2026/7 following updated QA processes.<br>• Consider appropriate timing/value of Medical Engagement Survey<br>• Continue to follow the actions as set out in the People Strategy<br>• Ongoing attendance at RO Networks<br>• Maintain our strong position across the RO function as we merge with WCHC to form a single designated body. |

| Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year): |
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| Good progress has been made against the actions identified for the previous reporting period. Appraisal compliance has remained consistently high. Recruitment and retention of medical appraisers has been successful, ensuring continued capacity and resilience within the appraisal process.<br><br>This year we have introduced a new QA tool which came into effect April 2026.<br><br>• Appraisal will be reviewed regularly using this guide.<br>• Importantly, this will review the entire appraisal - not just the output summary page. If the information required is present in the folder by appraiser of the doctor being appraised, it will be marked as complete.<br>• Total score is out of 20<br>• Score >16 means no issues and that appraiser will not be sampled again for next 2 years.<br>• <16. Advice and guidance will be provided on how to complete an appraisal write up.<br><br>In the year ahead we will continue to actively participate in the expanding peer support network with Countess of Chester Hospital NHS Foundation Trust, Mid and East Cheshire NHS Trusts, strengthening collaborative working across the Trusts.<br><br>We will build on the success of collaborative training opportunities and cost-sharing arrangements, to maximise value, enhance professional networks, and support continuous improvement. NHS Resolution have provided Case Investigator Training in May 2026 and will Provide Case Manager training in November 2026.<br><br>Continue to explore affordable and relevant training opportunities for WUTH's medical appraisers, enabling them to maintain up-to-date knowledge, develop their skills, and support high-quality appraisals for our doctors.<br><br>This year, we have refreshed and successfully relaunched our Medical Mentorship Programme, including providing formal training to a new cohort of mentors. The programme offers significant benefits for new doctors by helping them build confidence, navigate challenges of a new role, and fulfil their potential. At the same time, our mentors gain valuable experience, enhance their leadership and coaching skills, and support their own professional development through the mentoring process.<br><br>Maintaining these high standards will remain a key priority for the year ahead. |

**Section 4 – Statement of Compliance**

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

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| Official name of the designated body: | |

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| Name: | |
| Role: | |
| Signed: | |
| Date: | |

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| Name of the person completing this form: | |
| Email address: | |